House of Lords
House of Commons
Joint Committee on the Draft
Mental Health Bill

Draft Mental Health
Bill

Session 2004-05

Volume II

Oral and written evidence

Ordered by The House of Lords
to be printed Wednesday 9 March 2005
Ordered by The House of Commons
to be printed Wednesday 9 March 2005
The Joint Committee on the Draft Mental Health Bill

The Joint Committee on the Draft Mental Health Bill was appointed by the House of Commons and the House of Lords on 22 July 2004 to examine the draft Mental Health Bill and report to both Houses by 31 March 2005.

Membership

Lord Carlile of Berriew (Lib Dem) (Chairman)

Liz Blackman (Labour) Erewash
Mrs Angela Browning (Conservative) Tiverton and Honiton
Mr David Hinchliffe (Labour) Wakefield
Mr George Howarth (Labour) Knowsley North and Sefton East
Tim Loughton (Conservative) East Worthing and Shoreham
Mr Paul Marsden (Lib Dem) Shrewsbury and Atcham
Laura Moffatt (Labour) Crawley
Ms Meg Munn (Labour) Sheffield Heeley
Dr Doug Naysmith (Labour) Bristol North West
Mr Gwyn Prosser (Labour) Dover
Dr Howard Stoate (Labour) Dartford
Hywel Williams (Plaid Cymru) Caernafon

Baroness Barker (Lib Dem)
Lord Carter (Labour)
Baroness Cumberlege (Conservative)
Baroness Eccles of Moulton (Conservative)
Baroness Finlay of Llandaff (Cross Bench)
Baroness Flather (Conservative) (Discharged 29 November 2004)
Baroness Fookes (Conservative) (Discharged 14 September 2004)
Lord Mayhew of Twysden (Conservative) (Appointed 14 September 2004)
Baroness McIntosh of Hudnall (Labour)
Baroness Murphy (Cross Bench) (Appointed 29 November 2004)
Baroness Pitkeathley (Labour)
Lord Rix (Cross Bench)
Lord Turnberg (Labour)

Powers

The Committee has the power to require the submission of written evidence and documents, to examine witnesses, to meet away from Westminster, to meet at any time (except when Parliament is prorogued or dissolved), to appoint specialist advisers, and to make Reports to the two Houses.

Publication

The Report and evidence of the Joint Committee are published by The Stationery Office by Order of the two Houses. All publications of the Joint Committee (including press notices) are on the Internet at:

www.parliament.uk/parliamentary_committees/jcdmhb.cfm
Committee staff

The staff of the Joint Committee were drawn from both Houses and comprised Glenn McKee (Commons Clerk), Chloe Mawson (Lords Clerk), Annette Toft (Inquiry Manager), Manjit Gheera (Legal Adviser), Alison Mara (Committee Assistant), Richard Dawson (Committee Assistant), Lisette Pelletier (Team Manager), Jonathan Coe (Senior Office Clerk), Tes Stranger (Senior Office Clerk), and George Fleck (Office Support Assistant). This inquiry was run from the Scrutiny Unit in the Committee Office, House of Commons.

Contacts

All correspondence should be addressed to the Clerk of the Joint Committee, House of Commons, 7 Millbank London SW1P 3JA. The telephone number for general enquiries is 020 7219 8363 the Joint Committee’s email address is scrutiny@parliament.uk.
Witnesses

Wednesday 20 October 2004

Professor Genevra Richardson, Professor of Law, Queen Mary University of London

Professor Kamlesh Patel OBE, Chairman of the Mental Health Act Commission and Mr Christopher Heginbotham, Chief Executive of the Mental Health Act Commission

Wednesday 27 October 2004

Dr Tony Zigmond, Vice-President, Professor Sue Bailey, Chair, Faculty of Child and Adolescent Psychiatry, Professor Greg O’Brien, Chair, Faculty of the Psychiatry of Learning Disability, Dr John O’Grady, Chair, Faculty of Forensic Psychiatry, Royal College of Psychiatrists

Mr Yens Marsen-Luther, Chief Executive Officer, Ms Jennifer Scudamore, Chairman, Mr Guy Davis, Honorary Treasurer, Miss Melanie Woodcock, North Thames Regional Group Chair, Institute of Mental Health Act Practitioners

Wednesday 3 November 2004

Mr Paul Farmer, Director Public Affairs, Rethink, Chair of the Mental Health Alliance; Dr Rowena Daw, Head of Policy Development, Mind, Chair of the Mental Health Alliance Policy Group; Dr Mike Shooter, President, Royal College of Psychiatrists, and Mr Graham Estop, Voices Forum

Ms Lucy Scott-Moncrieff, Joint Chair of the Mental Health and Disability Committee, Law Society, Mr Tim Spencer-Lane, Policy Adviser to the Mental Health and Disability Committee, Law Society; Mr Paul Bowen, Barrister, and Ms Aswini Weereratne, Barrister, Bar Council

Wednesday 10 November 2004

Mr Richard Brook, Chief Executive Officer, Mind, Ms Kay Sheldon, representative of Mindlink, Mind’s service user Network, Ms Lindsay Foyster, Director, Mind Cymru, Dr Anneke Westra and Mr Roger Keeling, No Force

Mr Cliff Prior, Chief Executive Officer, Mr Mike Took, Service User and National Policy Officer, Ms Elaine Barnes, Carer, Ms Mary Teasdale, Advice Service Manager, Rethink, Ms Jo Roberts, Service User, and Ms Vicky Yates, Carer, Hafal
Wednesday 17 November 2004

Ms Angela Greatley, Chief Executive and Mr Malcolm King, Programme Leader, Sainsbury Centre for Mental Health, Mr Niall Dickson, Chief Executive, and Mr Simon Lawton-Smith, Senior Policy Adviser, Mental Health, King’s Fund

Mr David Hewitt and Ms Lucy Scott-Moncrieff, solicitors

Mr David Congdon, Head of External Affairs, Mencap; Mr Richard Kramer, Director of Policy, Turning Point and Co-Chair Making Decisions Alliance; Mr Jonathan Coe, Chief Executive, POPAN (Prevention of Professional Abuse Network), and Ms Henrietta Marriage, Head of Mind Legal Unit (Making Decisions Alliance)

Wednesday 1 December 2004

Dr Brian Jacobs, Child Psychiatrist, and Dr Patrick Byrne, Adolescent Psychiatrist, South London and Maudsley NHS Trust

Mr Gavin Baylis, Senior Policy Officer, Mr Gul Y Davis, YoungMinds, Ms Nancy Kelly, Principal Policy Officer, Barnardo’s, Ms Christine Daly, Social Policy Adviser, Children’s Legal Centre

Wednesday 8 December 2004

Professor Nigel Eastman, Professor of Law and Ethics in Psychiatry, University of London and Head of Forensic and Personal Disorder Psychiatry, St George’s Hospital Medical School, London, Professor Tony Maden, Professor of Forensic Psychiatry, Imperial College, London, Honorary Consultant, West London Mental Health NHS Trust and Lead Clinician Dangerous Severe Personality Disorder Service, Broadmoor Hospital

Ms Jayne Zito, Patron, Mr Michael Howlett, Director, the Zito Trust, Mr Nick O’Shea, Director of Development, Revolving Doors Agency, Ms Ethel Samkange, Director of Link Worker Schemes, Revolving Doors Agency, Ms Sue Kesteven, Policy Development Manager, and Ms Lucy Smith, Research and Information Officer, Nacro
Wednesday 15 December 2004

Ms Jane Hutt AM, Minister for Health and Social Services, Welsh Assembly Government  
Mr David Melding AM, Chairman of the Health and Social Services Committee of the National Assembly for Wales, Ms Kirsty Williams AM, Health Spokesperson for the Liberal Democrats, Mr Rhodri Glyn Thomas AM, Health Spokesperson for Plaid Cymru, National Assembly for Wales  
Ms Mag Richards, Development Worker, Powys Agency for Mental Health, and Ms Celia Cowie, Development Worker, Powys Agency for Mental Health  
Mr Prys Davies, Director of Strategic Operations and Mr Andrew White, Leader of the Health and Care Unit, Welsh Language Board

Wednesday 12 January 2005 (morning)

Dr Patrick Power, Lead Consultant Psychiatrist and Honorary Lecturer at the South London and Maudsley NHS Trust  
Mr Colin McKay, Scottish Executive, formerly Leader of the Mental Health Bill Team; Mr Colin Faulkner, Scottish Executive, Policy Officer working on implementation of the new Scottish Mental Health Act, Ms Fiona Tyrrell, Scottish Executive, Implementation Team Leader, Mental Health Act, and Dr Madeline Osborne, Deputy Director of the Mental Welfare Commission for Scotland

Wednesday 12 January 2005 (afternoon)

His Honour Judge Phillip Sycamore, Liaison Judge for Mental Health Review Tribunals, Mrs Carolyn Kirby, Regional Chairman, Mental Health Review Tribunals for Wales, Rt Hon Lord Newton of Braintree OBE, Chairman of the Council on Tribunals, and Ms Penny Letts, member of the Council on Tribunals  
Mrs Paula Hallam, Strategic Service Manager for Mental Health, Hampshire County Council, Ms Jenny Goodall, Director of Social Services, London Borough of Brent, both on behalf of the Association of Directors of Social Services, Cllr Maureen Robinson, New Forest District Council, Local Government Association; Mr Martyn Ayre, Head of Policy (Adult Services), Mr Don McLeod, Strategic Policy and Performance Manager, Kent County Council
Wednesday 12 January 2005 (afternoon) (continued)

Mr Nigel Edwards, Director of Policy, NHS Confederation, Mr Jeremy Taylor, Chief Executive, Nottinghamshire Healthcare NHS Trust, Ms Mel Wilkinson, MHA/CPA Advisor, and Mr Nigel Maguire, Director, Tees and Northeast Yorkshire NHS Trust, Dr Tim Bullock, Associate Medical Director, and Mr Kevin Towers, Patient Services Manager, West London Mental Health Trust

Wednesday 19 January 2005

Ms Rosie Winterton MP, Minister of State, Department of Health, Paul Goggins MP, Parliamentary Under-Secretary of State, Home Office, Professor Louis Appleby, Mental Health Clinical Director, Mr Adrian Sieff, Head of the Mental Health Legislation Branch, Department of Health, and Mr Nigel Shackleford, Deputy Head of the Mental Health Unit, Home Office.

Wednesday 26 January 2005 (morning)

Lord Adebowale, Chief Executive, and Mr Ronnie Watson, Mental Health Act Coordinator, Turning Point, Dr Joanna Bennett, Workforce Development Manager, Breaking the Circles of Fear Project, Mr Chinyere Inyama, Mental Health Lawyer, and Mr Nisar Khan, mental health voluntary worker and service user, BME Mental Health Network

Mr Richard Mills, Director of Research, and Dr Juli Crocombe, Consultant Psychiatrist of Care Principles, National Autistic Society

Mr Clive Evers, Director of Information and Education and Professor Clive Ballard, Director of Research, The Alzheimer’s Society

Wednesday 26 January 2005 (afternoon)

Mr Roger Hargreaves, Chair, Mental Health Special Interest Group, Ms Hazelanne Lewis, Member of the Mental Health Special Interest Group, British Association of Social Workers, Mr Ian Hulatt, Adviser, Royal College of Nursing, Ms Gail Adams, Head of Nursing, and Mr Owen Davies, Senior National Officer, Local Government, UNISON

Dr David Harper, Senior Lecturer in Clinical Psychology, University of East London, Professor Peter Kinderman, Professor of Clinical Psychology, University of Liverpool, Ms Sue Ledwith, Consultant Clinical Psychologist and Clinical Lead, North Yorkshire Forensic Psychiatry Service, Dr Graham E Powell, President Elect, British Psychological Society
Wednesday 2 February 2005 (morning)

Ms Imelda Redmond, Chief Executive, and Mr Mark Robertson, Public Affairs Manager, Carers UK, Dr Gwen Wallace, Chair, and Mrs Linda Lansdell, Forum Committee Member, North Derbyshire Forum for Mental Health Carers

Mr Rick Henderson, Director, and Ms Karen Mellanby, Policy and Communications Manager, Action for Advocacy, Ms Hilary Dyter, Director, Leeds Mental Health Advocacy Group and member of the Association for Mental Health Advocates Steering Committee, Mr Jonathan Coe, Chair of AMHA Steering Committee, Chief Executive of POPAN (Prevention Of Professional Abuse Network) and Chair, Mental Health Alliance Advocacy Special Interests Group, Mr Peter Munn, Secretary, Cymar, and Ms Beverly Mills, Member, Management Committee, United Kingdom Advocacy Network (UKAN).

Wednesday 2 February 2005 (afternoon)

Mr Mike Firn, Chairperson, Mr Michael Hicks, Northern and Yorkshire, Ms Judith Fairweather, London area, National Forum for Assertive Outreach

Dr Peter Bartlett, Senior Lecturer in Law at the University of Nottingham, and Professor Graham Thornicroft, Professor of Community Psychiatry at the Institute of Psychiatry, King’s College London, and Director of Research and Development of the South London and Maudsley NHS Trust

Dr Michael Wilks, Chair, Ethics Committee, Dr JS Bamrah, Chair, Psychiatric Sub-Committee, Dr Robin Arnold, Member, Psychiatric Sub-Committee, British Medical Association, Professor Andre Tylee, and Dr Alan Cohen, Royal College of General Practitioners.
List of written evidence

Volume II

Professor Genevra Richardson (DMH 378) (DMH 408) Ev 9, Ev 12
Mental Health Act Commission (DMH 20) (DMH 90) Ev 13, Ev 48
Royal College of Psychiatrists (DMH 24) (DMH 61) (DMH 330)
(DMH 381) (427) Ev 50, Ev 76, Ev 79, Ev 88, Ev 90
Institute of Mental Health Act Practitioners (IMHAP) (DMH 50) (DMH 410) Ev 92, Ev 113
Mental Health Alliance (DMH 105) (DMH 382) Ev 119, Ev 164
Law Society (DMH 111) Ev 165
Law Reform Committee of the Bar Council (DMH 191) Ev 175
Mind (DMH 210) (DMH 400) Ev 189, Ev 228
No Force Campaign (DMH 44) Ev 210
Ms Kay Sheldon (DMH 377) Ev 226
Rethink (DMH 192) Ev 230
Hafal (DMH 161) (DMH 413) (DMH 414) Ev 244, Ev 256, Ev 257
Sainsbury Centre for Mental Health (DMH 107) (DMH 394) Ev 259, Ev 273
King’s Fund (DMH 269) (DMH 448) Ev 263, Ev 274
Mr David Hewitt (DMH 21) Ev 279
Lucy Scott-Moncrieff (DMH 304) Ev 282
Making Decisions Alliance (DMH 230) Ev 297
Mencap (DMH 268) Ev 299
YoungMinds (DMH 64) Ev 316
Children’s Legal Centre and the National Children’s Bureau (DMH 194) Ev 319
Barnardo’s (DMH 315) (DMH 419) Ev 321, Ev 331
Revolving Doors Agency (DMH 324) Ev 348
Zito Trust (DMH 174) Ev 350
Nacro (DMH 156) Ev 352
Ms Jane Hutt AM, Minister for Health and Social Services, Welsh Assembly Government (DMH 312) Ev 371
Health and Social Services Committee, National Assembly for Wales (DMH 389) Ev 380
Powys Agency for Mental Health (DMH 181) Ev 389
Welsh Language Board (DMH 310) Ev 395
Scottish Deputy Minister for Health Services and Community Care (DMH 393) Ev 410
Professor Jeremy Cooper, Mrs Carolyn Kirby, His Honour Judge Phillip Sycamore and Mr John Wright (DMH 200) (DMH 444) Ev 426, Ev 440
Council on Tribunals (DMH 305) Ev 429
Association of Directors of Social Services (ADSS) and the Local Government Association (LGA) (DMH 208) Ev 444
Kent County Council (DMH 217) Ev 448
NHS Confederation (DMH 283) Ev 456
Tees and North East Yorkshire NHS Trust (DMH 196) Ev 460
West London Mental Health NHS Trust (DMH 243) Ev 464
Ms Rosie Winterton MP, Minister of State, Department of Health (DMH 396)
(DMH 405) (DMH 429) Ev 473, Ev 507, Ev 525
Department of Health (DMH 404) (DMH 428) (DMH 439) Ev 475, Ev 524, Ev 530
Home Office (DMH 434) Ev 531
Turning Point (DMH 162) (DMH 438) Ev 534, Ev 551
National Black and Minority Ethnic Mental Health Network (DMH 241)
(DMH 445) Ev 541, Ev 554
Mr Nisar Khan (DMH 435) Ev 552
National Autistic Society (DMH 271) Ev 563
Alzheimer's Society (DMH 242) Ev 570
British Association of Social Workers (DMH 60) (DMH 433) Ev 577, Ev 595
Royal College of Nursing of the United Kingdom (DMH 301) Ev 581
UNISON (DMH 328) (DMH 415) Ev 584, Ev 586
British Psychological Society (DMH 19) (DMH 402) (DMH 431) Ev 596, Ev 602, Ev 605
Carers UK (DMH 193) Ev 609
North Derbyshire Forum for Mental Health Carers (DMH 259) (DMH 442) Ev 613, Ev 623
Action for Advocacy (DMH 46) Ev 625
Association for Mental Health Advocates (DMH 267) Ev 629
Cymar (DMH 45) Ev 640
UK Advocacy Network (UKAN) (DMH 227) Ev 641
Cymar and UKAN (DMH 436) Ev 649
National Forum for Assertive Outreach (DMH 406) Ev 651
Dr Peter Bartlett (DMH 418) Ev 659
Professor Graham Thornicroft (DMH 420) Ev 661
British Medical Association (DMH 248) (DMH 446) Ev 684, Ev 700
Royal College of General Practitioners (DMH 222) Ev 691
Oral evidence

Taken before the Joint Committee on the Draft Mental Health Bill

on Wednesday 20 October 2004

Members present:

Barker, B
Carlile of Berriew, L (Chairman)
Carter, L
Cumberlege, B
Eccles of Moulton, B
Finlay of Llandaff, B
McIntosh of Hudnall, B
Pitkeathley, B
Rix, L
Turnberg, L
Mrs Liz Blackman
Mrs Angela Browning
Mr George Howarth
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Mr Gwyn Prosser
Dr Howard Stoate
Hywel Williams

Witness: Professor Genevra Richardson, Professor of Law, Queen Mary University of London, examined.

Chairman: Good morning, Professor Richardson. So far I have only told the clerks how long you and I have known one another. It is a pleasure to see you here. I am afraid we are going to have to do a little bit of formal business in public session first which is the declaration of Members’ interests, so would you bear with us while we do that because it has to be done in public session. I will start. I am Alex Carlile, Chairman of the Committee. My interests are as declared in the Register. In particular though, I should mention that I am the Vice Chairman of a small mental health charity founded in mid-Wales called “Rekindle”, and I also have family experience of mental illness in my own family.

Baroness Pitkeathley: I am Jill Pitkeathley and my interests are as in the Register, though I should perhaps particularly draw your attention to my experience and interests in carers’ issues.

Dr Naysmith: I am Doug Naysmith. I have no relevant interests to declare.

Baroness McIntosh of Hudnall: I am Jenny McIntosh. My interests are in the Register are none of them is relevant to this inquiry, but I do have a personal interest in mental health issues.

Lord Turnberg: I am Leslie Turnberg. My interests are in the Register, but, in particular, I am Scientific Adviser to the Association of Medical Research Charities, and I am Vice President of the Academy of Medical Sciences, and a retired physician.

Mr Prosser: I am Gwyn Prosser. I have got no interest other than the declaration in the Register.

Baroness Cumberlege: I am Julia Cumberlege and my interests are in the Register, but I also chair the Council of St George’s Hospital Medical School. I am a council member of Sussex University and a senior associate of the King’s Fund and also run my own company, Cumberlege Connections.

Dr Stoate: I am Dr Howard Stoate. My interests are as in the Register. My only relevant interest in this Committee is that I am a practising GP and, therefore, actually treat people with mental health problems on a week-to-week basis.

Lord Rix: I am Brian Rix. My interests are as on the Register. I am President of the Royal Mencap Society.

Lord Carter: I am Lord Carter. My interests are declared in the Register.

Baroness Finlay of Llandaff: I am Ilora Finlay. My interests are declared in the Register and I am a practising palliative medicine physician.

Ms Munn: I am Meg Munn. My interests are declared in the Register, with no particular relevant interest.

Mrs Browning: I am Angela Browning. My interests are declared in the Register and I am the carer of an adult with an autistic spectrum disorder.

Tim Loughton: I am Tim Loughton. I am the Conservative spokesman on mental health issues. I have no pecuniary interest, but I am Patron or Vice President of various mental health charities in my constituency.

Baroness Eccles of Moulton: I am Diana Eccles. I have no specific interests, but I was Chairman of a west London health authority for 12 years partly before the trusts were formed, so I had direct responsibility for mental healthcare.

Mrs Blackman: My name is Liz Blackman. My interests are as declared in the Register. I chair the All-Party Group on Autism and I do have a family interest in mental health.

Mr Howarth: I am George Howarth. My interests are declared in the Register. The only indirect interest I have is that my constituency contains a specialist hospital.

Hywel Williams: I am Hywel Williams. I have no direct interests, but I should say I am a former social worker.

Laura Moffatt: My name is Laura Moffatt and my interests are declared in the Register, that I chair the All-Party Group on Depression.

Q1 Chairman: Thank you very much. We have about an hour for this session. I think you can take it, Professor Richardson, that we have read the report of the Expert Committee. Anyone who has
not should have and will. I understand that you would like to make a very short introduction, and then we will move to questions.

Professor Richardson: Thank you very much and thank you for the opportunity to come and give evidence. I just thought it might be useful to explain the presence of this sole academic here giving evidence. I am simply a legal academic, but in 1998 I was invited to chair the Expert Committee which was set up by the Department of Health to advise Ministers and we were multi-disciplinary, so we were lawyers, psychiatrists, GPs, a police officer, nurse, social worker, carers. We covered a broad area of experience and we presented our report in July 1999 to the Minister and it was published along with the Green Paper in November 1999. The policy was set within the Department of Health and we were simply to advise on the reformulation of the law and at the time the most significant issue was the proposal that compulsory care and treatment should be extended beyond the hospital into the community, and that was highly controversial. But early on in our deliberations we concluded that there was nothing fundamentally unacceptable about that idea, provided it was set within an appropriately principled legal framework. So, in consultation with all the relevant interest groups, we tried to provide at least the essential elements of such a framework. For us, consultation was extremely important because we wanted to know what other people thought, we wanted to hear what the people with daily contact with mental health in all its aspects felt and we certainly did not have all the answers within our team. In the end we did produce a unanimous report which I am very pleased to hear you have in front of you. In particular, we recommended the introduction of express underlying principles on the face of the Act, a single gateway to involuntary care and treatment, whether that was to be in hospital or in the community, and that single gateway was to have a broad diagnostic definition coupled with tight conditions for the use of involuntary powers, and there was to be early involvement of an independent decision-maker to approve the use of compulsory powers on the basis of an agreed care plan. We hoped at this stage that we had got the balance just about right. We certainly had engaged the community. There was a lot of enthusiasm out there to discuss the issue and there was I think that stage quite a lot of goodwill to get the very difficult issues debated and a properly principled Act in place. In strictly formal terms, the Government seems to have accepted much of that institutional structure. In the new Bill, you have got a single gateway to compulsory power, you have got a broad diagnostic definition and you have got early intervention of an independent decision-maker in the shape of the Tribunal, and an agreed care plan. Obviously over the five years between our report and the current Bill, there has been an awful lot of change in detail and thought, but the basics are there. So why am I not happy with it, I suppose is the primary question. Before I came here I tried to concentrate on why, what was the primary source of my unease, not the sort of clause-by-clause issues, but the fundamental deep-seated worry. Here I am obviously speaking for myself because I have not had the opportunity to talk to all the other members of the committee, but I think that for me most of my worries spring from the fundamental difference in the approach between the Government and our committee. We started with a very strong commitment to principle of non-discrimination on grounds of mental disorder. We believed very strongly that, as far as possible, people with mental disorder should be treated according to the same set of principles as those which govern the treatment of people with physical disorder. We thought this was of absolutely central importance, first, because it would help, we hoped, to reduce the stigma attaching to mental disorder, the sort of circular where, if you have discriminatory law, it feeds on the stigma and the stigma feeds on the discriminatory law, so we thought it was very important in terms of reducing stigma. We thought it was important in order to set the new Act in a principled context that was compatible with thinking in the 21st Century and in order to make sure that the new Act was compatible with the emerging jurisprudence of the European Court of Human Rights. It followed from this emphasis on non-discrimination that we attached considerable importance to the principle of respect for patient autonomy. As I am sure all of you know, in the context of treatment for physical disorder, the capable patient can refuse treatment almost without consideration of the consequences; not so under the current Mental Health Act, not so at all. It may sound odd to talk about non-discrimination and respect for patient autonomy in the context of a Bill which is primarily designed to single out mental disorder, to discriminate in that sense by singling out mental disorder and providing a power to treat people for their mental disorder in the absence of their consent, so apparently in conflict with the principle of patient autonomy. So it is odd to talk about those two principles in that particular context. But we felt very strongly that it was in fact necessary to do so in order to ensure that every infringement of patient autonomy under the new powers was properly justified, properly considered and properly justified. So we tried to make our recommended framework as respectful of non-discrimination and patient autonomy as possible given the very obvious need to provide for the prevention of harm to the patient and to other people. By contrast, the Government, and I am not quite sure whether I should be talking about the Department of Health or the Home Office here, has focused on the prevention of harm or the reduction of risk without ever really engaging with the issues of non-discrimination or patient autonomy. And, as a result, the guiding principles described in our report and those considered in the Bill are very different and, perhaps most significantly, the conditions for the use of compulsory powers in the two documents differ really quite significantly. I am sure the substance of those differences will come out in the course of our conversation to follow, but,
if I may, I would just like to offer four reasons why I think this debate between the Expert Committee and the Government is important. It is not just an academic debate; it has important consequences. First, a statutory framework in an area like mental health will have to be operated on a daily basis by non-lawyers; it is not going to just enforce itself. It will only work smoothly if it reflects the values of those who are going to use it, mental health professionals, carers and Health Service users. If it contradicts those values, its chances of working will be significantly reduced. Secondly, the conditions for the use of compulsory lie at the heart of the Bill, so you have got to get them right; they have got to be workable and they have got to be predictable, they must not be under-inclusive, but they must not be over-inclusive. Thirdly and very closely linked under the supervision of an approved clinician. We must not be under-inclusive, but they must not be workable and they have got to be predictable, they must not be under-inclusive, but they must not be over-inclusive. Thirdly and very closely linked under the supervision of an approved clinician. We have got to police. Over-broad conditions will mean weak safeguards and they will mean an over-worked Tribunal because you will have an awful lot of people under compulsory powers. Fourthly and finally, you have got to have a Bill that works alongside other relevant legislation in the area, obviously the Human Rights Act and the ECHR, but, perhaps even more practically significant now, it has got to work with the Mental Capacity Bill. I really just wanted to say that I think there are very important practical implications that flow from the, if you like, principled debate between the Expert Committee on one side and the Department on the other.

Q2 Chairman: Thank you very much indeed. I think you have given us in broad terms your views as to the improvements this Bill makes on what was previously offered and also your concerns. Can I ask you to be a little bit more concrete with reference to clause 9 of the Bill which sets out the relevant conditions because, apart from the Code which I will turn to in a moment, clause 9 seems to me the fundamental building block on which everything else is constructed. Which parts of clause 9 do you believe need to be changed, and can you indicate in what ways, in order to meet the set of principles set out very clearly in the Expert Committee Report?

Professor Richardson: Certainly. Clause 9, I could not agree more, is absolutely crucial and if we look at it in detail, I suppose the first condition, suffering from mental disorder, I do not have any particular problem with that. We were in favour of a broad diagnostic definition of mental disorder. I am not entirely convinced that there has been a significant change in the change of wording between the 2002 and 2004 Bills, but I am happy in broad terms with a broad definition of mental disorder. Although I would say that I would like to see some express exclusions, and in our committee report we were quite clear after our consultation that we did want to see an exclusion on sole grounds of drug and alcohol abuse. It was quite difficult to come to that conclusion and we had to take a lot of evidence on it, but, on balance, that is the way we concluded in the end. There are other exclusions too which I think need to be considered quite seriously. So I am happy with the broad definition, but I would like to see some further thought given to express exclusions. The second condition, that mental disorder must be of a nature or degree to warrant provision of medical treatment, well, under the existing Act, as you will know, there has to be a bed available, so there is a sort of physical rationing system in there. Under the new Bill, the mental disorder would just have to be of a nature or degree to warrant provision of medical treatment. Medical treatment is defined very broadly in the same way as treatment is defined under the current Act, and under the new Act the treatment has to be given under the supervision of an approved clinician. We are not entirely sure exactly what “an approved clinician” will mean, but it is clearly of great significance to clause 9 that not only must your mental disorder warrant the provision of treatment very broadly defined, but in order to narrow that, there is this requirement that it be under the supervision of an approved clinician. Well, I think to be satisfied that this is really some kind of real limitation, we do need to know exactly who this approved clinician is going to be. However, it is the third condition that I suppose I have the most difficulty with. Here treatment has to be necessary either for the protection of the patient from suicide, serious harm or serious neglect or for the protection of other persons. The treatment cannot be lawfully provided without using the Act and medical treatment is available. There is also subsection (7) which I know is controversial, but I can say something about that later. On this third condition particularly in some respects I think it is better than it was in the 2002 Bill because the threshold for self-harm has been ratcheted up quite significantly and now, before somebody can be made subject to compulsory powers simply in the interests of their own health and safety, it has to be in order to prevent serious suicide or self-harm. I, because of my interest in non-discrimination and patient autonomy, am pleased to see that threshold raised insofar as self-harm is concerned. However, perhaps I could just make two out of a considerable array of points that could be made. In respect of protection of others, clause 9 I think is very over-inclusive. What it says under the third condition is that the treatment must be necessary for the protection of other persons. Well, from what? It could be from very slight harm, it could be from noise or it could be from nuisance. There is nothing in the Bill itself to confine the sort of harm to others that we are suggesting should be sufficient grounds for the imposition of compulsory powers and I think this has problems in principle and I think problems in practice. The principle first. These patients may have capacity, may still be able to make decisions about their own treatment and care and they will not be consenting to the proposed treatment because if they were consenting, they would fall foul of the fourth condition, so we can assume that they are non-consenting. Is it...
acceptable to treat them against their will in these circumstances because there is no mention of significant risk or serious harm to others? Would we force medical treatment for physical disorder on a competent, refusing patient in these circumstances? If not, how do we justify the discrimination that we would be showing towards people suffering from mental disorder? We are not restricting it to significant harm or significant risk of serious harm.

Q3 Chairman: Can I stop you there in relation to that because I think you have highlighted very well something that has appeared in a lot of correspondence we have had and can I just ask you one question which I think will allow a fairly brief answer, but will be of assistance to the Committee. The Codes of Practice, and of course there are two because there is a Welsh Code of Practice as well, are mentioned right at the very beginning of the Bill, clause 1(1), but we do not have them. Do you think that the Committee will certainly be inhibited, but do you think it will be prevented from conducting complete and meaningful pre-legislative scrutiny if we do not have at least a draft of the Codes of Practice very soon or do you think we can really second-guess the Codes of Practice from existing codes of practice?

Professor Richardson: I think you are going to be in a very difficult position if you do not have the Codes of Practice or some clear idea of what will be contained in the Codes of Practice, particularly in relation to the relationship between the Mental Capacity Bill and the Mental Health Bill where a Code of Practice will be essential.

Q4 Lord Carter: You remember that the Expert Committee made a very strong recommendation, that, “The Committee recommends the inclusion within new legislation of the statements of principle which will set the tone of the new Act and guide its interpretation.” As you know, the principles are not in the draft Bill, so what are the consequences of them not being included and are there any sound reasons for placing the general principles only in the Code of Practice?

Professor Richardson: I am pleased that the idea of principles has emerged. I would obviously like to see them contained within the Bill itself. I would like to see them included very significantly respect for patient autonomy because I do think that that is central for the non-discriminatory reasons that I outlined earlier. I would like to see the principle of non-discrimination there too, but I appreciate that that might look a bit odd on the face of the Bill itself and I think in our committee report we suggested that might go in the Code of Practice.

Q5 Lord Carter: I think the Department have told us that the reason why they are not including them is because there will be occasions when they will not apply. Of course in the draft Bill under 1(4), it says, “The Code may provide that one or more of the general principles is not to apply” and they give the circumstances, and they leave that to the Code of Practice. Is that not a bit extreme? That is a big power to have only in the Code of Practice and not actually in the statute.

Professor Richardson: I agree entirely. I think it is a big power and I think the idea of disapplying principles that you think are sufficiently important to indicate in the Bill and then put in the Code of Practice is an extraordinary idea. Principles do not have to be absolute to be effective.

Q6 Lord Rix: I think to a certain extent you have largely answered question four, but I am still going to ask it because I wish to add a little extra. The Expert Committee recommended a broad diagnostic definition of mental disorder “coupled to rigorous entry criteria”. Do the definitions and conditions for the use of compulsion included in the Bill comply with this principle and are they adequate and appropriate? In your report you say that under a Mental Health Act, you do not recommend that learning disability be expressly excluded from the scope of the new Mental Health Act and yet a moment ago you said that you would like to see a longer list of exclusions. Would you not consider it appropriate that learning disability per se without the additional problems of mental health and mental illness should be excluded from this Bill because you are adding another label to people who already are labelled?

Professor Richardson: I think this is a really difficult issue and we grappled with it at some length. It was made the more difficult because at the time when we reported we had not even got a draft Bill from the then Lord Chancellor’s Department, so we did not know what the Incapacity Bill was going to look like. In other similar jurisdictions learning disability is excluded from the mental health legislation. Should it be here? I find it very difficult to be very firm on this because I think the context of our legal structure suggests sometimes that there are advantages for people with learning disability to not be expressly excluded from a Mental Health Act and one of those, I suppose, is if they come up against the criminal justice system, that it would be unfortunate if it were not possible to give them a hospital disposal.

Q7 Lord Rix: I am not suggesting that the Bill would not have safeguards in that respect; I think they should be added to the Bill as amendments when the Bill eventually comes before us, I think it could be done so that you would exclude people with learning disability in its natural form, as it were, but that there would be certain safeguards regarding criminal proceedings, et cetera, et cetera, which would actually be put on to the face of the Bill, so if a person with learning disability tipped over into the mental health problems, that would be covered in the Bill rather than placing them automatically in the Bill right from the word go.

Professor Richardson: I am sympathetic to that view, subject, I suppose, to what the Mental Capacity Bill finally looks like.
Q8 Mrs Browning: The definition of mental disorder has been broadened and I have similar concerns to Lord Rix in respect of people on the autistic spectrum disorder because at the moment under the 1983 Act autism is certainly not defined as a mental health condition and I would wish it to remain that way. However, because it is a spectrum, we do have people with ASD who would also have a learning disability and who would also have an overlying genuine mental health problem and some of the more high-profile cases we have seen recently, and Bournewood obviously is one, but there have been others, have shown that people with ASD have fallen foul, to their own detriment, of mental health legislation. What I wonder is how we would deal with this particular group because they do not fit neatly into any of these categories, not least because for many of them on that spectrum, they are not learning disabled, they have high IQs, they have capacity, et cetera, but they do have what are very often seen as quite challenging behavioural problems in certain sets of circumstances. Now, I wonder what your view would be in terms of that particular group and how they could be justly accommodated in the legislation without changing the status they currently have in law.

Professor Richardson: If I follow you, you would not like them to be included within the basic definition?

Q9 Mrs Browning: I would not like autistic spectrum disorders to be changed, and it would be a change for autism to be regarded as a mental health condition. It is a dysfunction of the brain, we understand that, although we do not have all the science yet to tell us exactly where, but I think it would definitely be to the detriment of ASD for it suddenly to be categorised as a mental health disorder.

Professor Richardson: I suppose the question is whether there are any circumstances in the individuals’ interests when it would be appropriate to give them care and treatment in the absence of their consent and what those circumstances might be. I do not know enough about the care and treatment for people with ASD to know whether there are circumstances in which it would be appropriate, or you would feel it would be appropriate, to impose care and treatment.

Q10 Mrs Browning: I think if somebody on the spectrum presented with a genuine mental health diagnosis on top of the autistic diagnosis, they would be treated as anybody else would be within the terms of the Act. What I am concerned about is changing the definition and understanding of their condition from the 1983 Act which does not regard autism as a mental health diagnosis and I would not want that to be applied universally to everybody on the ASD spectrum and I am worried that this broader definition would catch them in that definition.

Professor Richardson: I suppose, if I turn myself into the Department of Health for a moment, their answer would be that the clinician will not provide appropriate care plans, so if there is no appropriate care for people with this disorder, which might be provided under the mental health legislation, then they will not be included in practice, compulsory powers will not be used in the absence of appropriate care being provided for them.

Mrs Browning: It is a rather unique situation.

Chairman: I think what we are identifying here is a threshold issue which is going to need more consideration and is a common theme from Lord Rix and Mrs Browning.

Q11 Baroness Finlay of Llandaff: You very helpfully outlined already your concerns over the way that the Bill is now drafted over compulsion in the community, as proposed. I wondered if you would like to say something a little bit about the link between compulsion in hospital and compulsion in the community and also, in the light of your introductory remarks, how you felt that compulsion in the community would now actually work in practice as envisaged in the Bill and how it should possibly be changed in the Bill to meet your concerns.

Professor Richardson: What I said about clause 9 in respect of treatment in hospital is magnified when you move it into treatment in the community. I go back to our initial conviction that you want a single gateway, but the conditions have got to be strict, otherwise I am fearful in the climate of a sort of defensive practice, that there will be a very significant increase in the use of compulsory power and I think particularly for the protection of other persons. As there is no lack of capacity requirement in the Bill, which obviously I would like to see, you could have somebody who might come in under compulsory powers when they were really quite florid and really quite ill and they would become better and it would be appropriate to move them perhaps into the community. Under this Bill it would be possible to continue the compulsory powers into the community, and that is what worries me. It is a sort of lobster pot; it is easy to get in, but it is very difficult to get out because the broad conditions are very difficult not to meet. It puts the Tribunal in a very difficult position, I think.

Q12 Chairman: This is going to be dependent in part on the rigour of the Tribunal, is it not, about which there are big economic questions?

Professor Richardson: Yes.

Q13 Baroness Pitkeathley: Professor Richardson, you spoke very powerfully in your introduction about patient autonomy and patient rights. The Bill has a series of safeguards for those. Could you tell us how you feel about those safeguards, how adequate you think they are, and if they are not adequate, I wonder if you could give us some specific examples of how you think they might fall short.
**Professor Richardson:** I am pleased to see advocacy there as it is something we wanted and I am delighted it is there. I am not the person to advise you on whether the provisions are ideal or not. I think my real concern is the ability of the Tribunal to provide a proper safeguard. It is excellent, in theory, to have automatic oversight by the independent body, but if the conditions that the independent body are trying to police are too broad, then the safeguard itself becomes far less real and the Tribunal becomes over-worked. I do really worry about whether, given clause 9 as it currently stands, tribunals will be overcome by numbers and I have a very real worry about the practicality. My lobster pot problem is very real and it is going to be extremely difficult. Just one specific point I think is that at the moment the Tribunal has an overall discretion to discharge at least civil patients. There is in the present Bill no discretion in the Tribunal to discharge a patient under civil compulsory powers, so if the conditions are still met, there is no discretion in the Tribunal to discharge. So I do have some problems about the Tribunal as a real safeguard. The lack of principles on the face of the Bill troubles me because they would have been a way of knowing how to interpret all the powers within the Bill. One other point that I am sorry has been missed out is that we were very keen that there should be proper regulation to safeguard the residual rights of patients. I am thinking particularly about patients in secure accommodation, so questions of seclusion, searching, visiting, the sorts of residual rights that patients might expect to retain, provided that they did not in any way compromise their safe containment. That is all going to be in the Code of Practice and I am not really satisfied and I am not entirely sure that the European Court will be entirely satisfied with protecting these very fundamental rights in that way. So I would like to see them in the Bill.

**Chairman:** When the Committee visits Wales we may find that in practice more progress has been made in Wales than elsewhere in keeping children out of adult wards, but that is something we will see when we go there.

**Q14 Tim Loughton:** Professor, you give only a page in your report to the subject of children, yet we all know that counts as perhaps one of the most pressing concerns amongst the mental health profession at the moment. You quite rightly say in that report that the whole law about the treatment of children needs to be clarified. Do you think that the new draft Bill has gone any way, or far enough, to providing that clarification, firstly, and what sort of things relating to the treatment of children would you like to see changed in the Bill? I am particularly referring to the final paragraph of the section about children where you recommend that children subjected to compulsion be entitled to accommodation within an appropriate environment, which is a great concern amongst all of us. Should we be going a lot further in the Bill to have some safeguards on the face of the Bill in order to achieve that because we know how many young people are in adult wards and adult provision at the moment, so do we need to lay it down on the face of the Bill to make sure that sort of thing cannot happen?

**Professor Richardson:** I am afraid I am really no expert when it comes to children and I think you will get more useful evidence from other witnesses. I think what is contained in the Bill is a start. It indicates that people have started to think about how you can rationalise all the various statutory provisions that sort of bear down on mental health treatment for children and young people. I understand those who are much more knowledgeable about children than I am are still concerned about certain gaps, particularly for children between 17 and 18, but I do not think I am the person to help the Committee particularly on that. On the second point you raise about children being held in adult wards, I am very disappointed that there is not something there. I think it is a very extreme example of what we were trying to get at with our notion of reciprocity which was one of our favoured principles. If you impose care and treatment on somebody against their express wishes, then you are obliged to provide it in the best form possible, and putting a young person on an adult ward is certainly not the best form possible.

**Chairman:**

**Q15 Baroness McIntosh of Hudnall:** Professor Richardson, in your report, you made the point that you were being asked to report to the Department of Health and that, therefore, issues to do with the criminal justice system were, to some extent, to one side of the issues that you were being asked to address. Nonetheless, you did devote quite a substantial part of your report to the question of mentally disordered offenders. I wondered if you could tell us whether you have any concerns about the way in which your recommendations and observations on this subject have been digested into the draft Bill.

**Professor Richardson:** Yes, we did have a problem because we were appointed by DoH and the Home Office obviously had its own agenda. Looking though generally at that section of the Bill, I think there are considerable improvements, particularly for the pre-sentence stages. I think there are considerable improvements. I am a little bit concerned about the approval by the Crown Court of care plans when a hospital order is made and I think that something will have to be introduced to beef up the expertise in the Crown Court if they are really seriously going to do a mental health tribunal job on looking at the care plan proposed, so I would certainly want to see something in there. There was one particular aspect of our report that has not ever seen the light of day and that was the question of restriction order patients and leave and transfer.
Q16 Chairman: Just on the Crown Court point, would you see any value in, immediately after the making of the restriction order by the Crown Court, which is plainly part of the criminal justice process, the care plan then being transferred to the Tribunal to deal with on the basis that the Crown Court judge is not a person who has everyday dealings with the mental health sector, whereas obviously the Tribunal is very much involved in it? Do you see a transfer procedure as being of value?

Professor Richardson: I suppose the transfer procedure would be one way of doing it, but you would have a slightly difficult point in that the Crown Court, in theory at least, is meant to be approving the hospital order on the basis of approving the care plan, so if it were delegating that part of its own decision-making to another body, it may be easier perhaps to require the Crown Court to ask for a member of the Expert Panel to be present at that point. I am not quite sure if that is do-able.

Q17 Chairman: But that may be an issue to be addressed there?

Professor Richardson: Yes.

Q18 Dr Naysmith: As you have just indicated in reply to the previous questions, the Home Secretary has the power at the moment to refuse and to authorise transfer and leave and you recommended that this should change and that has not been followed in the Bill. Could you tell us just a little bit about why you recommended a change and how you think it might work in the context of the current Bill if we were to feel strongly enough about it to follow your recommendations?

Professor Richardson: Well, thank you for asking. I think our concern first sprang from our awareness that it was a considerable inhibition on moving patients across or down levels of security within the hospital system. So when we looked at it, it seemed to us that because transfer from high security to medium security and on down is really an essential precursor to ultimate discharge from compulsory powers, there was at least in spirit a potential conflict there with our obligations under Article 5(4) of the European Convention. All right, we now have a Tribunal that can order the discharge of somebody from a restriction order, but we do not have a Tribunal that can order the essential precursors to discharge, the leave and the transfer. So we felt that there was a potential problem there with compliance with Article 5(4). We also felt that in practice if you took it away from the Home Office, we were not saying that you could get rid of the Home Office’s oversight of the individual restriction order cases. I think the Home Office is the place where the sort of continual history of a long-term dangerous patient is located and they have considerable expertise, so I certainly would want them to retain that role. But perhaps by removing their executive power, if you like, and encouraging them more to present evidence to a Tribunal when a Tribunal was deciding on a question of transfer of leave, that would make it easier for the Tribunal because it would have better access to the experience within the Home Office.

Q19 Dr Naysmith: So you would see the Tribunal coming in at an earlier stage, and this is more work for the Tribunal, to authorise as a separate issue?

Professor Richardson: Well, it would not be because what happens at the moment is that a restriction order patient will apply to the Tribunal and the Tribunal says, “We can’t discharge you, but we recommend . . .” And I think what I am saying is that they should have power to order, in the final analysis, leave or transfer.

Q20 Chairman: Is there a problem of perception about the Home Office having these powers? Might there be an alternative repository for the powers, albeit not very much change in terms of what they are, such as, for example, the Department of Health?

Professor Richardson: Yes, I suppose so. It would not get round the Article 5(4) problem if there really is an Article 5(4) problem and I can imagine an extreme case where one could make quite a strong Article 5(4) point if the Tribunal does not—

Q21 Chairman: But is there a perceptual problem about the Home Office’s involvement?

Professor Richardson: There is perhaps a perceptual problem both ways, is there not, because the Home Office would say it is reassuring to the public and perhaps some mental health professionals would say that the Home Office is only concerned with reassuring the public and is not concerned sufficiently with the welfare of the individual patient or shifting our bed block.

Q22 Dr Stote: That brings us on to what I think is rather an important part of this Bill. I am in a fairly unique position in that I actually have patients of course with mental health problems, some of whom very occasionally require compulsory detention treatment, although fortunately it is very rare. Nevertheless, I agree entirely with you about the paramount importance of patient autonomy and the need to respect that wherever possible. I am also of course a back-bench constituency MP and I recognise the very real public concerns that there are about the safety of the public. Whether it is the perception or the reality is not the issue; the fact is that there is a real feeling out there. How, therefore, do we balance the two things because that is the thing I am struggling with mostly with this whole Bill? How do we balance the need for patient autonomy with the very real right of the public to feel that they need protection and does this Bill get that balance right?

Professor Richardson: Well, I do not think it does because I think that the bit in clause 9 that just talks about the protection of others is too broad, so it is weighted too far and I think perhaps the debate need not be seen as either/or. I think if you have an accessible mental health system that does not deter people from accessing it, that is there and
is a reality in the community, then you stand a better chance of engaging people with mental disorder earlier on in the history of their disorder than you do if you have a legal structure that is at least perceived by mental health service users as over-interventionist and over-protective.

Q23 Dr Stoate: I appreciate that, but does that address the issue of public concern?

Professor Richardson: Well, I think in part it would. I know there is a very real public concern. I think it is unfortunate that the Department of Health has not done more to try to present to the public the reality of the relationship between mental disorder and violence. There is a relationship, but it is not the relationship that the media would have us believe it is.

Q24 Dr Stoate: So how do we draft the Bill, if that is what we would use, to reflect that?

Professor Richardson: Well, I am entirely happy with the idea of patient autonomy ceding to the need to protect the public from serious harm if there is a real risk, so it is possible, I would hope, for a parliamentary draftsperson to contrive a tighter requirement of public protection. We have certainly got to have it, I am with you entirely, but I think there are dangers if it is over-played.

Q25 Lord Rix: I would like to ask a question about Bournewood. Do the provisions in the Mental Capacity Bill and the new draft of the Mental Health Bill adequately close the “Bournewood gap” to which you refer of course in your report on pages 113 and 114 in considerable detail?

Professor Richardson: Yes, and that report was 1999 and we still have not got the answer. Yes, I am really troubled about the relationship between the two Bills and it would seem as if the safeguards provided within the Mental Capacity Bill are not going to be sufficient to meet the court’s requirements, so someone somewhere has got to decide how to put us into compliance. You could either do it by increasing the scope of the Mental Health Bill so that all people who lack capacity can be brought in for treatment for mental disorder in about how it came to its figures, I really could not say. “someone somewhere gap”, as we put it, and if you were able to find the time to assist the Committee in writing as to ways in which, with your expertise and experience, you think we might fill the “Bournewood gap” legislatively, I am sure the Committee would all be very grateful to you for that.

Laura Moffatt: So would the Government?

Chairman: So thank you for walking gently, but skilfully into that one. Now, there are one or two members of the Committee who would like to ask you some questions about resource issues. I know you are a lawyer, but I do not think you can duck these because you have a lot of experience as a result of the Expert Committee’s work of dealing with, and looking at, these resource issues.

Q26 Mrs Blackman: Professor Richardson, how important do you feel access to advocacy is in safeguarding a patient’s rights and autonomy; secondly, does advocacy kick in sufficiently early in the process; and, lastly, there is a recommendation that there be 140 new advocates introduced, is that sufficient?

Professor Richardson: Yes, I do think the provision of advocacy is very important; I am pleased that it is there, as I said earlier. I think there are problems about training and supervising of advocates which are well-known in the advocacy world. You have to get the balance of independence and sufficient expertise right, but I am very pleased with the introduction of advocacy. Whether it should be introduced earlier is difficult because there is every reason why it is almost more important at the front end, when the person is perhaps still at their most disturbed and most unfamiliar with the system. But the difficulty the Government seems to have got itself into in attaching advocacy to the presence of compulsion means that it is not prepared to propose advocacy earlier in the system. It is important to investigate that a bit further and work out in what way it might be possible to get advocacy in earlier, because I do think it is important at that very first engagement. As to 140, I do not know, I really do not know. Again, I think the Department of Health needs to be interrogated about how it came to its figures, I really could not say.

Chairman: I drew the CAFCASS analogy earlier in our deliberations; we do not want to find ourselves in a situation in which we have new legislation and the problems that CAFCASS has faced as a result of under-resourcing on the advocacy front. Mr Hywel Williams—bearing in mind that there are going to be separate Tribunals in England and in Wales—has some questions about the resourcing of the Tribunals.

Q27 Hywel Williams: Indeed, the new Tribunal arrangements will require increases in the number of lay, legal and medical members. How significant do you expect the increase in the workload for the Tribunal to be; secondly, could you take a stab at what would be a reasonable number of hearings for a legal Tribunal member to attend each year?
**Professor Richardson:** This gets recorded, does it not? As I said earlier, I do think there is a very real problem with the workability of the Tribunal. Obviously, I am entirely in favour of the automatic role of the Tribunal, the 28 days approval, we suggested that and I have not gone back on that, but I am troubled because of the breadth of clause 9. My fear is that however responsible clinicians will be in their use of compulsory powers, it will build up because it could be very difficult to get people off compulsory powers once they are through hospital and out in the community. The workload of the Tribunal will build up and build up, so it is circular, the workload will depend on the gateway and, if the gateway is too broad, the workload will be too great and the resources spent on the Tribunal to make it work will be disproportionate to the role it plays—we would rather have those resources put into services. I do have a very real worry about it and I know that the Tribunal in Wales particularly, but also in England, is deeply concerned about the hearing numbers and the new members that will be required and the training of the new members. Perhaps I should say that although I am not speaking at all on behalf of the Council on Tribunals, I am a member of the Council and we are very worried about these issues as well.

**Q29 Chairman:** Are you aware of the concerns felt by many Mental Health Review Tribunal part-time presidents as to the resourcing of the Tribunals at the present time?

**Professor Richardson:** In my role as a member of the Council on Tribunals very aware, yes.

**Chairman:** Thank you. One final question from Mrs Browning.

**Q30 Mrs Browning:** Do you think there is any merit, not just from a resource point of view, in bringing together the Mental Capacity Tribunal and the Mental Health Tribunal into a unified Tribunal?

**Professor Richardson:** Before coming here I went back to see what we had said about that in 1999 and I think, yes, there has to be some. If the Mental Capacity Tribunal, following the Bournewood decision—if we get such a body—is going to be primarily concerned with reviewing detention, effectively, within a hospital and the care plan that is provided for the person without capacity, then there seems to me every case for trying as far as possible to use the expertise that will build up in one Tribunal across the other Tribunal. And, certainly, there is every reason to suppose that would happen given the Department of Constitutional Affairs’ desire to rationalise the tribunal service across all tribunals, so, yes.

**Chairman:** Thank you very much. I hope you will not have to come back in 2009 to speak to a similar committee on an unresolved issue, Professor Richardson. You mentioned recording, I should have said at the beginning—I am sure you are aware of this and it applies to all witnesses—that you will be sent a copy of the record of the Committee’s hearing today and you will of course be permitted to correct it contextually and grammatically, but not in terms of the evidence you give. The same, of course, goes for those who have asked questions. Can I thank you very much for this gallop through some very important issues? I think I have already tried to persuade you to give us a little written help on the Bournewood gap because we all rightly consider you as a considerable expert, if not the considerable expert, in this area, and we look forward to hearing from you on that. Thank you very, very much on behalf of the Committee for attending this morning.

---

**Supplementary memorandum from Genevra Richardson (DMH 378)**

At the conclusion of my oral evidence to the Committee on 20 October 2004 I was invited to submit further evidence on the relationship between the Mental Health Bill and the Mental Capacity Bill with particular reference to the Bournewood gap. I now do so.

**The relationship between the Mental Health and the Mental Capacity Bill**

1. The government has published two Bills concerning similar, but not identical, populations and dealing with some similar decisions. The Mental Capacity Bill (MC) covers those, mainly adults, who lack decision-making capacity, while the Mental Health Bill (MH) covers people, including children, who have
a mental disorder of the required severity. Both Bills deal with decisions relating to care and treatment for mental disorder. So adults:

— who have a mental disorder of sufficient severity to attract MH powers,
— who require care and treatment for mental disorder, and
— who lack decision-making capacity,

could fall under the remit of either Bill.

**THE PRESENT CONFUSED RELATIONSHIP**

2. MC, clause 28, gives priority to MH powers where these have already been engaged, but offers no indication of how the initial choice is to be made. MC further provides that people acting under the Bill (clause 6), including attorneys and court appointed deputies (clauses 11 and 20), may in certain circumstances restrain the incapable person (P). MC therefore envisages the need to override physical objections on the part of P, suggesting that its intended remit is to extend beyond the compliant.

3. MH, clause 9, sets out the conditions for the use of compulsory powers. These would cover people with a mental disorder, who require treatment for that disorder in order to protect them from suicide, serious self-harm or serious self-neglect, or in order to protect others. There is no requirement that the person must first lack capacity, but many of those who met these conditions would certainly do so. However, clause 9(5) specifically excludes from MH powers those who can be lawfully treated without the use of those powers, provided they pose no serious threat to others. This suggests that MC might take priority in cases where care and treatment for mental disorder can be provided under its remit, provided there is no substantial risk of serious harm others. This would include most cases where the person lacks capacity. Indeed, on a very literal reading of MH clause 60, a person who entered MH powers while having capacity would have to be discharged from those powers if he or she subsequently lost that capacity. This could impose on the clinical supervisor a continuing duty to keep capacity under review.

4. Further clause 9 does not cover people who need treatment for mental disorder and who lack capacity, but who present no threat to others and the danger they pose to themselves is insufficiently severe to meet the clause 9 threshold of risk of suicide, serious self-harm or serious self-neglect. Such people would have to be treated under MC, if at all, even if they were non-compliant.

5. There is therefore a considerable area of ambiguity and possible overlap. This uncertainty matters in a number of different ways and in certain crucial respects cannot be left to resolution through the Codes of Practice.

**IMPLICATIONS FOR PATIENTS**

6. It matters for patients because the choice of framework will carry significant implications. In many respects the provisions of MC might be preferable because all decisions would have to be made in P’s best interests, the principle of least restriction would apply, a valid advance decision would be respected, a single framework would apply to all decisions P was unable to make for him or herself and there would be less stigma. However, under MC P would enjoy less rigorous safeguards than those which would apply under MH (see below).

**IMPLICATIONS FOR CARERS AND HEALTH PROFESSIONALS**

7. The uncertainty also matters for carers and for health professionals who need to know with as much clarity as possible which framework to apply. It is possible that they too might have a preference for MC powers because they would involve less bureaucracy and would place all decisions under the same framework, an issue of particular importance in relation to medical care and treatment. To some extent the required clarity might be achieved through Codes of Practice but some of the issues reach beyond the proper scope of a Code.

**SAFEGUARDS AND BOURNEWOOD**

8. While it might be possible to accommodate most of the above issues by selective redrafting of both Bills and the production of carefully co-ordinated Codes of Practice, this would not deal with the central issue of safeguards. MC provides far less rigorous safeguards to the patient, in relation to both treatment and the deprivation of liberty, than does MH. It is hard to justify this distinction in anything other than pragmatic terms and it is now evident that no pragmatic justification for the absence in MC of adequate safeguards in relation to the deprivation of liberty will suffice. The HL decision of the ECtHR is quite clear that the common law regime under which individuals who lack the capacity to consent are currently deprived of their liberty in hospital fails to comply with the requirements of either article 5.1 or article 5.4. The detention in hospital under the authority of the common law is itself unlawful, since there are no formal admission procedures, no clarity over the purpose of admission and insufficient safeguards to protect against arbitrary detention, as required by article 5.1. Also there is no access to a court to determine the legality of
the detention under article 5.4. Although this note is primarily concerned with those people who are deprived of their liberty within hospital, the reasoning of the court in HL could apply equally in respect of those detained in non-hospital institutions.

HL AND BOTH BILLS

9. In broad terms the provisions of MH are designed to comply with the requirements of article 5. The same is not true of MC. Significantly perhaps the explanatory notes accompanying MC make no mention of article 5 in their section Compatibility with ECHR.

10. Article 5.1: MC has been drafted with no appreciation of the implications of the fact that the people resident in hospital under its provisions would often be detained in the terms of the ECHR. As a consequence no provision has been made for the formal recognition of detention, its recording, its justification and its review. While the substantive provisions of the Bill are such as to render detention under its powers potentially lawful under 5.1, there are insufficient procedural safeguards. And, according to the court in HL, lawfulness under 5.1 requires “the existence in domestic law of adequate legal protections and ‘fair and proper procedures’” (para 115).

11. Article 5.4: The breach of article 5.4 is perhaps even more obvious. In HL the court refused to accept that either proceedings for judicial review or habeas corpus, or the ability to seek declaratory relief from the High Court could satisfy the requirements of article 5.4. Neither the developments in judicial review following the Human Rights Act nor the present extension of the role of the Court of Protection under the Bill would be sufficient to fill the gap. In theory the role of the Court of Protection could be amended to do so, but it is not the obvious body for the task since its expertise lies in the assessment of decision-making capacity and in the determination of the best interests of people lacking capacity, not in reviewing detention, imposing compulsory treatment or approving care plans.

12. Quite clearly steps have to be taken to bring the new provisions into compliance with article 5 and, against the uncertainties outlined above, those steps must involve redrafting the primary legislation. There is no single obvious solution but two distinct and, to some extent, polar options present themselves. Each has both advantages and disadvantages but it is possible that a combination of their strengths might eventually be achieved. As a first step the two options are described below.

THE EXTENSION OF THE MENTAL HEALTH BILL

13. On the assumption that the admission and discharge procedures in MH will comply with article 5, one option would be to extend the ambit of MH to cover all those who lack capacity and need treatment for mental disorder in hospital. This could be done by amending clause 9 to restrict the scope of clause 9(5), and by extending the conditions to include those with mental disorder who need medical treatment in hospital in the interests of their own health and/or safety and who lack the capacity to make the necessary decisions themselves. This would include both compliant and non-compliant patients and, because of the breadth of the definition of medical treatment (clause 2(7)), could include those who simply require secure accommodation in the interests of their own safety. Further, in order to remove any residual borderline issues, it might be necessary to restrict the use of restraint amounting to the deprivation of liberty under MC to situations of emergency.

14. Advantages:
   — Such an extension would ensure compliance with article 5.
   — It would also clarify the relationship between MH and MC.

15. Disadvantages:
   — The application of full MH requirements to all patients lacking capacity and requiring treatment in hospital would have unrealistic resource implications. In part this could be dealt with by reintroducing provisions similar to those included in Part 5 of the 2002 Draft Mental Health Bill. These could be adjusted to enable them to relate specifically to the amended clause 9 conditions and to provide sufficient procedural formality within the process of admission to ensure compliance with article 5.1.
   — Patients without capacity who would now move from MC to MH would be at a disadvantage unless MH was also amended to reflect the provisions in MC in relation to best interests, the least restrictive principle, advance decisions etc.
   — The relevance of the MC framework would be significantly reduced for a significant proportion of those for whom it was specifically designed: those lacking capacity who require medical treatment for mental disorder (very broadly defined, clause 2(7)) in conditions amounting to detention under the ECHR.
The Introduction of Enhanced Safeguards in the Mental Capacity Bill

16. The procedure for admission to detention could be tightened up in MC and access to a tribunal to review the legality of that detention could be introduced. The MC framework might then become the preferred option for the provision of treatment and care for mental disorder in hospital in cases where the individual lacked capacity.

17. Advantages:
   - It would achieve compliance with article 5 for all people detained in hospital who lack capacity.
   - It could reduce the need to use MH powers with all their resource and stigma implications.
   - It would enable the provision of treatment for both mental and physical disorder under the same provisions.
   - It would extend the remit of capacity legislation designed in accordance with the principles of non-discrimination and respect for patient autonomy.

18. Disadvantages:
   - It might be difficult to achieve at this late stage in the progress of the MC Bill, but it could perhaps be effected through consequential amendments to the MC Act made subsequently in the MH Bill.
   - There may be a concern that the article 5.1 safeguards included in MC would be too resource intensive if they replicated those in MH and included the early automatic involvement of the tribunal. However, article 5.1 compliant admission procedures could be devised which were essentially administrative with a right of appeal to a tribunal.
   - There might be fears that the provision of article 5 safeguards in MC would lead to the creation of a second tribunal. This could be avoided by the creation of a single body to operate under both MC and MH.
   - If MC were to become the primary framework for the provision of treatment in hospital in cases of incapacity, then attention would need to be paid to the safeguards relating to treatment provided within that framework: the inclusion of regular reviews of care and treatment plans, for example, and access to advocacy services.
   - An extension in the coverage of MC would not solve all the borderline issues unless a matching restriction in coverage were to be expressly introduced in MH. Thus MH might be expressly restricted to, for example, the core population of those who, whether capable or incapable, present a substantial risk of serious harm to others and possibly those who, despite being capable, present a similar risk to themselves.
   - There would remain a need to provide for the transfer of an individual from MC to MH if he or she remained a sufficient risk after regaining capacity.

19. The preceding paragraphs do not provide a comprehensive answer to the difficulties raised by the interface between the two Bills, nor to the issues presented by HL. The solution which is eventually chosen will have to reflect government priorities. However, it is possible to argue from the above that the weight of advantage lies with an extension of the Mental Capacity Bill and a corresponding restriction in the scope of the Mental Health Bill.

October 2004

Memorandum from Professor Genevra Richardson (DMH 408)

I was interested to see the government’s recent Memorandum of evidence to the Joint Scrutiny Committee. In this Memorandum the government describes its approach to compulsory powers as one based on necessity, not capacity, and it is certainly not my intention to pursue the debate on the relative merits of these two approaches in this letter. I would, however, like simply to restate the arguments set out in the Expert Committee Report because I fear that the account of them given in the Memorandum could lead to misunderstanding.

In paragraphs 3 and 4 of the Memorandum the government purports to describe the arguments in the Expert Committee Report. Unfortunately this account elides two distinct issues, harm to self and harm to others, with possibly misleading consequences. In chapter 2 of our Report, having set out our commitment to the principles of non-discrimination and patient autonomy, we accept “that the safety of the public must be allowed to outweigh individual autonomy where the risk is sufficiently great” (2.7). This conclusion accords with the views of the majority of those who responded to our consultation, only a small minority of opinion would argue otherwise. The points included in the last two bullets in paragraph 3 of the government’s Memorandum, and the quotation given in paragraph 4, relate to the question of overriding individual autonomy in the interests of the patient’s own health or safety. It was here that we found opinion more evenly divided and, having set out the arguments on both sides (2.8–2.10), we left the final choice to the politicians.
Thus we never argued for a pure autonomy approach and always accepted that autonomy could be trumped by a sufficient risk to the safety of others. The judgement on harm to self, where views were evenly divided and strongly held, we left to politicians. Our intention was to introduce an initial assumption in favour of autonomy and the express articulation of the interests which might be allowed to override that assumption, whether those interests be restricted to harm to others or be enlarged to encompass harm to self as well. Insofar as paragraph 6 of the Memorandum suggests that our Report simply endorsed the overriding of autonomy on the ground of mere harm, either to self or to others, it is a startling oversimplification.

Whatever the history of the arguments and the accuracy of their expression, however, the main differences between the Expert Committee’s views and those of the government would seem to lie in:

— the status to be accorded to the assumption of respect for individual autonomy and,
— the severity of the risk, whether to others alone or to others and self, which should be allowed to trump that assumption.

I hope this may help to clarify some of the arguments described in the Memorandum.

Genevra Richardson

January 2005

Memorandum from the Mental Health Act Commission (DMH 20)

INTRODUCTION AND SUMMARY OF CONCERNS

1. The Mental Health Act Commission is a special health authority charged with keeping under review the powers and duties of the Mental Health Act 1983 as it relates to the detention and treatment of psychiatric patients. We are pleased to have this opportunity to comment upon the draft Mental Health Bill’s provisions.

2. The Commission supports reform of mental health legislation to establish legal criteria for psychiatric compulsion fit for developing services and expectations in the twenty-first century. We share much of the conceptual basis upon which the Bill is established, with some important reservations. For example, we welcome the model of single-entry formal powers that do not have a necessary connection with detention in hospital. We support the general notion of formal reviews at the early stage of civil compulsion, speedy access to a Tribunal in accordance with the UN Declaration of the rights of mentally ill people, and statutory access to advocacy for all patients. We are pleased that the Bill would address the 1983 Act’s incompatibility with human rights requirements regarding dealings with patients’ families. There are many benefits to be gained in reforming the present legislation.

3. However, we have important reservations as follows:

(a) We are concerned about the complexity of the Bill’s drafting and at its length. The likelihood of the Bill being misapplied is greatly increased in proportion to the opacity of its construction. Mental health law must be accessible to persons without legal qualification for it to be effective.

(b) Despite the complexity of drafting, many provisions of the Bill provide broadly defined and therefore ambiguous powers to practitioners and authorities over the rights of patients. We are particularly concerned at the potential for over-inclusive readings of the conditions for compulsion, particularly given the ambiguities in the meaning of key terms such as “mental disorder”, “treatment” and “appropriate” (see paragraphs 2.1–2.30 below). We also note some instances of rather ill defined powers consequent to these conditions, such as the apparently unrestricted power given to the Tribunal to order that any non-residential patient does not engage in any conduct that the Tribunal chooses to specify (para 3.8). These ambiguities endanger the appropriate application of the proposed powers in relation to patients’ human rights. Alongside the potential for abusive practice, this could lead to a great many applications to the courts to test practical applications of the law and establish its boundaries. Wide reliance on the courts to resolve disputes over the meaning of the law would be unhelpful to practitioners and is likely to have serious financial implications for Government and health service providers.

(c) The broad scope for defining mental disorder, coupled with the uncertainty over what practical use may be made of powers of compulsion in the community, undermine the attempt to establish a threshold for compulsion in the community. Although the conditions require that medical treatment must, for example, be necessary to protect a patient from serious harm or self-neglect, “necessity” and indeed “seriousness” are not fixed values, but may be judged relative to the invasiveness of any intervention. (para 2.17)
(d) The Bill leaves matters that will determine the thresholds of compulsion, and therefore interference with personal liberty, in the gift of ministerial regulation. As draft regulations are unavailable at the present time, we are unable to establish a clear picture of some of the likely effects of the proposed legislation. (see para 7.2)

(e) The Bill affords weak status to the principles it establishes: practitioners will be required only to “have regard to” such principles as are stated in a Code of Practice. This weakness is compounded by the provision that they may be disappplied where inappropriate or impractical, and that principles shall not be binding upon the Secretary of State in making regulations and determinations under the Bill’s powers. (see paras 7.3–7.6)

(f) The Bill’s provisions appear to lessen the safeguards available to patients under the current consent to treatment provisions of part IV of the 1983 Act as these apply to the day-to-day treatment of detained patients’ mental disorder:

— The protections available to patients of Tribunal authorisation of a care-plan could easily be compromised by the adoption of generic care-plans that describe, in broad terms, a range of types of medication and other interventions. The proposals for primary legislation would seem to require that only such treatments as are being given in the absence of consent should be detailed on the care plan submitted to the Tribunal.

— The workings of the Tribunal in authorising amendments to plans of patients that they have admitted to compulsion may be overly bureaucratic and not cost-effective in terms of patient protection. The Bill will replace the current single-doctor “second-opinion” approval of medication or ECT with a three-stage Tribunal process (doctor’s application, expert second opinion visit, Tribunal negotiation with original doctor and authorisation). It is not clear whether this will increase patient safeguards, and it is doubtful that it is necessitated by the ECHR. (para 5.5)

— The Bill is inconsistent in its proposals regarding ECT and psychiatric medication. It would abolish the current Act’s requirements regarding the recognition of patients’ consent to medication, whilst retaining such requirements with regard to ECT, and adding a right of refusal to ECT treatment. The Bill would abolish current powers of emergency treatment for medication. These changes in the legal safeguards and powers regarding psychiatric medication would leave such matters to the common law, reducing patient protection. (paras 6.14–6.19)

— The Bill provides no specific regulatory powers in relation to the control and management of patients, and no provision equivalent to section 63 of the 1983 Act which can provide a general authority for such interventions. This would appear to make uncertain what powers are available for the control and management of patients in hospital, and may inadvertently require clinicians to anticipate emergency control and restraint procedures (including seclusion) in patient’s approved care-plans, to avoid having to seek justification under common law. This is impractical, and may be counter-productive in reinforcing measures such as seclusion as standard “treatment” options for difficult to manage patients. (para 6.21)

(g) In establishing quasi-judicial procedures for admission to long-term compulsion, the Bill appears also to have incorporated concepts and mechanisms that are currently only applicable to mentally disordered offenders dealt with through the criminal justice system. In particular, we are concerned about the introduction of the equivalent of restriction orders for civil patients deemed to be at substantial risk of serious harm to others, where the Tribunal may reserve powers of leave, discharge or transfer to itself. (para 3.4)

(h) We question the general necessity or desirability of making particular provision in the conditions for compulsion of civil patients who are deemed to be at “substantial risk of serious harm” to others, above and beyond those provisions that set a threshold for the compulsion of civil patients for the protection of other persons. We question whether it is reasonable to expect the risk-assessment of civil patients to distinguish between those patients who pose a serious risk of substantial harm and those patients whose risk to others cannot be so described, but is nevertheless sufficient to warrant the application of formal powers. (para 2.23)

(i) Whilst we would not have wished for the demise of the Mental Health Act Commission, we are less concerned about organisational structure than about safeguarding functions. We would want to ensure that the rights of detained patients are given the same high priority within the Healthcare

1 ie the definition of a clinical supervisor (paras 2.12–2.13 below); the categorisation of patients who may be eligible for compulsory powers initiated without inpatient assessment (paras 2.32–2.41); the scope of civil restriction orders (para 3.4).
Commission as under the current structure, and that monitoring the use of legal powers does not become subsumed under the wide focus of general healthcare inspection. We are concerned that without functions protected by legislative requirement and specific accountability, the pressures on a general body such as the Healthcare Commission will be bound to marginalise specialist monitoring and therefore patient protection. (paras 5.6–6.12)

4. A summary of our recommendations and suggestions for further consideration is given below.

**Summary of MHAC Recommendations and Suggestions for Further Consideration**

<table>
<thead>
<tr>
<th>Recommendation/suggestion for further consideration</th>
<th>Para no</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We propose that the following principles should have statutory force without restriction:</td>
<td></td>
</tr>
<tr>
<td>(i) That informal treatment is always to be preferred over compulsion when circumstances permit.</td>
<td></td>
</tr>
<tr>
<td>(ii) That treatment and care should be provided in the least restrictive manner compatible with ensuring the health or safety of the person concerned or the safety of other people.</td>
<td></td>
</tr>
<tr>
<td>(iii) That treatment and care should, insofar as is possible, be determined by or reflect the wishes of the patient concerned.</td>
<td></td>
</tr>
<tr>
<td>(iv) That treatment and care must be provided in such a way as to respect the qualities, abilities and diverse backgrounds of individuals, and properly takes account of age, gender, sexual orientation, social, ethnic, cultural and religious backgrounds without making general assumptions on the basis of any of these characteristics.</td>
<td></td>
</tr>
<tr>
<td>(v) That all powers under the Act shall be exercised without any direct or indirect discrimination on the grounds of physical ability, age, gender, sexual orientation, race, colour, language, religion or national, ethnic or social origin.</td>
<td>1.6</td>
</tr>
<tr>
<td>2. We recommend that the exclusions in the current Act relating to the definition of mental disorder should be retained in an updated form in new legislation, such as, for example: no person should be considered to be suffering from mental disorder for the purposes of the Act solely on the grounds of:</td>
<td></td>
</tr>
<tr>
<td>— dependence upon, or recreational use of, alcohol or drugs;</td>
<td>2.5</td>
</tr>
<tr>
<td>— sexual behaviour or orientation; or</td>
<td></td>
</tr>
<tr>
<td>— commission, or likely commission, of illegal or disorderly acts, although the presence of one or more above grounds must not be used to exclude the possibility of concurrent or underlying mental disorder</td>
<td></td>
</tr>
<tr>
<td>3. We question whether it is appropriate that the definition of medical treatment, and therefore the scope of the Bill, is in part dependent upon regulatory powers identifying the requirements for approval of professionals to be “clinical supervisors”.</td>
<td>2.14</td>
</tr>
<tr>
<td>4. We recommend caution over legislating far-reaching but ill-defined powers for the restriction of civil liberties</td>
<td>7.2</td>
</tr>
<tr>
<td>5. We believe that a Code of Practice can and should play a pivotal role in determining how new legislation is operated, but it should support rather than establish legal thresholds. If the Code is used appropriately, as we suggest, its authority could be strengthened without making its guidance legally binding, by the creation of a statutory duty to record and provide reasons for departures from such guidance in patients’ clinical records</td>
<td>7.6</td>
</tr>
<tr>
<td>6. We are concerned that the fourth condition for compulsion is not to be applied in the case of a certain category of patients whose definition will itself not be without problem. We recommend that further thought be given as to whether this is appropriate.</td>
<td>2.21</td>
</tr>
<tr>
<td>7. The Commission has suggested to Government that the problem of ensuring that patients are not detained without appropriate reason could be addressed by the adoption of the concept of therapeutic benefit</td>
<td>2.30</td>
</tr>
<tr>
<td>8. How mental health professionals should proceed in their dealings with a patient requiring treatment under formal powers in the absence of resources is an issue that requires some clarification in relation to the proposals and indeed the current law.</td>
<td>2.31</td>
</tr>
<tr>
<td>9. We recommend that the intention that “normally assessment or treatment in hospital will be needed before someone is judged suitable for treatment in the community” should be established and clarified on the face of the Bill rather than in regulations.</td>
<td>2.33</td>
</tr>
<tr>
<td>10. We urge that the primary legislation and its regulations provide a sufficiently robust safeguard against a two-tier threshold for imposition of formal powers: one for new patients, and one, less stringent, for patients known to services.</td>
<td>2.40</td>
</tr>
<tr>
<td>Recommendation/suggestion for further consideration</td>
<td>Para no</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>11. We urge reconsideration of the empowerment of the Tribunal to restrict to itself clinical decisions in the case of civil patients, particularly given the indeterminacy of the category of patients suggested.</td>
<td>3.5</td>
</tr>
<tr>
<td>12. We urge reconsideration or clarification of the proposed empowerment of the Tribunal to authorise minimum periods for inpatient treatment.</td>
<td>3.7</td>
</tr>
<tr>
<td>13. We recommend that:</td>
<td></td>
</tr>
<tr>
<td>(i) Care-plans submitted to Tribunals in respect of patients with mental capacity must be required to state what treatment, if any, the patient does consent to, as well as those treatments for which authority in the absence of the patient’s consent is sought;</td>
<td>5.6</td>
</tr>
<tr>
<td>(ii) Provision should be made in the Bill to regulate the assessment and recording of a patient’s consent to psychiatric medication when that patient is otherwise subject to compulsion, as with the 1983 Act;</td>
<td></td>
</tr>
<tr>
<td>(iii) Emergency powers to provide psychiatric medication should be provided in the draft Bill on the model of the 1983 Act; and</td>
<td>5.6</td>
</tr>
<tr>
<td>Consideration should be given to less bureaucratic means of authorising changes to approved treatment plans, possibly allowing the medical expert powers of authorisation relating to specific treatments (such as ECT and psychiatric medication) under specific circumstances, such as in amending extant orders.</td>
<td></td>
</tr>
<tr>
<td>14. We hope that further consideration will be given to establishing in law powers, duties and accountability that will preserve a specialised monitoring focus upon patients subject to compulsion irrespective of organisational structures.</td>
<td>5.11</td>
</tr>
<tr>
<td>15. We urge reconsideration of the acceptability of differences in the principles underlying the use of the Children Act 1989 and the Mental Health Bill, when either legislation may be used to require the formal residency of children aged 16–18.</td>
<td>6.1</td>
</tr>
<tr>
<td>16. The Commission supports the Government’s proposal to allow the High Court to authorise Neurosurgery for Mental Disorder for incapacitated patients.</td>
<td>6.6</td>
</tr>
<tr>
<td>17. We feel that there should be a clear justification for ending the equivalence of legal protections and rights of patients under the present law in relation to the imposition of ECT and long-term psychiatric medication.</td>
<td>6.13</td>
</tr>
<tr>
<td>18. We recommend that there should be specific provision on the face of the Bill with regard to treatment with medication for mental disorder, allowing that a patient’s consent can provide authority for such treatment, and setting out provisions for safeguards in relation to authority for treatment without consent. Where treatment is authorised by the patient’s consent, regulatory powers should establish requirements for records to be made in statutory form that assessments of mental capacity and consent status have taken place.</td>
<td>6.17</td>
</tr>
<tr>
<td>19. The Bill should be amended to include provision for emergency administration of medication for mental disorder, modelled upon the clauses providing such powers in respect of ECT</td>
<td>6.19</td>
</tr>
<tr>
<td>20. We urge that naso-gastric feeding of patients subject to formal powers be afforded the protections of type B treatment arrangements</td>
<td>6.20</td>
</tr>
<tr>
<td>21. We recommend that there should be a dedicated regulatory power in relation to issues over the control and management of patients where regulation can be made over training, use of staff, and record keeping etc in relation to seclusion and restraint. Such a power could also enable future regulation of problem issues such as searching, confiscation of property, use of CCTV etc.</td>
<td>6.21</td>
</tr>
<tr>
<td>22. We recommend reconsideration of the interface between the Mental Capacity Bill and draft Mental Health Bill, particularly in light of <em>H.L. v UK</em>.</td>
<td>8.7</td>
</tr>
</tbody>
</table>

1. Is the draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

1.1 In recent years the Mental Health Act Commission has repeatedly stressed its view that the task of Government in preparing the next mental health legislation is to ensure fairness, certainty and transparency in the legal framework for the compulsion of psychiatric patients. We know that a culture of human rights cannot be imposed upon services from above, and that the law is a blunt instrument for instilling good practice in the care of patients. But we also recognise that for Government to fulfil its obligation to ensure that powers used in its name are implemented in accordance with human rights principles, it must provide a robust framework that balances the empowerment of professionals to provide necessary treatment and the needs of public protection with safeguards to protect individual liberties. We do not believe that the draft bill, in its current form, does provide a sufficiently robust legal framework.
1.2 We are sympathetic to the aim of Government in establishing a legal framework that has no arbitrary or unhelpful limitations on mental health powers (as, for example, are presently established by the current Act’s apparent exclusion of patients with acquired brain injuries). We note, from Improving Mental Health Law and from our correspondence with Government departments, that it is the Government’s stated intention that the legislation should be “inclusive”:

“What we do want to achieve is inclusive legislation which enables practitioners, at their own discretion, to provide treatment which they assess as necessary and appropriate...that leaves us with the serious task to redress the legitimate concerns of those who fear a more intrusive, as opposed to more inclusive, legislative structure...It will be hard to demonstrate how the balance works until it is used in practice”

Home Office Mental Health Unit, 13 July 2004, personal communication with the MHAC

1.3 A balance must be reached between “inclusive” legislation and a meaningful framework of defined powers and duties. We view with some caution the Government’s overly positive reading of the measures that it proposes, which we think may overlook the potential for use of powers in ways other than it intends. We do not think the potential for overly broad interpretation of mental health powers is sufficiently safeguarded against by reason only of the duty provided by the Human Rights Act 1998 upon public authorities to construe the powers of mental health legislation in a way compatible with the European Convention. This may be true particularly over the question of who can be made subject to the powers of mental health legislation, which we deal with in paragraphs 2.1–2.3 below. The Convention itself can be interpreted quite widely in terms of acceptable interventions regarding the mentally disordered. We cannot accept the premise that the wide powers proposed in the Bill should be curtailed through the checks and balances of professional judgment and the Tribunal. For the law to be of value—to patients, State administrators, mental health professionals, the police, the courts or the Tribunal—its meaning cannot rest upon the discretion of those working within its framework. We do not find it difficult to envisage the inappropriate use, however well meant, of mental health legislation for non-medical purposes of social control.

1.4 The Commission believes that the scope and purpose of the legislation should be defined as far as is possible through a statement of principles on the face of the Bill at the start of its provisions. There are precedents for such principled statements within legislation (in particular the Children Act 1989, section 1). We accept that certain statements of principle that should be set out for those using the proposed powers of the Bill are, in part, established by existing primary legislation, such as the Race Relations and the Disability Discrimination Acts. If this means that the detail of principles needs to be established in a Code of Practice, then we would suggest that the Bill’s description of what such principles are designed to secure should be strengthened.

1.5 We consider that it is unacceptable for the Bill to allow that principles will have no universal application, but will be conditional in that they can be disapplied wherever “inappropriate or impractical”, and will be excluded from applying to functions of the Secretary of State in making certain regulations or directions.

1.6 We therefore propose that the following principles should have statutory force without restriction:

(i) That informal treatment is always to be preferred over compulsion when circumstances permit.

(ii) That treatment and care should be provided in the least restrictive manner compatible with ensuring the health or safety of the person concerned or the safety of other people.

(iii) That treatment and care should, insofar as is possible, be determined by or reflect the wishes of the patient concerned.

(iv) That treatment and care must be provided in such a way as to respect the qualities, abilities and diverse backgrounds of individuals, and properly takes account of age, gender, sexual orientation, social, ethnic, cultural and religious backgrounds without making general assumptions on the basis of any of these characteristics.

---

2 Improving Mental Health Law: Towards a New Mental Health Act, para 3.20.
3 The European Convention does of course allow for the lawful detention of persons of unsound mind, alcoholics or drug addicts or vagrants (Article 5(1)(e)), and allows restrictions on liberties as prescribed by law for the protection of health or morals (Articles 9(2), 10(2)). The Convention itself could not therefore be relied upon to exclude the use of mental health law to incarcerate drug addicts, alcoholics or other persons where the law itself made no clear limitation on such use. Although the interpretation of Convention rights is dynamic in nature, leading cases such as Herczegfalvy v Austria (1993) have also shown that treatment which falls below acceptable practice standards may nevertheless not be in breach of the Convention.
4 Where mental health powers have extended to the compulsory detention or treatment of alcohol abuse it has on occasion been used widely for that purpose. For example, a three-year study of the Cavan/Monaghan Psychiatric Service (Eire) between 1989–91 found that alcoholics accounted for 24% of all compulsory admissions under the then extant 1945 Irish Mental Treatment Act. Most of these admissions were of short duration, “which suggested that certification was being used as a way of dealing with social and behavioural crises in relation to intoxication” (Carey, T and Owens, J (1993) “Involuntary admissions to a district mental health service—implications for a new mental treatment act”, Irish Journal of Psychological Medicine, 1993 October; 10(3):139–144).
5 Draft Mental Health Bill, clause 1; schedule 1. Such broad criteria for disapplication must compromise the purpose of establishing principles at all. The present Code of Practice, which has more legal weight than the Bill’s proposals will allow is successor (see discussion below at paragraphs 7.4–7.5), establishes principles without such qualification of their applicability. We can see no reason why principles on the lines of those we suggest should not be universally applicable.
2. Is the definition of mental disorder appropriate and unambiguous?

2.1 Mental disorder is defined in the Bill as “impairment of or disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain.” We support the emphasis of effect over cause, but we are concerned that the definition is liable to extremely broad interpretation. It has been pointed out that the 2002 Bill definition potentially covered a range of conditions for which compulsion under mental health legislation is not appropriate, from multiple sclerosis to nicotine addiction. The redraft does nothing to alter this.

2.2 The Government proposes its definition of mental disorder as “a neutral description of the gateway to the use of formal powers”. It does not matter, according to this argument, what the scope of the definition is, as no-one will be subjected to compulsion simply because their mental state falls within its description. This argument, quite properly, defers the question of defining the boundaries of compulsion to the effect of the conditions considered as a whole. We are not convinced that the Bill’s “relevant conditions”, considered as a whole, are sufficiently demanding for this purpose. We discuss our concerns at paragraphs 2.6–2.31 below.

2.3 We believe that not reproducing the 1983 Act’s exclusion relating to drugs and alcohol in new legislation could lead to counterproductive compulsion being imposed on the basis of substance misuse alone. The technical definitions of mental disorder as outlined in the American DSM-IV and World Health Organisation classifications (ICD-10) encompass conditions that we would not consider to be appropriately within the scope of compulsion under the Bill proposals. We therefore cannot support the Government’s proposal to define mental disorder without including equivalent clauses to the 1983 Act’s exclusions regarding sexual deviance, immoral conduct or dependence on alcohol or drugs as sole factors constituting “mental disorder” for the purposes of the Act. The Government’s proposal would leave as a matter of professional discretion (possibly guided by a Code of Practice, and no doubt liable to judicial interpretation) whether dependence on or harmful use of psychoactive substances, or disorders of sexual preference, etc, could be construed as the sole basis of mental disorder and thus compulsion under mental health law.

2.4 The Government justification for its proposal to set aside exclusions is that the excluding clause has been widely misunderstood by clinicians as a bar to the detention of persons with drug or alcohol problems under the current law, even in the face of a coexisting mental disorder. We are not aware of strong evidence that the law is the real problem here: it is quite possible that mental health services seek to turn away such persons, or divert them to addiction services, but this may be more to do with practical resource limitations than mistaken ideas about the limit of mental health powers. Even if the extant law is being misapplied by some practitioners, we view this as a training issue rather than a justification for reducing the protections established against misuse of mental health powers.

2.5 We recommend that the exclusions in the current Act relating to the definition of mental disorder should be retained in an updated form in new legislation, such as, for example:

6 Draft Mental Health Bill, clause 2(5).
7 These examples of the potential reach of the 2002 Bill proposals are from the Royal College of Psychiatrists’ response to the 2002 Bill consultation exercise (Journal of Mental Health Law 8:377).
8 Improving Mental Health Law, para 3.12.
9 The Richardson Committee took a similar position, and concluded that for a broad definition of mental disorder to be acceptable, “it becomes essential to ensure that the other criteria are sufficiently demanding to prevent the inappropriate use of compulsion”. Although it determined that an inclusive definition of mental disorder was appropriate and appeared confident that it had established “sufficiently demanding” criteria for compulsion, the Committee nevertheless suggested retaining the exclusions of the 1983 Act in a modified form, suggesting that the ICD-10 category of “disorders of sexual preference” be excluded from the Act’s definition, and that drug or alcohol misuse should be excluded as a sole ground for believing mental disorder to be present. See Department of Health (1999) Review of the Mental Health Act 1983: Report of the Expert Committee (the Richardson Report), page 49 para 5.17, and page 38–39, paras 4.9 et seq.
10 Richardson Report, para 4.11.
11 The ICD-10 does however state that “social deviance alone, without personal dysfunction, should not be included as mental disorder”—see World Health Organisation (1992) ICD-10 Classification of Behavioural and Mental Disorders, page 5 (“Problems of terminology: Disorder”). We do not, however, conclude from this note in the introductory pages of ICD-10 that a legal threshold is thereby established.
12 We note in this context that recent mental health legislation in Scotland and the Republic of Ireland has contained explicit exclusions from the definition of mental disorder. In 2001 the Irish Government passed the Mental Health Act 2001, which provides that a person may not be admitted to hospital under its powers by reason only that he/she is socially deviant or is addicted to drugs or intoxicants (see footnote 4 above on the use of mental health powers to detain intoxicated persons in Eire prior to this change). The Mental Health (Care and Treatment) Scotland Act 2003 states that a person cannot be considered mentally disordered for the purposes of that Act “by reason only of sexual orientation; sexual deviancy; transsexualism; transvestism; dependence on, or use of alcohol or drugs; or behaviour which causes, or is likely to cause harassment, alarm or distress to any other person; or acting as no prudent person would act”.

---

(v) That all powers under the Act shall be exercised without any direct or indirect discrimination on the grounds of physical ability, age, gender, sexual orientation, race, colour, language, religion or national, ethnic or social origin.
— no person should be considered to be suffering from mental disorder for the purposes of the Act solely on the grounds of:
— dependence upon, or use of, alcohol or drugs;
— sexual behaviour or orientation; or
— commission, or likely commission, of illegal or disorderly acts,

although the presence of one or more above grounds must not be used to exclude the possibility of concurrent or underlying mental disorder.

Are the conditions for treatment and care under compulsion sufficiently stringent?

2.6 We do not consider that the conditions for compulsion proposed by the Bill are sufficiently stringent or clear.

2.7 At figure 1 below we set out a comparison of the conditions for compulsion in the current Act and the draft Bills of 2002 and 2004. For the purposes of comparison, to show the essential differences between the current law and what is proposed, we have summarised provisions and rearranged their order, but notwithstanding this we note the very similar conceptual structures in each.

2.8 We believe that the following aspects of the conditions for civil compulsion under the current Act are unsatisfactory:

(a) It is apparent that the current Act uses hospitalisation itself as a threshold to establish whether a disorder is serious enough to warrant intervention (line 1 in our table).

(b) There is no requirement for patients classed under the mental illness or severe mental impairment categories that such intervention will provide any therapeutic benefit (line 2)—and such patients may therefore be initially detained solely for their protection or for the protection of others (line 3).\(^{13}\)

(c) The criterion of “necessary for health” (line 3) is liable to broad interpretation.

<table>
<thead>
<tr>
<th>1983 Act</th>
<th>2002 Bill</th>
<th>2004 Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nature or degree of disorder makes treatment in hospital appropriate</td>
<td>Nature or degree of disorder warrants medical treatment under the supervision of an approved clinician</td>
<td>Nature or degree of disorder warrants medical treatment under the supervision of an approved clinician</td>
</tr>
<tr>
<td>2. In the case of personality disorder or mental impairment, treatment in hospital will alleviate or prevent deterioration of condition</td>
<td>Appropriate medical treatment is available in the patient’s case</td>
<td>Medical treatment is available which is appropriate in the patient’s case, taking into account the nature and degree of the mental disorder and all other circumstances of his case</td>
</tr>
<tr>
<td>3. It is necessary for the patient’s health or safety (or the protection of other people) that treatment in hospital is provided(^{14})</td>
<td>It is necessary for the patient’s health or safety (or the protection of other people) that medical treatment is provided</td>
<td>It is necessary to protect the patient from suicide, serious self-harm, or serious neglect of health or safety (or to protect other people) that medical treatment is provided</td>
</tr>
<tr>
<td>4. The treatment cannot be given lawfully without the use of compulsion</td>
<td>The treatment cannot be given lawfully without the use of compulsion, unless the patient is at substantial risk of causing serious harm to others</td>
<td>The treatment cannot be given lawfully without the use of compulsion, unless the patient is at substantial risk of causing serious harm to others and is over 16 years of age</td>
</tr>
</tbody>
</table>

\(^{13}\) The treatability test does apply to any category of mentally disordered patient in the case of renewing detention for treatment—see Mental Health Act 1983, section 20(3),(4).

\(^{14}\) Under section 2 of the 1983 Act, (detention in hospital for assessment for up to 28 days with treatment powers) this threshold is simply “ought to be detained in the interests of his own health or safety . . . “.
2.9 The proposals in the 2004 draft Bill are based upon a recognition of these problems in current law, but it is not evident that they are successful in providing a firm basis upon which the restriction of liberties can be founded. We examine the proposed conditions below.

The first and second conditions: the patient is suffering from mental disorder of such a nature or degree as to warrant the provision of medical treatment to the patient under the supervision of an approved clinician.

2.10 We have explored the very wide potential definition of “mental disorder” in our answer to question 1 above. The first two conditions (read alongside the definition in clause 2(7) of “medical treatment”)\(^\text{15}\) attempt further description of the sort of mental disorder, or the circumstances associated with any particular mental disorder, that are to fall within reach of the Bill’s powers. But they fail to do so in any way that establishes a minimum threshold against which compulsion may be justified.

Medical treatment under the supervision of an approved clinician

2.11 The uncertainty over thresholds for compulsion are in part caused by a problem in defining the nature of the “medical treatment” that must be necessary for formal powers to be invoked. The Bill defines this as “treatment for mental disorder” that may include:

- nursing;
- care;
- therapies, counselling and other psychological interventions; or
- rehabilitation or habilitation, including education or training in work, social or independent living skills,

provided that these are given under the supervision of an “approved clinician”.\(^\text{16}\)

2.12 The definition of “medical treatment of mental disorder” is thus fundamentally reliant upon the definition of “approved clinician”. Although regulations are to establish the exact criteria for the approval of such clinicians, the Bill itself attempts to provide a core requirement in the statement that this must be someone “with special experience in the diagnosis or treatment of mental disorder”.\(^\text{17}\) The definitions of “medical treatment for mental disorder” and “approved clinician” in the Bill itself are therefore circular. This, coupled with the wide definition of “mental disorder” discussed at question 1 above, provides very little certainty regarding the potential scope of the Bill’s powers. It will depend entirely upon the content of regulations (establishing requirements for the approval of clinicians to supervise treatment) to limit this scope.

2.13 Just as compulsory psychiatric treatment is linked under the current Act to detention in hospital, so the professional who is responsible for such treatment must be a registered medical practitioner. The Government has signalled that it intends to pass regulation allowing that “clinical supervisors” of patients subject to compulsion under the Bill need not be registered medical practitioners, but may be, for example, psychologists.\(^\text{18}\) Whilst Government has no apparent intention of further extension of the role to, for example, drug or alcohol service workers, there is nothing in the Bill that would prevent such regulation in future, in which case the nature of treatment under the Act could shift accordingly.

2.14 We question whether it is appropriate that the definition of medical treatment, and therefore the scope of the Bill, is in part dependent upon regulatory powers identifying the requirements for approval of professionals to be “clinical supervisors”.

Mental disorder . . . warrants the provision of medical treatment

2.15 For a patient to be made subject to long-term compulsion under section 3 of the 1983 Act, practitioners must be of the view that it is necessary to administer treatment in hospital under conditions of detention. The first condition of compulsion under the present law is therefore that the nature and degree

\(^{15}\) Draft Mental Health Bill, Clause 2(7); this provides that all references to “medical treatment” are to be understood as references to treatment for mental disorder provided under the supervision of an approved clinician.

\(^{16}\) Draft Mental Health Bill, Clause 2(7).

\(^{17}\) Draft Mental Health Bill, Clause 3(2).

\(^{18}\) Improving Mental Health Law proposes the qualification of “approved clinician” as a “specialist doctor or senior mental health practitioner” (page 11). The closest equivalent role under current law is the responsible medical officer (RMO), who must be a registered medical practitioner and is, as the title suggests, responsible in law for the patient’s treatment (MHA 1983 s64(1)). It is not clear that a clinical supervisor who is not a registered medical practitioner could, in fact, be “responsible” for their patient’s treatment in an equivalent sense, having, for example, no legal authority to prescribe medication. In this sense the “clinical supervisor” role would seem potentially much more of a co-ordinating one, closer to the role of ‘supervisor’ under supervised discharge arrangements in current law. This shifting of roles and responsibilities is of concern to us in that it may imply a potential for the use of the Bill’s powers for purposes less directly connected with medical necessity than is acceptable under the present law.
of the mental disorder makes treatment in hospital appropriate. The Bill has only that the nature and degree of mental disorder must warrant treatment of some kind. This condition would be met by the majority of mental disorders.

2.16 Although all the proposed conditions for compulsion must be viewed in conjunction to assess their overall effect, it is apparent from this problem in the first condition that the Bill needs to provide an equivalent to the practical threshold for intervention provided by the current legal connection between the instigation of formal powers and detention in hospital. There has been widespread concern that powers of community treatment proposed under the draft Bill could be applicable to persons who, under present law, are not “detainable”. Although Improving Mental Health Law states that “there is no intention to reduce the threshold of the use of formal powers”, it is questionable whether this intention will be realised by the overall effects of the proposed Bill.

The third condition: that it is necessary—

(a) For the protection of the patient from—

(i) suicide or serious self-harm, or
(ii) serious neglect by him of his health or safety, or

(b) for the protection of other persons,

that medical treatment be provided to the patient.

Necessary for the protection of the patient

2.17 We welcome the replacement of the current Act’s concept of treatment being “necessary for health or safety” with the more exacting “necessary for the protection of the patient from suicide, serious self-harm or serious neglect of . . . health”. The current Act’s phrasing gives no indication that its powers cannot be used for the general benefit to a patient’s well-being, even where there is no real risk to a patient of not using such powers. However, even with the more robust wording proposed under the Bill, it is the case that “necessity” and indeed “seriousness” are not fixed values, but may be judged relative to the invasiveness of any intervention. This condition could therefore be undermined as an effective protection for patients if the practical threshold of using formal powers is lessened by the Bill’s proposals. We discuss such potential use of the Bill’s proposed powers at paragraph 2.40 below.

Necessary for the protection of others

2.18 As with the current Act, in this condition the Bill does not define what it is that persons other than the patient may be protected from. This leaves its scope very wide, although perhaps appropriately so, as any qualification (such as, for example, protection “from serious harm”) would imply that there is an acceptable level of harm to others that it would be inappropriate to prevent by use of formal powers. However, in combination with very broad definitions of mental disorder and treatment, this condition provides a wide scope for the inappropriate use of mental health legislation for reasons of social control rather than medical treatment (see also paragraphs 225–2.30 below).

The fourth condition: medical treatment cannot be provided to the patient unless he is subject to the provisions of this Act.

2.19 The Bill provides that, generally, powers should continue to be applied on a “last resort” basis, in that clause (9)(5) states as a condition of compulsion that medical treatment cannot otherwise lawfully be provided. This is a continuation of the 1957 Royal Commission’s assumption of favouring voluntary treatment over formal compulsion wherever possible.

2.20 In conjunction with the third condition’s requirement of intervention being necessary, the fourth condition should provide assurance that compulsion is only used where there is no acceptable medical or legal alternative. However, considered in isolation, the fourth condition may be met in any case where the patient refuses consent. In this sense the fourth condition cannot make good the deficiencies of other conditions of compulsion, particularly in relation to the definition of mental disorder and the scope of the general powers of the Bill.

The function of “substantial risk of serious harm” in the conditions for compulsion.

2.21 We are concerned that the fourth condition is not to be applied in the case of a certain category of patients whose definition will itself not be without problem. We recommend that further thought be given as to whether this is appropriate.

---

19 Improving Mental Health Law, page 28, paragraph 3.35.
20 In part, this will depend upon as yet undetermined limitations to be placed upon the use of proposed community powers as a patient’s entry into compulsion by regulation: see paragraphs 2.32–2.40 below.
2.22 The Bill proposes that, in the case of any patient at “substantial risk of causing serious harm” to others, the condition that treatment may only be given under compulsion if no lawful alternative exists is to be waived. The concept of “substantial risk of serious harm” was introduced into mental health legislation by the Mental Health (Patients in the Community) Act 1995, as a threshold for the risk that must be posed by a patient to himself or others to warrant the imposition of supervised discharge. In the current law it therefore applies to “revolving-door” patients, for whom it serves as a threshold for establishing whether the dangers of relapse and repeated formal admissions due to non-compliance with medication justify the use of formal powers. The Bill uses the concept only to describe risk of harm to others, which of course must restrict its scope from that of present usage.

2.23 The principle that a patient’s apparent (if perhaps disinclined to fluctuating) consent may not be a bar to the use of formal powers where safety requirements predominate is established in current practice and described by the Mental Health Act Code of Practice. The Code suggests that the use of formal powers should be considered where a mentally capable patient’s current medical state, together with reliable evidence of past experience, indicates a strong likelihood that he or she would have a change of mind about informal admission or treatment prior to its commencement, with a resulting risk to the health or safety of the patient or the safety of others. This does not provide a very certain footing for the use of formal powers where a patient is willing, however temporarily and perhaps with a view to obstructing authorities in the provision of care, to “consent” to interventions. It may therefore be sensible to establish in primary legislation exactly where practitioners stand in this situation. But the Bill’s provision at Clause 9(7) fails to do this, and we draw the Committee’s attention to the following problems that it presents:

(a) The proposal does not address the issue of patients who are a risk to themselves. Firstly, the 1983 Act’s Code of Practice suggests that all safety considerations— that is, regarding not only risk to others but also risks to patients themselves— should be considered where a incapacitated patient’s consent is a fluctuating or otherwise doubtful basis upon which to provide informal care. The Bill’s proposed removal of the “last resort” principle only for those patients posing substantial risk of serious harm to others would therefore leave untouched the question of how the principle of last resort is to be applied with patients whose consent is fluctuating and who pose a serious risk to themselves. Given that mentally disordered patients are statistically more likely to be a danger to themselves than they are to pose a danger to others, we question why the Bill’s proposal only addresses the minority group.

(b) The proposal apparently posits two levels of dangerousness in civil patients. Secondly, it is difficult to arrive at a clear conceptual picture of a patient who may be made subject to civil compulsion “for the protection of other persons” (clause 9(4)(b)) who does not pose “a substantial risk of serious harm to others”, although the Bill appears to intend the latter group as an especially dangerous subset of the former. The courts have interpreted “substantial risk” as a risk that is more than remote and not merely minimal, which we believe should be the standard for any definition of risk that meets the most basic threshold for the civil use of psychiatric compulsion. It is similarly difficult to accept that harm which is not “serious” can or should be considered to provide justification for compulsory powers. As such the Bill appears either to provide a wide-ranging exception to the principle of last resort, or, in an attempt to specify a particular group of patients posing a risk to others, extends too greatly the potential meaning of “protection of others” as a basic reason for the civil use of mental health law.

2.24 We raise these concerns in the knowledge that the Parliamentary Joint Committee on Human Rights (JCHR) has questioned whether risk-assessments could provide strong predictors of future violence in civil cases and has recommended that Government should make publicly available an account of risk factors that are to be taken into account, and their reliability. The JCHR raised this issue as an aspect of its concern that the powers proposed in the 2002 Bill could be used to justify preventive detention, which is the fourth and final concern that we wish to raise in relation to the conditions of compulsion. The JCHR was also told that risk prediction in this area was extraordinarily difficult.

22 By “disinclined consent”, we refer to the apparent voluntary agreement of a patient to engage with services, given to avoid use of compulsion, but liable to be withdrawn before services are provided.
23 Mental Health Act 1983 Code Of Practice, paragraph 2.7.
The Fifth Condition: Medical treatment is available which is appropriate in the patient’s case, taking into account the nature and/or degree of his mental disorder and all other circumstances of his case

The question of non-therapeutic detention

2.25 The Bill proposes as a universal condition for the application of powers that “medical treatment is available which is appropriate in the patient’s case, taking into account the nature or degree of his mental disorder and all other circumstances of his case”27. We welcome the idea of a universally applicable test, but have some doubts that the Bill’s drafting achieves a proper protection for patients against detention or other restrictions on liberty without the reciprocity of meaningful or appropriate treatment.

2.26 In its report on the 2002 Bill, the Parliamentary Joint Committee on Human Rights (JCHR) stated that

the...condition that appropriate medical treatment is available to the patient, would offer no protection against use of the powers in a manner inconsistent with the Government’s intention, particularly in a case where powers are used to protect others, because the only possible treatment might be no more than day-to-day care (perhaps with education, training or rehabilitation) under the supervision of an approved clinician...28.

Although the JCHR accepted that preventive detention is not unlawful under the European Convention29 and that the proposals, in themselves, would not lead to a violation of human rights, it did state that “this raises human rights issues, flowing mainly from the breadth of the circumstances in which a patient could be subjected to compulsory, non-consensual treatment”30. It also warned that precedent case-law regarding the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, which dealt with patients convicted of violent offences and subject to restriction orders, cannot be regarded as necessarily supporting the compatibility of preventive detention in civil cases with the Convention right under ECHR Article 531.

2.27 We do not think that the Government has answered the concern of the JCHR with the condition that “appropriate medical treatment is available in the patient’s case” “taking into account the nature and degree of the mental disorder and all other circumstances of the case”. The criterion of “appropriateness” has no necessary connection to any potential benefit to the patient. In the eyes of the deciding authority, detention of a person for the protection of others may be appropriate in all the circumstances notwithstanding that for the patient concerned it is no more than warehousing under preventive detention.

2.28 We are not reassured by the Government’s answer to fears over preventive detention as set out in Improving Mental Health Law, which is essentially that detention for the protection of others “has been with us since 19592 and that it will be for clinical and social care staff to decide whether all the conditions for compulsion are met, including the condition that appropriate treatment is available32. We accept that “there is no intention of requiring general facilities to detain people for whom no treatment is available”33, but we are not convinced that this intention is will necessarily shape the future interpretation of the law once it is enacted.

2.29 The “treatability” requirements of current law are not ideal from the patient’s perspective. They initially only apply to certain categories of patient (including, however, persons classified as having psychopathic disorders, who are perhaps most at risk of non-therapeutic detention)34. The broad definition of treatment under the 1983 Act provides them with questionable rigour as safeguards. However, these requirements do at least make a clear connection that the beneficence of treatment under formal powers must extend to the patient, in that treatment is likely to alleviate or prevent deterioration in the patients’ condition. The Bill’s proposal to replace this with a requirement that available treatment is “appropriate”, taking into account all the circumstances of the case, does not necessarily relate to therapeutic benefit for the patient, and may as easily be met by preventive, non-therapeutic detention as by a therapeutic intervention.

27 Draft Mental Health Bill, clause 9(6).
28 JCHR Report, page 17, para 42.
32 Improving Mental Health Law, page 8, figure 2.
33 Improving Mental Health Law, page 26, para 3.23. The Committee may wish to consider whether the use of the phrase “general facilities” in this statement implies that detention of people for whom no treatment is available is envisaged in any other facility, such as DSPD units.
34 See paragraph 2.8 and footnote 13 above.
2.30 The Commission has suggested to Government that the problem of ensuring that patients are not detained without appropriate reason could be addressed by the adoption of the concept of therapeutic benefit, which was introduced in the Government’s White Paper of 2000 but subsequently dropped. Improving Mental Health Law acknowledges stakeholder suggestions for the reinstatement of “therapeutic benefit” but gives no reason why this concept is deemed less suitable than the test being proposed.

Availability of treatment as a condition of compulsion

2.31 Mental health law cannot provide a right to treatment for which no resources are available. The condition of treatment being “available” for a patient to become liable to formal intervention seems nevertheless to raise some problematic questions. The effect of the provision would appear to be that treatment appropriate to the patient’s disorder must be known to be available for the individual at the time of the determination whether to examine the patient for possible use of formal powers. There must be agreement with service providers that the services that are needed, at least initially, will be provided. There is a risk of bureaucracy here, but also a question of principle. Services for certain types of patient (such as people with personality disorder or dual diagnosis) can be relatively scarce, and we believe that, under the present law, it is scarcity as much as any misunderstanding of the law that excludes such patients from services. We would be concerned that the requirement of availability should not be open to misuse to exclude patients inappropriately from services by limiting services’ responsibilities. How mental health professionals should proceed in their dealings with a patient requiring treatment under formal powers in the absence of resources is an issue that requires some clarification in relation to the proposals and indeed the current law.

Are the provisions for assessment and treatment in the community adequate and sufficient?

2.32 Government has acknowledged fears that treatment under formal powers in the community could be used inappropriately leading potentially to an increase in the overall numbers of patients subject to compulsion. It proposes to limit the applicability of community powers:

It will not be possible for a patient who is brought under the formal powers to be assessed in the community without previously having had an assessment in hospital at some time. [Regulations] will define which patients will be eligible, from the outset, to be a non-resident patient. Primarily, these will be people who have previously been treated in hospital and who are well known to services, but who are prone to cycles of discharge, relapse and readmission into hospital (sometimes called “revolving door” patients).

The explanatory notes to the Bill also state that “normally assessment or treatment in hospital will be needed before someone is judged suitable for treatment in the community.”

2.33 We are very concerned that the important question of the scope of proposed community powers will be established by regulation, and recommend that the intention that “normally assessment or treatment in hospital will be needed before someone is judged suitable for treatment in the community” should be established and clarified on the face of the Bill.

2.34 The Committee may wish to consider further with Government the precise implication of the statement that patients subjected to powers in the community at the outset of their compulsion “primarily” will be revolving-door patients. It is unclear exactly how such a patient group will be defined by proposed regulation, and which other patient groups will be liable to initial compulsion in the community. The Bill also makes provision for courts to make mental health orders for non-resident treatment, and these presumably will not be fettered by such regulation.

---

37 *Improving Mental Health Law* para 3.33.
38 *Improving Mental Health Law* para 3.37.
39 Explanatory Notes, para 7.
40 *Improving Mental Health Law* para 3.37.
41 Mental Health Bill, clause 119.
2.35 Although the exact scope of the proposed non-residential orders is yet to be determined, the powers proposed for such orders are similar to existing provisions of the Mental Health (Patients in the Community) Act 1995 (supervised discharge) and Guardianship under the 1983 Act. Government has indicated its expectation that the majority of patients under compulsion at any one time will continue to be in hospital. This would seem to be a reasonable expectation, given the relatively slow take up of existing community powers.

2.36 Alongside patients subject to formal community-based powers under the present legislation, there is now probably an increasing number of patients managed outside hospital under legal conditions that closely approximate those proposed as "non-residential" orders. However, the current legal position would still appear to prevent a patient from being made subject to the 1983 Act without an initial hospital position. This would seem to be a reasonable expectation, given the relatively slow take up of existing but diffuse and uncertain legal powers.

2.37 It is possible that the proposal to establish a duty upon supervisors to keep the residency status of their patients under review is thus equivalent to proposing a requirement under the current legal structure for responsible medical officers to grant leave at the earliest safe opportunity. This is a welcome recognition in law of the current good practice requirement that patients should be treated in as least restrictive manner and in receipt of inpatient care at the time of that detention's renewal. Because of this change in the current law, there is now probably an increasing number of patients managed outside hospital under legal conditions that closely approximate those proposed as "non-residential" orders. However, the current legal position would still appear to prevent a patient from being made subject to the 1983 Act without an initial inpatient period. This extended scope of the 1983 Act is not easily applicable to patients detained under section 2, whose detentions are neither renewable nor, if such a patient is on leave at the time, convertible to section 3, although there is little to stop an inpatient's detention under section 2 from being converted to a section 3 with the aim of granting long-term leave. Such proposals for general powers to use formal powers on a non-residential basis could provide something of a consolidation of existing but diffuse and uncertain legal powers.

2.38 The Government has made it clear that the Bill does not allow enforced treatment outside of hospital. Our reading of the Bill suggests that, in cases where intervention was deemed necessary as a result of a patient's non-compliance, the least restrictive option available to clinical supervisors would be to use powers of conveyance to take that patient to hospital where he or she could be treated forcibly. Clinical supervisors are also empowered to change the residency requirements of patients subject to community powers who fail to comply with treatment, so that they can be taken and detained in hospital as resident patients provided that such conveyance takes place within 24 hours of the clinical supervisors'...
determination that the patient’s material conditions are changed. The Tribunal or court making any non-residency order will be required to recommend to the clinical supervisor what action she might take if the patient fails to comply with treatment. The clinical supervisor must “have regard” to such recommendations, but will effectively be empowered to admit a patient to hospital without further safeguards. If these powers are used to manage patients following assessment in hospital, then they extend no further than existing powers available to clinicians who grant their detained patients leave. As such, non-residency is for all purposes a form of leave arrangement from hospital, and the thresholds for keeping a patient under such powers should be appropriately high. If, however, such powers are applied in the case of patients who have not been made subject to detention in hospital and whose treatment requirements are of a different order, then they are broad and potentially excessive powers. Although patients subject to non-residency orders may not be physically detained in hospital, the possibility of such detention and enforced treatment with no further formality will hang over them as a possibility at any given time.

2.39 If non-residential powers can serve little purpose that is not provided for by leave in the management of patients who begin their compulsion as inpatients, they may still find a role as a form of enhanced guardianship or as an alternative to use of the Powers of Criminal Courts Act 1973 to make a psychiatric probation order. Case Study 5 in Improving Mental Health Law provides an example of a court using the new powers in the latter sense. The use of non-residential orders by the courts to divert mentally disordered offenders seems to us to be a relatively uncontroversial use of the proposed powers; not least because, by the time of a conviction, there will have been opportunity to make an initial mental health assessment of the offender.

2.40 It is less clear how such powers might be used reasonably in a civil context to initiate a period of compulsory treatment. It seems possible that the practical thresholds for imposing some legal restraints on patients under non-residency powers may be lower than those for the use of residency powers. We remain sceptical over the implication that the decision whether to impose serious legal restrictions on a patient’s liberties could be taken through community-based assessment if the patient is known to services. We would urge that the primary legislation and its regulations provide a sufficiently robust safeguard against a two-tier threshold for imposition of formal powers: one for new patients, and one, less stringent, for patients known to services.

3. Does the Draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

3.1 Because we view the definition of mental disorder and the consequent conditions for compulsion as unnecessarily wide-ranging, we are bound to conclude that the Bill as currently drafted fails to achieve a balance between individual rights and personal or public safety concerns.

3.2 In our discussion of the conditions of compulsion (paragraphs 2.25–2.30) we have expressed our concern that the Bill provides no adequate safeguard against the use of civil powers for the preventive non-therapeutic detention of patients judged to be at risk of causing harm to others.

3.3 In establishing quasi-judicial procedures for admission to long-term compulsion, the Bill appears also to have incorporated other concepts and mechanisms that are either only applicable to mentally disordered offenders dealt with through the criminal justice system, or otherwise redolent of criminal justice measures. The following examples demonstrate our concerns:

CIVIL RESTRICTION ORDERS

3.4 The Tribunal will be empowered in certain civil cases to restrict to itself the exercise of the power of discharge from compulsion, granting leave from hospital or arranging transfer from one hospital to another. The categories of patient to whom such civil restriction orders may apply is yet to be determined by regulation, although it seems likely that patients “at risk of causing serious harm to others” will qualify. This indeterminacy precludes the Committee from proper examination of the proposal, and also means that the boundaries for this restriction over civil patients would be subject to change by Ministerial regulation after enactment of the Bill. We are concerned that decisions regarding the compulsion of any civil patient

52 Draft Mental Health Bill, clauses 48(7), 51(9), 121(6). It is not clear from the Bill and explanatory notes what purpose this time-limit has, although we surmise that it may be intended either to ensure that action is taken speedily where a patient may be at risk and/or to limit this power as an emergency measure. The imposition of a time limit in these circumstances is a questionably enforceable requirement, not least because establishing when the 24-hour period starts can surely only be determined subjectively by the clinical supervisor, who is then bound by the time limit that it imposes. Furthermore, what happens if the time limit is exceeded but action needs to be taken?

53 Draft Mental Health Bill, clauses 46(6), 49(6), 119(6).

54 Draft Mental Health Bill, clauses 48(5), 51(7), 121(4).

55 Improving Mental Health Law, page 19.

56 Draft Mental Health Bill, clause 46(5). This provides that a Tribunal may only reserve powers to itself in the case of patients found falling within a description to be established by regulation.
should be taken out of the hands of clinicians in the way proposed. Our concern about the use of the concept of “substantial risk of serious harm”, which we set out at paragraphs 2.23(b) and 2.24 above, is relevant in this context.

3.5 We urge reconsideration of the empowerment of the Tribunal to restrict to itself clinical decisions in the case of civil patients, particularly given the indeterminacy of the category of patients suggested.

Tribunal power to order residency for a set period

3.6 The Tribunal appears to be enabled to direct that a civil patient be held as a resident patient for a period of time specified in the order, and thereafter, whilst the order remains in force, as a non-resident patient. The Bill’s explanatory notes give no indication of the intended purpose of this power. It is possible that this is intended simply for administrative convenience, where arrangements need to be made to establish a patient safely as a non-resident patient. It gives the appearance of detention in hospital being used in a penal context rather than as a medically necessary requirement for treating mental disorder. There can be no justification for hospital orders of any kind to have a minimum time-limit that may extend beyond what is clinically necessary.

3.7 We urge reconsideration or clarification of the proposed empowerment of the Tribunal to authorise minimum periods for inpatient treatment.

Tribunal powers over patients in the community

3.8 The Tribunal is empowered, when making a non-residential order, to make it a condition “that the patient does not engage in specified conduct”. In this context, “specified” means specified by the Tribunal itself, and does not imply any limitation by regulation or otherwise on the scope of this power. Consequently, this power is extremely broad and has a wide potential for use as a form of social control that is only tangentially related to medical treatment. Our concerns over this are heightened by the over-inclusive definition of “mental disorder”, the broad scope of conditions for compulsion, and the uncertainties over how so-called “revolving door” patients or other categories are to be identified as eligible for assessment in the community without inpatient assessment.

4. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient, and clear? Are there any important omissions in the Bill?

The necessity for change

4.1 The draft Bill, despite its length and complexity, does not provide a paradigm shift in the underlying principles used to justify compulsory treatment since 1959. In particular, its basis for providing compulsion is the necessity of treatment, rather than the inability of a patient to make their own choices. From the Expert Committee’s consultation in 1999, we have taken the sometimes-unpopular position that it would be premature to embrace such a shift, given as yet unresolved problems in defining mental capacity in the context of taking decisions about the treatment of mental disorder (see also paragraphs 6.8–6.9 below). We considered that even the Expert Committee’s proposals, which nominally embraced mental capacity as the threshold of compulsion, in the end were unable to avoid perpetuating a threshold determined in many cases by the necessity of providing treatment to a patient, rather than whether the patient’s refusal of that treatment was capacitated.

4.2 Aspects of the 1983 Act require urgent amendment. In particular, the 1983 Act’s provision regarding “Nearest Relatives” have been deemed incompatible with ECHR Article 8, and it may be that the current Tribunal arrangements will not withstand challenges based upon the requirements of Article 5 of the ECHR. It would be possible to deal with such matters through an amendment Bill, if perhaps no less complicated than redrafting the law as a new Bill.

Unnecessary changes

4.3 Given that the draft Bill is built upon the foundations of extant law, and has not proposed a radical review of the principles of compulsion, we question whether some of the changes to the current legal position of patients are necessary or indeed likely to be beneficial. We have particular concerns, for example, at the inconsistent rewriting in the draft Bill of the 1983 Act’s consent to treatment provisions. These could undo the protections currently provided to patients in relation to compulsory psychiatric medication (see paragraph 6.14–6.19 below). We can see no reason to depart under this Bill from the basic structures regarding consent to treatment for medication for mental disorder under current law, and we would expect any change to be justifiable in terms of benefit to patient protection. In our view there is no such justification for the proposals as drafted.

57 Draft Mental Health Bill, clause 46(4)(c)

58 Draft Mental Health Bill, clauses 46(7)(b), 49(7)(b), 119(7)(b).
Are the changes workable?

4.4 At paragraph 5.5(e) below we question whether the proposed Tribunal procedure will be cost effective in providing safeguards for patients that are balanced against the resource implications for front-line professionals as well as others. It will be important that a balance is struck, not least to counter any tendency of judicial-style commitment proceedings towards routine and ritual hearings\(^{59}\), or the rubber-stamping of standardised applications containing stock phrases\(^{60}\).

Omissions

4.5 A number of omissions are dealt with elsewhere in our response:

(a) We note the omission of important consent to treatment powers and safeguards (see paragraphs 5.5 and 6.14–6.19 below)

(b) We have urged the Government to take the opportunity of new legislation to establish statutory regulation of the administration of naso-gastric feeding to patients (para 6.20)

(c) We have urged Government to take the opportunity of new legislation to establish statutory regulation of the use of seclusion and restraint in hospitals, and to consider other issues of the management of patients (para 6.21)

(d) In our view the omission of defining exclusions for the term “mental disorder” is unhelpful and could lead to misuse of powers (paras 1.5–1.6)

Inefficiencies

4.6 The Bill may be said to be inefficient in that it does appear, in some instances, to establish numerous unenforceable duties by stating that persons must do something at their discretion, and, in other instances, appears to wish to limit the discretion that it has given to professionals with arbitrary rules.

4.7 We have already highlighted an example of the former inefficiency in paragraph 2.38 and footnote 52 above, where the Bill appears to propose a duty upon an individual that is dependent upon, or at the discretion of, that individual’s subjective judgments. This is the oddity of establishing a legally binding timescale on a clinical supervisor that starts from the point at which he or she determines that a patient’s circumstances have changed. The Bill’s various duties of consultation with nominated persons or carers are also questionably enforceable, given that the person on whom the duty rests usually has discretion to put it aside. We would not question that it is appropriate to allow discretion in the latter case (indeed one problem with the current law is that it does not provide such discretion), but we do wonder whether duties that are conditional upon their subjects are really duties at all.

4.8 The most serious example of the second inefficiency (ie attempts to limit the discretion given to professionals with arbitrary rules) is perhaps the Bill’s use of the concept of “substantial risk of serious harm” by Tribunals in fettering clinical discretion over civil patients (see paragraph 3.4 above). The following are also examples where the Bill appears to limit discretion in places where this may be otiose:

(a) One serious inefficiency that we have previously raised with Government is the establishment at clause 16 of a prohibition on the full examination of any potential patient from the point that any one of the three examiners (two doctors and a social worker) concludes that all the conditions are not met. This legal duty appears to disallow discussion amongst the professionals as to the best outcome for a patient, or for an examiner to set aside any doubts pending discussions with his or her examining colleagues. Whilst sensible examiners could, where fulfilment of this duty would be detrimental to the patient’s welfare, easily circumvent it by reserving their judgment for such time as it takes for a full examination to be made, it is perhaps unwise to rely on all parties taking such a pragmatic view of the law. By preventing a full examination, the Bill may foster poor decision-making over whether the conditions are met, and it may also hamper sensible alternative arrangements being made where the use of formal powers is unnecessary.

(b) Although the Bill leaves the “suitability” of a patient’s preferred “nominated person” to the discretion of the professional who acts as appointer, regulations are also promised that will set out

---

\(^{59}\) See, for example, Warren, C (1982) The Court of Last Resort, Mental Illness and the Law, University of Chicago. This is a study of the Los Angeles mental health court’s use of the Californian Lanterman-Petris-Short Act (LPS). Under LPS, involuntary hospitalisation of more than 72 hours had to be sanctioned through adversarial court proceedings, with either “grave disability” (essentially similar to incapacity) or “dangerousness” as the key criteria for compulsion. Under the first criteria commitment was then subject to annual judicial review; under the second it had to be renewed every 90 days, with evidence that the patient continued to act violently under confinement. Less than a decade after the establishment of the LPS Act, all commitment hearings were for patients deemed to be gravely disabled, and hearings took even less time than the five-minute average prior to the Act, the statistic which had prompted legislative interest in the first place. See Scull A (1989) Social Order / Mental Disorder, Anglo-American Psychiatry in Historical Perspective, University of California, p287–289.

\(^{60}\) The accusation that the Board of Control, which between 1913 and 1959 had a role for certain types of patient similar to that proposed for the Tribunal under the Mental Health Bill, was the uncritical recipient of stock-phrases justifying involuntary commitment, has been reported to the MHAC by a psychiatrist who worked under the system of that time.
extending the detention period to a maximum of six months. From the patient’s point of view, appealing subject of the appeal. The Tribunal also can impose additional formal powers over the patient, for example not, however, consider only whether or not to discharge the patient from the form of compulsion that is the unresolved difficulty in the right of appeal for a patient who is liable to assessment. (ie during the 28 day period prior to the Tribunal’s necessary involvement in a case). A patient under assessment can appeal to the Tribunal at any time, although the Tribunal will consider the case within 28 days even if no appeal is forthcoming. The right to appeal assessment is therefore a right to bring forward the hearing date.

5. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft Bill?

The role of the Tribunal

The right of appeal against liability to assessment

5.1 The Tribunal under the Bill proposals has a dual function of hearing patients’ appeals against the imposition of formal powers and providing the authority for such impositions. There appear to be unresolved difficulties in the right of appeal for a patient who is liable to assessment. The Tribunal also can impose additional formal powers over the patient, for example extending the detention period to a maximum of six months. From the patient’s point of view, appealing against liability for assessment is therefore a hazardous business, as it may result in more stringent legal powers being applied than were in place at the time of the appeal.

5.2 A Tribunal that convenes earlier in the assessment process as a result of an appeal by the patient does not, however, consider only whether or not to discharge the patient from the form of compulsion that is the subject of the appeal. The Tribunal also can impose additional formal powers over the patient, for example extending the detention period to a maximum of six months. From the patient’s point of view, appealing against liability for assessment is therefore a hazardous business, as it may result in more stringent legal powers being applied than were in place at the time of the appeal.

5.3 It would seem to us to be a requirement of justice that Tribunals held in the first 14 days of assessments should not be empowered to make further orders, but should only consider the patient’s appeal against the existing compulsion.

Care-planning and the Tribunal process

5.4 We recognise that the involvement of the Tribunal in authorising compulsory treatment is designed to meet human rights requirements and support the Government’s policy of the Care Plan Approach. However, there are aspects of this process that could compromise these aims, rendering the Tribunal process effectively meaningless.

---

61 Explanatory notes, para 414. See also Improving Mental Health Law, para 4.12.

62 It is unfortunate that no detail is available for parliamentary scrutiny on the question of how “certain categories of people” are to be defined as disqualified in regulations established under clause 232(4)(a). The Bill’s Explanatory Notes gives as an example “a convicted child abuser in the case of a child patient” (para 414). It is not clear how regulations would define a convicted child abuser (presumably it would be with reference to the sexual offenders register). The Government’s example is relatively sensible, but very specific. We do not see how the principle that appears to underlie it can easily be extended to adult patients and their relationships with other people in their lives. We would be very concerned if, as has been mooted during the development of this policy, conviction of any serious criminal offence automatically disqualified a person from nomination by a patient.

63 It may be that the law will therefore have to rely largely upon the discretionary powers of appointors to not appoint a nominee whom they find unsuitable. The power of the patient to appeal any disregard of their nomination (clause 243) provides protection against the arbitrary or unjust use of this discretion. There is, however, no right of appeal (short of application for judicial review) for the disregarded nominee.

64 If the Tribunal declines to discharge the patient from compulsion, the Bill provides it with the following options:
- it may confirm the patient’s liability for assessment, leaving the patient subject to the original 28-day assessment period;
- it may make a further assessment order, giving the clinical supervisor another 28 days to consider applying for treatment order; or
- it may make a treatment order lasting up to six-months.

In any option the Tribunal is empowered to change the residency status of the patient (clauses 35–36). The hazards of appealing against assessment can be demonstrated by the scenario given in the Government’s own case study showing the working of the Tribunal (Improving Mental Health Law: Case Study 3—The Tribunal, page 16–17). Patient P has been detained in hospital for assessment for two weeks and appeals to the Tribunal. His clinical supervisor not only contests the appeal, but submits an application to the Tribunal for a treatment order which is heard simultaneously with the patient’s appeal against the use of formal powers. In the Government’s scenario the Tribunal finds something of a middle-way between patient and clinician, and is able to gain the clinician’s agreement to a non-residential treatment order of up to six months. In this scenario the patient, who is suffering from depression, gains discharge from hospital but is made subject to a lengthier order than that which he appealed against. Other outcomes that could have resulted from patient P’s appeal are his discharge, the extension by the Tribunal of his assessment period to run for up to another 28 days before reconsideration, or his detention in hospital for up to six months.
5.5 Our particular concern is that the protections available to patients afforded by Tribunal authorisation of a care-plan could easily be compromised by the adoption of generic care-plans describing, in terms that allow for wide discretion concerning prescription, medication and other treatments to be given in the absence of consent. The main elements of our concern are set out below.

(a) We are alarmed at the implication that only such treatments as are being given in the absence of consent should be detailed on the care plan submitted to the Tribunal (see 6.15 above). We recommend that care-plans submitted to Tribunals in respect of patients with mental capacity must be required, as a matter of primary legislation, to state what treatment, if any, the patient consents to, as well as those treatments for which authority in the absence of the patient’s consent is sought. This information should be required by provision on the face of the Bill, with requirements for its submission by statutory form established within regulations.

(b) The lack of provision to provide medication under emergency powers (see 6.18 below) will increase the pressure on clinicians to produce generic and wide-ranging care-plans. Practitioners would seek to avoid reliance on common-law powers in emergencies through anticipating any emergency administration of medication in care-plans.

(c) Medical treatment for mental disorder has been very broadly defined by the courts and continues to be so in the Bill. It is unclear, therefore, whether interventions such as seclusion\textsuperscript{66} or control and restraint would need to be anticipated in care-plans authorised by the Tribunal. Without advance authorisation practitioners will have to rely on common-law powers to impose such controlling measures, which will reduce their protection and the protection of patients from the current position. We continue to call for statutory regulation of seclusion and control and restraint practice (see 6.21 above).

(d) The medical expert undertaking a role equivalent to that of a Second Opinion Appointed Doctor (SOAD) is not required to consult with nursing and non-medical professionals before writing a report to the Tribunal on the merits of the case.

(e) Unlike a SOAD, the medical expert is not empowered to provide authority for treatment, but must report to the Tribunal on the merits of the proposal for treatment for a Tribunal decision. Also unlike a SOAD, the Tribunal is not empowered to authorise treatment without first negotiating the agreement of the clinical supervisor\textsuperscript{67}. The Bill will thus replace the current single-doctor “second-opinion” approval of medication or ECT with a three-stage Tribunal process (doctor’s application, expert second opinion visit, Tribunal negotiation with original doctor and authorisation). It is not clear whether this will increase patient safeguards, and it is doubtful that it is necessitated by the ECHR. This could be cumbersome and bureaucratic, and the role of the Tribunal may be perfunctory in some circumstances (particularly where the issue at stake is an amendment to a care-plan for a patient already admitted to compulsion by the Tribunal). It may be just as effective protection for patients, and may relieve pressure on the Tribunal system, to provide the medical expert with powers of authorisation relating to specific treatments (such as ECT and psychiatric medication), perhaps limited to specific circumstances, such as amending extant orders.

5.6 We recommend that:

(i) Care-plans submitted to Tribunals in respect of patients with mental capacity must be required to state what treatment, if any, the patient does consent to, as well as those treatments for which authority in the absence of the patient’s consent is sought;

(ii) Provision should be made in the Bill to regulate the assessment and recording of a patient’s consent to psychiatric medication when that patient is otherwise subject to compulsion, as with the 1983 Act;

(iii) Emergency powers to provide psychiatric medication should be provided in the draft Bill on the model of the 1983 Act; and

(iv) Consideration should be given to less bureaucratic means of authorising changes to approved treatment plans, possibly allowing the medical expert powers of authorisation relating to specific treatments (such as ECT and psychiatric medication) under specific circumstances, such as in amending extant orders.

\textsuperscript{66} Seclusion was found to fall within the definition of medical treatment for mental disorder in R (on the application of Colonel Munjaz) v Mersey Care NHS Trust & Another; S v Airedale NHS Trust [2003] EWCA Civ 1036.

\textsuperscript{67} Under the 1983 Act, Second Opinion Appointed Doctors (SOADs) are not required to gain the agreement of treating doctors when authorising treatment plans. SOADs may, for example, authorise a limited version of a proposal even in the face of continued disagreement by the treating clinician. Under the Bill proposals, the Tribunal has no equivalent power to change a treatment plan without the agreement of the clinical supervisor.
FUTURE MONITORING ARRANGEMENTS

5.7 The legal remit of the Mental Health Act Commission is stated in the Mental Health Act 1983, which requires the body to keep under review the exercise of the powers and discharge of duties conferred or imposed by that Act in respect of the detention of patients for psychiatric care and treatment\(^{68}\). This role focuses primarily on meeting in private with such patients, as required by statute, monitoring the implementation of the Act in healthcare establishments. It includes the examination of documents and other evidence of practice in the use of the Act to detain and treat patients, culminating in a report to the hospital managers on our findings. Our core function is the general protection of detained patients, in recognition of such patients’ unique position in not being able to discharge themselves from care\(^{69}\).

5.8 It was considered important upon its establishment that the functions of the MHAC were kept separate from other inspectorial bodies. The MHAC was not to inspect and report on services in psychiatric units in the way in which then extant inspectorial bodies did:

The Commission’s concern will be the particular problems which arise from detention...the name “Mental Health Act Commission” has been chosen deliberately to emphasise its responsibilities for seeing that patients have full advantage of all the available legal safeguards under the Act\(^{70}\).

5.9 The Commission also meets with representatives of social services and engages with the police over their use of the Act’s powers. The Bill’s proposal reflects this cross-disciplinary aspect of the current MHAC focus, although it unfortunately does not extend powers to areas where the MHIAC would suggest that monitoring of the use of powers is required, such as by the police in using emergency powers, or by prison authorities where prisoners are assessed for detention under mental health law\(^{71}\). It also, crucially, does not extend a specific monitoring role to patients who are subject to detention or treatment under the proposed powers of the Mental Capacity Bill, although the MHAC has called for its monitoring role to be extended to similarly de facto detained patients from its earliest days.

5.10 The draft Bill proposes that monitoring of the Mental Health Act will be transferred to the Commission for Healthcare Audit and Inspection, commonly known as the Healthcare Commission. Whilst we would not have wished for the demise of the Mental Health Act Commission, we are less concerned about organisational structure than about safeguarding functions. We have worked enthusiastically with the Healthcare Commission to effect joint working and to establish the groundwork for a transfer of responsibilities should this be enacted by Parliament. We do want to ensure that the rights of detained patients are given the same high priority within the Healthcare Commission as under the current structure, and that monitoring the use of legal powers does not become subsumed under the wide focus of general healthcare inspection. The benefits of rationalisation amongst health service bodies must be balanced against the need to ensure that the core statutory function and duties towards patients subject to care under the State’s compulsion, including and especially visiting practices, are not lost.

5.11 To this end we hope that further consideration will be given to establishing in law powers, duties and accountability that will preserve a specialised monitoring focus upon patients subject to compulsion irrespective of organisational structures.

5.12 We have previously suggested powers and duties based upon those of the Children’s Rights Director as a model for the sorts of powers and duties that could be set out within a broader inspectorate to protect the specific monitoring focus of compulsion\(^{72}\), although we are unconvinced that the structural relationship between the Director and the inspectorate is exemplary\(^{73}\). We are concerned that without functions protected by legislative requirement and specific accountability, the pressures on a general body such as the Healthcare Commission will be bound to marginalise specialist monitoring and therefore patient protection. We believe that it should be possible to develop proposals which, without necessarily implying the continued existence of a separate monitoring body, retain the advantages of having an identifiable mental health division of the Healthcare Commission while providing for a separate and independent role in overseeing the strategic planning and implementation of monitoring functions in relation to patients under compulsion.

---

\(^{68}\) Mental Health Act 1983, s 120(1).


\(^{70}\) Cmnd 8405: para 34

\(^{71}\) Draft Mental Health Bill, clause 258(2)

\(^{72}\) MHAC response to the Draft Mental Health Bill Consultation, September 2002, para 1.15. The powers and duties that we suggested included:

(i) to secure as far as possible that the inspectorate safeguards and promotes the rights and welfare of patients subject to compulsion and gives proper consideration to their views;

(ii) to monitor action taken by the inspectorate to review the implementation of the mental health legislation and Code of Practice and advise it on the staff necessary for this purpose;

(iii) to provide advice to service providers on good practice and to ensure consistent application of mental health legislation;

(iv) to ensure that appropriate action is taken in relation to any concerns raised about individual patients or groups of patients subject to compulsion; and

(v) to report on the availability and effectiveness of services provided for patients subject to compulsion.

\(^{73}\) MHAC response to the Draft Mental Health Bill Consultation, September 2002, para 1.16.
6. Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient?

Children

6.1 The Bill proposes that children under the age of 16 will be exempt from its provision at clause 9(7), which states that any patient who poses “substantial risk of serious harm” to other persons may be made subject to powers of compulsion even where legal alternatives exist. It is therefore the case that clause 9(7) can be applied to children aged between 16 and 18. We question at paragraphs 2.21–2.23 above whether clause 9(7) needs to apply to any patient, but in the context of child and adolescent services we remain particularly concerned that the provision appears to sets a different standard for decision-making in respect of adolescent patients (ie aged 16–18) from that which is established under s1 of the Children Act 1989. As compulsory psychiatric admission or treatment could be provided to adolescents under either the Children Act or the Mental Health Act, we question whether such differences of fundamental approach are appropriate.

6.2 We are broadly supportive of the provisions of the Bill specifically relating to children’s treatment. The provision ensuring that, except in emergency situations, all proposals for ECT to under-16s are subject to Tribunal approval will, we believe provide a welcome safeguard to clinicians on the rare occasions where they feel that such treatment is necessary, and should provide a helpful support to parents, who at present are usually placed in the difficult position of providing or withholding consensual authority for ECT to be given to their child. The Commission has recently been involved in one such case where this change in the law would have been welcomed by all concerned.

Black and minority ethnic patients

6.3 The Commission has taken a leading role in working alongside Government over initiatives to address questions raised by the over-representation of Black and minority patients in the detained psychiatric population, and by the adverse care pathways experienced by many Black patients. It is well established that Black and minority ethnic patients are over-represented in the detained patient population under the current Act. The numbers of Black patients assessed for possible detention is also disproportionately high. A recent systematic review of published research suggested that the statistical odds on a Black and minority ethnic patient being detained under the Act, compared to a similarly unwell white patient, are at least 4:1. Black patients, particularly from Black Caribbean and Black African communities, may fare worse than white patients in risk-assessments and can become caught in a cycle of fear and prejudice that leads to increasingly adverse pathways into mental health care.

6.4 We consider it to be highly likely that Black patients’ care is adversely affected under the current law by stereotyping and prejudice. Black and ethnic minority patients may be deferred from early contact with services by (perhaps not unjustified) perceptions of the likelihood of detention or compulsory treatment, and may well be likely to be assessed as a higher risk of non-compliance or of potential violence than their White counterparts once such contact is made. We consider it important that the principles for the implementation of the Bill should reinforce the requirements of respect for diversity and anti-discrimination established under other primary legislation. But we are concerned that any such statement of principles could be undermined in practice by the Bill’s wide scope for defining the conditions of compulsion, alongside the emphasis placed upon perceived dangerousness as a criterion for such compulsion. These factors are unlikely to help in reversing the adverse care experiences of many Black and ethnic minority patients.

Are there enough safeguards against misuse of aggressive procedures such as ECT and Psychosurgery?

“Aggressive” treatments

6.5 ECT and Neurosurgery for Mental Disorder (NMD) are controversial treatments and there are aspects of each treatment that warrant special safeguards against their misuse. However, all psychiatric treatment, such as detention in hospitals, as well as the administration of psychiatric medication, has potential for “aggressive” misuse, and it is of course part of the purpose of mental health law to provide a framework to safeguard against this.

Allowing the High Court to authorise NMD for incapacitated patients

6.6 The Commission supports the Government’s proposal to allow the High Court to authorise Neurosurgery for Mental Disorder for incapacitated patients. We are aware of the case referred to in the Government’s explanatory notes to the Bill, where a patient with obsessive-compulsive disorder was mentally incapacitated by another condition, and was therefore precluded in law from receiving the NMD

74 Clause 9(7).
75 Children Act 1989, s.1: “the child’s welfare shall be the . . . paramount consideration”
76 See Improving Mental Health Law, paragraphs 3.27–30.
that has been deemed in his best interests. It does not seem to us to be helpful that the law designed to safeguard patients should prevent individual consideration of their cases in relation to NMD. We can therefore see no reason why the High Court should not be empowered to consider such cases and provide authority for treatment where it finds it appropriate to do so in accordance with the criteria suggested at clause 194 of the Bill. We do not believe that such cases will be numerous, and we are confident that the Court will appreciate the gravity of the decisions placed before it when they occur.

Electro-Convulsive Therapy

6.7 The Bill proposes that ECT shall not be given to patients under compulsion, where such patients refuse consent, except in an emergency. Many stakeholders have also demanded that the thresholds for compulsion as a whole should be based upon a capacity test, so that patients with mental capacity would have a right to refuse hospital admission or treatment in general, except where safety considerations might override this. The Government has not acceded to this demand, and many aspects of compulsion—including admission to hospital and treatment with medication—can be imposed notwithstanding capacitated patients’ refusal of consent if the conditions for compulsion are met.

6.8 Because the 2002 draft Bill did not adopt the capacity-based model proposed by the Richardson Committee, we suggested last year that the problems and dilemmas of capacity-based thresholds for compulsion would not have to be put before Parliament in relation to a Mental Health Act in the immediate future. The 2004 Bill’s proposal of a capacity test as the threshold for imposition of ECT treatment has perhaps brought the issue back into the centre of the debate. The Commission is sympathetic to calls for an approach to compulsion that gives proper regard to mentally capacitated patients’ wishes. We do, however, have concerns as to whether the concept of mental capacity can provide the panacea of natural justice that its supporters seem to suggest. The concept is adopted in a wide variety of definitions for different purposes and in different jurisdictions; in the current Mental Health Act Code of Practice it is defined in relation to the judgment of Re C (Adult: Refusal of Treatment) [1994], as essentially a test of cognitive ability, and one that may be viewed as a point on a sliding scale rather dependent upon the seriousness of the procedure under consideration.

6.9 We have concerns that any indeterminate concept of mental incapacity, prematurely adopted as a legal threshold in the context of psychiatric compulsion, may too easily be equated with a failure to agree to a treatment that is considered necessary by a supervising clinician. As such, capacity-based legislation could merely result in an increase in the proportion of patients considered to lack capacity to consent or refuse consent. Conversely, there are dangers that a rigorous capacity test could mean that patients who have mental capacity but whose conditions are deteriorating would either have to be denied clinical intervention until such time as their conditions have deteriorated to the point of loss of capacity or, perhaps more likely, clinical intervention will be justified under emergency treatment powers to prevent such deterioration. There is also, of course, the question of when a danger to the patient or others should provide reason to override a capacitated refusal to treatment.

6.10 The Commission administers the Second Opinion Appointed Doctor (SOAD) system, through which all impositions of ECT upon refusing patients under current law are processed. We set out below at figure 2 data collected through that administration that has not, as yet, been considered as a part of this policy formation.

<table>
<thead>
<tr>
<th>Refusing consent</th>
<th>Male 219 (11%)</th>
<th>Emergency powers used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female 615 (29%)</td>
<td>Yes 67 (11%)</td>
<td>No 548 (89%)</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incapable of consent</th>
<th>Male 390 (19%)</th>
<th>Emergency powers used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female 865 (41%)</td>
<td>Yes 46 (12%)</td>
<td>No 344 (88%)</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Fig 2: ECT SOAD authorisations 2002–03 by consent status, gender and use of emergency powers

Draft Mental Health Bill Explanatory Notes; page 71, paragraph 371.


The report commissioned by the Department of Health (Pearson, Middleton & Shaw (2000) Analysis of information obtained upon patients detained in England and Wales and visited by Second Opinion Doctors administered by the Mental Health Act Commission, Nottingham University, August 2000) does not distinguish between data relating to ECT and medication authorisations in its analysis of the ratio between refusing and incapable patients.
6.11 The data in figure 2 above shows that, in England and Wales over the financial year 2002–03, 40% of SOAD authorisations of ECT were in respect of mentally capacitated patients who were refusing consent. ECT was authorised on 834 occasions in such circumstances, which is an average of between three and four such authorisations every working day. Under present law, similar thresholds for the emergency use of ECT apply as are proposed under the Bill\textsuperscript{83}, and our data shows that for 11% of refusing patients emergency powers are used before the SOAD authorisation is secured\textsuperscript{84}. 

6.12 For each authorisation, two separate medical practitioners have concluded that ECT is in the patient’s best interests\textsuperscript{85}. Given this, and our concerns at the indeterminacy of the concept of capacity, we do have some doubts that the proposed change in the legal framework for administering ECT under formal powers would lead to all of these patients not receiving treatment. Although it is possible that there would be some reduction in the numbers of patients treated overall, we therefore suggest two equally likely effects of the change:

(a) The apparent fluidity between categories of “refusing” and “incapable” patients in current practice suggests that, were the law to make mental capacity the determinant over whether ECT could be given, a number of patients currently considered to be “refusing” would be classified as “incapable”; and

(b) For those patients who could not be classified as incapable, the use of “emergency” powers could increase as a means for practitioners to provide ECT where clinicians feel it is necessary for the patient’s treatment. The invocation of emergency powers does, of course, deprive the patient of any safeguard over potential misuse of an intervention.

6.13 We are also uncertain of the basis upon which mental incapacity may be deemed suitable as the legal threshold for the imposition of ECT, but not for other forms of psychiatric treatment. In particular, we feel that there should be a clear justification for ending the equivalence of legal protections and rights of patients under the present law in relation to the imposition of ECT and long-term psychiatric medication. We discuss this further below.

Abolition of consent to medication under the provisions of a Mental Health Act

6.14 Unlike the 1983 Act, the Bill gives no express provision that allows for a patient who is subject to the general powers of compulsion to consent to psychiatric medication and thereby provide authority for its administration\textsuperscript{86}. We have grave reservations over the advisability of this change from the current legal framework. There is a serious imbalance in the Bill, in that patients with capacity are being given the right to consent and refuse ECT, but the right to do neither for medication\textsuperscript{87}.

6.15 Under the Bill’s proposals, psychiatric medication would be classified in the catch-all category of “other treatments” (ie those that are neither ECT nor type A nor type B treatments). For such treatments, the Bill provides simply that such patients’ consent “is not required” in the initial 28 days or for any treatment plan subsequently authorised by the Tribunal or court\textsuperscript{88}. Therefore, any patient who consents to his or her medication whilst otherwise subject to compulsion under the Bill will do so, and may receive it, under the general powers of the common law. The Bill also provides that care-plans submitted to the Tribunal will only require a record of psychiatric medication (and any other treatment) for which the patient has not consented or cannot consent\textsuperscript{89}. The recording of either details of the treatment being given under consent, or the details of the consent itself, will be a matter outside the provisions of the Mental Health Act and a matter of policy guidance at best.

\textsuperscript{83} See Mental Health Act 1983, s62; Draft Mental Health Bill, clause 182. The lowest threshold for using such powers will be that such treatment is necessary to prevent serious suffering (provided that the doctor will state that the ECT is neither irreversible nor hazardous). If the use of ECT in a particular circumstance is considered hazardous, it may only be given to prevent a serious deterioration in a patient’s condition. If its use in a particular circumstance is considered both hazardous and irreversible it can only be used to save a patient’s life. Any of these thresholds potentially can be met by circumstances in which emergency ECT is considered.

\textsuperscript{84} As the application of ECT under emergency powers should trigger a request for a second opinion, we are relatively confident that the numbers on our table give a fair representation of the total emergency use of ECT over the year. The table does of course, indicate how many patients have received emergency treatment, and not how many times ECT was applied during those emergencies. Although we have used the majority of cases, however, this is likely to have been a single application. The Commission advises that any emergency use of ECT should be followed by a request for a second opinion, and aims to provide a second opinion doctor within two working days of any request to consider ECT treatment.

\textsuperscript{85} The criteria for overriding a patient’s refusal of consent under s58 of the MHA 1983 was dealt with in R \textit{(on the application of PS) v (1) Dr G and (2) Dr W} [2003] EWHC 2335 (Admin). The Commission has issued a guidance note on this case (GN 2/04, January 2004).

\textsuperscript{86} The 1983 Act (s58) provides an initial three month period for a detained patient’s treatment with medication, after which the treatment cannot be given unless either the patient consents or a second opinion appointed doctor authorises its administration in the absence of consent. Where a patient consents at the end of the three-month period, his or her doctor must complete a statutory form listing the medication and certifying that the patient has the mental capacity to consent and does so. The 1983 Act also has a “catch-all” category of medical treatment other than medication (or ECT and NMD) for which a detained patient’s consent is not required (s63).

\textsuperscript{87} The 1983 Act is more consistent in this respect, if less rights-orientated, in that it provides patients the right to give consent to but not refuse either form of treatment.

\textsuperscript{88} Draft Mental Health Bill, clause 199.

\textsuperscript{89} eg Draft Mental Health Bill, clauses 39(5)(b), 58(6)(b). We have consulted with Department of Health officials over our interpretation of the meaning of these clauses and related provisions.
6.16 We are very concerned at this reversal of the position established under the 1983 Act, for the following reasons:

(a) This looser structure in the law pertaining to consent to treatment could allow less regard to be given by practitioners to consent status, and therefore have a deleterious effect on the recognition of patients’ rights and an effect counter to Government’s intention.

(b) Practitioners are often nervous of administering treatment under the common law to patients subject to detention in hospital, which may lead to practitioners becoming reluctant to recognise patients’ valid consent as they may feel more exposed to legal challenge in giving treatment on that basis.

(c) The Bill’s provisions are very unclear over the authority to give medication to patients who are subject to compulsion. There could be a real danger of practitioners misreading clause 199 to imply that such patients’ consent is superfluous or irrelevant.

(d) The recording of patients’ consent to medication will be outside of statutory provisions, leaving the form of such records to local practice. This will make such records difficult to review or monitor (and indeed will prevent any such monitoring under the reviewing powers contained in the Bill itself\(^90\)), even where such records or the reality of the consent that they attest to is questionable. Lack of statutory requirements in assessing and recording consent status will hamper legitimate challenges to practice by patients’ representatives or inspecting bodies. Good practice gains in encouraging records of consent discussions, capacity assessments, etc could be reversed.

(e) Care-plans submitted to the Tribunal, if they are only required to state what treatment is being administered without consent, will give an incomplete and misleading picture of patients’ treatment. This will hamper reasonable decision-making (ie to establish whether compulsion is necessary the Tribunal must consider what treatment could be provided without compulsion) and will mean that care plans for the Tribunal will be unsuitable for use in documenting Care Plan Approach requirements for the patient’s overall treatment.

(f) The proposal regarding medication is not consistent with other provisions of the Bill, which provide that a patient subject to powers of compulsion under the Bill may consent to ECT or NMD under the powers of the Bill. In both cases, the Bill provides detailed requirements regarding the certification of the patient’s consent. The requirements in relation to certification of consent to ECT\(^91\) provide a model for similar provision in relation to medication and should be adopted. There is no reason for inconsistency of approach between ECT and medication over this issue.

6.17 We recommend that there should be specific provision on the face of the Bill with regard to treatment with medication for mental disorder, allowing that a patient’s consent can provide authority for such treatment, and setting out provisions for safeguards in relation to authority for treatment without consent. Where treatment is authorised by the patient’s consent, regulatory powers should establish requirements for records to be made in statutory form that assessments of mental capacity and consent status have taken place.

Abolition of emergency treatment powers regarding psychiatric medication

6.18 We consider it to be a serious oversight that the Bill provides no legal framework for the emergency administration of medication for mental disorder. In the absence of such a framework, practitioners will have to rely on common-law powers to administer any medication in an emergency to a patient whose Tribunal-approved care-plan does not specify that such treatment should be given. This:

(a) encourages over-inclusion of proposed treatments on care-plans;

(b) provides practitioners and patients with less safeguards than under the present law;

(c) is inconsistent with the proposals to allow emergency administration of ECT\(^92\) and

(d) denies the possibility of monitoring the use of emergency medication.

6.19 The Bill should be amended to include provision for emergency administration of medication for mental disorder, modelled upon the clauses providing such powers in respect of ECT.

\(^90\) Draft Mental Health Bill, Part 10.

\(^91\) Draft Mental Health Bill, clause 179.

\(^92\) Draft Mental Health Bill, clauses 182–184.
Other treatments requiring safeguards—naso-gastric feeding

6.20 The Commission has long called for the regulatory powers of the 1983 Act to be used to provide equivalent safeguards for naso-gastric feeding of patients under the Act’s powers as are provided for ECT. We are disappointed that it appears there are no plans to use the regulatory power to specify such interventions as “type B” treatments for this purpose\(^93\). We urge that naso-gastric feeding of patients subject to formal powers be afforded the protections of type B treatment arrangements.

Issues of control and management requiring safeguards

6.21 The Bill provides no specific regulatory powers in relation to the control and management of patients, and no provision equivalent to section 63 of the 1983 Act which can provide a general authority for such interventions. This would appear to make uncertain what powers are available for the control and management of patients in hospital, and may inadvertently require clinicians to anticipate emergency control and restraint procedures (including seclusion) in patient’s approved care-plans, to avoid having to seek justification under common law. This is impractical, and may be counter-productive in reinforcing measures such as seclusion as standard “treatment” options for difficult to manage patients. We recommend that there should be a dedicated regulatory power in relation to issues over the control and management of patients, where regulation can be made over training, use of staff, and record keeping etc in relation to seclusion and restraint. Such a power could also enable future regulation of problem issues such as searching, confiscation of property, use of CCTV etc.

7. Is the balance struck between what has been included on the face of the draft Bill, and what goes into Regulations and the Code of Practices right?

Matters established by regulation

7.1 In its report on the 2002 Bill, the Joint Committee on Human Rights established that “in general . . . elements in a statutory scheme which are vital to the capacity of the scheme to operate compatibly with human rights should be spelt out in legislation itself”\(^94\).

7.2 We have indicated in several of our answers to the Committee’s questions that the scope of matters dealt with by regulation in the draft Bill is of concern to us. Regulatory powers are used, wholly or in part, to define fundamental conditions and thresholds of compulsion, including:

(a) the definition of mental disorder (para 2.12), and therefore the conditions for compulsion;
(b) the scope for instigating compulsion from a community assessment (para 2.32–4); and
(c) the scope of civil restriction orders (para 3.4).

The positing of legally weak principles underpinning the use of the Act, to which regulation-makers need not have regard, heightens our concern over this broad scope of regulation. We recommend caution over legislating far-reaching but ill-defined powers for the restriction of civil liberties.

Matters left to a Code of Practice

7.3 The Bill appears to leave issues of serious importance to the operation of formal powers within a human rights framework to its Code of Practice:

(a) the principles upon which the law is to be interpreted (see question 1 above);
(b) seclusion and restraint (it is conceivable that, in emergency situations, the Bill can provide no powers for such interventions and that the common-law would have to be relied upon) (see paragraph 6.21);
(c) other control and discipline issues, such as searching of patients or control and confiscation of patient’s property (para 6.21).
(d) consent to treatment issues, including the regard to be given to questions of mental capacity, refusal of consent and advance directives; the framework for consent to psychiatric medication for people subject to compulsion; and the emergency administration of psychiatric medication (for which the Bill proposes no powers, so that the common-law will be relied upon) (see paras 6.14–6.19 above).

\(^93\) It appears that there are no plans to make regulations under clause 197 identifying or providing safeguards for any “type B medical treatment”. See Improving Mental Health Law, para 7.17, explanatory notes para 372.

7.4 Although the judgment is subject to appeal to the House of Lords, we draw the Committee’s attention to the conclusion of the Court of Appeal regarding this aspect of the present legal framework. The Court of Appeal confirmed that the State has an obligation to ensure that public authorities act compatibly with the ECHR and that the law is sufficiently defined for this purpose. Where the law lacks the transparency and predictability required for ECHR compliance, and this can only be provided by “guidance” in a Code of Practice, then this guidance should be afforded a status consistent with its purpose. Therefore, where the Code takes on a quasi-legislative role, it should be observed by all hospitals unless there is a good reason for particular departures in relation to individual patients or identified groups of patients. It is not acceptable to depart from the Code as a matter of policy, although policies may identify circumstances when such departures might be considered on a case-by-case basis.

7.5 Ideally, we would like the Code to have such authority, and for matters vital to the operation of compulsion compatible with human rights to be dealt with by primary legislation. However, under the Bill proposals, the Code appears to take on a quasi-legislative role and yet practitioners must only “have regard to” its general principles. We view such a status for the Code as inconsistent with the use to which it is put under the proposals.

7.6 We believe that a Code of Practice can and should play a pivotal role in determining how new legislation is operated, but it should support rather than establish legal thresholds. If the Code is used appropriately, as we suggest, its authority could be strengthened without making its guidance legally binding, by the creation of a statutory duty to record and provide reasons for departures from such guidance in patients’ clinical records.

8. Is the draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

8.1 We have serious concerns that the potential scope of the Mental Capacity Bill and the draft Mental Health Bill will overlap and interfere with each other in a way that could be inherently unworkable. The following problems seem to us to require further exploration.

8.2 The Bills are based upon different conceptual approaches to decision-making regarding mentally disordered persons. The determining threshold of the Mental Capacity Bill is whether or not a person is able to make a decision over his or her own affairs. The key determining threshold in the draft Bill is a professional opinion regarding the necessity of providing treatment. This difference of approach may be problematic in areas where the Bills propose overlapping powers, especially where a patient is treated under the powers of each legislative framework during the course of treatment and care as his or her circumstances change.

8.3 The Mental Capacity Bill proposes broad powers concerning the treatment of patients without capacity, even in the face of their resistance, provided that they have not made an advance directive refusing consent or their attorney/deputy does not refuse consent on their behalf. As the powers of draft Mental Health Bill may only be used where treatment may not lawfully be provided by other means (unless the patient poses a serious risk of substantial harm to others), where an incapacitated patient has neither made an advance statement nor has an attorney/deputy who refuses consent on their behalf, the Mental Capacity Bill’s powers would seem to take priority over the draft Mental Health Bill. Conversely, where a patient is provided with safeguards through the Mental Capacity Bill, such as the right to make advance directives, these safeguards may both be overridden by, and indeed the justification for, the use of powers proposed in the draft Mental Health Bill.

8.4 The Mental Capacity Bill thus modifies the operation of the Mental Health Bill and vice versa. It will be possible for a compliant incapacitated person to be treated under either Bill even though the lack of capacity might be due to a diagnosed mental illness which falls squarely within the definition of mental disorder in the Mental Health Bill.

8.5 The recent judgment in *HL v United Kingdom* must raise the question of whether the powers proposed in the Mental Capacity Bill provide adequate safeguards to ensure their compatibility with Article 5 of the European Convention. It would seem likely that the safeguards available to any patient given medical treatment in hospital under the powers proposed in the Mental Incapacity Bill must be reconsidered in the light of a requirement to prescribe by law procedures regulating admission and mechanisms of appeal. This could, for example, imply an extension of the Mental Health Tribunal’s scope to have an overview of all mentally incapacitated patients’ mental health care.

---

95 R (on the application of Colonel Munjaz) v Mersey Care NHS Trust & Another; S v Airedale NHS Trust [2003] EWCA Civ 1036, especially paras 58–76.
96 Draft Mental Health Bill, Clause 1(2).
97 Mental Capacity Bill, clauses 5, 6.
99 Mental Capacity Bill, clause 11.
100 Draft Mental Health Bill, clause 9(5), (7).
8.6 However the European Court’s ruling in *HL v UK* is interpreted by Government, we are of the view that the safeguards available to patients generally as proposed under the Mental Capacity Bill’s powers are in any case inadequate, but especially if any incapacitated patient (ie whether compliant or not) would be liable to treatment under its powers rather than the powers of a Mental Health Act. In particular:

(a) The Mental Capacity Bill’s requirement for the treating authority of patients who are incapacitated but compliant to first appoint an “independent consultee” (who may or may not be a registered medical practitioner, dependent upon regulation) and then “take account” of his or her views in the patient’s subsequent treatment is much weaker than the Tribunal-based safeguards of the Mental Health Bill (even taking account of our reservations over the latter); and falls very short of a meaningful safeguard against unreasonable detention and/or treatment;

(b) Patients treated under mental incapacity legislation would have no right to advocacy, whereas patients subject to Mental Health Bill powers would; and

(c) The specific duties of visiting and review afforded to the Commission’s successor body under the draft Mental Health Bill would not extend to patients treated under mental incapacity legislation.

Such differences in provision across the two Bills, if not already unacceptable as a result of *HL v UK*, are surely equally susceptible to similar legal challenge.

8.7 We recommend reconsideration of the interface between the Mental Capacity Bill and draft Mental Health Bill, particularly in light of *HL v UK*.

9. Is the draft Mental Health Bill in full compliance with the Human Rights Act?

9.1 In our evidence above we have pointed to the wide scope provided by the European Convention on Human Rights in relation to the State’s intervention in respect of mentally disordered people. We have noted, for example, the Joint Committee on Human Rights’ conclusion that preventive detention is not unlawful under the Convention and that the proposed measures of the 2002 Bill, whilst raising human rights concerns, would not in themselves lead automatically to violations of human rights. Government has stated that it believes its proposals in this draft Bill are compatible with the Human Rights Act 1998. Our study of the proposals would suggest that, even so, they raise human rights concerns and there is likely to be a considerable volume of legal challenge that will test, or in some cases establish, the boundaries of the law.

9.2 Areas of particular difficulty appear to be:

(a) The broad scope of possible interventions created by the conditions for compulsion, including the definition of mental disorder (questions 1 and 2 above).

(b) The lack of certainty over the relationship between the draft Mental Health Bill and the Capacity Bill. Any psychiatric treatment that may amount to detention that is given under the proposed framework of the Mental Capacity Bill may fail the requirements of ECHR Article 5 (see question 8 above).

(c) The criteria and threshold for instigating compulsory powers in the community where a patient has not been assessed in hospital immediately beforehand (para 2.39).

(d) Powers of restriction provided over civil patients that may have questionable links to clinical need: non-therapeutic detention (para 2.25–2.30 above); civil restriction orders, orders requiring residency in hospital for a minimum period and requirements that patients in the community do not engage in specified activities (paras 3.4–8 above).

(e) The use of powers in respect of adolescents aged between 16–18 (para 6.1).

(f) Decisions made by the Tribunal on the basis of care-plans that may only indicate treatment to which the patient is opposed (para 6.16(e)).

(g) The adequacy of safeguards regarding consent to treatment provision, particularly where a patient refuses consent (questions 5, 6).

(h) The continued legal authority for control and restraint measures, including seclusion (para 6.21).

Our previous recommendations and comments have touched upon these matters.

102 See footnote 3 above.
103 See paragraph 2.26 above.
10. What are likely to be the human and financial resource implications of the draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

10.1 The Commission does not have a general view over the resource implications of the Bill, except to note that these are widely accepted to be considerable. The new systems would require more resources than at present, especially to operate the Tribunal structures required to authorise all compulsion at 28 days and any changes to such authority thereafter. Inevitably, these resources would include “front-line” services, and would in particular provide additional pressures of work on psychiatrists in preparing for and attending Tribunal hearings.

10.2 It is important that the Bill should be cost-effective, in that the diversion of resources to administer it should be justified by the benefit and safeguards to patients, and the assurance that it provides to professionals. On the basis of the criticisms contained within this paper we are concerned that the Bill at present may fail this test.

10.3 In particular, we think that the proposed Tribunal’s effectiveness when measured against its resource requirements will be questionable. This is partly a question of whether the Bill establishes adequate conditions for compulsion that the Tribunal may use as criteria (as discussed in our evidence to questions 1 and 2 above), and partly due to our concerns over how the Tribunal safeguards may work in practice as set out at paragraph 5.5 above.

Mental Health Act Commission

12 October 2004

Witnesses: Professor Kamlesh Patel OBE, Chairman of the MHAC and Mr Christopher Heginbotham, Chief Executive of the MHAC, examined.
list all the areas that we think are important, and all powers under the Act should be exercised without any direct or indirect discrimination. We think these are fundamental principles and underlying this is what Professor Richardson said in terms of maximising autonomy, that that must be an underlying principle.

Q35 Chairman: Do you want to add anything Mr Heginbotham?

Mr Heginbotham: Only to emphasise what Professor Patel has said. We would like to see those extended principles on the face of the Act. If it was not possible to persuade Government to put the full list of principles, we would certainly want to support the point that Professor Richardson made about the autonomy principle. We really do need to be clear what this Bill is concerned with? Is it concerned with the protection of vulnerable people and the provision of appropriate treatment to people with mental disorder, or is it a public safety measure? I know there is a balance to be struck and, clearly, that is a matter that you discussed with Professor Richardson. We recognise that there is a public safety concern but, primarily, what is the Bill concerned with? Primarily, the Bill must be concerned with maximising the autonomy of people who have suffered from mental disorder or suffer mental disorder, and we feel that putting those principles on the face of the Bill provides that direction, that tone. It will then assist everybody to understand what was the primary purpose of the Bill, notwithstanding there are secondary purposes.

Chairman: Lady McIntosh.

Q36 Baroness McIntosh of Hudnall: Thank you. If we accept, as I think we must, your assertion that the Bill is primarily designed to provide protection for people with mental disorder then, obviously, the definition of mental disorder becomes a vital part of establishing how that is to be provided. In your evidence you have said that you favour the retention of some of the exclusions that were in the 1983 Act, and substance misuse is one of the obvious ones. One of the concerns that has been raised about those exclusions has been that they have been used by mental health professionals or resulted in mental health professionals feeling uncertain about whether it was appropriate for them to treat patients as if they had a mental disorder. You have said in your evidence again that you think that there is no particular evidence that this has been a problem and you suggest, quite robustly, that in fact what may have been happening is that mental health services have in some way attempted to deflect people presenting with certain behavioural problems or whatever away from mental health services and towards other kinds of service provision. Could you just elaborate on why you want to see these exclusions retained in the new Bill and what the implications of that would be?

Professor Patel: Just to take the point about where people are being passed in the service currently, in my experience—and I worked in the drugs field for many years prior to joining the Mental Health Act Commission—this is a training issue as opposed to a legislative issue, very clearly. Nobody wants drug users at their door and if drug use is a presenting factor in terms of a mental health service they will push them off to drug services; that is what has been happening and I think there is a big training issue there in terms of how we deal with that. The anxiety is that if these exclusions are not there, because of the broadness of the compulsion definition at the moment, we will end up with situations where certainly in terms of substance misuse we will see a rapid increase I believe in terms of, particularly, those with alcohol dependency on wards. Some would argue that that is the best way for them to get a service because we know lots of people who are dependent on alcohol are probably drinking themselves to death and not getting the service, and, if you could detain them they will get a service, but what is likely to happen is that we will get a huge number coming on wards that are already stretched and that are not dealing with what they need to deal with, with short stays and people going back out and drinking again. Families will put pressure on clinical supervisors, saying they are harming themselves, and they have probably got an organic disorder as well.

Q37 Chairman: We should not be allowing compulsory mental health procedures, should we, as a gateway for, say, alcoholics in order to solve a-getting-to-the-beds problem?

Professor Patel: Absolutely, and I think that is what will happen unless we are clear about this exclusion. If we look at the study in Eire1, over a three year period 24% of all those who were compulsorily detained were people with alcohol problems. That is why they put the exclusions back in the Act.

Q38 Baroness McIntosh of Hudnall: May I just unpack this a little bit for the benefit of people who are not professionals in this field? A lay person, possibly an under-informed lay person, might think that somebody who suffers from severe alcoholism or persistent drug misuse is manifesting symptoms of an underlying mental disorder. I am aware that that is not an orthodox view, but I think it would be very helpful if you could just explain to us how you would make the distinction between somebody presenting as an alcoholic, let us say, and somebody presenting with mental health problems, and where the boundary is to be drawn which would allow some of these issues to be clearer for us.

Mr Heginbotham: Before answering that specific point I would just re-emphasise the point you have touched on, which was in our evidence. We said we were not aware of any strong evidence at all, other than some anecdotal evidence, that the law was a problem in this area. There is no evidence, so far as we are aware, that this is a problem or that clinicians do not understand the law. To answer the

1 See DMH20, footnote 4.
specific point that you have made, we are not clinicians and therefore cannot, in a sense, give you a clinical threshold between what is an alcoholism which does not have an underlying mental disorder and alcoholism that does, but what we are suggesting is that the exclusion should be written very clearly—and we set this out in our evidence to you—that no person should be considered to be suffering from mental disorder for the purposes of the Act on the grounds solely of dependence upon alcohol or drugs, sexual behaviour or orientation, or the commission or likely commission of illegal or disorderly acts. This is important in the context of the conditions for compulsion that we have discussed at clause 9. Clause 9 is very broad, the definition of mental disorder is very broad, and when you take that in the context of the other sections in relation to the detention of a person by a Tribunal it does allow, as Professor Patel said, the opportunity to detain a very wide range of people for disorders or problems which are not what this Bill is intended to cover.

Professor Patel: If I could add two points to that, one is certainly in terms of substance misuse and in working with drug users one of the key principles we have moved towards is that the drug user accepts there is an issue for themselves and that there is a number of issues that they need to work through. By having this in the Bill you are almost saying we have taken that away from you and we are going back to a medical model where we are saying you are sick, we need to do something about it. Secondly, it is quite an important statement in law to say that something like sexual deviance is not mental disorder. To make that bald statement can be quite a significant problem and we think that the non-resident order arrangement may well be used as a way of managing that although, to be honest, it is not going to make a huge difference perhaps over the current situation unless adequate resources are made available for our mental health services to deal with patients who present now. Again, if one looks back to clause 9 and the conditions for compulsion, it is likely, we think, that the Bill is going to apply to a larger number of patients than it has applied to in the past; potentially, more patients will fall within the terms of the Act and, therefore, the problem we have just been discussing of bed occupancy and pressure on resources can only get worse and not better and the Bill is therefore not going to help in that regard, other than putting more and more emphasis on patients being placed on non-resident orders. What we could find therefore is a very substantial number of people on non-resident orders which may not be appropriate.

Q40 Ms Munn: Just on that point, do you in principle think that compulsion in the community, the non-resident orders, is a good idea and actually could, if properly resourced, make a real difference to people’s lives in that they do not have to be in hospital but could get the treatment within the community? Meg Munn.

Professor Patel: Setting the context for this, I suppose it is almost a fact of life that hospital provision operates according to the principles of triage and in a psychiatric hospital this means finding the least unwell patients, to send them out on leave to make room for the most urgent cases. We might all deplore this, particularly when something goes wrong and the patient comes to harm while on leave, but I do not know that we can legislate against it, that is really important. The key must be to have sufficient provision so that services are not dreadfully oversubscribed as they are now. The key fact is that under the current law decisions about leave are taken for reasons other than the best interest of the patient concerned—that is just setting the context for it.

Mr Heginbotham: I think it is fairly evident that leave is used as a way of managing beds at the moment. Many psychiatric units, particularly in our inner cities, run at over 100% bed occupancy. Beds are allocated to two or three patients simultaneously: one is in the bed, one is in the day room and one is out in the community. This is a very significant problem and we think that the non-resident order arrangement may well be used as a way of managing that although, to be honest, it is not going to make a huge difference perhaps over the current situation unless adequate resources are made available for our mental health services to deal with patients who present now. Again, if one looks back to clause 9 and the conditions for compulsion, it is likely, we think, that the Bill is going to apply to a larger number of patients than it has applied to in the past; potentially, more patients will fall within the terms of the Act and, therefore, the problem we have just been discussing of bed occupancy and pressure on resources can only get worse and not better and the Bill is therefore not going to help in that regard, other than putting more and more emphasis on patients being placed on non-resident orders. What we could find therefore is a very substantial number of people on non-resident orders which may not be appropriate.
you would have to keep coming back to the Tribunal. It seems to me that that is a danger, particularly in view of what Professor Patel said earlier about drug and alcohol abuse. Our serious concern would be that perhaps over time those clauses would start to be used in a way that would provide controlling arrangements, perhaps, for young black people who are thought to be drug addicts and they are placed on what would be the equivalent of an Anti-Social Behaviour Order but run under the Mental Health Act. I think that is a very serious concern. We would have to think this through more, but just to put down a marker, if you like, I think that is an issue that I would want to look at in more detail.

**Chairman:** Thank you very much, Lord Turnberg.

**Q41 Lord Turnberg:** Can we turn now to some of the safeguards? You indicate that you are quite happy with the idea that statutory rights of advocacy and access to Tribunals is available, but on the other hand you are suggesting that the safeguards are perhaps weaker than the 1983 Act would suggest. Do you want to tell us a bit more about that?

**Mr Heginbotham:** The safeguards that we feel are welcome are those which mirror the UN Declaration of the rights of people with mental illness and the European Convention on Human Rights: speedy access to a court or similar body. So the Tribunal is available within 28 days. In some countries in Europe it is essential that you are seen by an appropriate court, a magistrate or other body within seven days. That is often considered to be speedy, but certainly 28 days is much speedier than it used to be or as it is at the moment at six months. There are certain improvements, the advocacy proposals clearly are an improvement, notwithstanding the problems that you discussed with Professor Richardson. Our concern is, particularly, with the weakening of the consent arrangements and those of you who have been involved in this debate over many years, as I have, will recall the lengthy discussions we had prior to the 1982 Amendment Act in the run-up to the 1983 Act, and the work that Larry Gostin and Tony Smyth did at Mind in fighting for consent provisions to go into the 1983 Act. We feel that the Bill in front of us weakens those consent provisions, that we are going backwards on that. It will apply of course to ECT and to what are known as Type A treatments under the Bill, but for other treatments which fall within the care plan that the Tribunal will be approving the consent arrangements are quite clearly taken away completely in terms. We feel that is a retrograde step and that some form of consent arrangements need to be re-provided, linked to some form of second opinion arrangement post-Tribunal. I understand how the drafting has developed because, if you have a Tribunal which is of speedy access, if you do have that Tribunal as an entry arrangement to compulsion rather than an exit arrangement, then you have to deal with some sort of Expert Panel arrangement prior to the Tribunal. But we feel that the arrangements post-Tribunal for reviewing the care plan and taking a second opinion, in relation to the consent of the patient to treatment down the line, are weakened and are simply not acceptable under the current drafting.

**Q42 Lord Turnberg:** Do you think that potential is worsened by the community aspect?

**Mr Heginbotham:** Yes, the way in which the non-resident orders will develop leaves us with a number of concerns. One is the second opinion arrangement, the other is the point I have already referred to which is the potential for a civil restriction order without immediate end and the other is the way in which that will be monitored, because at the moment it is not at all clear from the clauses in relation to the Healthcare Commission how monitoring will take place of community provision and whether patients will have a safeguard in relation to that. I do not know how you do that. I can see that there are problems about that, but I do not think it is addressed in the Bill.

**Chairman:** I think Mr Loughton has a connected question really.

**Q43 Tim Loughton:** Getting on to children and adolescents, in section 6 of your report you highlight the disconnect between the clause 9 provisions and the exemption to the fourth condition in part of sub-section 7 and the conflict potentially with the Children Act, Part 1, on the age groupings of 16 and 18. Can you elaborate on that because those of us dealing with the Children Act are only too aware of the definition of what applies to what children at what age, and this appears to be a serious one?

**Mr Heginbotham:** We would agree with that. We are very concerned about why clause 9(7) talks about people “under the age of 16” because we have been concerned for some time as a Commission about children in the 16 and 17 age range. The Children Act, of course, has a different principle on its face in section 1 and talks about the child’s welfare being of paramount consideration, whereas the Mental Health Bill in the way it is constructed at the moment, notwithstanding our earlier discussion, seems to be more concerned with the protection of others than the paramount concern for the child’s welfare. I think we need to get that balance right. We have a notification process at the Mental Health Act Commission whereby we are told of all young people under the age of 18 detained on adult wards where, often, the facilities are inadequate for young people. We get about 260 notifications a year and that is probably an under-estimate therefore, those are the ones that are actually sent to us. But that is five a week; young people being detained on adult wards where the facilities are inadequate. Our view is that any new legislation must provide a framework to treat children and young people in the most appropriate way for them. The stories we hear—some anecdotally and some by report in writing—are of young people who are often harassed by adults on
those wards, who have drugs pressed upon them, who are abused in various ways, and anything that we can do under the new legislation to outlaw that or to make those sorts of abuses difficult to achieve must be a good thing, we must find a way of doing that and, therefore, we would want to see that age threshold moved up to 18 at least.

Q44 Chairman: We are going to struggle to get through all the important questions that we have asked and we would be grateful, if there are any that we do not cover, if you could write to us with responses on those. Mr Prosser.

Mr Heginbotham: Yes, of course.

Q45 Mr Prosser: Professor Patel, the Mental Health Alliance and others have expressed their serious concerns about Part 3 of the Bill which deals with patients involved in the criminal justice system. The Commission has been largely silent on that part of the Bill; does that mean that the Commission is largely satisfied with it, or do you have any safeguards or recommendations for us?

Professor Patel: At the moment the proposals in Part 3 of the Bill are not much of a departure from the current law so we have not had a great deal to say about it. We need to emphasise that our criticism of the conditions for compulsion reach across to the provisions of Part 3, in particular that the wide definitions of mental disorder medical treatment, coupled with a lack of treatability criteria, must make the misuse of powers under Part 3 all the more possible. Chris has got some very crucial points about this I know.

Mr Heginbotham: We have said this before this morning, it keeps coming back to clause 9 because, if you have a very broad set of conditions of compulsion, then that will impact on Part 3 as well. In the main, the procedures under Part 3 do not give us tremendous cause for concern because they are not dissimilar to those under the present Act, but it is that widening of the scope, particularly when you look at what is actually happening at the moment under the 1983 Act, Section 35, Remand to Hospital and section 37, Hospital Treatment Orders for Offenders, and section 48, Transfers from Prison to Hospital, have all reduced significantly over the last 10 years. In other words, the courts at the moment are not sending offenders with mental disorders to hospital, they are going to prison, and what we have seen is that the psychiatric morbidity in prisons has gone up to the point where, on the Home Office's and the Department of Health's own figures, 90% cent of prisoners have some psychiatric morbidity; 15% of prisoners have serious mental illness. The widening of the scope for Part 3 because of the broad conditions of compulsion can only make that situation worse in our view, unless of course we have significant additional resources which will make it possible to have hospital orders for those who need them, but at the moment the evidence is not good that patients are receiving appropriate hospital treatment rather than being sent to prison.

Q46 Mr Prosser: You both say that there have been no significant departures from the 1983 Bill, but should the Commission not be looking at opportunities within this Bill to make some departures in some areas? For instance, the present almost absolute authority of the Home Secretary to make decisions over transfers and leave arrangements, have you got no concerns about that?

Mr Heginbotham: Yes, we have, and we have said this in other places. We have been very concerned for some time about the number of prisoners being transferred, just at the end of their sentence, where they thought they were on a fixed term sentence and literally a few days, sometimes a few weeks, before the end of that sentence it is determined that they have a psychopathic disorder and are transferred to either one of the special hospitals or to another psychiatric hospital. Whether that is a cynical misuse of the arrangements or whether it is that the Prison Service does not have sufficiently good mental health services to detect mental disorder earlier in the prisoner’s period in prison is a difficult one to call, but we would be concerned that too many prisoners are being transferred in that way and any way in which the new arrangements could both ensure appropriate facilities are available to prisoners—prisoners being transferred to hospital as soon as possible if they have a genuine mental disorder—and outlaw prisoners being transferred to hospital simply as a way of continuing their sentence, because the Home Office feels there may be a risk to the public, is something that we are concerned about.

Professor Patel: One very quick point, if the Mental Health Act Commission was not going to be abolished we would have been saying today that we should extend our powers to visit prisons as well in the way we inspect and interview detained patients. I think that would be a very important clause because the things we find in hospitals by interviewing detained patients are where all the evidence comes from.

Chairman: I can see Lord Rix in the corner of my eye but I am conscious of the pressures on Members of the Commons. I am just going to ask Mr Howarth and Mrs Browning if they would like to deal with some questions about the interface with the Mental Capacity Bill at this stage. Mr Howarth.

Mr Howarth: A number of us sit on the Standing Committee also dealing with the Mental Capacity Bill. That takes a very different approach and it is based on the idea of capacity, which you may or may not think is a useful way of dealing with some of the problems, whereas this particular Bill deals with necessity. Do you see those two concepts, the way the two systems will work, as being complementary or do you think there is some clash between the two?

Chairman: Before you answer that, Mrs Browning has the next question.

Q47 Mrs Browning: Thank you. I too sit on the Mental Capacity Bill and I just wondered whether I could ask you to comment on the view of Alison...
Foster QC, talking about the Bournewood judgment when she said “What the Government cannot do is simply bolt these cases [referring to the case of HLJ onto the current Mental Health Act or the new Bill as there will be many people who are HL who will be detained, but who do not meet the criteria for the use of compulsory powers under either the current Act or the new Bill.” I wonder how you see the Bournewood case in respect of which of these two new Bills is going to fill the gap, is it going to be the Mental Health Bill or the Mental Capacity Bill, if either, or both?

Mr Heginbotham: Yes, the fact is that there is a problem here between these two Bills, let me just say a few words about that. The first is, are they complementary? Yes, they are, but are they complementary in the right way and are they sufficiently clear in the boundary between them? They touch on each other and they could touch on each other in a variety of ways; the way it occurs at the moment though is rather a grey area and there are some patients who could be detained under either Bill, or could ping-pong back and forth between the Bills, depending upon whether they have capacity or not at a particular time. I am thinking, say, of a young person with schizophrenia who has lost capacity and whose parents have, through various procedures, had that person come under the Court of Protection, but who could under various circumstances be treated under one Bill or the other. Our view is that there are some concerns about the way in which the Mental Capacity Bill is drafted although, in broad terms, I would want to support the Mental Capacity Bill. As a general approach I think it is right and we need that Bill, but there are serious problems in relation to treatment for mental disorder. The critical clause is clause 28 which says that no patient can be treated under the Mental Capacity Bill if subject to Part 4 of the current Mental Health Act. Part 4, of course, deals with the consent provisions in the current Act and one wonders why clause 28 is drafted in that way because it is actually rather narrow. In a sense if we were to have a tighter boundary line between the two Bills you would say that no patient who properly fell within the Mental Health Bill for the purposes of treatment would fall within the Capacity Bill. But actually that would be too rigorous, so trying to find the right form of drafting here is a problem and I do not have anything to offer you this morning. It is something which I know the Department of Health and the Department of Constitutional Affairs are thinking about at the moment.

Q48 Chairman: Like all witnesses, in my 30 odd years at the Bar, when asked two questions you answered the last one. I should like to ask you to have a go at the first one as well, Mr Howarth’s question.

Mr Heginbotham: I did try to answer the complementary point; what I am going to come on to, if I may, is the Bournewood point, if that is acceptable. There I would have to concur with what Professor Richardson said; I do not think it is at all clear which Bill would most appropriately cover the situation of HL. Actually, you could argue that the High Court procedures (the Court of Protection provisions) would provide the appropriate procedures for dealing with HL cases, but whether the Government wants the High Court to be dealing with all those incapacitated but compliant patients where there is no great contention but where you would need to then use the High Court provisions to detain them, is a moot point I think. The argument would be no, you would not want to use the Court of Protection for that potentially huge—

Q49 Chairman: It is much too slow a train, is it not?

Mr Heginbotham: Yes, and you are talking about potentially over 20,000 people. There are some people who say that if you take the very specific circumstances of HL there are somewhat fewer than that, but actually if you are going to be strict about this you are talking about a very large number of patients. If you try and do it under the Mental Health Bill you then come into a clash with the Mental Capacity Bill’s other provisions. Clearly, we are concerned, as Professor Richardson said, about the lack of those protections within the Mental Capacity Bill now given that the original Part 5 proposals in the Mental Health Bill were not transferred over, so you have not got the equivalent of the Tribunal with the second opinion and so on, facilities that follow. It is a problem and we need to look at that very carefully.

Q50 Lord Carter: The Mental Capacity Bill, as you know, is before Parliament now. Are you suggesting that that Bill should be amended as it goes through Parliament now to deal with this problem?

Mr Heginbotham: Yes, I am. I think it needs to be amended in a number of ways, but that is not to say that I take that simplistically, nor in a way which I would want to see undermine that Bill. This is about trying to strengthen it and make sure that it fits with the Mental Health Bill. We do have a problem, if you like collectively, because you are looking at the Mental Health Bill now and your report is not likely to be available until after, technically, the Mental Capacity Bill will have gone through Parliament. It seems to me we have a real timing problem here and I hope that between the DCA and the Department of Health there will be some opportunity for a proper intermediate stage of scrutiny if you like.

Chairman: Thank you for that. Mr Howarth and then Mrs Browning briefly, please.

Q51 Mr Howarth: Professor Patel said earlier, I think, that he thought this Bill would benefit from having a statement of principles. Are you aware of the statement of principles that is in the Mental Capacity Bill and is that the sort of thing you had in mind?
Mr Hegiinbotham: Yes, it is, and of course the Capacity Bill does make clear that the purpose is to maximise patient autonomy, which is exactly what we would want to see on the face of the Mental Health Bill. Also, of course, the definitions are complementary in the two Bills as well, so there are a number of starting points here for us to try and bring them together, and some work urgently needs to be done.

Mrs Browning: We shall reach clause 28 of the Mental Health Bill by Tuesday next week, so the time is not very long and I just wonder if you have a final word of advice about what the Government should actually put in, because they are going to need to table those amendments by next week.

Chairman: There is always the House of Lords as well.

Q52 Mrs Browning: Yes, but we would like to analyse it.

Mr Hegiinbotham: Chairman, I was going to say there is another place, but I have urgently been having discussions with Department of Health colleagues and I hope we might at least be able to offer some form of words, particularly in relation to clause 28 and widening that, but in a way that is helpful.

Chairman: Plainly, this is a very, very important issue and I think we would be grateful for further guidance with you on this, in both Houses—we do occasionally in the Lords save the Commons from its worst excesses. Moving quickly on, Lady Pitkeathley wanted to deal with some issues about the European Convention on Human Rights.

Q53 Baroness Pitkeathley: In view of our time I will ask you one very specific question. In your evidence you draw attention to the urgency of amending the 1983 Act in relation to the breach of Article 8 of the European Convention on Human Rights apropos of nearest relatives and family life and so on. Do you think the introduction of the nominated person in this draft Bill will succeed in dealing with this problem?

Mr Hegiinbotham: Probably, certainly in relation to the Article 8 issue. We do have some continued concerns, but this is a real step forward if you like in providing greater choice to the individual patient about whom should represent him or her. The patient does not, of course, have unmediated choice in the provision of the person. the AMHP is the appointer and can disregard the patient’s choice, and there will be within regulations and guidance statements about who might be barred—perhaps anybody with a criminal conviction or whatever may be barred from being able to be the nominated person, but as a general point I think this is a step forward.2

Q54 Baroness Pitkeathley: Do you think any further safeguards would be necessary?

Mr Hegiinbotham: There are concerns about the capacity of the patient and the need to ensure that they are not encouraged to choose somebody who they actually are not happy with, and similar safeguards to those in the Mental Capacity Bill may be appropriate.

Professor Patel: It links in with a much broader point that we are not really able to cover today, but I will just briefly mention it, the fact that a third of the patients detained currently are from the black ethnic minority group, with an increasing number of people from South Asian backgrounds where language is a major difficulty. If we do not get the advocacy system right, there is a cultural issue filtering through that which will impact on all these issues. How are you going to choose a suitable person? Will somebody be given, will somebody be forced upon somebody? That is one principle that needs to run all the way through.

Chairman: Can I ask Dr Naysmith to deal with a very specific question in this respect?

Q55 Dr Naysmith: Dealing with the European Convention on Human Rights is it your opinion that clause 183 of the draft Bill which permits the administration of ECT against the will of patients with capacity to refuse treatment, amounts to a breach of Article 3 or Article 8 of the ECHR?

Mr Hegiinbotham: Probably not. I am not sure that that is where I would start with the concern about this particular clause.

Q56 Dr Naysmith: There is a very helpful section in the document you gave us about this whole area.

Mr Hegiinbotham: Our concern is about emergency provision and the way in which ECT is given at the moment and the second opinion arrangements in relation to ECT. Under the 1983 Act anyone who is to be given ECT who refuses or is incapacitated has the right to a second opinion, and what we find under those second opinions is that 40% are refusing consent and 60% are incapable of consent, and approximately 11 to 12% of all of those are an emergency. Our concern would be that this clause may have a perverse effect in that anybody refusing ECT may then be considered to be incapacitated, or what we will see is many more emergency provisions of ECT. What we may find therefore is that although this appears on the surface to be a step forward, there is a consent provision only if you are fully capacitiated. Incidentally, it is the only clause in the whole thing where capacity is a criterion within the Mental Health Bill and we do wonder why capacity is relevant here but not for anything else, but that is another issue. We are worried that there is a perverse effect built into this potentially in practice.

Chairman: Thank you. Can I ask Lady Cumberlege and Lady Eccles to deal with some resource issues, please?
Q57 Baroness Cumberlege: Thank you very much, chairman. I actually want to start by paying tribute to the Commission for the work that you do and I want to thank you for that because it really is very impressive. In your evidence to us you had a self-denying ordinance in not seeking preservation of the Mental Health Act Commission, but one has to look to the future and in an answer to Meg Munn you were saying that you expect a larger number of patients to be subject to the draft Bill if it is enacted, particularly in the non-resident orders, and you said you did not actually see a way of monitoring that in the community. It would be really useful for us if some further thought was given to that because, clearly, it is going to be a very important issue in the future, and whether that comes into the Code or however I think perhaps we could think about that later on. Under the proposals in the draft Bill and with the Healthcare Commission it is clearly a very different body that is going to be doing the monitoring and the inspections; I wondered whether you felt that is developing the whole spectrum, advocacy at the Commission it is clearly a very different. The bulk of our evidence comes from talking to people and we think that is very different to a large body which can inspect you in terms of information gathered—you can almost get to a tick box approach and that is very dangerous. What we have is a group of people who understand mental health issues, not general health issues, because that is very different. The bulk of our evidence comes from talking to people and we probably deal with lots of issues that do not come before Government now because before problems happen we deal with them. So there are limitations with the Healthcare Commission but the potential is to develop a mental health section of the Healthcare Commission that takes this on board in a big way and helps with monitoring but continues to have the visiting function. Unless that is enshrined in legislation there is a danger with all the pressures on the Healthcare Commission that they will not visit, they will not talk to patients.

Professor Patel: There is potentially a real problem and we are working with the Healthcare Commission now to try and address that. There are potentially lots of problems because if *HL v United Kingdom* happens and more patients are going to be detained who need monitoring, we will need to monitor patients in the community. The problem currently with the Commission is that we have very specialist people who understand, who go and visit and talk to people, and I think that is very different to a large body which can inspect you in terms of information gathered—you can almost get to a tick box approach and that is very dangerous. What we have is a group of people who understand mental health issues, not general health issues, because that is very different. The bulk of our evidence comes from talking to people and we probably deal with lots of issues that do not come before Government now because before problems happen we deal with them. So there are limitations with the Healthcare Commission but the potential is to develop a mental health section of the Healthcare Commission that takes this on board in a big way and helps with monitoring but continues to have the visiting function. Unless that is enshrined in legislation there is a danger with all the pressures on the Healthcare Commission that they will not visit, they will not talk to patients.

Q58 Chairman: Is this not going to require a huge training programme, given that mental health is an area in which there are many unfilled job vacancies? Is that a fair observation?

Professor Patel: Absolutely it is a fair observation. The fact that we have over 100 qualified people currently, one hopes that the transition from Mental Health Act Commission to Healthcare Commission will involve all those people. We do not simply go and inspect or visit, we actually give a lot of advice and guidance when we are there and that is a very different role to what is envisaged in the future.

Mr Heginbotham: Can I underline one point, chairman, and that is the point about visiting? The current Bill, although it places most of the current Mental Health Act Commission responsibilities on the Healthcare Commission, does not actually have an equivalent to the present section 120 of the Mental Health Act 1983 which requires the Secretary of State to have people go and visit patients. We would like to see that replicated within the new Bill.

Chairman: Still on resources, Lady Eccles.

Q59 Baroness Eccles of Moulton: Can I just say how very helpful I found the written evidence that you provided? We have seen in the explanatory notes a table which compares the number of people who are involved at the minute and the number of people who will be involved under the Act in developing the whole spectrum, advocacy at Tribunals, mental health professionals *et cetera*. We have been told that the Department is doing some modelling work on this, but how concerned should we be about the reality of actually providing the number of skilled, qualified, competent people to carry out these duties in being able to implement the Act correctly?

Mr Heginbotham: I think you should be very concerned. It is clear from the processes as set out in the Bill that, in our view, there are many more patients potentially, many more people who potentially will come within the terms of the Bill—thus, that is going to increase the number of reports that will be required from the Expert Panel, from clinical supervisors, from AMHPs, it will mean more Mental Health Tribunals and the whole process will require greater resourcing. We, I think, are not the right body to give you any figures on that, however, and I hope that when you receive evidence from the Royal College of Psychiatrists and other bodies of that nature that they will have been doing some work on that, but it is quite clear that the number of professional staff that will have to be involved, simply in the procedures associated with the Bill rather than caring for patients directly, will increase quite significantly.

Chairman: Thank you very much. A Welsh question, I think, from Mr Williams.

Q60 Hywel Williams: We do not have a very large private healthcare sector in Wales at all; however the Healthcare Commission does not have responsibility for the inspection and investigation of the private healthcare sector whereas the Mental Health Act Commission does appear to have this right. With the transfer of functions to the Healthcare Commission would that mean having a separate body to inspect private healthcare in Wales?

Professor Patel: The Healthcare Commission will have general inspection functions in Wales while the Commission, as you well know, covers England and Wales. I believe the Bill gives the Healthcare
Commission responsibility for England and Wales in respect of mental health so there are three particular ways we could go: the Healthcare Commission could continue to inspect the way the Mental Health Act Commission does in terms of mental health; secondly, the Welsh Assembly Government could introduce some secondary legislation to create an alternate body—the Welsh Mental Health Act Commission—although I think that would be a considerable cost to what it is now because we have the infrastructure, so it is a lot cheaper in terms of how we provide it; thirdly, HIW (the Health Inspectorate Wales) could take on the functions as delegated responsibilities on behalf of the Healthcare Commission.

Q61 Chairman: The question highlights another devolution issue, does it not, clarity of functions in Wales, which we will certainly address and hopefully receive some evidence on when we go to Wales?
Professor Patel: Just one point that struck me, as you well know Wales is a bilingual country and the question is has this been reproduced in Welsh?

Chairman: Ritual slaughter if you do not. Thank you very much. Are there any other burning questions? Lord Rix.

Q62 Lord Rix: I am hoping for a friendly response from Chris Heginbotham because he and I served together 20 odd years ago on what we called the Community Care Campaigners when we were trying to get people out of hospitals and into the community. Going right back to one of your first questions, the exclusions, would you recommend—you heard me say it to Professor Richardson—the exclusion of learning disability per se from the actual Mental Health Bill?

Mr Heginbotham: We have been, as we said earlier, very concerned about the specific exclusions that we have mentioned here, and I have listened to the debate this morning very carefully, particularly in relation to autism spectrum disorders—and of course this affects people with Asperger’s particularly—and learning disability. I would like to duck your question in the sense of saying absolutely yes to that because I think it is an issue that we perhaps need to give some more thought to. However, as a principle the Bill should be concerned with persons where there is a mental disorder under the terms of DSM4 or ICD10, so where somebody has a very stable learning disability which does not have what we might consider to be psychiatric conditions associated with it, then I would have thought an exclusion in that area would be appropriate.

Lord Rix: Thank you.
Chairman: Mr Williams, you wanted to ask something.

Q63 Hywel Williams: You referred earlier on to language in Wales; the 1983 Act has a specific point about Approved Social Workers interviewing in a suitable manner and, although in some places that may include the use of sign language, in Wales it has been interpreted as referring to Welsh or English, subject to the patient’s own choice in fact. Are you satisfied that those sorts of imperatives are reproduced in this current draft Bill?

Mr Heginbotham: One of the problems is that the AMHP could be one of a number of different professions and we therefore have a philosophy which is beginning to become a medically driven approach to the Bill. That is not to say that that in itself is wrong, but it really does need a balance from the social model of illness as well as the medical model of illness, particularly given that there are these concerns about using medicine and possibly putting a pressure on doctors, psychiatrists, to detain people preventively or in relation to potential dangerousness which really does need to be balanced off by people from social work and those who have got that social model of illness. I do not know if that was the burden of your question, but certainly that is something that we have been concerned about.

Q64 Chairman: I think behind the question what you said about the social component is a strong issue. Part of the experience of mental illness in Wales in recent years has been a high incidence of mental illness among people who work in an isolated situation in rural communities—like those in which Mr Williams and I live as it happens—and the language is a much more important issue than many people on this side of Offa’s Dyke would even begin to believe.

Mr Heginbotham: We have recently undertaken a national visit in Wales—which Kamlesh has got here—where we looked at the communication needs of patients, and one of our serious concerns was that most providers did not have sufficient staff or in some cases any staff who spoke Welsh. Many of the providers did not make the sorts of information available in Welsh that they should do, and I think that a lot of people simply do not understand that Wales is officially now a bilingual country.

Q65 Chairman: And really, it is not just officially. Sorry, that is not intended as a criticism.

Mr Heginbotham: No. I do not think that is accepted by a lot of people and we still have some way to go to get people to understand that that is a really critical issue and that we do need to find AMHPs, nominated persons and so on who speak Welsh and can properly represent the patient.

Q66 Chairman: Could you provide us with a copy of that report?

Professor Patel: Yes, certainly, it is really important.
Chairman: Thank you. Mrs Moffatt, you have been very patient.

Q67 Laura Moffatt: Although I am an English MP I am very interested in this whole principle of looking at two sets of codes of practice and the
interface between the Commission and Welsh Assembly. As you know, we are going to seriously attempt to make sure that we work properly in the areas that the Bill will cover, so I wonder if you could just say a little bit about the work that you have been doing with the Assembly?

Mr Heginbotham: We have worked closely with the Wales Assembly Government and the Wales Assembly Government funds the Commission—to a small degree, but appropriately. We worked with the Welsh Assembly with Jane Hutt as Minister and with her officials closely in relation to the visit we undertook on communication needs, and we are in discussion with them about the national census that we are undertaking next March, which we are calling “Count Me In”, which is the census concerned to understand the way in which black and minority ethnic patients are treated within mental health services, and we want to look at that in England and in Wales. So we have some good working relationships with your colleagues in the Wales Assembly Government and have met with the Minister on a number of occasions.

Q68 Chairman: If I may say so, in your paper you highlighted the issues relating to black and ethnic minority patients very strongly indeed, it had a considerable impact on me. Thank you very much indeed for, as I said earlier, an excellent paper and an excellent evidence session. I am sorry it has been a bit of a gallop, there were a lot of questions, but you have so many issues that you can deal with.

Professor Patel: That is right.

Q69 Chairman: I am very impressed by an organisation that is to be demolished but is not protesting at the demolition as a matter of principle.

Mr Heginbotham: We would not have sought our own demise, chairman.

Chairman: I understand that. I am also relieved to hear that although you have apparently gone straight in recent years, Lord Rix remains a recidivist. Thank you, the meeting is finished.

**Supplementary memorandum from the Mental Health Act Commission (DMH 90)**

As requested by the Committee, I have set out below some further points over the interrelation of the Mental Capacity Bill and the draft Mental Health Bill, with specific reference to Clause 28 of the Mental Capacity Bill.

1.1 We believe that the objective of the Mental Capacity and Mental Health Bills must be to afford the maximum possible protection for individuals who are subjected to treatment under their powers whilst also providing a robust legal framework for decision-makers. To this end, it is necessary in our view to establish as great a certainty in the consequences of the wording and interrelation of each Bill as possible. This implies that it should be apparent which of the two legal frameworks provided by mental capacity and mental health laws should form the basis of a patient’s treatment, whether the determining factors rest upon classifications of patients, classifications of treatments, or classifications of wider circumstances.

1.2 It is evident that both the Mental Capacity Bill and draft Mental Health Bill deal potentially with the same range of medical treatments. It follows from this that there is a wide potential overlap between “medical treatment for mental disorder” as defined under the draft Mental Health Bill and matters regarding the care and treatment of patients that would fall to decision-making under the Mental Capacity Bill.

1.3 The Mental Capacity Bill at Clause 28 appears to establish the relationship between that Bill and the Mental Health Act. It provides that nothing in that Bill would authorise anyone to give a patient “medical treatment for mental disorder” (or to consent to such treatment being given to that patient) if, at the time of that treatment, the patient’s medical treatment for mental disorder is regulated under Part 4 of the Mental Health Act (or its equivalent: Part 5 of the draft Mental Health Bill).

1.4 The effect of the Mental Capacity Bill’s Clause 28 is simply to state that, where a patient is already receiving treatment under the authority of the Mental Health Act, the Mental Health Act’s powers will always be deemed to override powers of the Mental Capacity Bill. We think that this statement, although setting a priority of effect that is not in itself without value (although itself far from clear in practical effect), fails to address the more fundamental question of which law practitioners should turn to when considering the administration of treatments in the absence of consent.

---

104 The definition of “medical treatment for mental disorder” in the Mental Health Bill (and indeed in the current Mental Health Act) is very broad. The Bill at Clause 2(7) proposes the definition to encompass nursing; care; therapies; and “habilitation”, the latter to include education or training in work, social or independent living skills. The whole of the broad spectrum of “medical treatment for mental disorder” will be covered by Part 5 of the draft Mental Health Bill (in a similar way Part 4 of the current Act covers all such treatment). Both the current Act and the draft Bill provide authority to clinicians over certain specified treatments subject to some safeguards, as well as a general authority for any “other” (ie unspecified treatments), provided that patients fall within the legal categories to which each part applies.

105 See footnote 7 below.
1.5 As any type of medical treatment for mental disorder will fall within Part 4 of the current Act (or Part 5 of the draft Bill), the reference to these parts at the Capacity Bill Clause 28 neither includes nor excludes any forms of day-to-day psychiatric treatment from the reach of either Bill. In this way the treatment proposed will have no bearing over which of the Mental Capacity or Mental Health Acts might be the appropriate legal framework for its imposition in the absence of consent.

1.6 Clause 28 of the Mental Capacity Bill is similarly unhelpful in determining whether there are certain groups of patients, or certain circumstances, that may be relevant factors in making this choice. It seems to us very unclear how practitioners are to decide, at the point where psychiatric treatment of an incapacitated patient is initiated, whether to use the powers of the Mental Capacity or Mental Health Acts.

1.7 In our evidence to the Committee we have pointed to what we see as potential confusion over whether incapacitated patients’ psychiatric treatment will fall under the Mental Capacity Bill or Mental Health Act. The draft Mental Health Bill proposes as a condition of using its formal powers that, except in the case of patients posing a substantial risk of serious harm to others, there must be no other lawful route to provide necessary treatment. This would appear to prioritise the Mental Capacity Bill’s powers over those proposed by the draft Mental Health Bill when practitioners are initiating treatment of an incapacitated patient. The Mental Capacity Bill provides no check on its powers being used in the face of resistance from the patient, so there could be no distinction made between patients who are compliant to treatment and those who are resisting their treatment. We do not believe, however, that the Mental Capacity Bill was drafted with the intention that its powers should extend to provide the authority and safeguards for the psychiatric treatment of all mentally incapacitated patients, with Mental Health Act powers used only to provide treatment in the face of competent refusals of consent, or in situations where there is substantial risk of serious harm to others.

1.8 In our evidence to the Committee we have already flagged our concern that the safeguards provided for patients under the Mental Capacity Bill would be insufficient in the light of the judgment in H.L v United Kingdom. If patients are to be detained for psychiatric treatment under Mental Capacity Bill’s proposed powers then there is surely a strong case for instigating stronger safeguards, including Tribunal-based approval of long-term powers and reviews of treatment. The strengthening of safeguards in the Mental Capacity Bill could, of course, encourage its use as a means of psychiatric detention alternative to the Mental Health Bill. Inconsistencies across the two Bills in relation to practical measures (such as advocacy arrangements) and more conceptual matters (such as the role of capacitated decision-making) may cause legal difficulties, particularly as some patients’ care may move back and forth from one statutory framework to the other as their mental capacity changes over time. There will surely be considerable pressure, even after enactment, for a standardisation of the effects of each Bill in respect of psychiatric treatment without consent.

1.9 Alternatively, the Committee may wish to consider whether it could be appropriate to seek a formulation that reserves powers of enforced psychiatric treatment to a Mental Health Act, leaving only less coercive measures in the scope of a Mental Capacity Bill. This would not, in our view, necessarily absolve the Capacity Bill from its current difficulties following H.L v United Kingdom, nor is it easily apparent how such a formulation is to be achieved. In the time available to the Commission we have not been able to provide any concrete suggestions as to how a distinction of this sort might be formulated, and we do recognise the difficulties of definition that arise.

I hope that this letter has gone some way towards setting out the problem that needs to be addressed, even if I have not been able to suggest any ready solution to it. I hope that the Committee finds this of use and I shall be happy to expand upon any of these points, or address any other questions that Committee members may have of the Commission.

October 2004

106 The exception here is Neurosurgery for Mental Disorder and any other treatment listed under section 57 of the Mental Health Act 1983, or any “Type A” treatment under the draft Mental Health Bill (Clause 191 et seq). These rare and hazardous treatments will only be able to be authorised through the framework of the Mental Health Act.

107 DMH 20, para 8.3.

108 Draft Mental Health Bill Clause 9(5).

109 Draft Mental Health Bill Clause 9(7).

110 It would seem, in part as a consequence of Clause 28 of the Mental Capacity Bill itself, that where a practitioner wishes to override any safeguard provided to a patient under the Mental Capacity Bill (as refusal of consent via an advance directive, deputy or attorney), this wish may itself constitute the required condition for formal treatment under the Mental Health Act. Because of the very different criteria for imposing treatments (ie treatment with ECT may not be given under the Mental Health Act in the face of a capacitated refusal of consent, whereas treatment with medication may be given in such circumstances), it is unclear what legal consequences might follow from a practitioner choosing to use Mental Health Act powers to override certain decisions made under the Mental Capacity Bill, for example an advance directive refusing consent to ECT. Clause 28 of the Mental Capacity Bill does not clarify whether, in such circumstances, the patient should be treated for the purposes of the Mental Health Act as having refused consent, or to having been incapable of refusing consent. We can envisage arguments made to the courts of either case.

111 DMH 20, paras 8.5–8.6.
Wednesday 27 October 2004

Members present:

Carlile of Berriew L (Chairman)  Mrs Liz Blackman
Carter, L  Mrs Angela Browning
Cumberlege, B  Mr David Hinchliffe
Eccles of Moulton, B  Mr George Howarth
Finlay of Llandaff, B  Tim Loughton
Flather, B  Laura Moffatt
McIntosh of Hudnall, B  Ms Meg Munn
Mayhew of Twysden, L  Dr Doug Naysmith
Pitkeathley, B  Dr Howard Stoate
Rix, L  Hywel Williams
Turnberg, L

Memorandum from The Royal College of Psychiatrists (DMH 24)

“The whole picture (on the provision of care and treatment) is distorted by the use or prospect of compulsion, which deters people from seeking treatment, denies them the right to choose the treatment they want, and prioritises certain kinds of patient in the offer of services.” Baroness Hale of Richmond, Sieghart lecture, British Institute of Human Rights 2004.

CONTENTS

Summary of key points
Summary of recommendations
Introduction

1. Is the draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

2. Is the definition of Mental Disorder appropriate and unambiguous?

Are the conditions for treatment and care under compulsion sufficiently stringent?

Are the provisions for assessment and treatment in the Community adequate and sufficient?

3. Does the draft bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

4. Are the proposals contained in the draft Mental Health Bill necessary, workable, efficient, and clear?

Are there any important omissions in the Bill?

5. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft bill?

6. Are the safeguards against abuse adequate?

Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient?

Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

7. Is the balance struck between what has been included on the face of the draft bill, and what goes into Regulations and the Code of Practices right?

8. Is the draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

9. Is the draft Mental Health Bill in full compliance with the Human Rights Act?

10. What are likely to be the human and financial resource implications of the draft bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

Additional Information (Wales, black and ethnic minorities, dangerousness, psychiatrists and psychologists, forensic psychiatrists, mental health acts across the United Kingdom)

Appendix 1: The Royal College of Psychiatrists
Appendix 2: Ethical Standards in Psychiatry
SUMMARY OF KEY ISSUES

Reform of mental health law can only play a small part in improving patient care:
— reducing stigma and discrimination;
— enhancing awareness within society;
— ensuring an adequate and well-trained workforce; and
— access to a range of psychological and medical treatments
are all far more important in improving mental health (including issues of safety).

The legal framework for non-consensual treatment for the mentally ill should:
— Mirror that for the physically ill as closely as possible. There is no place, in the 21st Century, for
forcing treatment which they do not want on people who retain full decision-making capacity.
— Ensure the Government’s intention not to increase the number of patients subject to compulsion
is realised. The proposed definition of Mental Disorder is only workable if the conditions for
compulsion are restricted.
— Not be used solely for the control of social, or anti-social, behaviours, in a health service, unless
there is a health need and benefit.
— Be consistent between different parts of the United Kingdom.

A Mental Health Act should not:
— Have an adverse effect on voluntary patients either by making them fear using services or by
limiting the services available for such patients due to an increase in resources for those subject to
compulsion.
— Have an adverse effect on the safeguards for compelled patients because staff requirements cannot
be met.
— Require practitioners to have to balance the ethical principles of their profession against
compliance with the law.

A Mental Health Act should:
— Be understandable to practitioners.
— In relation to children and young people, involve psychiatrists and other professionals, including
lawyers, with expertise in working with children.

The Royal College of Psychiatrists is the leading medical authority on mental health in the United
Kingdom and Ireland. The College is pleased to be afforded the opportunity to present written and oral
evidence to the Committee.

The Royal College of Psychiatrists is a member of the Mental Health Alliance.

SUMMARY OF KEY RECOMMENDATIONS

1. The draft Codes of Practice must be made available, alongside the draft Bill, in order fully to
understand the provisions of the Bill.

Question 1

2. Principles should include: non-discrimination, respect for diversity, respect for personal autonomy,
informal care where possible, reciprocity, least restrictive alternative, patient participation and consensual
care where possible, respect for carers, patient benefit, child welfare.

Question 2

3. The definition of mental disorder in the draft Mental Health Bill is satisfactory ONLY if combined
with extremely tight conditions and limitations. Otherwise either the New Zealand or Australian definitions
of mental disorder should be adopted.

4. The Bill should contain the following exclusions: Nothing in the conditions for compulsion shall be
construed as implying that a person may be dealt with under this Act as suffering from mental disorder solely
by reason of: cultural, political or religious beliefs or promiscuity, sexual deviancy or other immoral conduct
or dependence on, or misuse of alcohol or drugs or impairment of intelligence or the commission, or threat,
of illegal or disorderly acts.

5. Use of the Act should be prohibited in cases where the capacitous patient willingly accepts assessment
and treatment as recommended by the medical practitioner.

6. Patients who lack decision-making capacity must not be excluded from receiving treatment because
they resist treatment and yet present only moderate risk to their health.
7. There should be two important additional conditions for compulsion in the draft Bill:
   (a) Impaired decision-making by reason of their mental disorder.
   (b) In relation to a treatment order: therapeutic benefit for the patient.

8. Community Treatment Orders should be available for patients only on authorisation of the Tribunal after a period of in-patient assessment and whilst the person suffers impaired decision-making by reason of their mental disorder. Leave of absence powers enable assessment and treatment in the community during the assessment period.

Question 3

9. Tribunal should not be permitted to authorise a treatment order if it is hearing an appeal within the first 14 days of the period of assessment.

Question 4

10. Compulsion should only be possible, other than in an emergency, if two doctors certify that the patient suffers from a mental disorder satisfying the conditions.

11. Clinical supervisors must be qualified to assess if a person meets the conditions for compulsion in order to be able to keep under review if the conditions continue to be met.

12. The Mental Health Tribunal should be permitted to authorise specified medical treatments only if they are agreed as necessary by both the clinical supervisor and medical expert panel member.

13. There should be no limitation of the right to discharge by the Clinical Supervisor for patients detained under civil sections. The College would also wish those rights (and associated limitations) currently available to the nearest relative to be available to the nominated person.

14. Transfer between hospitals should require consultation, other than in an emergency, but without specific time limits.

Question 5

15. Medical treatment, provided it is not irreversible or hazardous, may be given under the direction of a registered medical practitioner, within the first five days, if it is necessary to alleviate, or prevent a deterioration, in the patient’s condition.

Question 6

16. Safeguards, both legal and clinical, for persons under 16 years of age must be re-evaluated.

17. Changes to the medication plan after 28 days should be authorised by a medical member of the Expert Panel, with similar requirements to consultation as specified. If a full Tribunal was to be required there is a real danger that either:
   (a) necessary changes in medication would be significantly delayed leading to prolonged suffering and increased risks; or
   (b) the initial treatment plans authorised would be very broad giving limited or no protection to the patient.

18. It should be clear from the legislation, or Code of Practice, that one option for a care plan presented to a Tribunal would include the statement that identified treatments will only be given with the patient’s consent (subject to an emergency treatment clause).

19. Electro-convulsive therapy (ECT) should only be prescribed by qualified psychiatrists. There should be no compulsory ECT in the face of the refusal of a capacitous patient. The current provision in relation to surgery for mental disorder (requiring capacitous consent) should not be extended.
Question 7

20. The College believes the principles underpinning the legislation should be on the face of the Bill, as with the Mental Capacity Bill.

Question 8

21. The rights, and safeguards, for patients should be the same under the Mental Capacity and the Mental Health Bills.

Question 9

22. The Mental Health Act for England and Wales must meet the requirements both of Human Rights legislation and the recommendations of the Council of Europe.

Question 10

23. Further research is required to assess the realistic likely impact of the proposals, on the workforce, in relation to numbers, recruitment and morale.

Additional information

24. A review of the of the Bill’s workforce and service impact in Wales should be undertaken.

25. The principles and essential provisions of mental health legislation should not differ significantly between different parts of the United Kingdom.

INTRODUCTION

Reform of mental health legislation must be set in context. Improving patient care (including issues of safety) depends on a range of measures. First it must relate to reducing stigma and discrimination. Enabling people to feel able to seek help early, to talk about their fears and difficulties, without fearing scorn, humiliation or loss of status, freedom, job and friends would result in a marked improvement in care. Secondly, we cannot escape the need for resources including an adequate, well-trained workforce and access to a range of treatments including psychological therapies and new generation of medications. Patient choice and involvement in their own care and treatment is as important in psychiatry as any other part of the health service. Thirdly, all law in relation to healthcare should exist to enable patients to receive treatment, within a clear legal framework, to improve personal health and well-being, to protect against abuse and, through these measures, to increase the health and safety of the nation.

The College has welcomed the many important Government initiatives (including making mental health a priority, the NHS plan, the National Service frameworks, the additional financial investment, the Mental Capacity Bill, the Disability Discrimination Bill and the report on social exclusion report) in mental health.

Against this background the College welcomes reform of the Mental Health Act. The provisions of the current Act (based on the recommendations of the Royal Commission which set the framework for both the 1959 and the current Mental Health Act) have fulfilled their functions very well. Nonetheless the practice of psychiatry (new treatments, more multi-disciplinary working, much greater patient and carer involvement) and the expectations and aspirations of patients, their families and staff have changed substantially. Medicine as a whole, of which psychiatry is an integral part, has recognised the central importance of both patient choice and the patient/doctor partnership in decision making. Discrimination and stigma are unacceptable and their elimination must be our goal.

One of the unexpected changes, since the introduction of the 1983 Act, is the doubling in the number of patients detained under the Act. There is no suggestion of an equivalent increase in rates of severe mental illness. Likely explanations include the Nation’s reduced tolerance of risk, the climate of blame within which mental health professionals work and the reduction in number of acute psychiatric beds. Psychiatrists are increasingly reluctant to risk their reputation, and perhaps their career, by respecting a patient’s choice if there is ANY risk in that decision (this is particularly important in the light of the conditions for compulsion in the draft Bill).

The Royal Commission (Percy Commission) of the 1950s helped frame mental health legislation which led the world in reinforcing enlightened psychiatric practice. New legislation should do the same for the 21st century. Clinical discretion and a Code of Practice cannot rescue a bad Mental Health Act.

A significant question, as described in the report of the Joint Committee on the draft Mental Incapacity Bill, is whether or not it is either necessary or appropriate to have separate legislation for those suffering from mental disorder (given the Government’s intention to pursue both bills we acknowledge it is their view that separate legislation is warranted). The Mental Capacity Bill sets out a legal framework for the health
and social care of those who are unable to make decisions for themselves. The College believes the principles and provisions of this Bill will significantly aid the care, treatment and safeguards for a vulnerable section of the community. The final provisions of the Mental Capacity Act are not currently decided.

The need for, and content of, a Mental Health Act will clearly depend, in part, on the provisions of the Mental Capacity Act. It is essential therefore that, as has recently taken place in Scotland, the capacity legislation should be passed prior to the introduction of any Mental Health Bill.

It is essential that the proposed Codes of Practice are available if the provisions and likely effects of this Bill are to be fully understood.

**Recommendation**

The draft Codes of Practice must be made available, alongside the draft Bill, in order fully to understand the provisions of the Bill.

**Question 1** Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

“Recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world”. United Nations declaration of Human Rights 1948.

“The use of compulsion also raises some more fundamental questions about discrimination between people with mental disorders and everyone else. Why should the conditions for treatment for mental disorder be different from the conditions for treatment for physical disorder? In other words, why should not this too depend upon consent or incapacity? And why should capacitated people be able to make advance directives about treatment for future physical disorder but not about treatment for future mental disorder? If incapacity were the criterion, rather than the severity of symptoms or the prospect of harm to others, then some people might be given the help they need before their situation became too desperate.” Baroness Hale 2004

1. It must be consistent with the Human Rights Act 1998 which embodies the European Convention on Human Rights (ECHR).

2. It must be recognised that legislation in relation to health care may, like medication, do harm as well as good. The Hippocratic Principle of “first do no harm” should apply in the field of legislation as in any other medical intervention. Harm may be done to the patient (in terms of reducing personal autonomy, breaching individual liberty, damaging health, social or employment prospects) or to the population at large (by increasing stigma and discrimination). It may also cause harm by damaging both the professional and public perception of psychiatry, which in turn would impact adversely on recruitment to an already heavily under-recruited specialty.

3. The Expert Committee set up to review the Mental Health Act 1983 (Richardson Committee) in its report of November 1999 included the following underlying principles:
   (a) Non-discrimination (that wherever possible the principles governing mental health care should be the same as those which govern physical health).
   (b) Patient autonomy.
   (c) Informal care wherever possible.
   (d) Least restrictive alternative.
   (e) Consensual care.
   (f) Participation by service users.
   (g) Reciprocity (where society imposes an obligation on an individual to comply with a programme of treatment and care it should impose a parallel obligation on the health and social care authorities to provide appropriate services).
   (h) Respect for diversity.

Non-discrimination as between those suffering between mental and physical illnesses is a central area of concern (and being addressed in a number of areas such as the proposals in the Disability Discrimination Bill). The Joint Committee on Human Rights when reviewing the draft Mental Health Bill stated, “we have doubts about whether it should be possible to override the wishes of the patient, expressed when capable of making a decision, about treatment. The ECHR permits treatment to keep a person alive against his or her will, if he or she is suffering from a mental disorder at the time, because the state can rely on its positive obligation to preserve life. The same duty would justify the state in compulsorily providing treatment to someone who would otherwise be likely to cause death or serious harm to others. But we have doubts as to whether this duty would justify overriding a direction given with proper capacity where the patient later became ill, but not a threat to himself or others.”
If proper regard is given to advance directives by people capable of making them, then it would clearly be nonsense for directions given by a capable person, at the time the decision needs to be made, to be disregarded.

Finally, any new Act must not have an adverse effect on voluntary (consenting) patients eg by limiting the amount of resource available for such patients or by directing services and resources in such a way that there will be access to resources without cost for compelled (detained) patients but at a cost for those who willingly accept treatment.

Specified principles should include:

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-discrimination, respect for diversity, respect for personal autonomy, informal care where possible, reciprocity, least restrictive alternative, patient participation and consensual care where possible, respect for carers, patient benefit, child welfare.</td>
</tr>
</tbody>
</table>

Question 2. Is the definition of mental disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? are the provisions for assessment and treatment in the community adequate and sufficient?

(A) Definition of Mental Disorder

Current position (Mental Health Act 1983)

Mental disorder is sub-divided into four categories: mental illness, mental impairment, severe mental impairment and psychopathic disorder. The major category (over 80%) of detentions is mental illness and this is undefined. The absence of a definition, along with guidance from the Courts, has enabled a practical and developmental use of the category to ensure that when patients are described as mentally ill it is in line with developing practise.

In relation to learning disability, the definitions in the current Act for mental impairment and severe mental impairment include the requirement for the person to have “abnormally aggressive or seriously irresponsible conduct” in addition to having a learning disability.

The draft Mental Health Bill defines mental disorder as “an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain”. This is the same definition as in the Mental Capacity Bill and includes neurological and other physical causes of brain dysfunction including intellectual impairment, head injury, multiple sclerosis and so on. Whilst it is clear that this would not result in any inappropriate exclusions it undoubtedly gives the potential for serious over inclusion. If such a broad definition is to be used then it is imperative that the conditions for compulsion, including exclusion conditions, which follow this definition, must be extremely strict, a matter overlooked in the 2004 draft Mental Health Bill.

It should be noted that in New Zealand and Australia (countries quoted by the Government because of their use of community treatment orders) there is a much narrower definition of mental disorder.

New Zealand—Definition of Mental Disorder

“An abnormal state of mind shown by delusions or disorders of mood, perception, volition or cognition.

Australia, New South Wales—Definition of Mental Disorder

“Mental illness means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

(a) Delusions.
(b) Hallucinations.
(c) Serious disorder of thought form.
(d) A severe disturbance of mood.
(e) Sustained or repeated irrational behaviour indicating the presence of one or more of the symptoms referred to in paragraphs a–d.

Recommendation

The College believes the draft Mental Health Bill definition to be satisfactory ONLY if combined with extremely tight conditions and limitations, as described below. Otherwise either the New Zealand or Australian definitions of mental disorder should be adopted.
EXCLUSIONS FROM DEFINITION OF MENTAL DISORDER

Most definitions of mental disorder have a number of exclusions. Indeed the College is not aware of any mental health act which has no exclusions from the definition of mental disorder, or required conditions for compulsion, in any other common-law jurisdiction. For example the current Mental Health Act (1983) states that people may not be “dealt with under this Act as suffering from mental disorder, or from any form of mental disorder described in this section, by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs”.

The Draft Mental Health Bill has no exclusions.

Scotland (Mental Health Care and Treatment Scotland) Act 2003—Exclusions

“A person is not mentally disordered by reason only of any of the following:
(a) sexual orientation;
(b) sexual deviancy;
(c) transexualism;
(d) transvestism;
(e) dependence on, or use of alcohol or drugs;
(f) behaviour which causes, or is likely to cause harassment, alarm or distress to any other person; and
(g) acting as no prudent person would act”.

New Zealand—Exclusions

“That persons political, religious, or cultural beliefs; or that persons sexual preferences; or that persons criminal or delinquent behaviour; or substance abuse; or intellectual disability”.

Australia, New South Wales—Exclusions

“Certain words or conduct may not indicate mental illness or disorder. A person is not a mentally ill person or a mentally disordered person merely because of any one or more of the following:
(a) That the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political opinion or belief.
(b) That the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular religious opinion or belief.
(c) That the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy.
(d) That the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular sexual preference or sexual orientation.
(e) That the person engages in or refuses or fails to engage in or has engaged in or refused or failed to engage in a particular political activity.
(f) That the person engages in or refuses or fails to engage in or has engaged in or refused or failed to engage in a particular religious activity”.

Recommendation

The Bill should contain the following exclusions:
Nothing in the conditions for compulsion shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder solely by reason of: cultural, political or religious beliefs or promiscuity, sexual deviancy or other immoral conduct or dependence on, or misuse of alcohol or drugs or impairment of intelligence or the commission, or threat, of illegal or disorderly acts.

Drug and alcohol misuse

The issue of excluding from compulsion “solely by reason of misuse of drugs or alcohol” is more contentious than the other exclusions. There is little doubt that in the past there has, at times, been a misunderstanding of this provision. A small number of patients who should have been detained were not on the grounds of their substance misuse despite the presence of serious mental illness. This is a matter for training. It is the College’s view that including compulsion solely due to alcohol or drug misuse will have significantly damaging consequences in the following areas:

Clinical: A central tenet for the treatment of people who misuse substances is the acknowledgement of their difficulties and the need to accept responsibility for them. Taking control away and making others responsible for their behaviour may seriously damage the
prospect of recovery. Patients with drug and alcohol problems do not generally see themselves as “mentally ill”. Many, for example, will not attend psychiatric hospitals specifically because of the inferred “label” of a psychiatric disorder. The addiction services have developed widespread community-based services so as to increase access and the availability of services to those with drug and alcohol problems. Fear of being made subject to compulsion is likely to discourage people coming forward for treatment and to be a major retrograde step in the addiction field. It may also lead to a decrease in patients presenting for help to statutory services, with an increase in the number of complex cases attending non-statutory agencies. This could have implications in terms of management of the more complex problems.

Resources: The mental health resources, including new teams being developed under the National Service Framework such as Crisis Teams, would be overwhelmed by drug and alcohol consumers’ emergency assessments and admissions. These individuals may only be intoxicated for one night, but still trigger the proposed new system to detain them. This will have considerable resource implications for Accident and Emergency units and out of hours assessments in police custody suites, as well as mental health on call services. It is not appropriate to apply a Mental Health Act to a person with intoxication.

Inpatient units: In the care of people with substance misuse or dependence, use of the Mental Health Act (and, in the absence of consensual treatment, detention would be necessary) is likely to be detrimental to their care. Individuals with chronic drug and alcohol problems if admitted compulsorily into mental health wards may also pose difficulties for other patients through damaging the therapeutic environment for those with functional mental illness.

**Learning disability**

The College proposes that people with a learning disability should only be liable to compulsion under the Act if they have a mental disorder in addition to their learning disability. The use of the “impairment of intelligence” exclusion condition should enable this. It is Government policy, as set out in “Valuing People”, that people with learning disability should access services in the same way as anyone else, and this proposal would achieve that aim.

If the “impairment of intelligence” exclusion is not included, then the definition of mental disorder in the draft Bill would include almost all people with learning disability, who would then be liable to compulsion at any time they decline medical treatment (including education and training). Leaving aside the serious ethical issues, this would lead to the inappropriate detention of more people with learning disability, and the growth of institutional care. This would not be in keeping with the aims of “Valuing People”.

**Illegal or disorderly acts**

Most people with mental disorder do not commit offences. Most offenders do not suffer from a mental disorder. Diagnosing mental disorder solely on the basis of illegal acts, or for the prevention thereof, would enable this legislation to be used for political purposes. Any possible perception of this would be extremely damaging to psychiatry, the mental health services and the law.

**B. Conditions for Treatment and Care Under Compulsion**

**Current position (MHA 1983)**

The current conditions are that it is necessary for the person to be in hospital (this immediately defines the severity of the patient’s condition which is necessary prior to compulsion), that they need to be detained in the interest of their own health or safety or with a view to the protection of others, that the treatment cannot be provided unless the patient is detained, and, in those people who are deemed to be suffering from mental impairment or psychopathic disorder, that the treatment is likely to alleviate or prevent a deterioration in the patients condition.

Many people would argue that patients should only be made subject to compulsion if they are unable to make a decision for themselves. Others have argued that doctors would be unable to stand back and see people harm themselves on the basis that the patient retained capacity and would broaden the definition of incapacity until it essentially meant anyone who disagreed with their doctor. However, the inclusion of an incapacity requirement is the only way to ensure lack of discrimination from those suffering from physical illnesses. It is worth repeating the law in relation to those suffering a physical illness. This was most recently spelt out by Dame Elizabeth Butler-Sloss in the case of *Ms B* (2002):

“**A competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his or her death**”. It should be noted that Dame Butler-Sloss had, inadvertently, excluded the mentally ill from her words. A person diagnosed as mentally ill, even though competent, does not have the right to refuse to consent to medical treatment.
It may be that there is a source of confusion here. The vast majority of people with mental illnesses retain fully their ability to make decisions throughout their illness. Most patients with mental illnesses, who require medical intervention are treated by General Practitioners or as informal/voluntary patients by psychiatrists.

Both the current Mental Health Act and the draft Mental Health Bill require psychiatrists to force treatment on patients who are perfectly capable of making decisions for themselves whilst offering no protection, or legal framework, for patients who lack capacity but, because of their illness, do not object to the treatment (this is the so-called Bournewood Gap). The absurdity of both the current position and the proposals may be clarified with two examples.

Example 1: A patient with depression recognises that he is ill. He understands that he is at increased risk of suicide but feels he is safe enough at home, with the support of his family, and does not wish to be admitted to hospital. He wishes to be treated with cognitive therapy. His family support this plan. The doctors believe that because of the suicide risk it would be unsafe to leave him at home. They feel obliged to make the patient subject to compulsion, in hospital (to be on the safe side), and, because of the waiting time for availability of cognitive therapy he is forced to have medication.

Example 2 (the Bournewood Gap): A patient with depression believes he is responsible for all the ills of the world. He wishes to die. He agrees to be admitted to hospital as he believes he will be killed in hospital—which is what he believes he deserves. Such a patient will be admitted to hospital and treated informally, with none of the protections (statutory second medical opinions, Tribunals etc) offered by being subject to a mental health act.

A recognised difficulty is that there are different ways of determining capacity. It is argued that the definition in the Mental Capacity Bill centres around cognitive (thinking) ability without giving weight to the importance of factors such as emotion or delusions. The Common Law determination of capacity in “Re C” (the person should be able to understand, remember, believe, weigh in the balance and express a decision) may be a little better. However, the College’s preferred approach is that taken in Scotland. This is to recognise that patients may have impaired capacity, which damages their ability to make decisions, without losing capacity altogether.

Other issues, which it is important to consider, are whether or not patients should be compelled to accept “treatment” if they cannot benefit from the treatment (the draft Mental Health Bill has no benefit requirement) and whether or not it is necessary for the treatment to be in their best interests (the Mental Capacity Bill requires any treatment to be in the person’s best interest, the draft Mental Health Bill has no such requirement).

**CONDITIONS IN THE DRAFT MENTAL HEALTH BILL**

The Bill lists the following conditions:

(A) The first condition is that the patient is suffering from mental disorder.

(B) The second condition is that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.

(C) The third condition is that it is necessary:
   (a) For the protection of the patient from:
      (i) Suicide or serious self-harm; or
      (ii) Serious neglect by him of his health or safety; or
   (b) For the protection of other persons, that medical treatment be provided to the patient.

(D) The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.

(E) The fifth condition is that medical treatment is available which is appropriate in the patient’s case, taking into account the nature or degree of his mental disorder and all other circumstances of his case.

(The definition of medical treatment (clause 2(7)) includes:

(a) Nursing;
(b) Care;
(c) Cognitive therapy, behaviour therapy, counselling or other psychological intervention;
(d) Habilitation (including education and training in work, social and independent living skills); and
(e) Rehabilitation).

(F) The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons. (It should be noted that this deviates from the “least restrictive option” principle).
(G) For the purposes of this Part, a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.

Issues

The wording in relation to the third condition presents a problem in that some patients’ diagnoses are associated with a significant risk of suicide or self-harm at all times. For example, up to 10% of patients with schizophrenia may commit suicide. In the context of the “blame culture” and society’s low tolerance of risk it seems likely that clinicians will err on the side of safety leading to inappropriate detention in hospital (with a significant impact both on the individual who is deprived of his liberty and the resources available for mentally ill people who would benefit from hospital care and yet do not display such behaviours). If the wording were as in the 1983 Act “In the interest of” rather than “for the protection of” it would enable the clinician to weigh up relative risks.

Furthermore, because the conditions now centre on risk it would appear to be unlawful to apply the Bill’s provisions for patients with mental illness who have lost capacity (and so refuse effective treatment) if the consequences of the illness cause moderate physical or mental damage to the individual.

The fourth condition would presumably require patients to be treated with the authority of the Mental Capacity Act if they lack capacity and are compliant. It may be, we do not know the final provisions of that legislation, that this will also apply to incapacitated patients who resist treatment. In either case this is likely to lead to confusion.

In relation to point (F), the principle of least restrictive alternative should apply to all categories of patient.

Recommendation

Use of the Act should be prohibited in cases where the capacitious patient willingly accepts assessment and treatment as recommended by the medical practitioner.

The College finds it difficult to understand the meaning of the fifth condition. It does not appear to equate to a condition that treatment should be available which will provide therapeutic benefit to the patient.

In addition the final paragraph, if taken as stated, to apply to all other conditions, may be interpreted as suggesting that a determination of dangerousness is, of itself, evidence of mental disorder. The two conditions, taken together, suggest that a “clinically appropriate” determination might be solely to prevent criminal behaviour.

There are no exclusion conditions (see below).

Recommendation

Patients who lack decision-making capacity must not be excluded from receiving treatment because they resist treatment and yet present only moderate risk to their health.

The Conditions in Scotland (Mental Health (Care and Treatment) (Scotland) Act 2003)

The conditions for an assessment order are:

(a) The patient has a mental disorder.

(b) That because of the mental disorder the patient’s ability to make decisions about the provision of medical treatment is significantly impaired.

(c) That it is necessary to detain the patient in hospital for the purpose of:

I. Determining what medical treatment should be given to the patient; or

II. Giving medical treatment to the patient.

(d) That if the patient were not detained in hospital there would be significant risk to:

I. The health, safety or welfare of the patient; or

II. To the safety of any other person.

(e) That the granting of a short-term detention certificate is necessary.

The conditions for a treatment order are:

(1) That the patient has a mental disorder.

(2) That medical treatment which would be likely to:

(a) Prevent the mental disorder worsening.
(b) Alleviate any of the symptoms or effects of the disorder is available for the patient.

(3) That if the patient were not provided with such medical treatment there would be a significant risk:
   (a) To the health, safety or welfare of the patient.
   (b) To the safety of any other person.

(4) That because of the mental disorder the patient’s ability to make decisions about the provision of such medical treatment is significantly impaired.

(5) That the making of a compulsory treatment order in respect of the patient is necessary.

(6) Where the Tribunal does not consider it necessary for the patient to be detained in hospital such other conditions as may be specified in regulations.

The phrases underlined are particularly pertinent here.

**Recommendation**

The College believes there are two important required conditions additional to those in the draft Bill.

1. Impaired decision-making by reason of their mental disorder. The concept of impaired decision-making may be easier to use in a clinical setting than lack of capacity whilst still ensuring that there is no compulsion in the face of a fully competent refusal and no failure to treat an incapacitated person on the grounds that the person does not present sufficient risk.

2. In relation to a treatment order:

   Therapeutic benefit for the patient. Therapeutic benefit means medical treatment which is likely to bring about an “improvement in the symptoms, or signs, of mental disorder, or reduce or prevent deterioration in the person’s mental or physical health”.

The College preferred conditions would mirror those in the new legislation in Scotland both in relation to short-term detention and compulsory treatment orders. An alternative would be that the conditions for England are left looser than those for Scotland but combined with a tighter definition of mental disorder and stronger exclusion condition (as in New Zealand or Australia). It is recognised that should impaired decision-making be accepted as a necessary requirement for compulsion then particular consideration will need to be given in relation to offenders (see below).

Note: The usual argument against impaired decision-making or incapacity as a condition is that some people might decide that they did not want medical treatment without which they would die. It is worth recalling the case of Ms B (2002). She had become paralysed by a bleed into her brain. She wished the hospital to remove the ventilator which was keeping her alive. The Court determined that, given she retained full decision-making capacity, this was her right as an autonomous individual. Ms B’s condition would fit within the proposed definition of mental disorder. Consequently the provisions of this Bill would have deprived Ms B of this human right.

The College is able to give details in relation to other European countries if this would be helpful to the committee.

**C. COMMUNITY TREATMENT ORDERS (REFERRED TO AS “NON-RESIDENT” ORDERS IN THE DRAFT MENTAL HEALTH BILL)**

**Current position**

It is often, mistakenly, assumed that treatment in the community (under compulsion) is not available under the “83 Act. It occurs under the following circumstances:

(a) Patients subject to guardianship under the Mental Health Act. They may be required to live in a particular place, to attend a health or social care facility for treatment or education or training. Patients subject to guardianship must permit access to health or social care professionals. There is no authority to administer medication in the absence of consent or compliance. There is no authority to convey a person.

(b) Section 25 of the Mental Health Act. This is similar to guardianship other than it can only be applied once a person has already been detained in hospital under a treatment order (Section 3 or Section 37) but does include a power to convey patients including the authority to compel a patient to attend a health care or social facility. Again there is no authority to compel a patient to accept medication.

(c) Section 17 leave of absence. Patients detained under Sections 2, 3 or 37 of the Mental Health Act may be sent on leave. Whilst they cannot be forced to have medication in the community there may be grounds for recall to hospital if the patient does not comply with their medication. Patients certainly believe they will be returned to hospital if they stop their medication. For practical purposes, therefore, this is a form of community treatment order.
(d) Patients detained under Section 37 with a 41 restriction order currently on conditional discharge. Such patients are in the same position as those on Section 17 leave, i.e., they have a right to refuse medication whilst in the community but most patients feel that they would be ill advised so to do given the authority to recall to hospital.

In addition there are patients who lack capacity to consent but who are compliant with the treatment and receive it under the common law (c.f. Bournewood).

Recent history

Prior to 1986 it was established practice that under certain relatively rare circumstances patients coming to the end of their Section would be readmitted overnight in order that their Section might be renewed (under Section 20 of the Mental Health Act) following which they would then again be sent on leave under Section 17. This, as described above, was a form of continuing community treatment order in all but name.

Following a Court Case (Halstrom) in 1986 this was declared unlawful in England and Wales and the practise ceased.

That decision was modified by the Court of Appeal in 1999. The Court held that it was lawful to renew the detention of a patient (Section 20) as long as the patient’s medical treatment viewed as a whole involved treatment as an inpatient (the particular patient, at the time of the renewal, had a treatment plan which consisted of five days on leave and two days in hospital each week).

The circumstances in which a renewal of section could take place were further amended in 2002 (DR). Here the Court determined that a patient’s Section could be renewed (Section 20) if the patient was required to attend a hospital once a week (this patient was required to attend occupational therapy at the hospital once a week and also to attend a ward round). This has markedly increased the opportunity for the renewal of Section 3 leading to what has been termed a “long leash” arrangement.

It has been argued that there are a small number of patients, well known to the service, whose clinical history includes serious mental illness, repeated compulsory admission to hospital, ceasing medication when discharged from the order and prompt and inevitable relapse.

One model for enabling such patients to be placed directly on a community treatment order is that from Saskatchewan:

1. A person must suffer from a mental disorder, for which he or she is in need of treatment or care that can be provided in the community.
   — In the previous two years the person must have;
   — Spent at least 60 days as an involuntary in-patient in a psychiatric facility; or
   — Been an involuntary in-patient in a psychiatric facility on three or more separate occasions; or
   — Previously been the subject of a community treatment order.

2. There must be a likelihood that if the person were not to receive treatment while residing in the community, he or she would likely cause harm to self or others or suffer substantial mental or physical deterioration as a result of the mental disorder.

3. The services the person requires in order to reside in the community must be available in the community.

4. The person is unable to understand and to make an informed decision regarding his or her need for treatment, care or supervision as a result of the mental disorder.

5. The person must be capable of complying with the requirement for treatment and supervision contained in the CTO.

It should be noted that this requires the patient to lack capacity.

The arguments in favour of community treatment orders are:

(a) That if a patient is to be forced to have treatment many would prefer to do so at home rather than in hospital if this were a reasonable option.

(b) Some patients who stop their medication against medical advice when informal would continue to take it whilst continuing to be subject to mental health legislation. This might reduce the relapse rate for some of the so-called revolving-door patients who are admitted to hospital, take their medication, become well, leave hospital, stop their medication, relapse, have to be readmitted and so on.

(c) There is a clear advantage in terms of inpatient resources.

The arguments against community treatment orders are:

(a) Patients who are well enough to be in the community are generally well enough to make decisions for themselves even if the decision is not necessarily in the interests of their health (putting them on an equal footing with those suffering from physical illnesses).
(b) That the numbers of people subject to compulsion will inevitably rise. Currently all people who are subject to compulsion are ill enough to need to be in hospital therefore if patients are going to be made subject to compulsion who are not ill enough to need to be in hospital they will be in addition to those currently subject to the Mental Health Act.

(c) By removing the conditions of needing to be ill enough to warrant admission to hospital patients may become subject to compulsion despite suffering from only very mild illnesses.

**Draft Mental Health Bill**

The provisions are confusing.

Clause 26 authorises the Clinical Supervisor to make a patient resident for assessment, non-resident if he determines this is appropriate. This appears to conflict with Clause 15 (2) which determines that additional conditions, required if assessment is to be carried out in the community, will be set out in regulations.

Further it is difficult to understand the distinction between the powers set out in Clause 26 (transfer to the community) and those Clause 30, Power to give leave of absence.

**Recommendation**

Community Treatment Orders should be available for patients only on authorisation of the Tribunal after a period of in-patient assessment and whilst the person suffers impaired decision-making by reason of their mental disorder. Leave of absence powers enable assessment and treatment in the community during the assessment period.

**Question 3  Does the Draft Bill Achieve the Right Balance Between Protecting the Personal and Human Rights of the Mentally Ill on One Hand, and Concerns for Public and Personal Safety on the Other?**

“In part, the long standing ambiguity between Asylums as places of imprisonment and social control, as opposed to places of protection and individually orientated support and treatment, lives on in the public debate over psychiatry. To the extent that the atmosphere so generated needlessly undermines professional morale and patient confidence it continues to act as a barrier to progress.”

The Office of Health Economics 1989

The College confines its answer to clinical rather than legal matters.

The question presupposes that these are opposing requirements. This is, in general, an error. Safety can best be improved by making the service accessible and effective. Public safety in this area of medicine is no different from, for example, in relation to sexually transmitted disease. It is essential that prospective patients are not deterred from seeking help. Indeed, because suicide and other risks are largely assessed from information given by the patient, it is necessary for the person to feel able to talk freely. Fear that being open will lead to loss of liberty does not aid this process. Hence if mental health law is seen to be overly coercive it will lead to patient avoidance of mental health services and, paradoxically, and increase in risk both to the individual and the public.

Nonetheless there are a small number of mentally disordered people who present serious risks to others. If such a person lacks decision-making capacity, medical intervention should not, with the correct safeguards, infringe personal or human rights. This applies also for those who are convicted of serious crimes. For those who fit neither of these categories the central issue is what degree of certainty should be required before determining that such a person is dangerous. For example if a person suffering from tuberculosis, or other notifiable infectious disease, refuses treatment they will only be detained if the form of TB makes it almost inevitable that other people will become infected. Any lesser standard in relation to the mentally disordered would be inappropriate. Clinically this is particularly difficult to determine, hence, for example, the estimation that, with current knowledge and skills, between 2,000 and 5,000 people would need to be detained to prevent one homicide (Crawford, Psychiatric Bulletin February 2000).

The Government has rightly stated, in our view, that it has no intention of increasing the number of people subject to compulsion. The proposals in the Bill (the combination of a very broad definition of mental disorder combined with wide conditions for compulsion and the absence of exclusions) will lead to a marked increase in compulsory orders. All patients who meet the current conditions will meet the new conditions along with many people who could not currently be detained. For example patients who will be subject to compulsion in the community cannot be ill enough to need to be in hospital and, therefore, could not be detained under the current Act. A new Mental Health Act should ensure that the Government’s intention becomes a reality.

It remains the view of the College that safety and human rights are best enhanced by a mental health act which focuses on those people whose decision-making is impaired by reason of their mental disorder.
**Appeals**

**Current position**

A detained patient can appeal once in each period of detention. If appealing during detention for assessment (Section 2) the appeal must be made in the first 14 days. The Tribunal can release the patient from detention immediately, at a time in the future or confirm continuing detention. The Tribunal cannot increase the period of detention.

**The Draft Mental Health Bill**

The patient, and the nominated person on the patient’s behalf, may appeal to a Mental Health Tribunal (MHT) at any time during the first 28 days and again during any period of further assessment. A further appeal may be made during any period when the Tribunal has authorised detention for more than three months. There is a mechanism for appealing to a Mental Health Appeal Tribunal (the members of which are all lawyers) against the decision of the MHT on points of law.

The concept of an appeal within the framework of mental health legislation is, of course, rather different from that in the Courts. In the Court an appeal is against the decision of the first Court. In the framework of mental health legislation there is no appeal against the initial detention be it by professional staff or a Mental Health Tribunal (other than judicial review). The appeal is against the continuation of the detention given the patients mental state at the time of the hearing. The College has two concerns:

If the patient appeals within the assessment period the Tribunal could convert the assessment order into a treatment order. This may be seen as a disincentive to appealing during this period.

A concern is that it would be perfectly possible for the patient’s appeal to be heard by the same Tribunal as authorised their continuing detention. The College has reservations as to whether this would be seen as sufficiently independent and therefore acceptable to patients. There may be a perception that Tribunals would fear giving the impression that they were overturning the decision of a previous Tribunal and therefore might be reluctant to discharge the patient from the order.

**Recommendation**

A Tribunal should not be permitted to authorise a treatment order if it is hearing an appeal within the first 14 days of the period of assessment.

**Question 4  Are the Proposals Contained in the Draft Mental Health Bill Necessary, Workable, Efficient, and Clear? Are there any Important Omissions in the Bill?**

The proposals, as set out in the Bill, are long, extremely complex, confusing and, some would say, incomprehensible. Some of the measures (Mental Health Tribunal, Advocacy, some of the children’s and forensic provisions) will rightly enhance patients’ rights. The College believes the impact of the proposals overall will damage safety for both the patient and society. The workforce implications are discussed in relation to a later question. The College believes the Bill as now drafted to be unworkable.

**Further Issues in Relation to Compulsion/Detention**

**Current position**

Detention is authorised by two registered medical practitioners making recommendations, one of whom must be approved under Section 12 of the Mental Health Act (as having special experience in the diagnosis or treatment of mental disorder) and an Approved Social Worker making an application. This applies to both assessment (28 day) and treatment (six month) orders.

**Draft Mental Health Bill**

**Treatment order**

The College welcomes the introduction of Mental Health Tribunals with the role of authorising compulsion and treatment after 28 days. The draft Mental Health Bill proposes that the membership of the Tribunal should consist of a lawyer, a clinical person (who need not be medically qualified) and a layperson. Medical input will be given by an independent psychiatrist appointed from an “Expert Panel” established for this purpose. This psychiatrist will interview the patient, present his/her findings to the Tribunal and may be cross-examined.

If the Clinical Supervisor is not a registered medical practitioner then the assessment of mental disorder and conditions necessary for continuing compulsion are made by only one registered medical practitioner. The College believes this to be unsafe.
**Recommendation**

Compulsion should only be possible, other than in an emergency, if two doctors certify that the patient suffers from a mental disorder conditions.

**Clinical Supervisors**

**Current position**

All patients subject to the Mental Health Act are under the care of a Responsible Medical Officer (RMO) ie a registered medical practitioner who is a Consultant Psychiatrist.

**The Draft Mental Health Bill**

The RMO is replaced by a Clinical Supervisor who may be a consultant in another mental health profession such as clinical psychology. There are a number of issues:

1. One of the central duties of the person in overall charge of the care of a person subject to mental health legislation is to keep under constant review whether or not the “relevant conditions of compulsion are still satisfied” and to discharge the patient from compulsion if the conditions are not satisfied. This requirement is made clear both in the current Mental Health Act Code of Practise and in the explanatory notes which accompanied the draft Mental Health Bill.

   The Government has determined that only registered medical practitioners are deemed to have the necessary training to comply with the need for “objective medical evidence” from the European Convention on Human Rights and so to make the initial recommendation that a patient meets the relevant conditions for compulsion. The draft Bill supports this interpretation. Indeed it is noted that schedule 3 of the draft Mental Health Bill requires a registered medical practitioner to undertake the assessment for the new equivalent of a Section 5(2), (the order which enables an informal inpatient to be detained whilst a proper assessment for detention is undertaken). It is unclear how a psychologist or other person who is not medically qualified is able to satisfy the legal requirement of ensuring that “the relevant conditions are still satisfied” if they are unable to determine the presence or absence of these conditions in the first instance.

2. Currently a Section 3 (the six month treatment section) requires two medical recommendations (one from a specially trained doctor, usually a psychiatrist, the other a doctor who should have known the patient previously, ideally the patient’s GP) and an Approved Social Worker. The draft Bill proposals (the Clinical Supervisor plus the Tribunal plus a medical member of the Expert Panel) mean that the longer term order would rely on only one medical recommendation if the Clinical Supervisor is not a doctor.

3. The person in charge of a patient’s care is responsible for their care either directly or via a duty rota consisting of equivalently qualified people for 24 hours a day, seven days a week, 365 days of the year. It is unclear whether all other professions who might fulfil the role of clinical supervisor have an infrastructure which would support such a system.

4. The person in charge of the patients’ care initiates the prescription of many treatments. The proposals in the draft Mental Health Bill include that one of the roles of the clinical supervisor will be the prescribing of electro-convulsive therapy (subject to the patients consent or the authority of the Tribunal). The College does not consider that, at present, any professional, other than a psychiatrist, is trained to prescribe electro-convulsive therapy. Authority to prescribe medication would continue to be determined by the Medicines Act (there is no equivalent control in relation to electro-convulsive therapy).

5. The College is fully supportive of multi-disciplinary working and respects the strengths of other disciplines working with the mental health field. This has resulted in the College having some difficulty in determining a policy in relation to the issue of Consultants in other disciplines having overall responsibility for patients subject to compulsion. We would welcome further discussion in relation to the issues raised above.

**Recommendation**

Clinical supervisors must be qualified to assess if a person meets the conditions for compulsion in order to be able to keep under review if the conditions continue to be met.
**Expert Panel Member**

It is understood that the expert panel member will advise the Tribunal in relation both to grounds for compulsion and the care plan. However, clauses 47 and 49 suggest that the Tribunal can alter a care plan only with the agreement of the clinical supervisor.

The MHA 1983 only permits specified treatments after three months if agreed by both the second opinion appointed doctor and the responsible medical officer. It is understood that the Clinical Supervisor cannot be required to give treatment that he thinks is inappropriate for the patient. However, it is hard to understand the role of the expert panel member if his findings cannot ensure amendment of the care plan.

**Recommendation**

The Mental Health Tribunal will be permitted to authorise specified medical treatments only if they are agreed as necessary by both the clinical supervisor and expert panel member.

**Discharge from Compulsion**

*Current position*

Patients (other than those on restriction orders) may be discharged by their Responsible Medical Officer, Nearest Relative (subject to limitations), the hospital managers and the Mental Health Review Tribunal.

**Draft Mental Health Bill**

It is proposed that discharge will be limited to the Mental Health Tribunal and the Clinical Supervisor. Furthermore for some patients, even though detained under a civil section (ie they have not been charged with or convicted of any offence) the Mental Health Tribunal may remove from the Clinical Supervisor the right to discharge.

**Recommendation**

The College is opposed to any limitation of the right to discharge by the Clinical Supervisor for patients detained under civil sections. The College would also wish those rights (and associated limitations) currently available to the nearest relative to be available to the nominated person. The College supports the removal of the authority of Hospital Managers to discharge a detained patient against medical advice.

**Transfer Between Hospitals**

The proposal to require a minimum the clinical supervisor to give a minimum seven days notice of transfer, other than in an emergency, is understandable but likely to have a significant adverse impact on patients, services and utilisation of resources. Two brief examples are:

Patients may be moved at their request to be nearer home or family.

Patients may be moved, in an emergency, to a hospital with a psychiatric intensive care unit, but would not be able to be moved back as soon as their condition improved. This would harm both the patient whose transfer is delayed and another patient requiring the intensive care bed.

**Recommendation**

Transfer between hospitals should require consultation, other than in an emergency, but without specific time limits.

**Offenders**

Whatever amendments are made to the legal provisions in relation to mentally disordered offenders there is a significant shortfall in required resources. The College is keen to play its part in ensuring that there are proper facilities available in the National Health Service for the treatment of mentally disordered prisoners.

In general we believe that Part 3 of the draft Mental Health Bill is an improvement on the old Act. There is increased flexibility throughout a defendant’s progress through the criminal justice system from arrest to conviction and sentence. We believe that the drafting of Part 3 ensures sufficient flexibility to meet the needs of those potentially subject to Part 3.
Conditions for making a mental health order

The College believes the conditions for compulsion should generally not differ for different groups of patients dependent only on whether they are alleged to have committed, or have been convicted of, a crime. However, the college recognises that those in custody cannot access hospital treatment as informal patients. The College supports the retention in Mental Health Orders of the principle that such orders can be used as the “best disposal” (clause 116[1b]) at point of sentencing. For these reasons the College would support the omission of impaired decision-making capacity as a criterion under Part 3 of the act.

Court authorisations of care plans

The College has serious reservations about the likelihood of Courts having a level of experience to enable them to scrutinise care plans to the same standard as the Mental Health Tribunals. Consideration should be given to requiring all care plans to be subject to MHT scrutiny after a defined period.

Interim Hospital Orders

Section 38 of the Mental Health Act 1983 was designed to allow patients to have a prolonged period of assessment in hospital prior to determining whether conditions for a hospital order are met. In practise section 38 is used to determine if the clinical team in hospital can provide treatment that prevents or alleviates deterioration of a person’s condition, particularly in the case of psychopathic disorder. In the draft Bill similar issues would arise for the second and third conditions for detention, namely whether the mental disorder is of a nature and degree to warrant the provision of medical treatment or “that appropriate medical treatment is available which is appropriate in the person’s case . . .” Clauses 86–92 of the draft bill provides a flexible means of determining the first issue, namely whether a mental disorder is of a “nature or degree” to warrant a hospital order. The Home Office has told us that clauses 93–96 of the draft Bill will allow for a period in hospital to determine if “appropriate treatment” is available. However, we are concerned that in remanding someone for medical treatment before sentencing, the third condition, under clause 96, already requires that appropriate medical treatment is available in the person’s case. We appreciate the subtlety that clauses 93 and 114 (the Mental Health Order) have different purposes and therefore it is possible to have conditions for appropriate “treatment being available” interpreted differently in each section. The Home Office believe that remand for treatment under clause 93 (remand for treatment) will be sufficient to deal with cases where the clinical supervisor (for clause 86) is unable to advise the court after 16 weeks whether the conditions for a medical disposal are met. Yet condition at clause 96 (3) (appropriate treatment available) is drafted in the same words as for making a mental health order at clause 116 (3). If the bill is passed with the proposed uniform wording we can see lawyers arguing that it is wrong to detain somebody on the basis that appropriate treatment is available in order to then determine whether “appropriate treatment is available” for another section of the Act. The bill should make clear that “appropriate treatment” is interpreted differently in each clause.

Question 5 Is the Proposed Institutional Framework Appropriate and Sufficient for the Enforcement of Measures Contained in the Draft Bill?

Members of the College found this question difficult to understand and we hope the answers are not inappropriate.

In relation to the processes leading to, and during compulsion.

The requirement for a Trust to arrange an examination of any person at the request of any other person is likely to be particularly burdensome in relation to the available workforce and damaging in relation to stigma. The provision may be abused, for example, as a means of causing embarrassment to neighbours, or inducing guilt in elderly family members. Furthermore it might lead to persecution of a person with a history of mental health problems. The College believes the potential disadvantages of such a provision outweigh the advantages. If it is decided that this provision should remain then consideration should be given to making it a criminal offence to require an assessment without due cause.

The further processes in relation to production of care plans, Tribunals and appeals are appropriate in order to achieve good care and safeguards. However, there is currently an insufficient workforce (see below) to achieve these provisions without causing significant detriment to clinical care in two particular regards unless the numbers of patients subject to these provisions is extremely limited.

First, in relation to medical treatment and care plans. Patients who are unable to consent to medical treatment will be deprived of such treatment (unless it is “immediately necessary”) until it is authorised by the Clinical Supervisor who must be a Consultant. This may take up to five days to arrange potentially resulting in considerable suffering.
Recommendation

Medical treatment, provided it is not irreversible or hazardous, may be given under the direction of a registered medical practitioner, within the first five days, if it is necessary to alleviate, or prevent a deterioration, in the patient’s condition.

Secondly, the College fears that mental health services will be directed away from those services which should reduce the need for compulsion such as early intervention, assertive outreach and other developments. This will have a significantly negative effect in relation to voluntary (informal) patients.

Secure beds

The current and future shortfall in secure beds is difficult to quantify and is currently the subject of a major Department of Health capacity exercise. The shortfall is significant at all levels of security including low secure district level. The length of stay in medium secure units is increasing, reducing their ability to respond to demand.

The impact is increasing delays for transfer from:

— Prison, resulting in prolonged suffering.
— General adult psychiatric wards. This causes significant risks to others and frightens many would-be voluntary patients leading to delayed treatment and an increase in use of formal detention.

There is also frustration on the part of Courts at not being able to transfer for treatment many mentally disordered individuals.

There are many factors currently operating which, it is thought, are exacerbating the shortfall by increasing the demand for secure beds.

— The planned contraction of high secure beds in the high secure hospitals through the accelerated discharge programme.
— The transfer of responsibility of prison health care from the Home Office to the NHS (very much welcomed), as this emphasises unmet need for hospital admission.
— There is a trend within the criminal justice system for increased length of sentences, including, life sentences, which will have an impact on length of stay in secure units. The prison population is rising and is set to continue its upward trend for the foreseeable future.
— Multi Agency Public Protection Arrangements are already having an impact on services as they uncover unmet need for treatment.
— The DSPD services may impact by requiring step-down rehabilitation for those treated by those services.
— The proposals in the draft Bill will increase the potential pool of mentally disordered offenders liable to be compulsion.

Question 6 Are the Safeguards Against Abuse Adequate? Are the Safeguards in Respect of Particularly Vulnerable Groups, for Example Children, Sufficient? Are there Enough Safeguards Against Misuse of Aggressive Procedures such as ECT and Psychosurgery?

The College welcomes the right to independent advocacy and believes this to be an important advance in ensuring that the patient’s voice is heard in the setting of a system of compulsion. The College has reservations only in terms of how the service is to be developed given the current level of available skills and resources.

Also welcomed is the role and responsibility of the Mental Health Tribunal.

The College welcomes the increased penalties in relation to abuse of patients.

The College supports the proposal that the new inspectorate (The Healthcare Commission) should take over the role of the Mental Health Act Commission. The College strongly supports the importance of good quality information being available, but emphasises that there are particular issues that pertain to patients subject to compulsion. It is important that monitoring arrangements for such patients recognise that different skills and protocols are required.

(A) Children and Young People

Child and adolescent mental health problems are characterised by complexity, severity and often multiple co-existing diagnoses. Also legal provision for the assessment and treatment of mentally disordered minors is made more complex by the issues of:

(a) parental rights and responsibilities
(b) assessment of competence of a growing child (with particular reference to “Gillick” competence)
(c) other legislation relating to minors including the Children Act and the Family Reform Act.

Clinical provision is hampered by such a significant resource shortfall that many Mental Health Act assessments of minors are undertaken by psychiatrists specialising in Adult services. Young people detained under the MHA 1983 are commonly detained on Adult wards.

Particular areas of concern in relation to children and young people are:

— The definition of mental disorder and the absence of exclusions. These issues are addressed in detail elsewhere in this draft. It is clear, however, that the breadth of the definition coupled with the absence of exclusion will have a significant impact on CAMHS (Child and Adolescent Mental Health Services) and services for children and young people with learning disabilities.

— The Part 6 safeguards for the under 16 are welcome, although the impact on CAMHS will need to evaluated.

— The Royal College do not consider that the safeguards in relation to the under 16 are adequate. Firstly the safeguards only apply to resident patients. Secondly the non-resisting incapacitated under 16 year-old is not eligible for any protection. (These young people will also not fall within the Capacity Bill.). These young people are recognised to be highly vulnerable.

— The potential for conflict between those who have parental responsibility for a child patient needs to be addressed; particularly as the role of the nominated person cannot be shared. We foresee that unless this is dealt with the child patient may suffer.

— The principles and protections provided by the new legislation should, if at all possible, be the same as for adults.

Particular provisions for minors should include:

— At least one medical assessment prior to use of the Act must be by a doctor specialising in the assessment and treatment of children and adolescents.

— The medical member of the Expert Panel giving evidence to the Tribunal must be a doctor specialising in the assessment and treatment of children and adolescents.

— At least one member of the Mental Health Tribunal must have specialist knowledge in relation to the care and treatment of children and adolescents.

— All young people deemed to be competent to consent to medical treatment should also be competent to refuse such treatment.

— All minors detained in hospital should be assessed and treated by, and in, age appropriate services.

— There should be an obligation on commissioners to ensure sufficient numbers of doctors specialist in the assessment or treatment of Children and Adolescent are available to meet the provisions of this Act.

There should be an obligation on Health Trusts to ensure that there is sufficient in-patient provision such that children and adolescents are not detained within Adult wards.

Recommendation

Safeguards, both legal and clinical, for persons under 16 years of age must be re-evaluated.

(B) SPECIFIC TREATMENTS

Medication

Current position

Medication for mental disorder is prescribed for detained patients under the authority of the Responsible Medical Officer. Medication for mental disorder can be given without consent for up to three months. After three months medication for mental disorder can only continue:

(a) With the consent of a capacitous patient or
(b) With the authority of an independent Second Opinion Appointed Doctor (in practice a psychiatrist) appointed by the Mental Health Act Commission or
(c) In an emergency to save life or prevent serious suffering. There is an obligation under these circumstances to request a second opinion from the Mental Health Act Commission at the earliest opportunity.

The Draft Mental Health Bill

It is proposed that the Clinical Supervisor may prescribe medication for mental disorder for the duration of the assessment order (up to 28 days). This presumes the Clinical Supervisor is a registered medical practitioner (prescribing of medication is controlled by the Medicines Act).

It is proposed that at the time the Mental Health Tribunal authorises continuing compulsion it will also authorise the “treatment plan” including medication for mental disorder. Unless the care plan, in relation to medication, is to be very general and over-inclusive, it will likely need review and amendment periodically through a period of compulsion. It is unclear what is proposed for authorising these changes (whether this should be a Tribunal or a member of the Expert Panel alone). If it is to be the Tribunal this will have a significant impact on the workload, and need for prompt availability, of the Tribunal.

The draft Bill leaves it unclear as to whether or not there will be provision for patients to have the authority to consent to medical treatment after 28 days, as opposed to the authority coming from the Tribunal. It is not unusual for patients to believe they shouldn’t be subject to compulsion, or lack the capacity to make such a decision, yet be capable in relation to a specific medical treatment and to wish to consent to it (eg “I need anti-depressants but I don’t need to be in hospital, I’d be able to look after myself at home”).

Recommendation

The College is supportive of reducing the time for authorising non-consensual medication from three months to 28 days. The College would suggest that changes to the medication plan thereafter should be authorised by a medical member of the Expert Panel, with similar requirements to consultation as specified. If a full Tribunal was to be required there is a real danger that either:

(a) necessary changes in medication would be significantly delayed leading to prolonged suffering and increased risks or

(b) the initial treatment plans authorised would be very broad giving limited or no protections to the patient.

It should be clear from the legislation, or Code of Practice, that one option for a care plan presented to a Tribunal would include the statement that identified treatments will only be given with the patient’s consent (subject to an emergency treatment clause).

Electro-convulsive therapy (ECT)

Current position

Electro-convulsive therapy can be given to detained patients:

(a) With the consent of a capacitous patient.

(b) With the authority of an independent Second Opinion Appointed Doctor (whether or not the patient is capacitous).

(c) With the authority of the Responsible Medical Officer in an emergency to save life or prevent serious suffering to the patient. There is an obligation under these circumstances to request a second opinion from the Mental Health Act Commission at the earliest opportunity.

The Draft Mental Health Bill

It is proposed that the Clinical Supervisor may prescribe ECT. As the law stands this would give Consultants who are not medically qualified the authority to prescribe ECT.

ECT could be given to compelled patients:

(a) With the consent of a capacitous patient.

(b) With the authority of the Clinical Supervisor in an emergency.
If ECT is prescribed for an incapacitous patient it would require the authority of the Tribunal in addition to the evidence of a medical member of the expert panel. Whilst there is provision for the giving of emergency ECT it will be essential that tribunals can be established rapidly to ensure full authorisation in order to limit delay causing undue suffering.

**Recommendation**

The College believes that ECT should only be prescribed by properly trained and qualified psychiatrists.

The College is firmly against compulsion in relation to ECT in the face of the refusal of a capacitous patient. If a patient retains decision-making capacity he or she cannot be sufficiently ill to warrant ECT without their consent on the grounds of a life-saving emergency.

**Brain Surgery for Mental Disorder (psychosurgery)**

**Current position**

Only patients, whether detained or informal, who give capacitous consent and have an independent second opinion may receive this treatment. The second opinion is given by a three-person team (two to confirm capacity and consent the third, a psychiatrist, to confirm the necessity of the treatment), appointed by the Mental Health Act Commission.

**The Draft Mental Health Bill**

It is proposed extending the availability of this treatment to incapacitous patients with the authority of the High Court.

**Recommendation**

The College believes that the current provision in relation to surgery for mental disorder is satisfactory without the proposed extension.

**Question 7** *Is the balance struck between what has been included on the face of the Draft Bill, and what goes into regulations and the code of practices right?*

**Recommendation**

The College believes the principles underpinning the legislation should be on the face of the Bill, as with the Mental Capacity Bill.

The College would wish to see the limitations on the use of the provisions such as exclusion conditions or limitations on the use of community treatment (non-resident) orders within the Bill.

**Question 8** *Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?*

The College is very supportive of the proposals in the Mental Capacity Bill albeit whilst wishing for strengthened safeguards (particularly in relation statutory second medical opinions). Many, perhaps most, patients detained under Part 2 of the Mental Health Act 1983 would also meet the conditions for being subject to the provisions of the Mental Capacity Bill. This is also likely to be the position with the Mental Health Bill.

Some important issues:

1. **Rights under the Mental Capacity Bill exceed those in the draft Mental Health Bill in relation to lasting power of attorney (a nominated person with real authority) and advanced refusals of treatment.**
2. **Safeguards in the draft Mental Health Bill exceed those in the Mental Capacity Bill in relation to statutory second medical opinions, care plans, advocacy, Tribunals authorising treatment, oversight by the Healthcare Commission and, perhaps, ease of access to appeals.**
3. **Restriction of liberty and enforced treatment (treatment which is resisted by the patient) will have to be authorised by the Mental Capacity Bill (or by Common Law) in relation to treatment of physical illnesses in people who lack decision-making capacity. We are unclear about the provisions for people who resist treatment of mental disorder.**
Government has decided that provisions for incapacitous compliant patients (Bournewood patients) should be in the Mental Capacity Bill. Such patients would lose some of the safeguards present in the draft Mental Health Bill. However, they would keep enhanced rights.

An example of the difficulty of differential rights is as follows: A person makes an advance directive in relation to refusing further treatment should they develop advanced Alzheimer’s disease. If, having developed the condition that person does not resist medical intervention they will be subject to the Mental Capacity Bill and the advance directive will be honoured. If, on the other hand, they resist medical treatment they may be subject to the draft Mental Health Bill and the advance directive may not be honoured.

Further, the College can see no good reason why, for incapacitous patients, there should be any distinction between using force in relation to treatments for physical disorder as opposed to treatments for mental disorder. There are a number of reasons for saying this:
— There is no distinction made between treatments for physical and mental disorder if the patient is incapacitous but compliant.
— A patient with, for example, Alzheimer’s disease would be able to receive treatment (under a mental capacity act), despite resistance, for dental disease but not for the Alzheimer’s disease itself.
— The distinction between treatment for mental disorder and treatment for physical disorder is often one of semantics eg, disease of the thyroid gland may cause depression or pseudo-dementia. In either of these circumstances treatment of the depression or pseudo-dementia would also be treatment of the thyroid disorder.

Note: If it is determined that the Mental Capacity Act should enable treatment of patients who lack capacity whether or not they resist then a Mental Health Act becomes the authority for non-consensual care and treatment solely in relation to persons with a mental disorder who retain decision-making capacity and present risks.

Recommendation

The rights, and safeguards, should be the same under the two Bills.

The recent European Court judgement in relation to Bournewood supports this recommendation.

Question 9 Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

The College does not have the expertise to fully address this issue.

It is essential that mental health law does not place professionals in positions which would put them in difficulty in relation to their international obligations. International ethical standards in relation to psychiatry are attached in appendix 2.

The College has considerable disquiet at the Government’s decision that the UK, despite being a signatory, is to be only country, out of 45 nations, to reserve the right not to comply with the Council of Europe’s Recommendation ((2004(10)) on protecting the human rights and dignity of people with mental disorder. There appear to be significant discrepancies between the draft Mental Health Bill and the Recommendation which are likely to have an effect when the Act is tested in the Courts. These include:
— the lack of a clear statement that “lack of adaptation to moral, social, political or other values of society, should not, of itself, be considered a mental disorder” (Article 2.2).
— use of the least restrictive or intrusive alternative, taking into account their health needs and the safety of others, in all circumstances (Art 8);
— a narrower definition of:
  — mental disorder;
  — treatment (Art 3.3)—an intervention that has a therapeutic purpose, “taking into account the social dimension”, which is in turn defined as “prevention, diagnosis, control and cure of the disorder including rehabilitation”.
— Conditions (Art. 17) requiring:
  — Significant risk of serious harm to health to self or other persons;
  — involuntary measures should only be for therapeutic purposes and never for custodial purposes only (EM—para 132).
— There is a requirement that a doctor provides objective medical evidence in relation to the imposition, extension (Art 20.4) and termination (Art 24.2) of involuntary measures. Further evidence may be provided by other professionals.
— Measures should be in place to ensure that the approved mental health professional will be taking an independent decision (Art 2.3—definition of “competent body”) on the basis of being “distinct” from those proposing the measure (usually the carer, psychiatrist or care co-ordinator).
— Registration of all premises in which involuntary placement occurs to ensure effective monitoring (Art 9.2).
— The stipulation in relation to orders that a “person does not engage in specified conduct” (draft MHA; eg 15.4(b) appears very wide-ranging and should at least be qualified by a requirement that this should be for therapeutic purposes.
— Psychosurgery without consent is contrary to Article 28.2.
— Criteria for involuntary measures by the court are very broad: the Recommendation states that the criteria and other processes used in the courts take into account those used in civil proceedings and “any non-application should be justifiable” (Art 34(1)).

The College also supports the views expressed in the submission of the Mental Health Alliance.

**Recommendation**

The Mental Health Act for England and Wales must meet the requirements both of Human Rights legislation and the recommendations of the Council of Europe.

---

**Question 10** What are likely to be the human and financial resource implications of the draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

**WORKFORCE IMPLICATIONS**

The College is only able to comment in relation to psychiatrists.

**Current position**

Currently approximately 12% of consultant psychiatry posts in England and Wales are vacant. There is a problem with recruiting young doctors into the specialty and a serious fall-out rate during training. All possible initiatives for increasing the number of Consultant Psychiatrists are being pursued, including recruiting from overseas.

The Committee will be aware of the difficulties in relation to Mental Health Review Tribunals. The current delays are primarily due to the shortage of psychiatrists. Many psychiatrists serving on the Mental Health Review Tribunal (and as Second Opinion Appointed Doctors) are retired. Given the new General Medical Council requirements in relation to revalidation, the availability in the future of retired doctors is likely to be markedly diminished.

The removal of the need for psychiatrists from Tribunals will not ease the workforce problem because of the need for the presence of a psychiatrist, from the Expert Panel, at each Tribunal.

The Department of Health have stated that an extra 130 psychiatrists will be needed. The College is unclear how this figure was reached. As far as can be ascertained it relates only to the demands of the Mental Health Tribunal and Expert Panel membership. It takes no account of the increased number of people likely to be subject to compulsion.

Furthermore the Bill, correctly, requires markedly increased levels of consultation, enhanced care planning and information sharing. No time is allocated for these important and, if undertaken properly, time-consuming, tasks.

The extra demands on consultant psychiatrists’ time include: more Tribunals and appeals (each patient to have at least one Tribunal after 28 days in addition to any appeals), increased numbers of patients subject to the Act, all patients to have formal care plans and expert panel doctors required after 28 days (rather than three months as currently), increased care planning, consultation and information sharing. It is the College’s view that such medical provision could only be acquired at the expense of patient care, particularly to those patients at earlier, less severe stages of illness or not requiring compulsion.

**Recommendation**

Further research is required to assess the realistic likely impact of the proposals, on the workforce, in relation to numbers, recruitment and morale.

---

**IMPACT ON THE PROFESSION**

“There are many quite well educated people who believe that psychiatrists have special and mysterious powers that are denied to the rest of the profession and to the rest of humanity. Such people do not appreciate the simple fact that a psychiatrist is a physician who takes a proper history at the first consultation.” Henry Miller, (Vice-Chancellor, University of Newcastle) 1969.
The draft Mental Health Bill suggests that a psychiatrist’s primary role relates to public safety rather than the treatment of individual patients. This contrasts with the rest of medicine where the General Medical Council is quite clear about the role of a doctor: “Make the care of your patient your first concern” and “Listen to patients and respect their views”. Surveys undertaken amongst trainees demonstrate that if there is a perception of a new law being increasingly coercive, or the role of the psychiatrist moving from that of a doctor (with roles and responsibilities similar to doctors in other branches of medicine) to a role primarily of social control this will exacerbate the recruitment difficulty. Many members of the College have stated they will take early retirement or transfer to branches of psychiatry where the Bill would have little or no impact. It is the College’s view that significant damage will be done to the morale of the profession, the esteem in which the profession is held and, consequently, to patient care.

PROTECTION FOR ACTS DONE IN PURSUANCE OF THIS ACT (CLAUSE 298; MHA 1983 SECTION 139)

The proposal to increase the penalties for offences under the Act is welcomed. However, the College has concerns regarding the proposals in clause 298 of the draft Bill. First they exclude entirely protection for staff in relation to criminal proceedings, secondly they reverse the current process so as to place the onus on the person complained against to prove that they acted in good faith and with reasonable care, finally they remove the need for High Court approval in relation to civil proceedings.

It may be that this is required on a “human rights” basis. However, many of the actions required in treating detained patients (such as preventing people leaving hospital, forcibly injecting people with medication and so on) would leave staff guilty of both civil and criminal wrong were it not for the requirements of the Bill.

The College believes that such a change is likely to result in:

(a) considerable financial and time costs for many staff, given the removal of what was previously a disincentive to potential spurious litigation driven sometimes by mental disorder; and

(b) a significant and serious impact, particularly on nursing care. For example, there are likely to be circumstances where nurses would be more reluctant to restrain patients or give medication forcibly despite proper authorisation and clinical necessity.

ADDITIONAL INFORMATION

Wales and the Draft Mental Health Bill

The issues of principle, values and ethics raised by the Bill are the same in Wales as England. This is a brief description of particular matters that are brought to the fore by the separation of policy, policy implementation and practice in Wales as compared with England.

Local Health Boards cover smaller areas and populations and command smaller budgets compared with Primary Care Trusts in England. They may be less able with regard to commissioning of new services.

The Care Programme Approach, policy in England since the early 1990s, is just being introduced in Wales.

There has been no substantial increase in funding for mental health services in Wales.

There is a higher reliance on unsuitable traditional institutional bases. Community services are less developed and there are few facilities and staff who are available for and trained to deliver assertive outreach and home treatment services particularly for people who have a serious mental illness.

The specialist forensic mental health services in Wales are poorly placed to respond to present challenges and current legislation. In particular, there are few low secure services and limited relationships between them and medium secure units. As a consequence the forensic services may be poorly placed to take on the challenges of this Bill.

In 2002 there were 43 vacancies for all consultant psychiatrists in Wales (28% of the established workforce) and vacancies in general adult psychiatry posts of 34%. It is thought the position may have improved a little since then. New figures are currently being collected. The College estimated that the requirements of the 2002 draft Mental Health Bill would require an additional 30 psychiatrists in Wales if there was to be no diminution to services for patients not subject to detention.

Advocacy, Tribunal and Appeal services will need to be available in the Welsh language. This will have additional financial and training implications.
The College believes these factors, taken together, may make implementation of the Bill particularly difficult in Wales with the risk of even greater damage to services than in England.

**Recommendation**
A review of the workforce and service impact in Wales of the Bill is undertaken.

**Black and Ethnic Minorities**

At the present time disproportionately high numbers of people from BME backgrounds are diagnosed with major mental illness and detained in mental hospitals or institutions. The broad definition of mental disorder in the new draft Bill has the potential to increase the already high numbers of people from BME backgrounds in the system with all the negative consequences which will ensue—the hostility with which traditional psychiatric services are viewed, resulting in an exacerbation of the difficulties in providing good care for those who have great need for it.

**Dangerousness**

It is with some reluctance that the College includes this section. Mentally ill patients are more likely to be victims than the rest of the population. This is due both to the vulnerability caused by some illnesses and the stigma of being seen as “a mental patient”. However, it is recognised that there is a tiny minority of patients who, at times, may be dangerous to others.

Every death is a tragedy, for the victim, perpetrator, their family and friends and any professionals involved. The percentage of homicides committed each year by the mentally ill, as a percentage of the total, is falling (Gunn and Taylor). The following figures are not intended to minimise the importance of each death but may help to put the matter into perspective.

For each citizen killed by a mentally ill person:
- 10 are killed by corporate manslaughter;
- 20 by people who are not mentally ill;
- 25 by passive smoking; and
- 125 by NHS hospital acquired infection.

The proposed legislation is extremely unlikely to have any impact on suicide or homicide rates. With reference to suicide, recent research (Powell) demonstrated that even within the high-risk group of in-patients there would need to be 100 patients detained unnecessarily in order to prevent one suicide. With regard to homicide, (Crawford) has shown that with a predictive test with a sensitivity and specificity of 0.8 (far better than anything available currently) 5,000 people would need to be detained to prevent one homicide. Szmukler has shown that if the predictive test became even better (0.9) this would still require the detention of 2,000 people to prevent each homicide. This emphasises that prevention of homicide and suicide can only ever arise as a secondary benefit from improved mental health care for a population and never via prediction per-se of such events.

The starting point in risk reduction is encouraging patients to seek help and talk about their thoughts and feelings. The impact on patients’ behaviour when they believe that doctors are acting neither with their consent nor in their best interest was demonstrated forcefully in relation to the body parts scandal and agreement rates for post-mortems. It is hard to believe that potential patients will not be deterred from the services if they know that psychiatrists will have a duty to enforce treatment on them, not only in hospital but also in the community, even when they are perfectly able to make decisions for themselves. Patient avoidance will certainly limit effective intervention.

Nonetheless the consequences of violent behaviour, committed by the mentally disordered or not, may be profound. The College is acutely aware of the impact on victims, perhaps exacerbated when there is a perception that the violence was both predictable and preventable. Resources (workforce as well as financial), training and research are necessary in order to try and minimise risk from this (and other) populations. Support for victims must be available.

**Psychiatrists and Psychologists**

We understand that some explanation as to the differences between the roles and responsibilities of these two professional groups would be welcome.

The College can only comment on the roles and responsibilities of psychiatrists and would advise that similar information is requested from the British Psychological Society in relation to clinical psychologists.

Psychiatrists are qualified registered medical practitioners (clinical psychologists are not), commonly acquiring a science degree during this training. This takes six years. Many then undertake further general medical training before embarking on their psychiatric career.
Training in psychiatry consists of:

- Basic training taking three to four years working under supervision in a variety of psychiatric sub-specialties, requiring attendance at a recognised training scheme and passing the specialist examinations set by the Royal College of Psychiatrists (MRCPsych).
- Higher training consisting of three to four years in specialities such as adult, children, psychotherapy, forensic, learning disability, addictions or rehabilitation.
- Most psychiatrists also undertake, and publish, research.

Other important factors:

- Psychiatrists assess and examine patients’ physical health in addition to their mental health.
- Psychiatrists prescribe medicines.
- Psychiatrists have 24 hour seven days/week on-call and cover arrangements both in the community and in hospital.

**FORENSIC PSYCHIATRISTS**

We understand that brief clarification of the role of forensic psychiatrists would be helpful.

Forensic psychiatry concentrates on those patients and problems at the interface of law and psychiatry.

The particular skills of forensic psychiatrists include:

1. Clinical risk assessments, especially on the relationship between mental disorder and violence to others. The patient population treated by Forensic Psychiatrists will be mainly those mentally disordered offenders who pose significant risks to others.
2. Writing of medico-legal reports and the giving of evidence in court.
3. The giving of advice to and collaborative working with practitioners in the health service and the criminal justice system. This will include giving advice and working with other agencies in managing exceptional risk offenders subject to Multi Agency Public Protection Arrangements.

**MENTAL HEALTH ACTS ACROSS THE UNITED KINGDOM**

Transfer of patients from England and Wales, Clause 161. The College is concerned that the legislation in different parts of the United Kingdom should not have substantially different provisions. Should the current proposals be adopted in England and Wales a person who met the conditions for compulsion in England or Wales may not do so in Scotland or Northern Ireland. Sub-clause 10 sets the provisions. A person from Scotland, detained in England, may be unable to be transferred back to Scotland because he does not meet the conditions in that jurisdiction. We see no evidence that the Government have thought through the implications of considerably different forms of mental health legislation in Scotland and England/Wales.

**Recommendation**

The principles and essential provisions of mental health legislation should not differ significantly between different parts of the United Kingdom.

**September 2004**

**APPENDIX 1**

As the professional and educational organisation for doctors specialising in psychiatry, the Royal College:

- sets the standards of training, through examinations and continuing professional development of psychiatrists;
- develops and improves the quality of mental health service provision;
- conducts and promotes research into psychiatry;
- raises medical and public awareness of mental health issues;
- advises government on mental health and disability legislation; and
- improves the quality of support for people with mental illness and their carers.

As an educational body, the College runs the “MRCPsych” examination for doctors to become psychiatrists, visits and rigorously inspects training facilities, organises scientific and clinical events and overviews psychiatrists’ continuing professional development.
— As a professional body, the College advises government on mental health and disability legislation and publishes academic journals, books and policy documents.

— As a registered charity, the College campaigns to raise public awareness of mental health issues and produces a range of public education materials available both online and as leaflets. (see www.rcpsych.ac.uk)

APPENDIX 2

The World Psychiatric Association approved at the General Assembly, on August 25, 1996 the following ethical standards that should govern the conduct of psychiatrists worldwide.

1. Psychiatry is a medical discipline concerned with the provision of the best treatment for mental disorders; with the rehabilitation of individuals suffering from mental illness and with the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are the least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the equitable allocation of health resources.

2. It is the duty of psychiatrists to keep abreast of scientific developments of the specialty and to convey updated knowledge to others. Psychiatrists trained in research should seek to advance the scientific frontiers of psychiatry.

3. The patient should be accepted as a partner by right in the therapeutic process. The therapist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. It is the duty of psychiatrists to provide the patient with relevant information so as to empower the patient to come to a rational decision according to his or her personal values and preferences.

4. When the patient is incapacitated and/or unable to exercise proper judgment because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. No treatment should be provided against the patient’s will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient.

5. When psychiatrists are requested to assess a person, it is their duty first to inform and advise the person being assessed about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment. This is particularly important when psychiatrists are involved in third party situations.

6. Information obtained in the therapeutic relationship should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or financial or academic benefits. Breach of confidentiality may only be appropriate when serious physical or mental harm to the patient or to the third person could ensue if confidentiality were maintained; in these circumstances, psychiatrists should whenever possible, first advise the patient about the action to be taken.

7. Research that is not conducted in accordance with the canons of science is unethical. Research activities should be approved by an appropriately constituted Ethics committee. Psychiatrists should follow national and international rules for the conduct on research. Only individuals properly trained for research should undertake or direct it. Because psychiatric patients are particularly vulnerable research subjects, extra caution should be taken to safeguard their autonomy as well as their mental and physical integrity. Ethical standards should also applied in the selection of population groups in all types of research including epidemiological and sociological studies and in collaborative research involving other disciplines or several investigating centres.

Further memorandum from the Royal College of Psychiatrists (DMH 61)

This briefing is written on behalf of the Royal College of Psychiatrists to members of the Standing Committee suggesting amendments that the Committee may wish to consider, as well as making further comments on specific aspects of the Mental Capacity Bill, particularly in response to the second reading in the House.

We would first like to confirm the continuing support of the College for this legislation and hope that, with minor amendments, it will become law. We commend the Government for placing the key principles at the beginning of the Bill and for making this an empowering rather than restricting piece of legislation. The problems that can occur in the absence of statute were well illustrated by the case of L vs Bournewood NHS Trust. We welcome the fact that the European Court has now ruled on this particular case and we have considered the Court’s ruling when making the recommendations below. We have primarily limited our comments to the implications of the Bournewood judgement and to issues relating to research.
First, however, we note the continuing concerns expressed by some Members of Parliament about LPAs and advanced decisions to refuse treatment. The College’s views are clear and similar to those put forward by the BMA. We would like to stress that, in the context of both LPAs and advanced decisions to refuse treatment, the Bill does not create new clinical problems but rather provides a framework for resolving dilemmas that have always been present. How these dilemmas are handled has and remains subject only to evolving common law, and for this reason there is no ready means of challenge, other than by judicial review, and no established framework that sets out the standards by which Parliament have a right to expect doctors and others to work to, and to be judged by. The Bill has broadly been welcomed by the majority of organisations representing those who are likely to be affected by incapacity and professional organisations who work with this group of people.

This Bill is empowering in that it allows people, whilst fully capable, to express their own view as to future care if they were to become incapacitated, either directly through advanced directives, or through others who have been chosen by the person him/herself. A person making a LPA can choose not only whether or not to authorise someone to make decisions on his/her behalf, but also the extent of the decisions the authorised person can make. We wish to support the thorough safeguards that are present in the Bill for those that make such an advanced decision or make a LPA. There are likely to be those who wish to leave such decisions to the doctor to act in his/her best interest if he/she becomes incapacitated, without influencing this process. Others prefer the thought that they can plan for their future.

As noted by the scrutiny committee there is no authority to stop fluid and food being offered, and basic care and comfort being provided. The College recognises there has been considerable discussion as to whether or not artificial nutrition and hydration (such as by intravenous drip or naso-gastric tube) should count as medical treatment or as food and drink. We do not wish to express a view. Our concern, however, is that the real strengths of the Bill, such as the enabling principles and respect for autonomy, enhanced with additional safeguards and means of appeal, should not be lost.

Specifically from the perspective of psychiatry we ask that the Standing Committee consider the following two issues:

**BOURNENWOOD**

We are of the opinion that the rights of incapacitated people to second opinions and to accessible appeal mechanisms are crucially important. The European Court ruled in Mr L’s favour arguing that he was actually detained and that there was no clear process to be followed in relation to his admission to hospital, nor clarity over the purpose of the admission, nor a means for he or his carers to appeal against his admission. The College has argued that a Mental Capacity Act, rather than a Mental Health Act, provides the most appropriate means to fill this gap in English and Welsh law for two main reasons. First, a Mental Capacity Act, if passed, will apply to the full range of situations including the treatment of physical as well as mental disorder. The Mental Health Act is only concerned with mental disorder. Secondly, the Mental Health Act, 1983 is only concerned with treatment of mental disorder in hospital, not in the community. The need for safeguards for people who lack capacity applies to a range of situations, both in and out of hospital. However, the problem with the Mental Capacity Bill, as it stands at present, is that it does not have sufficient safeguards (such as rights to second opinions and a clearly established system of appeal to Tribunals).

We acknowledge the sound intentions of the Government with the introduction of “independent consultees” in Section 34 but believe that this confuses two different, but related, issues: (a) the need for expert professional second opinions and (b) the role of advocacy. For the vast majority of people lacking capacity, decisions are now made under common law in their best interests. This will continue under the Mental Capacity legislation under Section 5, “Acts in connection with care and treatment”. Guidance in the Mental Capacity Bill and the Code of Practice on best interest will enhance this process and ensure a voice for the incapacitated person, as well as for families and other carers. With the enhanced Court of Protection this framework provides safeguards that are less stringent than the Mental Health Act but sufficient for the majority of situations.

The problem is to be able to define those situations where additional safeguards are needed, similar to those in the Mental Health Act. In our view the European Court judgement on Bournewood and the example of the Mental Health Act provides some guidance. The former was concerned with detention and the need for a readily accessible process of appeal, the latter sets out specific situations where second medical opinions are required. A particular problem for those who would be covered by the Mental Capacity Act if in force is that by definition they are unlikely to have the ability to appeal themselves because of their incapacity. Thus, a robust appeal mechanism, which triggers second opinions or appeals to the Court of Protection, is particularly important.

In earlier evidence to the pre-legislative scrutiny committee and the Department of Constitutional Affairs we proposed that statutory second opinions should be required under specific circumstances, and we supported the scrutiny committee’s view that there should be a stronger role for advocacy. We have refined these earlier views further in the light of the Bournewood judgement. We propose significant re-writing of Clauses 34 to 36. What we have suggested is an outline of some changes and we would be pleased to be involved further in refining these suggestions, if this was considered appropriate. We appreciate that
additional expertise is required to fully refine what we have suggested as we are not experts in drafting law. What we have suggested is therefore only an approximation of what might be appropriate. The specific suggestions are as follows:

Clause 35: Duty to seek advice in connection with serious medical treatment

1. This section applies if an NHS or private health provider—
   (a) is proposing to provide serious medical treatment for a person (“P”) who lacks capacity to consent to treatment; and
   (b) there is significant difficulty in determining “best interest” due to the following:
      (i) a difference of views amongst relevant interested parties;
      (ii) there is a significant possibility that the adverse effects of treatment may outweigh the benefits;
      (iii) where the use of potentially life sustaining treatment and its impact on the person’s quality of life is difficult to determine and subject to dispute; or
   (c) the treatment to be given is outside of clinical guidelines; or
   (d) specific treatments, as set out in regulation, are proposed (an example would be ECT when not covered by mental health legislation).

2. Before the treatment is provided the NHS body or private health provider must seek a second expert opinion with respect to whether the treatment proposed is in the best interests of P and the least restrictive option;

3. Certain treatments set out in regulation may only be undertaken with the authorisation of the Court of Protection (this would include sterilization).

Clause 36: Duty of NHS body, private health provider or local authority to make available independent support to P

1. If any of the conditions set out in the sub-sections below apply the NHS or private health provider or local authority must make such arrangements, as it considers reasonable, to enable persons (advocates or independent consultees) to be available to represent the past and present wishes of P, as far as they are possible to ascertain.
   (a) the decision to be made will result in a change of accommodation, including to NHS, private or local authority provision, unless such change will be limited to a period of less than 28 days; or
   (b) where specific treatments are proposed as laid down in regulation; and
   (c) there is an absence of support from others able to represent the ascertainable views of P; and/or
   (d) where there is a difference of views among relevant parties and/or the potential of conflict of interests such that the best interests of P cannot be readily determined.

2. If, following the appointment of an independent representative, differences of views as to what is in P best interests cannot be resolved the independent representative may apply to the Court of Protection for a decision to be made.

Phrasing similar to the above would adequately have covered the Bournewood situation. Under 35 above given the fact that there was a difference of views with Mr L’s carers this would have triggered an expert second opinion (this is what happened when he was subsequently detained under the Mental Health Act, 1983). Under 36 above an independent representative would have to have been appointed if Mr L was likely to live in the hospital for more than 28 days and if there were differences of views among relevant parties. This mechanism would provide a clear process to be followed that in itself might result in agreement between parties. If it failed to do this, this would lead to the decision being made in a properly constituted judicial forum.

Research

We are pleased that a section on research has been included in the Bill and that there are clear safeguards set out in the Bill and Code of Practice. We recommend that the wording of the Bill should not result in the possibility only of what is described as therapeutic research (i.e., it might bring some immediate benefit to that person). Therapeutic research will inevitably have required non-therapeutic research to have developed the treatment or intervention that ultimately is to be tested. If such a limitation were to be included this would in effect prevent therapeutic research and advances that will eventual lead to effective treatments.

If research into incapacitating disorders cannot be undertaken the consequences would be very considerable. For example, it would not be possible to investigate how people who are unconscious following acute severe head injury should be best treated, the reason why people with Down’s syndrome have the highest risk of the whole population for developing Alzheimer’s disease could not be discovered and preventative treatments eventually developed, investigation into the causes of acute and incapacitating
mentally ill or organically determined disorders of brain function, such as severe psychotic illness or new variant CJD, could not be effectively undertaken. This Bill proposes a strict process that must be followed and sets clear standards through the Code of Practice that doctors, psychologists and others would be judged by. This is a considerable strengthening of safeguards from the present confused position.

Whilst research can be undertaken to provide knowledge of causes or treatment of, or care of the person it does not refer to complications associated with a particular incapacitating disorder—for example pressure sores affecting those with advanced Alzheimer’s disease. We would suggest that 31 (4) (b) might read:

Be intended to provide knowledge of the causes or associated complications of, or treatment of, or of the care of persons affected by, the same or similar conditions.

The above are complex issues and we would be very willing to help in any way that might be seen to be appropriate.

Prof Tony Holland
Royal College of Psychiatrists

Witnesses: Dr Tony Zigmond, Vice President, Professor Sue Bailey, Chair, Faculty of Child and Adolescent Psychiatry, Professor Greg O’Brien, Chair, Faculty of the Psychiatry of Learning Disability, and Dr John O’Grady, Chair, Faculty of Forensic Psychiatry, Royal College of Psychiatrists, examined

Chairman: Good morning and welcome. Before we start taking evidence, there are some members of the Committee who, because they were not present at the appropriate part on a previous occasion, will need to make declarations of interest.

Lord Mayhew of Twysden: My Lord Chairman, my interests are declared in the Register of Members’ Interests. It may be relevant to say that I had some ministerial responsibility for the 1983 Act; I am also President of Mental Health Resource in Tunbridge Wells.

Baroness Flather: My husband sits as one of the presidents of the Mental Health Review Tribunal, Gary Flather, and also I had nearly 21 years connection with Broadmoor hospital, not locked up.

Mr Hinchliffe: My interests are in the Register. It is probably worth placing on record that I used to work for many years as an authorised mental welfare officer and social worker for mental health legislation. I also at one point, on a voluntary basis, represented patients on behalf of Mind at certain Mental Health Review Tribunals.

Laura Moffat: I would like to change my submission to the interests from Mental Health Alliance to Depression Alliance, please.

Q70 Chairman: Thank you very much indeed. Welcome. Dr Zigmond, are you, as it were, taking Chair?

Dr Zigmond: As it were.

Q71 Chairman: As you know, we would like to ask you questions. If you feel absolutely driven to make an opening statement, then we will just about put up with it, but we are not terribly keen, to be frank, because we would be much happier with the questions. I think you have been told that in advance.

Dr Zigmond: You have had 17,000 words of our opening statement.

Q72 Chairman: Exactly. I was going to say, thank you very much for the written evidence which you have provided us, including the addenda. I should say to you that this is a public session and that a transcript of the evidence will be produced and placed on the Internet. You will be given the opportunity to make textual, but not substantial, alterations to the transcript. Can I remind the witnesses and, indeed, members of the Committee, to speak directly into the microphones? There are a few of us on the Committee whose hearing is not quite what it was once, so it is important to speak up. I am afraid we are under some pressure of time: we have got about an hour or so. We will try and get through as many questions as we can, with a bit of discourse. Would you like to introduce your team very briefly?

Dr Zigmond: This is Greg O’Brien. Professor O’Brien: I am the Chair of the Learning Disability Faculty of the College.

Dr O’Grady: John O’Grady, practising forensic psychiatrist and Chair of the Forensic Faculty of the Royal College.

Professor Bailey: I am Sue Bailey. I am professor of child and adolescent mental health and I currently Chair the Child Analysis Faculty of the College.

Dr Zigmond: I am a full-time NHS general adult psychiatrist in Leeds and I am Vice President of the Royal College of Psychiatrists.

Q73 Chairman: Thank you for bringing such a broad team. If I could start. You have said in your written evidence that you want to see basic principles included on the face of the Bill. Two questions would appear to arise from that. First of all, durability: if there are going to be principles in the Bill they need to be durable. It is 1983 since the last major statute on this subject. Do you believe that a set of principles can be established that will last for a generation? You propose that the Richardson criteria should be used. Do you think that those criteria will last for a generation, and, as an associated question, does it make any difference to clinicians whether the principles are on the face of the Bill or in the Codes of Practice? Might it be a little bit more flexible if they were in the Codes of Practice rather than on the face of the Bill?

Dr Zigmond: I will try and answer those, my Lord. We do believe that they will last a generation. They are very fundamental principles and we cannot see that they will lose either their authority or their
Chairman: Just acting as devil’s advocate for a moment, one of the complaints one hears if one has operated in the criminal justice field dealing with sections 37 and 41 is that legal concepts are often very different from clinical concepts. If the principles were in the codes of practice rather than on the face of the Bill, would it not be easier for the law, particularly the criminal justice system, to respond to changing clinical concepts which may, for example, be affected by significant advances in drug treatments?

Dr Zigmond: I think the principles as set out are fundamental, and I cannot see how any change in treatment would alter the basic things about personal autonomy and the least restrictive alternative, and so on. It does seem to me to be absolutely fundamental and I would not want any part of the service to deviate from that without very clear authority of Parliament.

Q75 Chairman: Does your forensic psychiatry colleague have any comment on that?

Dr O’Grady: I think the role of a forensic psychiatrist in court is essentially to translate from the language of psychiatry to the language of law, and, as I see it, both psychiatry and the law would sit above them, have the principles that they operate from. So I cannot see any incompatibility. As far as I am concerned, the job would still remain the same, which is that we give the court evidence of mental disorder, we translate that mental disorder into the legal terms the court uses and a set of principles would simply aid that rather than impede it.

Q76 Lord Carter: We are told that one of the reasons why the principles are not in the draft Bill is because of the need for disapplication which should be left to the Codes of Practice. Would you be satisfied if the criteria for disapplication of the principles were left to the Codes of Practice, or would you sooner see the criteria for that on the face of the Bill?

Dr Zigmond: On the face of the Bill. The only way to ensure confidence is for everybody to know—clinicians, potential patients, all other workers—that these are the fundamental issues against which the application of the provisions of the Bill will be set.

Q77 Lord Rix: In your written submission of 11th October you advocate on page eight either a narrow and very specific definition of mental disorder or the current broad definition in conjunction with strict conditions for the use of compulsion similar to those in the Mental Healthcare and Treatment of Scotland Act 2003, similar to those in the New Zealand Act and in Australia, New South Wales. You also go on to say on page ten, and this obviously warms the cockles of my heart, “The College proposes that people with a learning disability should only be liable to compulsion under the Act if they have a mental disorder in addition to their learning disability.” You then warn that if the exclusion of impairment of intelligence is not included, people with a learning disability would be liable to compulsion at any time that they decline medical treatment. Would you care to expand on these proposals: the narrow definition, the broad definition and the exclusion of people with a learning disability?

Dr Zigmond: Certainly. The broad definition with narrow conditions is quite clearly our preferred option, and it has been our position from the start of the suggestion of reforming the Mental Health Act, for two reasons. The first is that it enables the definition of “mental disorder” to be in line with that in the Mental Capacity Bill, and, secondly, because impaired decision-making, which reflects that if people retain full decision-making capacity they cannot be made subject to compulsion, they would retain their autonomy, again is in line for people suffering from mental illnesses with the grounds for non-consensual treatment for people with physical illnesses, and the closer that we can get to having similar grounds and to reducing discrimination the better. If it was decided that we really could not have those conditions, then we know that there are other practicable ways of dealing with it from New Zealand and Australia, and it would certainly limit, in the way that the Government has stated it intends to limit, the numbers of people subject to compulsion, albeit not in quite as satisfactory a way as to use a narrow definition with their conditions. In relation to learning disability, we certainly do feel very strongly, but I will, if I may, ask my colleague here to explain why.
people, many of whom do not have behavioural problems, many of whom do not threaten society or themselves. It is very important, it is an important safeguard, that there must be grounds for detention—other than learning disability alone.

Q78 Baroness McIntosh of Hudnall: Could I just ask you to talk to us a little bit about the other definitions that you have drawn to our attention, the Australian and New Zealand definitions, wherein the specific exclusions are very carefully set out. It is a notable feature of the draft Bill that it does not specify any exclusions, which sets it apart from the previous legislation, the existing legislation? Could you tell us why, in your view, it is so important to specify the exclusions and how in some areas, particularly in relation to drug and alcohol abuse, it is possible clearly to make a distinction between being mentally disordered and being an alcoholic or an abuser of drugs or other substances?

Dr Zigmond: I think the starting point is to say under what circumstances is it right and proper for people to have treatment to which they are not consenting? An obvious one would be if they are unable to make a decision for themselves. Another might be that they are going to gain some benefit from it. If there is no benefit for them, if there is no therapeutic benefit, then they should not. In addition, there are certain groups of people who, if one is not careful, would always be liable to intervention the minute that they said that they did not want something; and we have to exclude that so there is some good reason why we are overriding somebody’s resistance, if not refusal, outright refusal, and that would be those with impaired intelligence, the learning disability group.

We also need to be very careful that the mental health services do not become solely part of either the criminal justice system or an anti-social order system; that it has to be part of the health service. People who make life-style choices either to behave in a criminal manner, or to drink to excess, or to gamble, or be addicted to cigarettes should not normally be forced to stop those by a health service. If a government feels that those behaviours are inappropriate, then they should legislate in relation to those behaviours, but they are not part of what is generally understood as people who are ill.

Q79 Baroness McIntosh of Hudnall: May I clarify that you would like to see on the face of this Bill specific exclusions. Would you like them to be as detailed as those which are listed in the definitions that you supplied to us from other jurisdictions?

Dr Zigmond: Yes, and in our evidence we have given the suggested ones that we would wish, but they need to be on the face of the Bill.

Q80 Lord Carter: The College proposes two extra conditions for the use of compulsion, one of which is impaired decision-making. Is this not simply a capacity criterion by another name? Can you explain how the approach that you propose there would deal with a patient who had the capacity to make decisions, was seriously mentally ill, was a clear danger to him or herself and adamantly refused treatment? In other words, would you regard the refusal of treatment of itself a sign of impaired decision-making?

Dr Zigmond: A series of fairly complex questions, but I will go through them, if I may. The first is to recognise that although we talk perhaps glibly about somebody being incapacitated or retaining capacity, it is a matter of degree for just about everybody; all sorts of things vary our ability to make decisions. Clinical practice, supported, as I understand it, by the courts, have confirmed that the degree at which one is declared or one declares a patient to be incapacitated depends to quite a significant degree upon the seriousness of the potential consequences of that decision. The notion that there is a particular cut off point one side of which somebody lacks capacity, the other side they retain capacity, is of itself wrong. We are only adding to that variation. Why do we use the words we do? One of the acknowledged difficulties with the current definition of “incapacity” is that it relies almost entirely on a person’s ability to think, what we call cognitive ability, and we recognise that in the field of mental health, of course, emotions play a large part, and so at a very practical clinical level we think that the notion of impaired decision-making by reason of mental disorder would be much easier for people to understand and relate to patients with mental health problems and, of course, it would keep us in line with the provisions in Scotland. You went on and asked about patients who retain capacity but were seriously ill, a danger to themselves, a clear danger to themselves.

Q81 Lord Carter: And refused treatment?

Dr Zigmond: And refused treatment. I think the first thing to say, and I have to say this, whilst I accept this is a slightly side issue, that the only way that I can generally decide that somebody is a danger to themselves is because they have come to see me, I have interviewed them and they have told me what is in their mind. If they do not do that, I will not know about it; and so any law that drives people away from the service, I have to say, increases risks for everybody and damages health, and so on; so we need to get people to come and see us. The second thing is the notion of predicting that somebody is a clear danger either to themselves or, indeed, anybody else, I have to say, is rather a fallacious one. My colleagues and I are not good at it. It raises the question as to how many people we should force to have treatment or lock up in hospital unnecessarily in order to try and pick this one. The third, I think, relevant bit, if I may just for a moment mention from about two years ago the case of Ms B. Ms B was a lady who had had a bleed into her brain stem and she wanted the medical treatment stopped; she wanted the ventilator switched off. This was going to be an act of suicide; she was going to die as a result of that. She went to court and, of course, the court rightly said that her autonomy must be respected and this must be switched off. So we accept the notion—whether it is right or wrong I do not want to enter into—but we accept the notion that people are autonomous and are entitled, as it were, to end
their lives by refusing medical treatment. When you use the words “seriously mentally ill” it seems to me that either one is using those words saying that such people will have impaired decision-making, and, if they do, we believe the law enables a means to protect them. I do not know if there are people with a serious mental illness who do not have impaired decision-making, but, if they do exist, if such a person is as competent at making a decision as Ms B was, then it seems to us that the same rules should apply; otherwise one is just being discriminatory and rather stigmatising.

**Q82 Lord Carter:** Obviously this is an extremely complex area. Will the criteria for capacity in the Mental Capacity Bill and in the Codes of Practice help the situation at all?

**Dr Zigmond:** The assessment of “capacity”. I think, is helped, but it is why we would prefer impaired decision-making: because, as I have said, the definition in the Capacity Bill remains much more to do with thinking ability, with precious little to do with emotion. So if one, for example, has a person who is really quite profoundly depressed and that depression is clearly influencing their thinking, they will understand that they are depressed, they will understand that the treatment might stop them being depressed, but they may, for example, say, “But I am not worthy. I do not deserve treatment.” Whether that would amount to incapacity in relation to the definition in the Capacity Bill we have reservations, but clearly they have impaired decision-making as a result of that depression.

**Q83 Chairman:** Can I try and narrow down what the College means by “impaired decision-making”? Supposing you had a patient who was capable of fully understanding that there was a recommendation that they should have some treatment but they were not capable of understanding the nature of the purpose and the likely effect of that treatment which is being suggested, which is an illustration of how broad an impaired decision-making situation can be, would you say that that person’s capacity to make decisions was impaired? They can see the principle, but they do not understand the effect of the treatment.

**Dr Zigmond:** So long as one is not expecting very detailed understanding, in other words that they understood broadly that this treatment would alleviate their condition and that it would not have significant adverse consequences, and so on, if they were able to understand it at that level, then I think they retain capacity. One has to be able to explain it in a way that there is a duty, as described in the Capacity Bill, to explain it in a way that a person can understand. If they are quite clear that, for example, this treatment is irrelevant, cannot do anything to alleviate the condition and that belief is due to their mental disorder—because what we have said very clearly is it is impaired decision-making by reason of the mental disorder—then, yes, they would fit that criteria.

**Q84 Chairman:** Can I go on to something that is in a way related to that? The draft Bill, as you know, makes special provision for electro-convulsive therapy. In part those arrangements seem to be driven by patients’ fears about ECT but in part also by controversy about the efficacy of ECT. Given those concerns, is it the College’s view that the Bill should prevent ECT being given in any circumstances, even in an emergency, unless the patient (a) has the capacity and (b) actually agrees with it?

**Dr Zigmond:** No. We certainly understand the fears that are shared by quite a number of patients, although I do have to say that amongst those patients, or a proportion of those patients who have had ECT very successfully, they do come along requesting it—that is not unusual—but the efficacy really has been established. I think, by the National Institute of Clinical Excellence that has reviewed the position in relation to ECT, has given clear guidance as to which conditions it is efficacious for and for which it is not, and under those circumstances it seems to us right and proper that, whilst nobody who retains capacity should ever be forced to have it, and we do not accept that that should be overridden by an emergency because we cannot envisage an emergency which required ECT in which somebody retained capacity—it just would not be that urgent—but where somebody lacks capacity, then, within the clear recommendations from NICE (National Institute of Clinical Excellence), we think it should be available as a treatment, preferably with the authority of the Tribunal.

**Q85 Ms Munn:** Can I follow up on that in relation to those under the age of 16, because obviously there are quite strong guidelines in the draft Bill about that. Given that, although you are saying the efficacy has been established, there are still understandably lots of concerns about ECT, do you think that anybody under the age of 16 should ever be given ECT?

**Professor Bailey:** I think the evidence base is difficult, but I think to deny that form of treatment to a very small number of children under 16, and it is very, very a small numbers, would be wrong. In my clinical career I have used ECT in children under 16 on two occasions. It is very rare to do it, but to withdraw it as a treatment, I think, would be unwise.

**Q86 Ms Munn:** What were you treating and what were the other alternatives? That is obviously the issue. Is it really something that should be used at all?

**Professor Bailey:** A young lady with a serious mood disorder who had gone into a state of stupor, where all other forms of treatment had been used, where she had a drip to keep her hydrated and where the physio was giving her two-hourly physio to her legs to avoid deep vein thrombosis—that is the intensity and degree of a life-threatening condition that I think would warrant that treatment in that age range—and she was able to speak to that treatment
and the effect it did have afterwards. I think it is very rare that to deny somebody a treatment, however rare, in rare circumstances would be wrong.

Q87 Lord Rix: Dr Zigmond, you said, if I recall correctly, that people could come along and request to have an ECT. Is that common, and, if they do come along and request it, is it automatically granted that they are given this treatment, or does a considerable debate go on as to whether it is going to be efficacious or not?

Dr Zigmond: It tends to be people who have had ECT in the past and have recovered very well. In fact, I do not personally recall anybody just asking for it, as it were, out of the blue. Is it common? I suppose that depends how you define “common”. I do not believe there would be a psychiatrist that has not had that experience with reasonable regularity: it is certainly not rare. I think it would be discussed with a particular patient as to why they felt it was necessary, and hopefully a consensual decision would be made as to whether it should be given now or whether something else should be tried this time. I think it is very difficult to answer. It certainly would not be a routine finding at the start.

Chairman: Can we move on to an issue concerned with the community treatment. Dr Stoate.

Q88 Dr Stoate: Thank you, Chairman. I am a practising GP and therefore my main interest is treatment in the community for a range of conditions, and obviously I want to raise questions about compulsory treatment in the community. You recommend Community Treatment Orders should only be used whilst a person has impaired decision-making. How does that get round the current revolving door problem where somebody has impaired capacity; they are treated; their capacity and decision-making improves; they then decide to stop taking the treatment because they decide they are better; they then relax, go back and we end up perpetuating the system that we have had over many years, which is a real stumbling block for treatment in the community?

Dr Zigmond: I think it is very important to separate medical advice, which, of course, as a doctor, I would urge everybody to take in all circumstances at all times—

Q89 Dr Stoate: Very wise?

Dr Zigmond:—and personal autonomy, and I think the question demonstrates the stigma which our patients suffer, which is that people constantly fail to follow medical advice in relation to their physical healthcare. The figure I would like to quote was from an article in the BMJ, probably about 18 months ago now, looking at what percentage of patients who had had a heart attack took their statins as prescribed three months later, and the figure was 8%. I have not looked at the figures recently, but some years ago it was true to say that approximately 70% of admissions—I am not talking about under the Mental Health Act but admissions to acute psychiatric wards—were readmissions, which is the identical figure for acute medical wards. The issue is if people are not able to make decisions for themselves, if their decision-making is impaired, of course we must have a law which enables that treatment to continue in the least restrictive environment, including the community, which, of course, we do not have now; but where people are fully able to make decisions for themselves, I think there should be no difference.

Q90 Dr Stoate: So you firmly believe that, once someone has improved with treatment, it is perfectly okay for them to stop it, even though there is a very high risk of relapse and of them being readmitted, possibly under difficult and very distressing circumstances, which is what often tends to happen in these cases?

Dr Zigmond: I think that, first of all, it is important to have services which support and explain to people why it is necessary they continue their treatment. Some of the recent developments relating to, for example, Assertive Outreach are very valuable for this; services must be accessible; they must be friendly; they must be non-threatening; but ultimately is it any more distressing than those people who continually are admitted with heart disease? I do not believe it is. I think the consequences of forcing—having a system which says, “Even when you are well we will continue to force you to have treatment”—the fear that that engenders, and we have seen it in relation to the proposals in this Bill, will be further to drive patients away from the service, which is why we have such difficulty in supporting people. Can I add one thing? As a psychiatrist for many years, I have found that for the first few times patients recover and they stop or reduce their treatment, often, I have to say, because the side-effects are so unpleasant, and who am I to say they should put up with those side-effect when they are otherwise well. As an aside, if you take a condition like schizophrenia, we know that within two years 80% of patients will relapse without treatment, but of course 20% will not, so you will be forcing them to have treatment they do not need indefinitely; so it is a serious matter; but, after three or four cycles, people get the message: “If I stop taking the tablets I end up in hospital”; and then they can carry on and they carry on consensually, and it is far more effective but essentially there is no difference. I have to say, between my patients and any other patients: that are hopeless at following doctors’ advice.

Q91 Dr Stoate: May I say, that is a very good answer and I entirely agree with everything you have said there, but a further point, briefly. You talked about having an increase in help in the community to deal with people. It would mean a lot of support and help in the community. Do you see that in any way unbalancing resources available in the community so that too much emphasis is put on this small group of people that might undermine the service that should be spread amongst a much wider number of people in the community who do not ever come anywhere near the Mental Health Act?
Dr Zigmond: Yes, and if we have an Act which says that the only way to get resource is to refuse treatment, I mean we are in a sorry state of affairs, frankly?

Q92 Mr Hinchliffe: My question might be directed at Dr O’Grady and it is slightly at a tangent to the question from Howard. I recall, probably about four years ago, being in one of the special hospitals and being told by the head of women’s services in this particular hospital that the majority, if not all, of the women in that particular hospital could have been treated within the community if there were appropriate provisions, something along the lines that we are looking at here, and also proper support within the community and supervision within the community. In your evidence you state on page 24 that there is currently a shortfall in secure beds; this shortfall is significant at all levels of security, including low secure district level. You go on to say that the proposals in the draft Bill will increase the potential pool of mentally disordered offenders liable to compulsion. I am interested, in particular, as to whether you feel the provision that Howard has just asked about in terms of compulsion in the community could have a bearing in any way on the secure bed capacity, whether you feel, in line with your prediction, that there will be increased pressure on the secure bed capacity that, alongside the legislation, we ought to be looking at how we organise that capacity and broadly what your thoughts are. We are talking specifically about the Act here, but obviously we need to look at the resources to ensure that the Act would be able to work; and, in particular, on the secure bed front, I am very interested in your views on how we can perhaps improve provision alongside improving legislation?

Dr O’Grady: I hope the clinician in Broadmoor publishes the research that is based on, because it will revolutionise psychiatry.

Q93 Mr Hinchliffe: I did not say Broadmoor. It is a nice guess though.

Dr O’Grady: I am not sure that is an opinion. I am not sure there is a body of evidence in support of that. I think the bed-rock of forensic practice in a community setting is always the relationship with your patient. As one of my patients pointed out, if certain aspects of this Bill were implemented, he would stop seeing me, because he knows I would have too much power. So I think you have to balance the tools you have under the Mental Health Act with the clinical tools, and the clinical tools are the relationship with the patient and the safety of the community which is ensured by that. I think you then have to have a balance, as Dr Zigmond has pointed out, in terms of the compulsion in the community. However, I would point out that if somebody was at a very high risk in the community, in the same way as capacity is determined by the seriousness of the decisions you have to make, if somebody in the community was at such a severe level of risk, then the level at which you would be assessing impaired decision-making would be at a much higher level than other patients. I think, in practice, I do not believe it would be a problem for the population you are referring to if their decision-making were the criterion: because, as I have said, the threshold would alter according to the seriousness of the issues you are dealing with. I think that in terms of secure beds, yes, we always need more secure beds, but they are very expensive and the best way of ensuring the best use of those beds is to ensure that there are housing, employment, education, leisure. Which are actually the services that will prevent most violence and will create more stability. The Mental Health Act will not actually do it. It is that that does the job. Therefore, you start at the bottom with foundations, which is education, housing, employment, leisure, all the things we as human-beings expect in our lives, and mentally ill people expect the same. If you ensure that and build on that foundation and then you build in supported housing, crisis houses and various other services, you will eventually get to your secure beds and make the best use of them without having to increase them substantially.

Q94 Mr Hinchliffe: Can I press you further on this. One of the problems that I have in looking at your argument over the increased demand for the use of secure beds is that when my committee, the Health Committee, looked at the system of the use of secure beds we found, wherever we looked, that there are people occupying beds within a system, whether it be in prison, within special hospitals, within regional secure units, who really ought to be in another part of the system?

Dr O’Grady: Yes.

Q95 Mr Hinchliffe: That is a huge problem for our mental health system. Do you see there is anything in this draft legislation that will ensure that we have a more appropriate use of the different parts of the system compared to what we have at the present time?

Dr O’Grady: I think forensic psychiatrists very much welcome the vastly increased flexibility within Part III of the Act which allows community treatment for offenders in contrast to Part II of the Act and increased flexibility in terms of reporting, et cetera, so I think that that will have an effect and is a very welcome addition to the new Act. As I said, I think that legislation in itself does not ensure services. I would agree with you; I think if we were taking a proper approach to the whole of secure services, you start with foundations, as I said, with the community part of the service and work your way up rather than starting at the top and working down, which unfortunately is the way that services have been approached traditionally, but I do think that Part III of the Act, relating to mentally disordered offenders in the way it has been drafted will have a beneficial effect for mentally disordered offenders as it increases the flexibility for the courts and the number of options available to mentally disordered offenders.

Chairman: Mrs Browning, perhaps we can step into the Bournewood swamp!
Q96 Mrs Browning: You very kindly sent us a very helpful further memorandum on 19 October on the Mental Capacity Bill, and particularly your notes on Bournewood, I think, were very helpful. Can you tell me, as you see it now, given that we do not yet know, whether the Government is going to seek to close the Bournewood gap through the Capacity Bill, the Mental Health Bill or any other method, but clearly they have got to do it. Given that those same two sets of legislation, when they are enacted, could possibly apply to the same person, how do we differentiate? Which is the most appropriate legislative framework to apply?

Dr Zigmond: As you will have gathered, I am moderately confident in all sorts of areas, but you have certainly found my Achilles’ heel. Patients and the vast majority of carers would always prefer to be subject to capacity legislation because it is so much less stigmatising. No question that we would prefer Bournewood to being dealt in the capacity legislation. As for the relationship between the two, if I assume for a moment that there will be the same safeguards in both—I think I have to make that assumption—I can only describe it as potentially a mess. If you wish, I can give what I think are three possible scenarios, and they are the only three that I can think of. One would be that the Mental Capacity Bill would deal with all those people who lack capacity or have impaired decision-making, leaving the Mental Health Bill for the forced treatment of people who retain capacity. That would at least be a start. So that is one option. Second, would be that the Capacity Bill could be for those who are compliant, with the Mental Health Bill being for those who resist treatment. The difficulty with that, if I may give you quick example: supposing I make an advance directive that should I develop Alzheimer’s disease I would not wish, once it was advanced, to have any further treatment? If I develop Alzheimer’s disease but, having done so, I am compliant, then I would be dealt with under the Capacity Bill and my wish would be honoured, but if I resisted any intervention, then I would be dealt with under the Mental Health Bill and treatment would be forced on me, which is a rather odd quirk. Another option is that the Capacity Bill deals with physical illness, the treatment of physical illness, and the Mental Health Bill deals with the treatment of mental illness, and that in some ways is what we have got now. That presents all sorts of difficulties. Two quick examples. One is that sometimes there is no real difference between the two—for example, thyroid disease can cause depression—so it is rather confusing. But again, if I may just turn to somebody: let us say a patient with Alzheimer’s disease who requires dental work, which is the example often used. They have to have the dental treatment under one Act but the treatment for the Alzheimer’s under another Act, which is a recipe for confusion. So we do not have an answer. What we have clearly recommended is that the Mental Capacity Bill should complete its passage through Parliament so that there is a clear understanding of its provisions, and then one should look again at a Mental Health Bill to see what, if anything, is needed.

Q97 Mrs Browning: Can you tell me, in your experience how frequent do you think cases such as Bournewood are?

Dr Zigmond: Could I turn to this colleague in relation to learning disability, and I do not have an old-age colleague, but my understanding is that they are very common.

Q98 Mrs Browning: Before you reply, could I just add this. You have just mentioned learning disability. For the purposes of the existing Act, autistic spectrum disorders are not regarded as a mental problem as such. It does not come within the scope (ASD) of the 1983 Act. Do you regard ASD as a learning disability, because clearly there are people with an ASD diagnosis who would have a learning disability but we have this spectrum of people, certainly some with very high IQs above 70, some also might have an ASD diagnosis and have a diagnostic mental health condition overlying it, but we do have this difficulty with ASD. So when you reply I wonder if you would give me your view specifically on where you see the ASD spectrum comes within this legislation, because, personally speaking, I would not categorise it specifically as a learning disability per se?

Dr Zigmond: Could I answer that one point. I heard you say it a week ago when I was listening. The current Act definition of “mental disorder” includes “any other disorder or disability of mind”. So I am not sure that I would share your view that autistic spectrum disorder per se is excluded from the current Act. If you are saying that by and large such people are not made subject to the Act, then, of course, we would say, “Jolly good thing too”, but I just, as it were, correct the issue whether they could be.

Professor Bailey: In certain individual casework where we have been dealing, for example, particularly with adults in some of the complex cases, we have always maintained that ASD is not by definition in itself a mental disorder?

Dr Zigmond: I accept that.

Chairman: Before Professor O’Brien makes a comment, I know that both Lord Rix and Lord Carter would like to make short comments and then maybe you could respond.

Q99 Lord Rix: In your earlier response you said you would like to see the Mental Capacity Bill passage go through both Houses and then the Mental Health Bill could be, as it were, re-written in the light of this Mental Capacity Bill, and yet in your recommendations here on page 29 you say that the rights and safeguards should be the same under the two bills. Would you not think it necessary for us, the Commons and the Lords, to try and get amendments already into the Mental Capacity Bill so that we anticipate the Mental Health Bill when it eventually comes onto the floor of the House?

Dr Zigmond: Yes, I think it is very important that the safeguards as are necessary in relation to Bournewood, and we would think are necessary in any event for non-consensual treatment, should be in the Capacity Bill.
Q100 Lord Carter: You described the complications of the overlap between the two bills quite well, but is it not much more complicated than you said, because there will be a Mental Capacity Act by next March. We do not report until the end of March. The Government has to respond and then has to draft a Bill. In my view, even if the first session of the next Parliament, if there is an election in the Spring, will be an eighteen-month session, it will be well into 2006 before there is a new Mental Health Act. It could even be squeezed into the 2006–07 session. Could you comment on the problems of resources, but also can you explain why it is that the treatment of children and adolescents does require a different kind of treatment?

Dr Zigmond: It is very difficult, and it is difficult to answer, as I say, until we know the provisions of Capacity Act. The clinical issues have, of course, been thrown in the air in any event because of the European court judgment on Bournewood, so I am just not sure that I can give a clear answer.

Q101 Chairman: I was looking at our specialist advisers. I think this may be the sort of very thorny issue that our specialist advisers might consider for us. Professor O'Brien.

Professor O'Brien: Shall I address both the issues of autism spectrum disorder, learning disability and also the Bournewood?

Q102 Chairman: Yes.

Professor O'Brien: On the issue of autism spectrum disorder and the Act, in the current Code of Practice in the current Act we are directed to code autism as a mental illness. That is the current Code of Practice and that is quite clear. If people are detained on that at present, they are categorised as mental illness and this is something that we are directed to and is not supported either within the profession or within the broader community. So it is one of the problems which we have to rectify. In terms of the Bill, the Bill as we support it with the broad definition and strict criteria, that would include autism when the person requires detention. So if there is a broad definition and strict criteria, that effectively deals with autism very well. As for is autism spectrum disorder a learning disability? No; it is a different sort of problem. Of course, as a learning disability psychiatrist I see many more people with autism than anyone else does. 10% of people under 70 have autism. However, it is not a learning disability. It is not a mental illness. It needs to be dealt with under the Mental Health Act, and, with the broad definitions and strict criteria, that deals with it. On the Bournewood issue, MENCAP gave a very cogent, a very clear repose to the European ruling and they give the figure of 50,000. We have discussed that within our faculty within the college and I have also discussed it with colleagues in the British Psychology Society, and we recognised that figure. This is an accurate pragmatic figure for the UK: 50,000.

Chairman: Can we move on to another important issue relating to children and young people.

Q103 Mr Howarth: You draw attention in the evidence to a significant resource shortfall in specialists who are involved in the assessment of children and young people. You also recommend that suitably qualified specialists should be involved at every level in the treatment and assessment. If there is a shortfall of those suitably qualified professionals, clearly the two things are not going to match up; there are not going to be enough people to do the job that you would require. So perhaps you could comment on the problems of resources, but also can you explain why it is that the treatment of children and adolescents does require a different kind of treatment?

Professor Bailey: If I take your first point that we argue that we need specialists at all levels to undertake this important work and yet we are all aware of the resource shortfall, at least in England we do now have an NSF going into implementation, and, added to that, we are enthusiastic about new ways of working that specialists are going to have to use their expertise in particular ways. So we are aware of the pressure, but we still think that the issue stands. In terms of why we need specialists, I think it is important to make analogies with the physical healthcare of children, as NSF did. So child and adolescent psychiatrists working with multi-disciplinary teams in child analysis mental health services, like paediatricians, are working with 20% of the population, children and adolescents, who from infancy to eighteen are going through the most unique and major maturational changes, whether it is around physical growth, emotional and psychological or intellectual growth, and it is these developmental contexts that is the major driver and the strongest influence to the way in which illnesses present the prognosis and the treatment requirements. Beyond that, we are in an important context. Our work is set in the context of hopefully working with families and looking at the child/parent relationship. We have a different set of contexts in terms of other important legislation, in the Children Act, the new Children Bill, and other partnerships with social care, with youth justice and with education. The whole structure and framework is different. In terms of the disorders, we know that some psychiatric disorders, like paediatric disorders, are unique to childhood. This is not reflected in this international classification of diseases or any other we are going to get for the next 10 or 20 years. They only occur in children or adolescents. A lot of disorders predominantly have their onset in childhood and adolescence and we have a major role in prevention. ADHD, attention deficit hyperactivity disorder, although it occurs in adulthood, is primarily an issue in childhood. Conduct disorder can only occur in childhood, by definition, but only six% of these children go on to have adult antisocial personality disorder. Psychiatric disorders in childhood are complex. There is often more than one diagnosis, with one part of the illness having a prominent effect on that child's life, on their ability to function. It waxes and wanes. Even where we share psychiatric disorders across the seven ages of man, the presentation, the
aetiology and the treatment needs are different. Depression in childhood is environmentally driven up to the age of 10. In adolescence, it does have genetic factors, but it has different treatments, different needs, different approaches. Post-traumatic stress disorder is radically different in its presentation in children and in adults. Perhaps we come nearer to issues around detention and compulsion, early onset psychosis in adolescents has a long lead-in period. It is very good at mimicking all sorts of other disorders, where you need expertise to recognise when to make that diagnosis and when not to, given the implications for that person’s future. That would be my case for saying that this is different and it needs a different specialist approach. We have a higher training of three years to become child and adolescent psychiatrists. Our training is respected across European as being good training. We need life long specialist training. We are giving specialist section 12 approval training to child and adolescent psychiatrists to deal with these issues of compulsion with the current Act, to work with our adult colleagues. Therefore, that is the reason it is a specialist area. We recognise the importance of training with general practitioners.

Dr O’Grady: There are two aspects to the courts’ decisions. One is the decision whether to make use of the Mental Health Act and to detain or not. Very clearly, the court is in a perfect position to do that, having heard all the evidence, having medical and other reports. Rather than talking about the court not having the right level of expertise, I would put it more positively. The Mental Health Act in its draft form at least, in relation to mental health review tribunals, properly puts in three members. It very properly looks at treatment in the wider sense, not just medication but psychological treatment, habilitation, rehabilitation and all aspects of a patient’s care. If it is right for most patients when we look at a care plan to have that level of specific expertise in the mental health review tribunal to address a care plan, why is it different in part three? It puzzles us. It does not make sense and there does not seem to be any particularly practical reason for it. The court’s main determination is: is a mental health order the best disposal for this offender and is it in that person’s interests and in the interests of society to proceed in that way? That is their expertise. Why get the court involved in looking at treatment issues when you have a much better system in the Act in relation to mental health review tribunals? An obvious way of doing it would be to parallel the procedures for part two and simply give the courts the job of determining the detention and, say, 28 days later asking a mental health review tribunal to address the care plan that the care team draws up. Given that it is a very positive aspect to the Bill that you have mental health review tribunals properly addressing care plans, why not apply that to mentally disordered offenders?

Chairman: I have a special request from one of the Members of the Commons who is on the Committee which I take to be a declaration of the greater importance of our meeting than Prime Minister’s questions. We will also take a question about clinical supervision because I think it is a very important issue that should be dealt with, even if briefly, face to face.

Q104 Mr Howarth: If there is a shortfall, what is the scale of that shortfall and, given the long lead-inspectors for training that inevitably apply in these cases, how long would it be likely to take to be able to train young people to bridge that gap?

Professor Bailey: The whole of the children area is set in a 10 year context and higher psychiatric training is three years. Therefore, it is going to take us at least, three, four or five years to embed and encourage people to be recruited into this specialty. One of the issues at the moment is that we have new ways of working. We are looking at recruitment, but many of the core things of this Bill are mitigating against recruitment.

Chairman: What you have highlighted is one of the many resource issues which we are going to have to ask the Department of Health to deal with for us. You have had notice of the particular questions we had in mind so perhaps you could write to us further if there is anything you would like to add to what you have already said in relation to the other questions, but I think we ought to deal with the interface with the criminal justice system.

Q105 Baroness Pitkeathley: Could I ask you about the bit in your written evidence in which you express your reservations about the court having a sufficient level of expertise and experience to enable them to scrutinise care plans? Are you suggesting that, under the draft Bill, there would be inadequacies in the way the courts deal with people with mental health problems, even though there is a provision for them to be able to appoint members of the Expert Panel?

Dr Zigmond: I must not have written that particular level of expertise and experience to enable them to appoint members of the Expert Panel? Secondly, could you say a bit more about the recommendation that you make that all care plans should be subject to mental health tribunal scrutiny after a defined period and could you perhaps give us some indication of what that defined period might be?

Q106 Dr Naysmith: It is the question of the draft Bill proposing the role of a clinical supervisor. In your evidence, you rather suggest that only psychiatrists could properly fill this role. There is evidence from the British Psychological Society which says the opposite. It says that they could fulfil that role as well. If a psychologist meets the required competences, why do you think he or she should be prevented from becoming a clinical supervisor?

Dr Zigmond: I must not have written that particular bit as well as I thought I had. We have no difficulty at all. We are sure that clinical psychologists are well able and have the skills necessary—or will have with appropriate training—to fulfil the general functions of a clinical supervisor. We raise just two issues. The first is that whilst we do not really understand why it is clear from the Bill that only registered medical practitioners are deemed—maybe due to their medical education; I do not know—to be qualified to assess whether a person meets the definition of mental disorder and the conditions required to make
them subject to compulsion. If only a doctor can do that in the first instance and given that one of the obligations of a clinical supervisor is to keep under constant review whether a patient continues to meet the criteria, we are not quite sure how somebody who is not deemed competent to assess if somebody meets the criteria can decide that they continue to meet them.

Q107 Dr Naysmith: Do you think that is a valid judgment, that only you can do it?
Dr Zigmond: We are not sure at all that it is a valid judgment.

Q108 Chairman: I do not want to be too forensic about this important question but when you say you are not sure that it is a valid judgment that may be another double negative as appears on page 20 of your document. I wonder if what you are really saying is you are perfectly sanguine about the judgment that is implicit in Mr Naysmith’s question.

Chairman: Thank you very much. We cannot deal with absolutely everything. We have dealt with most things. We are very grateful to you for giving us such clear and helpful answers and, if there is anything you would like to add, please let us know in writing.

Supplementary memorandum from Royal College of Psychiatrists (DMH 330)

As requested, please find below an answer to the Resource Issues question, which we did not have time to answer at the evidence session on Wednesday 27 October.

10. One of the areas this Committee has to address is the resources that will be required to implement this draft Bill. Your written evidence points to a severe shortage in consultant psychiatrists. What detailed assessment have you made of the level of additional resources that would be necessary to implement this legislation, and how long would it take to have suitably qualified staff in place to operate the legislation fully?

BACKGROUND

The workforce demands of the Bill must be seen in the light of the current significant shortfall in the number of Consultant Psychiatrists in England and Wales. The latest census figures, 2002, are 388 out of 3,249 consultant posts in England (372 out of 3,187 in 2001) and 24 out of 180 consultant posts (14 out of 165 in 2001) in Wales. There are considerable regional differences in vacancy rates. A further census is about to be undertaken and the figures will be sent to the Committee when they are available. Currently there are also vacancies within the training posts. Even should all training posts be filled it is uncertain that this would produce sufficient Consultant Psychiatrists to make up the current deficit, taking account of the increase in Consultant posts and retirements and the fact that some trainees do not wish to undertake the arduous and responsible role of Consultant.

It will be noted that over the year 2001 to 2002 the vacancy rate increased despite an increase in number of Consultants in post (45 in England, five in Wales). This is because of the necessary expansion in posts needed to service the requirements of the National Service Frameworks. The European Court judgement in Bournewood and the Mental Capacity Bill, when it becomes law, are both likely to make significant demands on Consultant Psychiatrists’ time.

There are two further relevant factors. Many medical members of the Mental Health Review Tribunal and the Second Opinion Appointed Doctors (SOAD) panel are retired from clinical practice. Until recently doctors could continue working until the age of 70 (and beyond in private practice) without having to provide evidence of the quality of their work or of continuing professional development. Starting this year all doctors will be required to provide considerable evidence of fitness to practise in order for the General Medical Council to issue a licence to continue to practice. This process of revalidation will be required every five years. The impact of these changes on the continuing availability of doctors, who are otherwise retired, is not known. It is likely to be significant. Secondly, locum Consultants (some of whom are not qualified to be appointed as substantive consultant) currently fill a number of posts. The numbers are not known to us.

The Department of Health and Royal College of Psychiatrists are working closely on issues of recruitment and retention of psychiatrists. All possible avenues are already being utilised, including recruitment from overseas.

We have evidence from a survey of College members that if the current proposals became law this may damage both recruitment and retention of psychiatrists.
DIRECT IMPACT ON WORKLOAD OF THE PROVISIONS OF THE BILL

A working group, including membership from the College, NHS Confederation and Department of Health was established to try and undertake a mapping exercise. This lead to the Department producing a number of figures. The initial report estimated the requirement at an additional 204 (whole time equivalent—wte) Consultant Psychiatrists. This was reduced to 160 when the Bournewood provisions were transferred to the Mental Capacity Bill. It was reduced further, to 130, by assuming that the “New ways of working” proposals would release 30 wte psychiatrists (this is a proposal to utilise Consultant Psychiatrists’ time differently).

The mapping exercise requires much further work.

First, the model assumes there will be no increase in the number of people under compulsion. The College does not accept this view for the reasons given in the submission. Briefly it is because all the patients currently detained under the Mental Health Act meet the new criteria, along with many others who are currently excluded.

Secondly, it assumes a minimal increase in the number of initial examinations of patients. We believe that as a result of provision for anybody to be able to require a Trust to arrange an examination of any other person this number will increase markedly.

Thirdly, there is no acknowledgement of the marked increase in expert panel doctor work which will be required each time there is a change in care plan after 28 days. Currently the 1983 Act SOAD is only required after three months. A further SOAD is required each time the Responsible Medical Officer requests a change in medication from that which is already authorised (initial authorising of the full range of possible medications is, rightly, considered poor practice). In clinical practice such changes are more likely earlier in a patient’s care. The additional number of Expert Panel doctor visits (and Tribunals) is unknown but likely to be significant.

Finally, whilst the model accounts for additional Clinical Supervisor time in relation to preparing care plans and reports for tribunals, there is no acknowledgement of any time required for the substantial increase in statutory consultations and care planning required by the Bill.

October 2004

Supplementary memorandum from The Royal College of Psychiatrists (DMH 381)

RE: PROFESSIONS TAKING ON THE ROLE OF CLINICAL SUPERVISOR

Thank you for your letter. The Royal College of Psychiatrists supports the views of the committee that currently senior clinical psychologists may have extensive experience and authority in relation to a number of forensic inpatients, particularly in high and medium security, but much less experience in relation to general adult and rehabilitation services.

Within the profession of psychiatry there are consultants whose training would not support their undertaking the role of clinical supervisor in relation to severely mentally ill patients eg consultants in psychotherapy or substance misuse. Equally general adult psychiatrists generally lack the expertise to act as clinical supervisors for learning disabled patients or children.

In other words the College is supportive of a range of suitably trained professionals being able, in principle, to undertake the duties of a clinical supervisor. However Trusts would need to exercise great care in determining who should act as a clinical supervisor in relation to individual or particular groups of patients.

The College notes that the British Psychological Society, in its evidence, suggested that there should be equivalent training for both groups of professionals in relation to clinical supervisor responsibilities. We cannot wholly support this view because the training which underpins the ability to act as clinical supervisor consists of all the person’s professional training. The College firmly believes that for the vast majority of severely mental ill patients in general adult and old age services it is essential for the clinical supervisor to have a medical training. A range of medical illnesses play an important part both in relation to the causes and consequences of psychiatric disorders.

In summary the Royal College is supportive of clinical psychologists undertaking the role of clinical supervisor with those patients where their training and expertise would be effective and where there is little need for more general medical education. This would largely confine their role to non-psychotic patients usually in longer-term forensic settings.

I hope this answer is clear. Please let me know if further clarification is required.

A S Zigmond
Vice President; Royal College of Psychiatrists

November 2004
1. **Introduction**

Thank you for this opportunity to provide evidence to the Joint Committee. This memorandum represents the views of the Royal College of Psychiatrists Child Faculty on the possible impact on some of the provisions of the 2004 draft Mental Health Bill on children—that is any person under the age of 18.

The interrelationship between statute and the common law concerning the compulsory psychiatric treatment of children is recognised to be complex and therefore problematic for service providers. Evidence indicates that the number of children and young people who are being cared for and treated by specialist Child and Adolescent Mental Health Services (CAMHS) is increasing.

We are particularly aware of the government’s concerns to balance the rights of children against the rights of the parent to make responsible treatment decisions on behalf of their children, especially in relation to the protection of children with serious mental disorder.

2. **The Definition of Mental Disorder**

The breadth of the definition will include all types of disorder common to children. Anything from minor disorder of conduct through conditions not normally associated with loss of liberty eg Obsessive Compulsive Disorder to full blown psychosis will fall within this definition. The definition will also encompass all children with learning difficulties. Questions our members have raised include:

- Will clinicians now be required to justify all decisions not to use compulsion on children?
- Will Code guidance clarify the types of disorder common to children that will require compulsion?
- We are concerned about the absence of exclusions in the new legislation. We wonder whether the breadth of the definition of mental disorder actually underlines the need for exclusions to prevent children people being subject to inappropriate compulsion.

3. **Part 6 Safeguards**

We welcome the Part 6 safeguards which we consider represents a significant advance insofar as the preparation and external scrutiny of care plans is now a statutory requirement. The Part 6 safeguards are, however, limited in scope:

- The safeguards only apply to in-patients.
- The safeguards only apply to children who either have capacity, or who are resisting treatment.
- The safeguards will also only apply if the child meets the risk criteria contained in Part 6.

4. **The Under 16s who Lack Capacity and are not Resisting Treatment**

We are concerned that a highly vulnerable group of children will remain outside the framework of statutory protection. The individual profile of a child within this group would be a child, who is a resident patient, with a treatment resistant psychotic illness who is passive and is responsive to authority figures. Not only will this group of children lack protection, their basic human rights may be violated without recourse to any independent review.

Concerns have been expressed about this group for many years by the Mental Health Act Commission and yet they still remain unprotected.

5. **Inter-relationship between the Children Act and the Mental Health Act**

We welcome the formal links in the Bill between the Children Act and Mental Health Act. (Section 198) Currently there is little crossover between the statutory regimes that apply to young people/children with complex mental disorders. If the Bill becomes law it is likely that more children and young people will become eligible for compulsion. Some of these young people will be subject to care orders under the Children Act, and some may have been subject to secure accommodation orders under section 25 the Children Act. This, therefore, underlines the importance of introducing a common set of standards for decision makers in relation to children across statutory regimes.

In 2000 the Government expressed a commitment to incorporating the welfare principle in any new legislation. (Para 16 page 6 and Para 2.10 page 15 Reforming the MHA Part 1) The Bill contains no such provision.

The welfare principle and the welfare checklist govern most judicial decision making in relation to children and young people. Unless these principles are re-enacted in the Bill, or contained in a Code, the purpose in enacting a protective regime for children and young people in Part 6 will be weakened.
STATUTORY MEASURES TO PROTECT THE 16 AND 17 YEAR OLD

We support the measures recommended by the Government in the Consultation Document which would have the effect of requiring the use of compulsory powers for young people aged 16 and 17 if the conditions justifying the use of compulsion are met.

THE MENTAL HEALTH TRIBUNAL

We see the Expert Panel member as having a crucial role in protecting the interests of all children who appear before tribunals. We believe that an Expert Panel member who specialises in working with children should be appointed in all cases involving children. We would support the need for guidance to the Expert Panel on identifying and representing the best interests of the child and wonder whether a modified form of the welfare checklist would assist in that respect.

In general this links with the need to develop children’s specialists at all levels of compulsion process eg child and adolescent psychiatrists to be a Tribunal member in all cases involving children and young people and the President of the Tribunal in children’s cases having specialist expertise.

CHILD VISITING

We believe that the child visiting requirements contained in section 116 Mental Health Act 1983 continue to serve a useful function in safeguarding children in care and should be retained.

CARE PLANS FOR CHILDREN

We wonder in what ways the new care and treatment order will ensure that the needs of a child are reflected in ways that are consistent with their best interests. One way of doing this would be to import existing “best practice” standards into legislation, or guidance, in assessing the sufficiency of a care plan. Children’s NSF standards could be incorporated alongside current guidance as to children’s education in hospital. Other relevant guidance includes:

- All children/young people subject to compulsion should be placed in accommodation with others of their own age group, separate from adults.
- All children/young people subject to compulsion should be placed in accommodation as close to home as possible.

(Standard Five National Service Framework for Mental Health 1999)

COMPULSION OUTSIDE HOSPITALS

It seems inevitable that children will be subject to compulsion in a number of residential and therapeutic settings. We would welcome discussion around the establishment of stringent safeguards to regulate the provision of this care and treatment.

What, for example, will be the position of mental health units in local authority secure units? What protection will be afforded to children who will be outside Part 6 safeguards as Part 6 only applies to patients resident in hospital?

FREE CARE SERVICES

If a child/young person becomes subject to compulsion (this will not apply to Part 6) he/she will be entitled to a free service—but only for a period of six weeks. Children/young people who are cared for, and treated by, CAMHS have complex needs. We suggest that that extending this six week period should be considered.

THE NOMINATED PERSON

We believe that further consideration must be given to the provisions relating to the appointment of a nominated person. This is to minimise the potential for conflict where the Approved Mental Health Professional has to make a decision as to which parent is to be the nominated person, where the parents are in disagreement as to the treatment plan which best meet the interests of the child.

January 2005
Memorandum submitted by the Institute of Mental Health Act Practitioners (IMHAP) (DMH 50)

This submission is provided by the Institute of Mental Health Act Practitioners, assisted by Professor Anselm Eldergill a founder member of the Institute.

The Institute of Mental Health Act Practitioners IMHAP was founded in 1990. It has 675 members drawn from all of the relevant mental health professions, the majority of its membership is made up of Mental Health Act managers and administrators. It specialises in providing advice on Mental Health Act administration and management issues. It has published several books in this field.

The Institute welcomes some of the changes that the Government has made to the Draft Bill originally published. For example, we support the amended conditions for compulsion, the new safeguards for children aged under 16 and the removal of Part 5 of the original Bill (which concerned the informal treatment of incapacitated patients).

The Institute remains concerned about several aspects of the Bill.

Our concerns are explained under the following headings, each of which refers to a theme on which the Committee has indicated it particularly wishes to receive evidence:

1. Basic Principles
2. Definition of Mental Disorder and Related Definitions
3. Conditions for Compulsion and Detention
4. Separation of Powers and the Executive
5. Safeguards concerning Forced Medication and ECT
6. Safeguards against Abuse
7. Safeguards—Abolition of Mental Health Commission
8. Omissions
9. Compliance with the Human Rights Act
10. Balance between Collective and Individual Rights
11. Integration with the Mental Capacity Bill
12. Practicality of the Proposals
13. Concluding Remarks
14. Contact Details

1. THEME—BASIC PRINCIPLES

This part of our submission deals with the following theme, on which the Committee wishes to receive evidence: “1. Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?”

We are not aware that the Government has set out a set of “unambiguous basic principles”. It has stated that the existing Act does not adequately protect people from “the significant risk posed by a minority of patients”. It “remains based on treatment in hospital, and too often has allowed severely ill people outside hospital to drift out of contact with services.”

In our opinion, the proportion of violence in society attributable to mental illness remains low, and people are better protected from violence of this kind than from most other kinds. Violence has much more to do with education, upbringing, alcohol, drugs and testosterone than mental illness. That is not to say that it is appropriate to detain and treat people in these classes under mental health laws.

When enacting mental health legislation, Parliament has generally sought to erect a balanced legal structure that harmonises three things: individual liberty; bringing treatment to bear where treatment is necessary and can be beneficial; the protection of the public. Those we describe as “patients” are themselves members of the public, so that the law must seek to ensure that members of the public are not unnecessarily detained, and also that they are protected from those who must necessarily be detained.

The use of compulsion has been permitted when significant harm is foreseeable if an individual remains at liberty. Its purpose is to protect the individual or others from those risks that arise when a person’s capacity to judge risks, or to control the behaviour giving rise to them, is impaired by mental disorder.

2. THEME—DEFINITION OF MENTAL DISORDER AND RELATED DEFINITIONS

This part of our submission deals with the following theme on which the Committee wishes to receive evidence: ”2. Is the definition of mental disorder appropriate and unambiguous?”

In our opinion, the definition of “mental disorder” must be understood together with the definitions of “medical treatment” and “hospitals”, and we have therefore considered their combined effect.

The approach taken in the Bill is essentially a reworking of the consultation document on “dangerous severe personality disorder” that was published by the Home Office and the Department of Health in July 1999.
In this document, the two departments advocated that risk alone, as well as mental disorder and criminal punishment, can justify detention. As a result, consideration was given to detaining such people in “third units”, in essence adult secure accommodation of the kind presently provided for some behaviourally-disturbed children.

The “third-unit” option seems to have been abandoned, probably because it was thought that indefinitely detaining non-offenders in civilian accommodation risks infringing the European Convention on Human Rights.

Article 5(1) permits the detention of convicted persons and those of unsound mind in appropriate facilities (prisons and hospitals, respectively), but does not in clear terms permit the detention of citizens who have not offended merely because there is a risk they will do so in future.

Detention in secure non-hospital accommodation rather rules out pleading mental disorder, and a need for treatment, as the justification, and nor can punishment or lawful sentence be pleaded, because the individuals are not serving a term of imprisonment.

Probably for these reasons, therefore, the Government seems to have retreated, at least for the present, to the justification that such people are mentally disordered: they require medical treatment in hospital or medical treatment under supervision in the community.

**Key Point Further Explanation**

**Meaning of “mental disorder”**

The definition of “mental disorder” is too broad.

Unlike the present Act, the Bill does not provide that no one may be dealt with as mentally disordered by reason only of promiscuity, immoral conduct, sexual deviancy or dependence on alcohol or drugs. Thus, one is entitled to assume that the Government intends that it will be lawful to compulsorily treat individuals on the sole ground that their behaviour is of such a kind. See Clause 2(5).

**Meaning of “medical treatment”**

The definition of “medical treatment”, which includes education and work training, is too broad.

References in the Bill to “medical treatment” are references to treatment for mental disorder provided under the supervision of an “approved clinician.” The term “treatment” includes education, work training, and training in social skills. See Clause 2(7). Consequently, a person who is drug-dependent and whose behaviour is anti-social and alarming may be said to have a mental disorder that warrants providing medical treatment, in the form of work training or social skills training, under psychological supervision.

**Meaning of “a hospital”**

The definition of “a hospital” includes private houses that provide compulsory education, work training or social skills training under psychological supervision to people with personality, alcohol or drug dependency problems.

What constitutes a hospital is broadly defined: see Clause 2(3). A private establishment, such as a converted Edwardian house, is a hospital if its main purpose is to provide medical treatment for mental disorder to persons subject to Part 2 or 3. Because people with “personality disorders”, substance abuse problems or sexual deviancy may now be categorised as having a mental disorder, and education or training under psychological supervision constitutes medical treatment, an establishment offering such a service is a “hospital”. Provided it is suitably registered, it may detain people who meet the conditions for compulsion.

**Combined effect of the new definitions**

The consequence is that social interventions that most people do not think of as medical treatments, given to individuals who most people do not regard as mentally disordered, constitute medical treatments for mental disorder.

Defining anti-social people as mentally disordered, supervised social interventions as medical treatments, and establishments which detain such people or provide social services as hospitals, enables adult secure accommodation to be dressed up for European Convention purposes as hospital treatment for persons of unsound mind. The Institute would prefer that the containment and management of people categorised as having only personality or substance-dependency problems should either be excluded from the Bill or dealt with under a separate Part of the Bill.

This would ensure that those suffering from mental illness are afforded greater protection from being subject to legislation that makes it relatively easy to subject people to long term, and possibly life-long, containment.
3. **Theme—Conditions for Compulsion and Detention**

This part of our submission deals with the following theme on which the Committee wishes to receive evidence: “2. Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the community adequate and sufficient?”

For obvious reasons, we have divided this part of our submission into three parts:

- The conditions for short-term compulsion (up to 72 hours)
- The conditions for compulsory assessment and treatment under Part 2.
- The conditions for compulsory treatment under Part 3 (criminal provisions).

<table>
<thead>
<tr>
<th><strong>Key Points</strong></th>
<th><strong>Further Explanation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The new short-term powers</strong></td>
<td></td>
</tr>
<tr>
<td>It is constitutionally inappropriate that a doctor may detain someone s/he believes requires assessment in the community.</td>
<td>The Bill provides that a doctor may authorise the detention for up to 72 hours of an informal in-patient who appears to require, not detention in hospital, but assessment in the community. See Schedule 6.</td>
</tr>
<tr>
<td>It is constitutionally inappropriate that who is authorised to detain an informal patient is not defined and left to regulations.</td>
<td>A “person falling within a description described . . . in regulations” may likewise detain such a person for up to six hours: See Schedule 6. Who is authorised to use this power will therefore be determined by the Minister after Parliament has enacted the legislation. It may be that the power will remain reserved to suitably qualified nurses. However, the Bill does not require this.</td>
</tr>
<tr>
<td>It is constitutionally inappropriate that a single doctor may authorise a citizen’s compulsory admission and detention if the approved mental health professional accompanying her/him is not also of the opinion that detention is appropriate or that there is any urgent necessity for this.</td>
<td>The new “section 4” emergency admission procedure is set out in Clause 17. It provides that the patient shall be admitted to hospital if the doctor—rather than both professionals, as at present—determines that the person’s assessment is an urgent necessity, and that awaiting a second medical examination would involve undesirable delay.</td>
</tr>
<tr>
<td>Because the professional opinion is evenly divided, the citizen’s detention is not then founded on reliable evidence, which is a Convention requirement.</td>
<td>This is unsatisfactory. Although the approved mental health professional’s opinion is that the relevant conditions for compulsion are met, it may also be their opinion that admission and detention are inappropriate.</td>
</tr>
<tr>
<td>The conditions that govern when a warrant to remove a citizen to a place of safety may be issued require amendment, in order to bring them into line with practice.</td>
<td>If so, the individual’s detention is then founded on one medical opinion with which the approved professional disagrees, and that possibly from a general practitioner, or a doctor with no previous acquaintance of the patient. Furthermore, even if the approved professional believes that detention is appropriate, s/he may not agree that detention or assessment is urgently necessary, or that it is undesirable to await the second medical examination, for example from a consultant psychiatrist.</td>
</tr>
<tr>
<td>The new section 135(1) power (Warrant to remove a person to a place of safety) is set out in Clause 227. It adopts the existing statutory grounds and, because they remain unchanged, so they remain defective. Whether a person can care for themselves, or is being ill-treated or neglected, is not the same issue as whether the only way in which a statutory assessment can be undertaken is by forced entry and removal. Although this is the usual reason for using the power, it continues not to be a ground for issuing the warrant.</td>
<td></td>
</tr>
</tbody>
</table>
Key Points | Further Explanation
--- | ---
It is constitutionally inappropriate to use mental health legislation to allow constables to remove citizens who are drug or alcohol dependent from their homes without any need for a warrant. We are concerned that the power may be misused. | The most controversial short-term provision is the urgent removal power in Clause 228. Necessarily, this power, as with all of the others, extends to people who are alcohol or drug dependent, or “sexually deviant”. In other words, they too are liable to be removed to a place of safety by a constable acting without a warrant.

The “relevant conditions” for compulsion under Part 2

The relevant conditions for compulsion must be understood in the context of the statutory definitions of “mental disorder” and “medical treatment” | The statutory criteria for compulsion under the civil provisions in Part 2 are called “the relevant conditions” (See Clause 9). The conditions for compulsion must be understood in the context of the very broad definitions of “mental disorder” and “medical treatment” referred to above.

The meaning of the word “lawfully” in Clause 9(5) needs to be clarified. | In most cases, compulsion under Part 2 is only permissible if “medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.”

The word “lawfully” has been added here, and it is ambiguous. | Is it intended to mean that the person cannot be “sectioned” if s/he consents to informal treatment, or does it mean that an incapacitated person cannot be “sectioned” if s/he can be treated instead under the Mental Capacity Bill or the common law doctrine of necessity? This is an important point that needs to be clarified.

In contrast to the present Act, the Bill allows for the compulsory treatment of people who are not treatable. If they are not treatable why force treatment on them? | The Bill abolishes the existing “treatability test”.

In other words, where a person has a learning disability or personality disorder, it will no longer be a condition of longer-term compulsory treatment that treatment is likely to alleviate their condition or prevent its deterioration. The equivalent condition in the draft Bill is that “appropriate medical treatment is available”. This “appropriate” medical treatment may, of course, consist of nothing more than education or work training not provided under any medical supervision.

“Appropriate” is a very general word, and the Bill does not say that treatment is only appropriate if it is likely to alleviate the patient’s condition or prevent its deterioration.

Because what constitutes “medical treatment” may be extended by making regulations that extend who is an “approved clinician” under the Bill, so the relevant conditions for compulsion may be extended by regulations. | Because “treatment” only constitutes “medical treatment” if it is “provided under the supervision of an approved clinician”. and who is or may be approved will be determined by the Secretary of State after the legislation has been passed, it can be seen that the grounds for compulsion can periodically be varied by secondary legislation.

This is unsatisfactory, and may be unlawful. For example, because it enables the conditions for compulsion to be varied periodically by Ministers without going back to Parliament.

The criteria for detention in hospital under Part 2

Provided a citizen meets the relevant conditions for compulsion, the Bill leaves to regulations the issue of whether s/he should be liable to be detained in a hospital. This is constitutionally inappropriate, and we are sure that it does not comply with the European Convention. | The new Clause 15(2) provides that, “If the patient falls within a description specified by the appropriate authority in regulations, each of the examiners must, in carrying out an examination, also determine whether it is appropriate for the patient to be detained in a hospital while an assessment of him is carried out.”

It is therefore proposed that Parliament should be silent as to the circumstances in which citizens will be liable to detention under mental health laws, imposing no conditions or safeguards, entrusting instead the “liberty of the subject” to the executive and regulations made by the Minister from time to time.
The Bill provides that a citizen may be detained even though the medical evidence is evenly divided as to the need for detention. Again, we are sure that this does not comply with the European Convention, which requires that detention is founded on reliable evidence.

The test for detention is as subjective as such tests can be. Not “is the individual’s mental disorder sufficiently severe to warrant deprivation of liberty?”, or “is depriving this individual of their liberty justified by the risk of harm?”, but “does a professional person think it is appropriate to detain them while an assessment is carried out?”

The conditions that may be imposed on a non-resident patient should be specified.

The conditions that may be imposed on a non-resident patient include those specified in Clause 15(4). The use of the word “include” leaves open, and unclear, what other conditions may lawfully be imposed, and this is unsatisfactory.

The conditions for imposing longer-term compulsory treatment under the criminal provisions in Part 3 are much laxer. It suffices that the individual has a mental disorder of a nature or degree that warrants providing medical treatment to them, and that appropriate medical treatment is available (Clause 116).

This is a matter that requires the most careful consideration, given the broad definitions of mental disorder and medical treatment, and the number of people with personality or substance-dependency problems who appear in court.

4. Theme—Seperation of Powers and the Executive

This part of our submission deals with the following theme on which the Committee wishes to receive evidence: “7. Is the balance struck between what has been included on the face of the draft bill, and what goes into Regulations and the Code of Practices right?”
Key Points Further explanation

Balance between legislation and regulations

The drafting of the Bill is “back-to-front” and reserves constitutional issues affecting “the liberty of the subject” to regulations made by the Secretary of State.

The drafting of the Bill is unusual, and “back-to-front”. It is silent about matters which one would expect to find defined by Parliament, such as the grounds upon which a citizen can be detained, and prescriptive about matters that are probably not intended to be legally enforceable and are merely directory, e.g., the numerous requirements to consult and notify people and to keep the status of patients under review.

As already noted, who may detain an informal in-patient for up to six hours, when a person is liable to detention for assessment under Part 2, and who is an “approved clinician” (and, therefore, what constitutes medical treatment) are all matters left to regulations.

The Bill even states that the Secretary of State may prescribe matters that must be dealt with in tribunal applications (see, e.g., Clause 39), a function that surely belongs to the Lord Chancellor.

It also enables the Secretary of State to regulate the giving of ECT without the usual certificates (see Theme 5).

5. Theme—Safeguards concerning Forced Medication and ECT

This part of our submission deals with the following theme on which the Committee wishes to receive evidence: “Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?”

Key Points Further Explanation

Safeguards concerning medication given without consent, etc

The Bill abolishes the existing right of patients to an independent, binding, second-opinion concerning the appropriateness of the medication they are forced to take. This seems contrary both to common-sense and recent court decisions, so that we doubt whether it complies with the European Convention.

We strongly believe that the Expert Panel should be given this function to perform.

Fairness and commonsense dictate that decisions to authorise treatments that can be given by force should be subject to safeguards. The Government’s intention appears to be that anti-psychotics and other drugs given for mental disorder constitute “Other medical treatment”, and will be governed by Clauses 198 to 200.

Clauses 199 and 200 provide that the consent of a patient who is liable to assessment or treatment under Part 2 or 3 is not required in respect of any medical treatment of such a kind provided it is described in her/his care plan (or care plan as approved by the tribunal with modifications).

Because a tribunal can only modify the medical treatment in a care plan with the patient’s consultant’s consent, this amounts to abolishing the right that patients detained for treatment presently have to a binding second-opinion on their drug treatment from an independent consultant psychiatrist appointed by the Mental Health Act Commission. The Bill could, but does not, transfer this protective function to the new Expert Panel.

Administering medication without consent in “hospital settings”

The broad definition of what constitutes a hospital leads to a correspondingly broad list of places where citizens may be held down and given medication by force.

The Bill allows for administering medication without consent in a hospital (Clause 198). Medication may be given without consent in an NHS clinic, in small “mental nursing homes” that are willing to provide this service, and small private establishments that constitute “hospitals” for legal purposes.

Administering medication without consent in non-hospital settings

If one takes “patient consent” to mean that the patient freely consents to treatment then it is

In practice, it is likely that consultants or tribunals will impose a requirement or condition that the patient takes prescribed medication, in addition to a requirement that s/he attends hospital as
inevitable that drug treatments will often be given to people in their own homes without their consent. After all, if they accept the need for treatment there is no need for it to be given under a compulsory order. required. It will be pointed out that there will be no need to require the patient to attend hospital, or to convey them there, if an injection can be given at home. The patient has this option. It may be objected that any medicines given in such circumstances are not given with consent, for if the person truly consented to their administration a compulsory treatment order would be unnecessary. Against this, the procedures for patients liable to compulsory treatment under the 1983 Act provide for medicines being given with or without consent. The current statutory position is therefore that a patient may give a valid consent to medication notwithstanding that a refusal may result in administration by force. If this is the case, home treatment and assertive outreach teams will be giving medication within the home to people who would refuse it if free to decide. To the non-lawyer, this amounts to administering medication without the person’s consent outside hospital settings.

Safeguards concerning ECT given without consent, etc

We are concerned that it will be too easy in practice for consultants to by-pass the protective scheme set out for ECT. In our opinion, the safeguards concerning ECT, though modified, remain unsatisfactory. They are set out in Clauses 177 to 190. Under Clauses 182 to 184, a patient may effectively be given a whole course of ECT if their consultant certifies at the outset of the course of treatment that the treatment is immediately necessary to alleviate serious suffering. That being so, it is unclear how often consultants will decide that it is necessary to apply to a Mental Health Tribunal for authorisation. Here again, the Secretary of State has reserved to himself the power to regulate the scheme although, by constitutional convention, all significant encroachments on the liberty and security “of the subject” should, we believe, be determined by Parliament and entrenched in statute law.

6. Theme—Safeguards against abuse

This part of our submission deals with the following theme on which the Committee wishes to receive evidence: “6. Are the safeguards against abuse adequate?” Many safeguards against the poor or inappropriate use of compulsion are abolished. In addition to those already mentioned: The Bill:

— fetters the new Mental Health Tribunals;
— revokes the powers of a patient’s nearest relative;
— provides that the guidance in the Code of Practice may be qualified;
— abolishes the statutory duty to provide long-term after-care;
— revokes the discharge powers of NHS bodies and local authorities;
— may endanger professional independence;
— does not provide for an independent, standalone, Mental Health Commission.

We believe that tribunals should continue to have a discretionary power to discharge people from compulsion. The powers of the new tribunals are limited. In particular, they have no discretion to discharge a person who meets the statutory conditions for compulsion. Here too, practitioners are prohibited from taking into account matters not referred to in the Government’s test. As a result, more patients will be subject to perennial compulsion, because some people with chronic illnesses never satisfy the statutory test for discharge.
<table>
<thead>
<tr>
<th>Key Points</th>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Bill should provide that a tribunal must release a citizen from detention unless it is satisfied that clear grounds which Parliament has determined justify depriving a citizen of her/his liberty are met.</td>
<td>That is not to say that they ought not to be discharged once they are functioning at their optimum level, provided that neither they nor anyone else is at significant risk.</td>
</tr>
<tr>
<td>Whether a patient who meets the conditions for compulsion is actually released from detention, but not compulsion, is left entirely to the tribunal’s discretion, there being no grounds which qualify when detention is or is not lawful.</td>
<td>Whether a patient who meets the conditions for compulsion is actually released from detention, but not compulsion, is left entirely to the tribunal’s discretion, there being no grounds which qualify when detention is or is not lawful.</td>
</tr>
<tr>
<td>If citizens who have not committed an offence are to be subject to restrictions of the kind imposed on dangerous offenders then similar protections should be put in place.</td>
<td>A notable feature of the new scheme is that people who have not committed an offence may be placed under restrictions on discharge, transfer and leave of the kind now imposed by the Crown Court on offenders who pose a risk of serious harm to the public.</td>
</tr>
<tr>
<td>Where a person applies to be discharged from short-term compulsory assessment, we do not agree that a tribunal should be empowered to not only refuse their application to be released but also to extend the period of compulsion by up to six months.</td>
<td>Where a person who has been detained for up to 28 days asks the tribunal to review the grounds for the detention, it can extend the period of compulsion by up to six months.</td>
</tr>
<tr>
<td>Because the rules will no doubt provide that where two applications are outstanding they may be heard together, it is better to leave it to the clinical supervisor to decide whether to apply for a further order.</td>
<td>Necessarily, many patients will be wary of challenging their detention, given the purpose and possible consequences of independent review. This wariness is likely to be reinforced by the fact that their perception of tribunals will change. Instead of being the independent body that can order their release, it will be seen as the authority that imposes long-term compulsion. It must still be doubtful that these provisions satisfy Article 5.</td>
</tr>
<tr>
<td>We are concerned that a tribunal may authorise a person’s further detention for up to eight weeks when it has just determined that s/he does not satisfy the relevant conditions for compulsion, let alone detention.</td>
<td>Where a detained Part 2 patient does not meet the relevant conditions for compulsion in the community, the tribunal must in some cases authorise her/his detention for a further eight weeks. See Clauses 63 and 64.</td>
</tr>
</tbody>
</table>

**Nearest relatives and nominated persons**

A patient’s spouse or partner should retain their existing power to object reasonably to admission to hospital. Why get rid of the right to lodge a reasonable objection? That person should also retain the existing power to discharge from detention a patient who is not likely to act in a manner dangerous to her/himself or others.

If the patient has no spouse or partner, any relative who is her/his ordinary carer (as defined in the Bill) should also have these rights. A person’s nearest relative has several important powers under the present Act, two of which protect patients against the inappropriate use of compulsion.

Although most of our members know of instances where an inappropriate person has been entitled to act as the patient’s nearest relative, the nearest relative’s right under the existing Act to order the patient’s discharge is a key protection for patients that should not be abandoned lightly.

These powers recognise the importance of the family in people’s lives, and the need to limit the circumstances in which the state may interfere with individual and family life. A balance is achieved between the state’s claim to provide protective compulsory care and the right claimed by families to care for their loved ones, and to cope with and manage behaviour that mostly affects only them.
<table>
<thead>
<tr>
<th><strong>Key Points</strong></th>
<th><strong>Further Explanation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A scheme of this kind still enables necessary treatment to be given as a non-resident patient.</td>
<td>The vast majority of patients have caring, responsible, relatives. When relatives see their children or other close family members detained on a ward that for varying reasons is either not therapeutic or causes the patient undue distress, they should retain the right to care for the individual at home, provided the patient is not a danger to themselves or others.</td>
</tr>
<tr>
<td>We wonder whether the “nominated person” is given a sufficiently useful role to justify all of the consultation and notification requirements.</td>
<td>A new “nominated person” replaces the nearest relative. However, this person has but one power, which is to apply to the tribunal for the patient’s discharge.</td>
</tr>
<tr>
<td>We are concerned that the functions of independent MHA Advocates include explaining things such as the requirements imposed on the patient—who are they advocating for—and we are not clear how their independence of the detaining authority (who may well be paying them) is to be guaranteed.</td>
<td>Patients and nominated persons have a right to help under the Bill’s advocacy provisions. However, their statutory role is as much concerned with explaining the consultant’s treatment, and why the patient must comply with it, as it is with protecting or promoting the patient’s legal rights. Such advocates will be appointed by the NHS—and probably often by the detaining trust in practice—and the detaining trust may refuse the advocate access to the particular patient’s records. See Clause 247.</td>
</tr>
<tr>
<td>We generally welcome the rights given to carers by the Bill.</td>
<td>Carers who provide regular and substantial care must also be consulted about some decisions. However, by definition, these rights are carers’ rights, and of course their advice may be that the patient should remain subject to detention or compulsion.</td>
</tr>
</tbody>
</table>

**Qualified Code of Practice**

We are concerned that the Secretary of State has excluded her/himself from having to comply with good practice requirements set out in a Code of Practice, and that it is considered inappropriate in certain circumstances to say what is good practice. The new Code of Practice may provide that one or more general principles shall not apply in circumstances in which its application would be “inappropriate”, or in relation to specified decisions or persons. A new sub-clause now also provides that certain matters are excluded from the remit of the code. Almost all of these matters relate to functions of the Secretary of State. In other words, the Secretary of State will not himself be subject to the Code of [Good] Practice. See Clause 1 and Schedule 1.

**Abolition of section 117**

As a general principle, where a person has been so ill as to require long-term detention and compulsory treatment in a psychiatric unit, we think it a good thing that the after-care authorities should be under a duty to provide them with such after-care as is reasonably necessary to minimise the risk of relapse and readmission. We do not believe that it is fair to require people to pay for treatment they are compelled to receive. The Government indicated in the White Paper that patients would not be charged for services they are compelled to receive. Clauses 53 and 68 deal with free care services before and after discharge. Patients who are required to reside in accommodation that is their ordinary place of residence may be charged all or part of the cost of that accommodation.
**Key Points**

**Powers of hospital managers and others**

We believe that the managers of a hospital should retain the power to discharge a person detained by them if they are of the opinion that the statutory conditions which make detention lawful are no longer met.

<table>
<thead>
<tr>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital managers, Health Authorities, NHS trusts, and local authorities all lose their powers to discharge individuals from compulsion. Only the patient’s clinical supervisor or the tribunal may discharge a patient.</td>
</tr>
<tr>
<td>Under the Mental Health Act 1983, the hospital managers have the power to discharge patients from liability to detention. This has resulted in NHS trusts appointing local people with suitable experience and qualifications to hear requests for discharge made by patients to the detaining NHS trust. Our research shows that approximately 3–4% of these hearings result in the patient having her/his appeal against detention upheld.</td>
</tr>
<tr>
<td>We believe that these informal “appeal hearings” are an important additional protection for patients against unjustified detention. However, the draft Bill abolishes the hospital managers' power of discharge, and with it this avenue of appeal.</td>
</tr>
</tbody>
</table>

We do not believe that the “independent” MHA advocacy service is an adequate substitute for the protection presently afforded to citizens by co-opted independent managers.

<table>
<thead>
<tr>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>We do not consider that the new Mental Health Act advocacy service is an adequate substitute. The advocates possess no formal powers. Furthermore, the new advocacy services will require extensive training and considerable payment. They will be superimposed onto existing advocacy services and many patients are likely to be confused about the respective functions of qualified solicitor advocates and the new informal advocates. We feel that patients will end up with less protection and increased confusion.</td>
</tr>
</tbody>
</table>

Hospitals should continue to co-opt managers from the local community.

<table>
<thead>
<tr>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>It will also be important that hospitals continue to co-opt managers from the local community, to fulfil some of their functions under the Bill.</td>
</tr>
</tbody>
</table>

**Professional independence**

We are concerned about the possibility that all three examiners may be employed by the prospective detaining authority.

<table>
<thead>
<tr>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The existing separation of powers, which requires that the applicant is independent of the doctors recommending compulsion, is abolished. Subject to regulations, in future examinations may be conducted by three health service colleagues employed by the detaining body. See Clause 14.</td>
</tr>
<tr>
<td>There is currently a shortage of approved social workers and the situation is due to get worse. The broadening of the pool of mental health professionals who may be approved as AMHPs under Clause 3 is therefore understandable. However, their independence must be preserved and safeguarded by ensuring that when they undertake this function they act independently of the employing NHS trust.</td>
</tr>
</tbody>
</table>

**Abolition of Mental Health Commission**

We consider this constitutional issue to be so important that we deal with it under a separate major heading immediately below.

7. **Theme—Safeguards—Abolition of Mental Health Commission**

This part of our submission deals with the following theme on which the Committee wishes to receive evidence: “6. Are the safeguards against abuse adequate?”

When vulnerable people are subject to detention or compulsory medical treatment, the law has usually sought to protect them by requiring that a specialist, independent, legal body visits them periodically, in order to ensure that these powers are not being abused.

Agreed international standards now require governments to provide for this: See, eg, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, adopted by United Nations General Assembly resolution 46/119 of 17 December 1991. Inspections must be sufficiently frequent to ensure that the conditions, treatment and care of patients comply with international principles.

The Mental Health Act Commission presently performs this essential function. Its active visiting regime has had a positive impact on most NHS trusts in the country, and many detained patients have benefited from these visits during the past 21 years. Members of the Institute have found the Commission to be supportive and helpful in improving compliance with the Code of Practice and the Mental Health Act.
The Bill provides for the Mental Health Act Commission’s abolition, and it also abolishes the visiting function. The Government proposes that henceforth the Commission for Healthcare Audit and Inspection (CHAI) will exercise some functions in relation to the new Act: see Clauses 256 to 277 and 289 to 292.

In our opinion, getting rid of a small, standalone, semi-independent, specialist Mental Health Commission will do enormous harm.

A much better funded specialist Mental Health Commission, with a clearer and more focused remit, would be a better and more positive development, rather than hiving this function off to a large Healthcare Commission whose remit is far too broad and politically sensitive to do justice to this relatively small and vulnerable group of patients. These patients are citizens who are being detained, and in most cases medicated against their will.

A separate Commission is essential, given the number and range of people who will be liable to compulsion; the fact that compulsion will now take place in the community; the position of incapacitated people; and the overall reduction in safeguards for those subject to compulsion.

The danger is that the constitutional imperative will be consumed by the larger political imperatives if the MHAC becomes one small division within a super-Commission dedicated to monitoring compliance with the NHS programme. When CHAI budgets are set, “mental health legal money” will compete with NHS performance-targets, and be diverted to the inspection of acute care—in the same way that funds announced for mental health initiatives are now sometimes diverted by Health Authorities to reducing waiting list times.

It must also be doubtful whether any merger will achieve its stated aim of reducing NHS bureaucracy.

Visiting patients, and ensuring that they are being treated kindly and lawfully, does not increase regulation. It is not a regulatory exercise. CHAI does, however, operate as a regulatory body and is concerned with general management systems.

Furthermore, merging “quangos” so that they exercise their functions as divisions of one “super-quango” does not reduce regulation. This requires reducing the range of functions performed. Furthermore, one can only successfully join institutions that perform similar functions.

**Recommendation**

1. There should continue to be an independent, standalone, Mental Health Commission, the functions of which comply with agreed international standards.

In 1982, Parliament amended the last Mental Health Bill by strengthening the role of what was to be the new Mental Health Act Commission. We hope that it will again perform a similar valuable service. If it does, there is much to be said for placing the Mental Health Commission on the same footing as the Health Service Commissioner: that is, accountable to and funded by Parliament, or (if this is not possible) accountable to and funded by the Department of Constitutional Affairs.

8. **Theme—Omissions**

This part of our submission deals with the following theme on which the Committee wishes to receive evidence: “Are there any important omissions in the Bill?”

<table>
<thead>
<tr>
<th>Key Points</th>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Seclusion and mechanical restraint</strong></td>
<td>For reasons that are obvious, we consider that the Bill should regulate the use of seclusion (solitary confinement) and mechanical restraint.</td>
</tr>
<tr>
<td><strong>Rehabilitation provisions</strong></td>
<td>The Bill does not include any rehabilitation provisions of the kind set out in the Mental Health (Northern Ireland) Order 1986. We think that if person’s detention or compulsion does not exceed 28 days, s/he should not be required to state in any future employment or insurance application that s/he has been “sectioned”.</td>
</tr>
<tr>
<td><strong>Offences</strong></td>
<td>The Bill seems to make no provision.</td>
</tr>
</tbody>
</table>

Who has the duty to investigate and prosecute offences under the new Act should be made clear.
9. **Theme—Compliance with the Human Rights Act**

This part of our submission deals with the following theme on which the Committee wishes to receive evidence: “9. Is the Draft Mental Health Bill in full compliance with the Human Rights Act?”

<table>
<thead>
<tr>
<th>Key Points</th>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-compliance issues</strong></td>
<td></td>
</tr>
<tr>
<td>Our opinion is that some of the Bill’s provisions in relation to detention and compulsory treatment are likely to breach the European Convention on Human Rights</td>
<td>These matters have been dealt with above.</td>
</tr>
</tbody>
</table>

10. **Theme—Balance between Collective and Individual Rights**

This part of our submission deals with the following theme on which the Committee wishes to receive evidence: “10. Does the draft bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?”

<table>
<thead>
<tr>
<th>Key Points</th>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Whether the Bill achieves the right balance?</strong></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Patients are themselves members of the public, so the law must ensure that members of the public are not unnecessarily detained, and also that they are protected from those who must necessarily be detained.</td>
</tr>
<tr>
<td></td>
<td>The Bill removes many important protections against abuse that either have no impact on the risk of self-harm or harm to others (such as the abolition of the Mental Health Act Commission and its visiting function, of second-opinions concerning antipsychotic drugs, of clear criteria for detention) or only a minimal impact that is outweighed by the protection afforded to citizens (such as the abolition of managers’ powers). It is this fact, perhaps more than any other, that has given the impression of uncaring disregard and caused such opposition to the Department of Health’s proposals.</td>
</tr>
<tr>
<td></td>
<td>Even if people are inadequately protected from the actions of people who have a mental disorder, this may not be a fault of our laws. It may be due to insufficient resources, poor government, poor service management, poor risk management, faulty practice, a faulty understanding of the law, or simply part of the human condition. In other words, a problem or limitation that is to a significant extent replicated across a world full of different mental health laws.</td>
</tr>
<tr>
<td></td>
<td>Implicit in any discussion about the need for new laws is the assumption that modifying their content modifies outcomes. However, the extent to which this is true is unclear. Legislation is actually a relatively ineffective means of modifying behaviour. Although it can provide a framework for managing violence associated with mental disorder, it cannot significantly reduce these risks. That this is so is clear from the many homicide inquiry reports. Had the professional carers foreseen what was about to happen, they already had power under the present law to intervene. That they did not intervene was due, not to any lack of legal powers, but to the fact that they did not foresee what was about to occur. Yet no amount of new legislation can improve foresight.</td>
</tr>
</tbody>
</table>
11. Theme—Integration with the Mental Capacity Bill

This part of our submission deals with the following theme on which the Committee wishes to receive evidence: “8. Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill introduced in the House of Commons on 17 July 2004?”

<table>
<thead>
<tr>
<th>Key Points</th>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Capacity Bill and common law powers</strong></td>
<td></td>
</tr>
<tr>
<td>The Bill does not refer to the Mental Capacity Bill or to common law powers. That being so, it must be the case that it is not integrated.</td>
<td>The Draft Bill does not refer to the Mental Capacity Bill introduced in the House of Commons on 17 June 2004. It is clearly important that considerable attention is given to the extent to which the various powers, duties and rights concerning incapacitated patients set out in the Mental Health Bill, the Mental Capacity Bill and the common law conflict. The interplay between the different statutory and common law schemes is a potential minefield that could take years to resolve, and be very expensive for healthcare providers.</td>
</tr>
</tbody>
</table>

12. Theme—Practicality of the Proposals

This part of our submission deals with the following themes on which the Committee wishes to receive evidence:

“4. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient, and clear?

5. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft bill?

10. What are likely to be the human and financial resource implications of the draft bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?”

Having regard to these requirements, and the many demands already made on the time of Mental Health Act administrators, doctors and other health service professionals, we have significant reservations about the practicality of the new provisions. Indeed, we think that many of the provisions may be unworkable.

<table>
<thead>
<tr>
<th>Key Points</th>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drafting ambiguities and errors</strong></td>
<td></td>
</tr>
<tr>
<td>We believe that the Bill would benefit from being redrafted.</td>
<td>We believe that the Bill contains many drafting ambiguities and errors, and it is certainly highly repetitive and unnecessarily complicated. We think that it would be sensible for the Department of Health to seek further legal advice.</td>
</tr>
</tbody>
</table>

**The “assessment period”**

We believe that the period allowed before a clinical supervisor must apply to a tribunal for an assessment or treatment order should be extended.

However, during this extended period, the patient should be entitled to apply for her/his discharge if s/he so wishes.

We are concerned about the impact that the very short assessment time frame for producing reports will have on the ability to provide care plans that are agreed with the patients and are sufficiently detailed to be able to have clarity of purpose and intent. The Institute would suggest, as it has in the past, that a six week time frame for assessment should be used. In the majority of cases, this will enable an agreed care-plan to be produced, with a medication regime that has the opportunity of having settled prior to the tribunal.

Further benefits may be a significant reduction in the number of tribunal hearings, fewer adjournments (to allow for further assessment) and a more inclusive approach to report preparation for tribunals. This would better reflect the direction that good practice has been developing over the past 10 years.

**Implementation issues**

The Institute’s concerns about the implementation of the Bill include that:

The Institute has a number of significant concerns about the implementation of the Bill.
Key Points | Further Explanation
---|---
The new tribunal system will not work | In our opinion, the proposed Mental Health Tribunal system will not work. The present system is already at breaking point, and we estimate that the number of tribunal hearings will quadruple.
It will be impossible to recruit sufficient professionals | We believe that it will prove impossible to recruit sufficient professionals to carry out the necessary tribunal hearings three weeks after the commencement of compulsion.
Care teams will provide less care | The preparation of reports within that timescale will also create major problems, and care teams will need to focus increasingly on meeting statutory deadlines rather than on patient-focused therapies and creating inclusive care plans.
Psychology services will be placed under an even greater burden | There is a desperate shortage of clinical psychologists at present, and consequently they have high workloads. It is unlikely that many of them will be interested in taking on the additional and substantial responsibility of being a clinical supervisor. Those that do will put further pressure on the clinical workloads of those that do not.
The number of Mental Health Act Administrators will need to be at least doubled | The workload involved at the service provider end of the process will require at least doubling the number of Mental Health Act administrative staff. This will have major cost implications.
The accommodation requirements of tribunals will be difficult to meet. | The accommodation requirements of the Mental Health Tribunal hearings will also pose a major problem for a majority of service providers. This too will have major cost implications.

Administration of the new Act

If the Bill is viable, it will be necessary to allow those who must implement it a lengthy induction period before it comes into force. | The time allowed should, we think, take the following considerations into account:
  — The extension of compulsion to community settings.
  — The extension of the population liable to compulsion.
  — The transitional provisions in Schedule 14.
  — The need for services that today are not involved in compulsory procedures to familiarise themselves with practice in this area, eg psychology departments and substance-dependency services.
  — The need for hospitals to recruit additional staff in order to comply with the Bill’s extensive consultation and notification requirements.
  — The anticipated increase in the number of tribunal applications (applications for discharge, assessment orders, treatment orders, further orders, applications relating to transfers or leave, applications to vary orders).
  — The need for the tribunals to reorganise and for the Legal Services Commission to make the necessary arrangements for patients to be legally represented.
  — The requirement that NHS trusts determine whether a citizen appears to meet the relevant conditions for compulsion every time it is requested to do so by any person.
  — The requirement that NHS trusts arrange for every person who appears to meet these conditions to be examined by two doctors and an approved mental health professional.
  — The duty to record the many kinds of determinations provided for by the Bill and the reasons for them.
  — The many formal requirements imposed on the managers of hospitals, eg to “secure” that clinical supervisors make tribunal applications when required to do so by the terms of the Bill, to appoint clinical supervisors, to secure that patients are assessed and that care plans are prepared, to require patients to comply with conditions imposed on them, to deal with requests for determinations, to register patients, to record changes in the status of resident and non-resident patients, to process tribunal applications, to liaise with the new tribunals and the Expert Panel, to furnish reports and other prescribed information, etc.
<table>
<thead>
<tr>
<th>Key Points</th>
<th>Further Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>— The many formal duties imposed on clinical supervisors, eg to review and amend patients’ care plans, to make tribunal applications when required by the Bill, to keep the legal status of all patients under review, to comply with the consent to treatment provisions, etc.</td>
<td></td>
</tr>
<tr>
<td>— The need to retrain all doctors, social workers, nurses, managers and other mental health professionals who will be involved in implementing the new Act. They will need to be familiar with the Act, regulations, statutory forms, rules, Code of Practice, and the guidance issued by the Department of Health, Home Office, CHAI and Mental Health Tribunals.</td>
<td></td>
</tr>
<tr>
<td>— The need to organise the necessary nominated person and advocacy services.</td>
<td></td>
</tr>
<tr>
<td>— The need to put into place systems for approving clinicians and mental health professionals.</td>
<td></td>
</tr>
<tr>
<td>— The need to make arrangements for the inevitable increase in NHS litigation, and to allow the NHS and independent hospitals time to agree satisfactory legal cover and insurance.</td>
<td></td>
</tr>
</tbody>
</table>

**Issues concerning statutory forms**

The new statutory forms will require careful consideration and they should be devised in conjunction with IMHAP

The need to monitor and report on the use of the new powers will necessitate developing statutory forms which ensure that each stage of a patient’s compulsion and care, from assessment through to treatment, is recorded.

There are many possible different paths and the devising of these forms will require careful consideration and discussion. IMHAP represents over 80% of Mental Health Act Administrators, and we believe that it should play the central role here.

The statutory forms used to record patients’ care plans should take account of the lessons of the 1983 Act, and require the clinical supervisor to specify each drug and dosage (and not allow any drug within a general class to be given up to the maximum licensed dosage).

**Training**

Training is a crucial issue. Substantial time and money will need to be set aside for training on the Bill.

It will be necessary to retrain all those doctors, social workers, nurses, hospital managers and other mental health professionals who will be involved in implementing the new Act.

Services that today are not involved in compulsory procedures will need to familiarise themselves with practice in this area, eg psychology departments and substance-dependency services.

They will all need to be familiar with the Act, regulations, statutory forms, rules, Code of Practice, and official guidance.

**Sharing of information**

The clauses that deal with “information sharing on request” (Clauses 286 to 288) are extremely unhelpful.

Having set out what seems to be a new set out statutory duties concerning the sharing of information, this part of the Bill then ends with, “Nothing [above] authorises the provision of information if such provision would be prohibited or restricted under or by virtue of any enactment or by any rule of common law.”

In other words, the poor practitioner is told to decide for her/himself whether any of the “duties” in the Bill is a new duty or a breach of confidentiality.
13. CONCLUDING REMARKS

We recognise that the Government has attempted to address the concern expressed by many people about the criteria for civil compulsion contained in the original Bill. We also welcome the introduction of new safeguards for children aged under 16.

Unfortunately, we also feel bound to note that in most other respects the contentious provisions of the original Bill remain unaltered. Indeed, the relevant conditions aside, the new Bill is if anything less satisfactory in terms of the constitutional balance it strikes between those persons in positions of authority and those subject to their authority.

We are particularly concerned about the abolition of a specialist Mental Health Commission, the way in which central government departments have excluded themselves from the Code of Practice and other safeguards, and the fact that matters such as the criteria determining whether a citizen is detained are left to regulations. Lastly, we remain concerned about the length of the Bill and the quality of the drafting, the practicality of the proposals and the complexities and expense involved in administering it.

14. CONTACT DETAILS

All correspondence and enquiries concerning this submission should be addressed to:

Yens Marsen-Luther
Chief Executive
IMHAP

Witnesses: Mr Yens Marsen-Luther, CEO, Ms Jennifer Scudamore, Chairman, Mr Guy Davis, Honorary Treasurer, and Ms Melanie Woodcock, North Thames Regional Group Chair, examined.

Q109 Chairman: Can I welcome you to the Committee? I should tell you at the outset that the evidence you give will be recorded and a transcript will be placed on the internet. You are perfectly free to make textural connections to the transcript but not corrections of substance. If we do not cover everything that is in your written submissions, which have been very helpful, because of pressure of time, please feel free to write to us. We have two specialist advisers, Professor Fennell, who is a legal expert, and Professor Burns, who is a professor of community psychiatry, with whom you may communicate too. I think you have been discouraged from giving an introduction but if you feel absolutely compelled to do so please do. Which of you is leading the team?

Mr Marsen-Luther: Myself.

Mr Davis: My name is Guy Davis. I am Mental Health Act manager in East London and City Mental Health Trust. I am a former community psychiatric nurse as well and I am currently treasurer of the Institute of Mental Health Act Practitioners.

Q111 Laura Moffatt: Welcome. I want to return to the issue that we were raising with those giving evidence before and that is the definition of the mental impairment and what constitutes treatment. You are quite clearly critical of the way that appears in the draft Bill. If you are critical, how could you feel absolutely compelled to do so please do. Which of you is leading the team?

Ms Woodcock: My name is Melanie Woodcock. I am Mental Health Act manager for Central and North West London Mental Health Trust and I am also the chair of the North Thames Regional IMHAP Group.

Ms Scudamore: My name is Jenny Scudamore. I am Mental Health Act manager for South West London and St George’s Mental Health Trust. I am also chairman of the Institute of Mental Health Act Practitioners and a Mental Health Act Commissioner.

Mr Davis: My name is Guy Davis. I am Mental Health Act manager in East London and City Mental Health Trust. I am a former community psychiatric nurse as well and I am currently treasurer of the Institute of Mental Health Act Practitioners.
Q112 Laura Moffatt: Do you also agree on their views on Asperger’s syndrome and also with the definition of alcohol and substance misuse, because obviously we have concerns about that?
Ms Woodcock: Yes, we would.

Q113 Baroness McIntosh of Hudnall: Can I pick up on this issue about substance misuse? We have heard conflicting evidence about whether or not mental health practitioners under the current Act have used the exclusion that is specific in the 1983 Act in respect of alcohol and substance misuse to avoid treating people who have mental disorder. What is your view about whether or not that has been the case?

Mr Marsen-Luther: I think we are very aware that most general psychiatric units or mental health units have beds specifically set aside for treatment of people who are suffering from drug or alcohol induced psychosis. Therefore, we do not think that generally speaking consultants have refused to treat or recognise the mental health aspect that some alcohol or drug abusers suffer from. The fact is that it is a matter of judgment and it is their judgment as to whether it is primarily a drug abuse or alcohol problem or whether they have an overriding mental health problem that might have been started off by that and therefore we do not agree with the Department’s contention that there is a need to exclude abuse or to include alcohol or drug abuse.

Q114 Chairman: You feel there is sufficient flexibility in the system as it operates currently for the exclusions to be retained?

Mr Marsen-Luther: Yes.

Q115 Chairman: You would reject the implication of Lady McIntosh’s question, which I think is a very important question, that the exclusions are used as excuses sometimes to close the gate on people who need treatment?

Mr Marsen-Luther: Yes. We are dealing with a service that is human. We are not saying that it does not happen on the occasion but I think here we are talking about locking people up and treating them against their will when only a small minority of cases may be slipping through the net. We do not think it is right that the majority of people who choose to abuse alcohol or drugs find themselves becoming subject to the Mental Health Act. That is not what the Mental Health Act is there for. It is there for people who have mental illness.

Q116 Baroness McIntosh of Hudnall: May I ask you the same question that I asked the previous witnesses? Is it the case that you would specifically like to see, on the face of the Bill, not only the exclusions which are in the current Bill but other exclusions as well?

Mr Marsen-Luther: Yes, I think so. I do not think that we have addressed this in our submission but I think we have general support for the idea that there should be principles on the face of the Bill.

Q117 Lord Turnberg: I would like to come to the specific issue of non-resident patients. In your submission, you indicate that the conditions which should be imposed on them should be specified. Why do you say that and what conditions do you mean?

Mr Davis: I think the issue of compulsory orders in the community is a big one in itself. We have heard from the previous witnesses about some of the problems attached to that regarding people's autonomy in choosing what treatment they do and do not have or what advice they do and do not take. As far as the conditions themselves go, the fact that the Bill does not specify what those conditions may be or what they may not be is to be regretted. To give an example, we could have a situation where a condition of non-residency is that the patient takes medication. Fine. Another condition could be that they reside at a particular place. Another condition could be that they are inside their place of residence during night time hours. They are not allowed out, a curfew, if you wish. Then you could go all the way and say they are not allowed out of their house at all. They have to stay in there 24 hours a day. They are not allowed to go out to a certain place to buy drugs or go to the pub and essentially they are under some form of house arrest, if you will. If the Bill is going to say, “We are going to impose conditions on people who are non-resident but subject to a compulsory order” I think the Bill should be saying what those conditions may or may not be. I am not sure that we are in a position at the moment to say what those conditions should or should not be.

Q118 Chairman: This is a difficult issue. If the choice for the patient is between being detained in a secure psychiatric hospital and being effectively detained in what may be the greater comfort and flexibility of their own home, is not the detention in their own home, for some patients at least, a preferable option?

Mr Marsen-Luther: Certainly most people would prefer that they were in their own home rather than in hospital but I am not sure whether people would be happy with the concept that they were actually detained in their own home.

Mr Marsen-Luther: There are serious bed shortages as far as mental health services are concerned. What we are talking about here is a bed shortage on a ward where a clinical supervisor, under this Bill, could say, “Right, you are going home because you have a home to go to, but the condition I am going to place on you now is that you are not allowed to leave home.” That is still preferable in most cases to being on a ward. The next thing that you have to think about, if you are going to allow clinicians the authority to say that to people, is what is the impact going to be on carers. They then are going to have to police and report back if those conditions are not being applied. It is not good enough.

Q119 Chairman: Can it not be dealt with in the code of practice?

Mr Marsen-Luther: Yes, it could be dealt with in the code of practice but we are very keen that reference should be made here to the code of practice. We are
very aware that the current Bill does not support the implementation of the code of practice in all cases. It gives people the option of opting out for groups of patients and we do not think this is good enough. If you strengthen the code of practice in the Bill, we would be quite happy for you to say, “All right. Guidance will be set in the code of practice which will ensure that people’s homes are not used as alternatives to hospitalisation because of bed shortages. I think this is the reason why we feel very strongly that you need to take this issue into account and you need to ensure that it is sufficiently tight not to be abused.”

Q120 Lord Turnberg: I wonder about the practicality of putting these sorts of qualifiers in on the face of the Bill and how one might do that. That aside, maybe there is a way. It does seem to me that you are saying that you would not want the community to be an extension of the ward simply because there were not sufficient beds and that there would be a good reason for discharging someone home because they were better treated at home rather than in hospital; and it was not simply a matter of using a bed outside the hospital as a bed because there is not one in the hospital. Is that what you are saying?

Mr Marsen-Luther: I think we are but I think we are also saying that we are very aware that section 17 leave is currently being used as a way of freeing up beds in hospitals. If you are going to have and if you are going to give the authority to clinical supervisors to subject people to certain conditions in the community and make sure that they continue to receive treatment, you are opening a Pandora’s Box unless you ensure that there is a lid on the breadth of authority that you are giving them. We would look to you to be doing that.

Q121 Tim Loughton: Effectively, the way it is structured, somebody could be treated by compulsion at home and, at the whim of beds, treated back home without any difference in the condition of that patient’s medical position at all. Do you foresee that is going to happen? What is effectively the difference between what is being proposed and an ASBO?

Mr Marsen-Luther: That is what we would like to know really. We do feel that it is an ASBO really or it is the same as. We are not going to suggest that you are going to tag mental health patients. We hope you will not. The fact is that it is very similar and that is of real concern. If you are detaining a patient and forcing them to have treatment, they should be in a therapeutic environment that can monitor that treatment very carefully. You cannot monitor carefully and closely treatment being provided at home. The other issue is that I think you also need to take the carers into account. What a dreadful position to be put in when you get this loved one back at home and they have what may, in some cases, seem unreasonable conditions put on them because of the risk element and the carer has to

ensure that those conditions are applied. I would just ask you to please get your advisers to tell you how to put a lid on it.

Q122 Lord Rix: I was going to say you are turning carers into prison warders, basically, which is absurd because they cease to become carers as such. Would this not fall foul of the present legislation in England of when is care care and when is nursing nursing if people are discharged home? Would they have to pay for their care if they had sufficient funds or would they be receiving nursing with their carers appropriate to their condition for free on the National Health Service?

Mr Marsen-Luther: I think you make a very valid point. My understanding is that while they are subject to detention, albeit at home, or to treatment at home, they will not have to pay for their care. The point that you make is a very good one.

Chairman: It is a characteristically good point by Lord Rix but it is not one you can answer. What has been said may well be right in some cases but would it not be right to say that there are going to be some cases where you will have willing carers who want to play an active part in the permanent return of their loved one to everyday life at home; and who may be far better than some clinicians at playing an active part in the care plan and its every day application? Therefore, one must have a degree of flexibility to enable it to occur in those cases. If so, is not the code of practice a useful place to incorporate this kind of potential care plan for individual patients? I merely ask as devil’s advocate, not as an expression of opinion.

Baroness Pitkeathley: Many of the carers will have been doing that for years anyway, long before the hospitalisation.

Q123 Dr Naysmith: What do you think the reason for these proposals being there is? Do you think it is perhaps, as you were suggesting a little cynically, that it will save the National Health Service money or do you think there is, as the Lord Chairman was suggesting, the potential of using it for therapeutic benefit in some situations?

Mr Marsen-Luther: Quite clearly what we have in mind is the best outcome for the patient and we absolutely acknowledge that in a lot of cases that is care at home if they can get it. What we are terribly concerned about is that at the same time in this Bill the proposals get rid of the opportunity for the nearest relative to discharge the patient if they are not a danger to themselves or others, which we have said in our submission we think is throwing out the baby with the bathwater. If you have a Bill that does that, you tend to be a little cynical when it comes to suggesting the patient should be treated at home under conditions imposed by the clinical supervisor. We absolutely acknowledge that there are many carers, many relatives, who would be delighted to have their loved ones at home and to care for them but we do think that the conditions should not just be whatever somebody chooses so that the system can be abused.
Q124 Baroness Eccles of Moulton: I have a point of clarification on the distinction between compulsion and being forced to take your medication. Presumably, if somebody has been released from hospital and is back home, in the community under a compulsion order, it is not possible for the medical staff who will be supervising that compulsory order to forcibly make the patient take medication if they refuse. Therefore, they would have to be returned to hospital. Am I correct?

Mr Marsen-Luther: You are correct but not necessarily. Under the new definition of “hospital”, it does not have to be an in-patient hospital. It could be a unit that provides services in the community. They would be taken from home, have their injection in a “hospital setting” and then be returned home possibly.

Q125 Baroness Eccles of Moulton: If they would not go willingly, they would have to be taken by force to have the forced treatment in an out-patient situation?

Mr Marsen-Luther: You are correct but not necessarily. Under the new definition of “hospital”, it does not have to be an in-patient hospital. It could be a unit that provides services in the community.

Chairman: Can we move now into what I call the minefield question, because it is exercising a large number of Members of the Committee?

Q126 Dr Naysmith: You said in your written evidence that the interplay between the different statutory and common law schemes is a potential minefield that could take years to resolve and be very expensive for health care providers. I imagine since you wrote that there have been developments. How would you integrate the draft Bill and the Mental Capacity Bill in order to avoid this minefield?

Mr Marsen-Luther: That is really a million dollar question that nobody has been before you yet has managed to answer.

Chairman: That is why we keep asking it.

Mr Marsen-Luther: We also do not have an easy answer. Obviously, we have heard the submissions that have been made et cetera. In the brief discussion that we have been able to have since seeing your questions, we very much felt that for those people who suffer from long term incapacity they should be dealt with under the Capacity Bill because we think that if you have enduring lack of capacity the Capacity Bill is a Bill, once it has been amended and beefed up to meet the HR requirements, that is the kindest way of dealing with people who lack capacity. The real minefield of course is those people who have perhaps temporary capacity problems, perhaps waiving capacity. There we think that, because of the clinical staff that you have in hospitals, perhaps the Mental Health Bill is a better place to place that form of incapacity. Having listened to the submission this morning, there are various degrees of capacity. With people who do not have a permanent capacity problem, there should be a regular review of the individual’s capacity. I think that could be much better provided under the Mental Health Bill than it could be under a Capacity Bill. I may be mistaken. We have only had a brief debate about this.

Q128 Dr Naysmith: What would you think would be the drawbacks to all patients without capacity who were being treated under the Mental Capacity Bill?

Mr Marsen-Luther: I think you are introducing elements into the Capacity Bill which have to deal with other issues than capacity. If you have various degrees of capacity, I think the Capacity Bill is to deal with a large swathe of people who have lost capacity either to control themselves or their lives or their money or whatever. That is a long term issue. As soon as you introduce short term issues into the Capacity Bill it will unnecessarily complicate it. For example, in terms of reviews, you may decide that in the Capacity Bill—and to be quite honest I have not been concentrating on that; I have been concentrating on the other 300 pages—you may have a six monthly review of somebody’s capacity, their treatment and their care plan et cetera. For people who have an intermittent capacity problem, that is not sufficient and you need very many more reviews to be built into the system.

Lord Carter: I want to make the point that I made to the previous witnesses, which I think you heard. There will not be a new Mental Health Act for probably two or three years. In that case, you will have to deal with the Mental Capacity Act from next March and the existing 1983 Mental Health Act. As parliamentarians with the Mental Capacity Bill now in front of the Commons and then the Lords, should we be looking very carefully at the relationship between that Bill and the 1983 Act to see if amendments can be made to the Mental Capacity Bill to take care of the situation until we eventually get a new Mental Health Act?

Q129 Mrs Browning: For clarification, the Mental Capacity Bill has a presumption of capacity. That presumption is based on a particular circumstance and a particular given circumstance in which a decision is made. The idea that we review every six months is not the ethos of the Mental Capacity Bill; it is that one presumes capacity and where there is fluctuating capacity or degrees of capacity it is based on the individual circumstances of a particular decision to be made at that point. When we took evidence in the draft committee stage of the Mental Capacity Bill, some of the most enthusiastic people for advance decisions were the professionals who deal with people with mental health conditions, who Lord Carter will recall, were very enthusiastic about advance decisions because they could see something that they thought would be helpful to them, for example, with a schizophrenia patient where, in their periods of capacity, they could get an advance decision from them in terms of how they would be treated during their periods of incapacity. They were really up for those advance decisions. They were the most enthusiastic group we interviewed.

Mr Marsen-Luther: To be honest, I am sure that you will come to a far better decision at the end of the day than we can offer you. I would like advance directives to be able to be made within the mental
health field and perhaps the Capacity Bill can lead the mental health field into considering that. I will watch it closely.

**Q130 Mr Hinchliffe:** You are quite critical of the proposals to get rid of the Commission and to replace its function by CHAI. Do you not feel that there could be positive advantages with the new organisation providing the funding for mental health being ring fenced, in that that organisation will be in a position to make wider links within the health service than perhaps the Commission has not done so far?

**Mr Marsen-Luther:** I hear what you say. The nub of the argument is that when you are dealing with constitutional rights is the most appropriate body to join up with a body that deals with mental health policy *et cetera*. I think that we feel very strongly that the constitutional rights of individuals, where quite clearly the power is being handed to clinicians to deal with—a lot of power—this needs to be monitored and reported on by a specialist committee. We rather fear that the Healthcare Commission or CHAI will be sending out a myriad of reports to all hospitals. This issue is one not of whether the service is good or not; this issue is about monitoring how the Mental Health Act is being implemented. It should be concentrated on monitoring the implementation of the Act. In the past, the Commission has tended to spread its wings a bit. We have looked at environmental issues *et cetera*, and I think that has, in a way, undermined the Commission albeit it has improved patients' lives. I know it from both sides of the table. When we have had Commission reports that have been very critical of the facilities, people have been told to sort it. That has been very effective in helping to improve conditions for patients that are detained and informal patients, but that is not the central issue really that the Commission is about. You are talking here about a Bill where you have got rid of the discharge rights of hospital managers, where you have got rid of the discharge rights of the nearest relative, where you have got rid of during a six month period the ability to appeal against continuing detention. What you have put in its place in this Bill is a mental health tribunal that is constrained in the decisions it can make because, so long as people meet the criteria, it has no option but to say that they should be detained in hospital or in the community. You have had numerous reports and submissions that have made it quite clear to you that the criteria that the current Bill proposes are so broad that we could all meet up one day. It is desperately important that if this Bill is going to go forward—and of course some of us think it would be better for it not to and for the 1983 Act to be amended—you do need, with all those powers vested in relatively few people, a body that has that sole purpose: to make sure that people's human rights are not being abused.

**Q131 Mr Hinchliffe:** One area where I may differ with you is that I was struck by your answer on the issue of community treatment and the pressure on beds. The worry I have about your evidence is it is very bed and hospital focused. Perhaps I would differ with you on the Commission issue in that I feel it would be very helpful if the new body took a somewhat wider view, taking account of the constitutional points that you have raised, because, if we are looking at the shortage of beds, the shortage of beds is very much in many areas down to the fact that we have failed to develop the wider services that prevent people having to come into hospital. I see from area to area very marked differences. Do you not feel there is a role there for CHAI to perhaps have that wider perspective that will enable us to develop those alternative services that we are desperately crying out for in some areas that could avoid people being put under compulsion in the first place?

**Mr Marsen-Luther:** Yes. I do not think we are poles apart because if you are looking at detained patients, what treatment they are getting and how appropriate is it for them to be detained and what outcome are we getting, we would certainly say that the Mental Health Commission body successor should be visiting proactively both in the community and in hospital. That is something that we are absolutely committed to. Currently, the Bill does not under CHAI give it sufficient rigorous powers to ensure that it can carry out, let alone its core function—which is making sure that the Act is properly applied—let alone the broader function that you wish to see. We have to be absolutely up front here. The fact is that the budget, although it has been increased recently, is still pitiful for the job it has to do. When you are considering this Bill or any future legislation, I hope that you will remember that, if people are going to have their rights taken away and they are going to be treated against their will, there must be a specific body that monitors how that is being done and the effects of it.

**Chairman:** There is something that one might view as an idiosyncrasy in your submission that Mr Loughton would like to deal with.

**Q132 Tim Loughton:** Why do you not like advocates?

**Mr Marsen-Luther:** We do.

**Q133 Tim Loughton:** Why do you not foresee a role in the Bill for them as it is laid out?

**Ms Woodcock:** In our discussions, when we received your questions, we want to make clear that we do support the introduction of an advocacy service but not in the format that is described in the draft. As it is in the draft, we think it is going to introduce a two tier level of advocacy because, as it reads at the moment, it appears that the advocacy service being suggested is about an advocate who will describe and explain to a patient their compulsion and treatment a clinician wishes to give them. If we have a situation perhaps where a patient wishes to have advocacy advice around other issues such as benefits and welfare issues, they then would have to approach a second advocate to receive such advice. We would really wish to push for a well trained, skilled, knowledgeable advocacy service that can provide an
all-encompassing service to patients so that it does not become confusing for them and they are not having to approach different advocates for different reasons. Also, if you add a potential third tier, it is the legal advocacy. Patients are appealing to tribunals. Most patients would have a solicitor or legal representative so you are then adding another person into the equation. We do support the role of advocacy very strongly, but a better service than is described in the draft Bill at the moment.

Q134 Chairman: It is an issue of organisation.

*Mr Marsen-Luther*: Yes. It is a matter of not introducing yet another tier of specialists who only deal with one thing. I think you will understand that, if you are in hospital confused and ill, the last thing you want is somebody coming along, introducing themselves as a Mental Health Act advocate, telling you what your rights are under the Bill and what is going to be done unto you, having already heard that because the managers have a responsibility to do that as well in the Bill. If they strike up a conversation and say, “Yes, but I am really worried about my cat at home” or, “Can you help me with this?” they are told “No, you must see the other advocate for that. I do not deal with that.”

Q135 Tim Loughton: You draw attention to the fact that you would need to have extensive training and considerable payment but do you not fear though that what we have at the moment is a complete fudge because we have a very patchy service of unpaid advocates who are highly street cetera? There is a suspicion that what the government is trying to do is to beef up the advocacy service in order to minimise the legal services. What we really need is a beefed up advocacy service not in place of but complementary to and it needs to be streamlined. Certainly we are not going to get that on the numbers of 130 which the Government seem to think as additional advocates will sort the whole system out. In principle, you would be in favour of a proper advocacy service, properly streamlined, properly trained and resourced, but not one that is going to fill the boots of all the huge legal aid bills which the government seems to have turned its face against?

*Mr Marsen-Luther*: Absolutely. We see some really excellent advocacy services when we go around visiting hospitals with the Commission hat on. There are some very good services and those should be there right across the board, as far as mental health services are concerned. There should be more training for them. There should be more funding for them. The problem that we really had with this Mental Health Act advocate was that it was traded as one of the safeguards for patients. Having got rid of hospital managers, quite clearly the thought was, “We had better put something else in their place so we will give them Mental Health Act advocates.” I am terribly sorry but I would have to describe that as a joke because it offers no safeguard at all, being told what people can do unto you. The safeguard is when you can test what is being done unto you in front of people who can do something about it. At the moment, the Bill has nothing in it that gives people a proper counter balance to the authority that is being given to the MHTs and clinical supervisors.

Q136 Lord Carter: Do you see any problem in the potential overlap between what I would call the informal advocate, because often carers do a great deal of advocacy on behalf of the patient, and the formal advocate? In your experience, do you see overlap and confusion there?

*Mr Marsen-Luther*: Sometimes. I think advocacy is desperately important. In a lot of cases, advocacy is run by ex-patients and who knows better what hell people have to go through sometimes than the patients themselves. I am a great supporter of it. I think it is very important that we have a proper advocacy service. Picking up on the point that you make, we have in this Bill a situation where, at an MHT hearing, you could get the patient, a nominated person, a separate carer, an IMHAA, or independent Mental Health Act advocate, and of course you can get a solicitor there as well. You imagine if those people are of different opinions what sort of a bun fight you are going to have at that MHT. What are people thinking of here? Central to all this is the patient.

Q137 Mrs Blackman: In this more unified concept that you have of advocacy, do you think the Bill has it right in terms of when advocacy becomes available to the patient or do you think it should come in earlier? I am thinking of people particularly with ASD who have social and communication disorders, who would need that kind of support much earlier in the process, as would other patients.

*Mr Marsen-Luther*: I would bring you back to one of the things that have been thrown out of the 1983 Act and that is the nearest relative. Currently, a mountain is being made out of a molehill, getting some remedial action to make sure that the nearest relative continues to have a say, or another person where the nearest relative is not appropriate, in whether detention under those circumstances is right. I think somebody needs to come in before the detention is issued. Of course, under the current legislation, that takes place. The nearest relative has to be contacted as far as possible before somebody gets detained and I think that is something that you will want to think about very carefully in terms of the way the process works currently, because the fact is we all know that you are going to get a lot of calls requesting assessments. Then you are going to get a lot of assessments that may be made on people who are at a very excitable stage but not necessarily mentally disordered. When the assessors come along, you are going to find that they will flip their lid and get even more excited and be called psychotic. I think it is very important that there is some person who comes in between that process beforehand.

*Lord Mayhew of Twysden*: Have you any comment on the reliability or otherwise of the estimate that 140 additional advocates will be required?

Chairman: Before you answer that question, there is a broader, different resource question that Lady Eccles wanted to ask.
Q138 Baroness Eccles of Moulton: This is very relevant to your description of tribunal hearings because it seems that the number of people who would be involved and the number of tribunals that would have to be held within 28 days—do you have an idea about how that would be humanly possible depending particularly on the number of highly skilled, qualified people who will be called upon? We have been given statistics about the increase in the number of people who would be needed to carry out these functions.

Ms Scudamore: The Department of Health’s estimate in 1982 was that the tribunals would all be heard within four weeks of the date of the application and there would be 2,000 tribunals a year. From the evidence that we have from our members, it suggests that the figure would be much higher than this. That is a very conservative estimate because it is unknown. Because the definition of mental disorder has been widened by the Bill, the number of extra people who might be detained under the new Act would be probably a lot larger than it is now. The number of people who would be on community orders is also an unknown number. Possibly, there might be an increase in people that come under the Bournewood definition, detained under the Act. The number of hearings that could be taking place would be far higher than the Department of Health estimates.

Q139 Chairman: To pick up the Department of Health’s figure for the need for 59% more administrative staff for the tribunals, it is a very raw figure and it may conceal a number of rather important issues. Do you agree that not only should there be a sufficient number of staff but that they should be permanent, which does not necessarily mean full time, properly trained, knowledgeable and capable of servicing the tribunals so that the tribunals do the decision making which is becoming much more complex under these proposals, and not be burdened by administration themselves? I think it is a common complaint of those who sit on mental health review tribunals—and I can tell you it was the cause of my resignation as a part time chairman—that the administrative arrangements were unsatisfactory, putting it at its lowest, for busy people who were trying to fulfill the role of sitting on the tribunals but really could not cope with managing them as well.

Ms Scudamore: I agree completely with you. It is not only the tribunal that is disadvantaged in not having clerks and administrators to help them. It is also the trusts. Mental Health Act administrators are also disadvantaged because they are the ones who have to stand down from what they should be doing in order to assist the tribunals. Just recently this has become a lot worse and it is going to need a hell of a lot more resources and recruitment to bring it back up to a good standard again.

Mr Marsen-Luther: If you are intending or if you were to succeed in getting hospital administrators or Mental Health Act administrators to clerk—

Q140 Chairman: I am going to express an opinion. I think there is too great a potential conflict of interest involved in that. I have been told frequently by hospital Mental Health Act administrators that they regard it as a very major conflict of interest potentially.

Mr Marsen-Luther: That is why I was coming in there. Clearly, vast resources will be needed to make sure that the system works. You will need very many more Mental Health Act administrators to deal with the paperwork that is created by this massive increase in tribunals. That has some major implications, not only from a person power point of view—I just managed to slip that in—but also from the point of view of suitable accommodation which unfortunately MHRTs do not get in a lot of hospitals. I think the 140 is a gross underestimate.

Chairman: Thank you very much for giving your evidence so clearly to us. We are very grateful.

Supplementary memorandum from Institute of Mental Health Act Practitioners (IMHAP) (DMH 410)

There were a number of questions put to the panel that we were not able to cover on the 27 October to which we now wish to submit our response for consideration. We have also included a few lines of clarification on questions that were put but where on inspection of the proceedings on the day we thought it might be helpful to add a few sentences.

PERSONS IN CRIMINAL PROCEEDINGS

Question 6. In your written evidence you express concern that the conditions for longer term compulsory treatment under the provisions in Part 3 (at clause 116) for offenders are much laxer than those in Part 2 (at clause 9) for civil patients. Would you like the conditions in Part 3 to be tightened up? And, if so, how?

Answer

We are of the view that the criteria for detention and treatment under mental health legislation should be the same for Part 2 and Part 3.

We do not think that the deprivation of an individual’s liberty and self determination under mental health legislation should be purely determined by whether they are perceived to pose a possible risk to themselves or others if they are Part 3 patients.
We would welcome the exclusions to be inserted in the new Bill as well as the treatability clause so as to avoid patients without a mental health problem being detained indefinitely purely on the basis that they pose a risk to society although they were not availing themselves of the treatment that was available.

**Powers of Hospital Managers**

We would like to reiterate our concern at the withdrawal of the power of discharge from hospital managers. Hospital managers have an excellent record in terms of risk regarding their ability to discharge detained patients when compared to consultants or patients’ responsible medical officers and Mental Health Review Tribunals. Lay people have played an active role in the British justice system as magistrates without being denigrated for their “non-professionalism”.

Recruiting quality people to carry out a hospital manager’s function without offering them any authoritative role is going to be nigh impossible. It is also going to undermine their authority to a point where under the current proposals in the Bill they will become ineffectual in carrying out their role of ensuring that the Act is properly applied.

We would urge great caution on the Committee in agreeing to abandon the role that hospital managers play in the 1983 Act because there have been some areas where management has not invested in their training sufficiently to enable them to be fully effective. Where hospital managers have been given proper support and training hospitals have generally performed better in terms of applying the Code of Practice and good practice in the way the Act has been implemented.

**Mental Health Act Commission**

We were asked why we did not support the integration of the new Mental Health Act Commission functions into the Healthcare Commission. It was suggested that this might help to bring Mental Health Care into the mainstream of Healthcare.

We would like to take this opportunity of stating once again why we are opposed to this suggestion and the newly perceived role in the proposed Bill.

Firstly, we would wish to point out that the Healthcare Commission already has a remit to review Mental Health providers/provision. The Healthcare Commission has singularly failed to have a major impact on mental health services or on bringing these into the mainstream of healthcare. The relatively minute addition to its budget of the inclusion of the Mental Health Act Commission will not have any real impact that could bring this change about.

However, more importantly the primary purpose of the Mental Health Act Commission is to safeguard patients who are detained under Mental Health Act legislation. The legislation is draconian in terms of the patients who are subject to it for reason of mental illness. To find oneself locked up and subject to being medicated against ones own wishes because one is unfortunate to be suffering from mental illness is a situation that requires monitoring by a special independent body or specialist Commission whose sole function is to ensure that the law is being properly and appropriately applied. This Commission should be made up of people who have the training and experience to carry out that very specific duty.

People, members of the public, who may be subject to this Act, would expect legislators to ensure that they have a right of appeal against their detention, but also a body that ensures that if they are to be detained that this is done legally and the powers that go with the detention are being used appropriately.

This is not an issue about bringing mental healthcare into the mainstream of health provision which is a political or financial prerogative. This is an issue of legislators ensuring that if they are going to pass draconian laws that safeguards are built in to ensure that people that may need to be detained under those laws are given all the appropriate safeguards that parliament can provide.

Please ensure that there is a specialist Commission whose sole function is to monitor the application of the Act on individuals who are detained and who are able to report on its application biennially, preferably to the Legislature.
Question 7. You argue that the assessment period before the first review of detention by a tribunal should be extended from 28 days to six weeks. Would this not serve simply to make life easier for managers at the cost of patients’ rights and safeguards?

Answer

No. This suggestion arises from the fact that if you consider the implications of the current proposals then you will end up with generic care plans which will include treatment orders that have not been finalised and which patients have had a minimal if any input into.

It has taken the best part of 20 years for RMOs to adhere to consent to treatment regulations and the guidance in the Code of Practice. These are aimed at ensuring that every effort is made to empower patients to become involved in their treatment plans so that on discharge they have ownership of them and are less inclined to abandon their medication. The current proposals give little time for this process to start before the MHT imposes the clinical supervisors’ care plan, including medication on the patient. In many cases this will result in disempowering patients which will be a retrogressive step rather than a step forward.

The patient has the ability to appeal against their detention during the period of assessment and we do not propose to take this away. We would prefer to see this right of appeal being one which is based, as at present, on an appeal against detention for assessment only and not an appeal against detention for assessment that can result in a patient being detained for treatment before the assessment period has been completed. The latter is the case with the current Bill and this is a deprivation of patients’ safeguards rather than our proposal.

If the new MHT are not to become a rubber stamping exercise then they must be presented with individually tailored care plans that demonstrate an engagement with the patient and their nominated person or carer. The proposed Bill does not allow sufficient time to provide the MHT with a meaningful care and treatment plan. The Institute’s members are all too aware of the adverse effect that the abandonment of the current Consent to Treatment regulations and a hastily completed Care Plan and treatment orders will have on patient care outcomes.

So we would wish to stress once again that our primary concern with the current proposals are that they will have an adverse effect on patient empowerment and the inclusive care plan creation that during the last 10 years has been taken on board by an increasing number of care teams.

We are also acutely aware that the current proposals for the MHT to be held after three weeks, in week 4, will result in a dramatic increase in MHT hearings. This will not only result in a chaotic situation, with possibly patients having to be released because hearings do not go ahead and this in turn putting them at risk, but also in countless appeals to the AMHT or judicial reviews where hearings are held that do not have the required expert panels to advise the Tribunals, etc.

We would ask the Committee to take the opportunity of giving patients better safeguards by allowing patients to appeal against their assessment orders without fear of being prematurely detained for treatment on an order lasting up to six months. We would also ask the Committee to take the opportunity of ensuring that the care plans and treatment orders should demonstrate real attempts at patient engagement and empowerment and be sufficiently detailed to have more than generic language which means that all too often the clinical supervisor chooses what it is to mean without the due consultation with the patient to ensure that ownership of the care plan is with the patient whenever possible. This does, however mean that in the majority of cases extra time is needed for a meaningful and worthwhile process to be completed.

The Committee has received a number of representations suggesting that the current MHT proposals will lead to a “system overload” and we would suggest that where there is an extension of two weeks prior to the MHT hearing taking place that this will significantly reduce the MHT hearings that will take place and thereby enable the new proposals for the MHT to be implemented.

We hope to be able to provide some more evidence for the Committee by the end of January but give you the following figures as an example taken from one large psychiatric unit during a three month period last year.

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons detained under the Act during the three months</td>
<td>340</td>
</tr>
<tr>
<td>Number of the above patients detained after four weeks</td>
<td>174</td>
</tr>
<tr>
<td>Number of the above patients detained after six weeks</td>
<td>104</td>
</tr>
<tr>
<td>Number of appeals heard during the same three month period</td>
<td>50</td>
</tr>
</tbody>
</table>
RESOURCES

Question 8. In your written evidence you estimate that the number of tribunal hearings will quadruple and at least double the current number of administrative staff will be required. These estimates are significantly in advance of those calculated by the Department of Health who calculate a likely increase in tribunal hearings of 84% and a need for 59% more administrative staff. Why should we believe your figures?

We refer you to the example given above and have received many comments from members about the implications that the new Bill would have on administrative staffing. Our estimates are lower than most of our members have suggested because we have decided to err on the cautious side.

(i) Currently no more than a third of patients at the most apply to the MHRT. In future we will need to notify the MHT of every person detained within a short space of time to enable the Secretariat to make the necessary arrangements for the MHT Panel and the Specialist advisers required for the panel, there is a proposal that the specialist panels will reflect the needs of the patient whose care plan is to be reviewed and if MHTs are to have more than one hearing this may involve a different make up of the panels advising the MHT.

(ii) Administrative staff will have to log all requests for assessments to ensure that they are dealt with within the required time frames.

(iii) Administration will have to log all changes of Clinical Supervisors of which there may be quite a few as patients requiring medication will have to have this prescribed by a medically qualified Clinical Supervisor.

(iv) All movements between assessment in the community and in hospital will have to be logged and monitored.

(v) All uses of the Act will have to be notified and this is not a current requirement.

(vi) There will be many more cancellations to notify to the MHT.

(vii) There will be far more work involved in ensuring that all the reports required for the MHT are available because these will have to be produced in a shorter time frame.

(viii) There will be an increase in the administration of requests for patients’ notes if the Statutory Advocates are to have sight of these.

(ix) The current proposals for sharing of information will need some form of monitoring that will most likely require some administrative guidance and monitoring.

(x) This is a complex Bill that will lead to many questions being raised and these are normally dealt with by the MHA administration team. Consultation requirements will in many cases lead to additional workload for the administrative staff to ensure that this can be effectively pursued.

Wales

Question 9. Will the provisions of the draft Bill place a heavier burden on your members in Wales, and if so, in what respects?

Welsh members of the Institute have real concerns over the following issues:

Problems arising from the introduction of a Community Care based Bill

The development of Community Services in Wales is at its infancy with many areas not having the Community Mental Health Teams and certainly not the Assertive Outreach or Crisis Intervention Teams that the Bill will rely on for its implementation. Urgent pump prime funding will be needed if these services are to be established in the relatively short space of time left before implementation.

Geographical Issues

(a) The anticipated increase in the numbers of hearings will cause difficulties in the more remote parts of Wales outside of the major cities. It may be difficult to obtain sufficient tribunal psychiatrists, presidents or lay members prepared to attend rural venues at relatively short notice.

(b) Detained patients should, if so desired, have access to or be represented by a solicitor who is also a member of the Law Society’s Mental Health Review Tribunal Panel. Should there be more tribunals, more specialist solicitors would be required. Supply of legal services is controlled by the Legal Services Commission which grants contracts to solicitors and not for profit agencies to carry out publicly funded work under the Controlled Legal Representation Scheme. Unless implementation is prepared for well in advance and sufficient resources used to increase solicitors’ Legal Services Commission contracts to carry out mental health work, there may be a shortage of solicitors which could lead to repeated tribunal adjournments, particularly in rural areas or locations where large numbers of tribunals are anticipated.
Cultural and Linguistic Issues

(a) Given the likely increase in the number of tribunals, there may be a corresponding rise in the numbers of patients who choose or prefer their hearing to take place through the medium of Welsh. This would have cost implications as additional interpreters would be required because a patient may seek a Welsh-medium hearing in any part of Wales including such areas where few if any of the tribunal members or expert witnesses are conversant in the language. Guidance should be taken from the Welsh Language Board as an appropriate Welsh Language Policy may need to be devised and/or amended in accordance with the Welsh Language Act.

The new MHT Secretariat

In a post-devolution society, there may be political sensitivities should the bureaucracy of the proposed Mental Health Tribunals continue to be administered almost exclusively in London.

Revisit to the Question regarding the Integration of the MHAC role into CHAI or the Healthcare Commission (Question 130 on transcript)

The discussion around our contention that the MHAC role was a specialist role that was there to protect patients who had had their constitutional rights taken away. That this was too important for that function to be subsumed by a very large general healthcare inspectorate purely for reasons of efficiency. There was a suggestion that Mental Health Services might benefit from the MHAC being taken into this generic Healthcare Commission and indeed that this might help to reduce the stigma attached to mental health services. We would wish to make the point that the Healthcare Commission already have the inspection of Mental Health Services as part of their remit and unfortunately no benefit of this nature has accrued as a result of this.

Revisit to Question 5 on Advocacy

We are concerned to stress that we do not wish to undermine the development of advocacy services that have developed patient empowerment greatly over the past 10 years.

We are more concerned to highlight the inadequacy of the safeguards offered under the new Bill compared to the 1983 Act. We therefore attach Appendix A to highlight the imbalance of safeguards to enable discharge from section in the new Bill as compared to the current Mental Health Act 1983.
MENTAL HEALTH ACT 1983 AND MENTAL HEALTH BILL 2004 CIVIL DETENTION ORDERS

<table>
<thead>
<tr>
<th>Mental Health Act 1983</th>
<th>Safeguards/Discharge</th>
<th>Mental Health Bill 2004</th>
<th>Safeguards/Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Point of entry</strong></td>
<td>Nearest Relative</td>
<td><strong>Point of entry</strong></td>
<td>MHT*</td>
</tr>
<tr>
<td>Section 2</td>
<td>Hospital Managers</td>
<td>Assessment Order Hospital</td>
<td>Clinical Supervisor</td>
</tr>
<tr>
<td>Up to 28 day assessment and treatment order</td>
<td>MHRT</td>
<td>Assessment Order Community</td>
<td>Statutory MHA Advocacy</td>
</tr>
<tr>
<td></td>
<td>RMO</td>
<td>Both last up to 28 days</td>
<td>Free Legal Assistant</td>
</tr>
<tr>
<td></td>
<td>Advocacy</td>
<td>Treatment only in emergency</td>
<td>Care Plans</td>
</tr>
<tr>
<td></td>
<td>Free Legal Assistant on Appeal</td>
<td></td>
<td>Nominated Person</td>
</tr>
<tr>
<td></td>
<td>Care Plans</td>
<td></td>
<td>Carer</td>
</tr>
<tr>
<td></td>
<td>MHAC***</td>
<td></td>
<td>CHAI*** or Healthcare Commission</td>
</tr>
</tbody>
</table>

**Treatment Order**

| After 28 days continuing detention for | Nearest Relative | After 28 Days an MHT will determine whether the patient should be placed on a treatment order in hospital or the Community |
| Treatment is possible under Section 3 | Hospital Managers | The Clinical supervisor has the power to recall the patient to hospital whenever he chooses and vice versa |
|                                          | MHRT                | |
|                                          | RMO                 | |
|                                          | SOAD                | |
|                                          | **Section 117 Aftercare** | |
|                                          | Advocacy            | |
|                                          | Free Legal Assistant | |
|                                          | Care Plans          | |
|                                          | MHAC***             | |

**Notes:**

*Safeguards in bold indicate those safeguards that can lead to patients being taken off section*

*Safeguards that are in bold italics are those that have statutory force. The SOAD can refuse to agree a proposed treatment plan, Section 117 is a statutory requirement on authorities to provide aftercare services*

*Safeguards in italics only indicate those safeguards that have no statutory force and are therefore consultation or representation only where practicable*

* Patients can apply to the MHT once only and may as a result of their appeal find themselves on a treatment order which is not possible under the 1983 Act*

** Once a Treatment Order has been imposed patients can only appeal to the MHAT on a legal technicality or their detention will be reviewed by the MHT at the end of the order. Under the 83 Act they can appeal once at any time during their treatment order. Patients can apply to Hospital Managers as often as they like*

*** The MHAC is a specialist body that monitors the application of the MHA and looks after the interests of detained patients. CHAI or the Healthcare Commission is a generic health service inspectorate that already has Mental Health Services within its remit*
Wednesday 3 November 2004

Members present:

Barker, B
Carlile of Berriew, L (Chairman)
Carter, L
Cumberlege, B
Finlay of Llandaff, B
Flather, B
Mayhew of Twysden, L
McIntosh of Hudnall, B
Pitkeathley, B
Rix, L
Turnberg, L

Mrs Liz Blackman
Mrs Angela Browning
Mr David Hinchliffe
Mr George Howarth
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Mr Gwyn Prosser
Dr Howard Stoate
Hywel Williams

Memorandum from the Mental Health Alliance (DMH 105)

Part 1

GENERAL COMMENTS

ROLE AND SCOPE OF THE MENTAL HEALTH ALLIANCE

1.1 The Mental Health Alliance consists of 32 core and 34 associate members. It is a unique alliance of user groups, psychiatrists, social workers, nurses, psychologists, lawyers, voluntary associations, research bodies and carers’ associations. The core members are: Mind; Rethink severe mental illness; Macau; Royal College of Psychiatrists; Mental Health Foundation; Turning Point; King’s Fund; Sainsbury Centre for Mental Health; Young Minds; Afiya Trust; AWAAZ (Manchester); British Association of Social Workers; British Psychological Society; the College of Occupational Therapists; the Critical Psychiatry Network; Ethnic Health Forum North West; GLAD; the Manic Depression Fellowship; Mental Health Nurses Association; the National Autistic Society; POPAN (Prevention of Professional Abuse Network); Revolving Doors; the Richmond Fellowship; Royal College of Nursing; SANE; SIRI; UKAN (UK Advocacy Network); the UK Federation of Smaller Mental Health Agencies; UNISON; United Response; US Net; Voices Forum.

1.2 Associate members include the British Medical Association, the Law Society, NHS Confederation and Justice.1

1.3 The Mental Health Alliance formed in 1999, solely for the purpose of working for improved legislation, following the Government’s response to the Expert Committee’s Report of the Review of the Mental Health Act 1983 (the Expert Committee Report). Since then the Alliance has responded to the consultations on the White Paper and the 2002 Draft Bill and developed its own policies on key areas of reform of the 1993 Act. Our sub-committees have produced 16 position papers which form the backbone of our submission, some of which provide extra information on the issues we raise.2 We will provide these for the Committee separately.

1.4 The degree of consensus among the different professional sectors and between the professionals and service users who make up the Alliance has been surprising and reinforced our belief that we have found, in broad terms, the way forward. Many of the recommendations of the Expert Committee, the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003 (hereafter the Scottish Mental Health Act), together with laws from other common law jurisdictions, tend in the same direction. It would be hard to imagine how legislation could work better than through such widespread consensus.

1.5 In essence our agreement over details of the Bill derives from a shared belief in the values that should underpin such a law (which we state as our general principles). The Alliance is united in its belief that based on these values, humane and effective mental health legislation for the 21st century is achievable. We welcome the opportunity to present these proposals to the Joint Scrutiny Committee.

---

1 African Caribbean Community Initiatives (ACCI); Age Concern England; Alcohol Concern; AWETU; The British Deaf Association; British Medical Association; Carers’ UK; Church of England Mission and Public Affairs Council; Confederation of Indian Organisations; Democratic Health Network; Depression Alliance; Drugscope; Footprints UK; Greater London Mental Health Advocacy Network; Hafak; Having a Voice Ltd; Homeless Link; JAMI; Justice; Kente; Law Society; Mencap; NHS Confederation; Race on the Agenda; RADAR; Refugee Action; Royal College of GPs; Sign; Social Action for Health; Somali Mental Health Project; Supporting Carers Better Network; UK College of Psychotherapists; West Dorset Mental Health Forum; WISH.

2 The papers cover the following issues: definitions; conditions and exclusions; advance directives; community treatment; treatment safeguards; advocates; nominated persons; carers; criminal justice provisions and police powers; Tribunals; children and young people; continuity of care; rights to assessment; special users perspectives; black and minority ethnic views.
BACKGROUND TO THIS SUBMISSION

1.6 We welcome Government policy initiatives through the National Service Frameworks, the Choice agenda and anti-stigma campaigns. We also welcome positive developments for mental health patients in service delivery. There are also new horizons in psychiatric and psychological practice, healthcare programmes, user action and legal rights.

1.7 Nevertheless, mental health patients continue to be poorly served within the NHS and by community care. Mental health service funding has undoubtedly increased in recent years, but below the rate for the rest of the NHS. Mental health care is difficult to access and highly stigmatised. People are frequently turned away when seeking help in the early stages only to become so ill that compulsory treatment is considered. Those developing a psychosis typically get no specialised help until 12–18 months after clear signs and symptoms. Those developing more common mental health problems may get no specialist help at all. As a result it is likely that a patients’ first experience of specialist help will be under compulsory powers—a traumatic experience that may poison relationships with the professionals s/he depends on for care. Follow up care for those admitted to psychiatric hospitals is patchy and inadequate. The existence of powers to compel individuals to accept treatment against their will without matching powers to secure the help they need has distorted mental health care. A new Mental Health Bill should tackle this problem but the Bill as presently drafted will compound it and, rather than supporting the positive developments in policy and practice, will set them back.

1.8 Stigma against people with mental health problems in society has increased rather than declined. The current 1983 Act reinforces discrimination against people experiencing mental ill health through its failure to address the issue of capacity. The Department of Health’s study of public attitudes to people with mental illness found that “levels of fear and intolerance of people with mental illness have tended to increase since 1993” and particularly that “attitudes towards people with mental illness . . . have become less positive between 2000 and 2003” The Social Exclusion Report found stigma to be the biggest problem people with mental health problems face as a group. This Bill will do nothing to redress this problem. We are particularly disturbed by the over-emphasis in the Bill on protection of the public from “dangerous” people and the disastrous impact this will have on those people it targets and on the vast majority of mental health patients who pose no danger to anyone.

1.9 It is clear from our membership that the new law does not have the support of the people who will use it, both as patients and as professionals. It is in danger of diverting even more resources into compulsory care at the expense of voluntary patients and of setting up new structures in place of those in the 1983 Act that may be of little real value. Above all it is likely that the aim of health legislation to improve the lives of people with mental health problems will be jeopardized by those parts of the law that remain stigmatising and overly coercive.

1.10 Vacancy rates for the full range of mental health professionals remain a major cause for concern. Mental health service funding has undoubtedly increased in recent years, but below the rate for the rest of the NHS. Many of the pressures on Mental Health Trust spending are caused by staff shortages. Some Trusts are spending millions of pounds each year on bank and agency staff. Imposing a Bill that entails considerable extra work on health professionals for a system that is already experiencing acute staff shortages and funding problems risks causing major problems in the system. Additional pressures on staffing would be felt if the new Act did not enjoy the confidence or support of staff. If the Act contradicts professional ethics or damages working relationships it is likely to result in high staff turnover and a significant loss of experienced workers.

1.11 In view of the fundamental nature of our proposals for change and of the different context brought about by the Mental Capacity Bill the question arises whether this Bill can be salvaged. This is not a question that we believe it is our place to answer. However, in order to implement the changes we propose, a different Bill which is closer to the Expert Committee Report, the Scottish Mental Health Act or significant amendments to the 1983 Act may be options. The Scrutiny Committee may wish the Government to consider these alternatives.

1.12 Many of our members will be making individual submissions to the Joint Scrutiny Committee but will also have participated in this submission. In order to prevent duplication we will, where relevant, cross refer to those submissions.

---

3 Page 73, Paragraph 6.37.
5 The Government’s own figures (which measure three-month vacancy rates) show rates of 11.5% in psychology, 3% nursing, 5% allied health professionals (including occupational therapists), 6–9% (adult) social workers and between 3 and 9% in psychiatry.
6 In 2003–04, the NHS received a real-terms increase of 5%, while for mental health care the figure was just 1.6% (SCMH 2003 Money for Mental Health).
Caveat

1.13 The Bill is complex and unduly complicated in its drafting. The Explanatory Notes do not greatly assist its understanding and in places are misleading. Even with the help of the lawyers amongst us we cannot rule out the possibility that we have misinterpreted some of the detailed provisions. We believe this also raises an issue of principle—that a law which is inaccessible is also unworkable.

Positive Aspects of the 2004 Bill

1.14 We welcome in broad terms the following aspects of the new Bill, which are improvements on the 1983 Act:

— The provision for advocates;
— The role of the Mental Health Tribunal and the provision for an Appeal Tribunal;
— The single assessment process for civil patients;
— The ability to appoint a “nominated person” (but not its reduced role);
— Improvements to treatment safeguards for patients undergoing ECT;
— Special provisions for children and young people;
— Enhanced powers in the criminal courts to acquire mental health reports;
— The duty to consult the patient where appropriate.

1.15 In Parts 2 to 14 of this submission, the Alliance will provide its response to the specific questions asked by the Scrutiny Committee in its call for written evidence, and highlights recommendations for amendments where we feel they are necessary. These recommendations are summarised below. The headings correspond to the Parts of the main text from which they are taken for ease of reference.

SUMMARY OF RECOMMENDATIONS

Part 2

GENERAL PRINCIPLES

There should be a statement of general principles on the face of the Bill. These should include:

(a) Respect for autonomy;
(b) Wherever possible care, treatment and support should be provided without recourse to compulsion (compulsion as the last resort);
(c) Reciprocity—where society imposes an obligation on an individual to comply with a programme of treatment and care it should impose a parallel obligation on health and social care authorities to provide appropriate services, including aftercare;
(d) Non-discrimination—where possible the principles governing mental health care should be the same as those which govern physical health;
(e) A holistic approach—the approach to care and treatment and support in mental health should be holistic, incorporating a service user’s social care needs as well as medical treatment;
(f) Equality—all powers under the Act should be exercised without discrimination on grounds of race, age, gender, sexual orientation, religion and disability;
(g) Respect for diversity—in particular service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse cultural and religious backgrounds;
(h) Least restrictive alternative—treatment should be provided in the “least invasive” manner as well as in the least restrictive manner and the least restrictive environment, compatible with the delivery of safe and effective care and the safety of other patients, carers and staff.

Part 3

DEFINITION OF MENTAL DISORDER

1. Reinstatement the exclusion clause in the 1983 Act to make clear that:

(a) a diagnosis of substance or alcohol abuse or sexual behaviour does not preclude an additional diagnosis of mental disorder, even if the primary diagnosis is the former.

(b) a person shall not be considered as suffering from mental disorder solely on the grounds of the commission, or likely commission, of illegal or disorderly acts.

2. The impact of the definition on people with learning difficulties needs to be examined to ensure they are not adversely affected by the Bill.
Part 4

CONDITIONS FOR COMPULSION

1. The conditions for compulsion should include:
   (a) requirement of assessment in hospital;
   (b) the need to show that the person has impaired decision-making capacity in relation to treatment;
   (c) the need to show that compulsion is necessary to effect treatment in all cases;
   (d) In relation to a treatment order that there be a therapeutic benefit for the patient, where therapeutic benefit means medical treatment which is likely to bring about an “improvement in the symptoms, or signs, of mental disorder, or reduce or prevent deterioration in the person’s mental or physical health;”
   (e) The need to prove that the protection of others is from “serious harm”; and
   (f) Discretion in the decision-makers (including the Tribunal) over whether to admit a patient who meets the conditions.

2. The conditions for assessment or care and treatment orders for Part III patients should include the same threshold of risk as for Part II patients.

Part 5

ASSESSMENT AND TREATMENT IN THE COMMUNITY

1. The Government should abandon its current approach to non-resident status and non-resident orders (NROs).

2. Any form of compulsory order in the community should require narrower conditions for compulsion, be of a finite time and only as ordered by Tribunal when particular criteria are satisfied. These are:
   — A history of several previous admissions within a short period of time;
   — Impaired decision-making;
   — Demonstrated capability of community services to deliver;
   — That if there was no order, the person’s condition would deteriorate; and
   — Capability of the patient to undertake the treatment and supervision required, taking into account his personal circumstances.

Part 6

PUBLIC SAFETY

Provisions for high-risk offenders should be dealt with in separate criminal legislation.

Part 7

OMISSIONS

1. Right to an Assessment for the Provision of Mental Health Service

   There should be a duty on local authorities to provide assessments of need, leading to statements of health and social service provision to meet that need, similar to the rights accorded in Part 2 of the Bill for patients preparing for discharge or being discharged from compulsory treatment. Such assessments and statements would be provided on establishing a threshold of presenting need and should apply equally to children and young people.

2. Patients Subject to Formal Examination

   The Bill should make provision for the following situations:
   1. Where, on examination, a patient does not meet all of the relevant conditions described in Clause 9, the Approved Mental Health Professional must consider a referral of the patient for an assessment of health and social service need or alternatively, make a determination to refer the patient to the Community Mental Health Team or the tier 3 team with reference to children and young people.
   2. Where a determination is made on examination to carry out an assessment under clauses 22 to 33, the care plan made under clause 31 shall include information stating:
      — what services in the community the patient will need to support his recovery, if the relevant conditions are not met; or
— whether services provided by the relevant local authority and the appropriate authority would secure that the patient could receive treatment in the community other than by order of the Tribunal.

3. Nominated Persons

Appointment of the Nominated Person

Three criteria are needed:
1. that the person chosen by the patient to be the nominated person is willing to perform the function,
2. that that person has capacity, as defined in the Mental Capacity Bill 2004; and
3. that a person who is not related or connected to the person need not be appointed (see section on children under Rights and Powers section).

Timetable for Appointment of the Nominated Person

1. The nominated person should have a role where possible at the examination stage.
2. The appointment should not lapse on discharge.
3. The patient should be able to revoke the appointment.

Rights and Powers of the Nominated Person

1. The nominated person should have:
   (a) a right to apply for an assessment of the patient and a right to written reasons for a failure to detain; as in section 11 of the 1983 Act;
   (b) right to block an admission to hospital; and
   (c) power to make an order for a discharge, subject to 72 hours notice.
2. The roles of nominated person and advocate should be stated in primary legislation or the Code of Practice.

4. Continuation of Care

1. On the principle of reciprocity there should be a duty on authorities to provide free aftercare in accordance with need as at present.
2. The six week limit to not charging for any post-discharge care should be removed.

5. Advance Statements

1. The Code of Practice should place an obligation on the clinical team to discuss advance statements with the patient prior to discharge and to give help with their preparation.
2. Duties to consult the advance statements should be put in the Bill and should be available for the Tribunal.
3. Advance refusals should have the same status for compulsory as for informal patients except where, in the clinical view, imminent danger to the person or another makes it necessary for it to be over-ridden. In this situation the professional should be required to consider all alternatives and, in recording reasons for overriding the advance refusal, indicate why alternatives have been rejected.
4. The Tribunal should have the same power to over-ride an advance refusal but should record their reasons for so doing.

Part 8

INSTITUTIONAL FRAMEWORK

1. Advocacy

1. Advocates should, where practicable, be available to all patients subject to formal examination as soon as possible after the examination begins.
2. Advocates should be available to people held in a place of safety.
2. THE TRIBUNAL

Each Mental Health Tribunal should comprise:
1. a legally qualified member;
2. a member with experience of providing mental health services, but not necessarily a doctor, NB Panels of Tribunals for an area should include doctors but will, in any case, be advised by an independent doctor from the proposed Expert Panel;
3. a lay member, who may be a person who has experienced mental illness, an informal carer or someone who represents their interests; and
4. a children’s professional where the patient is a child or young person.

3. CARE PLANS

The care plan should be comprehensive including all treatments and relevant social issues.

Part 9

SAFEGUARDS

1. CHILDREN AND YOUNG PEOPLE ADMITTED TO ADULT PSYCHIATRIC WARDS

1. There should be a duty on health authorities to provide age-appropriate accommodation for under-18s subject to the Bill or needing in-patient treatment.
2. Wherever young people are admitted to adult wards the law should require the clinical supervisor to obtain advice from a children’s clinical specialist.

2. EDUCATIONAL AND FAMILY NEEDS

Care plan provisions need to cover educational needs, both under compulsion and for qualifying children. In section 31 (3) and (slightly adjusted) 210 (8) on care plans, the “required information” should include:
1. if the patient is a child, a description of what is to be provided to meet his educational needs (unless the child has already left education, other than because of his mental health)
2. if the patient is a child or has parental responsibility, a description of what is to be provided, if anything, to meet his family needs.

3. PATIENTS IN THE CRIMINAL JUSTICE SYSTEM

Treatment under compulsion

1. The criteria for compulsory treatment of an accused person and a convicted person should mirror those available under the civil system. There should be a right of access to a nominated person and an advocate and the patient should be consulted in drawing up the care plan.
2. In principle criminal courts should not be able to make care and treatment orders. These should, in all cases, be made by a Mental Health Tribunal.

Police powers

The police power to detain a person without warrant should not be extended to private property.

Part 10

SAFEGUARDS AGAINST MISUSE OF AGGRESSIVE PROCEDURES

1. PSYCHOSURGERY

Exclude the provision for allowing psychosurgery by High Court order from the Bill, and maintain the current safeguards in the 1983 Act.
2. **Electroconvulsive Therapy (ECT)**

1. ECT should be given only with informed consent for people with capacity to give or withhold consent.
2. The emergency criteria for ECT for those incapable of giving consent should be restricted to saving life.
3. The nominated person should be notified and (if the patient wishes) an advocate involved if ECT is being considered.

3. **Drug Treatments**

1. Doses above BNF limits should only be given with fully informed consent or to prevent serious risk to the life of the patient, subject to the approval of the Tribunal and a limited time period.
2. Drug treatments should only be used outside their product licence in the interests of the patient’s health if there is no licensed alternative, with the Tribunal’s approval.

### Part 11

**CODE OF PRACTICE**

1. The Bill should specify that the Code of Practices should be statutorily enforceable and that parties should be required to act within the Code unless there is a necessity for departure in the individual case.
2. The Bill should lay down a procedure for amendment of the Code of Practice which involves a duty to consult and a duty to lay before both Houses of Parliament.

### Part 12

**OVERLAP BETWEEN THE MENTAL CAPACITY BILL AND THE DRAFT MENTAL HEALTH BILL**

People with a mental disorder who lack mental capacity to consent to treatment should be dealt with under Mental Capacity legislation with the following safeguards:

- Clear conditions and assessment process for the safeguards;
- Clarity concerning the duties of the responsible clinician and the availability of a second opinion from someone with the relevant clinical expertise concerning the person’s mental disorder and/or lack of capacity to consent to treatment;
- Notification and appointment of a representative for the person (independent advocacy);
- Preparation, approval and procedure for review of a care plan;
- Procedure for resolving disputes, including application to the Court of Protection

### Part 13

**HUMAN RIGHTS**

No recommendations.

### Part 14

**WORKFORCE IMPLICATIONS**

1. A thorough examination of the proposals for workforce implications, with detailed explanation of the assumptions made, is needed.
2. Particular attention should be given to the plans for implementing the right to advocacy so that advocates are available when needed.
3. The Scrutiny Committee may wish to recommend a minimum time period between the passing of the legislation and the implementation date.

### Part 2

**QUESTION 1. IS THE DRAFT MENTAL HEALTH BILL ROOTED IN A SET OF UNAMBIGUOUS BASIC PRINCIPLES? ARE THESE PRINCIPLES APPROPRIATE AND DESIRABLE?**

2.1 The stated principles on the face of the Draft Bill (least restriction, patient involvement in decision-making and fair and transparent processes) are of course commendable but insufficient as a framework for legislation. Nor are they all complied with in the operation of the Act. For instance, a patient’s consent to treatment is irrelevant under the Bill despite the principle of patient involvement in decision making. The
Bill also refers to “general principles” which will relate to decision-making under the Act but allows for these to be disapplied. We do not consider it acceptable that principles can be disapplied for a category of patients. This gives the legislator the power to stigmatise service users from the outset.

2.2 We also believe that the Bill should contain on its face a set of general principles.

The Government believes that principles that restate rights and duties in other legislation should not appear on the face of this Bill. We disagree. The principles would not be directly enforceable but they would give confidence to service users and act as guidance to practitioners and Tribunals in applying and interpreting the Act, as is the case with the Scottish Mental Health Act.

2.3 In our view the following 10 principles need to be in place:

(i) Respect for autonomy;
(ii) compulsion as the last resort;
(iii) Reciprocity;
(iv) Non-discrimination;
(v) A holistic approach;
(vi) Equality;
(vii) Respect for diversity;
(viii) Least restrictive and least invasive alternative;
(ix) A right to information;
(x) Rights for carers.

(i) Respect for autonomy

2.4 Respect for individual autonomy has been defined as “the freedom to decide for oneself, the ability to make choices which others will respect”. The Code of Practice expresses the principle as the right to be treated “in such a way as to promote to the greatest practicable degree their self determination and personal responsibility . . .” This in turn demands that a person’s view of himself or herself, their wishes and preferences must not be overridden without very good reason and if they have full capacity to make choices for themselves those choices must prevail. The health services increasingly adopt this approach and the law states, “A competent patient has an absolute right to refuse to consent to treatment for any reason, rational or irrational or for no reason at all when the decision may lead to his or her death”. The corollary that advance refusals and advance statements (see paragraph 7.27) should in general be upheld is gaining recognition.11

(ii) Wherever possible care, treatment and support should be provided without recourse to compulsion

2.5 The Code of Practice under the 1983 Act states that “compulsory admission powers should only be exercised in the last resort”. The reasons for a reduction in the use of compulsion are compelling. Mental health legislation providing compulsory powers has a specific role to play in the healthcare of patients with mental disorder but it should only apply after all other alternatives have been exhausted. Compulsory admission can be a traumatic experience for the person being admitted, and for those close to them. The fact of compulsory admission can have a damaging effect on the person’s condition, and can delay recovery. The use of coercive powers to treat a person may not be therapeutic for the individual and may hinder recovery because the fear of compulsion drives people away from mental health services. Compulsion is seen by patients as humiliating and deeply stigmatising. It carries immediate legal consequences and it can bring about discrimination in employment and housing. Research studies show that patients, users and carers want to share in decisions about their treatment and care and this results in improved outcomes.13

---

7 Expert Committee Report, Paragraph 2.2.
8 Baroness Hale (Law lord in the House of Lords) “I see the logic of saying that treatment for mental disorder should be no different from treatment for physical disorder. If so, it can only be given with the consent of a capable patient or where it is necessary in the best interests of an incapacle one. The use of compulsion also raises some more fundamental questions about discrimination between people with mental disorders and everyone else. Why should the criteria for treatment for mental disorder be different from the criteria for treatment for physical disorder? In other words, why should not this too depend upon consent or incapacity? And why should incapacitated people be able to make advance directives about treatment for future physical disorder but not about treatment for future mental disorder? If incapacity were the criterion, rather than the severity of symptoms or the prospect of harm to others, then some people might be given the help they need before their situation became too desperate”. Paul Sieghart Lecture, 8 July 2004.
9 The recent Government document on choice “Fair for all personal to you” Our ultimate objective is to improve patient and user experience and build new partnerships between those who use health and social care and those who work in them.
11 R (on application of Burke) v General Medical Council [2004] EWHC 1879.
12 Paragraph 2.7 (section 118).
13 Including implications with relation to the DVLA, insurance providers and public office.
2.6 There is also a pragmatic reason for the numbers of people under compulsion to be restricted. The compulsory process is resource intensive. It takes front line staff away from voluntary patients and adds to over-stretched health and legal aid budgets. Legislation that sets a framework for an increase in compulsion can therefore exacerbate problems in mental health for patients, staff and the public, rather than diminish them.

Reciprocity

2.7 Where society imposes an obligation on an individual to comply with a programme of treatment and care it should impose a parallel obligation on health and social care authorities to provide appropriate services, including aftercare. The Government considers that the Bill meets this requirement but we do not agree. The Court of Appeal has recently reaffirmed this principle and the House of Lords concurred in deciding that aftercare should be provided free of charge.

Non-discrimination

2.8 Where possible the principles governing mental health care should be the same as those which govern physical health. Any departure from this needs to be justified by a relevant difference between the nature of illness or service provision. The refusal to incorporate capacity as part of a test for compulsory powers promotes discrimination between mental and physical health. The recent Social Exclusion Report found stigma to be the greatest problem faced by people with mental health problems. The Mental Health Act Commission reports, “Of all mental health patients, none are so stigmatised as those who receive treatment under compulsory powers, because of widespread ignorance and fear regarding the purpose and usual causes of detention under the Mental Health Act 1983.”

A holistic approach

2.9 The approach to care and treatment and support in mental health should be holistic, incorporating a service user’s social care needs as well as medical treatment. A multidisciplinary approach should be central to patients’ care and treatment as provided in the care plan.

Equality

2.10 All powers under the Act should be exercised without discrimination on grounds of race, age, gender, sexual orientation, religion and disability. Given the extent of discrimination faced particularly by people from black and minority ethnic backgrounds, a statement of non-discrimination would give these groups a basis for confidence in the law.

2.11 The Alliance is concerned that the Mental Health Act is implemented equally among all groups in society. There is considerable evidence that the current Act is applied more heavily among African and Caribbean people than other groups. It is vital that the face of the Bill contains a statement about race equality. Beyond such a general statement, each stage of the process must have built-in safeguards for ethnicity. This may include, for example, the provision of advocates from different ethnic groups and who can interpret for those whose first language is not English. It should also be specified that services people are compelled to use must be culturally appropriate. The detail of these provisions may be best placed in the Code of Practice.

Respect for diversity

2.12 In particular service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse cultural and religious backgrounds and that properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

16 Mental Health Act Commission, 9th Biennial Report [Page 72, Paragraph 6.34].
17 For example in Breaking the Circles of Fear Sainsbury Centre for Mental Health 2002.
(viii) Least restrictive and least invasive alternative

2.13 Treatment should be provided in the “least invasive” manner as well as in the least restrictive manner and the least restrictive environment, compatible with the delivery of safe and effective care and the safety of other patients, carers and staff. Treatment that is provided through psychological interventions as talking treatments should be promoted as non-invasive and non-restrictive. This principle upholds the White Paper principle of respecting the individual needs of patients and will gain the trust of patients in proposed treatments, thus increasing their willingness to work with mental health professionals.

(ix) A right to information

2.14 Service users should be provided with all the information necessary to enable them, where possible, to participate in all aspects of their assessment, care, treatment and support.

(x) Rights for carers

2.15 Those who provide care to service users on an informal basis should receive respect for their role and experience and have their views and needs taken into account.

Part 3

QUESTION 2(A). IS THE DEFINITION OF MENTAL DISORDER APPROPRIATE AND UNAMBIGUOUS?

3.1 The Alliance agreed in principle with the replacement of the 1983 definition by a broad definition of mental disorder. We note that the new Draft is said to focus on the effect (the presence of psychological dysfunction) rather than the cause (disability or disorder) but we doubt that the redrafting achieves its aims.

3.2 It is vital however that such a broad definition sets some clear boundaries (as is the case in the 1983 Act and the law of other countries) through a series of exclusions. Exclusions ensure that practitioners carefully consider the basis for compulsory treatment. If there is an underlying mental health diagnosis the person is covered by the Act, if not it is unhelpful and inappropriate for mental health service users to have their needs confused with those whose problems arise from different sources.

3.3 Having decided that the exclusions in the 1983 Act are misunderstood, the Government does not favour exclusions in the new act. We believe that this rationale is spurious. Existing law does not prohibit treatment of a mentally disordered person who also has other behavioural issues. If the current law is misunderstood, the problem should be addressed by information and training, and if necessary by a rewording of the 1983 Act. (see page 10).

3.4 Some service providers have pointed out that, while it may seem unacceptable in principle to put under compulsion a person with drug or alcohol dependence, at least it will ensure that s/he receives treatment and it will assist in the development of these services as a whole. However, legislation should not be used as a lever to improve service provision, nor should people should be subject to social control and loss of liberty to get the help they need. Furthermore, the use of compulsory powers over recalcitrant drug or alcohol users will be more likely to backfire than to succeed as cooperation is a key component of behavioural change. There could also be a confusing overlap between the powers proposed in the Draft Bill and drug treatment and testing orders (DTTOs). For this group there is no substitute for targeted and well-resourced voluntary programmes.

3.5 The impact of the wide definition is of particular concern for people with learning difficulties. Under the 1983 Act a person with a mental impairment (being a state of arrested or incomplete development of mind) is only included if their impairment is associated with abnormally aggressive or seriously irresponsible conduct. In our view this issue may also need to be addressed through the exclusion clauses. We have not considered this issue in detail but refer to the Submission of the Royal College of Psychiatrists to this Committee for more detailed discussion of this point and urge the Government to give further consideration to this issue. The Draft Bill’s proposed widening of the definition of mental disorder would have an even more significant impact on Part III admissions than for civil admissions. (See section 9.7)

RECOMMENDATIONS ON THE DEFINITION OF MENTAL DISORDER:

1. Reinstate the exclusion clause in the 1983 Act to make clear that:

   (c) a diagnosis of substance or alcohol abuse or sexual behaviour does not preclude an additional diagnosis of mental disorder, even if the primary diagnosis is the former; and

18 W (A patient) v Secretary of State for Scotland (Times 21 April 1999) made clear that “made clear that the provisions meant that a person could not be detained by virtue of a sexual deviancy that was unrelated to a mental disorder, but detention was not prevented where the disorder manifested itself in deviate sexual behaviour”.

19 ?? Footnote to come ??
(d) a person shall not be considered as suffering from mental disorder solely on the grounds of the commission, or likely commission, of illegal or disorderly acts.

2. The impact of the definition on people with learning difficulties needs to be examined to ensure they are not adversely affected by the Bill.

**Part 4**

**QUESTION 2(B). ARE THE CONDITIONS FOR THE TREATMENT AND CARE UNDER COMPULSION SUFFICIENTLY STRINGENT?**

4.1 The definition and the conditions together with the nature of discretion act as the gateway into the exercise of compulsory powers and are the cornerstone of the act. A new Mental Health Act should not be designed to increase the numbers of people under compulsion, both for the sake of individual patients and for the viability of the mental health services at large (see 1.6–1.8).

4.2 While the 2004 Draft Bill has tightened the conditions for compulsion (which we welcome) they remain broader even than those in the current law let alone those delineated by the Government’s Expert Committee. We have not discovered any other developed country with a Mental Health Act which has such an all embracing definition of mental disorder combined with such loose criteria.20 The Draft Bill thus provides the legal framework for an increase rather than a reduction in the amount of compulsion.

4.3 In particular:

(i) Unlike the 1983 Act compulsory powers can be used for people who are not ill enough to warrant admission to and compulsory treatment in hospital but who will be assessed and treated in the community;

(ii) There will be increased use of compulsion for people with a mental disorder who need treatment “for the protection of others”. This condition combined with the definition of mental disorder, the lack of exclusions and the broad definition of treatment will bring many more people within the scope of the law;

(iii) A person who poses a significant risk of serious harm to others would need to be detained despite his/her willingness to take treatment on a voluntary basis;

(iv) The Bill makes clear that if the conditions are met there is no residual discretion for the decision-makers (see Clause 16). Under the 1983 Act the presence of the conditions permits but does not compel detention, and the absence of a condition does not prohibit it. The British Association of Social Workers has stated that in their view, with the removal of the discretion which at present allows them to take into account the person’s capacity and other circumstances of their case, they will be forced to detain “very large numbers of people suffering from self neglect caused by drug or alcohol misuse but who retained capacity to make their own decisions and would not be seen as detainable at present”.21 Given that hospitals could not cope with the numbers of people involved, examiners would have to use non-resident assessment and treatment even where this was impracticable because of the patient’s situation;

(v) because the criteria for compulsion are so broad it will be difficult for a patient to establish the grounds for his/her discharge if the clinical supervisor opposes it; and

(vi) The broader criteria for “appropriate treatment” to include people with personality disorder: the NHS Confederation reports that contrary to the Government view, around 2,000 additional people with personality disorders, currently not liable for detention, will be eligible under the new Bill.22

4.4 Overall, we believe that this will lead to increased demands on a health and tribunal system that is already over stretched and characterised by patchy service.

4.5 Some examples of the impact of the law:

*The depressed woman who fails to keep her appointments with the psychiatrist because she doesn’t think the medication is helping her; the woman with a dual diagnosis of drug addiction and depression who is self harming but wants to be left alone to be with her boyfriend, the young woman with learning difficulties whose unruly behaviour is offending the neighbours; the young person with behavioural problems at school and a diagnosis of attention deficit disorder who is aggressive to other children and the school feels that he needs clinical treatment; the man with schizophrenia who has gone off his medication and is hearing voices but managing to cope with the help of a support group but whose mother is worried he will relapse; a young woman with a borderline personality disorder who is acting aggressively and whose relatives want her out of the way.*

---

20 For a discussion of Canadian jurisdictions see Gray and O’Reilly “Clinically Significant Differences Among Canadian Mental Health Acts” *Canadian Journal of Psychiatry* Vol 46 No 3 p 315 where of 12 jurisdictions one (Newfoundland) has arguably broader powers; the Irish Mental Health Act; Scottish Mental Health Act(2003); NSW Mental Health Act(1990); SA Mental Health Act 1993; Australian jurisdictions.

21 British Association of Social Workers Submission to the Joint Scrutiny Committee 2004.

22 Crilly May 2003, “Assessment of Implications of New Mental Health legislation on Mental Health Service Organisations” NHS Confederation.
4.6 Each of these people may well need supportive mental health services—home treatment services, assertive outreach, early intervention services, or crisis resolution services—but none of them might be considered ill enough to warrant hospitalisation. However, if they refuse to take the treatment proposed for them and come into contact with inexperienced professionals they could be, indeed might have to be, made subject to compulsion. People in this situation tend to disengage from services. Disengagement may mean that someone who could have, with the appropriate support and treatment, been reintegrated back and contributed to society, instead loses that potential and becomes a cost to society.

4.7 The application of the conditions to people who are at risk of harming others is most worrying. It differentiates between levels of seriousness of risk to others. “For the protection of others” is an extremely broad category embracing emotional as well as physical harm as shown by the interpretation of the 1983 Act. Compulsory powers should never be used in these circumstances. They will particularly impact on people who misuse drugs or alcohol, those with learning disabilities or a personality disorder who react aggressively to attempts to control their behaviour or who have done so on some previous occasion. In the context of a history of misunderstanding and discrimination in the use of compulsory powers on people from black and minority ethnic backgrounds we can see that it could perpetuate that discrimination all too easily. We note that legislation in other jurisdictions tends to require “imminence” and “seriousness” of harm to others to justify the intervention of compulsory powers.23

4.8 We disagree with the decision to impose compulsion on those in the more serious category of risk irrespective of their willingness to comply with medical treatment. Case law makes clear that practitioners can impose compulsion on patients whose fluctuating or perhaps self-serving consent (as shown by past history) makes it unreliable.24 No extension to this should be permitted. It is also unnecessary since professionals can always use compulsory powers if co-operation changes to resistance. If people are partners in their care and treatment, they will take responsibility; coercion where it is not needed disregards personal autonomy and may contravene human rights.

**Appropriate Treatment**

4.9 We support the inclusion of psychological treatment in the definition of treatment. It is recognised that drug treatment alone may not be the most appropriate treatment and is considerably more effective if combined with talking therapy. We are concerned that the vagueness of the fourth condition falls short of a requirement to show that the individual will receive some benefit from the treatment. Given the breadth of the concept of treatment—as interpreted in case law25—we consider it will not be unduly onerous to show some benefit—without it the possibility of the act being used as a form of preventive detention cannot be excluded. Further, it gives too much leeway for disputes between lawyers and clinicians at Tribunal. The Expert Committee considered the need to show positive clinical measures which were likely to prevent deterioration or secure improvement in the patient’s mental condition. “A health intervention of likely efficacy” was required.

4.10 Clause 9 (9) is unclear. It seems to underline the importance of ensuring that significant harm to others is considered at all stages. Given that the Government itself recognises that this is a very small group of patients we question the need for them to be emphasised in this way.

4.11 In addressing the issue of the conditions the Committee needs to take account of the problem of discharge from compulsion. The vagueness and breadth of the key concepts (for instance “appropriate”, “for the protection of”, “treatment”, “all the circumstances of his case”) increase the difficulty for the patient to oppose his/her detention. For instance as Fennel states *The Tribunal is more likely to respect the view of the supervisor that the patient whose symptoms are in remission is benefiting from medication and that without it he would relapse than the view of the patient that he no longer needs treatment. It is difficult to see what convincing evidence the patient could bring in support of his own position*.26

**Capacity and Impaired Decision-making**

4.12 The current Act treats people with mental illness differently from those with physical illness and in the view of the Alliance this is discriminatory. People who are physically ill are not detained in hospital against their will because they refuse to take the treatment that should improve their condition; neither should people with mental illness.

---

23 For instance 10 of 15 States in the EU specify a level of danger that is “serious”, “immediate”, “significant” or “substantial”; the US law specifies a higher level of danger as for instance suicidal behaviour or harmful attacks and provides clear time frames for this behaviour. Compulsory Admission and Involuntary Treatment in the EU-Results, p 23.


25 The court’s interpretation of treatment under the 1983 Act is so wide that it has reduced the requirements of the necessary effect of that treatment to the point where it is difficult to exclude anything done to the patient within the hospital from its ambit as long as a person is contained in a therapeutic environment. A Foster QC, “Treating People: Conflict of Rights” Conference Paper 15/10/04.

26 See Fennell “Balancing Care and Control” 1992 p 229.
4.13 The Alliance accepts the view of the Expert Committee that, in the face of a mentally ill person at risk, of committing suicide for example, professionals could not just stand by on the grounds that the person was not incapacitous. The temptation to broaden the definition of incapacity might be considerable. In the light of the clear definition in the Mental Capacity Bill it would be unfortunate to cause confusion around this concept.

4.14 An alternative is to acknowledge that mental illness may impair decision-making ability. This is seen as a softer option to mental capacity in that it permits a more relative approach—it does not ask whether a person is unable to understand and make a decision in relation to a particular issue but whether their ability to make decisions is “impaired”. The more serious the decision, the less evidence of impairment may be required.

4.15 The Scottish Mental Health Act permits compulsion only if the person has impaired decision-making in relation to medical treatment. Under the Scottish Mental Health Act a compulsory treatment order: requires that:

(i) The patient has a mental disorder;
(ii) Medical treatment would be likely to prevent the mental disorder worsening or alleviate any of the symptoms or effects of the disorder; is available for the patient;
(iii) If the patient is not provided with the treatment there would be a significant risk to health, safety, welfare of the patient or safety of others;
(iv) Because of the mental disorder the patient’s ability to make decisions about the provision of such treatment is significantly impaired;
(v) That making the order is necessary.

4.16 Another option would be to define both mental disorder and the criteria (and retain exclusions) in such a way as to permit compulsion only when the threshold of symptoms or signs of disorder is high.

RECOMMENDATION ON CONDITIONS FOR COMPLICATION

The conditions for compulsion should include:

(a) requirement of assessment in hospital;
(b) The need to show that the person has impaired decision-making capacity in relation to treatment;
(c) the need to show that compulsion is necessary to effect treatment in all cases;
(d) In relation to a treatment order that there be a therapeutic benefit for the patient, where therapeutic benefit means medical treatment which is likely to bring about an “improvement in the symptoms, or signs, of mental disorder, or reduce or prevent deterioration in the person’s mental or physical health;”
(e) The need to prove that the protection of others is from “serious harm;” and
(f) Discretion in the decision makers (including the Tribunal) over whether to admit a patient who meets the conditions.

THE IMPACT OF THE DEFINITION AND CONDITIONS ON PART III PATIENTS

4.17 The exercise of compulsory powers under Part III over people within the criminal justice system is a cause of concern. The conditions for remand or committal for medical treatment are significantly broader than the relevant conditions for compulsory treatment under Part II. A person can be detained irrespective of whether it is necessary for their own protection from suicide, serious self harm or serious neglect or for the protection of other persons. This applies to people on remand as well as those who have been convicted of an offence.

4.18 In the Alliance view the starting point must be the position that a person’s mental health needs should be treated in the same way whether or not s/he is a civil patient under Part II or a Part III patient. Any difference in legal provision needs to be justified by reference to relevant distinctions in their situation. So for instance it cannot be necessary to satisfy the fourth? condition because people in custody can not be voluntary patients but the threshold of risk should not be removed. The Expert Committee took the view that the conditions for detaining Part III patients should be the same as for Part II patients.

4.19 The Government states that the risk assessment has already been done and therefore the condition can be dispensed with but this is not the point.27 Risk assessments for persons on remand do not relate solely to risk arising from a mental disorder. A person may be kept in custody rather than be put on bail for a whole host of reasons. This could mean for example that a depressed woman on a shoplifting charge or a substance abuser charged with illegal possession of drugs could find themselves subject to compulsory treatment, even if they are not subsequently convicted of the offence.

---

27 Improving Mental Health Law: Towards a New Mental Health Act (DOH, 2004), 4.10, p 37.
4.20 The provisions on risk in the Bill are confusing, but appear to have the following consequences. A treatment order can be made on a remanded person even if there is a risk assessment which establishes there is no risk to himself or another. A hospital direction can be imposed on a convicted offender without a risk threshold and the absence of evidence of risk to self or others will not of itself justify a termination of the hospital direction. The Bill therefore alters the 1983 Act whereby all patients, whatever their route into detention, are entitled to be discharged if the criteria are not met.28

RECOMMENDATION ON CONDITIONS FOR ASSESSMENT AND CARE OF PART III PATIENTS

The conditions for assessment or care and treatment orders for Part III patients should include the same threshold of risk as for Part II patients.

Part 5

QUESTION 2(C). ARE THE PROVISIONS FOR ASSESSMENT AND TREATMENT IN THE COMMUNITY ADEQUATE AND SUFICIENT?

5.1 The Alliance does not consider that the provisions are adequate or sufficient. They would appear to be only slightly less all-embracing than in the 2002 Draft. A clinical supervisor is given unfettered discretion to place a patient under compulsion in the community after the initial period of assessment (which may last no more than a day). Thereafter there are no limits on either Tribunal or clinical supervisor to change a patient’s status from resident to non-resident. There is also a power for a nominated person to request to the Tribunal that a resident patient become non-resident, but not the reverse. There is no power to challenge this. There is also a real danger that the facility to switch patients between resident and non-resident status could be led by bed shortages rather than patient needs.

5.2 Compulsion in the community is one of the most controversial of the new measures in the Bill. If, as the Government proposes, a person complies with a compulsory care and treatment order they are, in effect, doing so voluntarily because enforcement can only take place in a hospital setting. This throws into question their whole rationale. The research evidence has therefore been considered in depth by the Alliance and a view taken that there is no case for introduction of non-resident orders (NROs) in the Bill as drafted. The Alliance background paper on this issue will be submitted to the Committee.

SERVICE USER FEARS

5.3 Service users fear that NROs will increase their chances of being compulsorily detained if they disagree with the treatment recommended by their psychiatrist.

However, some consider that when they have been very unwell, hospital provided security because it is a contained environment, with regular monitoring of their condition and any medication. NROs cannot provide this, and consequently give rise to fears that compulsion will be used when people are not severely unwell, or that people who are severely unwell will not be given appropriate and sufficient support to help them through this time. “If I hadn’t decided to stop taking that medication it would still be ruling my life—and ruining my life. My psychiatrist was of course most unhappy. He was sure I wouldn’t cope”.

5.4 They consider the element of control of their home life an infringement of their privacy. They fear the impact on other family members who must have the burden of their care in a situation in which they are opposing treatment. One service user stated that he thought his marriage would break down if his wife had to look after him at such times. Another said “treatment when you are ill carries bad memories. I would prefer to associate these with a place that is not my home” another “To be treated at home that unwell with lots of people coming in attracting attention. If that were to happen again I don’t think I could go home. My home is my castle, my husband, my children. I wouldn’t want to ruin that for them again”.

5.5 They also fear that it will be difficult to come off an NRO, even if their mental health has improved, because clinical staff will practice defensively and “play safe” by ensuring treatment is continued. Service users fear that once they are placed upon an NRO they might never be taken off as clinicians might see it simply as a way of maintaining the person’s “compliance” with medication. They believe that the security of being in a contained environment, with regular monitoring of their condition and any medication, is the safest option in the circumstances when compulsory powers may reasonably be used. The danger is that these quite realistic fears about NROs will further drive people away from the services and the treatment they need.

28 Relevant clauses: Clauses 92(3); 96; 130; 132; 135; 116; 147.
5.6 With the continued absence of any form of capacity test in the Bill, such an order, once applied, will be too longstanding in its application. Clinicians are likely to face real pressure to continually renew such powers, forcing patients to remain on NROs almost indefinitely. In addition, given the breadth of the criteria for compulsion it may be difficult for a patient to oppose the renewal of an order successfully if the clinical view is that the medication is keeping the patient well.

5.7 Evidence suggests that these orders will increase the use of coercion in treatment of patients. It has been acknowledged that they can “tend to add further coercion to the existing inpatient coercion”. Studies have shown that when benevolent treatment and coercion operate together, coercion tends to become pervasive and treatment remains nominal. If this result is replicated, it is clearly a serious objection. It could impact most on people from black and minority ethnic backgrounds.

5.8 If NROs are used as an alternative to hospital admission they are more likely to be drug focused as that is the only treatment that can be effectively enforced. They may therefore increase the number of people on long term medication who derive no benefit from it. NROs are likely to increase the consumption of medications which may have unpleasant, harmful and in some cases irreversible side effects because people would previously have exercised their right to decline to take them. Non-medical forms of treatment, such as psychosocial interventions, need the person to want the treatment to ensure that s/he engages and actively participates. Compulsion does not encourage this.

5.9 The clinical and therapeutic relationship developed between service users and their professional carers could be damaged by compulsory treatment. This relationship is central to the effectiveness of care and the development of successful engagement with services. Such a relationship may take several years to develop, is often fragile and requires an interactive and participative approach from the clinician and the service user towards a shared goal of recovery. Introducing an element of coercion into this relationship will increase the likelihood of disengagement from mental health services with the risk of relapse and readmission to hospital. The supervised discharge amendments to the 1983 Act failed largely because of professionals’ unwillingness to implement them. “From the viewpoint of patients admitted to hospital, the distinction between legal compulsion and voluntary treatment is not always clear. Many informal patients feel coerced, and only a minority are confident of their freedom to leave a ward. If compulsory treatment is extended to the community, it may be that even patients who are not in fact subject to compulsion will feel increased coercion in their relationship with services”.

5.10 Compulsion in the community is said to offer a less restrictive environment although some commentators dispute this. However service users want this principle to apply when deciding whether or not someone should be put under compulsory powers not where compulsion should occur. For example, the provision of home support may avoid the need for using compulsion; this is very different from imposing treatment at home under compulsory powers.

5.11 Developments for the care of people in the community offer alternatives to hospital admission but we are not persuaded that these should in general be linked to compulsory care. They may indeed substantively conflict with positive approaches to engagement and service user autonomy through new services (such as assertive outreach and intensive home treatment services) for a group of people who have often been unable or unwilling to engage with mental health services. The models upon which they are based emphasise a partnership approach with the users of their services, any element of coercion in that equation serving to provide a mixed message.

**Research Evidence of Overseas Experience**

5.12 We have benefited from discussions with overseas experts. Professor Dawson, an international expert who is not opposed to community treatment orders (the commonly accepted term), nonetheless stated at a seminar in London in 1992 that in his view the conditions for success were not in force in the UK. \(^{37}\) They include:

1. Tight criteria for compulsion;
2. Well-established community service provision geared towards high-risk groups;
3. Public liability insurance; and
4. Effective enforcement mechanisms.

5.13 The Government points to the reported benefits of community treatment orders in New Zealand and Australia. The Alliance disputes this finding. It is relatively rare for patients to be placed on a community order in some jurisdictions without first being admitted to hospital because the definition of mental disorder and the criteria are more restrictive in their legislation \(^{34}\) and because community services are better resourced and more consistently available than in the UK.

5.14 The Orders in overseas jurisdictions are broadly of two types: those intended to operate after a stay in hospital on a compulsory basis, in order to reduce the chances of readmission and revolving door syndrome working as a conditional release system (a form of this is in force under the Mental Health Act) and those intended to act as a complete alternative to hospital admission, as a least restrictive alternative. The NRO in the Draft Bill falls into the first group.

5.15 Given the differences between the legal regimes comparison is very difficult, but even in those studies dealing with one jurisdiction the picture remains confused as to whether and in what circumstances NROs are effective, and indeed what that might mean for patients’ recovery or quality of life. It is also striking that the views of service users seem not to have been systematically researched. In studies where an arguably positive effect has been found, the community treatment order was combined with extensive community services. A lack of inter-agency working, communication breakdown, inadequate care planning and poor risk management were more significant issues in a patient’s condition than the fact of being on an order.

5.16 Evidence shows no significant benefit in terms of hospital admissions. The most recent study found, in a matched-groups study, that community orders in Western Australia did not reduce numbers of hospital admissions or number of days spent in hospital in the year following placement on the order. \(^{35}\) They further commented that it is impossible to tell whether any beneficial effects are due to the compulsory nature of the order or the increased community services made available. This concords with most other studies which have shown no significant difference in outcome between provision of well developed services and community based orders. \(^{36}\)

5.17 In conclusion we believe that there is a sufficient evidence base to justify rejecting the proposals in this Bill. These proposals, combining community orders with a wide definition of mental disorder and loose criteria, in an environment in which community services are insufficiently developed and defensive professional practice persists, will not work.

**Is There a Way Forward?**

5.18 Some members of the Alliance—including all service user groups—are opposed to NROs in any circumstance. The Alliance, however, recognises that, given the Government’s commitment to introducing them, it is necessary to consider how they could be introduced in a constructive manner and with appropriate safeguards. Work by the Royal College of Psychiatrists in the 1980s and 1990s \(^{37}\) and overseas research gives some credence to the view that there may be a small group of patients for whom repeated access to hospital may not be necessary although compulsion might be beneficial. These patients have multiple compulsory admissions but on discharge they relapse severely because they fail to take the medication which they are considered to need. We recognise that in this small number of cases an NRO may be appropriate as a less restrictive alternative than a long hospital admission.

---

33 Institute of Psychiatry June 2002; Dawson, Ambivalence about CTOs, JLP 2003, 243–255.
34 Eg in New Zealand the definition of mental disorder: An abnormal state of mind shown by delusions or disorders of mood, perception, volition or cognition and; this abnormal state of mind means that either: There is a serious danger to the person’s health and safety, or the health and safety of another person; or the person’s ability to care for him/herself is seriously reduced. Exclusions: that person’s political, religious, or cultural beliefs; or that person’s sexual preferences; or that person’s criminal or delinquent behaviour; or substance abuse; or intellectual disability.
5.19 However, it is imperative that there should be more substantive criteria for their application and safeguards for their use and the conditions for compulsion must be narrower than at present. We consider that a hospital is a safer environment for the initial exercise of compulsory powers, and that the decision whether detention should be in the community or in hospital should be made at the time when the care and treatment order is before a Tribunal. The Tribunal should be guided by strict criteria to limit their discretion.

5.20 For instance, legislation in the Canadian province of Saskatchewan states:

(i) A person must suffer from a mental disorder, for which he or she is in need of treatment or care that can be provided in the community;

(ii) In the past two years, the service user must have:
— Spent at least 60 days as an involuntary in-patient in a psychiatric facility; or
— Been an involuntary in-patient in a psychiatric facility on three or more separate occasions, (or previously been the subject of a community treatment order);

(iii) There must be a likelihood that if the person were not to receive treatment while residing in the community, he or she would be likely to cause harm to self or others or suffer substantial mental or physical deterioration as a result of the mental disorder;

(iv) The services the person requires in order to reside in the community must be available in the community;

(v) The person is unable to understand and to make an informed decision regarding his or her need for treatment, care or supervision as a result of the mental disorder; and

(vi) The person must be capable of complying with the requirement for treatment and supervision contained in the order.

5.21 The issue of compulsory treatment orders has not been properly analysed by the government. It was not part of the Expert Committee’s brief to question their desirability although they did not dissent to their use. Before such a radical shift in policy is introduced we believe that the Government should have undertaken such analysis. We would be pleased to make available to the Government the material and research paper we have completed.

RECOMMENDATION ON ASSESSMENT AND TREATMENT IN THE COMMUNITY

The Government should abandon its current approach to non-resident status and orders. Any form of compulsory order in the community should require narrower conditions for compulsion, be of a finite time and only as ordered by Tribunal when particular criteria are satisfied. These are:

— A history of several previous admissions within a short period of time;
— Impaired decision-making;
— Demonstrated capability of community services to deliver;
— That if there was no order, the person’s condition would deteriorate; and
— Capability of the patient to undertake the treatment and supervision required, taking into account his personal circumstances.

Part 6

QUESTION 3. DOES THE DRAFT BILL ACHIEVE THE RIGHT BALANCE BETWEEN PROTECTING THE PERSONAL AND HUMAN RIGHTS OF THE MENTALLY ILL ON ONE HAND, AND CONCERNS FOR PUBLIC AND PERSONAL SAFETY ON THE OTHER?

6.1 There is no doubt that this Bill is distorted by an emphasis on the protection of others from dangers posed by those with mental disorder. Throughout the legislation the duty to detain dangerous people (ie those who pose a significant risk of serious harm) takes precedence over both the human rights of the detainees and the clinical judgment of the decision-makers. While we agree that the protection of others is a legitimate goal of the law we believe that the overemphasis on risk is misplaced and will backfire and far from protecting public safety, it will undermine it.

38 The Expert Committee recommended that there should be a “formal assessment” in the community and a “compulsory assessment” only in hospital. (Paragraph 5.25).
39 For instance in the right to disapply general principles to this group, the right to detain a person who is willing to accept treatment.
40 For instance in permitting the Tribunal to reserve to itself the power to discharge a patient who has not committed a criminal offence.
RISK ASSESSMENT

6.2 First, the belief that it is possible to predict who will commit a violent offence is false. The most frequently cited principle on risk assessment is that “nothing predicts behaviour like behaviour.” Szmukler estimates for example that using the most accurate data available, if 5% of the population of interest is violent, the test will be wrong 92 times out of 100.41 It would require the unnecessary detention in hospital of between 2,000 and 5,000 people to prevent a single homicide. Over-reliance on risk assessment may divert scarce resources towards those assumed risky and away from the majority of those with mental illness, who pose no danger. At the same time it will be ineffective since there is no reliable way of assessing risk for people who have not yet committed an offence. It will also deter people from seeking help and increase risk for that reason.

6.3 Dangerousness is not an enduring trait. It can be exacerbated by some factors and restrained by others and can be modified over time. There is evidence that quality of care makes the biggest difference to offending behaviour. Analysis of 40 homicide enquiries between 1988 and 1997 concluded that in 11 cases (27.5%) violence could have been predicted but in 72% there had been insufficient evidence to alert professionals. Even more significantly, the findings suggest that “more homicides could have been prevented by good mental health care which detected relapse earlier (17 cases) than would be averted by attempts at better risk assessment and management (11 cases).”42

STIGMA

6.4 The bias in the Bill reinforces the common but false perception in the public’s mind that people with a mental disorder are dangerous. In fact they are broadly speaking about as prone to violence as the rest of the population although for people with psychotic illness there is a modest increase in levels of violence. Being young, male and of low social status are far more important factors than psychotic illness.43 In that respect, people with mental illness have been unfairly singled out for preventive detention.44 This is borne out by Taylor and Gunn’s research “that compared with about 40 homicides by the mentally ill per year, the public is at risk from 600–700 offences per year recorded as homicide”45 and by other studies in the UK and abroad. We question whether the provisions in the Bill are a proportionate response to the issue that Government wants to address, protecting the public from around 40 homicides a year by detaining thousands of people. There are arguments concerning other groups of the population whose actions result in greater loss of life who have no such legislation brought against them, eg drink-driving, speeding.

6.5 It will particularly stigmatise people with personality disorders, most of whom live safely in the community but who may be wrongly labelled as being dangerous.46 NIMHE Personality Disorder Capabilities Framework states “in recent years, the emphasis on risk and dangerousness associated with a very small number of people with a personality disorder has obscured the fact that very many people with the diagnosis are highly vulnerable to abuse and violence themselves—and to self-harm and suicide.”47

6.6 Reinforcing such misconceptions only strengthens a vicious circle: negative views in the community deter people from seeking treatment, when we know that seeking help early on a voluntary basis and receiving prompt care is the best way to stop problems escalating and to minimise risk. Both service users and clinicians report that the development of a trusting and non coercive relationship is the most effective way to reduce risk.

6.7 Particular powers in this Bill are of especial concern. The right to disapply principles, the lack of exclusions and the conditions relating to risk to others are all, we believe, disproportionate responses to the problem of public safety. In addition the Tribunal is given very broad powers over civil patients to restrict to itself the power to discharge, grant leave or arrange transfer from one hospital to another. It also has seemingly unlimited power to impose conditions that a patient not engage in “specified” conduct. We believe that the exercise of these powers may lead to the breach of human rights of patients.

6.8 For people with mental disorder who have capacity, criminal law should provide for sentencing options that balance public safety with individual rights. The criminal justice system already has adequate options for protecting the wider public from people who have already committed serious violent or sexual offences, and are considered dangerous, without recourse to mental health legislation.

---

46 The Health Select Committee in July 2000 took this view: “we are concerned at the use of what could be described as a “quasi-medical” definition of Dangerous Severe Personality Disorder], which runs the risk of being highly stigmatising for the many people suffering from personality disorder who are not judged by anyone to be dangerous.
— The Criminal Justice and Court Services Act 2000 places a statutory duty on police and probation services to assess and manage relevant sexual or violent sexual or violent offenders.48
— The Criminal Justice Act 2003 gives courts the option of imposing indeterminate sentences and extensions to mandatory life sentences for dangerous offenders, including where the offences relate to mental disorder.49 Where an offender is found guilty of a serious violent or sexual offence, the Court is obliged to consider the risk of further offences and danger to the public. Courts must assume that there is a risk unless it considers that it would be unreasonable to conclude that there is such a risk.
— The Sex Offences Act 2003 does not specifically mention mental disorder but it does allow for longer sentences for people who commit violent sex offences, some of whom may also have a mental disorder.50

In Scotland, separate legislation for offenders provides for indefinite detention for those who may not be treatable. The Mental Health (Public Safety and Appeals) (Scotland) Act 1999 has been upheld as compatible with the Human Rights Act. The Home Office should undertake a review of existing provisions to assess the need for more criminal legislation of this kind.

6.9 People with a mental disorder who harm others in circumstances in which they lack the capacity to be responsible for their own actions clearly need the care and protection of mental health law. The conditions we propose (in which an incapacitous patient with a mental disorder who poses a serious danger to others can be detained if there is a therapeutic benefit and if s/he is not accepting treatment on a voluntary basis) together with discretion in the clinician and the development of more robust risk prediction tools are the best way to keep such people engaged but not deter them from seeking help.

RECOMMENDATION ON PUBLIC SAFETY

Provisions for high risk offenders should be dealt with in separate criminal legislation.

Part 7

QUESTION 4. ARE THE PROPOSALS CONTAINED IN THE DRAFT MENTAL HEALTH BILL NECESSARY, WORKABLE, EFFICIENT AND CLEAR? ARE THERE ANY IMPORTANT OMISSIONS IN THE BILL?

7.1 The proposals in the Draft Bill are certainly not clear. The Bill is so poorly drafted that it is almost impossible to be sure what the law is saying. Its system of cross-references and repetition is unhelpful and unnecessarily convoluted. It can be compared with the 1983 Act and the legislation of other jurisdictions—Scotland, Ireland, New South Wales and Victoria to demonstrate that it is possible to draft a complex piece of legislation in a comprehensible fashion. With this problem we believe that staff will have real difficulty being sure that they are working within the law.

7.2 The Bill’s key omissions are detailed below. (We consider that there are aspects of the Tribunals provisions that are not workable but we will consider all our concerns on this issue in Part 8).

A RIGHT TO AN ASSESSMENT FOR PROVISION OF MENTAL HEALTH SERVICE

7.3 The Government accepts that compulsory powers should be a last resort. For the principle to be matched by practice the NHS and Social Services should ensure that a person’s mental health needs are met in a timely fashion. The statistic that one in three people are turned away when they seek help makes clear that this is far from the case at present.51 The likely result for those denied help is that their condition deteriorates, making compulsion more likely. Indeed people can end up under compulsion in order to receive services. The Expert Committee recommended that in accordance with the principle of reciprocity there should be a duty on the NHS and Social Services jointly to assess and meet the needs of people with mental health problems, with reasons if their needs could not be met. Such a principle would:

— Uphold the principle of the least restrictive alternative;
— Encourage preventive care and earlier intervention, avoiding hospital admissions;
— Remedy the imbalance between psychiatric and non-psychiatric care;
— Reduce dependence on medication;

48 Under the Act, the relevant statutory agency will then refer the individual for an official and initial assessment and then the normal provisions for others will apply. Those already within the prison system will also be able to be referred by the Home Secretary for assessment.
49 (Part 12, Sections 205–207).
50 The offences of rape and sexual assault by penetration carry a mandatory life sentence. These provisions ensure that all those convicted of these serious crimes will always be sentenced. Those who are also mentally disordered can only access treatment in hospital via a transfer and not an order.
51 35% of respondents in the survey conducted. Better Act Now! Rethink (National Schizophrenia Fellowship), 1999.
We do not agree with the Government that this duty has no place in legislation on mental health and note that it is provided in the Scottish Mental Health Act.

7.4 Local authority social services can prevent hospital admissions by providing support for families under pressure, by offering respite for carers and by combating isolation and social exclusion. The social costs of an emergency hospital admission are high. Although Government policy supports both statutory joint assessments and a Care Programme Approach that integrates health and social care on discharge from hospital, there is nothing in the Bill to promote preventive services and early intervention.

7.5 People with mental health problems have greater obstacles in receiving care than do people with physical health problems. The National Service Framework for Mental Health requires primary care services to assess a person’s needs, yet in practice many GPs do not have the time or skills to make a full assessment. GPs are not under a duty to make social service referrals, and they gate-keep access to the community mental health service and hospital specialists. Unlike people with physical health problems, who have direct access to specialist care through hospital A&E units, there are currently few open-access specialist mental health services. A right to seek help directly from specialist services—and to have an initial examination of needs within a specified time—would help to put this right.

RECOMMENDATION ON RIGHT TO ASSESSMENT FOR THE PROVISION OF MENTAL HEALTH SERVICE

There should be a duty on local authorities to provide assessments of need, leading to statements of health and social service provision to meet that need, similar to the rights accorded in Part 2 of the Bill for patients preparing for discharge or being discharged from compulsory treatment. Such assessments and statements would be provided on establishing a threshold of presenting need and should apply equally to children and young people.

7.6 Although there are some good examples of jointly provided community mental health care, there is great under-provision of social care to mental health service users. The Bill recognises this and makes unique provision for health and social care on discharge. Under this provision hospital managers and the local authority must provide to the Tribunal statements of services needed on discharge.

7.7 By contrast, no such statements would be required or permitted as part of the examination or assessment processes under the Bill when compulsory treatment is first considered. The Bill makes no provision for health and social care provision (or, where appropriate, a referral to the Community Mental Health Team) for:

— Those who are examined, who are found not to meet all the conditions for compulsory care, but who nevertheless are in need of services;
— Those who are assessed for or given compulsory treatment as non-resident patients.

7.8 The new Approved Mental Health Professional under the Bill will be a competence—rather than professionally-based appointment. The current Approved Social Worker is a social worker who would have had training to and owe a more general professional duty to refer mental health clients for a social care assessment. This change could serve to reinforce the absence of a social care dimension to a person’s assessment and care.

RECOMMENDATIONS ON PATIENTS SUBJECT TO FORMAL EXAMINATION

The Bill should make provision for the following situations:

1. Where on examination a patient does not meet all of the relevant conditions described in Clause 9, the Approved Mental Health Professional must consider a referral of the patient for an assessment of health and social service need or alternatively, make a determination to refer the patient to the Community Mental Health Team or the tier 3 team with reference to children and young people.

2. Where a determination is made on examination to carry out an assessment under clauses 22 to 33, the care plan made under clause 31 shall include information stating:

52 Although entitled to a community care assessment under the NHS and Community Care Act 1990 there is much evidence from individual case histories that this is routinely denied to mental health service users. Clinical services are also relatively inaccessible. The National Service Framework for Mental Health requires primary care services to assess a person’s needs, yet in practice many GPs do not have time or skills to make a full assessment. GPs are not under a duty to make social services referrals, and they gate-keep access to the community mental health service and hospital specialists.

53 Facilities “for the prevention of illness, the care of persons suffering from illness or the after-care of persons who have suffered from illness”, and Services provided by local authorities (including accommodation and welfare services under Part 3 of the National Assistance Act 1948; section 45(1) of the Health Services and Public Health Act 1968 and section 21 and Schedule 8 NHS Act 1977; section 29(1) Children Act 1989. These are some key statutory social care provisions.) (Clauses 53 and 63-68, Draft Mental Health Bill).
— what services in the community the patient will need to support his recovery if the relevant conditions are not met; or
— whether services provided by the relevant local authority and the appropriate authority would secure that the patient could receive treatment in the community other than by order of the Tribunal.

THE NOMINATED PERSON/CARER

7.9 We are concerned that this Bill involves a significant loss of powers for family members. In particular, we do not consider that the role of the nominated person adequately safeguards the interests of the patient nor gives an adequate role for the carer. We support the replacement of the nearest relative with the nominated person. The nominated person is likely to be someone in whom the patient has trust and confidence, someone who s/he believes will safeguard his/her interests and someone who can provide emotional support at a time of crisis. However unless this role carries with it real powers it is unable to act as a counterweight to the powers over service users given to professionals under the Bill.

APPOINTMENT

7.10 The Bill requires the nominated person to be “suitable” (232 (5))—a term which will be interpreted in the Codes of Practice. We do not accept that there should be any other criterion for “suitability” than the relationship or connection with the patient—which is already within the Bill. Giving the appointer (a mental health professional) discretion over the “suitability” of the nominated person will reduce the likelihood that his/her choice is respected. A person is also disqualified to act if “he appears to the appointer to be incapable because of illness or mental disorder” (Clause 232 (4) (b)). A patient may wish to choose someone with a mental disorder—indeed, people who have direct experience of mental disorder and of the mental-health system might be particularly effective nominated persons. It needs to be clear that a person can only be incapable if s/he lacks capacity within the Mental Capacity Bill’s definition.

RECOMMENDATION ON APPOINTMENT OF NOMINATED PERSONS

Three criteria are needed:
1. that the person chosen by the patient to be the nominated person is willing to perform the function,
2. that that person has capacity, as defined in the Mental Capacity Bill 2004; and
3. that a person who is not related or connected to the person need not be appointed (see section on children under Rights and Powers section).

TIMETABLE FOR APPOINTMENT

7.11 The Government has said that it would be impractical to appoint the nominated person before the initial examination because “An initial examination often needs to take place very quickly, particularly in emergency cases”. This is true, but the Draft Bill nevertheless states (15 (6) (b)) that if practicable the examiners should consult the patient’s carer. We agree with this provision, and believe that if it is possible to consult the patient’s carer it should also be possible to appoint a nominated person—after all, in many cases the nominated person may well be the patient’s carer.

7.12 The appointment of a nominated person ceases when the patient is discharged (242(4)) As a result, the whole process (including a possible delay in appointment at the assessment stage) has to be started again in the event of a further need for compulsion. The Alliance proposes that a nominated person should remain in post after discharge from an order subject to the agreement of the patient, though their powers would be held in abeyance. If s/he require a different nominated person next time s/he could be permitted to specify a person at the point of discharge. That person’s name would be included in the patient’s records or in an Advance Statement. This proposal has been strongly supported by user groups who are members of the Alliance and who have surveyed their members on the issue.

7.13 The patient must also have the power to revoke an appointment which s/he has made. Despite a recommendation to this effect in the Joint Committee on Human Rights (JCHR) Report it has not been taken up in this Bill.

54 Improving Mental Health Law: Towards a New Mental Health Act (DOH, 2004), 4.10, p 37.
55 Survey by JAMI of their members in 2002.
56 Joint Committee on Human Rights, Twenty Fifth Report, Para 64.
RECOMMENDATIONS ON TIMETABLE FOR APPOINTMENT OF THE NOMINATED PERSON

1. The nominated person should have a role where possible at the examination stage.
2. The appointment should not lapse on discharge.
3. The patient should be able to revoke the appointment.

Rights and powers

7.14 Under the 1983 Act the nearest relative has a significant role including:
   — a right to apply for an assessment of the patient and a right to written reasons for a failure to detain (1983 Act, section 11);
   — a right to block an admission to hospital (1983 Act, section 11(4)); and
   — power to make an order for a discharge, subject to 72 hours notice (1983 Act, section 23).

However, in the Draft Bill those “nearest relative” powers have been reduced. The net effect of this is to diminish the patient’s protection at the critical times, when compulsory powers are first being considered and at the point of discharge.

7.15 The right to request a decision as to whether “examination” will take place is much weaker than the nearest relative’s right to require the local authority to direct an approved social worker to consider an application for admission. This removes an important safeguard. In particular the carer and the nominated person should both have the right to apply for assessment and the right to a justification if they are not successful.

7.16 At the examination stage the nominated person (if already appointed) has no rights at all, the carer has a diminished role and the advocate is not included. If the person has no carer or does not want the carer to be involved s/he is completely unprotected. The nominated person should be included at this stage as should the advocate if the patient requests him/her. The role of the nominated person is to act as a knowledgeable friend to give advice, information and an opinion about the patient, the advocate is to explain the process and speak for the patient. We do not consider that this to be unnecessary duplication of effort because it may calm a crisis and help to avert an unnecessary use of compulsion.

7.17 The carer or nominated person should also have the right to block admission. The person who knows the patient best is more able to assess the seriousness of a situation and its likely course than a busy professional unacquainted with the patient’s case. It is a useful power for a caring friend or relative and assists professionals. Under current law the nearest relative can be displaced by an application to the county court if it appears s/he is not acting in the patient’s best interest in blocking admission. This could be replicated under the new Bill, although the Tribunal would be the appropriate forum.

7.18 We believe that, perhaps in their concern about a confusion of roles, the Government has seriously weakened the role of the family (as carer or nominated person). Even the duties to consult have limited force when they can be dispensed with wherever impracticable or inappropriate. In our view, in order to avoid confusion of roles the principal role of the nominated person and of the advocate (as a proxy for the patient, putting forward the patient’s views or what they believe are the patient’s views) should be clearly set out, preferably in primary legislation or in the Code of Practice.

7.19 With respect of discharge, under the 1983 Act the nearest relative has the right to discharge a patient from formal powers (section 23(2)(a), subject to giving 72 hours’ notice and the agreement of the responsible medical officer (section 25(1))). This is not provided in the Draft Bill which only allows a nominated person to apply to a tribunal for a discharge (clause 54(2)). The Government’s reasoning behind this change is that the Bill “provides a new legal framework with independent scrutiny by the Tribunal of all compulsion beyond initial assessment period providing, in every case, an important safeguard against the inappropriate use of formal powers”. 57 It is not clear, however, why the right to discharge a patient is incompatible with increased independent scrutiny. Furthermore, given the considerable demands on the Tribunal under this new law, another mechanism is preferable. There is some research that demonstrates that applications by nearest relatives for discharge are more successful than Tribunals. This seems to indicate that they can operate to alert professionals that a person’s condition is now sufficiently improved to warrant discharge.

7.20 Greater clarity is also needed on the role of carers in relation to the Nominated Person. Please refer to the submission by Rethink for further consideration of this.

RECOMMENDATION ON RIGHTS AND POWERS OF THE NOMINATED PERSON

3. The nominated person should have:
   (d) a right to apply for an assessment of the patient and a right to written reasons for a failure to detain, as in section 11 of the 1983 Act;
   (e) right to block an admission to hospital; and

57 Improving Mental Health Law, 4.16, p 37.
Continuation of Care (Including Aftercare)

7.21 Section 117 of the Mental Health Act 1983 places duties on both health and local social services to provide (free) aftercare services until they are satisfied that the person is no longer in need of them. The Draft Bill limits these duties to the provision of the compulsory components of the care while under a care order, and to a period of six weeks following the date of discharge. This unfair and unrealistic limitation could seriously endanger people’s continuing recovery in the community.

7.22 The current duty on authorities is crucial in ensuring people remain engaged with services on discharge, receive continuing support and do not relapse. The removal of this duty places the burden for continuing care on a patient’s care plan, which authorities will have no statutory obligation to implement. We know from experience that currently care plans very often fail to be effectively implemented, with many patients not even knowing that they have one.68 Diana Rose in her 2003 study found that on average awareness of the Care Programme Approach and its elements was less than 50% among service users and could be as low as 5%.59

7.23 The six week period for free continuing care appears randomly selected and takes no account of individuals’ needs nor of local gaps in service provision. Many people fail to get in place the conditions they need for recovery for several months because of chronic shortages of accommodation and staff in the community. Discharge from a compulsory order on the grounds that the criteria for continued compulsion are no longer met, is unlikely to mean that a person will be fully recovered. In fact, people are often likely to need quite intensive support. The fact that they have been subject to an order necessarily should indicate that they have been seriously ill and may not be good at engaging with services. Making people pay for their care after six weeks may prevent many from continuing to engage with services and could seriously endanger recovery. Treatment regimes that involve psychotherapy or other psychological interventions rather than drugs are not able to be completed in a 6 weeks time span and usually require at least a year.

7.24 The clause offers a significantly different, and considerably less satisfactory, position to that of the general duties set out in the new Scottish Mental Health Act 200360 which ensures that anyone discharged from a compulsory order receives those services they need. The proposed disparity between England/Wales and Scotland means there will be inequalities between people who live in the different countries. This will cause particular confusion to both patients, families and service providers when people move across the border.

7.25 The Alliance believes there is a strong case for imposing a statutory duty of continuing care on authorities. This should include a right to receive care and treatment in accordance with the care plan during a period of compulsion and a right to ongoing care after discharge—both recommended by the Expert Committee. First, this is necessary to ensure vulnerable people continue to receive necessary services to avoid relapse. Second, unlike other patient groups, the alternative for mental health patients if they disengage from services is not just a possible deterioration in health but also, if they have been discharged, a possible return to compulsion (and a small, though increased, public risk).

7.26 Accordingly, we propose that the Bill should include a duty on authorities to provide continuing care services following discharge from an order. The Expert Committee recommended that a person who has been subject to a period of compulsion would have a right to ongoing care for a specified period after compulsion, to be determined by the Tribunal in each individual case. The clinical team would be given the power to seek an extension if appropriate, or to request a formal early termination if the patient indicates a consistent desire to distance him or herself from care.61 However, in the view of Alliance members the concept of need would be preferable.

7.27 We see no reason to depart from the wording of section 117. As the Department of Health has made clear, this duty does not require free aftercare indefinitely but only so long as the need persists.62 The Government argues that this provision favours detained over voluntary patients—they may even be in adjacent beds. The House of Lords rejected this argument as “too simplistic”, holding that compulsorily admitted patients may pose greater risks upon discharge to themselves and others than compliant patients.63

---

58 Just 1 Per cent Rethink, 2003. A survey of 3,033 people with severe mental illness of whom 1,427 answered questions about care plans. 52% do not know their level of care, 48% do not have or do not know if they have a care plan.
60 Section 25 places a general duty on local authorities to provide both “care and support services” and “services designed to promote well-being and social development” to “persons who are not in hospital and who have or have had a mental disorder”.
61 Paragraph 3.10.
63 R v Manchester City Council exp Stennet (2002) UKHL 34.
RECOMMENDATIONS ON CONTINUATION OF CARE

1. On the principle of reciprocity there should be a duty on authorities to provide free aftercare in accordance with need as at present.

2. The six week limit to not charging for any post-discharge care should be removed.

ADVANCE STATEMENTS

7.28 Advance refusals and advance statements setting out a patient’s wishes for his/her care and treatment (including the choice of a nominated person) are an important mechanism for safeguarding and promoting a patient’s interests and health. Service users who have confidence that their doctors will abide by their wishes when they become unwell experience less concern and stress about future relapses. Recent research has shown that they can be effective in reducing the number of compulsory admissions to hospital.64

Patients should be encouraged by professionals to develop advance statements with the knowledge that these will be taken into account when making treatment decisions. As the White Paper states, the clinical team should be obliged to discuss advance statements with the patient as a component of care planning prior to discharge and to give help with their preparation.

7.29 Under current law an advance refusal to accept treatment, which is legally binding, can be overridden once a person is subject to compulsory powers. This gives too little acknowledgement of the patient’s wishes at the time when s/he had capacity. Mental Health Foundation researchers have reported that service users are discouraged from preparing advance statements because they are aware that they are not followed if they are sectioned.65

7.30 Alliance members have consulted widely on this issue. Our considered view is that advance refusals should have the same status for compulsory as for informal patients except where, in the clinical view, imminent danger to the person or another makes it necessary for it to be overridden. In this situation the professional should be required to consider all alternatives and, in recording reasons for overriding the advance refusal, indicate why alternatives have been rejected. The Tribunal should have power to over-ride an advance refusal, but should nonetheless take it into account and record their reasons if they decide to override it.

7.31 Wishes expressed in an advance statement should be a part of the information taken into account by professionals involved in drawing up a preliminary care plan and for nominated persons and advocates in carrying out their responsibilities under the Act. The Act should therefore contain a duty to consult an advance statement. It is particularly important that the Tribunal be required to take account of any advance statement in making a care and treatment order. Furthermore, given the arguments for advance statements we see no reason why England and Wales should not follow the example set by Scotland in its Mental Health Act whereby the right to make advance statements was included in legislation. Please refer to the submission by Rethink for further information on this.

RECOMMENDATIONS ON ADVANCE STATEMENTS

1. The Code of Practice should place an obligation on the clinical team to discuss advance statements with the patient prior to discharge and to give help with their preparation.

2. Duties to consult the advance statements should be put in the Bill and should be available for the Tribunal.

3. Advance refusals should have the same status for compulsory as for informal patients except where, in the clinical view, imminent danger to the person or another makes it necessary for it to be over-ridden. In this situation the professional should be required to consider all alternatives and, in recording reasons for overriding the advance refusal, indicate why alternatives have been rejected.

4. The Tribunal should have the same power to over-ride an advance refusal but should record their reasons for so doing.

Part 8

QUESTION 5. IS THE PROPOSED INSTITUTIONAL FRAMEWORK APPROPRIATE AND SUFFICIENT FOR THE ENFORCEMENT OF MEASURES CONTAINED IN THE DRAFT BILL?

8.1 Integral to the wide institutional framework of the Bill are the provisions for advocates and for the Mental Health Tribunal, both of which we welcome. There are, however, some issues in both cases to which we wish to draw the Committee’s attention.


65 The Mental Health Foundation (forthcoming) Advance Statements in Mental Health Practice—Lessons from Bradford.
Advocacy

Access to advocacy

8.2 Access to independent advocacy is vital for people who are:
— liable to compulsory treatment;
— at the point of “examination” for assessment;
— under assessment; and
— during periods of compulsory treatment; and, for people with a mental disorder who do not need the exercise of compulsion:
— under aftercare arrangements.

8.3 The current provisions do not sufficiently reinforce the value of this role or provide for all these circumstances. Service users regularly report that they do not know what is going on when they are subject to compulsion—either the information is not given to them or they do not receive it in a form they can understand. This can relate particularly to the medication they are being given. This also applies to whether or not they end up as voluntary patients or under compulsion. In this regard we would draw the Committee’s attention to the Scottish Mental Health Act which puts a duty on authorities to ensure that independent advocacy is available to all people with a “mental disorder” and that they have an opportunity to use it. We support these provisions in principle, but we limit our recommendations to those people who would fall under the 2004 Bill if amended to cover people with a mental disorder who are examined but not then brought under compulsion.

8.4 The carer has no access to advocacy unless s/he is also the nominated person. This is in spite of the rights identified under the Health and Social Care Act and the practice guidance of the Carers and Disabled Children Act 2000. This is an important issue as carers frequently complain that their requests for help are ignored on the one hand whilst they are expected to pick up the pieces of professional decisions on the other.

The Examination Stage

8.5 This stage of the process can last for up to five days (or possibly seven days) but the Bill specifically excludes the involvement of the advocate. The carer alone must be consulted. However, it is at this initial stage, when the patient’s co-operation or non-co-operation will be likely to determine whether or not compulsory powers will need to be invoked, that the presence of an advocate (and nominated person) is most desirable. S/he can play a vital role in interpreting and conveying the patient’s wishes, negotiating between the parties and assisting a resolution to avoid compulsion. Black and minority ethnic communities particularly value the advocate’s role in providing a culturally sensitive perspective and preventing the misunderstandings that can lead to a resort to compulsory powers. We refer in particular to the more detailed evidence on this point provided by the Association of Mental Health Advocates.

Advocates in Places of Safety

8.6 The Draft Bill should provide the right of access to specialist mental health advocacy when the person arrives at the place of safety, whether it is a psychiatric hospital or police station. Police officers have reported that they have found an advocate useful to help them decide what action to take with a person in crisis since they are not experts in mental health. The White Paper stated that where a police cell is used as the place of safety there will be a duty on the local Trust to arrange a preliminary examination within six hours if requested to do so by a Forensic Medical Examiner or to transfer the person to hospital for examination during that period. Regrettably this appears to have been dropped, except when the new emergency powers are being used. It is important at least that there should be access to an advocate in this situation.

Recommendations on Advocacy

1. Advocates should, where practicable, be available to all patients subject to formal examination as soon as possible after the examination begins.

2. Advocates should be available to people held in a place of safety.

66 Discussion at People’s Parliament, 9 November 2002 Debate on Mental Health Act (MHA); Mind Seminars on Mental Health Act 14 October 2004; Maca Annual Conference 16 September 2004.

67 Para 2.3.

68 Reforming the Mental Health Act 1983 (Dec 2000)—Part I at 3.84.
Ev 144  Joint Committee on the Draft Mental Health Bill: Evidence

The Tribunal

8.7 The Alliance supports the principle that the powers of compulsion may not be exercised beyond an initial period without an order from the newly-constituted Mental Health Tribunal. We would recommend some changes to the proposed Tribunal framework in order to safeguard patients’ rights.

8.8 We do not consider that the Tribunal fully constitutes the safeguard that the White Paper promised it to be. Our key concerns are:

1. A right of access to the Tribunal in the assessment process is of little value because of the fact that a patient’s application for discharge early in the period could be turned over to the Tribunal into an order—for up to six months. This is a powerful disincentive for the patient to make use of their right;

2. The lack of power in the Expert Panel to bring about a change in the care plan against the clinical supervisor’s wishes;

3. The narrow scope of the care plan before the Tribunal; and

4. The Tribunal’s lack of a role over Part III patients.

Composition of the Tribunal

8.9 Schedule 2 of the Draft Bill states that the new Tribunal should consist of a legal member, a clinical member—defined as a person who has “such knowledge or experience of the treatment of mentally disordered persons as the Lord Chancellor thinks fit” (Para 2(1)(b)) and another member with such experience who is not a legal or clinical member.

8.10 We do not agree with the requirement that the Tribunal must have a clinical member. The Tribunal is required to make a legal decision which has social consequences, and social care needs should be part of the patient’s care plan. Expertise in such issues as housing or other accommodation, benefits and social services are relevant. Other mental health professionals may also have a broader expertise to offer. The automatic membership of a clinical member will lead to hearings being based exclusively on the medical model of mental health care and be weighted against those whose case is being heard if:

— they contain a clinical member;
— they are advised by a doctor from an Expert Panel; and
— the clinical supervisor attends the Tribunal hearing.

We are also aware of the severe practical difficulties in recruiting medical members under the existing Act; this will be even harder under the proposed Bill.

8.11 The proposed membership of Mental Health Tribunals does not explicitly include people who themselves have experienced a mental illness or others who may have a lot to offer in terms of their experience of mental illness and mental health services. As a matter of principle the lay member of the Tribunal should be a person who has experience of mental health services as a user or carer, family member, volunteer or employee who works with and can represent any of these groups. This would be consistent with, for example, employment tribunals, which contain representatives of both management and employees.

Tribunal Powers

8.12 Clauses 46(5) and 49(5) provide that the Tribunal can reserve to itself the power to discharge, transfer or even give leave to a specified type of patient specified in regulations but no explanation is offered as to who this will cover. The prospect of the clinical supervisor losing control over the care of some civil patients, who will in effect be treated as if they were under a restriction order, is wrong in principle and may violate Article 5 of the European Convention on Human Rights.

Recommendations on the Composition of the Tribunal

Each Mental Health Tribunal should comprise:

1. a legally qualified member;
2. a member with experience of providing mental health services, but not necessarily a doctor, NB Panels of Tribunals for an area should include doctors but will, in any case, be advised by an independent doctor from the proposed Expert Panel;
3. a lay member, who may be a person who has experienced mental illness, an informal carer or someone who represents their interests; and
4. a children’s professional where the patient is a child or young person.
TRIBUNAL AND CARE PLANS

8.13 We welcome the requirement that the clinical supervisor should be required to produce a care plan for each Tribunal. We are, however, concerned that the proposed care plan before the Tribunal is very narrow in its scope, consisting primarily of the medical treatment which may be given in the absence of consent. This contrasts with the approach taken in the White Paper in which it was proposed that the care plan would be modelled on the Care Programme Approach. We regret that this has been dropped. The narrowness of the care plan renders the duties to consult patient, carer and nominated person of limited value. It also means that the Tribunal may be inadequately informed to make decisions required of it.

8.14 The Bill states that the contents of the care plan will be laid down in regulations. We believe that the statute itself should specify that the care plan will cover social care issues as well as the “compulsory element” of medical treatment. It should also be comprehensive in covering all medical or other treatment which the patient would like to receive. In the case of children, educational and family needs should be addressed. A good starting-point would be the form of care plan prescribed under the Children Act 1989.

8.15 The Tribunal will have no power to amend or refuse aspects of the care plan without the agreement of the clinical supervisor (clauses 46 and 59). The Tribunal may have misgivings about the clinical supervisor’s decision as to the appropriate treatment—a view which the Expert panel member may share. It appears, however, that the only option is one of persuasion. We accept that a clinical supervisor cannot be required to administer treatment which s/he thinks is not therapeutically appropriate, but we believe that as a matter of principle the Tribunal should be able to block treatment which it is satisfied is not in the patient’s interests. Otherwise it is difficult to see that the role of the Expert panel member is of great value.

8.16 It is not clear from the Bill which services are compulsory for the patient to follow and which services the patient would like to receive. In the case of children, educational and family needs should be addressed. A good starting-point would be the form of care plan prescribed under the Children Act 1989.

RECOMMENDATION ON CARE PLANS

The care plan should be comprehensive including all treatments and relevant social issues.

Part 9

QUESTION 6(a). ARE THE SAFEGUARDS AGAINST ABUSE ADEQUATE? (b) ARE THE SAFEGUARDS IN RESPECT OF PARTICULARLY VULNERABLE GROUPS, FOR EXAMPLE CHILDREN, SUFFICIENT?

9.1 The safeguards in the 2004 Draft Mental Health Bill are not sufficient, but they are much improved since the 2002 Draft Bill. In common law children may be treated under parental consent. In most cases parents will act in the best interests of the child but safeguards are required to protect the other cases. The 2004 Bill provides those safeguards: advocacy; nominated person; care plan (and date for review of care plan); requirement that the care plan be approved by a medical expert and the right to appeal to the Tribunal for discharge.

ADMISSION TO ADULT PSYCHIATRIC WARDS

9.2 In 2002–03, 213 under-18s were placed on adult mental health wards. This is a substantial proportion of all children and adolescents admitted under the Mental Health Act 1983. The Mental Health Act Commission stated that “it is becoming clear to everyone that this type of admission is inappropriate” and it violates the United Nations Convention on the Rights of the Child. There have been cases of a 16 year-old being offered illicit drugs under threat by adults on his ward and of a 17 year-old with a learning difficulty being assaulted by another patient on an adult ward.

9.3 The Government agrees that children should be treated by clinicians whose experience and expertise is with children (and the same should apply to advocacy, approved mental health professionals, etc). However, they are unwilling to require this by law because there are too few children’s clinicians, and it is better for a child to be treated by professionals who work with adults than by no one. They argue that this should be addressed through the National Service Framework for Children. In our view, however, the new law is an opportunity to place an obligation on health authorities to provide appropriate accommodation for children. While we do not expect this to give rise to an enforceable individual right it would impose a duty on the authorities. This would be similar to the Scottish Mental Health Act. A recent report from the Children’s Legal Centre stated that “there is no statutory protection from the use of adult wards in the

69 Or in case of dispute, the Tribunal—failing that, the local Social Services Department should consider whether to exercise Children Act powers.
71 Article 37(c), which states that “every child deprived of liberty . . . shall be separated from adults unless it is considered in the child’s best interest not to do so”.
72 Children and the use of Mental Health Powers, Children’s Legal Centre.
placement of children under compulsion. This is a matter of particular concern in view of the likely delay in introducing background checks in the NHS adult sector. At the very least, however, a child specialist should be consulted in relation to the care plan of a child.

RECOMMENDATIONS ON ADMISSION TO ADULT PSYCHIATRIC WARDS

1. There should be a duty on health authorities to provide age-appropriate accommodation for under-18s subject to the Bill or needing in-patient treatment.

2. Wherever young people are admitted to adult wards the law should require the clinical supervisor to obtain advice from a children’s clinical specialist.

CHILDREN AND PARENTS ADMITTED OR COMPelled TO RECEIVE TREATMENT: EDUCATIONAL AND FAMILY NEEDS

9.4 A child and parent patient’s mental health needs are closely intertwined with family and occupational needs. A 17 year-old on an in-patient unit may well be missing out on his or her educational opportunities and the knowledge of this can be counter-therapeutic. Typical comments to YoungMinds researchers are that “it would have been good if there had been more contact with school and college” and “one hour a day is not enough to keep up with the six hours that I would be doing at school”. Failure in this area could be in breach of the child’s right to education under the Human Rights Act (HRA).

9.5 Family is central to the life of anyone who has parental responsibility. The stresses of family life can contribute to mental health problems and mental illness can interfere with the way someone carries out their parenting responsibilities. For example, a parent who is deeply depressed will find it difficult to provide emotional warmth and care; someone with psychosis may struggle to provide consistent parenting. Children may be caring for parents while they are ill. There is strong evidence of links between parental mental health and children’s mental health. In rare cases there are child protection issues, although this should not be seen as the main reason for assessing family needs. Addressing family needs as well as medical treatment would go some way to rectifying this.

9.6 Where a parent is made subject to mental health law, therefore, it is important that his or her family needs are assessed. A failure to do this may delay his or her recovery because s/he continues to feel anxious about his or her family needs. It can also be very bad for the child who will possibly need action taken to ensure that adequate care continues despite his or her parent’s illness.

RECOMMENDATION ON EDUCATIONAL AND FAMILY NEEDS

Care plan provisions need to cover educational needs, both under compulsion and for qualifying children. In section 31(3) and (slightly adjusted) 210(8) on care plans, the “required information” should include:

1. if the patient is a child, a description of what is to be provided to meet his educational needs (unless the child has already left education, other than because of his mental health).

2. if the patient is a child or has parental responsibility, a description of what is to be provided, if anything, to meet his family needs.

SAFEGUARDS FOR PATIENTS IN THE CRIMINAL JUSTICE SYSTEM—IN CONTACT WITH POLICE OR IN THE COURTS

9.7 The criminal justice sections (Part III) of the 1983 Act have not been subject to detailed scrutiny or public consultation since the Reed Committee Report in 1992. The Expert Committee which was required to report to the Department of Health and not the Home Office, was not able to consider them and stated that it needed “far more rigorous and comprehensive consultation and consideration” than had been possible for it to do. They believed an urgent review was needed and that an independent body should be set up to undertake it in the light of their recommendations. This has not occurred. This is a matter of great regret as this group is extremely vulnerable and potentially accounts for many of the people brought within the Act. They are engaging with the police, the criminal courts, possibly prison—none of which are specialised in mental health. The new definition of mental disorder has been grafted on to the current provisions in Part III of the 1983 Act with very few changes for the purpose of the new Bill. While there are some improvements in the procedures for Part III patients there are also matters of great concern.

73 Ibid.
75 Paragraph 15.4.
REMARKS ON BAIL AND TO HOSPITAL

9.8 The Draft Bill introduces new powers for the court to remand on bail for a mental health report. The Alliance welcomes this proposal which is consistent with courts favouring the least restrictive regime. The Draft Bill retains the existing power of the court to remand to hospital for a mental health report (clause 59). This is based on the evidence of a single registered medical practitioner that there is reason to suspect the person is suffering from a mental disorder. The remand will be for a maximum of 28 days and be renewable by the court at 28-day intervals for up to 16 weeks. We are concerned that this increases the current limit of up to 12 weeks. During this period compulsory treatment will be provided to the patient.

TREATMENT UNDER COMPIULSION

9.9 Under the 1983 Act, when a person before the courts (defendant) is remanded to hospital for a report, Part IV provisions on consent to treatment do not apply. Therefore, the defendant can not be compulsorily treated. This has led to the practice of using section 2 or section 3 to run alongside section 35 (therefore the same definitions and conditions as apply for Part II patients). The Draft Bill changes this by allowing the court to authorise compulsory medical treatment for a person remanded under c59 based on the evidence of two registered medical practitioners.

9.10 The safeguards of a nominated person, an advocate and an appeal to a Tribunal do not apply. Nor is there a requirement to consult the patient.76 A care plan will be authorised after 28 days by a mental health order imposed by a criminal court without expertise in medical treatment and without automatic access to the second opinion from a member of the Expert panel. This power is now also given to magistrates’ courts (under the 1983 Act an accused person cannot be remanded to hospital by a magistrate without the bench being satisfied that they committed the offence or if the accused person consents to the remand). These are important safeguards and should be reinstated.

9.11 The provisions of the Bill give no opportunity for patient or advocacy input into the creation of the care plan that is necessitated by a mental health order. The making of a mental health order by the court is conditional upon the preparation and submission to the court of a care plan by an approved clinician.77 However, as a patient will only become a “qualifying patient” when a mental health order is “in force”, anyone for whom a mental health order is proposed will not have access to advocacy.78 It is recommended that advocates should be available to those people for whom a care plan is being drawn up; therefore before a mental health order is made.

RECOMMENDATIONS ON TREATMENT UNDER COMPIULSION

1. The criteria for compulsory treatment of an accused person and a convicted person should mirror those available under the civil system. There should be a right of access to a nominated person and an advocate and the patient should be consulted in drawing up the care plan.

2. In principle criminal courts should not be able to make care and treatment orders. These should, in all cases, be made by a Mental Health Tribunal.

POLICE POWERS TO ENTER PRIVATE PROPERTY

9.12 Police power to detain a person without a warrant in an emergency should not be extended to private property since it would be open to abuse. It is a fundamental civil rights principle that there should be no power to remove a person from his or her own property without court authority. If a crime has been committed the police powers for this already exist. The obtaining of a warrant is usually possible within hours rather than days. While this may not be a technical breach of Article 8 we believe it to be an undue interference with family and private life.

RECOMMENDATION ON POLICE POWERS

The police power to detain a person without warrant should not be extended to private property.

Part 10

QUESTION 6(c). ARE THERE ENOUGH SAFEGUARDS AGAINST MISUSE OF AGGRESSIVE PROCEDURES SUCH AS ECT AND PSYCHOSURGERY?

10.1 The revised Draft Bill contains improvements on the previous version in the section on treatment safeguards, particularly by introducing requirements on the expert panel member to consult when forming

76 Elsewhere in the act, clause 31(a), it is stated that in preparing a care plan for the patient, the clinical supervisor must consult the patient about the medical treatment to be specified in the plan unless it is inappropriate or impracticable. Schedule 5 states that provisions of part 2 do not apply to part 3 unless specified in part 3.
77 Clause 115(1).
78 Clause 248(f), Clause 247.
their opinion, and allowing patients with capacity to refuse ECT (electroconvulsive therapy). However, there are still significant improvements that need to be made, and the need for safeguards extends to psychiatric drugs as well as ECT and psychosurgery.

**Psychosurgery/Neurosurgery for Mental Disorder (NMD)**

10.2 Psychosurgery/NMD falls within the category of Type A treatment created in the revised Draft Bill. Such treatments may only be given under the legislation and not at all to under-16s. They require consent, second opinion and best interests, or where a patient lacks capacity to consent, is not expected to regain capacity and is unlikely to resist treatment, the requirement is second opinion, best interests and a High Court order. This differs significantly from the current position (ie under the Mental Health Act 1983) which does not allow the operation where a patient lacks capacity to consent.

10.3 Psychosurgery is an irreversible, invasive and hazardous procedure. The nature of the procedure precludes trials that could establish effectiveness. Possible side effects include fits and cerebral haemorrhage, apathy, excessive weight gain and disinhibition. Subtler effects on personality, being harder to assess, may be less recognised or documented. There are also risks generally associated with anaesthetic and surgery, including infection. During a period when the Geoffrey Knight Unit (now closed) was forced to suspend operations for technical reasons, they continued to admit patients for trials of high dose and combined antidepressants which has reduced the need for psychosurgery in recent years.79 At least for some people, it is possible that other treatment options have not always been fully tried before resorting to psychosurgery. Practitioners do not agree with operating on patients who cannot consent: reports on NMD by the Royal College of Psychiatrists (2000) and the NMD Unit in Dundee (2004) reject this option.

10.4 The Alliance view is that having an irreversible and/or hazardous treatment like psychosurgery should only ever be decided by the person having the operation, not by another person on their behalf. This is particularly so where there is no clear evidence for the treatment’s benefit in general, or for its likely success in the individual concerned. Service users are likely to feel under threat if there is no clear-cut prohibition on psychosurgery/NMD without consent. The Alliance therefore considers that this provision should not be included in the Bill, and the current restrictions on its use should be maintained.

**Recommendation on Psychosurgery**

Exclude the provision for allowing psychosurgery by High Court order from the Bill, and maintain the current safeguards in the 1983 Act.

**Electroconvulsive Therapy (ECT)**

10.5 ECT is an invasive procedure and some people experience permanent loss of memories, as well as other adverse effects. The extent to which it is used by individual clinicians varies a great deal. A systematic review of clinical research carried out for the Department of Health states: “the more effective forms [of ECT] tend to cause more memory impairment. There is, therefore, a trade-off between making ECT optimally effective in terms of ameliorating depressive symptoms and limiting cognitive impairment as much as possible.”80 A review of the literature about patients’ views of ECT, also commissioned by the Department of Health, found that at least one third of patients report significant memory loss.81 This loss is often of autobiographical memories which can have a profound psychological impact, as the following, from a Mind survey, indicates: “Very basic information [provided about the treatment] ie it is safe and effective and possible side effect ‘short term memory loss’ which I presumed to be forgetting names etc. No idea of depth of loss, places visited in the past, precious life memories.”82 Other psychological effects also feature prominently among adverse effects of ECT such as feelings of fear, worthlessness and betrayal.

10.6 Under the revised Draft Bill, patients with capacity to consent may not be given ECT without their consent. The Alliance welcomes this important change. However, the Bill includes a regulation-making power to make it possible to over-ride the patient’s refusal in emergencies. The definition of emergency is drawn quite widely. Also, the way that the criteria for emergency ECT are worded implies that the treatment is not in and of itself irreversible or hazardous, but that it might be either or both in any individual case. This may make interpretation of the law unclear and create fear and uncertainty for patients who do not want to have ECT. The variable use of ECT by clinicians (some prescribe it rarely or never), and the damaging effects reported by a large minority of people having ECT, call into question the necessity of ever giving ECT against a person’s will, even if it were thought justifiable to override the autonomy of a person.

---

79 P K Bridges, Correspondence, Psychiatric Bulletin, 21, 121–122.
who retains decision-making capacity in this way. This is particularly the case if the person is not in a life-threatening situation. The Alliance considers that a person with capacity should be able to refuse ECT without qualification.

10.7 Under the revised Draft Bill, patients who lack capacity and young people under 16 must have treatment authorised by the Tribunal, except in emergencies. As indicated, the wording of the emergency criteria requires attention. It is important that the Tribunal considers the treatment in advance when at all possible and it should not be open to individual clinicians to hold, for example, that ECT is never irreversible or hazardous. The Alliance view is that emergency criteria should be limited to saving life. Because of the seriousness of the procedure, and the greater vulnerability of young people to damage from it, the Alliance believes that the threshold for safeguards for young people should be 18 and not 16.

10.8 There is nothing in the legislation to prevent treatment being given in unsafe conditions by inadequately trained staff—a real possibility as audits of ECT show. The Alliance considers that the law should require compliance with national standards.

**Recommendations on Electroconvulsive Therapy (ECT)**

1. ECT should be given only with informed consent for people with capacity to give or withhold consent
2. The emergency criteria for ECT for those incapable of giving consent should be restricted to saving life
3. The nominated person should be notified and (if the patient wishes) an advocate involved if ECT is being considered

**Drug Treatments and Care Plan**

10.9 Drugs used in psychiatric treatment are not effective for everyone. They have a wide range of possible adverse effects that range from the uncomfortable to disabling and life-threatening. Even if tolerable in the short term they can have a serious long term impact on health. Responses to different drugs vary between individuals, and the person taking the drug knows how badly they are being affected (at least in relation to obvious effects such as muscle spasms, agitation, weight gain or loss of libido, as against effects such as impaired heart function).

10.10 There is no provision for patient’s consent to treatment in the revised Draft Bill. It is essential that people are as involved in treatment decisions as possible and that they first have the opportunity to receive treatments on a consensual basis before any consideration is given to treating against their will. The Alliance view is that people with capacity should be able to consent to or refuse any treatment, including drug treatment.

10.11 Currently, drug treatment after three months must be authorised by a second opinion appointed doctor. Under the revised Draft Bill patients would have treatment authorised by 28 days, by the Tribunal. However, it is unclear how specific the care plan would have to be in relation to the treatments being prescribed. The revised Draft Bill gives no indication of the contents of the care plan. The Alliance considers that the essential elements of a care plan should be set out in the Bill so as to provide a basis for assuring quality of care. It should include a multidisciplinary approach so that a wider range of treatment options is considered. This can only contribute to the health and safety of the patient, and help to reduce the use of emergency provisions and more invasive treatments.

**Doses Above BNF Limits**

10.12 Dose ranges set out in the British National Formulary (BNF) are generally the same as those for which the drug is licensed. Going above licensed limits of itself adds a level of risk and the BNF summarises guidance from the Royal College of Psychiatrists in avoiding and minimising the use of this practice in the case of antipsychotic drugs.

10.13 Such doses should not therefore be given unless with informed consent or in closely defined circumstances that would accommodate any justifiable exceptions to licensed doses. Similarly going outside the licensed uses of a drug in other ways (prescribing of a child).

**Recommendations on Drug Treatments**

- Doses above BNF limits should only be given with fully informed consent or to prevent serious risk to the life of the patient, subject to the approval of the Tribunal and a limited time period.
- Drug treatments should only be used outside their product licence in the interests of the patient’s health if there is no licensed alternative, with the Tribunal’s approval.
Part 11

QUESTION 7. IS THE BALANCE STRUCK BETWEEN WHAT HAS BEEN INCLUDED ON THE FACE OF THE DRAFT BILL, AND WHAT GOES INTO REGULATIONS AND THE CODE OF PRACTICES RIGHT?

11.1 In answer to previous questions we have referred to the need for principles and criteria for the imposition of compulsion in the community to be on the face of the Bill. We believe also that the powers of the Tribunal and the requirements for care plans should be set out clearly. In general however our main concern is with the very broad concepts that may or may not even be amplified within the Code of Practice (eg that nominated persons must be “suitable”; that “specified” conduct may be prescribed in an NRO; that consultation with patients must be “inappropriate or impracticable”) as constituting particular defects in the legislation.

11.2 The status of the Code of Practice is central to the proper safeguarding of patients’ rights under the Bill. As the Mental Health Act Commission has stated, “Government therefore has a role through its Code of Practice in providing guidance and standards to ensure that rights are respected by different authorities; to provide transparency and predictability in the operation of the law; and, not least, to help authorities avoid spending time and other resources “re-inventing wheels” in drawing up policies and attending to their own practice.” 83 Provided that it has an adequate status, detailed issues can be left to the Code of Practice.

11.3 The Expert Committee decided against recommending that the Code should have statutory force because some parts of the Code operate more as good practice than as details of the implementation of the act itself. However, this may not necessarily be an obstacle if it were clearly stated which parts of the Code were to have statutory force (eg seclusion and restraint provisions) and which were to operate as Good Practice. The Part III Code of Practice of the Disability Discrimination Act is an example of this separation.

11.4 The Expert Committee recommended that a Draft Bill should expressly contain a presumption of compliance with the Code. There is no such presumption contained in the new Draft and people working within the new Act’s powers will only need to “have regard” to the Code. This creates a far weaker requirement than that laid down by the Court of Appeal in R (Munjaz) v Mersey Care NHS Trust and R (S) v Airedale NHS Trust. The Court ruled that that hospitals and professionals are required to follow the Code unless they can show that it is necessary and in accordance with the law not to follow it. This would seem to require that at least, the Code of Practice must be followed unless there is a good reason to depart from it in relation to individual patients. It would not be acceptable to depart from the Code as a matter of general policy. The minimum requirement would be that authorities should “record and provide reasons in patients’ clinical records for departures from the Code’s guidance.” 84

11.5 The JCHR states in its Report on the 2002 Bill that “While the proposed Code has worthwhile objectives [. . .] breach of the Code of Practice would not seem to make a decision or action unlawful (although the legal status and effects of the Code of Practice are not specified in the Draft Bill, unlike those of the Codes of Practice issued under other legislation such as the Police and Criminal Evidence Act 1984). We note also the Local Authority Social Services Act which obliges authorities to act under the general guidance from the Secretary of State.” 85

11.6 While it is important that the Code of Practice can be changed with changing circumstances we do not think it appropriate for there to be unlimited flexibility and we note the problems caused by the last amendments. We consider that changes must be subject to consultation and be placed before Parliament in order to take effect. A model for this is contained in Section 53A of the Disability Discrimination Act.

RECOMMENDATIONS ON CODE OF PRACTICE

3. The Bill should specify that the Code of Practice should be statutorily enforceable and that parties should be required to act within the Code unless there is a necessity for departure in the individual case.

4. The Bill should lay down a procedure for amendment of the Code of Practice which involves a duty to consult and a duty to lay before both Houses of Parliament.

Part 12

QUESTION 8. IS THE DRAFT MENTAL HEALTH BILL ADEQUATELY INTEGRATED WITH THE MENTAL CAPACITY BILL (AS INTRODUCED IN THE HOUSE OF COMMONS ON 17 JULY 2004)?

12.1 On the surface there is apparent integration between the Bills; the Draft Mental Health Bill does not require compulsory powers to be used unless the patient poses a significant risk of serious harm to self or others. On the other hand, where a patient lacks mental capacity the scheme for substitute decision-making

83 Page 68, Paragraph 6.23.
85 Footnote to come.
under the Mental Capacity Bill (MCB) permits the lawful provision of medical treatment in most circumstances.\(^88\) In principle, therefore, it should not normally be necessary to invoke the powers in the Draft Mental Health Bill with regard to someone who lacks mental capacity.

12.2 However, what this highlights are the significantly different philosophies and procedures contained within the two provisions which, when looked at together, become highly problematic. The MCB is aimed at promoting autonomous decision-making where the person has capacity and this is enshrined in the “principles” of the Bill.\(^87\) In the Draft Mental Health Bill a person with a mental disorder who is believed to be at risk to himself or someone else may be restrained and compulsorily treated whether or not he has full mental capacity.

12.3 The MCB on the other hand makes it clear that a decision to provide treatment for a physical disorder may not be imposed upon a person who has sufficient mental capacity to refuse it, even if it appears to be in the person’s best interests. By contrast the Draft Mental Health Bill requires the use of compulsion if professionals perceive it to be necessary, whether or not the patient has sufficient capacity to consent to treatment and/or his or her own best interests. However, where the MCB is used for the purpose of treating someone who lacks capacity there are fewer safeguards, and of a very different nature, to those contained in the Draft Mental Health Bill. This is likely to lead to a clash of principles and practice, causing confusion and the application of potentially inappropriate legislation in a number of situations.

12.4 Many patients will move between the two regimes: this can be seen most clearly in a patient with fluctuating capacity (with, for example, bipolar affective disorder). When someone lacks capacity and is compliant s/he must not be treated under the Draft Mental Health Bill as treatment under the MCB will cover his/her situation (see clause 9(5)). If s/he regains capacity but refuses to continue his/her treatment it will be necessary to use the compulsory powers under the Draft Mental Health Bill until s/he loses capacity again, when s/he must be discharged, and so on. This will be immensely complicated because of the two different systems.

### The Bournewood Gap

12.5 The case of HL v United Kingdom (App no 45508/99), the so-called “Bournewood” case highlighted the plight under the existing law of those who were judged to require medical treatment but lacked the mental capacity to accept or refuse it: both restraint and treatment can be provided under common-law “necessity”, without any of the legal safeguards that protect those who have been detained under the Mental Health Act. This was described by one of the Law Lords as an “indefensible gap” in mental health law and is commonly referred to as the “Bournewood Gap”. The European Court of Human Rights held, contrary to the previous decision of the House of Lords, that HL was detained and that there were insufficient safeguards to protect him from arbitrary detention under Article 5(4) of the European Convention on Human Rights.

12.6 Neither the MCB nor the Draft Mental Health Bill addresses this issue. The range of safeguards for Bournewood patients that were included in part V of the 2002 Draft Bill were omitted on the basis that they have been taken forward in the MCB. However, the MCB provides none of the safeguards in Part V of the 2002 Draft Bill.

12.7 In Part V of the initial Draft Mental Health Bill there was the requirement for a plan of care and treatment to be drawn up with regular reviews; a nominated person appointed to act as the person’s representative and advocacy to be made available to the patient if they so wished; a second opinion doctor to be available for certain situations; procedures for resolving disputes; and applications allowed by the patient or their nominated person to the Tribunal for discharge. All of these safeguards were available irrespective of whether the patient had a relative or other interested person to consult. Under the MCB, individuals who lack the capacity can be admitted to hospital and/or treated if this is considered to be in their “best interests”. Such actions can be taken if they are “acts in connection with care or treatment”. No court order is required. Where it is proposed to give the person “serious medical treatment” (which the MCB fails to define) or admit the person to NHS or local authority accommodation and there is no relative or other interested person to consult, an “independent consultee” must be asked to advise on whether such actions would be in the person’s best interests and this advice must be taken into account. The “independent

---

\(^88\) For example, clause 11(6)(c) permits the donee of a Lasting Power of Attorney (“LPA”) to give or refuse consent to the carrying out or continuation of treatment by someone who is providing health care to the incapacitated donor of the LPA. Clause 17(6) gives a similar power to a court-appointed “deputy”. In addition, clauses 5 and 6 of the MCB permit anyone to take steps in the best interests of a mentally incapacitated person which are in his best interests. Any such step should not conflict with an authorised decision made by the donee of a LPA or a court-appointed deputy, but clause 6(6) permits the administration of life-saving treatment or any act which the person reasonably believes necessary to prevent a serious deterioration in the patient’s condition while a decision is sought from the court. These powers extend to permitting the donee of a LPA, the deputy or anyone else to “restrain” the person lacking capacity, if it is believed necessary and is proportionate to the harm he or she is otherwise likely to suffer.

\(^87\) “(2) A person must be assumed to have capacity unless it is established that he lacks capacity.

(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.”
consultee” and as yet to be clearly defined process of appeal to the Court of Protection (whose location and accessibility are also unclear) are not the equivalent of the Part V safeguards nor meet the requirements of the European Courts’ ruling.

ECT and Individuals who Lack Capacity

12.8 One of the discrepancies that arise from the failure to consider the relationship between the Draft Mental Health Bill and the MCB is the stark contrast between the provisions relating to ECT. Those patients who are detained under the Draft Mental Health Bill and lack capacity cannot be given ECT (save in emergencies) unless a Mental Health Tribunal has approved such treatment. No such independent approval would be necessary under the MCB.

Lack of Clarity on the Application of Legislation

12.9 The failure to address the potential overlap of the proposed legislation, the existing common law and Mental Health Act 1983, means that there is a huge potential for confusion and perverse incentives may be created which will require subsequent correction by Parliament. For example:

“Non-compliant patients” and the Mental Capacity Bill

12.10 Although this Bill specifically prohibits the provision of treatment for mental disorder when the person’s “treatment is regulated” by the compulsory treatment provisions of the Mental Health Act 1983, this applies only to those individuals who are at the time detained in hospital under the Mental Health Act 1983. The MCB allows individuals to be admitted to hospital and treated for mental disorder, if they lack capacity to make decisions about their admission and treatment. The MCB also allows force to be used to admit a person into hospital if this is considered to be a proportionate response to the risk that the person who lacks capacity may suffer harm. It is not clear whether this provision would override the House of Lords’ decision that a person who lacks capacity may only be admitted informally to hospital for treatment for mental disorder if s/he does not object to the admission. Confusion is also likely to arise when the health of psychiatric patients already in hospital on a voluntary basis deteriorates but they express a wish to leave, against clinical advice. Staff may be very unclear as to whether to use common law, mental capacity or mental health legislation if they try and restrain the person from leaving. Staff may also attempt to use the MCB for longer periods to detain someone in hospital if they perceive it as an “easier” and less bureaucratic option than mental health legislation. Thus, far from closing the Bournewood Gap, it could be greatly increased to include far more patients unless there is absolute clarity, and/or equivalent safeguards in the two Bills.

Individuals likely to be a danger to others and the Draft Mental Health Bill

12.11 Clauses 9(5) and (7) state that the Draft Bill’s compulsory powers cannot be used if the medical treatment can lawfully be given by other means. However, this does not apply if the person is considered to be at substantial risk of causing harm to other persons. This suggests that, under the current law, individuals who lack capacity but do not object to their admission to hospital would continue to be admitted and treated informally, unless they posed a danger to others. Where they present a risk to others they would be subject to the compulsory powers of the Draft Mental Health Bill. The same would apply if the provisions under the MCB were in force, save that, as discussed above, clarification would be required as to whether the MCB could be used to admit people to hospital to receive treatment for their mental disorder even if they objected to their admission.

Best interests

12.12 Professionals and carers are likely to experience considerable difficulty in the situations outlined above in weighing up the issue of “best interests” for a person without capacity to consent to treatment. For example, would the less procedurally bureaucratic approach of the MCB be preferable over the Draft Mental Health Bill, particularly given the stigmatisation that many people experience as a result of being detained and treated under mental health legislation.

Least restrictive alternative

12.13 Clause 1(3) (c) of the Draft Mental Health Bill states that “the interference to patients in providing treatment to them and the restrictions imposed in respect of them during that treatment are kept to the minimum necessary to protect their health or safety of other persons”. Clause 1(6) of the MCB states that “before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action”. As with “best interests” these similar (though significantly different) principles are likely to cause confusion among professionals and carers when deciding how best to professionals and carers are clear
about which legislation to use in general terms but less clear about the exact intent: the principle in the Draft Mental Health Bill implies that a decision has already been taken to provide treatment but that it should involve minimal interference where as the principle in the MCB demands that less restrictive alternatives should be considered before a decision is even taken.

Advance refusals of treatment

12.14 The MCB includes provision for people to make advance refusals of treatment whereby a person with capacity clearly states the circumstances and treatment they would wish to refuse should they lack capacity to consent in the future. This includes life-sustaining treatment. However, these could be overridden if the person is subject to compulsory treatment under the existing Mental Health Act and there is nothing in the Draft Mental Health Bill to indicate that this would not continue to be the case. This would therefore appear to be discriminatory against people with mental disorders who should have the same rights, unless there are exceptional circumstances such as the likelihood of causing imminent and serious harm to self or others, as people with physical disorders. This seems particularly anomalous when the Government is defending advance refusals in the MCB which would allow people to exercise some dignity and control at the end of their lives, which many members of the Mental health Alliance fully supports, yet allow no dignity or control for people in non-life threatening situations by virtue of them having a mental disorder.

12.15 The Mental Health Alliance contains a number of members who are also members of the Making Decisions Alliance which has been campaigning for mental capacity legislation. Broadly speaking we have therefore welcomed the MCB although recognise that for a number of reasons it still requires considerable improvements. We would view the MCB as the most appropriate piece of legislation to address the needs of people with mental disorders who lacked capacity to consent to treatment. However, as indicated, we do not consider the MCB to have sufficient safeguards at present to satisfactorily achieve this. We have therefore submitted a proposed amendment to the MCB aimed at incorporating these safeguards.

RECOMMENDATIONS ON OVERLAP BETWEEN THE MENTAL CAPACITY BILL AND THE DRAFT MENTAL HEALTH BILL

People with a mental disorder who lack mental capacity to consent to treatment should be dealt with under Mental Capacity legislation with the following safeguards:

— Clear conditions and assessment process for the safeguards;
— Clarity concerning the duties of the responsible clinician and the availability of a second opinion from someone with the relevant clinical expertise concerning the person’s mental disorder and/or lack of capacity to consent to treatment;
— Notification and appointment of a representative for the person (independent advocacy);
— Preparation, approval and procedure for review of a care plan;
— Procedure for resolving disputes, including application to the Court of Protection.

Part 13

QUESTION 9. IS THE DRAFT MENTAL HEALTH BILL IN FULL COMPLIANCE WITH THE HUMAN RIGHTS ACT?

13.1 While we lack the expertise to make definitive judgements on this issue it is unlikely that the Bill will fully meet the requirements of the Human Rights Act (HRA).

13.2 The recommendations of the Joint Committee on Human Rights have not been heeded in the new Draft Bill. We draw attention to their views on the status of the Code of Practice, the power to disapply principles, the lack of exclusions, the overriding of advance directives and the danger of preventive detention. In their view it is questionable whether the non-therapeutic detention of persons without conviction of an offence, on the grounds of “speculation about possible future behaviour and resulting risk to identified persons”, will be compatible with the HRA. The JCHR noted in its Report that explicit powers of preventive detention established by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 had been deemed compatible with ECHR Article 5 by the Judicial Committee of the Privy Council, but pointed to the fact that these powers related only to restricted patients who have been convicted of serious offences and set no clear precedent for patients who have had no contact with the criminal justice system.

13.3 It is also possible that the wide definition of mental disorder together with the vagueness and breadth of the key concepts (for instance “appropriate”, “for the protection of”, “treatment”, “all the circumstances of his case”) lacks sufficient certainty to comply with the requirement that loss of liberty must be in accordance with the law. A person must be able to know whether they fall within its ambit. We also believe that the disproportionate response to people who pose a significant risk to others (by providing that they can be detained despite their willingness to receive treatment), the discriminatory impact of the law for

88 Article 5 cases such as Litwa v Poland and Pretty v UK (both cited by Fennell in Mental Health law and Human Rights CCELS, 2004) show that proportionality applies to Article 5 and Article 8 cases.
those within the criminal justice system, the powers of the Tribunals to impose the equivalent of civil restriction orders and the power to defer release of patients for eight weeks may in some cases breach article 5(4) and article 14 of the HRA.

13.4 Professor Genevra Richardson has commented that the Home Secretary has retained the power to order leave or transfer of restricted patients and considers that this may be in breach of the HRA. We believe that the retention by the Home Secretary of this power is in any event undesirable. Leave and transfer to lower security accommodation are used as steps towards discharge for patients who are seen to be dangerous. Since the act will require the legality of a detention to be subject to a judicial decision we consider that it is only fair that this should also apply to the preliminary decisions towards discharge.

13.5 The Human Rights Act is a “living instrument” which changes its interpretation over time. There are indications that case law may decide that if treatment is forced on people with capacity to make their own decisions when they do not present a serious threat to others article 3 and article 8 could also be engaged. Recent case law from the European Court of Human Rights demonstrates that early case law can not be relied upon. In Keenan v UK the court stated:

“For example, in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3. Similarly, treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be capable of pointing to any specific ill-effects.”

Part 14


14.1 Throughout this submission we have emphasised the human implications of this Bill. It will increase stigma for service users, drive them away from services, increase the incidence of coercion, disrupt relationships between service users and those professionals who care for them and set back the Choice agenda.

14.2 The many professional bodies who have joined the Alliance—most recently the British Medical Association—have expressed their concern on the effect of the proposals both in terms of the nature of their likely future work and also the undermining impact of the Bill on their therapeutic relationship with patients. For many professionals, this feels counter-productive to the current emphasis on choice and within mental health of a more user-focussed mental health service.

14.3 The Bill in its inevitable increase in the numbers of people under compulsion will have significant resource and workforce implications. There will be a significant increase in tribunal hearings. There will also be a vast expansion in the types of decisions that tribunals will be empowered to consider, such as authorising care plans, displacing nominated persons, authorising ECT and examining whether the relevant conditions apply. This will require a huge change in the culture of Mental Health Tribunals. It is likely that hearings will be significantly longer and there will be massive implications for recruitment and training. The present Tribunal system is struggling to manage the present level of demand with appeals being cancelled and delayed. We have grave concerns about whether the new, expanded system is realistic and practicable.

14.4 We would particularly refer you to the submission by the Sainsbury Centre for Mental Health, which highlights concerns about the workforce issues.

14.5 Paragraphs 47–54 of the Regulatory Impact Assessment outline the anticipated additional resource required. However, it is extremely difficult to understand the rationale which has been applied to calculate these figures. In particular, we would question the additional number of advocates required (the submission by AMHA goes into this in more detail), which suggests the need for just 140 new staff. At present, most mental health advocates work across a range of health and social care environments not just in the compulsory arena. Access to an advocate is a significant safeguard, but becomes meaningless if the person under compulsion is unable to access an advocate when they need them.

14.6 In addition to the newly identified resources, we would highlight the effect the new proposals would have upon the existing workloads on many clinicians and community services. In human terms this is likely to lead to a reduction in support for those patients who are not considered to be in “crisis” but for whom early intervention and community-based support could prevent subsequent compulsion.

14.7 The Alliance recognises that our own proposals have cost implications, and that any system will have both an administrative and a resource burden. However, we believe that if resources are allocated to prevent compulsion being needed, and the conditions are appropriately set so that compulsion is seen as a last resort, then the resource implications would be more proportionate.

14.8 The implications of training and fully implementing the new Act are also significant. A key lesson from the 1983 Act was the failure to implement the measures consistently. The proposals in the Draft Bill have far-reaching consequences. They will require a very significant recruitment of new types of staff (AMHPs and advocate), each of whom will need to be developed. There will also be a significant amount of training for the current mental health workforce and at the local level new bodies will need to be created. This will require considerable time and money. The amount of both will need to be considered carefully in any plans to implement a new Act.

RECOMMENDATIONS ON WORKFORCE IMPLICATIONS

1. A thorough examination of the proposals for workforce implications, with detailed explanation of the assumptions made, is needed.

2. Particular attention should be given to the plans for implementing the right to advocacy so that advocates are available when needed.

3. The Scrutiny Committee may wish to recommend a minimum time period between the passing of the legislation and the implementation date.
Bill are precisely that as fundamental principles. Also, I think if they are left to the Code of Practice there is a problem in that we do not know what the status of the Code of Practice will be, and, of course, it is part of our argument that the Code of Practice should have a statutory force, but, if that is not the situation at the moment and if they are in the Code of Practice, there is only a need to have regard to them and, indeed, they could be changed. We think the principles that we have enunciated really must inform the practice of the legislation.

Q144 Chairman: But if they are imperative, if it is an imperative that they should be on the face of the Bill, then why should they not be enforceable as a matter of law?

Dr Daw: I think in the nature of the principles that we are suggesting, there are more underlying principles that, if you like, then come into play in individual provisions. So, for instance, where we talk about the principle of autonomy, that obviously is the background to what we think should be part of a test for compulsory powers,—one of the conditions for compulsory admission and treatment. So, as far as we are concerned, that is adequate. Also some of them by their nature would not be legally enforceable within the framework of this legislation, I think. Some of the principles around diversity and around equality are more principles of how practice should be conducted rather than specifically enforceable.

Q145 Baroness McIntosh of Hudnall: I just wanted to investigate a little bit the issue that you raise in your evidence about the relationship between the statement of general principles on the face of the Bill and the question of stigmatising people who suffer from mental health problems. I am not entirely clear what the connection is that you are making there. Can you unpack that for us, because clearly that is rather an important question?

Dr Daw: Again, I think it is at a general level that we make that point, because stigma is in terms of how the legislation works out in its detail. For instance, the distinction between treatment: the ability of people with a physical health problem to refuse treatment, whereas that is not available in the circumstances under the Bill for a person with a mental disorder—we believe that that very distinction in itself is stigmatising. So that is one aspect of it. The other aspect which is rather different relates to the way in which the Bill has an impact on.... People particularly from black and minority ethnic community backgrounds have been shown, as you know, from research year after year, to have been disproportionately sectioned and, in many cases, wrongly so. We feel from a public face point of view it is very important. tucked away in a professional code of practice.

Mr Farmer: Could I make a brief additional point? I think it is very important for us to consider where the legislation sits within the wider context of mental healthcare, and for many people the experience for somebody with a mental health problem or with a severe mental illness and their families is often one of intense stigmatisation; and this point, the point at which somebody might lose their liberty and also have compulsory powers imposed upon them, is, if you like, the end point often of that process of stigmatisation; and so I think there is an awful lot of concern from people who work and receive services that a piece of mental health legislation such as this needs to clearly and explicitly state the underlying principles on which the legislation is based. I think if you place those principles onto the face of the Bill, it sends a strong and clear message to users, to carers and also to practitioners that these are the underlying bases on which the process of compulsion is going to take place.

Q146 Baroness Cumberlege: Continuing that theme, I was very interested in your submission that you set out ten principles that you think ought to be taken into consideration, and 10 is a very even number and people always focus on the number 10, but I just wondered: do you leave out the question of protecting the public from harm? I appreciate that is something that perhaps you feel should not anyhow be part of this Bill, but do you think, as already we do have it incorporated in the Bill, that that ought to be one of your principles?

Dr Daw: We did not include that principle, it is true. I think it is important that we state quite clearly that rather an important question?

Dr Shooter: Yes. As far as what you have just said, I think it is important that we state quite clearly that any piece of mental health legislation always has to be a balance between individual autonomy and protecting the public, and I think that will run through any Act which comes out of the current debate. As far as the list of principles is concerned, I would like to say that I have been round several hundred users and carers groups over the last two years and, indeed, I was with another group yesterday afternoon in the south of England; and we looked at the principles that we were asking for and that were set in the context of extreme anxiety in that particular group. They would not let me come away without agreeing to say at least three things to you this morning, one of which was that they felt it essential that those principles for their confidence in the system were on the face of the Act rather than tucked away in a professional code of practice.

Q147 Mr Howarth: I did not understand fully the point that was being made in relation to stigmatisation where there are also present physical health problems. Could you elucidate further on that perhaps?
Dr Daw: Yes, I think it is best explained by saying that, if a person has cancer and chooses not to have chemotherapy, even though that could end their life very much faster, there is no way in which they can be forced to do so. That is a physical illness. If, however, a person has a mental disorder and chooses not to take treatment that a physician thinks will get them better but it is believed that they should do so, they can be sectioned, and that is a basic and fundamental distinction. In both cases I am assuming that the person had full capacity to make the decisions and, of course, you are aware, I think it has already been mentioned to you, about the case of Ms B who was entitled to refuse to continue to have treatment given to her in order that she could die with dignity. That choice is not given to people with mental disorder, and in our experience with service user groups and with professionals alike, this is the key issue that comes up again and again when we look at why people feel very hostile to the compulsory process. It is particularly in that circumstance where people feel that their wishes have been overridden because of a decision by a physician that something is in their best interests.

Q149 Chairman: Before we move on to the next question, which we will in a moment, can I put this to you. I am slightly puzzled by your submission because you propose that the principles should be on the face of the Bill, if one were to take, as an example, a principle—I am taking this from the Bill—decisions are made fairly and openly and there is a challenge on the basis that the decision has not been taken fairly and openly—why on earth should that not be enforceable if necessary by judicial review? You appear to be saying not; and I would simply ask you if you might like to consider that further. You may be right; you may not be; I am not expressing am opinion, but it is just an issue that may be of concern to the Committee when we come to deal with this question of where the principles should sit?

Dr Shooter: I think that is a very fair point, my Lord. I must say that I, as a member of the Alliance, and certainly the group of carers and users I was talking to yesterday are not so pessimistic about whether some of these principles are enforceable or not, and I would agree that there may be some for which services and individual clinicians can be held to account, and well and good.

Q150 Lord Rix: On page 11 of your submission you suggest that a broad definition of "mental disorder" has to be linked to specific exclusions and propose that the exclusions from the 1983 Act should be retained, albeit in a clarified format. Here I must declare an interest, playing on my one-string fiddle with Dr Shooter has already heard and my personal orchestra is now going to be joined by Angel Browning. I do not believe that a person with a learning disability should automatically be included in this Bill as they are now and were in 1983. I believe that a person with a learning disability should be added to that list of exclusions unless that person has a significant mental health problem. Can I take it that you agree with this? Certainly the Royal College appeared to last week, Dr Shooter. Even if the conditions for the use of compulsion were tightened and refined, would you still wish to see specific exclusions included in the Bill?

Dr Shooter: Yes, certainly. I would agree with everything that you say, as would have been clear from our evidence through Dr Zigmond last week. I think there are certain groups of people in society who are highly vulnerable, because of social disapproval, to being brought within the scope of the legislation. I do not think there is any room whatsoever for someone, purely and simply because of their learning disability or because of their drug abusing or alcohol abusing life style, to be brought within the remit of the Mental Health Bill. If they have a concomitant mental health disorder, then that is another issue, and one then has to decide on the basis of that concomitant disorder whether they fall within the remit of the Bill or not.

Q151 Mrs Browning: Could I ask you in this context about autistic spectrum disorders: because we heard from the Royal College last week, I thought very encouragingly, that we collectively have to decide how we deal with ASD; and I would endorse the point you have just made that it is, of course, quite possible and quite common sometimes for ASD to have an overlying mental health disorder problem, depression particularly, even schizophrenia, but we know, as we have seen in the submission from the National Autistic Society, that very often somebody presenting with an episode of behaviour is misdiagnosed as having a mental disorder, very frequently schizophrenia or personality disorder. I just wonder what your advice to the Committee would be and your views, how you see ASD in this context, because they are not included within the 1983 Act at the moment?

Dr Shooter: I think rightly so. I would agree entirely with the debate that we had here last week. I think I would like to couple it with another answer, in fact. I think that it is essential, even more essential, that we should have specialists in child and adolescent care involved in these situations, because I think there is a real danger that somebody who does not know much about the diagnosis of autistic spectrum disorder might, exactly as you said, confuse behaviour with a concomitant mental health problem.

Mrs Browning: Could I put on record, Chairman, I am terribly encouraged by the work that the Royal College is doing in this area. I think it is enormously helpful.

Q152 Mrs Blackman: Could you say a little bit about capacity in terms of the psychiatrist work force at the moment to diagnose people with autistic spectrum disorder?

Dr Shooter: I think we have a problem in adult psychiatry who are (a) less used to having experience with people with autistic spectrum disorder and (b) may not have the resources to do anything about their experience if they have not; and I think there is a real problem. We should admit that. That is a
question of resources and it is a question of education and training, and all of those things need carefully looking at in the future.

Q153 Ms Munn: I want to move on to the issue of care plans. In your submission you have stated that you think that the care plans that are set out in the current Bill are too narrow and that you favour the care programme approach, which has now been in use for some considerable time. I wonder if you could explain to us in a bit more detail what you think are the benefits of the care programme approach as opposed to what is set out in the Bill?

Mr Farmer: I will pick up this question. As you say, the care programme approach is broadly accepted within mental health as the best and the most appropriate vehicle, if you like, for ensuring that the support and care that somebody with a mental health problem receives is contained and is coordinated in a single plan, and this was on the back of a history of very confusing and very diverse forms of treatment and care with the individual not knowing what was or was not the appropriate form of care. This is now a broadly accepted mechanism; indeed it is part of the Government’s national service framework. It is a stated objective of the National Service Framework that all service users should have a written copy of their care plan and that it should be acted upon, most importantly. Why we see this as being a key theme within the legislation is that the principles of the care programme approach include a very holistic approach to the needs of an individual. So rather than accentuating, as currently, the proposals within the Bill do, the medical form of treatment, the care programme approach tries to take account of the wider social needs of the individual, and, in particular, issues like psychological care, around housing, social support, occupational issues and so on and so forth. What that means is that in considering a package of care a tribunal should really take into account all those issues rather than simply taking into account the medical considerations. The Government in its response to the Bill in publishing the current draft Bill has stated that there should be a wider consideration. However, unfortunately those wider considerations are once again to be contained within the regulations, and section 115(2) of the Bill, which is the relevant section, simply accentuates, continues to accentuate the medical and makes very little reference to other forms of treatment. This is worth comparing with the Scottish Act, which does include within it a duty within the face of the Bill to consider the wider concerns and considerations. I just wanted to perhaps give an example about why social care issues are important in this case, particularly if the Government is intent on introducing non-residential orders. We have worked... Rethink’s national advice service works with a number of people, and, sadly, we are working with a family who are from a black and minority ethnic background whose son committed suicide. They were in regular contact with mental health services, but, unfortunately, they were housed on the seventh story of high-rise tower block; and I think it kind of illustrates why any tribunal, any care programme, needs to reflect some of wider social needs of an individual.

Q154 Ms Munn: Can I ask one other aspect on this which I think is a bit unclear in the draft Bill, which is around the people subject to a care plan or care programme approach signing up to it: because it says "the care plan can be changed" and when we look across at other forms of social care, whether it is adult care under the NHS and Community Care Act or the Children Act, the central importance is people who are receiving that care and their families being aware of what is happening and agreeing to certain aspects of it; because they may also be part of that plan, so it is fundamental to the success of care plans. I am unclear as to whether that is properly included and I would like your view on that?

Dr Daw: I think we are unclear as well. It is simply not clear. There is not much in the Bill itself. There is more in the explanatory notes and in the other document that accompanies the Bill, but as far as the Bill itself is concerned, it seems that, from our point of view, is completely unclear and also a great deal is to be left to regulations anyway. So from that point of view we are not sure what else is going to be brought in.

Hywell Williams: Mrs Munn said earlier on that the care plan approach is widely accepted. However, the Commission for Health Improvements has said that the mental health services in Wales are at least 10 years behind England in respect of the care plan approach. What implications would you see for applying this Bill, should it become an Act, in respect of that particular question?

Chairman: Can we take a group of comments and then you can respond to them all. Lady Flather.

Baroness Flather: You mentioned this ethnic minority family. Would it be in any way different if it was a white family? I have not quite understood the significance of presumably a black family, Asian family, because ethnic minority does not mean much, because they have very different aspects. I would like to just pursue that.

Q155 Lord Carter: I think it was Mr Farmer who mentioned section 115; it is clear that the regulations will be made by the appropriate authorities, the Bill says, except in 3(c): “Information will be available to any other prescribed matter where the Secretary of State makes the regulations”. Are you happy with that? What is the information that would require regulations from the Secretary of State as opposed to the appropriate authority?

Dr Daw: One presumes that this is to do with risk, but I really think we would have to get back to you on this.

Q156 Chairman: I think we might ask the Bill team for an answer to that question.
Dr Daw: Yes.

Q157 Chairman: In due course, if you could let us have a note on that Bill team. Could you deal with the other two questions?
Mr Farmer: I think the point that Mr Williams is making around the kind of status of the care programme approach and its application in parts of the country—I know there are particular issues about the way in which mental health care is currently being delivered in Wales, and, as you rightly say, the Commission for Health Improvement in Wales has flagged up the need for the issue of mental health care in Wales being behind the progress of mental health care in England. I think what that highlights in particular for us is an importance in recognising that there are to be two codes of practice under this legislation, one a Welsh code and an English code, and I think it is important that both codes have a higher level of statutory enforcement in order to reflect the individual situations that are taking place within individual countries: because I think it may well be that within the Welsh code you may need to put in place some more rigorous safeguards for ensuring that the care programme approach is more fully supported and fully resourced than you might necessarily do within the English code, where the care plan programme is more established, although it is important to note that it still is not sufficiently universal for it to be totally used everywhere. Can I quickly come back Baroness Flather’s point? I fully accept the point you make. In this particular context the ethnicity of the family— they were a black family for clarity—

Q158 Chairman: It is not relevant, is it? It could be a white family in a tower block in Flint, could it not?
Mr Farmer: No, it is not relevant.

Q159 Chairman: I thought you were not going to try to extricate yourself on that.
Dr Shooter: I feel honour bound to say with my Welsh hat on, there are, of course, some bits of the mental health service in Wales that are in advance of those in England, but I take your general point. I would like to say in support of what Rowena Daw was saying in general, that what we are talking about in terms of a broader care plan, and perhaps we should call it that in the light of the fact we do not have CPA in Wales yet, makes clinical good sense. If somebody, a clinician like myself, is writing in a patient’s notes a formulation of what the options are and what the options for treatment are, then everything needs to go in that, not just isolated pieces of information like medication, and so on. Indeed that is the sort of broadness of evidence that would be required of us if we were talking to a second opinion doctor, who again would need to understand the totality of the patient’s experience and their options for their treatment.
Chairman: Can we now move on to what is a very important question under this draft Bill, which is the issue of compulsion in the community, or however one cares to phrase it. Dr Stoate and Liz Blackman want to make contributions on this. Dr Stoate, would you like to start?

Q160 Dr Stoate: Thank you, Chairman. As a practising GP I have particular concerns about the management of people in the community, and obviously you are well aware that patients and general practitioners have a lot of mental health issues which often are not addressed appropriately and clearly they need more resources and more help. In your submission you seem to be completely opposed to the use of compulsory treatment in the community under any circumstances. The Government, on the other hand, takes the view that, in a small and carefully selected group of patients, compulsory care in the community might avoid otherwise somebody having to say in hospital. Why is it that you have an unconditional opposition and perhaps you can enlighten us as to why you see no power whatever for compulsory use in the community?
Dr Daw: I should perhaps explain that our overall position is that we are not totally opposed to compulsion in the community. It is the case that service user groups in the Alliance are and that some of our individual members are, and those members have fairly similar sets of reasons for being totally opposed, and Graham will talk to that issue in a minute. But as far as the Alliance is concerned, we consider from the experiences that we have looked at in overseas’ jurisdictions and the experiences of our members and beliefs of our members, which covers the Royal College of Nursing, covers the Community Mental Health Nurses, covers the Royal College—in other words covers those who will be practising in that environment as well as those who will be service users in that environment—we believe that the case has not been made for the breadth of compulsion in the community that is being proposed. We do consider that there might be a case for compulsion in the community if the criteria are sufficiently narrow so that it can work for that group of patients that we think it might work for, which is a very small group, sometimes called “revolving door patients”, although I believe the Government is using the term to cover a much broader group of people than we are imagining. We have put in our written submission some of the criteria that we think would be needed in order to ensure that it was only that group that was covered; and we are talking about people for whom it might be beneficial to be under compulsion because they have had multiple admissions to hospital, they have a situation of relapsing very significantly if they no longer take medication and a lack of clear decision-making capacity, a lack of insight perhaps. For that group of patients it may be beneficial, there is some evidence that it may be beneficial, but I think we do need to say that what we have seen from the considerable research from overseas’ jurisdictions is that what really makes the difference is good community services. I would just like to say that our real fear about the Community Treatment Orders is not just at the point at which
people get onto Community Treatment Orders, but the problem of remaining on them for a very long period of time and not being able to get off them. So it is absolutely linked to the conditions for compulsion.

Q161 Chairman: Does Mr Estop want to add something on this?

Mr Estop: Yes. As Rowena Daw has made clear, everybody in the Alliance believes that the Government is opening the doors too wide to compulsion, and from a service user view point, all psychiatric compulsion is experienced as oppressive and restrictive. If it is in the community it is just a different form of being restricted from being hospital, and, in actual fact, being in hospital when you are in a very severe crisis or in state of total breakdown is a safer environment because you are receiving total support and care. Usually service users would ask that compulsion was unnecessary because service uses can make appropriate choices in consultation with professionals. For example, I know one of the officers of Voices Forum decided he would like to come off medication a few years ago. He had a serious breakdown and now he has decided he is going to stay on medication indefinitely. That is an extremely common experience. I know many service users who have decided for themselves that they need to stay on medication because they do not want to have a break down. On the other hand, there is another prominent member of Voices Forum, who I know quite well, who has had three or four serious breakdowns despite being on medication. He has had a breakdown once on old style medication and once on one of the latest medications. He has now gone back to one of the old style medications and, despite the fact that he is 100% compliant with mental health services and psychiatry and willingly takes medication, he realises that this may not prevent him having another breakdown. In my own case, I have had more than one breakdown. As it happens, I had one when I was in America in 1980 during the Regan v Carter election at that time.

Q162 Mr Howarth: No causal relationship!

Mr Estop: Indeed; I was quite freaked out by the way the part the media played, the mass media, so that instead of them watching several serious documentaries and news programmes and informational news programmes on their television, most of the campaigning was in terms of advertising, and sometimes the media, given that it is the dominated by private companies, did seem biased, and I was not the only person who thought that. So the sorts of worries in my mind were very similar to those of other people, but in my case those worries became exaggerated and overwhelming to the point I could not cope with my life as a whole. However, I have been able to learn from my experiences of breakdown. They have all had different circumstances, and I have learnt to avoid the sorts of causes which led me into hospital in the past and I have been able to successfully come off medication and proceed to a working career. I myself could have been regarded as a revolving door patient because I had three admissions within two years, but, whereas I might just have appeared to be a revolving door patient to other people, to me it was my own life and it was a historical progression and each breakdown was different. In conclusion, as Rowena Daw has mentioned, service users are worried that once they have been considered to need medication perhaps on a compulsory they are not going to be able to get off it. Whereas in hospital there is a natural time limit to the period of treatment, in the community it could go on indefinitely. Professionals may think you need to be on it when you think you do not. It is difficult to share all your personal problems which feed into why you had a breakdown, and you are not given that much opportunity to talk about your problems from your own viewpoint. Professionals of all kinds are very much rooted in their own perspectives, and that is one reason why we would ask that at the very least there be a role for a time limit on compulsion in the community. Indeed, that has been proposed in a paper from the Royal College of Psychiatrists authored by Professor Burns and others from several years ago where, I believe, a time limit of about three years was proposed. In my own case I do not believe I would have been personally able to return to a working career whilst still on medication and a mental patient.

Q163 Chairman: If under compulsion it would cause great difficulties?

Mr Estop: Yes. Most service users do experience side-effects from medication which can interfere with their efficient functioning.

Chairman: Can I stop you for a moment. You have provoked a lot of interest and I have a number of members of the Committee who would like to make contributions.

Q164 Mrs Blackman: One of our witnesses last week in effect suggested that the Bill and the compulsory powers in the community was a government mechanism for solving bed-blocking. Rowena Daw, you were not saying that. You would not go along with that particular thesis. Could you clarify again that you think there is a place for compulsory powers, but it ought to be far more restrictive?

Dr Daw: I think there is probably some truth in the view that there is a problem at the moment with the numbers of beds and that it is a way in which it restricts the numbers of people who become subject to compulsion. So I do not entirely disagree with the point that has been made that it does have that effect.

Q165 Chairman: Does it? Is it not quite possible that, in fact, it would increase the number of people under compulsion because people who had been under residential compulsion would remain under non-residential compulsion?

Dr Daw: I am sorry, I did not express myself properly. What I was trying to say was that I think it is true that one of the reasons for the Government’s decision is because of the pressure of beds, and, indeed, it will increase the numbers of people under compulsion.
Chairman: I think we will take some more contributions from the Committee, if we might, Dr Shooter and then ask your team for responses.

Laura Moffatt: I am particularly interested in the relationship between service users, clinicians, social workers, and, as a nurse for 25 years, I know that is a very precious thing, that relationship and very often is integral to somebody’s recovery and the treatment that they wish to accept. I really would like a comment from both clinicians and from service users before us today on how you believe that that relationship may well be change? I firmly believe, and certainly from consultations I have done in my constituency with CPNs, they are deeply worried that that relationship is about to change and they are concerned that that whole issue is going to alter for ever the relationship with service users?

Tim Loughton: I wanted to raise the situation about beds, but I wanted to know from you what proposals you have to guard against compulsion in the community being used as a bed-shortage mechanism. Also in the case of carers, is there some restriction one could place on people having compulsion in the community dependent on what standard of care they have at home, or do we just fall into the trap of using relations who are carers as surrogate staff due to shortages of staff? There is also the issue of what constitutes “a hospital” as well in the community. Definitions of “hospital” may be just “a house”, and again it is used as a mechanism simply because of the shortage of acute beds. How can we tighten up definitions so that if we are to have a small number of people to whom it would be applicable to have this sort of compulsion but it really can be tied down and defined quite tightly rather than abused in the way that it could be?

Baroness McIntosh of Hudnall: There is a word that is lurking about here which I think we might need to bring to the surface, which is “capacity”. This Bill is drafted on the principle of necessity, as has been said many times before. The question which has come up very clearly from Mr Estop’s evidence is that a patient’s capacity to take a decision about his or her treatment is clearly in the moment a very significant part of the relationship between the clinician and that patient. It is not embedded anywhere in this legislation as drafted. Do you believe it should be and what role should it have?

Chairman: Mr Prosser, and then perhaps we could have a group of answers and then I will come back to Dr Stoate who started this ball rolling.

Mr Prosser: I do not bring this in with a level of expertise as other members of the Committee—most of my knowledge is from the Bill and the White Paper—but on the issue of compulsion, my reading is that there are quite strict gateways to allow compulsion to take place with regards to the severity of the mental illness, with regards to self harm, suicide, danger to others and a whole series of other safeguards. That seems to almost have been discussed in what we have heard this morning. I would like some comments on that in general, but in particular could I ask Mr Estop whether he would have considered his particular mental condition in the United States which he has described to us would have got through those safeguards or not?
going to drive all of us away from mental health. The risk certainly is that it will drive patients and their carers away from the services that are there to help them because they will fear they are now susceptible to a wider Act; and it will also drive potential workers in mental health services, including psychiatrists, away from those professions.

Q167 Chairman: On your last point, can we ask Mr Estop if he agrees with what you have said about the perceptual point, because perception is very important, I am sure, in dealing with mental health issues. The point about potential patients being driven away from mental healthcare.

Mr Estop: Yes, I am sure that is the risk. I think service users’ fear is that the proposed legislation would reinforce the emphasis on medical rather than social and personal factors. I myself, I believe, would have been a candidate when I was a service user for compulsory treatment in the community because I was a text-book case of having a breakdown and somebody who did respond well to medication, both admission to hospital and treatment with medication was appropriate for me and I responded well. The risk then is that people think you need to be on it forever when you do not, because the factors leading to the breakdown were, in my case, primarily social and personal rather than biological, say. I feel the Bill does not go far enough in defining a sufficiently small group of people in a strictly clear way. I feel talking about revolving door patients is a very vague concept, and there does need to be a much more explicit definition of how any compulsion in the community would work. I am not sure what adequate safeguards would be apart from the treatment. So there are a whole lot of issues that category it is very unlikely that they could be too narrow to work. I am not sure what adequate safeguards would be apart from the treatment. So there are a whole lot of issues that need to be dissected.

Chairman: Thank you. Do you want to wrap this up, Dr Stoate. If there are any points you want to add later, you can write to us.

Q168 Dr Stoate: Surely the overriding principle must be the least restrictive option. As a GP, fortunately remarkably few of my patients over the years actually have had to be admitted to hospital at all, either under compulsion or voluntarily, and I have psychiatrist colleagues who now have all but dispensed with all the beds themselves voluntary and have actually chosen themselves to use the view that any admission to hospital is almost always avoidable and they would much rather use community orders. It seems to me, and this surely must us be the overriding principle, that if we use treatment orders appropriately, all the necessary safeguards, mental health tribunals reviewing them, advocates reviewing them, a constant series of checks and balances to keep somebody in the community and keep them well surely has to be a better option the vast majority of cases than forcing somebody into hospital with all the stigma that that entails?

Dr Daw: Of course, most service users that we speak to would much rather be in the community than be in a hospital, but we are talking about a situation— I think this also relates to the point that you were making—we are asking for a situation, as far as the conditions for compulsion are concerned, that are much narrower than the Bill has, and for people in that category it is very unlikely that they could be well enough to be safe, secure, looked after, have the support and the supervision and the monitoring of their condition in the community. We are talking about people who are seriously ill, and for those people they do need to be in hospital. I think when you look at the way in which we feel that the conditions should be restricted so that, for instance, a capacity test, as you were talking about, is part of what we have put in our written evidence and a higher threshold for people who are seen to be at some level of risk, however low, to other people, which is very vague in the legislation at the moment, that, if the threshold is raised in that kind of a way, we are talking about people who are at a crisis level, but of course, in the general sense, most people want to be in the community. However, what service users do tell us, and they tell us again and again, to a person seminar after seminar, is that if they are very ill in that condition they do not want to be a burden on their families. One person said to me his marriage would have been broken down if his spouse had to look after him in that circumstance. They absolutely do not want that and they do not want the privacy of their home being invaded in that way, and also, if they are actually objecting to treatment, the fact is that it is not going to work because they are going to have to be taken to hospital anyway in order to have the treatment. So there are a whole lot of issues around this that really need to be dissected.

Chairman: Thank you for that. Can I draw this bit of the debate to a close now. We have had rather longer on that question than we would have had on others, but it is a very important one. I think in the last 25 minutes the issues have been very strongly clarified, but if the Alliance wants to write to us further on that very informed issue in the light of the questions that have been put by members of the Committee, please do so. I think we can deal fairly briefly with the question of mental health tribunals, Mr Hinchliffe.

Q169 Mr Hinchliffe: I have a couple of brief questions on the evidence that you have given on mental health tribunals. Dr Daw said earlier on that in terms of your submission you all agree on the general points. Do I assume then that there is no dissent within the Alliance along the lines that we have had some dissent on the last day we were talking about on the issue of your evidence suggesting that tribunals should not be required to have a clinical member?

Dr Shooter: It has never been the assumption of the Royal College, either individually or as part of the Alliance, that there had to be a medical member on the mental health tribunal, as long as the tribunal is in receipt of expert evidence from a medical member of the Expert Panel. We also believe very strongly
with the Alliance that, when the tribunal is considering the options for a patient, they must take into consideration housing, benefits and so on which are just as crucial for that patient’s future welfare as medication and other medical model treatments. The patient needs to be seen in an holistic sense. We feel that whoever sits on the tribunal should have come clinical background of some sort to be able to put into a clinical context what the expert panel members are telling the tribunal.

Chairman: Is that not a rather different point from having someone on the tribunal who has seen the patient? I can simply give you my experience of presiding at a few Mental Health Review Tribunals. Because of manpower problems, the clinical member often arrived very late, only had the opportunity to see the patient for a few minutes on the morning of the tribunal and it was more vestigial than substantial. It might be better therefore to have broader clinical experience able to assist the tribunal in asking the right questions than somebody who has seen the patient and may, by that very act, have affected the quality advanced.

Q170 Mr Hinchcliffe: You have slightly qualified your evidence in responding to my first question. Although I certainly support the broad thrust of what you say and what the Alliance is saying, I have had experience giving evidence to tribunals when I worked in mental health and social services and representing patients where, had there not been a clinical member of the tribunal, I think the patient could have been very severely disadvantaged. I can think of situations where there were very important exchanges in terms of the specifics of clinical diagnosis, especially related to personality disorder and treatability. That was at the heart of the patient’s circumstances and whether they should have been detained or not. I would have felt that in those circumstances the lack of a clinical member would have caused some difficulties.

Dr Shooter: It is certainly essential that someone with clinical expertise is there because in modern services we need to get away from the idea that all that clinical expertise is locked up inside a doctor, for example. We are moving into a situation with new ways of working where other members of the mental health team may well have very highly skilled and trained clinical expertise which they could give to a mental health tribunal.

Dr Naysmith: What does “clinical expertise” mean in this context?

Q171 Chairman: Presumably it means somebody with experience of practising in the broad area concerned, either a psychiatrist or a clinical psychologist or a CPN.

Dr Shooter: We are not far away in mental health services from the concept of CPN nurse prescribing. It may well be in the not too distant future, certainly in the lifetime of this legislation, that nurses are as highly skilled and trained in the prescription of medication in mental health as anyone else in the mental health team.

Chairman: Would you countenance others too? For example, with some patients, you might find that the speech and language therapist had been the lead therapist in dealing with that patient. I am only using that example of a speech and language therapist being regarded as the clinical member of a tribunal in an appropriate case.

Q172 Mr Hinchcliffe: The Royal College of Psychiatrists support this position. How much of their support is driven by the point of principle about broadening out the perspective of a tribunal from the medical model and how much of it is driven by resourcing issues, being able to service the tribunals?

Dr Shooter: Of course resource issues matter. We have been working very closely with the Department for Constitutional Affairs to try and make the system work as it is, finding ways around the delays which have been occurring, largely because of the difficulty of finding medical members. On this particular issue, I think it is driven far more by principle. We are in a world of new ways of working. I co-chair with the National Institute of Mental Health in England a multidisciplinary committee which has been looking at how we might use different disciplines within mental health teams in very different ways from the traditional medical, hierarchical model that we used to practise in.

Chairman: Finally, can we try and deal with whether people are or are not offenders and what difference it makes?

Q173 Lord Mayhew of Twysden: Can I ask about people caught up in criminal proceedings? How important is it to you that, for a compulsory treatment order to be made, there should be evidence that the person concerned—because he need not necessarily by then be an offender—is either a risk to himself or to others? You make the point that the expert committee said that the conditions for Part 3 patients should be the same as for Part 2. How important do you think that is and whether they should have caused some difficulties.

Dr Daw: I think it is a mixture of the two. Primarily, it is not just the civil liberty angle but an issue of separating out what is a health issue and a criminal justice issue. I do not think we necessarily have that right. We obviously do not believe that part three of this current Bill has that right. Looking, for instance, at the Scottish legislation and looking at some of the recommendations from the Mental Health Act Commission as well, we believe that if a person is either on remand or is indeed up for sentencing, and there is an issue that they are to be given compulsory treatment under an order, the conditions should broadly speaking, except if there is a relevant distinction—and we do not believe risk is a relevant distinction—mirror those in the civil justice system. We do not see any reason for departing from that. That is the basis on which we have operated. It is the basis that a number of the voluntary organisations and others operate on. We cannot see a justification
for there being discrimination between those who are in the criminal justice system and those who are in the civil justice system from the point of view of their mental health needs and how those are attended to, except where it is relevant. Also, we feel that doing that makes compulsory treatment into a punishment rather than a therapeutic measure which is obviously not what it should be. That is one of the consequences of that. We also believe that people who have capacity, who are responsible for their actions, who may indeed be sentenced for that, people who have criminal responsibility despite the fact of their mental disorder, which may or may not be related to their offence—do not forget, we are talking about a very wide range of people and circumstances here—should be sentenced in the normal way, according to the normal criminal law provisions; and their mental health needs taken care of as mental health needs which might mean, for instance, that they would need to go to a hospital. We also think that the criminal justice provisions provide already enough flexibility for people’s mental health needs to be taken care of, if need be.

Q174 Chairman: There is a problem with offenders, is there not, because many offenders would rather not be sentenced to a term of imprisonment but would rather have the recognition that a section 37, without a section 41 order, brings of their mental health needs as a replacement for a sentence?

Dr Daw: In some circumstances indeed that would be appropriate but it is also the case that there are many people in that situation who would not prefer that. They would prefer to have their sentence and have it over with than to have the possibility of a very long period of time on a mental health order. I do not think we are in the game of deciding on behalf of offenders which they would prefer or which they would not prefer. In terms of their mental health needs, we think they need to be taken care of. We do not see the reason for there being a difference of view and approach.

Chairman: Thank you very much. You have all pressed a lot of buttons with the Committee and left us with a huge amount of food for thought. You have added significantly to your written submissions by your oral evidence.

Baroness Flather: You have often mentioned overseas things. You said New Zealand which I do not think is very much a question of like with like. If there is no time to do it now perhaps you could tell us which countries you have been looking at, and particularly it would be interesting to know if you look at any of our European partners where there are similar conditions.

Q175 Chairman: Could you write to us on that?

Dr Daw: Yes, absolutely.
— Raising the threshold for people who are seen to be a risk to other to require “serious harm” to others. This would replace wording that the patient needs treatment for the “protection” of another person.

— Requiring in all cases that compulsion must be necessary to provide treatment, thus ruling out the possibility that someone who was prepared to accept treatment could be detained.

**Compulsion in the Community**

If there is to be compulsion in the community extra criteria would be required. In our view it should only be ordered by the Tribunal if extra criteria were met. These should include:

— demonstration that appropriate services are available in the community to meets the needs of the patient;

— the patient has the ability to comply with the conditions for treatment and supervision provided in the order; and

— a history of previous compulsory admissions to hospital and relapse upon release has occurred (the Saskatchewan legislation for instance mentions three previous episodes as one criterion).

The Alliance position on community treatment orders or non-resident orders is set out in our submission. We do not approve at all of community orders while the definition and conditions are as broad as they are now. As we state in our submission we do not believe the case has been made for their introduction but are aware that the government is committed to them and so feel we need to engage with the issue. We would only see a place for them if the extra criteria we specify, or some like them, were already defined in the Bill.

**Overseas Jurisdictions**

We have examined the law in some Australian states (New South Wales, Victoria, Western Australia, South Australia and the ACT), in New Zealand and in most Canadian provinces. We have consulted the Irish and Scottish Acts and read some comparative research on 15 EU jurisdictions. We find however that the common law jurisdictions provide more fruitful comparisons because of the similarity of approach and of legal enforcement mechanisms. We would be happy to provide the Committee with more detailed provisions if they would be helpful to you.

I enclose two documents, a paper on community treatment orders and one on advance directives—both papers done by Alliance members. The latter may be useful to explain the legal position of advance directives under the current Mental Health Act.

**Resources**

We did not have a chance to answer the question on resources but I am aware that these issues were addressed by the Kings Fund and Sainsbury Centre and do not have anything to add to their oral evidence.

Rowena Daw,
Chair, Policy Group
Mental Health Alliance

---

**Memorandum from the Law Society (DMH 111)**

The Law Society is the professional body for solicitors in England and Wales. The Society regulates and represents the solicitors’ profession, and has a public interest role in working for reform of the law.

We welcome the opportunity to respond to the Draft Mental Health Bill 2004 (“the Bill”).

The Law Society has long campaigned for reform of the Mental Health Act 1983 (“the 1983 Act”), which is widely recognised as out of date and not fully compatible with the Human Rights Act 1998.\(^2\) However, we believe that the proposals contained in the Bill are misconceived and fail to provide adequate safeguards to protect the rights of people with a mental disorder.

The Law Society is an associate member of the Mental Health Alliance and as such endorses the Alliance’s submission to the Joint Committee.

---

\(^2\) There have been three declarations of incompatibility with the 1983 Act.
1. Is the Bill rooted in a set of unambiguous principles? Are these principles appropriate and desirable?

The Law Society is disappointed that the Bill does not contain an explicit statement of underlying principles. Instead it provides for a Code of Practice to be published which will set out general principles “to which a person must have regard whenever coming to a decision under or in pursuance of this Act in respect of a patient”. Therefore, the principles do not underpin the Bill, but instead relate to decision-making under it.

The Bill provides that the Code of Practice must design the principles to secure that patients are involved in decisions, decisions are made fairly and openly and any interference to patients is kept to the minimum necessary. The Law Society supports these general statements but believes they will not protect patients’ rights unless they are part of an explicit statement of principles on the face of the Bill. This would set the tone of the Bill from the outset and ensure enhanced legal status for the principles. The Mental Health (Care and Treatment) (Scotland) Act 2003 and the Mental Capacity Bill 2004 are examples of legislation which have successfully incorporated explicit statements of principles.

We also believe that the effectiveness of the proposed principles is rendered meaningless by the provision allowing the Secretary of State to disapply any of the principles in the Code of Practice. The circumstances in which the principles could be disapplied are left undefined and are potentially wide ranging. Therefore they cannot be relied upon as effective principles and merely resemble a set of “nice ideas”.

The Law Society is also concerned that the principles may fail to reflect the provisions in the Bill. For example, despite the provision of patient involvement in decisions, the Bill fails to take into account the capacity of the patient to agree to medical treatment. Many people with a mental disorder retain capacity to make treatment decisions and we believe that overriding a capable refusal of treatment should only take place in clearly defined and limited circumstances. This is recognised in the Mental Health (Care and Treatment) (Scotland) Act 2003 which provides that the patient’s ability to make treatment decisions must be “significantly impaired” by mental disorder before a compulsory order can be made.

Furthermore, where a patient is deemed to be “at substantial risk of causing serious harm to other persons” he/she will be subject to compulsory powers regardless of the patient’s willingness to accept treatment. This does not accord with the principle stated in the Bill that interference to patients and restrictions should be kept to the minimum necessary. Under Part 2 of the 1983 Act people with a mental disorder which would render them a danger to others are not subject to compulsory powers if they accept treatment voluntarily.

2(a) Is the definition of Mental Disorder appropriate and unambiguous?

“Mental disorder” is defined in the Bill as “an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain”. The Law Society is concerned that this is a circular definition and fails to exclude people who suffer a temporary impairment or disturbance in the functioning of the mind or brain as a result of a physical condition such as diabetes. We believe that this definition is too wide and many conditions that could never result in detention or compulsory treatment under the current legislation will come within the scope of the Bill. The Mental Health (Care and Treatment) (Scotland) Act 2003 provides a far tighter and more straightforward definition of mental disorder.
2(b) Are the conditions for treatment and care under compulsion sufficiently stringent?

The relevant conditions are set out in clause 9. The first condition is that the patient is suffering from mental disorder. Please see comments above at 2(a).

The second condition is that the mental disorder is of such a nature or degree as to warrant the provision of medical treatment to the patient.

The Law Society is concerned that this condition is too broad, as it provides that the mental disorder must be of a nature or degree to warrant the provision of medical treatment rather than the provision of compulsory medical treatment. This means that the mental disorder does not have to be serious enough to justify overriding the wishes of the patient, but merely serious enough to justify specialist treatment. This is a lower threshold than the one in the 1983 Act whereby the mental disorder must be of a nature or degree to require compulsory detention in hospital.

We are also concerned that the definition of “medical treatment” further undermines the purpose of this condition, which the explanatory notes argue is “to ensure that only those with a serious mental disorder can meet the conditions.” Medical treatment is defined as “treatment for mental disorder provided under the supervision of an approved clinician” and the explanatory notes confirm that approved clinicians will be senior specialists such as consultant psychiatrists and consultant psychologists. Under this definition of medical treatment, the “nature or degree” of the mental disorder would not need to be particularly serious. For example, it could apply to a person with schizophrenia who is stable and compliant with oral medication prescribed by a GP and receives monthly visits from a Community Psychiatric Nurse and who then decides, against the advice of the Nurse, to discontinue these visits. Such a person would fall within the ambit of compulsory powers even if they retained capacity to make treatment decisions. This may provide an unintended incentive not to accept help from the community mental health team.

The third condition is that it is necessary that medical treatment be provided to the patient to protect him/her from suicide or serious self-harm, or from serious neglect by the patient of his/her health and safety, and/or to protect other people.

The Law Society believes that this condition is flawed because of the Bill’s failure to take into account the patient’s capacity to make treatment decisions. The requirement that treatment must protect the patient from “suicide or serious self-harm, or from serious neglect by him of his health and safety” is too narrow for people who lack capacity and come within the ambit of the Bill. For example, it would prevent treatment being provided to an incapacitated patient who resists treatment but presents a low level of risk. On the other hand, where a person has capacity to make treatment decisions this condition is too wide. Such a person should only be subject to compulsory powers in clearly defined and limited circumstances, such as where there is a significant risk to the health and safety of the patient or the safety of others.

We are also concerned that the phrase “to protect other people” is potentially very wide indeed. Crucially the Bill breaks the link in the 1983 Act between the need to protect the public and the requirement that it is necessary for the patient to receive treatment in hospital. The Bill therefore establishes a lower threshold for the use of compulsion and in a risk-averse society such as ours, it is quite easy to imagine that mere nuisance behaviour could be used to justify making a person subject to compulsory powers in the community. This raises the alarming possibility of using mental health legislation to create psychiatric ASBOs.

The fourth condition is that the treatment cannot be lawfully provided to the patient without him/her being subject to the provisions of the Act. This would exclude from the remit of the Bill people who lack mental capacity whose treatment could lawfully be provided under the Mental Capacity Bill. It is therefore likely that the Bill will mainly be used to impose treatment on people who have capacity but refuse treatment.

This raises the issue of what level of service needs to be offered to an individual on a voluntary basis before the use of compulsory powers can be justified. There is clear evidence that many patients are willing to accept treatment voluntarily if they are given high levels of support. There may be discrimination issues if patients in some areas of the country are more likely to be subject to compulsory powers than those in other areas due to the patchy distribution of high level good quality community services.

---

105 Sections 2 (2) and 3 (2)
106 Para. 47
107 Clause 2 (7)
108 This is because in most cases a CPN would be a member of a Community Mental Health Team where a Consultant Psychiatrist would retain overall clinical responsibility for clients or maintain a supervisory role. Therefore in this example the mental disorder is of a nature or degree to warrant the provision of “medical treatment” by using this definition.
109 For example a person with a learning disability who lacks mental capacity to make treatment decisions and who is being treated by a psychiatrist for challenging behaviour but also suffers from mild depression and refuses treatment. Under the Bill they could not be treated for depression. The Mental Capacity Bill would also not allow forced treatment in these circumstances.
110 This concern also applies in relation to clauses 46 (7) and 119 (7), which allow a mental health order for a non-resident patient to include a condition that “the patient does not engage in specified conduct”.
111 Cause 5 of the Mental Capacity Bill 2004 provides for acts in connection with care and treatment in the patient’s best interests. See Q8 for a fuller discussion of this point.
The fifth condition is that medical treatment is available which is appropriate in a patient’s case, taking all circumstances into account. The explanatory notes state that no one can be brought under formal powers unless treatment is available in the individual case.\(^{113}\)

The Law Society is disappointed that the Bill does not specify that medical treatment must provide a health benefit to the patient. It may be that the Government intends “appropriate” to mean “a health benefit” but if this is the case it should be stated on the face of the Bill. The Government has argued that some people with personality disorders have not been brought under formal powers because of uncertainty about whether their personality disorder can be “treated”.\(^{114}\) However, court judgments have clearly established a wide meaning of treatability under the 1983 Act.\(^{115}\) The Law Society believes that the concept of a “health benefit” would ensure that the use of compulsory powers is in the best interests of the patient’s health needs.

The Law Society is also concerned that the Bill has removed the exemptions under the 1983 Act which specified that a person cannot be dealt with as suffering from a mental disorder by reason only of promiscuity or other immoral conduct, sexual deviancy, or dependence on alcohol or drugs.\(^{116}\) This helps to ensure that conditions and behaviour, which on their own should not be regarded as a mental disorder, are excluded from mental health legislation. We also believe that exemptions help ensure that practitioners consider carefully the basis for compulsory detention and treatment.

We believe that the Bill’s conditions for compulsory care and treatment are too broad. This is illustrated by the fact that a smoker, who has tried and failed to give up, would apparently meet all the relevant conditions in clause 9.\(^{117}\) The Government may claim that such situations are unlikely to arise because the good sense and discretion of doctors can be relied upon. However the Bill gives clinicians no discretion about the use of compulsory powers if the relevant conditions are satisfied.\(^{118}\) The Law Society believes that patients’ rights will be protected only by tightly defined relevant conditions and by providing clinicians with discretion about the use of compulsory powers.

In addition, the Law Society believes that the criteria for treatment and care of patients who are subject to criminal proceedings under Part 3 of the Bill are not sufficiently stringent. We are concerned that the conditions for remand or committal for compulsory medical treatment are significantly broader than the criteria for compulsory treatment under Part 2. This provides greater opportunities to subject people to compulsory treatment as an alternative or in addition to a criminal disposal. Any person charged with a criminal offence could be brought within the exercise of compulsory powers if he/she is suffering from a mental disorder of a nature or degree as to warrant the provision of medical treatment and where appropriate medical treatment is available. This is irrespective of whether treatment is necessary for their health or safety or the protection of others. We believe there should be greater congruence in the criteria for compulsory treatment for civil patients and those subject to criminal proceedings and under sentence.

(2c) Are the provisions for assessment and treatment in the community adequate and sufficient?

The Law Society believes that the Government plans for community assessment and treatment are impracticable. The experience of supervised discharge under section 25A of the 1983 Act illustrates that where people in the community are “required” to comply with certain conditions, this has proved difficult to enforce.\(^{119}\) Under the Bill, a clinical supervisor is given the power to “take and convey” a non-resident patient back to hospital where he/she fails to comply with the conditions, however it is not made clear how this is to be achieved.\(^{120}\) The use of a warrant under clause 225 may be intended for this purpose but would be dependent on police and ambulance availability and resources. Also, since the patient must be detained within 24 hours, it is likely that a hospital bed must be kept free thus putting extra strain on limited resources.\(^{121}\)

---

\(^{113}\) Para 47.


\(^{115}\) For example, see R (on the application of Wheldon) v Rampton HA [2001] EWHC Admin 134.

\(^{116}\) Section 1 (3).

\(^{117}\) A person with nicotine dependency would fulfil all the relevant conditions:

1. Nicotine dependency is included in the ICD-10 classification of mental disorders (F17) and is listed in the DSM-IV classification (code 305.20).
2. The mental disorder is of a nature or degree as to warrant the provision of medical treatment (nicotine patches, counselling, treatment for withdrawal).
3. Medical treatment is necessary to protect the patient from serious self-harm.
4. The fourth condition will be met because the patient continues to smoke despite being advised of the harm that he is doing to himself.
5. The fifth condition will be met because treatment is available for nicotine dependency.

\(^{118}\) Clauses 16 and 38.


\(^{120}\) Clause 48.

\(^{121}\) Clause 48 (7).
The Government intends to use regulations to limit the types of cases where a patient can be compulsorily assessed in the community without an immediately preceding hospital admission. The explanatory notes give the example of a “revolving door” patient. However, in light of the wide definitions and low thresholds for compulsory treatment in the Bill, we are concerned that this provision will be applied to a wider group of patients than intended.

3. Does the draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

The Law Society believes that the Bill unfairly discriminates against people with mental disorders. It makes non-offending individuals with a mental disorder who have capacity subject to compulsory powers, but does not explain why this is justified when people without mental disorders who have capacity and who pose as much risk to themselves or others, such as binge-drinkers, are subjected to the same powers.

This may be based on the misconception that it is a lack of legal powers which places the public at risk from people suffering from mental disorder. The various homicide inquiries overwhelmingly show that it is lack of resources, lack of information and lack of communication that causes care and treatment to break down in such a way as to increase the likelihood of a tragedy. Increased legal powers, such as community treatment orders, will not improve this situation unless they are backed-up by sufficient resources and if patients in the community are properly supported there would be less need for compulsory powers.

We also believe that a significant number of patients will be denied access to the safeguards provided in the Bill. Many people who lack capacity due to mental disorder will be excluded from the Bill and the safeguards it offers, such as the Mental Health Tribunal, because they could be “lawfully” treated under the Mental Capacity Bill. This would include many people who are currently detained under the 1983 Act. The safeguards provided by the Mental Capacity Bill are far more limited.

We also believe that the apparent safeguards in the Bill will not necessarily protect the rights of patients. For example, a patient would be able to apply to the Mental Health Tribunal to review the use of compulsory powers, but in order to be discharged the patient must show that he/she does not meet the relevant conditions, which are extremely wide (see 2(a) above). Furthermore, the Tribunal has no discretion to discharge an individual if all the relevant conditions are met and therefore it may be extremely difficult for a patient to be discharged from the provisions of the Bill.

4. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient and clear? Are there any important omissions in the Bill?

We believe that the Bill will be workable only if there is a dramatic increase in resources. For example, the new Mental Health Tribunal system would require a significant increase in the numbers of mental health professionals, approved clinicians, tribunal members and expert panel members, together with proper administrative support. However it seems unlikely that resources will be available in the foreseeable future given the current staff shortages in the provision of mental health services.

The proposals are extremely resource intensive, both in terms of time and money. The Mental Health Review Tribunal system is struggling to manage at present with many appeals being cancelled and delayed. The Bill will lead to a significant increase in the numbers of hearings and a vast expansion in the types of decisions that tribunals will have to consider, such as authorising care plans, displacing nominated persons, authorising ECT and examining whether the relevant conditions apply. This will require a major change in the culture of Tribunals. It is also likely that hearings will be significantly longer, which will have massive resource implications for recruitment and training.

Furthermore, although the Bill will require a Mental Health Tribunal to make decisions about a patient’s ongoing treatment and to authorise care plans, the Tribunal will not be in a position to monitor or police its decisions. This may result in considerable amounts of litigation when the arrangements go wrong and

122 Para 66.
123 For example, the Independent Inquiry into the Care and Treatment of X (2002) Bolton PCT and Greater Manchester Health Authority.
124 Clause 9 (5) provides that formal powers apply only if medical treatment cannot lawfully be provided to the patient without them being subject to Part 2 of the Bill.
125 At the time of writing, the Mental Capacity Bill includes a proposal for an independent consultee who can advise the decision making body where the person who lacks capacity has no close friends or family. The Court of Protection will only provide a judicial forum of last resort to deal with particularly difficult and complex decisions and the Government’s regulatory impact indicates that the Court will deal with only about 200 cases per year.
126 Clauses 45 and 56.
128 The Institute of Mental Health Act Practitioners (2004) have recently documented this in a survey of 11 Mental Health Trusts between May–August 2004.
129 The main function of the current MHRT is to review justification for continued detention. This is far narrower than the proposals in the Bill.
130 See question 10.
people suffer as a result of a Tribunal decision. Equally, there are likely to be many appeals to the Mental Health Appeal Tribunal.\footnote{For example, it is well established that the “reasonableness” of an action taken by a person carrying out a public function, such as an approved clinician or a Mental Health Tribunal, is a point of law.} We therefore have grave concerns about whether the new expanded system is realistic and practicable.

As to whether the proposals are clear, the Law Society refers the Committee to Schedule 5 of the Bill as just one of many examples of impenetrable lack of clarity.

We believe that the major omission in the Bill is the right to an assessment of need and the provision of services for people with mental health problems and their families.\footnote{A right to assessment is provided under the NHS and Community Care Act 1990 but evidence shows this is often denied to people with mental health problems and relates to social services rather than psychiatric care. This point is covered in more detail in the Mental Health Alliance submission.} The provision of well-resourced community services reduces the need for compulsory hospital admission and reflects the principle of the least restrictive alternative. This is recognised in the Mental Health (Care and Treatment) (Scotland) Act 2003 which provides that a local authority shall provide services for people with a mental disorder, which includes care and support services and services designed to promote well-being and social development.\footnote{Sections 25 and 26.} The Act also includes a duty to inquire into individual cases where it appears that a person with a mental disorder is being ill-treated or neglected.\footnote{Sections 33.} This issue is ignored in the Bill, which instead focuses on detention and the use of compulsory powers.

5. \textit{Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the Draft Bill?}

The Law Society believes that the proposals to create a new Tribunal system are elaborate and far-reaching. However, even if sufficient resources can be provided to ensure a fully operational Tribunal system, there remain serious doubts as to whether it would safeguard patients’ rights.

The relevant conditions in the Bill are extremely wide (see 2(a) above). The Mental Health Tribunal has no discretion to discharge if all the relevant conditions are met, and as the conditions are so widely defined, it may be extremely difficult for a person to be discharged once he/she has been made subject to the provisions of the Bill.\footnote{Clauses 45 and 56.}

The Bill does not address the difficulty that will arise if the Mental Health Tribunal and the approved clinician cannot agree on the care plan.\footnote{If the Tribunal is to have a real role in monitoring the treatment of patients, the care plans will need to be detailed and precise. The opportunities for disagreement will be considerable, not only between any particular Tribunal and the approved clinician, but also between one Tribunal and the next. It will be logistically impossible to ensure continuity of tribunal membership as a patient’s care develops. It will therefore be necessary for the approved clinician to re-argue the whole case before each Tribunal, as the new Tribunal members will have to be satisfied on their own account that the treatment plan is appropriate.} If the Tribunal is to have a real role in monitoring the treatment of patients, the care plans will need to be detailed and precise. The opportunities for disagreement will be considerable, not only between any particular Tribunal and the approved clinician, but also between one Tribunal and the next. It will be logistically impossible to ensure continuity of tribunal membership as a patient’s care develops. It will therefore be necessary for the approved clinician to re-argue the whole case before each Tribunal, as the new Tribunal members will have to be satisfied on their own account that the treatment plan is appropriate.

We are also concerned that the Bill proposes to give criminal courts the power to issue Mental Health Orders for up to six months on a person subject to criminal proceedings.\footnote{The court will be required to approve a care plan authorising compulsory treatment for resident and non-resident patients. We believe that criminal courts will lack the benefit of the experience and expertise of the Mental Health Tribunal.} The court will be required to approve a care plan authorising compulsory treatment for resident and non-resident patients. We believe that criminal courts will lack the benefit of the experience and expertise of the Mental Health Tribunal.\footnote{We are particularly concerned that the court is not under a duty to appoint a member of the Expert Panel to assist in this task. Furthermore, all discussions about care plans will need to be held in closed sessions for reasons of confidentiality and the length of time these discussions could take may cause major disruption to court lists.} We are also concerned that the Bill proposes to give criminal courts the power to issue Mental Health Orders for up to six months on a person subject to criminal proceedings.\footnote{The court will be required to approve a care plan authorising compulsory treatment for resident and non-resident patients. We believe that criminal courts will lack the benefit of the experience and expertise of the Mental Health Tribunal.} The court will be required to approve a care plan authorising compulsory treatment for resident and non-resident patients. We believe that criminal courts will lack the benefit of the experience and expertise of the Mental Health Tribunal.\footnote{We are particularly concerned that the court is not under a duty to appoint a member of the Expert Panel to assist in this task. Furthermore, all discussions about care plans will need to be held in closed sessions for reasons of confidentiality and the length of time these discussions could take may cause major disruption to court lists.}

6. \textit{Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?}

\textit{The role of carers and the nominated person}

The Law Society is concerned that the Bill removes the status of nearest relative and abolishes some of the important rights which families have in relation to the exercise of compulsory powers.\footnote{The Bill provides that any carer and any person with parental responsibility must be consulted before a} The Bill provides that any carer and any person with parental responsibility must be consulted before a
determination is made. However this is subject to the significant limitation, that it does not apply if the consulter considers it “inappropriate” or “impracticable”.140 The Law Society is concerned at the reduction of rights for families to question the need for compulsory admission, and, more importantly the right to object to compulsory admission for treatment.

The Law Society does not believe that the role of the nominated person will provide an adequate replacement of the rights and powers of the nearest relative. Under the Bill the nominated person is not appointed until after the patient becomes liable to assessment, whereas under the 1983 Act the nearest relative is involved prior to the decision to impose compulsory powers.141 This is a major reduction in an important safeguard. The nominated person has rights to be consulted over the wishes and feelings of the patient in relation to compulsory treatment and can apply to the Mental Health Tribunal for the patient’s discharge.142 However, this is again an inadequate replacement of the nearest relative’s right to ask the hospital managers to grant discharge under the 1983 Act.143

The safeguards in relation to ECT and other aggressive treatment.

The Bill identifies ECT as a treatment calling for special safeguards, in that a patient who retains capacity may refuse it.144 However, this is is subject to an emergency power to give ECT.145 It is difficult to envisage circumstances where the emergency power will apply yet the patient would retain capacity. The Law Society would therefore question the need for this emergency provision.

7. Is the balance struck between what has been included on the face of the Draft Bill and what goes into Regulations and the Code of Practices right?

The Law Society is concerned that the amount of information left to Regulations and the Code makes it impossible to understand the full aspects of the Bill. The Bill sets out that most patients will be assessed in hospital but a small group, to be outlined in Regulations, will be assessed in the community without a preceding hospital admission.146 Regulations will enable Ministers to disqualify certain categories of people from being nominated persons.147 The Bill also fails to define what it means by “type B” medical treatments, which would be subject to special safeguards. Once again this will be defined in regulations, as will the safeguards which will be available.148

It may be that the Regulations and Code of Practice will render less objectionable some of the provisions in the Bill. However, it is just as likely that the Regulations and Code of Practice will limit or undermine some of the apparent safeguards and benefits of the Bill. Until we see the Code of Practice and the Regulations, we cannot really comment any further.

8. Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

The Law Society is concerned that the relationship between the Draft Mental Health Bill and Mental Capacity Bill will be complex and confusing.

Under the Mental Capacity Bill a doctor can treat an incapacitated person in his/her best interests.149 This includes using restraint, whether or not the incapacitated person resists, if this is necessary to prevent harm and is proportionate to the likelihood of the incapacitated person suffering harm and the seriousness of that harm. Treatment cannot be provided where the incapacitated person has an Attorney or a court appointed deputy who objects.150 In that case the doctor could apply to the court to challenge that person’s objection but in the meantime could provide life-sustaining treatment or do any act which he/she reasonably believed to be necessary to prevent a serious deterioration in the incapacitated person’s condition.151

140 The obligation to consult carers is subject to the requirement of ascertaining the patient’s wishes and feelings about consultation (unless this is felt to be inappropriate or impracticable). If the patient has been consulted and does not wish the carer to be consulted, the would-be consulter must make a determination about whether it would be appropriate to consult the carer, and in doing so, they must have regard to the wishes and feelings of the patient and any other relevant circumstances (clauses 11–12).
141 Clause 19.
142 Clauses 238 and 35.
143 Section 25.
144 Clause 179.
145 Clause 182.
146 Clause 15 (2).
147 Clause 232 (4).
148 Clauses 196–197.
The Draft Mental Health Bill provides that an individual cannot be subject to compulsory powers unless “medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part”.152 This means that if a person lacks capacity and can be treated under the Mental Capacity Bill, he/she cannot come under the Draft Mental Health Bill. However if the incapacitated person’s Attorney or deputy refuses to agree to medical treatment, the Mental Capacity Bill cannot be used to authorise treatment and they would be subject to the Draft Mental Health Bill if the other conditions under clause 9 are met. This raises a number of complicated scenarios:

— A person (“P”) with a mental disorder has capacity to make treatment decisions but does not have an Attorney or a deputy. If P refuses treatment and the other relevant conditions are met, P will be made subject to Draft Mental Health Bill. However if P then loses capacity he/she will have to be discharged from the Draft Mental Health Bill and treated under the Mental Capacity Bill. If P then regains capacity, P can no longer be treated under the Mental Capacity Bill and he/she will have to be re-assessed under the Draft Mental Health Bill.

— A person (“D”) with mental disorder has capacity and has made a valid Lasting Power of Attorney. If D refuses treatment and meets the relevant conditions, he/she will be made subject to the Draft Mental Health Bill. If D then loses capacity and the Attorney consents to the continuing treatment, D must be discharged from the Draft Mental Health Bill because treatment could lawfully be provided under the Mental Capacity Bill. However if the Attorney does not consent to the continuing treatment, the doctor must apply to the Court of Protection to continue treatment. In the meantime the doctor can continue to treat the patient under the Mental Capacity Bill.

— A Person (“C”) has made a valid advance decision under the Mental Capacity Bill refusing admission to psychiatric hospital and/or the provision of psychiatric medication should they lose capacity in the future. In this case C could not be treated under the Mental Capacity Bill, whether or not his/her Attorney or deputy consented and would have to be treated under the Draft Mental Health Bill, so long as all the relevant conditions in clause 9 applied.

Under the Draft Mental Health Bill, the clinical supervisor must discharge a treatment order if at any time he/she is not satisfied that all of the relevant conditions are met in the patient’s case.153 This means that if the patient loses capacity and can be treated under the Mental Capacity Bill, he/she must be discharged from the Draft Mental Health Bill.154 Therefore the clinical supervisor must keep the patient’s capacity under constant review and discharge the patient as soon as he/she becomes aware that the patient has lost capacity to make treatment decisions (unless the patient has an Attorney or deputy who opposes treatment, or an advance directive refusing treatment, in which case treatment cannot be authorised under the Mental Capacity Bill).

Where a person (“F”) has fluctuating capacity and knows that he/she is likely to need psychiatric treatment in the future, F could decide beforehand which legislation he/she wishes to be treated under. If F believes that the Draft Mental Health Bill provides greater protection, he/she could make an advance decision to refuse treatment and if F is also intending to create a Lasting Power of Attorney, he/she could exclude decisions about psychiatric treatment so that the Attorney cannot override the advance decision.155 If F prefers to be treated under the Mental Capacity Bill legislation, he/she would not make an advance decision and would exclude decisions about psychiatric care from any Lasting Power of Attorney. This would prevent the Attorney refusing to consent to treatment on behalf of F thus bringing into effect the powers of the Draft Mental Health Bill.

The Law Society believes that the relationship between the two Bills is so complex that, in many cases, it would be practically impossible to work out when one Act should be used and the other should not.

HL v United Kingdom156

The case of HL has created further confusion about the interface between the two Bills. The decision makes clear that a person who lacks capacity to consent to his/her admission to hospital but who does not object, can nevertheless be “deprived of his liberty” within the meaning of Article 5(1) ECHR. Moreover, the legal framework provided by the common law doctrine of “necessity” and “best interests” contains inadequate procedural safeguards to protect such patients.

In future, such patients will need to be detained under a properly regulated system in order to guarantee them the kind of safeguards that are lacking at common law. This could apply to incapacitated informal patients in hospitals and people who lack capacity and are living in nursing homes or care homes whose particular circumstances may amount to a deprivation of liberty.

152 Clause 9 (5).
153 Clause 60.
154 This is because in accordance with clause 9 (5) lawful treatment can be provided under the Mental Capacity Bill and therefore the relevant conditions in the Mental Health Bill are not met.
155 This could apply if the LPA was made after a valid advance decision.
156 Application no 45580/09 5 October 2004.
The provisions of the Mental Capacity Bill may suffice for people who lack capacity and who are not being detained in accordance with the HL judgement. However it is difficult to see how the Bill could be adapted to accommodate those people lacking capacity who are currently unlawfully detained so as to provide the ongoing review and regulatory procedures required by Article 5(4).

In principle, the Court of Protection provisions would be sufficient to meet the requirements for procedural safeguards established in HL v United Kingdom. However, in practice, it is most unlikely that the Government would wish to use a High Court procedure to deal with thousands of routine decisions, many of which will be uncomplicated, uncontroversial and uncontested. The Government needs to urgently address this issue because there will be many people who are “HL” detained but who do not meet the criteria for the use of compulsory powers under either the current Mental Health Act or the Draft Mental Health Bill.

9. Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

The Law Society believes that the Bill is unlikely to fully meet the requirements of the Human Rights Act 1998 and highlights the following areas of concern.

The Law Society welcomes the provision of independent Mental Health Act advocates for patients and the nominated person. We are, however, extremely concerned that the Bill provides that advocates can help patients to exercise their rights by way of representation at a Tribunal hearing. The Law Society believes that the provision of independent advocacy is an important safeguard for patients’ rights but it cannot provide, nor should it be allowed to stray into, expert legal representation and advice. Failure to provide patients who are subject to compulsory powers with specialist legal representation would contravene fundamental human and legal rights.

The Bill provides that a person with mental disorder thought to be at substantial risk of causing serious harm to other persons will not be allowed to receive treatment informally, if the other relevant conditions in clause 9 apply. This will mean that people who have the capacity to consent to treatment and who do consent will still be made subject to compulsory powers. We believe that this fails the ECHR requirement that any restrictions on liberty must be proportionate to the objective to be achieved.

There has been increasing judicial recognition that the imposition of treatment on competent patients raises issues under Article 3 (prohibition of inhuman or degrading treatment) and Article 8 (respect for private and family life), especially where the person does not present a danger to the health or safety of others. This is likely to form the basis of future challenges to the Bill.

The introduction of compulsory community treatment would constitute an interference with the patient’s right to respect for private life under Article 8(1) and would need to be justified on one of the grounds set out in Article 8(2). Currently, compulsory medical treatment can only be imposed on those detained or liable to be detained in hospital. The introduction of community treatment orders would make people with mental disorders subject to compulsory powers even if their treatment needs could be met in the community with the provision of high quality services. This may also fail the ECHR test of proportionality.

ECHR caselaw has established a patient’s right to privacy under Article 8. The Bill allows a patient’s approved clinician to consult with a wide range of carers, both professional and informal. Although the patient’s wishes have to be taken into account when deciding whether or not to consult, the patient’s wishes do not override the views of the clinician. If “consult” means merely “listen to the views of”, then there may be no significant breach of confidentiality. However if “consult” means, “discuss with” then this would engage the right to private life established under Article 8.

Article 5 (4) of the ECHR requires that a person deprived of their liberty shall have the lawfulness of their detention decided speedily by a court. Court judgements have recognised that the current Mental Health Review Tribunal system has been beset with resource and administration difficulties that have led to delays and cancellations of hearings which have seriously prejudiced patient’s interests. We are concerned that the Bill will put additional stress on this system and unless considerable resources are made available, patients will continue to be denied a speedy review of their detention.

157 Clause 247.
160 Mental Health Orders for non-resident patients.
161 It is also of concern that clauses 46 (7) and 119 (7) allow a mental health order for a non resident patient to include a condition that the patient does not engage in specified conduct. The meaning of “specified conduct” is not defined but potentially include preventing a person going to the pub or associating with certain people. This raises further fears that the Bill authorises psychiatric ASBOs.
162 For example, R v MHRHT London South and South-West Region, ex p C [2002] 1 WLR 176 and R v MHRT and Secretary of State for Health, ex p KB [2002] EWHC 639.
The Bill provides a new police power to enter premises without a warrant and remove a person who is believed to be suffering from a mental disorder and in urgent need of removal based on the evidence of an Approved Mental Health Professional.\footnote{We are concerned that this power may be used simply to avoid the trouble of obtaining a warrant and may be open to challenge under Article 5. Section 17 of the Police and Criminal Evidence Act 1984 already gives the police power to enter premises for the purpose of saving life and limb or preventing serious damage to property.} We are concerned that this power may be used simply to avoid the trouble of obtaining a warrant and may be open to challenge under Article 5. Section 17 of the Police and Criminal Evidence Act 1984 already gives the police power to enter premises for the purpose of saving life and limb or preventing serious damage to property.

10. **What are likely to be the human and financial resource implications of the Draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?**

The Government anticipates that there are likely to be over 40,000 Tribunal hearings under the Bill, almost double the number under the current Act. It is estimated that 80 full time equivalent legal members will be needed to staff the new Tribunal and the total cost for the first year will be £70 million.\footnote{Explanatory notes paras. 47–54. This does not include hearings of the Mental Health Appeal Tribunal.}

The Law Society expects that in relation to the role of solicitors, virtually all patients will seek to be represented. Indeed, we believe this is essential in order to protect the rights of vulnerable patients, given the potentially serious consequences of decisions made by the Tribunal. It is not clear whether the Treasury has agreed to make additional funding available to the Legal Services Commission to cover the cost of these additional hearings. The success of the proposed Tribunal system depends on finding enough suitably qualified lawyers. The Department of Health must be prepared to set fee levels at an adequate level to attract sufficient, qualified members.

The workload of the Tribunal will also increase enormously. Not only will the number of hearings vastly increase but each hearing will take at least 50% longer, due to the Tribunal’s extended remit to include consideration and approval of the care and treatment plan, so there will be fewer hearings carried out per panel, per day.

This increase in workload and the numbers of hearings will require a large cohort of new members to carry out the additional work.\footnote{Clause 228.} There will also be a need to fully train the additional members of the Tribunal as well as additional training for all the continuing members to enable them to deal with the new remit. There are also major concerns about the availability of sufficient applicants who would be willing to work full time. We are not aware of any research being conducted on the availability of candidates for such posts and there are considerable doubts whether such posts would be attractive.\footnote{Clinical personnel, especially doctors, will have a far greater workload of preparation of reports under the new Act, as all their detained patients will be subject to regular compulsory Tribunal hearings. This is likely to reduce their availability for either Tribunal membership or the Expert Panel. It seems inevitable that members of the Expert Panel will be required to attend tribunal hearings to be cross-examined on their reports and therefore there could be three medical personnel at each hearing. With the increased number of Tribunal hearings there must be very serious doubts about the ability of the NHS to fulfil these demands.}

Following on from the recruitment of additional members, the cost of running the Tribunal system will rise sharply. If many panels, which currently hear two cases per day, are in future only able to hear one, then more panels will need to be convened. Since members cannot be required to sit more than a given number of days per year, it may be necessary to appoint even more members.

There is no doubt that the administration costs of the Tribunal will rise significantly. This will not only be due to the increased number of hearings, but also to the need to obtain far more reports, organise the attendance of and reports from the Expert Panel and arrange the large number of adjourned hearings which will inevitably arise from the non-availability of key people. For all these reasons, it is virtually impossible for the hearings envisaged by the Bill to take place with the frequency and within the time limits proposed. This is likely to result in judicial reviews of the Tribunal and possible liability to damages awards on the same basis as those now being awarded to patients because of the failures of the current administration.\footnote{There is no doubt that the administration costs of the Tribunal will rise significantly. This will not only be due to the increased number of hearings, but also to the need to obtain far more reports, organise the attendance of and reports from the Expert Panel and arrange the large number of adjourned hearings which will inevitably arise from the non-availability of key people. For all these reasons, it is virtually impossible for the hearings envisaged by the Bill to take place with the frequency and within the time limits proposed. This is likely to result in judicial reviews of the Tribunal and possible liability to damages awards on the same basis as those now being awarded to patients because of the failures of the current administration.}

It is clear from the Bill that the Tribunal is intended to play a pivotal role in safeguarding the interests of detained patients. However, the Law Society believes that the proposed Tribunal structure is unworkable. If we are correct, then the main safeguard for patients will fall away, patients will be left in a vulnerable position and the exposure to human rights claims will be very serious.

*October 2004*
Memorandum from the Law Reform Committee of the Bar Council (DMH 191)

1. The Law Reform Committee of the Bar Council welcomes legislation aimed at modernising mental health law, but is concerned that the Bill appears to be unworkable and to violate core human rights values in some significant respects. This memorandum will focus on the aspects of the Bill that are, in our view, most problematic, from a legal/human rights perspective, although, in the light of the limitations placed on the length of written submissions sought by the Committee and the complexity of the Bill, the issues raised can in no way be considered to be exhaustive.

2. The broad framework of compulsion for assessment and treatment within resident and non resident settings affects numerous rights. The starting point must be the significant infringement of dignity and autonomy of a vulnerable group by the use of compulsion, engaging related human rights including liberty (article 5 of the European Convention on Human Rights (ECHR)), the prohibition against inhuman or degrading treatment (article 3), the right to private and family life (article 8) and the prohibition on discrimination (article 14). These rights are among those given binding effect by the Human Rights Act 1998. Also of relevance are (non-binding) international human rights provisions contained in the International Convention on Civil and Political Rights (ICCPR), the International Convention on Economic, Social and Cultural Rights (ICESCR), the standards in the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the UN Mental Illness Principles) and the Council of Europe’s Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (opened to signature at Oviedo on 4 April 1997) (the Bioethics Convention).

3. Of particular relevance is “Recommendation No Rec(2004)10 of the Committee of Ministers of the Council of Europe to member States concerning the protection of the human rights and dignity of persons with mental disorder”, adopted on 22 September 2004 under the terms of Article 15(b) of the Statute of the Council of Europe. Rec(2004)10 sets out a number of principles which, despite not having binding effect and notwithstanding the United Kingdom Government’s decision (alone out of 45 member State) to reserve the right not to comply with the Recommendation as a whole, is likely to be particularly relevant in determining the ambit of the rights protected by the European Convention on Human Rights (and thus by the Human Rights Act 1998). The Convention is often called a “living instrument” and the European Court of Human Rights (ECtHR) will interpret and apply its terms in accordance with any “evolving convergence of standards to be applied”. Thus, even if the Bill as presently drafted does not conflict with the Convention as it has been construed to date, in so far as it fails to conform with Rec(2004)10 and other international instruments setting minimum standards it may end up being declared incompatible with Convention rights; that is quite apart from the fact that, by contrast with the 1959 Mental Health Act, the Bill signally fails to set the standards by which civilized nations should treat this vulnerable and stigmatised group.

4. We have had an opportunity to consider, among others, the written submissions made to the Joint Committee by the Royal College of Psychiatrists, the Law Society, the Mental Health Act Commission and the Institute of Mental Health Act Practitioners. We have also read a transcript of the evidence given to the Joint Committee by Professor Genevra Richardson. We endorse the views, in particular, of Professor Richardson and the very powerful submissions of the Royal College of Psychiatrists. We do not need to develop in detail the concerns we have about the Bill because of the careful manner in which these other respondents have already addressed them.

5. We have therefore decided to restrict our response to the single question posed by the Joint Committee, namely: is the draft Mental Health Bill in full compliance with the Human Rights Act? In answering that question we will touch upon issues relevant to the other questions posed by the Joint Committee, particularly Questions 1, 2, 3, 4 and 6.

6. We wish to highlight the following areas of concern:

---

170 Adopted by United Nations General Assembly Resolution 46/119 of 17 December 1991. The “Mental Illness principles” have been recognised as “the most complete standards for the protection of the rights of persons with mental disability at the international level . . . [these] principles serve as a guide to States in the design or reform of mental health systems and are of utmost utility in evaluating the practice of existing systems”: Case of Victor Rosario Congo, Inter-American Commission on Human Rights, Report 29/99 Case 11, 427. Ecuador, adopted in Session 1424, OEA/Ser.L-V/II. The principles have been used by international oversight and enforcement bodies as an authoritative interpretation of the requirements of the ICESCR and the American Convention on Human Rights (“The Role of International Human Rights in National Mental Health Legislation”, Department of Mental Health, WHO (2004), p 21).

171 Signed by 31 members of the Council of Europe, but not signed by the United Kingdom.

172 Article 15(b) provides: “In appropriate cases, the conclusions of the Committee may take the form of recommendations to the governments of members, and the Committee may request the governments of members to inform it of the action taken by them with regard to such recommendations.”

173 See Hansard 20 October 2004, column 796W, Rosie Winterton for the Government said: “The Government fully supports the majority of the Recommendation, including the principle that involuntary placement of persons with mental disorder should include a therapeutic purpose. We had no wish to oppose its adoption. However, because we are in the process of revising important aspects of legislation in England and Wales on mental health and mental capacity, we were not in a position to identify definitively whether there were specific points in the Recommendation on which we might wish to reserve our right not to comply. We therefore said that, at this stage, the United Kingdom wished to reserve its right not to comply with the provisions of the Recommendation generally.”

6.1 The criteria for the imposition of detention and compulsory treatment are too vague, the threshold for such imposition is too low and the safeguards against arbitrariness too weak to comply with the provisions of Articles 5 and 8 of the European Convention on Human Rights.

6.2 The absence of any reciprocal right to treatment of a minimum standard and in appropriate conditions and to suitable aftercare is incompatible with international human rights standards and may violate Articles 5 and 8 ECHR.

6.3 Treatment may be imposed upon competent, dissenting patients in circumstances that may violate Articles 3 and/or 8 and/or 14 ECHR.

6.4 The absence of any power in the Mental Health Tribunal to order a patient to be transferred to another hospital or to be given leave of absence in the face of objections from the patient’s doctor or (in restricted cases) the Home Secretary effectively neutralises its function where transfer to lower conditions of security or leave of absence are a necessary precondition to discharge, potentially in breach of Articles 5(4) and 8.

6.5 Inadequate protection is given to the residual rights of detained patients in relation to issues such as seclusion, searching, visiting, access to personal possessions, computers etc, potentially in breach of Articles 3 and 8.

**Criteria for Compulsion too Vague, Safeguards too Weak**

7. The criteria for the imposition of detention and compulsory treatment are too vague, the threshold for such imposition is too low and the safeguards against arbitrariness too weak to comply with the provisions of Articles 5 and 8 of the European Convention on Human Rights.

8. For detention to be lawful for the purposes of Article 5(1)(e) on the grounds of “unsound mind” the following relevant criteria must be established (the so-called “Winterwerp criteria”), with the burden being on the State to establish these criteria (Reid v United Kingdom):

8.1 The patient must be reliably shown, upon objective medical expertise, to be suffering from a true mental disorder (Winterwerp v Netherlands (1979) 2 EHRR 387, §39).

8.2 A person may not be detained simply because his views or behaviour deviate from the norms prevailing in a particular society (Winterwerp, ibid, §37).

8.3 The disorder must be of a “kind or degree” warranting compulsory confinement (Winterwerp, ibid, §39).

8.4 The detention will only be “lawful” for the purposes of Article 5(1)(e) if effected in a hospital, clinic or other appropriate institution authorised for that purpose (Ashingdane v United Kingdom 1985) 7 EHRR 528, §44).

9. For a detention to be lawful, however, it is not enough that these conditions are in fact met in any given case. The detention must have some justification in national law. Moreover, national law must itself meet the standard of “lawfulness” set by the Convention. In particular, the law must be sufficiently precise to allow the citizen—if need be, with appropriate advice—to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail. Furthermore, the law must provide adequate legal protections and “fair and proper procedures” to guard against arbitrary or mistaken deprivations of liberty (HL v United Kingdom, §114). It was this latter requirement that was found to have been breached in the HL case.

10. Where compulsory powers are imposed which do not give rise to a deprivation of liberty for the purposes of Article 5, a similar obligation is imposed on member States by Article 8, which safeguards the right to respect for private and family life. The imposition of a non-resident mental health order on a citizen will constitute an interference with this right which will only be justified if it is in accordance with national law that is sufficiently foreseeable and provides adequate guarantees against abuse.

11. We are concerned that the Bill as currently drafted does not meet the requirements of legality imposed by Articles 5 and 8, for the following reasons:

11.1 The failure to provide a set of guiding principles within the body of the Bill but instead to place these in a (non-binding) Code of Practice denies the Bill a strong (ie enforceable) and accessible framework. Contrast Rec(2004)10, Chapter II, and UN MI Principles, Principle 1.

11.2 The “first relevant condition” includes a definition of “mental disorder” (clause 2(5) and clause 9(2)) that is very broad, potentially including those with addictions and learning disabilities. A broad definition of mental disorder is justifiable only if suitable exclusions and other strict threshold criteria are also in place; this was the basis upon which the Richardson Committee proposed a broad definition of mental disorder.

11.3 There is no exclusion from the definition of “mental disorder” of those whose disorder arises solely by reason of dependence upon or use of drugs or alcohol, sexual preference, or other lack of adaptation to the moral, social, political or other values of society. We refer to Article 2(2) of Rec (2004)10 and Principle 4(2) and (3) of the UN Mental Illness Principles.
11.4 The “second relevant condition” that “that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him” is too low a threshold. It should be qualified thus: “... under compulsory powers” (clause 9(3), 116(3)).

11.5 The “third relevant condition” that “it is necessary... for the protection of other persons” (clause 9(4)) is too low a threshold. It should be qualified thus: “... from physical or psychological harm”. We note that Rec(2004)10 sets the threshold for compulsory detention that “the person’s condition represents a significant risk of serious harm to his or her health or to other persons”.

11.6 The “fourth relevant condition” that “medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part” (clause 9(5)) is plainly intended to prevent those who can be treated “informally” from being subject to compulsory powers. This goes some way to meeting the objection in §(iii) above. However:

11.6.1 Incapacitated patients who do not oppose treatment (so-called “Bournewood patients”) will “lawfully” be treated for mental disorder under the Mental Capacity Bill which does not provide for the specific protections of the Bill (or even those in Part 5 of the Mental Health Bill 2002). This may be incompatible with Article 5(1) and 5(4) in the light of *HL v United Kingdom*, ECHR, 5 October 2004.

11.6.2 This condition is excluded in the case of those who are over 16 and “at substantial risk of causing serious harm to other persons”. The only situation in which a person who poses such a threat might be “lawfully” treated other than under the provisions of the Bill is if s/he has capacity to consent to treatment, and does so consent. It is difficult to see why such an individual should not be allowed to receive treatment as an informal patient in hospital, as is the case under the current MHA 1983 (see section 3(2)(c)), and no justification for changing the law has been advanced by the Government. If the patient subsequently withdraws consent to treatment s/he may then be compulsorily detained.

11.7 The “fifth condition” that “medical treatment is available which is appropriate in the patient’s case” is too vague and will permit “preventive detention” of patients who are considered to be dangerous but have not committed any offence. This provision replaces the so-called “treatability” criteria that applies to patients detained under the category of “psychopathic disorder” under the MHA 1983. It is noted that the “treatability” requirement was very widely construed by the House of Lords in *Reid v Secretary of State for Scotland* and the ECHR has since ruled that “treatability” is not a necessary pre-condition for a lawful detention under Article 5(1)(e) (*Reid v United Kingdom*). However, those decisions were both taken in the context of individuals who had been convicted of serious offences. The Law Reform Committee of the Bar Council considers that there should be a requirement that “medical treatment” includes some “therapeutic benefit” for the patient, in line with Rec (2004)10, Article 17(1)(iii).

11.8 The Bill provides no additional threshold criteria for clinicians or the Mental Health Tribunal to determine whether compulsory treatment is to be imposed in the community (as a “non-resident patient”) or under conditions of detention (as a “resident patient”). The “relevant conditions” in clause 9 require only that the threshold for treatment under compulsion be reached: but a lower threshold is necessarily required for treatment under a non-resident treatment order than for detention. At the assessment stage, if the examiners decide the relevant conditions in clause 9 are fulfilled, detention is automatic: see clause 16(5) (and bearing in mind the limited category of patients who are to be eligible for assessment in the community under clause 15(2)). See also clause 17(3) (emergency patients). At the stage at which the Mental Health Tribunal determines whether to authorise an order for medical treatment (clause 46) or further assessment (clause 49), no additional threshold criteria is required in deciding whether the patient is to be a resident or non-resident patient (clause 46(4), 49(4)). On the face of it that is incompatible with Article 5(1). A contrast may be made, for example, with clause 147(6). There should be an additional threshold criteria to the effect that the patient must be treated/assessed as a non-resident patient unless the examiner/Tribunal are satisfied that treatment can only be given in hospital and it is necessary for the health or safety of the patient or the protection of the public from harm that he receive the treatment as a resident patient.

11.9 The same criticism may be made in respect of the power of the clinical supervisor (clause 48(4), 51(6), 57(2), 121(3)) and, in the case of restricted patients, the Secretary of State (clause 129(8)) to revoke a patient’s non-resident status so that he is recalled to hospital. The clinical supervisor or Home Secretary should be required to consider whether the threshold requirements for detention in Article 5(1)(e) (the “Winterwerp criteria”) are established at that stage. Non-compliance in and of itself does not mean that those criteria are established: see *Kay v United Kingdom*.

11.10 The burden of proof upon the detaining authority to establish the criteria for compulsion before the Mental Health Tribunal appears to have been eroded: see clause 36(3), 45(2), 56(3). It has been conclusively established that Articles 5(1) and 5(4) require the burden to be on the detaining authority (*R (IH) v Mental Health Review Tribunal; Reid v United Kingdom*). The wording should be “If... the Tribunal is not satisfied that all of the relevant conditions are met...”, see section 72(1) MHA 1983. There is no explanation why the latter wording appears in clause 59(1)(b) but not in the earlier provisions mentioned.

11.11 As regards safeguards, it is striking that the Bill removes the role and considerable powers of the nearest relative under the MHA 1983 and replaces it with three statutory consultees (nominated person, carer, advocate) who have no power whatsoever beyond applying on the patient’s behalf to the Tribunal.

---

173 The same criticism may be made of mental health orders imposed by the Crown Court: see clause 119(1).
11.12 The Bill removes any discretion in the tribunal or clinical supervisor so that, once the criteria are met, compulsion must follow. This is by contrast with the position under the MHA 1983 (and the 1959 Act). Once two medical recommendations have been made under section 3 MHA certifying that the criteria for detention are made out, by section 13(1) the approved social worker is under a duty to make the application for treatment only “where he is satisfied that such an application ought to be made and is of the opinion . . . that it is necessary or proper for the application to be made by him”. This discretion is a vital safeguard for the patient’s right to liberty, for example in those cases where the patient has been recently discharged by a Mental Health Tribunal in the face of opposition from his clinical team: see the recent decision of the House of Lords in R (Von Brandenburg) v East London & The City Mental Health NHS Trust [2004] 2 AC 280, §11. Similarly, by section 72(1) the Mental Health Review Tribunal has a discretion to discharge a patient even where it is satisfied that the detention criteria are made out. The lack of any discretion in the Tribunal under the Bill is striking and the Government has demonstrated no justification for the change in the law.

12. The effect of the above features of the Bill is cumulative: each makes it more likely that those who do not require compulsion will be compelled to receive treatment; and those that can be treated in the community will instead be treated in hospital. Taken together we are satisfied that the Bill, as currently drafted, does not comply with the requirements of Article 5(1) and Article 8.

13. We would also wish to add our voice to the concerns over the practicability of the proposals for the new Mental Health Tribunal. The Committee has already heard oral evidence to the effect that the Tribunal administration is “moderately chaotic”.176 Delays in tribunal hearings as a result of the over-burdened, under-resourced system as it exists have been found to violate the article 5(4) requirement of a “speedy review”, entitling some patients to compensation.177 While we welcome the single “gateway” to compulsion, if patients are to become “stuck” in the system under non-resident orders, then it is highly likely that the new proposals will extend the administration and resources of the tribunal office even further with the result that hearings will be delayed.

14. Further, if as anticipated, the sheer volume of hearings increases significantly, great care will be required to ensure that the quality of hearings is not compromised. For example, how detailed will care plans be if clinical teams are struggling to complete them in time for hearings? Will the Tribunal be adequately resourced in terms of its membership, to ensure that care plans are properly tested before applications for compulsion are approved? We note below at §51 that the Tribunal’s powers regarding care plans are insufficient to ensure that they are adequate and appropriate. The lack of adequate safeguards and powers in this regard means that Tribunals are more likely to make decisions that are wrong. This has implications not only for the rights of those patients who are wrongly subjected to compulsion, but also for the protection of the public in those (rare) cases where patients are wrongly released.

No right to appropriate treatment and after-care

15. In three respects the Bill fails to guarantee to patients a right to appropriate treatment reciprocal178 upon the imposition of compulsory powers:

15.1 No enforceable right to treatment for those detained in hospital or subject to compulsion in the community.

15.2 No enforceable right to treatment in the least restrictive environment consistent with the needs of the patient and the need to protect the public. The lack of any power in the Tribunal to direct that a patient be transferred to a hospital which provides an appropriate environment for their treatment lies at the heart of this problem (see §§33 and onwards, below).

15.3 No enforceable right to aftercare for patients released from hospital. The duty under section 117 of the MHA 1983 has been repealed, to be replaced by much weaker obligations in Cl. 53 (“free care services before discharge”) and Cl. 64 and 68.

16. Treating a person under compulsion as a resident or non-resident patient with attached conditions constitutes a significant interference with liberty (art. 5) and private life (art. 8), even more so in conditions of high security. Although Article 5(1)(e) is not in principle concerned with suitable treatment (Winterwerp v Netherlands ibid, §51) or conditions of detention (Ashingdane v United Kingdom 1985) 7 EHRR 528, §44), there must be a sufficient connection between the ground of detention (unsound mind) and the place of detention: thus, detention under Article 5(1)(e) is only lawful if in a “hospital, clinic, or other appropriate institution”. Moreover, where a patient is detained indefinitely because treatment (or aftercare services) are not available, that is capable of giving rise to a violation of Article 5(1) (Johnson v United Kingdom).

17. Also of relevance are Articles 3 and 8 of the Convention which can, in appropriate circumstances, impose positive obligations on the State to provide medical treatment to those in its care (Keenan v United Kingdom).

176 Professor Genevra Richardson.

177 R (KB) and others.

178 The Richardson Committee recommended that the principle of “reciprocity” be enshrined in legislation, entitling those who are subject to compulsion to the treatment that they need.
18. We accept that, as the law currently stands, it is not possible to claim definitively that any of Article 5, 3 or 8 give rise to an enforçable right on the part of a detained patient to treatment for his mental disorder, except in the most extreme circumstances, or to treatment in the least restrictive environment possible. However, there is a developing consensus to the effect that compulsion should give rise to reciprocal rights to appropriate treatment in the most appropriate environment.

18.1 Central government guidance issued in September 1999 provides, materially:

- Each service user who is assessed as requiring a period away from their home should have timely access to an appropriate hospital bed or alternative bed or place which is in the least restrictive environment consistent with the need to protect them and the public

18.2 The UN Principles provide for a right to appropriate treatment that enables care in the least restrictive setting (Principle 9.1); Rec(2004)10 establishes the same principle (Art 8). Principle 11 provides for a right to the best available mental health care; Rec(2004)10 puts the obligation less strictly, requiring member states to “take measures” to provide a range of services of appropriate quality, to make alternatives to involuntary placement as widely available as possible (Art 10).

18.3 The US Supreme Court has held that unnecessary institutionalisation of those who can, with adequate support, be cared for in the community constitutes unlawful discrimination under the Americans with Disabilities Act 1990: Olmstead v LC, 1999.

19. Thus, even though Convention case law has not yet recognised a right to treatment other than in extreme cases, it is arguable that as a “living instrument”, the Convention does now bear such an interpretation (or at least will during the lifetime of this piece of legislation), particularly in those cases where treatment is necessary to ensure that a person is not detained longer than absolutely necessary. At the least, this is a sound principle that should be contained in modern mental health legislation.

20. As regards a right to free after-care services (and free community care services for those who are subject to compulsion as non-resident patients), the Bill has removed the strong “right” to such care currently provided for by section 117 MHA and has not replaced it. Although Cl. 53 refers to “free care services etc. before discharge”, it only applies to those who are subject to compulsion in the community. Moreover, it does not give rise to a free-standing duty (and correlative right) to such services; it merely disappplies the charging provisions that apply to other community care duties, in particular under Part 3 of the National Assistance Act 1948 (which includes services provided under the Chronically Sick and Disabled Persons Act 1970). Those general community care powers and duties do not provide the same protection as the specific created by section 117, in particular (and by contrast with section 117) they do not impose any duty upon health authorities, trusts and Primary Care Trusts to provide medical treatment.

21. As regards community care services provided to those who have been discharged, there is no duty to provide such services to those for whom aftercare services are necessary to smooth their path back into the community and thereafter to remain there. The sole exception involves those patients who, without such services, would continue to be liable to be detained. In such cases the Tribunal may defer discharge for a period of 8 weeks, triggering a duty on the hospital and local social services authority to provide a Care Plan (within 8 weeks of the Tribunal’s decision to discharge) and to disapply the charging provisions of other community care provisions for six weeks (Cl. 64(4) and 68). If the Tribunal is concerned that a patient may deteriorate, but cannot say that it will happen within eight weeks, it has no power to defer and there is no duty on the relevant authorities to provide any aftercare.

22. Section 117 has its faults—in particular, it has been held to give rise to no more than a duty to use “best endeavours” to provide such services as are necessary to enable a patient to be discharged (R (H) v Home Secretary [2003])—but it is one of the few community care provisions in English law that have been found to give rise to a specific duty (ie enforceable in judicial review proceedings) on the part of Health Authorities, PCTs and local authorities to meet assessed needs, free of charge. The justification for treating detained mental patients in this way was obvious to the House of Lords when it considered arguments by local authorities that section 117 did not give rise to such a duty: see R v Manchester CC ex p Stennett [2002], per Lord Steyn:

In the Court of Appeal Buxton LJ observed . . . : “the statutory provision is not at all anomalous, and not at all surprising. The persons referred to in section 117(1) are an identifiable and exceptionally vulnerable class. To their inherent vulnerability they add the burden, and the responsibility for the medical and social service authorities, of having been compulsorily detained. It is entirely proper that special provision should be made for them to receive after-care, and it would be surprising, rather than the reverse, if they were required to pay for what is essentially a health-related form of care and treatment.” I agree . . . If the argument of the authorities is accepted that there is a power to charge these patients such a view of the law would not be testimony to our society attaching a high value to the need to care for the exceptionally vulnerable’

---

179 Mental Health—National Service Frameworks, Department of Health, September 1999, page 41
23. It is perplexing that the Government have chosen to repeal section 117 and replace it with such weak substitute. We would observe that the positive obligations upon the United Kingdom under Article 8 (and possibly Article 5) may include a duty to provide aftercare to those who, without it, will either not be released or, if released, will relapse and then be readmitted. The duties created by sections 64 and 68 fall short of that.

24. The process of deferred discharge for civil patients raises further issues. Clause 63 provides for a deferral order where no plan has been prepared by the managers of a hospital and relevant local authority with a statement by each of post discharge services to be available following discharge and where all the relevant conditions will be satisfied within eight weeks if the patient is discharged without post discharge services. So for a person entitled to immediate discharge ie in respect of whom the Winterwerp criteria are no longer fulfilled, but who is likely to deteriorate rapidly without post discharge services (the “revolving door patient”), a deferral order must be made.

25. In all cases where there is no post discharge plan available for a patient, the Tribunal must perform the feat of projecting eight weeks into the future to determine whether or not, in the absence of a discharge plan, all the relevant conditions are likely to be fulfilled once again. If the answer is yes, a deferral order must be made. This is not likely to be a precise exercise even in cases with a history of deterioration.

26. In the absence of a duty in the relevant authorities to provide such services, or a power in the Tribunal to compel such provision, a deferral order is likely to be unworkable, with the consequence of further or prolonged compulsion if deterioration takes place as predicted, or an unreasonable delay in achieving discharge if it does not: article 5(1)(e) violation.\(^{180}\) The patient is not given the opportunity to benefit from his or her “wellness”.

27. In principle what is the difference between a patient likely to deteriorate within eight weeks and one who is not? Are they both not entitled to post-discharge care? This provision envisages that a patient entitled to discharge and who is unlikely to deteriorate within a short period of discharge, be discharged immediately regardless of the availability of a post discharge plan.

28. This deferral order does not appear to be directed at the problem encountered with the deferred conditional discharge system under current legislation (applies only to restricted patients). It is not stipulated that where a Tribunal finds that the relevant conditions would be satisfied in the absence of post-discharge services being made available, that continued compulsion would be lawful; in other words that entitlement to discharge is conditional or provisional upon post discharge services, thereby making continued compulsion lawful, if no such services are provided.\(^{181}\)

29. There is no indication of what should happen in the event that it takes longer than eight weeks to organise post-discharge services. The performance of post discharge planning and the availability of suitable post-discharge services are real issues currently affecting the conduct of tribunals.

## Compulsory Treatment

30. We echo the concerns of other respondents as to the new framework for the regulation of compulsory treatment. The proposals seem to have created the worst of both worlds: they are over-bureaucratic in those cases where there is little dispute as to what is the proper treatment for the patient, and inadequate to protect patients where there is a real dispute. We focus on the latter issue here.

31. We are in favour of the proposal that the Mental Health Tribunal should now carry responsibility not only for decisions as to detention but also as to the proper treatment for patients subject to compulsion. However, our concerns are these:

31.1 First, although the Tribunal has been given this jurisdiction, it has been given no criteria whatsoever to apply in determining whether treatment is justified (see Clause 46). Given that compulsory treatment engages profound issues under (primarily) Articles 3 and 8 and a body of case-law has now developed as to the approach to be taken by a Court in determining whether such treatment is lawful (in particular the Court of Appeal decisions in \(R\) (Wilkinson) \(v\) Broadmoor SHA and \(R\) (N) \(v\) Dr M) we find this oversight startling.

31.2 Second, the Tribunal has no power to order the clinical supervisor to change the proposed treatment plan; only such amendments as are “agreed” with the clinical supervisor may be made (Cl. 46(2)). The Tribunal thus provides no guarantee of judicial oversight compatible with Article 6 of the Convention.

31.3 Third, although the Bill creates a (new) right for competent patients to refuse ECT, it gives no similar right to such patients to refuse medication, even where such treatment is not necessary to protect the patient from serious harm or to protect the public from harm. As has been emphasised by other respondents, in particular the Royal College of Psychiatrists and Prof. Richardson, the failure of the Bill to treat detained patients in the same way as non-detained patients by depriving them of the right of autonomy is discriminatory. We also consider that it may violate Articles 3 and 8 of the Convention. There is a developing international consensus

---

\(^{180}\) \textit{Johnson v UK}  
\(^{181}\) \textit{R (H) v Home Secretary [2003]}
to the effect that detained patients should retain their right to refuse treatment except where such treatment is necessary to protect the patient from serious harm or to protect the public from harm: see

31.3.1 Rec(2004)10 preamble, Article 1, Article 3 (non-discrimination), Article 12(2), Article 18, Article 20, Article 25 (right of appeal), Article 28;

31.3.2 Articles 5-9 of the Council of Europe’s Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (opened to signature at Oviedo on 4 April 1997) (the Bioethics Convention), in particular Articles 5 & 7.

31.3.3 UN MI Principles, Principles 9 & 11.

31.3.4 Note the approach of the US Supreme Court, which has held that the right of autonomy cannot be overridden unless a countervailing state interest of sufficient importance has been demonstrated by the State: Sell v United States, June 16 2003

31.3.5 There are plenty of examples of jurisdictions where a capacity based approach to treatment have been established, and there is no evidence to suggest that these have been unsuccessful. For example in Ontario the Health Care Consent Act 1996 gives statutory authority to the principles of consent and capacity, without differentiation between treatment for mental disorder and treatment for any other disorder. The Canadian Supreme Court recently upheld the right of a mentally disordered individual to refuse treatment in Starson v Swayze, 2003. Chief Justice Mclachlin said this:

75 The right to refuse unwanted medical treatment is fundamental to a person’s dignity and autonomy. This right is equally important in the context of treatment for mental illness: see Fleming v Reid (1991), 4 O.R. (3d) 74 (C.A.), per Robins J.A., at p. 88: Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side effects. Unwarranted findings of incapacity severely infringe upon a person’s right to self-determination. Nevertheless, in some instances the well-being of patients who lack the capacity to make medical decisions depends upon state intervention: see E. (Mrs.) v Eve, [1986] 2 S.C.R. 388, at p. 426. The Act aims to balance these competing interests of liberty and welfare: see B. F. Hoffman, The Law of Consent to Treatment in Ontario (2nd ed. 1997), at p. 3. Neither party raised the constitutionality of the Act as an issue in this appeal.

76 ... The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake.

32. We consider that this developing international consensus will, in time, be reflected in the approach taken by the European Court of Human Rights in determining the ambit of the rights protected by Articles 3, 8 and/or 14 of the Convention, at which point the new Mental Health Act will be found to be incompatible with those Convention rights.

Tribunal has no power of transfer or leave of absence

33. We share the view of Prof. Richardson and her Committee that the Tribunal should have power not only to order a patient’s discharge but also to order such steps as are a necessary precondition to the patient being discharged, in particular a power to order transfer between hospitals and leave of absence. At present the new Tribunal has no such power; in the case of restricted patients the Secretary of State takes the decision (Cl. 127(2)-(4), Sch. 8, Part 3, para 17), and the Tribunal is expressly prevented from taking such decisions (Cl. 147(4)).

34. The problem of patients stuck in inappropriately high conditions of security is a familiar one, identified in the Tilt Report182 in 2000 and since the subject of a concerted Government drive to provide adequate medium and low secure facilities to enable such patients to move through the system. While we welcome that initiative we consider that these decisions are of such importance to the individual’s liberty that they should lie in the hands of the Mental Health Tribunal. We concede that Article 5(4), as currently interpreted, does not require the Tribunal to have jurisdiction to take such essential decisions (Ashingdane v United Kingdom). Nevertheless we are of the view that the detention of a patient in inappropriate conditions of security may violate their rights under Article 8 (see above). The Tribunal is best placed to make decisions about the level of security a patient requires having heard all the medical evidence with representations from the patient, and it is both wasteful and unjust not to allow the Tribunal to act upon that information.

LACK OF ADEQUATE SAFEGUARDS FOR RESIDUAL RIGHTS

35. We are concerned that many of the residual rights that detained patients should enjoy (in relation to, for example, to seclusion, personal searches, visits and the like) are to be governed by the Code of Practice rather than the Bill itself.

36. As regards the Code of Practice, its provisions will not be binding (Cl 1(2), Parliament has no power to reject or amend it (contrast Clause 1(11) with section 118(4) MHA) and many functions (in particular those of the Home Secretary in relation to mentally disordered criminal defendants and transferred prisoners) are excluded from its remit (Schedule 1).

37. We note that the Court of Appeal recently ruled that, where decisions are taken affecting a patient’s rights under Article 8 (which includes searches, seclusion, restrictions on visits etc) the Code of Practice must be followed unless there is good reason not to do so: R (Munjaz) v Mersey Care NHS Trust. This case is shortly to be considered by the House of Lords.

CONCLUDING COMMENTS

38. We are very grateful for the opportunity to express our views to the Committee and hope that our response is helpful and constructive. We will be very happy to assist in any other way that we can.

1 November 2004

Witnesses: Ms Lucy Scott-Moncrieff, Joint Chair of the Mental Health and Disability Committee, and Mr Tim Spencer-Lane, Policy Adviser to the Mental Health and Disability Committee, both representing the Law Society; Mr Paul Bowen, Barrister, and Ms Aswini Weereratne, Barrister, both representing the Bar Council, examined.

Q176 Chairman: Thank you very much for coming and for giving us your submissions. We have received the Bar Council submission a little late but I think most of us have been able to at least read paragraph six and I have read it all. We are encouraging opening statements but if you feel appropriate, we have stressed that the Bill may absolutely drive us to make one, please do. That is a question expecting the answer no. Thank you. These sessions are recorded and a transcript will be available. You can correct the transcript for textual purposes only, not in substance, so please do so promptly if you would like to do that. Would you like to introduce yourselves?

Mr Spencer-Lane: I am Tim Spencer-Lane. I am the policy adviser to the Law Society on mental health and disability law.

Ms Scott-Moncrieff: I am Lucy Scott-Moncrieff. I am a mental health practitioner and I am the co-chair of the Law Society’s Mental Health and Disability Committee.

Mr Bowen: My name is Paul Bowen. I am a barrister specialising in public law and human rights with a particular emphasis on mental health law. I am also a member of the Law Society Mental Health Disability Committee.

Ms Weereratne: I am Aswini Weereratne. I am also a barrister specialising in mental health law. I also sit as a part time legal chair of mental health review tribunals.

Q177 Chairman: My question arises particularly from the Bar Council’s submission which was quite narrowly focused but I think helpfully so. You all may have a contribution to make on this. Do you think that the Bar Council’s submission may have exaggerated the risks of non-compliance with the European Convention on Human Rights or are you saying to us that there is a very real risk, despite the advice that we are obtaining from elsewhere, that there may be non-compliance with the Convention? We are still awaiting a response from the Joint Committee on Human Rights.

Mr Bowen: I hope that in our response, where appropriate, we have stressed that the Bill may violate the Convention. I hope we have also made it clear that the standards that are set out in the Convention are developing ones. It may be that, as the law has been currently interpreted by the Strasbourg Court and by our domestic courts, it will be impossible to point to a particular judgment of either of those courts and say that, when you look at it in the light of that judgment, the Bill is incompatible. Bearing in mind that those standards are developing ones, bearing in mind that the case law does not address a lot of the issues that are raised by the Bill, but given that there are other instruments—we refer to them in our paper; particularly the UN Mental Illness Principles and most recently the recommendation from the Council of Ministers of the Committee of Europe which does set out basic standards—it is our submission that as against those standards, which may in due course become enshrined in the Convention, the Bill falls short.

Ms Scott-Moncrieff: I defer to Paul’s greater knowledge on the ECHR but it seems very clear that there are specific provisions within the Bill that are going to be in breach of the Human Rights Act. To take one example, the provision that compulsory powers must be used if somebody is at substantial risk of causing serious harm to others, regardless of their compliance, regardless of decades of compliance. It seems to me that that simply must be in breach of the ECHR because it is an unnecessary restriction that is being imposed on a group of people for no justification. I do not
think that is the only example but it is the clearest example to me. It seems to me that that provision has been put in there to try and catch people with dangerous personality disorder but, because of the way it has been worded, it is going to be catching huge swathes of people with learning difficulties and people with autistic spectrum disorder. It cannot be right and it cannot be in conformity with the ECHR.

Q178 Lord Rix: As you mentioned learning disability, I would like to see learning disability per se excluded from the Bill and people with a learning disability would only come within the scope of the Bill if they had a severe mental health problem. Would you agree with that?

Ms Scott-Moncrieff: I was listening to what was being said earlier and I sort of agree. In one way it would be quite wrong to use compulsory powers on people where it is not necessary but mental health legislation also does provide protection. If somebody with a learning difficulty committed a crime, for instance, you would not want them to be excluded from being given a hospital order.

Q179 Lord Rix: That protection should also be on the face of the Bill but the exclusion would be there earlier on in the Bill, as far as plain, straightforward learning disability was concerned.

Ms Scott-Moncrieff: Yes, I completely agree, but I also think the same thing applies for ordinary mental illness. If you do not need compulsion, you do not need compulsion.

Q180 Chairman: You have highlighted very clearly that there is an issue that needs further consideration and regrettably there is plenty of work for lawyers left in all of this as well.

Ms Scott-Moncrieff: We think that is a good thing.

Q181 Baroness Barker: Like a number of the witnesses we have had before us, you have expressed strong views about the necessity of having principles set out on the face of the Bill. You say in your submission that you think that would provide greater protection for patients’ rights in practice. I would like you to expand on that, particularly because I noted in your submission that you said of the proposal from the Department to have the principles in the code of practice that the principles would not underpin the Bill but they would instead relate to the decision making under it. Is that not the point at which all of this does affect individuals and is that not an important point?

Ms Scott-Moncrieff: I think there are two issues with the principles. This is a piece of discriminatory legislation. It discriminates against people on the grounds of their mental health as opposed to on the grounds of their capacity. If they were going to be honest, they would come out and say, “In principle, this is a discriminatory piece of legislation.” I can understand why they would not do that but they also do not put in what the other underpinning principles are. You could put in a principle that the protection of the non-mentally disordered public is put at a higher priority than the rights of people with mental health problems, for instance. There seems to be evidence that that is an underlying principle here. You could put in that, if somebody has mental health problems, they are deemed to lack capacity even if they have capacity because that appears to be an underlying principle. Those are the principles that underlie the provisions in the Bill but then you have another set of principles which is how the Bill is going to be used once it has been brought in. Those should definitely be on the face of the Bill and they should be enforceable. My experience is that it is when you can enforce things that standards are raised, but of course they would have to be the right principles. I find it completely astonishing that the Mental Capacity Bill, which is about people who lack capacity, underlines the requirement for autonomy and supporting autonomy. The Mental Health Bill, which is going to be dealing very largely with people who do have capacity at some time or another, is completely silent on the question of autonomy. It is just extraordinary that they do not put it in. It depends what the principles are as well as having them on the face of the Bill.

Mr Spencer-Lane: Can I underline the last point that Lucy made which is that other legislation has successfully incorporated an explicit statement on the face of the Bill, probably most notably the Mental Capacity Bill, but also the Scottish Mental Health Act as well and the Scottish Adults with Incapacity Act. If the draft Bill went through without an explicit statement, it would be quite unique in that respect.

Mr Bowen: I approach this from the perspective of a lawyer construing a document. If one has principles which are set out as the guiding principles against which the Act is to be construed, that gives a proper context for lawyers and particularly judges when making decisions as to how those provisions are to be construed. The second important and crucial point is the question of legitimacy. If these principles are set out in an Act of Parliament, they have the force of an Act of Parliament. If they are set out in a code of practice which can be changed by a member of the executive, they lack the legitimacy that those principles should have and, for that reason, we would say that they should be in the Bill itself.

Q182 Chairman: I am thinking of an analogy with interception of communications and European Convention law. Are you saying that a code of practice might not be held to be a sufficient system of law?

Mr Bowen: That is not an easy question to answer but in the context of the Mental Health Act code of practice the Court of Appeal has already looked at the question whether a non-binding code of practice is sufficient for the purposes of the requirements in Article 3 and Article 8 that any interference with Convention rights being in accordance with the law—it is a case called Munjas—
Chairman: We will ask Professor Fennell, one of our special advisers, to assist us on that.

Q183 Baroness Barker: Do you see a problem where a Bill might contain principles which conflicted, for example, the public protection ones?

Ms Scott-Moncrieff: You have to use proportionality then, do you not? Of course, there are rights on both sides and it is a matter of balance but to underline the fact that there are rights on both sides and not just on one side does not seem to me to be a bad thing to do. The ECHR could be said to have conflicting principles: rights of freedom of speech, the right to publish what you like or whatever and the right to privacy, but it is a balancing act. Both rights are there on the face of the document so they are both things that have to be taken into account.

Ms Weereratne: I would take an approach based on accessibility here and endorse what Lucy has just said. From the perspective of a practitioner trying to access how to promote the balance between compulsion or autonomy and public protection, expressed as treatment in the community or treatment under compulsory detention, I have had the experience of sitting as a chair of numerous homicide inquiries and examining practitioners as to their understanding of provisions in Bills and Acts and regulation, including documents of the CPA. It is quite clear that there is a real fear of law and there is a lack of clarity in the understanding of law. Accessibility is key. A code of practice on the principles clearly on the face of the Bill would aid practitioners’ understanding.

Lord Carter: The draft of the Mental Capacity Bill did not include the principles but the Government accepted the recommendation of the joint committee that they should be included and they are now in that Bill. This Bill places a lot of weight on the use of the codes of practice. I did not entirely understand your evidence which I have only seen this morning. In paragraph 36, you say, “As regards the Code of Practice, its provisions will not be binding ... Parliament has no power to reject or amend it ...”. Do you mean it is not binding because of the use of the words “have regard to” in the Bill? Does that make it non-binding? Also, I do not really understand the point that Parliament has no power to reject or amend it because, if you look at section 1 and the various subsections, the order has to be laid before Parliament in draft. It is a statutory instrument and has to be approved by Parliament. I am not sure where the idea that Parliament could not amend or reject it comes from.

Chairman: Clause 1(11) onwards.

Q184 Lord Carter: Also, is it not the case that the arguments for the code of practice are that they are much more flexible in operation and would not require the power for judicial review which would be required if the principles were on the face of the Bill?

Mr Bowen: As far as whether it is binding or not, clause 1(2) says, “The Code must set out general principles to which a person must have regard.” If it is only to have regard, then—

Q185 Chairman: We do not want to get involved in judicial proceedings but a person must give effect to the words “have regard”. Mr Bowen: Of course. What it means is that the code of practice is a relevant consideration but the weight to be given to that relevant consideration is for the practitioner to determine. That means that, if it says, for example, that one must not carry out searches of patients except in certain specified circumstances, if the hospital has had regard to the code of practice but has decided nonetheless that they are going to go ahead and search, one cannot say that they have acted unlawfully; whereas, if it says on the face of an Act of Parliament that you cannot carry out a search except in these circumstances, if they do, it is unlawful. As far as the role Parliament has, what we sought to do was to contrast the situation under clause 1(11) with the situation under section 118 of the Mental Health Act, subsection (4), under which the Secretary of State is obliged to lay copies of the Code and any alteration of the Code before Parliament and, if either House of Parliament passes a resolution requiring the Code or any alteration in it to be withdrawn, the Secretary of State shall withdraw the Code or alteration. That provision does not exist in clause 1(11), so the power of Parliament to compel an amendment to the code of practice is significantly reduced. The suggestion would be that you simply incorporate section 118(4) in substitution for section 1(11).

Chairman: That is very helpful. We will take that on board and look closely at section 118 again.

Q186 Mrs Browning: In your submission to us, the Royal College emphasised the fact that the Mental Health Act should focus on those people whose decision making is impaired by reason of their mental disorder. I want to ask you about safeguards here and a particular scenario. We have heard quite a lot in evidence about the purpose of this Bill and the way in which it will relate particularly to people who are discharged into the community. We get the impression that there will be an emphasis on more people being treated in the community. I wonder whether you can comment on the scenario where somebody may well be subject, say, to a section 3 order but they do, for want of a better word, a runner. How do you think we should balance those people whose decision making may be impaired as a result of a mental disorder but who, while in the custody, for want of a better word, of a carer who may be a relative or close person living closely with them—what happens in terms of orders to bring them back. If they do that from a community basis, do they then go back to that place or do they go back into a mental hospital, for example, and who should direct those powers of compulsion on what happens? Very often the most common scenario of
somebody doing a runner in a community is because they have come off medication. They can do a runner while they are an in-patient but I am very concerned about this balance and the safeguards involved about their capacity because they may, when they go onto medication in the community, have capacity but if they come off medication and do a runner at that point they may have lost capacity. In fact, they probably will have lost capacity. I wonder how you think the law should put in a safeguard, not only for care in the community in those circumstances but care of the community, because that must also be important. **Ms Scott-Moncrieff**: Are you talking about under the current Act or under these proposals?

**Q187 Mrs Browning**: Under these proposals, because it is very unsatisfactory under the current Act.

**Ms Scott-Moncrieff**: I do not see how it would be an awful lot better under the new Act because compulsion does not provide very much in terms of a practical solution. If somebody is going to do a runner, the fact that they are under a section is not going to stop them because there is no one watching them. They are in the community. If you were trying to stop somebody, you could say to them, “You are going to be on a Community Treatment Order and therefore you must not leave.” If they are going to say, “All right. I will not leave” you should take them off the order because they are consenting then and therefore you should not be putting them on the order. If they say, “I will leave if I want to” what are you going to do? You have to take them into hospital. It does not seem to me that the provisions for compulsory treatment have been thought through in terms of what they are trying to achieve. If the person is compliant they should not be on the order because one of the relevant conditions is that, if people consent, they should not be on the order. If they are not compliant, you are not going to make them compliant by putting them on an order. The way forward is to have good, responsible, respectful, supportive relationships between professionals and service users so they will not do a runner if they are going to do a runner, it goes round and round in circles. I do not see how this is going to make any difference at all to the situation that you put forward because, apart from anything else, it used to be the case that when people came out of hospital if they did not want to accept treatment or see people and so on they would not follow it up. We now have the care programme approach and if somebody says, “I do not want to see you any more” that is a trigger for concern being expressed as to whether they might be relapsing and might need to be assessed to see whether they might need to go into hospital. Under the current system people do not avoid professional examination, support or follow-up or whatever simply because there is no compulsion there. The care programme system provides all of that. What is going to be added to that by saying, “You have to do this and that” when the only way you can make people do it is by taking them into hospital in the first place?

**Q188 Baroness Cumberlege**: About three years ago, you may recall there was a case where the present Mental Health Act was used to enforce a Caesarean section on a woman who did not wish to have one. She was resisting the obstetrician’s view that she should have one. Under the proposals in the new Act, could that be used in the same way as the present Act is used?

**Ms Scott-Moncrieff**: I do not think so.

**Q189 Baroness Cumberlege**: You feel there are enough safeguards in this proposal?

**Ms Scott-Moncrieff**: It is because it would not be treatment for mental disorder. That is the safeguard. That is unless the notion of treatment for mental disorder was extended.

**Mr Bowen**: The decision to detain was found to be unlawful in that case and under this Act I think it would also be found to be unlawful. That provides a very good example of, on the face of it, the discrimination between those who suffer from mental disorder and those who suffer from other disorders. As regards the position of those who have capacity to make a decision to refuse treatment, even if it is treatment that will save their unborn child, as the law stands in this country, they have an absolute right to refuse that treatment. The same is not the case under this Act; nor is it given any weight whatsoever and that is the concern.

**Q190 Chairman**: Do you think in the mental health field there is scope for people who may have a history of mental disorder but are capacitous at a given time to give advance directives for their treatment when they begin to suffer again from their mental disorder? There are a lot of questions in the area of safeguards but I think we will be interested in your view of advance directives.

**Ms Scott-Moncrieff**: Yes, I do think that. There are an awful lot of problems with advance directives.

**Q191 Chairman**: Generally?

**Ms Scott-Moncrieff**: Yes. People’s minds change and so on. Under the Mental Capacity Bill you can give advance directives to refuse treatment but not to accept treatment. It would have to be very carefully thought through but it would make life very much easier. Sometimes when there has been a crisis and compulsory powers have been used, afterwards the patient could be quite grateful that that intervention took place. If that could also be formalised in some way so that could be part of the discussion that would take place between patient and his clinical team, that seems to be all to the good, because once again it is encouraging autonomy, is it not? It is treating people’s decisions, feelings and wishes with respect.

**Q192 Lord Carter**: On the point you have just made about advance directives, has the *Burke* judgment changed the view on that? Certainly I think, for
those who were on the joint select committee that looked at the draft Mental Capacity Bill, if the 
Burke judgment had been available then regarding 
advance directives, I think we might have 
recommended differently. I know that is being 
appealed by the GMC but would you agree with me 
that, if it were upheld, it will have a very marked 
effect on the way in which we regard advance 
directives?

Ms Scott-Moncrieff: I am sure it will. Once again, 
you have a fine line because you have the advance 
directive about treatment and you also have the 
rights of doctors not to give treatment that they 
think is inappropriate. It is where the line is drawn 
but in the area of psychiatry that is not really going 
to be an issue because you can be sure that the 
doctor will want to treat the person and the 
advance directive is going to be a discussion about 
the way that treatment should go. If it is between 
that doctor and that individual, that service user, 
they are going to be talking about the real options 
that will be available in the real situation that will 
be occurring. I would not have thought that would 
be problematic.

Baroness Finlay: I am not sure that I agree with you 
about the doctor always wanting to treat the 
patient. My concern is where the patient ends up in 
acute medical services with an acute medical, non-
mental condition, where people may be completely 
unaware about the importance of the medication 
in terms of maintaining stability for someone and 
where, when they are very ill, they have difficulty 
expressing that. Therefore, they may find it helpful 
to be able to make an advance decision to state that 
they wish to remain on this medication. That 
hospital then has an obligation to bust a gut to get 
that medication if it is not on their standard 
formulary, which it may not be. Also, I am 
concerned about what happens to a patient who is 
on a community order when they perhaps have an 
acute accident and end up in acute services. How 
will that be played out in terms of that order 
continuing and their ongoing management 
continuing whilst they are going through acute 
medical services? I wonder if you have any view?

Q193 Baroness Pitkeathley: On the issue of 
safeguards, it is about how you feel about the 
concept of nominated person and the range of 
powers that person is currently given or what else 
they might be given.

Ms Scott-Moncrieff: They are not as good as the 
provisions under the current Act. The cases that 
have been taken about nearest relatives under the 
current Act have been to do with the rigidity of the 
identification of the nearest relative and the 
inability to displace certain unsuitable nearest 
relatives. What has happened is that the baby has 
been chucked out with the bathwater because 
nominated persons do not have the powers that 
nearest relatives currently have. They do not even 
have a continuing existence. They only come into 
being once the person has been made subject to 
compulsory powers and that is a bit late really. No, 
I do not think they are good enough.

Mr Bowen: The 1959 Act, which the 1983 Act was 
based upon, had very much at its heart the principle 
that treatment under compulsion should be a very 
last resort. That was the principle that was upheld 
by the House of Lords in the Bournewood case. 
There are two very good examples of how that 
acted in practice. One was that the patient’s nearest 
relative could discharge the patient if they felt that 
they could look after them and provided they were 
not a danger to others that was the choice the 
family member was entitled to make on behalf of 
their family member, it being assumed that those 
were the people who had the best interests of the 
patient at heart. The second was that both the 
social worker making the application in the first 
instance, or considering whether to make an 
application to admit in the first instance, and the 
tribunal, when considering whether to discharge, 
had an overriding discretion, in the case of the 
social worker, not to make the application and, in 
the case of the tribunal, to discharge, even where 
all the other conditions were satisfied. That again 
was based on the presumption that, even where 
somebody does meet the threshold for detention in 
hospital, it may be that their family can look after 
them better at home. Those are both safeguards 
that have been removed from the 1983 Act in this 
new Bill.

Q194 Dr Naysmith: In the Law Society’s written 
evidence, the claim is made that the workload of 
tribunals under the draft Bill will increase 
enormously and each hearing will take at least 50 
per cent longer than it currently does. The society 
believes it will be virtually impossible for the 
hearings envisaged under the draft Bill to take place 
with the frequency and within the time limits 
suggested and proposed. Is that what everyone 
believes?

Ms Scott-Moncrieff: We are using the Department 
of Health’s own figures. The most recent statistics 
that we have that came out a couple of years ago 
showed that there were something like 47,000 
compulsory admissions a few years ago and 
something like 20,000 tribunal applications and 
11,000 actual hearings. A lot were 
withdrawn, the patients were discharged or 
whatever. About 20 per cent of detentions led to a 
tribunal hearing. Under the current provisions, 
even if the Department of Health is right and they 
are not intending to section more people—and I 
think they have underestimated the number of 
people who are going to be sectioned—there are 
going to be, say, 47,000 tribunals as opposed to 
11,000. The tribunal system is in meltdown at the 
moment. The Department of Health is trying to do 
something about it but they have been trying to do 
something about it for years. Every time they 
reorganise it, it just gets worse. Maybe this time 
they will get it right. And maybe they will get it right 
with the 11,000 tribunals they are having at the 
moment and maybe that will also work with the 
50,000 tribunals they will be having when the new 
Act comes in. There is no evidence to that effect. 
Tribunals are uniquely complicated to organise
because, unlike other court hearings, they are not centralised in any way. They happen in hospitals. Every hospital that has detained patients is going to have compulsory tribunals. The Department may feel that people can be sectioned but they will not apply for a tribunal. They may feel that under the new regime, where people have compulsory tribunals, they will not bother to turn up. Maybe, but my experience is that when people do have compulsory tribunals they very often will want to be represented. They will want to turn up. Because of the way the draft Bill has been worded, that would put the tribunal on notice that there might be an issue here, because compulsory powers should only be used if somebody is not consenting. If somebody does not bother to turn up to oppose it, presumably they are consenting. Therefore, the tribunal should be discharging them and hearing evidence. They are all going to be very, very long. There are not going to be any rubber-stamping tribunals. I do not see how there can be. When you add into that the fact that the tribunal is not only dealing with detention but also the issue of the treatment plan, which will be about things like should somebody be a resident patient or a non-resident patient, there is no guidance for tribunals so that will have to be argued through. Should they be on oral medication or injectable medication? Should they be on old, dirty, cheap drugs or new, modern, expensive drugs? That is all going to have to be argued through. They are going to take much longer.

Q195 Chairman: Ms Weereratne, you told us you sit as a part time chair on tribunals. On average, how much time in a year are lawyers who sit as part time chairs of tribunals expected to give to sitting on tribunals?

Ms Weereratne: Expectation often does not meet reality. That would vary largely depending on the kind of practitioner you are considering. Speaking personally as a practising barrister and a part time legal chair, I find it very difficult to fulfil my commitment to the tribunal which is a minimum of 15 days and there is no maximum as far as I am aware.

Q196 Chairman: If what Ms Scott-Moncrieff has said to us is right—and it is consistent with what a lot of other people have said to us—and there might be a doubling of the expectation from 15 to 30 days, how realistic is it to expect that increase to be found quickly from practising barristers and solicitors?

Ms Weereratne: Personally, I find it very difficult to offer more than the minimum number of days. Anyone who carries a practice burden in addition to having to sit on a part time basis I believe will find it very hard. I know from my experience that there are still difficulties finding panels within the existing system.

Q197 Chairman: Are part time chairs paid the same fees as recorders or are they paid less? The recorder rate is just over £500 a day.

Ms Weereratne: A part time chair gets paid £400 a day.
Chairman: I have a little local knowledge on whether it be a full time or part time judge, who has sat or does sit as a chairman of Mental Health Review Tribunals or a practitioner who is accredited as having the relevant experience?

Ms Scott-Moncrieff: Oh, my goodness. As far as I understand it, the DCA says that as long as there are enough lawyers to do it the money must be okay. This seems rather a crude analysis to me but at the moment there do appear to be enough lawyers to do it. Whether there will go on being enough lawyers to do it is another matter. It is the worst paid form of legal aid by any standard. The people who do it do it because they love it but you learn to love it through starting off at a reasonable rate. Whether people are going to want to come into it I just do not know.

Mr Bowen: There is a curious feature of the new Bill. It is ironic that the Government have chosen to have representation realistic in its present form?

Ms Scott-Moncrieff: If these decisions are going to be made in the crown court, even if the judge has the benefit of the advice of the expert panel, the defendant will also be entitled presumably to bring their own expert evidence, so once again you will have the same battle with two doctors giving evidence, being cross-examined and so on taking place in the crown court which hardly seems a suitable venue. It is just not the area of expertise, is it, of a crown court? It will clog up the system.

Mr Bowen: Nor is that expertise shared by most criminal barristers representing patients.

Chairman: Thank you very much for the clarity of your submissions and your evidence. You have been of great assistance to the Committee.

Q206 Chairman: The Law Society has expressed concern that criminal courts lack the experience of the mental health tribunal but nevertheless will be required to approve care plans under part three of the Bill. Would it help if a member of the Expert Panel was required to assist the criminal court in that task?

Mr Bowen: Having represented defendants in both criminal proceedings and in tribunals myself, it would certainly help a crown court judge or a recorder but there is one aspect of the proposals under the new Bill which I think those recorders, judges and magistrates who do not have specific experience would find difficult, which is approval of the care plan. The new tribunals must not only approve detention or compulsion; they must also approve the care plan. I would have very grave concerns whether the necessary expertise that the tribunal would have to decide that issue would be shared by magistrates, part time recorders or even crown court judges.

Q207 Chairman: Would it be your view that where an order under the Act is to be made in the criminal court that case should only go before a judge, whether it be a full time or part time judge, who has sat or does sit as a chairman of Mental Health Review Tribunals or a practitioner who is accredited as having the relevant experience?

Mr Bowen: There is a curious feature of the new Bill. It is ironic that the Government have chosen to have a system of detention or compulsion that can only be authorised by tribunals when that is not something that is required by Article 5(4) of the Convention. Putting that to one side, what we will have under the new system will be compulsion that must be authorised by Expert Tribunals. It would appear logical then that even in criminal cases, once a criminal defendant has been put down the assessment route, the decision as to whether a compulsion order is appropriate in his case or her case should be made by the tribunal. If it is not appropriate, it will go back to the sentencing court who will then only have the option of imposing a non-Mental Health Act disposal. I only suggest that in light of the questions that were put. It is not part of the Bar Council’s written submissions but there would seem to be a certain logic in that approach.

Q208 Chairman: A consistency of expertise at least would be helpful.

Ms Scott-Moncrieff: If these decisions are going to be made in the crown court, even if the judge has the benefit of the advice of the expert panel, the defendant will also be entitled presumably to bring their own expert evidence, so once again you will have the same battle with two doctors giving evidence, being cross-examined and so on taking place in the crown court which hardly seems a suitable venue. It is just not the area of expertise, is it, of a crown court? It will clog up the system.
Wednesday 10 November 2004

Members present:

Barker, B
Carlile of Berriew, L (Chairman)
Carter, L
Cumberlege, B
Finlay of Llandaff, B
McIntosh of Hudnall, B
Pitkeathley, B
Rix, L

Mrs Liz Blackman
Mrs Angela Browning
Mr David Hinchliffe
Mr George Howarth
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Mr Gwyn Prosser
Dr Howard Stoate
Hywel Williams

Memorandum from Mind (DMH 210)

SUBMISSION TO THE JOINT COMMITTEE ON THE DRAFT MENTAL HEALTH BILL:

SUMMARY

Question 1: Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

Mind believes that most of the principles underlying this Bill are not appropriate or desirable. We believe that there are appropriate and desirable principles on which new legislation should be based and that these should be explicit on the face of the Bill. They are as follows:

— Informal treatment is always to be preferred over compulsion when circumstances permit.
— Treatment and care should be provided in the least restrictive and least invasive manner compatible with ensuring the health or safety of other people.
— Treatment and care should, insofar as is possible, be determined by or reflect the wishes of the patient concerned.
— Those dealt with under the Act should be treated and cared for in a way that will promote self determination and personal responsibility.
— Users of mental health services will be treated with dignity and respect and in particular will receive respect for and consideration of their individual qualities and diverse backgrounds.
— All powers under the Act shall be exercised without any direct or indirect discrimination on the grounds of physical ability, age, gender, sexual orientation, race, colour, religion or national, ethnic or social origin.
— Where society imposes an obligation on an individual to comply with a programme of treatment and care it should impose a parallel obligation on health and social care authorities to provide appropriate services, including aftercare.

Question 2a: Is the definition of mental disorder appropriate and unambiguous?

The definition of mental disorder in the draft Bill is unambiguous but in Mind’s view it is inappropriate because it lacks an exclusion clause to set some clear boundaries for its application.

Question 2b: Are the conditions for the treatment and care under compulsion sufficiently stringent?

Mind does not consider the conditions for compulsion sufficiently stringent. They lack a test of mental capacity, a requirement for therapeutic benefit and they are over-inclusive in their provisions for people who pose a risk to others. The provisions for high-risk patients should also be re-framed.

Question 2c: Are the provisions for assessment and treatment in the Community adequate and sufficient?

Mind believes that the provisions for treatment in the community are inappropriate and undesirable. They will not only add little therapeutic benefit, but are liable to backfire. In particular we believe that treatment in the community will:

— make compulsion more widespread and last for longer periods
— deter people from approaching services and destroy trust between service users and professionals
— focus unduly on medication and make managing side effects of drug treatments difficult.

Mind believes there would be less need for compulsion overall if there were better services in the community available for those who voluntarily request them.
Question 3: Does the draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on the one hand, and concerns for public and personal safety on the other?

Mind believes that the draft Bill responds to a misplaced concern about public safety and that the personal and human rights of individuals are being inappropriately eroded as a result.

Question 4: Are the proposals contained in the draft Mental Health Bill necessary, workable, efficient and clear? Are there any important omissions in the bill?

Because of its complicated drafting the provisions in the Bill are incomprehensible to ordinary people and unclear to many who may have to advise or use the law professionally. This may lead to unintended consequences and it will create injustice.

There are significant omissions.

— There is no provision for a duty to assess and provide services for people with mental health problems who do not meet the criteria for compulsion.
— Free aftercare provision should not be cut short at six weeks.
— Advance statements should have a legal status and advance refusals be upheld.
— The powers of the nominated person should be increased.
— Police stations should not be used as places of safety.

Question 5: Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft Bill?

Mind believes that the institutional framework in the Bill needs to be strengthened.

The role of advocates should be enhanced and extended to the examination stage, places of safety and the criminal justice system.

Approved mental health professionals need to bring a social model perspective to the application of compulsory powers and need independence from the clinical team.

The Part 3 framework has not been adequately reviewed and does not fit the new system. The criteria for compulsory treatment of an accused person and wherever possible a convicted person should mirror those available under the civil system and an advocate and the patient should be consulted in drawing up the care plan.

In principle criminal courts should not be able to make care and treatment orders. In particular there should be a right of access to a nominated person.

Tribunal membership needs to be broadened to ensure that professionals bringing a social model perspective are included and that lay members include people with direct experience of mental health services.

Question 6: Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

The provision to allow psychosurgery by High Court order should be removed from the Bill, and the current safeguards in the 1983 Act should be maintained.

ECT should be given only with informed consent for people with capacity to give or withhold consent. The emergency criteria for ECT for those incapable of giving consent should be restricted to saving life. The nominated person should be notified and (if the patient wishes) an advocate involved if ECT is being considered. ECT should not be given to anyone under 18.

Clinicians should always seek to provide treatments the patient is willing to accept. Drug treatment given without informed consent should be with Tribunal approval, and treatment above licensed limits should be with informed consent or to prevent serious risk to the life of the patient.

Question 7: Is the balance struck between what has been included on the face of the draft Bill and what goes into Regulations and the Code of Practice right?

The right balance is not struck between what has been included on the face of the draft Bill and what goes into Regulations and the Code of Practice. Too many issues are left to the Code of Practice.

The Code is welcome but it should be strengthened by a presumption of compliance and should not be used to introduce major changes in practice without consultation or parliamentary scrutiny.

Question 8: Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

The Mental Capacity Bill and Mental Health Bill cover some of the same ground but they are not adequately integrated. Some of their provisions conflict with each other. Both Bills need significant amendments in order to eliminate these contradictions.

Question 9: Is the draft Mental Health Bill in full compliance with the Human Rights Act?
It is most unlikely that the Bill will fully meet the requirements of the Human Rights Act and it is certain that it fails to meet internationally accepted standards in both the Council of Europe and the United Nations.

Question 10: What are likely to be the human and financial resource implications of the Draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation?

Mind believes the resource implications have not been fully thought through. Sufficient staff are unlikely to be in post to implement the legislation, and pressure on staff and financial resources will inevitably draw focus away from preventative work and community and primary care, leading ultimately to a greater need for compulsion.

Submission to the Joint Committee on the Draft Mental Health Bill

INTRODUCTION

Mind is the leading mental health charity in England and Wales. We work for a better life for everyone with experience of mental distress by advancing the views, needs and ambitions of people with experience of mental distress; promoting inclusion through challenging discrimination; influencing policy through campaigning and education; inspiring the development of quality services which reflect expressed need and diversity; achieving equal civil and legal rights through campaigning and education.

In forming our views, Mind consults with our networks including people with experience of mental distress and local Mind associations who provide a wide range of community support services including advice, advocacy and support on employment and benefit issues.

Mind is a founding member of the Mental Health Alliance and supports the Alliance submission to the Committee. Mind’s submission seeks to complement the Alliance submission with the perspectives of service users, and to highlight issues of particular importance to service users.

Our involvement in the process of the reform of the Act is longstanding. In response to the Expert Committee’s call for submissions in 1999, we conducted surveys of our extensive networks. Since then we have held workshops to examine the 2002 draft Bill or the current 2004 draft Bill. The information received in these surveys and the experience of Mind’s Legal Unit in giving legal advice inform our submission.

We welcome the opportunity to contribute to the process of improving the Bill through the Joint Scrutiny Committee process.

Mind welcomes some parts of the Bill because they improve on the Mental Health Act 1983. These parts include new provision for advocates, the role of the care plan and the Mental Health Tribunal, the nominated person, improved treatment safeguards for patients undergoing ECT, special provisions for children and young people, and the duty to consult patients in preparing a care plan. Mind’s submission concentrates on aspects of the Bill that need substantial change.

Mind believes that new mental health legislation provides an opportunity for new measures to enhance the dignity and respect of service users while protecting them when they need it. To achieve this aim it must be backed up with adequate and appropriate social and health services and must have the support of users and professionals who use it. We do not believe that this current draft of the Bill, despite some positive features, meets either of these objectives.

Question 1: Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

Mind believes that most of the principles underlying this Bill are not appropriate or desirable. We believe that there are appropriate and desirable principles on which new legislation should be based and that these should be explicit on the face of the Bill.

1.1 In our view there is a set of principles and premises underlying this Bill. They include:
— that the consent to treatment of a person with mental disorder is irrelevant and that it is legitimate to distinguish between physical and mental health in this regard
— that the public needs protection from people with mental disorder and that this justifies departure from existing human rights standards
— that compulsion in the community is a beneficial alternative to inpatient care—although it is not clear for whom it is beneficial or in what circumstances
— that the legal framework exists independently of service provision, and
— that no duties should be imposed on service providers.

1 Mind the Law, Mind’s Evidence to the Mental Health Act Review Team; Are You Listening?—four newspapers commenting on the Bill.
— The other underlying principles—that due process should be observed, and that patient and family should be heard, are welcome.

1.2 The set of principles stated in the Bill are commendable, but limited in scope and in some respects contradicted within the detailed clauses (e.g., there is no provision for consent to treatment). They are to be elaborated on by further “general principles” which will be contained in a Code of Practice.

1.3 We believe that mental health legislation must contain on its face a set of guiding principles. The Government disagrees, on the ground that this would involve restating the duties under existing legislation. However, this view ignores a crucial distinction between directly enforceable legal rights and duties and general principles. Principles need to be stated to give all users of the law (including service users and their families) confidence in the law, to support and guide professionals, to assist Tribunals in laying down principled and consistent case law and to inform the exercise of discretion under the law. The Children Act 1989, the Data Protection Act 1984 and the Mental Capacity Bill 2004 are all precedents for this approach in England and Wales. We consider the following principles should underpin the legislation and that they are included on the face of the Bill.

1.4 Informal treatment is always to be preferred over compulsion when circumstances permit. While mental health law can provide protection and support for people who need it, the exercise of compulsory powers and the threat of its imposition can also be damaging and not therapeutic for patients. Legislation that sets a framework for an increase in compulsion can therefore exacerbate problems in mental health for patients, staff and the public, rather than diminish them.

1.5 Treatment and care should be provided in the least restrictive and least invasive manner compatible with ensuring the health or safety of other people. We also consider that the following principles should be incorporated into a treatment section of the Code of Practice to supplement the principles on treatments on the face of the Bill:

— Treatments given without consent should be effective, both in general and for the individual concerned, offering most benefit and least harm of the treatments available.

— Invasive treatments with a high risk of harm should not be given without consent.

— As far as possible treatments should be acceptable to service users, be in keeping with any advance statement and as far as possible non-invasive treatments (e.g., psychological interventions) should be offered first, including in situations where treatment is considered urgent.

1.6 Treatment and care should, insofar as is possible, be determined by or reflect the wishes of the patient concerned. In order for that to occur relationships between health professionals and patients should be based on mutual trust and respect to allow the patient to make free and informed decisions. Patients (or their representative) should be provided with comprehensive information so as to empower the patient to come to a rational decision according to his or her personal values and preferences.

1.7 Those dealt with under the Act should be treated and cared for in a way that will promote self-determination and personal responsibility. In our view this requires recognition for the role of capacity in the mental health law.

1.8 Users of mental health services will be treated with dignity and respect and in particular will receive respect for and consideration of their individual qualities and diverse backgrounds.

1.9 All powers under the Act shall be exercised without any direct or indirect discrimination on the grounds of physical ability, age, gender, sexual orientation, race, colour, religion or national, ethnic or social origin. This principle is largely self-evident. But the degree of discrimination that service users from minority ethnic backgrounds continue to face in the mental health system makes it particularly important that this principle be made explicit on the face of the Act.

1.10 Where society imposes an obligation on an individual to comply with a programme of treatment and care it should impose a parallel obligation on health and social care authorities to provide appropriate services, including aftercare. The consequences of failure to make provision include, at the least, an increased prospect of enduring mental distress and recurrent crises, and at worst, further deprivation of liberty.

— The Expert Committee reported that the “overwhelming support for the principle of patient autonomy indicates that the enforced treatment of the capable and objecting patient simply in the interests of his or her own health as defined by professionals is no longer acceptable”. The Joint Committee on Human Rights in its Report on the 2002 draft Bill endorsed “autonomy, dignity and physical and moral integrity” as fundamental to the Bill and doubted that they were adequately safeguarded in the 2002 draft.
Question 2a: Is the definition of mental disorder appropriate and unambiguous?

The definition of mental disorder is unambiguous but in Mind’s view it is inappropriate because it lacks an exclusion clause to set some clear boundaries for its application.

2.1 Unlike the 1983 Act which specifically excludes people “by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs”, there are no exceptions in this Bill. We believe this to be a serious omission.

2.2 People with substance dependence should not come within the Act for that reason alone. In-patient mental health treatment does not provide care purely for substance abuse, and indeed, treatment for addiction cannot be given compulsorily, as a voluntary decision to adhere to treatment is essential. There are many initiatives for better treatment of people with substance abuse problems. The developments would seem a better use of resources than the use of compulsion.

2.3 Our BME network has commented: “Such actions will reinforce the high levels of stigma that already exist in these communities. This will also have a significant impact on Black people being over-represented due to the contentious debates about “cannabis psychosis”. People who have drug and alcohol problems should be referred for appropriate treatment. Psychiatry should not be used as an arm of the law. There is a danger that social problems such as these are being medicalised.”

2.5 Mind believes that to create circumstances in which people with addictions are sectioned will also create unacceptable pressure on services that are not intended for this category, possibly stalling patients’ progress, and depriving others in mental distress of scarce resources for the treatment they need. The Mental Health Act Commission has reported: “We have seen little evidence that this [existing] exclusion has been misinterpreted so as to prevent patients with dual diagnoses (ie both mental disorder and substance abuse problems) from the reach of the Act. We believe it to be more likely that such patients are often excluded from treatment because of the lack of effective services.”

2.6 We also believe that certain groups of anti-social offenders such as those who sexually abuse children should not come within the scope of mental health legislation merely by virtue of their offence. Use of the legislation should depend solely on whether people meet criteria related to mental health and criminal or antisocial behaviour or other relevant law should deal with other matters. To do otherwise merely strengthens the link in the public’s mind between mental health problems and child abuse and creates further stigma for all those with mental health problems.

2.7 The Joint Committee on Human Rights in its comments on the absence of exclusions warned against turning professionals into “guardians of morality” rather than of health, and infringing patients’ human rights. The definition needs to have explicit limits in order to avoid this possibility and to make clear the Government’s intention that the next Mental Health Act should not be used as a form of social control.

Question 2b: Are the conditions for the treatment and care under compulsion sufficiently stringent?

Mind does not consider the conditions sufficiently stringent. They lack a test of mental capacity, a requirement for therapeutic benefit and they are over-inclusive in their provisions for people who pose a risk to others. The provisions for high-risk patients should also be re-framed.

2.8 While we welcome the significant improvements to the conditions for compulsion since the 2002 draft Bill we do not believe the relevant conditions are sufficiently stringent. They cannot fail to lead to increased numbers of people being subject to the Act.

SERVICE USER CONCERNS

2.9 The conditions for compulsion is the issue which causes greatest concern and fear to mental health service users. Whilst some people have later been glad that they were treated against their will, many others have felt lasting resentment and incomprehension. Mind acknowledges that there are limited situations where compulsory intervention may be unavoidable as a last resort. It is important to recognise however that the existence of compulsory powers does distort the whole mental health system and can be counter-productive.

2.10 Reflecting on past episodes of being sectioned, most of the 60 participants of a recent Mind seminar were overwhelmingly negative about the experience. Although a few people thought in retrospect it was the right action to be taken many did not. They reported in particular on the disruption of the relationships between themselves and their psychiatrist as a result of the loss to trust they felt, the stigma associated with being publicly labelled as being incapable of taking their own decisions about their lives and the terror of

---

4 The Department of Health Dual Diagnosis Good Practice Guide (2002) states that patients (or potential patients) with dual diagnoses have “almost certainly been excluded from all the available services” because of a lack of integration between mental health and substance misuse services, clear care co-ordination pathways and a clear operational definition of dual diagnosis.”

5 Joint Committee on Human Rights. Twenty-fifth report, paragraph 10.
the imposition of control from another person when they are most vulnerable. The blurring of therapeutic and punitive role of medication when it is compulsorily admitted sometimes affected their view of its effectiveness for their condition.

2.11 It would be naïve to hope that trauma and distress can be completely eliminated when a person is sectioned but it is imperative that the law is framed to avoid unnecessary use of compulsory powers.

2.12 Key components of the conditions that would introduce greater stringency are
- a test of capacity
- a test of therapeutic benefit in relation to treatment
- a principle of necessity
- a higher threshold for harm to others to match the threshold for harm to self.

A Test of Capacity

2.13 Mind does not agree that a mental health act should be based on discrimination between physical and mental health in relation to medical treatment. While this is also the case with the 1983 Act we see this legislation as an opportunity to put in place more modern principles that recognises that mental health and incapacity are not inextricably linked and that people with mental disorder can be given responsibility for their own health.

2.14 The most authoritative study of the decision-making capacities of people who were hospitalised with mental illness, the MacArthur Treatment Competence Study, was designed to help policy makers and clinicians to address questions about the decision-making capacities of people who were hospitalised with serious mental illness. They found that most such patients have abilities similar to persons without mental illness for making treatment decisions. They concluded that:

“Future policy must take both these sets of findings into account when determining whether hospitalised patients should be allowed to make their own decisions about treatment . . . Our results clearly do not support a policy that denies to patients hospitalised with mental illness, on a blanket basis, the right to consent to or refuse treatment. Nor do they support the view that mental disorder has no effect on a person’s decision-making abilities”.

2.15 We believe it essential that the Act employs a concept of capacity to decide whether a person is able to choose their form of treatment. The government emphasises the difficulties in such an approach. But both clinicians (psychiatrists and psychologists) and, above all, service users support it. Much of the damage reported by service users, sometimes leading to complete disengagement from health services, is caused by their being forced to take treatment they do not want when they are perceived by others as being in need of it.

2.16 They speak of “the traumatising and humiliating impact of being injected and held down in order to be given medication I did not want”, the sense of “powerlessness and dehumanisation from having one’s views about treatment ignored” and the rage at having one’s rights taken away (and then for that rage to be taken as a symptom of illness). They explain that their treatment choice and in particular their dislike of the debilitating side effects of specific medication were insufficiently addressed because consent to treatment was not required.

2.17 The identified problem with this approach is that the capacity of people subject to detention may fluctuate, making it difficult to know exactly when someone should be discharged. This could be dealt with through guidance in the Code of Practice, giving clinicians a level of discretion to ensure that the person’s condition had stabilised before discharge. Alternatively reviews could be built in at intervals which should vary appropriately according to a person’s condition. An initial decision as to capacity could specify the appropriate time scale for reviews.

The Concept of Capacity and Criminal Responsibility

2.18 The government states that a criterion of capacity would be disadvantageous for offenders since many people with mental health problems had capacity when they committed the offence and could therefore not be diverted from a criminal sentence.

2.19 We believe that if a person is deemed responsible they should be dealt with in the normal way through the criminal justice system. Once sentencing has taken place they should then be offered mental health services either in prison, if that is where they have been sent, or by transfer to a hospital environment or in the community on the same basis as others. We further believe that those with capacity to do so should be entitled to choose to defend a charge through the criminal justice system rather than be diverted to the care of health and social services.

6 In the case of Re: C a man with a diagnosis of schizophrenia was held to have the right to disagree with doctors about his gangrenous leg and to refuse an operation which doctors believed would end his life (they were wrong) but not about the treatment for his schizophrenia.
2.20 Where a person is not responsible for their criminal acts as a result of their mental state, the use of mental health law may be appropriate and the provisions of Part 3 should come into play.

2.21 For non-offenders who pose a significant risk of serious harm to others as a result of their mental disorder, the issue is more problematic. The “all or nothing” test of capacity would not be acceptable to most people. In these cases it should at least be necessary to show that other, less restrictive, alternatives have been tried and failed, or there are reasonable grounds for believing that they are not appropriate in this case.

2.22 One option is to support the test of “impaired decision making” test in the Scottish Mental Health (Care and Treatment) Act as a criterion for all cases. We are also aware of the approach taken by the Richardson Committee, which decided that capacity should not be relevant at a level of the highest risk. In either case it is essential that the initial difficulties in settling on the precise nature of the test should not be an excuse for failure to act. The fundamental principle of capacity or impaired decision making needs a clear place in the Mental Health Bill.

A TEST OF THERAPEUTIC BENEFIT IN RELATION TO TREATMENT

2.23 Mind supports an explicit link between treatment and benefit to the patient, rather than a concept of appropriateness. Without such a link the “appropriateness” of treatment is likely to be viewed from the point of view of the clinician rather than the patient and, in the event of a dispute at Tribunal, a patient’s well founded preferences could be overridden by the clinician’s judgment. If the clinician had to demonstrate the benefit it would make a subtle but significant difference to the debate. Even more important from a practical point of view it would reinforce the need for clinicians to listen to their patients concerns and to inform them clearly of the nature of the treatments (including side effects) being proposed. The link between treatment and benefit is of particular concern for non-resident patients. The most likely form of treatment will be medication as it is the only form that can be effectively monitored in the community. Medication that provides no overall benefit to the patient is often provided and patients’ objections are overruled. This is of particular concern to BME communities. Over-prescribing and wrongful prescribing of medication has been well documented as a particular feature of their experience of the mental health system.

2.24 Mind supports in principle the inclusion of personality disorder within the scope of mental health legislation although we are aware of the difficult issues around the effectiveness of treatment for people who are resistant to it. In our view there are psychological interventions which can benefit some people with personality disorder and provided those are beneficial in the particular case the label should not be used as a means of excluding this entire group.

A PRINCIPLE OF NECESSITY

2.24 As drafted, and in combination with the Mental Capacity Bill, the fourth condition (“that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part”) would prevent most patients from coming under the Mental Health Bill unless they had capacity. This anomaly needs to be addressed.

2.25 In addition we strongly disagree with the fact that under Clause 9(7) this condition is dispensed with if the patient is at substantial risk of causing serious harm to other people. We do not consider this necessary (since a patient can be sectioned once his or her co-operation with treatment is removed), and it is not desirable in principle.

2.26 The Sainsbury Centre for Mental Health has reported: “The evidence clearly shows that people from these communities, in particular African and Caribbean communities, are disproportionately represented among those who are compulsorily detained under the Mental Health Act. There is already a schism between these communities and mental health services, and such actions will only reinforce the vicious circles of fear that we have documented in our research.”

A PRINCIPLE OF NECESSITY

2.26 As drafted, and in combination with the Mental Capacity Bill, the fourth condition (“that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part”) would prevent most patients from coming under the Mental Health Bill unless they had capacity. This anomaly needs to be addressed.

2.25 In addition we strongly disagree with the fact that under Clause 9(7) this condition is dispensed with if the patient is at substantial risk of causing serious harm to other people. We do not consider this necessary (since a patient can be sectioned once his or her co-operation with treatment is removed), and it is not desirable in principle.

2.26 The Sainsbury Centre for Mental Health has reported: “The evidence clearly shows that people from these communities, in particular African and Caribbean communities, are disproportionately represented among those who are compulsorily detained under the Mental Health Act. There is already a schism between these communities and mental health services, and such actions will only reinforce the vicious circles of fear that we have documented in our research.”

For example, a significant proportion (40% in one study) of people taking conventional antipsychotic drugs continue to have moderate to severe psychotic symptoms (NICE guideline on schizophrenia, 2002). In a recent survey in Scotland approaching a quarter of service users considered the drugs they took to be unhelpful overall (All You Need to Know? Scottish Association for Mental Health, 2004).

A HIGHER THRESHOLD FOR HARM TO OTHERS

2.27 Mind sees no justification for a lower threshold in law for the protection of others than for the protection of self. We believe that in practice it will be very difficult to decide which level of risk a person presents. If the risk is not significant and the harm not serious, a person’s liberty should not be taken away in order to give the person treatment he or she does not want. Who else, who has not committed (or who is suspected of involvement in) a criminal act, loses their liberty on the basis of what he or she may do to others?

Question 2c: Are the provisions for assessment and treatment in the Community adequate and sufficient?

2.28 In seminars held in response to the Mental Health Bills of 2002 and 2004, service users have made clear to Mind that they see compulsory treatment in the community as oppressive and unfair. Most view the proposals as unworkable and unnecessary and do not believe that they will increase public safety. There are very strong feelings that the safety of people experiencing mental health problems will actually be reduced by the proposals and that the stigma surrounding mental health problems will increase. These are just some of the quotes from the seminars:

“These proposals are impossible to enforce.”

“How will this be policed”.

“Are we going to have regular blood tests to make sure we are taking our medication?”

“What if a worker goes to visit a person who is on an order to check they are following the order and they are not there—how are they going to find them?”

“What are the practicalities of ensuring people are at a certain place at a certain time doing a certain thing?”

“This is ‘propaganda’ to try to make the general public feel safer . . . a knee-jerk response to media coverage”

“This will increase public fear. People will see other people taken from their homes for treatment. This will increase stigmatisation and prejudice”

MORE COMPULSION FOR LONGER PERIODS

2.29 Under the existing Act the requirement of hospital admission places a limit on compulsion since people have to be so distressed as to require hospital treatment. The finite number of beds available effectively raises this threshold further. The availability of a compulsory alternative to hospital treatment will inevitably increase the numbers of those under compulsion.

2.30 Although compulsory treatment in the community is put forward in the draft Bill as an alternative to hospital, its enforcement will ultimately also result in the hospital detention of people who would not have been hospitalised under the current law. If a person refuses to accept treatment they will have to be taken to hospital to receive enforced treatment and will presumably usually require some subsequent observation (and therefore detention) in hospital.

2.31 Mind is opposed to compulsory treatment in the community for any reason. Compulsory powers should only be available where a person’s condition is such that they require admission to a hospital or other inpatient setting for assessment and treatment. If a person is not ill enough to be an inpatient, compulsory treatment is not warranted. Anyone able to live in the community should be able to choose whether they take medication and should certainly not be faced with the prospect of enforced hospital admission.

2.32 People who are sufficiently distressed to warrant treatment on a compulsory basis are also sufficiently distressed to require detention and treatment in a hospital environment. Inpatient settings provide safer environments for the initial exercise of compulsory powers allowing, for example, medical staff to help monitor the effects of medication and help people cope with any side effects. As service users themselves say:
“If you are ill enough to be sectioned, you deserve and need 24-hour care and observation”
“If someone is so ill as to need compulsory treatment, they should be admitted”
“How can a protective hospital environment be extended to the community?”

DRIVING PEOPLE AWAY AND UNDERMINING TRUST

2.33 Many service users tell Mind that they already feel disempowered in the mental health system. Attempts at working in partnership will be further damaged by these measures which will introduce fear and mistrust into what should be therapeutic relationships. Many of the people we spoke to found the current relationships they had with their mental health professionals generally helpful, and felt these would be harmed by the increased threat of compulsion with mental health professionals being turned into “Mental Health Act police officers”. Many fear that the new measures will increase their chances of being subject to compulsion if they disagree with the treatment recommended by their psychiatrist. They also feel that being treated in the community would lead to less personal support and less immediate access to medical expertise:

“People will refuse to go for treatment.”

“Trust is the key to therapeutic relationships. Compulsory community treatment orders would destroy it.”

“Counselling or psychotherapy can be so helpful but it won’t work if you don’t want to be there.”

“The new Act will affect trust. You will stay quiet. You will become ill.”

In short, the fear of being unjustifiably detained will drive existing service users away from services and make people experiencing mental distress for the first time much less likely to seek the care and support they need.

2.34 Service users also believe that compulsory treatment in the community would damage their support structures:

“This will put further strain on the carer/service user relationship, which is often already a difficult one. There will be much more stress on carers. Carers are often relatives so there will be more stress on families.”

“These proposals will damage relationships between individuals and their carers.”

FOCUS ON MEDICATION

2.35 Another fear is that compulsory community treatment will focus on drugs since this is the only treatment which can be enforced effectively and which is available readily. The use of medication therefore is likely to increase, as it is the “easy option” for over-stretched workers. Similarly support for service users with their housing, employment and/or benefit problems is also likely to decline:

“People will prematurely be given medication rather than alternatives”.

“Psychosocial treatments depend on a relationship and therefore cannot be compulsorily given.”

“Compulsory treatment in the community will be an attempt at compulsory medication in the community but can ‘Government’ really ensure people do take medication in their own homes?”

2.36 Service users fear being forced to take drugs that cause them distress. They also fear that there will be no way to monitor side effects or to supervise withdrawal, changes in medication or levels of medication if they are treated in the community. There is particular concern about a potential increase in the use of depot medication and its associated side-effects:

“Side effects of drugs are already ignored. They are not explained and they are not monitored. Under these proposals you won’t see a doctor at all. At least now if you’re sectioned you’ll see a doctor as part of their rounds. And if you are really lucky your physical health will be taken care of too”.

2.37 People will be effectively prevented from making their own evaluation of the costs and benefits of particular medication. Stopping medication can often be a rational decision and lead to an improved quality of life. The following quotation from a respondent to the Mind survey is typical:

“I was diagnosed as suffering from schizophrenia in my teens and was treated for this for five years . . . I was reduced to a zombie until, finally, feeling I’d nothing to lose, I stopped taking the tablets (against medical advice). After initial withdrawal problems I was able to leave home, get a job and start living. I’ve been fine without drugs since then (for 24 years now). Thank God no-one forced me to keep on taking them.”

2.38 Mind’s experience is that people usually avoid complying with aspects of their care plan for legitimate reasons, such as the side effects of medication. Someone deemed fit to live in the community should be trusted to make these sorts of decisions, with support, for themselves. The approach to working with this group should be based on gaining their trust; not on compelling people to take their medication. In particular a person’s wish not to comply with their care plan should not be used as evidence of the need for compulsion.
LESS NEED FOR COMPULSION IF BETTER SERVICES

2.39 Research has shown that restrictive powers are more likely to be used where there is an absence of appropriate services (e.g., overnight or weekend services). Mind believes that the Government would be better served improving community and inpatient services instead of increasing the use of compulsory powers and thereby diverting resources from those services which people with mental health problems need. The aim should be to make services responsive to the needs of people who have to use them rather than to find new ways of forcing people to use services that they view as unattractive, or irrelevant to their needs.

2.40 Service users who have spoken to Mind feel there should be investment in early assessment and intervention, to avoid things becoming so bad for people that compulsory powers are needed. Most think there is not enough access to a range of treatments so that people are unable to choose those most beneficial to them:

“ECT, tablets or injections—that’s the only choice I’ve ever had.”

“Where is our opportunity to say ‘this is what we’d like?’”

2.41 For all these reasons Mind remains absolutely opposed to the introduction of compulsory treatment in the community. We emphasise that the provisions in the current draft are only slightly less all-embracing than in the 2002 draft. A clinical supervisor is given unfettered discretion to put a patient under compulsion in the community after the initial period of assessment (which may last no more than a day). Thereafter there are no limits on either Tribunal or clinical supervisor to change a patient’s status from resident to non-resident.

Question 3: Does the draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on the one hand, and concerns for public and personal safety on the other?

Mind believes that the draft Bill responds to a misplaced concern about public safety and that the personal and human rights of individuals are being inappropriately eroded as a result.

THE MYTHS OF DANGEROUSNESS AND RISK ASSESSMENT

3.1 There is no question that the focus of the draft Bill is on concerns for public and personal safety and that the Bill’s provisions place these concerns above the rights of service users. The Bill is based on the idea that people with mental health problems present a risk to others. Its purpose is to force people to be treated against their will in order to minimise this risk. The Government’s explicit policy has been that the Bill will contribute to public safety by giving doctors greater scope to detain dangerous people. A diagnosis of a mental disorder does constitute a slightly increased risk of violence—but this relates to a very small number of people. An analysis of characteristics of perpetrators of homicide (1996 to 1999) found that far higher proportions had a history of alcohol and drug misuse than a primary diagnosis of any of the main mental disorders. Nearly half of stranger homicides were committed by people with histories of drug misuse. Only 6% (one in 16) had symptoms of mental illness at the time of the homicide.

3.2 There is also an over reliance on risk assessment in the draft Bill, which exacerbates the imbalance between the rights of service users and the protection of the public. Risk assessment is a subjective and unproven technique in the mental health field and its inaccuracies will result in the unnecessary detention of large numbers of people. Where homicide is concerned, for example, authoritative academic studies indicate that to identify correctly one genuinely dangerous patient, 5,000 people will be incorrectly identified as being at high risk of committing a homicide.9

PERSONAL AND HUMAN RIGHTS

3.3 Mind agrees that the public interest in safety is important but believes that the draft Bill places too much emphasis on misplaced public fear to the detriment of service users’ rights. These rights are undermined by the criteria for compulsion. Where a person is deemed at “substantial risk of causing serious harm” (an assessment which, as explained, cannot be carried out with certainty) the threshold is lowered: the condition that compulsion only be used where treatment is only available under the Act does not apply.

3.4 A concern expressed at a recent seminar was that the draft Bill will add to the stigma attached to mental distress and the public perception of this group as dangerous. For example, as people subject to compulsory powers are seen being taken from their homes so that elements of their care plan can be enforced, neighbours are liable to view individuals with suspicion even if they have never been assessed as dangerous. The overwhelming view was that such powers sacrifice personal rights in favour of public concern and, paradoxically, will only serve to heighten public fear.

9 Mike Crawford, Senior Lecturer, Department of Public Mental Health, Imperial College School of Medicine, analysing Altman, 1991.
3.5 The lack of rights afforded to people labelled as having a personality disorder is of particular concern. The Bill focuses on people labelled as having a “personality disorder” who are also considered to be dangerous. However, the result is likely to be a blurring of these two terms so that all people diagnosed with a personality disorder become labelled as dangerous and experience further erosion of their personal and human rights.

3.6 Many service users believe that the powers in the bill will unfairly curtail the rights of people diagnosed with a personality disorder to live a life of their choosing. This diagnosis is in itself not always accurately applied and can be used, for example, to label behaviour which is simply difficult or different. The fear is that powers such as compulsory community treatment will be used to place a “moral straightjacket” on behaviours that are disapproved of by society (and doctors).

**INCREASED RISK TO PUBLIC SAFETY**

3.7 The provisions will in practice serve to increase the risk to public safety. Our consultations with service users indicate that widening the net of compulsion will deter people from seeking help at times of need and any potential risks (to service user and public alike) will be increased.

3.8 In addition, as explained elsewhere, the increased resources required for administering the legislation and the likely increase in the use of compulsion will draw resources away from preventative work, early intervention services, community and primary care. If people are not able to readily access services at an early stage, again their condition is liable to deteriorate potentially increasing the risk to them and to the public.

**Question 4:** Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient and clear? Are there any important omissions in the Bill?

<table>
<thead>
<tr>
<th>Because of its complicated drafting the proposals in the Bill are unclear.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>There are significant omissions:</strong></td>
</tr>
<tr>
<td>— There is no provision for a duty to assess and provide services for people with mental health problems who do not meet the criteria for compulsion.</td>
</tr>
<tr>
<td>— Free aftercare provision should not be cut short at six weeks.</td>
</tr>
<tr>
<td>— Advance statements should have a legal status and advance refusals be upheld.</td>
</tr>
<tr>
<td>— The powers of the nominated person should be increased.</td>
</tr>
<tr>
<td>— Police stations should not be used as places of safety.</td>
</tr>
</tbody>
</table>

4.1 The Draft Bill is unnecessarily difficult to understand. For that reason alone it fails to satisfy a basic requirement that service users need clear information about their position under the law, their rights and the likely outcomes of the process to which they will be subject. In addition, as we have already pointed out, we do not consider the provisions for non-resident orders necessary or workable given the level of service provision required for them. There may be alarming and unintended consequences as a result of the ability to switch patients between non-resident and resident status. In view of the fact that the Code of Practice is unavailable for comment it is difficult to know whether very broad terms in the Bill will be clear once further explanations are given.

**Omissions**

4.2 There are significant omissions from the Bill. In our responses to other questions we have identified some omissions and discussed them in greater depth. They include the list of general principles, and exclusions to the definition of mental disorder, as discussed above (questions 1 and 2), and provision for mental health advocacy (question 5).

4.3 In this section we discuss other powers, rights and duties which we believe would greatly improve the Bill. They relate to:

— the assessment process;
— aftercare provisions;
— advance statements;
— the nominated person; and
— places of safety.

4.4 The assessment process. Mind believes that the new Act must include a duty on public services to assess and meet the needs of people with mental health problems. Such a duty is the corollary of the power to impose compulsion. Both the Expert Committee and the Scottish Act took a similar approach. We
endorse the view of the Mental Health Alliance that when people are brought within the scope of the legislation by being examined for compulsory powers, they should then have rights to an assessment of their mental health needs, a care plan and service provision to meet those needs.

4.5 Aftercare provision. When people are discharged from compulsory hospitalisation (so that section 117 of the 1983 Act applies) they are currently guaranteed free, integrated health and social care (including accommodation). The proposals contained in the new draft Bill would replace this with a duty to provide care that is free of charge for only six weeks. Thereafter, services could be means-tested and contributions levied from people, even if they are on benefit.

4.6 People are driven away from mental health services by the complexity of securing services in the first place, coupled with the need to balance benefits and contributions towards the provision of any services which are eventually provided. The “six week” proposal will introduce an unacceptable level of uncertainty over future provision during the most vulnerable period post-discharge and it will drive even more people away from services. It will also result in severe hardship for patients who lose their accommodation, and perhaps their possessions, following admission or who have been in hospital for a long time—starting up an independent life takes time and resources. Even service users who might be able to resume employment will find it difficult to achieve the right degree of home stability within this period. All of these effects will impede recovery and reintegration, and increase the number of readmissions to hospital.

4.7 Since the publication of the 2004 draft, service users have expressed strong views to Mind about the lack of continuity and support in existing services. Their belief is that limiting the scope of the discharge package will only make things worse and make further hospital admissions more likely.

4.8 Advance decision-making. The consent of the patient is not needed for most forms of medical treatment under compulsory powers. Under the Bill, except for people judged at substantial risk of causing serious harm to others, refusal to consent generally to treatment is a crucial condition for compulsory assessment and treatment. The Bill denies legal force to advance refusals to take specific treatments once someone is placed under compulsory powers.

4.9 There is a critical value to care and treatment when consent is given. The potential benefits of advance statements are that individual autonomy and recovery are promoted, communication with those trying to help is improved, and patients are protected from ineffective, unwanted and possibly harmful treatment. Crises and the use of compulsion may be avoided. We therefore consider that valid advance decisions should be used during mental health crises as far as possible. When this happens, service users report that recovery is enhanced.

4.10 There is academic evidence to show that compulsory admissions are significantly reduced.10 The result of the Henderson et al, 2004 study demonstrated that using “crisis plans”, negotiated by a third party and agreed with clinical staff, more than halved the rate of compulsory re-admissions among service users who had had a psychiatric hospital admission in the preceding two years. However, many of those who were eligible to take part in the study declined, one of the reasons being that no one would take any notice of the plan. This underlines the need to give statutory force to service users’ statements.

4.11 Annex I provides an example of an advance statement and an individual account which illustrates both the value of advance statements and the need to give them legal force.

4.12 The nominated person. We support the principle in the Bill that patients have the right to choose the person who will support them during the compulsory process rather than to have a nearest relative defined by the law. In any event, the provisions of the 1983 Act have been held to be in breach of the European Convention on Human Rights. However we greatly regret the loss of powers of the nearest relative which served such a useful function under the 1983 Act.

4.13 There are unnecessary restrictions in the Bill on the patient’s right to choose the nominated person. If the appointer acquires power to determine the suitability of the nominated person this will compromise the independence of the person nominated and respect for the patient whose choice might be overridden. We accept that there is a need to protect vulnerable people from abuse. But if the intention is only to prevent an abuser of the patient being appointed, the Bill should make that clear and limit the discretion accordingly. A person is also disqualified to act if “he appears to the appointer to be incapable . . . because of illness or mental disorder” (this replicates section 11 of the 1983 Act). It should be made clear that a person can only be incapable if they lack capacity within the meaning of the Mental Capacity Bill.

4.14 The Government believes that it would be impractical to appoint a nominated person before the initial examination because it needs to take place very quickly. However this should not prevent an appointment in many cases; after all, the period of examination can last for up to seven days. Technical difficulties should not override the legitimate needs of the patient for support and protection at the critical time in the process. We also believe that it could be useful for the professionals—often meeting the patient for the first time—to have the help of the nominated person as well as that of the carer.

---

4.15 The current Bill makes clear that the appointment of the nominated person ceases once the patient is discharged from compulsory powers. Service users have particularly expressed their regret at this provision. They believe that it would be of greater protection for them to have the person’s name recorded in their medical records for any future occasion. It would be possible to retrieve that person’s name from the records and unless the patient made clear she or he was no longer appropriate the person should remain the nominee. Naturally, an advance directive could also be a source of information if the person lacks capacity at the time of the initial examination.

4.16 The nearest relative’s role has been greatly curtailed: from a guardian of rights under the 1983 Act to a consultee under the new Bill. No adequate explanation of this has been given. We have urged the Government to reconsider this position because we know that the powers of nearest relatives are an important check on the excessive use of powers of compulsion.

4.17 The power to discharge the patient has proved particularly useful. A survey in 2000 found that a significant proportion of discharge applications by nearest relatives were successful (just over one third of all reported cases). This exceeded the rate of discharge of the Mental Health Review Tribunal that amounted to an estimated 10 to 12%. This power enables a patient to receive a speedy discharge when under law they should technically no longer be subject to compulsory powers. This discharge power could therefore be a more efficient way of obtaining a patient’s discharge than the cost and delay of an application to the Tribunal.

4.18 Places of safety. Under the 1983 Act, the police can take a person from a public place to a place of safety, for a period of up to 72 hours, for assessment to determine whether compulsory admission to hospital is required. This provision is replicated in the Bill (clause 229). Although no conclusive figures exist due to lack of centralised reporting, a recent estimate has indicated that section 136 may currently be used approximately 10,000 times each year. There is also evidence that section 136 is used disproportionately in relation to Afro-Caribbean males, and that a poor understanding of cultural issues by police or clinicians was likely to account for some of this.

4.19 There has long been recognition that police cells are inappropriate as places of safety, and the Code of Practice states that police cells should not generally be used. But they are widely used in practice. It is estimated that, across the country as a whole, police cells may be used as a place of safety in approximately three out of every four uses of current powers.

4.20 Police cells are inappropriate because custody officers do not have the experience to care for someone experiencing a mental health problem, particularly someone that is extremely distressed and may be showing disturbed behaviour. Individuals are often left for many hours before an approved social worker and doctor can be found to assess them, by which time their physical and mental state may have deteriorated considerably. Allowing the current situation to continue would mean the lives of people detained under s136 may be placed at risk as a result of being detained in environments not designed to meet their needs, and supervised by staff not trained or equipped to do this effectively or safely.

4.21 Mind therefore believes that the use of police cells should be phased out and only used as a last resort. In rural areas, for instance, it is likely that they will continue to be needed in some cases.

4.22 The White Paper on the new mental health law stated that where a police cell is used as the place of safety there would be a duty on the local Trust to arrange a preliminary examination within six hours, if requested to do so by a Forensic Medical Examiner, or to transfer the person to hospital for examination during that period. Regrettably this proposal was dropped, except when the new emergency powers are being used. Mind believes that a maximum period of six hours should be specified for detention in a police station under clause 229. This six hours should form part of the 72-hour maximum period for initial assessment, and no further transfer between places of safety should be permitted. The Mental Health Act Code of Practice should state that local protocols should be in place which specify a local designated health-based place of safety which is to be used. Where a person is brought to a police station and is thought to have a mental health problem and to be under the influence of alcohol or drugs, the Forensic Medical Examiner should be called immediately to determine whether urgent medical assistance is needed. The person should continue to have his or her medical condition monitored closely until either being transferred to hospital or discharged, within the six-hour time limit described above.

4.23 The Bill should provide the right of access to specialist mental health advocacy when the person arrives at the place of safety, whether it is a psychiatric hospital or police station (see below).

Question 5: Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft bill?

Mind believes that the institutional framework in the Bill needs to be strengthened. The role of advocates should be enhanced and extended to the examination stage, places of safety and the criminal justice system.

Approved mental health professionals should bring a social model perspective to the application of compulsory powers and be independent of the clinical team.

The Part 3 framework has not been adequately reviewed and does not fit the new system. The criteria for compulsory treatment of an accused person and wherever possible a convicted person should mirror those available under the civil system and an advocate and the patient should be consulted in drawing up the care plan.

In principle criminal courts should not be able to make care and treatment orders. In particular there should be a right of access to a nominated person.

Tribunal membership needs to be broadened to ensure that professionals bringing a social model perspective are included and that lay members include people with direct experience of mental health services.

Advocacy Services

5.1 Advocacy services have an important and little understood role in the lives of people with mental health problems. Mind runs a legal advice service for our Advocates Network. We are aware how greatly advocates are valued by those who use them. They assist with social and personal issues such as debt, housing, social security—which can also have a direct impact on the person’s health, and they are often involved when treatment decisions are being made.

5.2 In the context of the Mental Health Act their role is essential in preventing the escalation of crises and easing tensions that can otherwise lead to a use of compulsory powers. Advocates do not make judgments or pass opinions but act as a channel of communication between patient and practitioners. They can be used to interpret and articulate the patient’s wishes and to negotiate resolution. They help to provide information in an accessible manner. A major complaint of service users and their families who have been involved in the compulsory process is that they were not told clearly what was happening, what the process would be and what their rights were—and at a time that they needed to have this information. They are in our view as central to the process as nominated persons and carers and even as other professionals.

5.3 Advocacy services may specialise in the needs of different social or ethnic groups or for people of different ages. Advocates that work with minority ethnic groups can play a particularly valuable role for people who are still subject to discrimination and substandard service in the mental health system. Black and minority ethnic communities particularly value the advocate’s role in providing a culturally sensitive perspective and preventing the misunderstandings that can lead to a resort to compulsory powers. In improving minority groups’ experience of the mental health system advocates could also help to redress the problem of their disengagement from services and consequent deterioration in health.

5.4 In view of these points we urge the government to enhance the status of advocates under this Bill. We believe the following to be essential points at which advocates should be available for a patient who wishes their services:

— at the examination stage of civil patients;
— at the time of a mental health report in a criminal justice setting;
— when special treatments are being considered;
— when a person is in a place of safety;
— on review of care or treatment;
— at discharge or transfer from hospital or release from compulsion; and
— when any other significant decision is being made.

5.5 The Bill does not set up a duty on the Secretary of State to provide an advocate for any individual. The only right for patients is to be referred to the “help available” from an IMHA under the arrangements in clause 274. We refer to the Scottish Mental Health (Care and Treatment) Act 2003, which puts a duty on authorities to ensure that independent advocacy is available to all people with a mental disorder and that they have an opportunity to use it. This would in our view be a stronger safeguard and would also ensure that advocates become integral to the process of compulsion.

5.6 The examination stage for civil patients. Under the Bill a referral to the advocacy service only occurs once the approved mental health professional has made the critical decision for a compulsory assessment. The referral is not made at the examination stage (when only a carer may be consulted). Some established
service users may be in touch with advocates at that stage. But the least knowledgeable and most vulnerable will not. Yet the examination stage is the most important period in which effective advocacy might help to avoid a hospital admission.

5.7 Places of safety. Advocates should be provided for people transferred to place of safety under clause 299 of the Bill. This is a time at which decisions will be made about whether the person has a mental disorder and where (or if) the person should be transferred for treatment.

5.8 Advocacy within the criminal justice system. Part 3 of the Bill does not provide specifically for access to advocates: there is no mention of a duty to inform the person of the availability of the service at any stage of the proceedings. We believe this is a major oversight. Difficult decisions may be made about whether an accused person with a mental health problems who is on remand should be sent for a mental health report, or transferred from custody to hospital, or given compulsory treatment during an assessment.

5.9 Part 8 of the Bill makes clear that advocacy is to be available once a mental health order is in place but this is far too late to be of use to the patient. Nor is there any suggestion that the advocate should be available at the time the care plan is being drawn up or reviewed. It appears that too little consideration has been given to the role that advocates can play within the criminal justice system.

The Approved Mental Health Professional (AMHP)

5.10 The AMHP has a key role in applying compulsory powers. It is essential that AMHPs are able to bring a social perspective to the application of compulsory powers and that they receive the depth and level of initial and follow-up training and accreditation currently required of Approved Social Workers (ASWs).

5.11 They need to be required (as are ASWs now) to exercise their own independent judgment and act in a personal capacity rather than at the behest of their employers or other persons who might be involved with the patient (as are ASWs now). They need to be independent of, or, at least, independently managed from the clinical team responsible for the patient’s ongoing care. They need a good knowledge of local facilities and services which may be available as an alternative to the use of compulsion and they should have the power to make referrals for social care assessments.

5.12 We welcome the assurances given in the Explanatory Notes to this Bill but consider that in the new joint working relationships in health and social care it will be particularly important to ensure that protocols are in place to ensure that the social model perspective is retained and that AMHPs receive a degree of independence from the clinical team.

Safeguards for Patients in the Criminal Justice System

5.13 The criminal justice sections of the 1983 Act have not been subject to detailed scrutiny or public consultation. As the Expert Committee were not asked to report to the Home Office on the criminal justice provisions they did not consider them in detail. This is a matter of great regret. In Scotland by contrast there were two scrutiny processes through separate committees—the Millan Committee and the McLean Committee which investigated the issue of violent offenders with mental health problems. This led to amendments to separate criminal legislation in Scotland.

5.14 In the draft Bill the new definition of mental disorder and new conditions have been grafted on to the current provisions in Part III of the 1983 Act. But it appears there has been little consideration of the effect this will have on the usage of the Act in the criminal context. People before the courts are engaging with the police, the criminal courts, and possibly prison—none of which have mental health specialisation. But it seems they will not receive the safeguards of a nominated person or a Tribunal. Nor is there a requirement to consult the patient. A care plan will be authorised after 28 days by a mental health order imposed by a criminal court without expertise in medical treatment and without automatic access to the second opinion from a member of the Expert panel. There is no opportunity for patient or advocacy input into the creation of the care plan that is necessitated by a mental health order. It is recommended that s248 be extended to those people for whom a “care plan” under s115 (1) is being drawn up; therefore before a mental health order is made.

---

14 Elsewhere in the Act, clause 31(a), it is stated that in preparing a care plan for the patient, the clinical supervisor must consult the patient about the medical treatment to be specified in the plan unless it is inappropriate or impracticable. Schedule 5 states that provisions of part 2 do not apply to part 3 unless specified in part 3.

15 The making of a mental health order by the court is conditional upon the preparation and submission to the court of a “care plan” by an approved clinician—clause 115(1). However as clause 248(f) states that a patient will only become a “qualifying patient” for the purposes of clause 247, when a mental health order is “in force”, anyone for whom a mental health order is proposed will not have access to advocacy.
THE ROLE AND POWERS OF THE MENTAL HEALTH TRIBUNAL

5.15 We believe that the composition of the tribunal needs to be reassessed. We do not accept that there must be a clinical member on the tribunal but would support that role being extended to professionals from a social work background. We accept that clinical expertise needs to be available to the tribunal but believe that this should be supplied through the mandatory examination from a doctor on the expert panel and by any other experts that may be recruited. We support the extension of the role to include psychologists as well as psychiatrists.

5.16 It is vital that the tribunal includes as its lay member representation from people with experience of mental health services as users, carers, family members or people who work for these groups in the voluntary sector. This would be consistent with, for example, employment tribunals which contain representatives of both management and employees. We believe it most unfortunate that these groups have not been included in the current draft and consider this a lack of respect for those with direct knowledge and expertise.

5.17 The potential length of the assessment period for both civil, and criminal justice patients seems to be as much as four months. We do not understand the reason for this and believe that the final care plan should be able to be drawn up within a much shorter period of time.

Question 6: Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

The provision to allow psychosurgery by High Court order should be removed from the Bill, and the current safeguards in the 1983 Act should be maintained.

ECT should be given only with informed consent for people with capacity to give or withhold consent. The emergency criteria for ECT for those incapable of giving consent should be restricted to saving life. The nominated person should be notified and (if the patient wishes) an advocate involved if ECT is being considered. ECT should not be given to anyone under 18.

Clinicians should always seek to provide treatments the patient is willing to accept. Drug treatment given without informed consent should be with Tribunal approval, and treatment above licensed limits should be with informed consent or to prevent serious risk to the life of the patient.

6.1 While treatment safeguards in the revised draft Bill are significantly greater since the 2002 draft, more are needed. There is a need for wider provision in the Bill to protect patients who are being forced to take medical treatments, which in many cases will be in the form of drugs—that is, safeguards should not be confined to instances of misuse or the most aggressive treatments.

THE NEED FOR SAFEGUARDS FOR DRUG TREATMENTS

6.2 When Mind held workshops with service users about the 2002 draft Bill, the need for safety from psychiatric treatments came out very strongly. One young woman said: “The medication had absolutely horrific side effects, which got worse, and when I said I didn’t want to take it, I was put under another section and forced to take it. I felt as though my skin had been peeled back and all my nerves were exposed. I felt as though electric shocks were being put through me. This went on for two or three months. I was told I would get used to it. In the end I was able to get off the section and off the medication because with help I was able to explain to the psychiatrist calmly and rationally what it was doing to me.”

Another stressed the need for changing medication quickly when necessary: “If I am having problems with medication I need to be seen quickly and I need the medication to be changed within hours. I don’t want to be forced to stay on the same medication for days or weeks when it is causing me such agony.”

Mind frequently hears from people who have difficulty getting their concerns about side effects or long term drug use taken seriously, and where their requests to reduce the dose or try without the treatment is met with the threat of more invasive or coercive measures16. More safeguards are needed to prevent this happening.

PSYCHOSURGERY/NEUROSURGERY FOR MENTAL DISORDER (NMD)

6.3 Psychosurgery is an irreversible, invasive and hazardous procedure. Possible side effects include fits and cerebral haemorrhage, apathy, excessive weight gain and disinhibition. Effects on personality (other than any symptom relief) are less likely to have been captured in the research literature. There are also the risks of anaesthetic and surgery. Professional opinion is mainly against operating on patients who cannot consent17 and service users are likely to feel under threat if psychosurgery/NMD without consent is not outlawed unequivocally.

---

16 Some of these comments are documented in Mind’s 2001 report, Mind’s Yellow Card for reporting drug side effects.
17 Reports on NMD by the Royal College of Psychiatrists (2000) and the NMD Unit in Dundee (2004).
6.4 Mind has concerns about any use of psychosurgery. Because of its hazards and the lack of clear evidence for the treatment’s benefit in general, or basis for predicting its success in the individual concerned, we believe that it should never be given to a person who does not have the capacity to consent to it. The provision in the Bill to allow psychosurgery by High Court order should be removed from the Bill, and the current safeguards in the 1983 Act should be maintained.

ECT (Electroconvulsive Therapy)

6.5 ECT is mainly used to treat severe depression. It is an invasive procedure and some people report permanent loss of memories as well as other adverse effects. The National Institute for Clinical Excellence issued guidance on the use of ECT in 2003, setting out the circumstances in which it is recommended and emphasising the need for joint decision-making with the patient where possible. It draws particular attention to the risks of cognitive impairment. People who have had ECT as voluntary patients often speak of feeling emphasising the need for joint decision-making with the patient where possible. It draws particular attention to the risks of cognitive impairment.18 People who have had ECT as voluntary patients often speak of feeling under pressure to consent, or of not knowing they could refuse it. Those liable to be treated under compulsory powers are even less likely to be able to assert their views or exercise their rights.

6.6 Under the revised draft Bill, patients with capacity to consent may not be given ECT without their consent, and Mind welcomes this. However the Bill includes a regulation-making power to allow ECT to be given against a person’s will in an emergency, even though they retain capacity. The criteria for emergency ECT are quite wide. They are conditional on the treatment not being irreversible or hazardous, but it is not clear whether ECT is considered irreversible or hazardous at all, or in any individual case. Weakening the person’s right to refuse, and this lack of clarity, will be unacceptable to many service users.19 Given the negative views of a large minority of people who have had ECT, and the variable use of ECT by clinicians, we question the necessity of giving ECT against the will of a person with capacity to decide. We do not consider it justifiable to override the person’s will in this situation.

6.7 It is important that the Tribunal considers whether ECT is necessary in advance of its being given when at all possible and that over-use of emergency provisions is guarded against. Even in situations of urgency, psychological and supportive approaches can be tried.

6.8 Children and young people are more vulnerable to the risks of ECT; their brains are still developing up to age 18. Every effort must be made to address their needs through psychological and supportive means. ECT should never be given to children or young people.

6.9 There is nothing in the legislation to prevent treatment being given in unsafe conditions by inadequately trained staff. This must be rectified. ECT should be given only with informed consent for people with capacity to give or withhold consent. The emergency criteria for ECT for those incapable of giving consent should be restricted to saving life. The nominated person should be notified and (if the patient wishes) an advocate involved if ECT is being considered. ECT should not be given to anyone under 18. ECT administration should be required to comply with essential national standards of practice.

Drug Treatments and Care Plan

6.10 Prescription drugs used for mental health problems have a wide range of side effects which can be very distressing, disabling or even life-threatening. They include for example muscle spasms, agitation, weight gain, depression, apathy, tremor, and heart problems. They are not even effective at providing symptom relief for everyone. Different people respond differently to the same drug or dose, for example because of differences in how people metabolise the drugs. Some combinations of drugs can be hazardous or raise the total dosage to hazardous levels. The person taking the drug usually knows best how badly they are being affected (at least in relation to immediate effects such as muscle spasms, agitation, or loss of libido) and whether the benefits they get from the treatment balance out any risks or harm.

6.11 The revised draft Bill does not allow people with capacity to refuse drug treatment. It is not clear that consent even has to be sought. Type B treatments will be subject to regulation, and for other treatments (not ECT or type A treatments) consent is simply “not required” as long as the person is under compulsory powers, in hospital, and the treatment is in their care plan.20 It is unclear how specific the care plan would have to be in relation to the treatments being prescribed.21 Indeed the draft Bill says very little about the nature and content of care plans.

---

18 A systematic review of clinical research carried out for the Department of Health states: “the more effective forms (of ECT) tend to cause more memory impairment.” (UK ECT Review Group, 2002). A review of the literature about patients’ views of ECT, also commissioned by the Department of Health, found that at least one third of patients report significant memory loss, often autobiographical memories. (D Rose, T Wykes, M Leese and P Fleischmann, 2003, “Patients’ perspectives on electroconvulsive therapy: systematic review”, British Medical Journal, 326.)

19 In Mind’s Shock Treatment survey (2001) of people who had had ECT, two-thirds of all respondents, and almost half of those who had had ECT in the last two years, said they would not agree to have ECT again.

20 Under the 1983 Act patients may consent to treatment and this is recorded; if they do not (or cannot) consent the second opinion procedure is used (or the treatment is not given).

21 Currently, drug treatment after three months must be authorised by a second opinion appointed doctor who agrees particular drugs and dose ranges.
6.12 Patients also require specific protection from drug treatment outside recognised practice and licensed dose levels. The British National Formulary (BNF) sets out the dose ranges and purposes for which prescription drugs are licensed. The maximum dose is often substantially above the usual dose range. For example the “maintenance dose” for chlorpromazine is 75–300mg a day but the maximum is 1,000mg a day, phrased as “but up to 1g may be required in psychoses”. It is this upper limit or its equivalent in other drugs that is generally used as the measure of a high dose. Even the usual maintenance dose may be above the level at which a maximum therapeutic effect has been demonstrated. In the case of haloperidol, until 1998 when there was a big reduction to 30mg a day, the licensed daily maximum was “100mg (rarely 120mg)”. Yet no additional benefit has been shown for doses above 4mg a day. Many side effects are dose related, so higher doses may give no additional benefit but substantially increase the risk of harm. The BNF summarises advice developed by the Royal College of Psychiatrists on how to avoid high doses, or use them as safely as possible.

6.13 When operating the 1983 Act some second opinion appointed doctors have authorised treatment expressed in multiples of the maximum dose—eg twice, four or six times.22 Yet according to one study, high doses are associated more with patients’ past reputation and prescriber differences than patients’ current behaviour or mental state. Those with a history of aggression had nine and a half times higher chance of being prescribed higher doses, and those with a greater than five year history of being prescribed these drugs received higher doses. Even in a forensic ward (where higher doses might be expected) one consultant prescribed significantly higher doses than his colleagues despite random allocation of patients.23 This calls into question the clinical validity of subjecting patients to the additional risk of these doses.

6.14 Mind considers that doses above the licensed limit should only ever be used in exceptional circumstances and a safeguard is needed on the face of the Act. We also consider that the hazardous nature of psychiatric drugs, and the bad experiences that some patients have had, justifies inclusion in the Act of an offence of reckless prescribing, to afford some protection against the worst practices.

6.15 Mind proposes that the following issues should be considered:
- Incorporating national guidance on drug treatments into a mandatory Code of Practice.
- Requiring the clinical supervisor to seek to provide treatments that the patient is willing to accept, and requiring the clinical supervisor to seek informed consent for each treatment being proposed. Provide for people with capacity to refuse any treatment, including drug treatment.
- Providing that all drug treatment given under compulsory powers without informed consent to be authorised by the Tribunal, except in emergencies, when the Tribunal would be notified. The Tribunal should use advice from a pharmacist in authorising drug treatments.
- Allowing treatment above British National Formulary limits only with informed consent or in order to prevent serious risk to the life of the patient, and with notification to the Tribunal.
- Allowing drug treatment outside its product license only on the grounds of the patient’s health when there is no licensed alternative and with express Tribunal authorisation.
- Making reckless prescribing an offence.

Question 7: Is the balance struck between what has been included on the face of the draft Bill and what goes into Regulations and the Code of Practice right?

The right balance is not struck between what has been included on the face of the draft Bill and what goes into Regulations and the Code of Practice. Too many issues are left to the Code of Practice. The Code is welcome but it should be strengthened by a presumption of compliance and should not be used to introduce major changes in practice without consultation or parliamentary scrutiny.

**CODE OF PRACTICE**

7.1 Mind welcomes the Department of Health’s acknowledgement (in its guidance to the draft Bill) of the role the Code can play in safeguarding patients’ rights.

7.2 Consultation. Mind is concerned that the Code should not be used (as has happened with the current Code)24 to introduce major changes to mental health practice under the Act without proper consultation or parliamentary scrutiny. We therefore welcome the consultation requirement contained in clause 1(8) of the draft Bill but believe this should be strengthened.

24 A particular example was the introduction of a ban on visits by children to any detained patient until a decision had been taken that the visit was in the child’s best interests.
7.3 There should be a requirement that, before the final draft of the Code is published, the Secretary of State must consult organisations representing the interests of service users and organisations providing mental health services about the proposals and then have regard to any representations made to him by those organisations. The Code should then be subject to approval by resolution of each House of Parliament.

7.4 Status of the Code. As the Mental Health Act Commission recently stated, the Code is one way in which the State can ensure that authorities exercising powers do so in accordance with human rights principles.\(^{25}\) Mind concurs with the Commission’s view that that the Code should be afforded a status consistent with its purpose and is therefore concerned that the new draft Bill creates a far weaker requirement than that laid down by the Court of Appeal in the recent Munjaz case.\(^{26}\)

7.5 The case involved the issue of “seclusion” and an NHS Trust’s failure to comply with guidance contained in the Code of Practice. Colonel Munjaz was a patient in Ashworth Special Hospital who was placed in seclusion with some regularity, occasionally for some months, contrary to the Code’s guidance that seclusion should be used “as a last resort and for the shortest possible time”. Ashworth issued a seclusion policy in 1999, which departed from the Code in a number of respects but, particularly, by reducing the number of medical reviews from four hourly (as stated in the Code) to twice daily on the second and third days and once daily thereafter. In Judicial Review proceedings, the Court of Appeal ruled that hospitals and professionals are required to follow the Code unless they can show that it is both necessary and in accordance with the law not to follow it.

7.6 Ashworth’s policy was reviewed and amended but continued to contravene the Code’s guidance and a further challenge was brought. At first instance the Court held that the Code was no more than guidance to which hospitals were obliged to have regard. However, the Court of Appeal overturned this decision stating that: “it would fly in the face of the original purposes of the Code if hospitals were in fact free not to follow it without good reason . . . In relation to those matters where a patient’s human rights are or may be engaged, the arguments for according the Code a greater status are compelling . . .”. The Court ruled that that hospitals and professionals are required to follow the Code unless they can show that it is necessary and in accordance with the law not to follow it. To depart from the Code with no good reason may be a tortious act and also may amount to a breach of Articles 3 and/or 5 and/or 8 of the European Convention on Human Rights.

7.7 The original review of the Mental Health Act (by the Richardson committee did not decide that the Code of Practice should have statutory force but did recommend that a draft Bill should expressly contain a presumption of compliance with the Code. Mind notes that there is no such presumption contained in the new draft and that people working within the new Act’s powers will only need to “have regard” to the Code principles. Like the Mental Health Act Commission, Mind believes that the Code should be given a clear status under statute that at a minimum reflects the position reached through judicial challenge. A Code which has no enforceable status cannot reasonably be said to fulfil the Government’s stated objectives of ensuring patients are lawfully and fairly treated with respect for their human rights. Such a “toothless” code is an illusory safeguard which merely creates a mirage of rights protection as those with responsibility for administering the new legislation can pick and choose when to comply with the Code at their discretion.

7.8 Mind believes that the phrase “have regard to” should be replaced with “is required to follow” the guidance contained in the Code unless warranted by exceptional circumstances. The Bill should make clear that the Code must be observed by all authorities where there are no such circumstances and that where these circumstances do exist, particular departures from the Code are only permitted in relation to individual patients. Breach of the Code should make a decision or action unlawful except where the decision to ignore the code is made in relation to an individual, is documented, and can be justified on this basis.

Question 8: Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

The Mental Capacity Bill (MCB) and Mental Health Bill (MHB) cover some of the same ground but they are not adequately integrated. Some of their provisions conflict with each other. Both Bills need significant amendments in order to eliminate these contradictions.

8.1 They both concern people who have a “mental disorder” within the terms of the MHB. However their approach to this group of people is entirely different. This will cause great confusion to patients, their carers and to the professionals who must operate within the rules set down by two conflicting pieces of legislation.

8.2 The MHB requires a person to accept treatment whether or not the person has capacity (indeed it appears to operate only when a person has capacity, since it can only be used where treatment can not lawfully be given otherwise). The person’s consent to treatment is immaterial: if she or he lacks capacity, any advance directive that has been made is irrelevant. Instead there is a set of safeguards to protect the patient and to limit the restrictions on his or her liberty.


\(^{26}\) R (Munjaz) v Mersey Care NHS Trust and others; R (S) v Airedale NHS Trust and others (2003) EWCA Civ 1036.
8.3 The MCB on the other hand is based on the premise that a person with capacity must consent to treatment before it can be given. (The only way around this is through compulsory treatment and the Mental Health Bill.) If a person lacks capacity, decisions about treatment can be made on the ground of their best interests. Their lack of consent to treatment must be still be upheld in certain circumstances—if for instance the person has stated in an advance refusal that they do not want a treatment, this decision will generally be honoured. If they have stated something they do want, that will be taken into account in deciding what is in the best interests. However there are very few safeguards to protect them beyond this.

8.4 The difficulties arise in different contexts. If a person lacks capacity and has made an advance directive about treatment (eg ECT) they donot want, the Mental Capacity Bill would not authorise the treatment. However they could then be sectioned—in which case it could be given if it were agreed by the Tribunal. There is a direct conflict between the Bills which must be resolved. In Mind’s view the advance directive should prevail under both Bills (see answer to Question 4).

8.5 If however the person had not made an advance directive the person could be given ECT or other treatment under the MCB if it was considered in his or her best interests. But in this case no safeguards are available. Clearly safeguards should apply to the administration of such treatment irrespective of whether the person has been sectioned. So there should be a requirement for the Court to authorize the treatment unless it was an emergency when the only basis should be that it was necessary to save life.

8.6 More difficulties arise when a patient with a mental disorder without capacity resists treatment. If the person also meets the definitional criterion for the MHB he or she should be sectioned in order to receive all the safeguards of that legislation. However in our view safeguards would also be appropriate for people with a mental disorder even when they do not meet the conditions under the MCB—an advocate, a care plan and recourse to a Court would be needed. The MCB does include provision to restrict the liberty and use force to restrain a resistant person under the doctrine of necessity—that is, their best interests. There are no formal safeguards on the use of this power in that Bill.

8.7 A different problem arises for patients who lack capacity but who are not resisting being treated. These are the so-called Bournwood gap patients who, being in hospital or other residential care are not detained under formal powers but who lack the capacity to decide whether or not to leave, or who, even if they would like to leave cannot communicate this decision or make it effective. Under the MCB as drafted this would be lawful if the so called detention was in their best interests and if their admission to hospital was “necessary”. Since the decision of the European Court of Human Rights has declared that detention in these circumstances is contrary to the European Convention on Human Rights more safeguards would appear to be needed.

8.8 Mind believes that the MCB should be strengthened in order to provide the safeguards needed for the Bournwood gap patients who are compliant but de facto detained. These safeguards include:

- A right to an advocate.
- A procedure for application to the Court of Protection.
- A statutory care plan with reviews.
- Treatment safeguards (as outlined above).

Question 9: Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

It is most unlikely that the Bill will fully meet the requirements of the Human Rights Act and it is certain that it fails to meet internationally accepted standards in both the Council of Europe and the United Nations.

9.1 The recommendations of the Joint Committee on Human Rights have not been heeded in the new draft Bill in respect of the status of the Code of Practice, the power to disapply principles, the lack of exclusions, the overriding of advance directives and the danger of preventive detention. In their view it is questionable whether the non-therapeutic detention of persons without conviction of an offence, on the grounds of “speculation about possible future behaviour and resulting risk to identified persons”, would be compatible with the Human Rights Act. The Committee noted in its report that explicit powers of preventive detention established by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 had been deemed compatible with ECHR Article 5 by the Judicial Committee of the Privy Council, but pointed to the fact that these powers related only to restricted patients convicted of serious offences, and set no clear precedent for patients who have had no contact with the criminal justice system.

9.2 It is also possible that the wide definition of mental disorder together with the vagueness and breadth of the key concepts (for instance “appropriate”, “for the protection of”, “treatment”, “all the circumstances of his case”) lack sufficient certainty to comply with the requirement that loss of liberty must be in accordance with the law. A person must be able to know whether they fall within its ambit. We believe also that the disproportionate response to people who pose a significant risk to others and who can be detained despite their willingness to receive treatment, the discriminatory impact of the law for those within the
criminal justice system, the powers of the Tribunals to impose the equivalent of civil restriction orders and the power to defer release of patients for 8 weeks may in some cases breach article 5(4) and article 14 of the HRA.

9.3 Professor Genevra Richardson (Chair of the Expert Committee) has commented that the Home Secretary has retained the power to order leave or transfer of restricted patients and considers that this may be in breach of the Human Rights Act.27

9.4 The Human Rights Act is a “living instrument”, as the European Court has expressed it. It is likely that before long, case law will have made clear that if treatment is forced on people with capacity to make their own decisions1 when they do not present a serious threat to others, Articles 3 and 8 could also be engaged. Recent case law from the European Court of Human Rights demonstrates that early case law may no longer be relevant. In Keenan v. UK, the court stated: “For example, in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3. Similarly, treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be capable of pointing to any specific ill-effects.”

Question 10: What are likely to be the human and financial resource implications of the Draft Bill? What will be the effect on the roles of professionals? Has the government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation?

Mind believes the resource implications have not been fully thought through. Sufficient staff are unlikely to be in post to implement the legislation, and pressure on staff and financial resources will inevitably draw focus away from preventative work and community and primary care, leading ultimately to a greater need for compulsion.

Human and financial resource implications

10.1 The Bill is likely to bring more people within formal statutory powers, and these individuals will be subject to more extensive procedures, such as Tribunal hearings. Mental health services are already strained to breaking point and there cannot be any doubt that scarce resources will be diverted to make this Bill work. The NHS Confederation study published in autumn 200328 made what it describes as a conservative estimate of additional work attributable to tribunal hearings alone of 60%, creating a deficit of 210 consultant posts.

10.2 The government states that it is committed to providing this number of additional consultants. However, this calculation was made before the long-anticipated judgement of the European Court of Human Rights in the Bournewood case, which opens up the prospect of as many as 50,000 additional patients who may require the involvement of a Tribunal.

10.3 Even assuming this calculation to be accurate, there remain concerns about the workforce:

— Psychiatric consultant vacancies are already running at 25% above the average for all specialties. Psychiatrists already report that they dislike the elements of their role relating to compulsion. The increase in this work is unlikely to make the role more attractive to new recruits. Psychiatry shortages are liable to continue into the future.

— The staff groups with the largest input to assessments and detentions are social workers and administrators. The additional demands on these groups were not fully computed. Social work vacancies are already high. There is no evidence to believe that removing the requirement for the Approved Mental Health Professional to be a social worker will ensure sufficient personnel to plug this gap.

— The existing Mental Health Review Tribunal service is under constant pressure. A major reason for the failure of tribunals to go ahead is the lack of a full panel of suitably qualified members. This problem can only increase in the future.

— The Bill makes provision for a specialist advocacy service, but no firm or workable plans are in hand to make this effective. Advocacy services do exist in most areas, but there is no national coverage and it is not clear how enough advocates are to be recruited, paid for or trained. In addition, there are as yet no nationally agreed training, competence or skill protocols. Advocacy is key to the good implementation of the legislation.

Has the government analysed the effects of the bill adequately, and will sufficient resources be available to cover any costs arising from implementation?

10.4 Professor Louis Appleby, National Director for Mental Health told the All Party Mental Health Group meeting on 27 April 2004 that new treatments and the modernisation services—Early Intervention, Assertive Outreach and Crisis Resolution—are bringing down the rate of sectioning and crisis admissions. Indeed, Assertive Outreach has been specifically designed to forestall this revolving door.

10.5 However, increasing use of compulsory powers for both resident and non-resident patients will create an enormous pressure on all elements of the service and the workforce to concentrate resources on compulsory crisis care and away from preventative work, early intervention community and primary care. In the long run this will lead to an increased need for compulsion, as people whose conditions have not attracted resources at an earlier stage become more ill.

October 2004

Annex 1

ADVANCE DIRECTIVE

The following is an example of what might be included in an advance directive/statement:

“Should I become incapable of making decisions for myself, I make the following advance statement:

— I do not wish to be prescribed the drug Haloperidol because I am thyrotoxic
— I do not wish to be treated by electro-convulsive therapy (ECT) because I become very distressed as a result of it
— I should like my sister, (name) to act as my nominated person under the Mental Health Act
— I agree that my sister (name) and my mother should be involved in assessing my needs and planning my treatment and care
— I should like my mother to be given sufficient information to enable her to care for me effectively but I do not wish any personal information about me to be shared with her
— I should like my cat to be looked after by (name)
— I should like my social security benefits to be cashed by (name)
— I am a vegetarian and wish to eat vegetarian food.”

2. The following was a letter in The Guardian on 12 March 2003:

“Communication breakdown

As someone admitted to hospital for occasional bouts of severe mental health problems, I have been in the invidious situation of being unable to communicate my needs.

“Having had bad experiences, I drew up an ‘advance directive’ with my psychiatrist (who thought that I was being obsessively over-cautious) to try to ensure I would receive the care I needed. Among other concerns, I requested that food be brought to my room, as, when ill, I am terrified of eating in public.

“This advance directive was mislaid three times by my psychiatrist, and each time I gave her another copy. When finally I was admitted to hospital, no food was brought to me, nor any attempt made to check I was eating. Consequently, I lost one and a half stone in a few weeks and fainted several times while being administered strong medication on an empty stomach. It was clear that my advance directive had never been consulted.

“I pursued a complaint with the chief executive of the NHS trust concerned and I’m now requesting an independent review. If my long and completely fruitless exchange of correspondence is anything to go by, I don’t hold out much hope of steps being taken to protect vulnerable patients.”

Memorandum from No Force Campaign (DMH 44)

The No Force Campaign was set up to provide a direct service user voice to express concerns about the Draft Mental Health Bill, without there being any conflicts of interest. All of our members have severe mental health problems, and are committed to ensuring, that our voices are heard, concerning the Draft Mental Health Bill. We believe that through our experiences of severe mental illness as well as mental health services, and being at the receiving end of mental health law, that our expertise, opinions and views should be recognised as being critically important, in helping to guide and direct, the development of mental health legislation fit for the 21st Century. To uphold our principle of providing a direct service user voice, and to respect the work we have done to provide you with our concerns about the Draft Mental Health Bill, we hope that you will read our evidence diligently, with reason and compassion, and provide us with the opportunity, to express the most important of our concerns, to you orally.
SUMMARY OF MAIN CONCERNS

1.1 A statement of principles should be put on the face of the Bill and should include protection of life, mental health and dignity, equality and respect, informal treatment wherever possible, non-discrimination, respect for diversity, care and treatment determined by the patient, least restrictive alternative, personal autonomy, reciprocity, patient participation and consensual care.

1.2 We believe that principles could not be upheld with a Bill that is so unbalanced in terms of favouring minimising risk with more compulsion, and disregards the protection and enhancement of basic human rights, and cannot offer adequate holistic mental health services to enable statutory enforceable care plans to meet the “real” needs of people with mental health problems. Our main concerns include the following:

— When a person is under compulsion and can be treated, without their consent whilst having capacity. We want a capacity test introduced.
— When compulsion in the community has been introduced through treatment orders.
— By a person not being entitled to the protection afforded by the Mental Capacity Bill, particularly by being able to determine their own care and treatment, when having capacity, and by being able to produce a legally enforceable Advance Directive/Statement.
— By the NHS not identifying people who are poor metabolisers of drugs, through gene testing, and therefore putting them at a serious risk of harm due to medical drug interventions.
— By enabling legally enforceable care plans, to be authorised, without ensuring a diverse range of holistic care and treatment options to be available to meet the “real” needs of people with severe mental health problems (see below).

2.1 The definition of “Mental Disorder” is too broad and ambiguous.

2.2 The conditions for compulsion are not sufficiently stringent.

2.3 We are strongly against the introduction of community treatment orders.

2.4 We strongly believe that any conditions for compulsion must include testing for capacity and provide therapeutic benefit.

3.1 There can be no balance when the Bill is so unnecessarily biased towards compulsion because of an un-realistic perception of violence.

3.2 No the Bill goes nowhere near enhancing and protecting our human rights.

3.3 We believe that the definition of mental disorder and the consequent conditions for compulsion are unnecessarily wide-ranging, and with the introduction of compulsory treatment in the community, no provision for capacity testing, no joined up thinking between the Draft Mental Health Bill and the Mental Capacity Bill, no opportunity for gene testing for “poor metaboliser” status, and lack of resources for implementation of therapeutic Care Plans, we see that the currently drafted mental health bill fails, quite dramatically, to achieve a balance between individual rights and personal or public safety concerns.

4.1 We believe the introduction of non-residents and compulsion in the community to be unnecessary, unworkable, not efficient, nor clear.

4.2 Omissions include not including capacity testing so that patients, not including important consent to treatment powers and safeguards, not interfacing the Mental Health Bill and the Mental Capacity Bill, not including the concept of “treatability” and not including gene tests to determine “poor metaboliser” status.

5.1 No the Mental Health Bill should be re-drafted. We believe there will not be enough resources, within Mental Health Services, to implement the care plans, particularly with the increasing number of people, from the current level, that will come under compulsion, if the Draft Mental Health Bill is introduced.

6.1 No the safeguards against abuse are not adequate.

6.2 However we very much welcome independent Mental Health Advocacy.

7.1 No the balance is not right the principles should go on the face of the Bill and the determination of supervisor should be in the Bill and not the regulations.

8.1 No the Draft Mental Health Bill is not integrated with the Mental Capacity Bill as it does not refer to the Mental Capacity Bill or to common law powers.

9.1 No the Draft Mental Health Bill is not in full compliance with the Human Rights Act, see above, and it must meet the requirements both of Human Rights legislation and the recommendations of the Council of Europe.

10.1 We believe that implementation of the Mental Health Bill, as it stands, would bring mental health service provision down onto its knees, in particular due to increases, that will be seen, in the number of people under compulsion, and the inability of the system to implement the care plans, which are additionally, not backed by adequate mental health services and resources.
10.2 Lack of resources will prevent what we believe to be mandatory, for the recovery of people with severe mental illnesses, and that is a mental health service provision shift, away from medical model dominance, towards a more balanced holistic model.

1. Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

1.1 No, the Government has not rooted the Draft Mental Health Bill in a set of unambiguous basic principles. We believe that the Government, in targeting people who may be a danger to the public, but do not have a conventional mental illness diagnosis, and who have not committed a crime, have produced legislation biased towards legislating for risk, and have therefore focused on compulsion to an unacceptable degree, and without appropriate safeguards to protect individual liberties. We know that the Government needs to re-evaluate the balance between the three fundamental elements of mental health legislation, which includes the provision of mental health services, strict criteria on compulsion and protection and enhancement of human rights. Any principles underpinning the Mental Health Bill are distorted by this unbalanced mental health legislation and will become even less apparent when putting the law into practice.

1.2 We believe that the scope and purpose of the mental health bill should be defined as far as is possible through a statement of principles on the face of the Bill. These principles should include protection of life, mental health and dignity, equality and respect, informal treatment wherever possible, non-discrimination, respect for diversity, care and treatment determined by the patient, least restrictive alternative, personal autonomy, reciprocity, patient participation and consensual care.

1.3 We consider that it is unacceptable for the Bill to allow that principles will have no universal application, but will be conditional in that they can be disapplied, wherever “inappropriate” or “impractical”; and will be excluded from applying to functions of the Secretary of State, in making certain regulations or directions.

1.4 We cannot see how the government can uphold any principles and values with integrity, towards individuals with mental health problems, within the mental health system and the public arena, particularly concerning stigma and discrimination, when the mental health legislation itself is un-balanced in favour of minimising risk with more compulsion, and disregards the protection and enhancement of basic human rights, and cannot offer adequate holistic mental health services to enable statutory enforceable care plans to meet the “real” needs of people with mental health problems. Our main concerns include the following:

- When a person is under compulsion and can be treated, without their consent whilst having capacity.
- When compulsion in the community has been introduced through treatment orders.
- By a person not being entitled to the protection afforded by the Mental Capacity Bill, particularly by being able to determine their own care and treatment, when having capacity, and by being able to produce a legally enforceable Advance Directive/Statement.
- By the NHS not identifying people who are poor metabolisers of drugs, through gene testing, and therefore putting them at a serious risk of harm due to medical drug interventions.
- By enabling legally enforceable care plans, to be authorised, without ensuring a diverse range of holistic care and treatment options to be available to meet the “real” needs of people with severe mental health problems (see below).

2. Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the Community adequate and sufficient?

2.1 No, the definition of “Mental Disorder” is too broad and ambiguous. The Bill does not provide that no one may be dealt with as mentally disordered by reason only of promiscuity, immoral conduct, sexual deviancy or dependence on alcohol or drugs. The definition of “medical treatment” is too broad, which includes education, and work and social skills training. The definition of “hospital” is too broad which includes a private house converted to provide training for people perhaps with a personality disorder, who are drug dependent, in work and social skills. The combination of the above allows conventional social intervention to be classed as “medical treatments” for mental disorder. We do not find it difficult to envisage the inappropriate use, however well meant, of mental health legislation for non-medical purposes of social control.

2.2 No, the conditions for compulsion are not sufficiently stringent. We are firmly against compulsion in the community and argue very strongly that if a person satisfies all the conditions for compulsion, which includes that they may be at risk to themselves or someone else, then they should be in a safe hospital setting, where they can have 24-hour monitoring, treatment and care. If they are not at risk to themselves or someone else, they should not be under any compulsory mental health legislation. We know, that if compulsion in the community remains in the bill, then many people with mental health problems will be at an increased risk of suicide, and many will succeed because of the lack of mental health service provision in the community.
Furthermore, the introduction of compulsion in the community will also increase the number of people becoming subject to compulsory treatment; will increase the risk of people being harmed by psychotropic drugs, as there will be minimal monitoring of users in their own homes; will increase the risk of people, who are “poor metabolisers” of psychotropic drugs, to severe adverse effects, toxicity and death, as it will be impossible for them to decide to reduce or withdraw from their medication, (one in 10 white Caucasians are born without the enzymes to breakdown medical drugs. One in 15 admissions to general hospitals are due to patients suffering from severe adverse events related to the drugs they are taking. Hospital deaths due to medical drugs are much higher in psychiatric hospitals due to patients not being able to stop their psychotropic medication and the government, DOH, the NHS and the Medicines and Healthcare products Regulatory Agency do not recognise these facts); will drive people away from seeking mental health services when they need it the most; will also lead to increased discrimination and stigma in the community and will effectively destroy the therapeutic relationship between the patient and the professional, which is understood to be crucial for recovery.

2.3 No, we firmly believe that any conditions for treatment and care under compulsion, must include a provision for capacity testing, so that if a person satisfies the conditions for compulsion, and they have capacity, then they have a right to determine what care and treatment they should receive, and any offered, must be with the full understanding and consent of the patient. We strongly believe that people with mental health problems should have the same rights as people with physical problems in being able to choose their own care and treatment, as far as is possible. The following is an example to show the huge disparity between the rights of people, with physical problems and mental health problems, to determine their own healthcare needs; a person is under a section in a hospital or at home, they have capacity, and they have leukaemia, they have the right to refuse chemotherapy, even though they will most probably die from the illness over the next few months. However, the same person, with capacity, and a mental illness diagnosis, cannot refuse, or even change, the psychotropic drugs, even if it is against their wishes, and even though their life is not in any danger.

2.4 There is no requirement for patients classed under the mental illness or severe mental impairment categories that such intervention will provide any therapeutic benefit, therefore such patients may therefore be initially detained solely for their protection or for the protection of others. We believe that in taking out “treatability” from the conditions, then the Bill becomes open, to being used as a means for social control, instead of solely for the treatment and care of people with mental health problems.

2.5 We also have grave concerns about many other conditions for compulsion within the Bill and believe them to be constitutionally inappropriate which includes: that a doctor may detain someone s/he believes requires assessment in the community; that who is authorised to detain an informal patient is not defined and left to regulations; that a single doctor may authorise a citizen’s compulsory admission and detention if the approved mental health professional accompanying her or him is not also of the opinion that detention is appropriate or that there is any urgent necessity for this; to use mental health legislation to allow constables to remove citizens, who are drug or alcohol dependent from their homes, without any need for a warrant; that the conditions for compulsion must be understood in the context of the very broad definitions of “mental disorder” and “medical treatment” referred to above; that the meaning of the word “lawfully” in Clause 9(5) needs to be clarified as does it mean or is it intended to mean that the person cannot be “sectioned” if s/he consents to informal treatment, or does it mean that an incapacitated person cannot be “sectioned” if s/he can be treated instead under the Mental Capacity Bill or the common law doctrine of necessity?; that provided a citizen meets the relevant conditions for compulsion, the Bill leaves to regulations the issue of whether s/he should be liable to be detained in a hospital; that the Bill provides that a citizen may be detained even though the medical evidence is evenly divided as to the need for detention; that in certain circumstances the Bill authorises the detention of a citizen to be founded upon a single medical opinion, and this an opinion that may conflict with the determinations previously made by three practitioners; that the conditions which may be imposed on a non—resident patient are not properly specified and can be determined by regulations.

3. Does the draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

3.1 No it does not (see 1 and 2 above). It is a myth and fabrication of the truth that people with severe mental health problems pose a very significant risk to the public in terms of being violent and dangerous. It is well known that the proportion of violence in society, attributable to mental illness, remains low and conversely the proportion of self-harm and suicide, attributable to mental illness, is extremely high. Violence has much more to do with education, upbringing, alcohol and drugs than mental illness. The Government in its haste to develop mental health law, which is based on the risk of violence by people with mental illnesses to the general public, have managed to create a Bill, which is seen by users of mental health services, as controlling and punitive, as opposed to enabling and therapeutic. The Government would be wise to remember that one in four of the general public will experience mental illness at some point in their lifetime, and we know, through our experiences of compulsion, that each person, within the general public, will then too experience the oppression, discrimination, stigma and the feelings of being completely out of control of; one’s own life, mental health care and treatment options, as well as being at the mercy of an under-resourced mental health system, as we do. Compulsion in hospital or coercion, in the community, is quite literally a
shocking experience, with or without ECT, and it is known that this experience causes trauma in a high percentage of people with mental illnesses. Even the language of mental health treatment is punitive, such as a patient who has not fulfilled their compulsory obligations has “gone AWOL” or they are put into “isolation or seclusion” or they are “restrained” for enforced drug treatment. We need enabling, transparent and therapeutic services with a language, and care and treatment, based on healing and hope.

3.2 No, we believe that the Government has not come anywhere near enhancing and protecting our human rights, those of people with severe mental illnesses, particularly with the following critical issues. We know that over time the following litigations will occur against the Government over breaches of our human rights particularly the following Articles in the Universal Declaration of Human Rights;

3.2.1 If the government does not put the principles, we have outlined, on the face of the Bill, so that they have to be enforced legally, then Article 1 (born free and equal with dignity and rights) and also, in particular, Article 7 (no discrimination on any grounds) will be breached, particularly when a patient is subject to compulsion.

3.2.2 If the government does not remove the concept of the non—residential patient, and compulsory treatment in the community, through treatment orders, then the Government will face litigations concerning breaches of Article 3 (the right to life, liberty and security of person). We believe that a person must be at risk of harming them self, or someone else, to satisfy the conditions of compulsion, and should therefore, be in a safe environment in hospital, and if the person does not satisfy these conditions then they should not be subject to any compulsion. Also if a person harms themselves or commits suicide whilst under compulsion in the community then we believe there will be a justified case for litigation; Article 5, (no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment). It is common knowledge that a significant proportion of patients have severe adverse reactions and toxic events, which may result in death, to many of the psychotrophic drugs. The risk of these events occurring and going unnoticed will be much higher, if the person is under compulsion in the community, as there will be minimal monitoring, due to lack of resources. When this occurs we believe that patients could litigate, particularly if the person is shown to be a “poor metaboliser” of medical drugs, through gene testing, which is not yet available in the NHS (we are currently working on raising awareness of this important issue), also the quality of life of many people on psychotropic drugs, long term, is severely compromised by this treatment, and in many cases the person will not be able to recover, and lastly Article 12 (right to privacy, family, home or correspondence), where just the concept of compulsory treatment in the community, and its unsubstantiated legal basis, in terms of people being able to meet all the conditions and then be “safe” at home, makes a mockery of any person’s rights to privacy, when the Bill states that the “non resident” will have to take drugs and attend places for treatment, or be under threat of hospitalisation, and allow mental health professionals to access their property. Not just the person under compulsion will lose their privacy, but so will any members of their family and household, and the person will also be open to probable further discrimination, stigma and potential harassment from neighbours and the community. Again this is not mental health care and treatment, it is punitive, with the analogy being that of criminals having to do community service, or being allowed home with a tag and monitoring device, and any breach means going to prison, when none of this is necessary.

3.2.3 If the government does not introduce capacity testing and therefore allowing a patient to be treated without their consent, whilst having full capacity to make their own decisions for their own care and treatment, then the following Articles will be breached; Articles 1, 2, 3, 5, 7, 18, 19 and 25 (Universal Declaration of Human Rights 1948). Significantly Article 5 (No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment) will continue to be breached when a patient is a “poor metaboliser” of drugs, and will be harmed by the drug intervention, and not be able to refuse or even change the drug they are being adminstered. We want compulsory treatment of patients, without their consent, whilst having capacity, to be removed from the Mental Health Bill and want capacity testing introduced, to determine whether a person is capable of making relevant decisions, with regards to their treatment, when under mental health legislation. If compulsory treatment of patients, without their consent, whilst having capacity, remains in the current Mental Health Bill, the repercussions of this will continue to be phenomenal, More explicitly: it can prevent them from trying to heal themselves in different ways to the medical model; or can prevent them from trying a different drug that may be beneficial to them; and it will prevent any person with a severe mental illness, and under a section, from benefiting from the Mental Capacity Bill, and in particular from being able to enforce an Advance Directive or have their treatment preferences in an Advance Statement even acknowledged. This section of mental health legislation makes a mockery of all that the Government says it is trying to achieve, in terms of reducing stigma and discrimination, through implementation of the NHS Plan, the National Service Framework for Mental Health and its more recent Social Inclusion Policy through the NIMHE.

3.2.4 If the Government does not interface the Mental Health Bill with the Mental Capacity Bill appropriately then we believe that we will again lose fundamental rights, that people with or without mental capacity, should be entitled to (as stated above). We believe that we should have the statutory right to be able to make our own care and treatment decisions concerning our own recovery from mental health problems and to be able to produce Advance Directives, which can specify what treatments that we do not want, and Advance Statements which can specify what treatments we would prefer to have, when subject to compulsion.
3.2.5 We believe that people who may be “poor metabolisers” of drugs should have a statutory right to a gene test, and if positive, be able to follow specialised treatment regimes that are therapeutic, rather than the conventional treatment regimes, that frequently result in severe adverse events, toxicity and death. The EC Convention on Human Rights and Biomedicine Article 4 on Professional standards states; that any intervention in the health field, including research, must be carried out in accordance with relevant professional obligations and standards. The Government, despite being given evidence on “poor metabolisers” of medical drugs, has still failed to take this on board and urgently needs to raise awareness of this within the NHS. People, who will be shown to be “poor metabolisers” of drugs (all medical drugs including psychotropic drugs) are right now, going through unnecessary suffering and harm, and are not able to get therapeutic benefit from the drugs they are taking. We believe the Government is opening itself up to future litigations of negligence, by not introducing gene testing within the NHS, to determine who are poor metabolisers of drugs. This applies to all patients within the NHS and not just patients subject to compulsion (see above 2.2).

3.2.6 We firmly believe that the Government must provide a Mental Health Service, which has the capacity to provide for the population of people with severe mental health problems, and that it be mandatory, that these resources are holistic, and therefore relevant, and specific, to their “real” needs, so that they can get therapeutic benefit, from the care and treatment on offer, and be able to choose their own individual paths to recovery. Until such a time, we believe that Article 25 (everyone has a right to medical care, which of course, must be healing) will continue to be breached, each time an individual has a Care Plan, which can be enforced legally, where drug treatment is the predominant, and in most cases the first line choice of treatment. We know that drug treatments alone do not “cure” people of mental illness, and many people including “poor metabolisers” of drugs may be harmed by any drug treatment, and that Mental Health Services are predominantly medical model based. People need to be able to access a holistic Mental Health Service, and be able to choose and determine their own path of recovery from severe mental illness, which may or may not include drug treatment. If the Government does not develop and produce a mental health service provision shift, away from medical model dominance, towards more holistic models, the repercussions of this will continue to be phenomenal. More explicitly: the medical model of mental health service provision will continue to dominate and this will continue to reduce peoples chances of recovery; people will not be able to recover fully, as at best the drugs can stabilise, but more commonly they repress recovery and cause debilitating side effects, which contributes to a very low quality of life; many people, particularly those who are poor metabolisers of drugs, will be at risk of an impoverished quality of life, toxic events and death; the population of people, with severe mental illnesses, in every locality, in the country, will continue to be made up of the same individuals, with more people joining them over time, as they are not being given the right resources to enable themselves to recover; and it will encourage, the already unholy alliances that have been made between mental health professionals and pharmaceutical companies, that threaten patient safety, with enforced drug interventions. At present, there are various litigations occurring against the large drug companies, and proof of falsified evidence from clinical trials, as well as huge abuses concerning conflicts of interests where, some psychiatrists and general practitioners are being asked to validate incomplete clinical research data, being “wined and dined” at conferences, even overseas and are being given sponsorship money, by drug company representatives. Drug companies are aware of the existence of “poor metabolisers” too and have withheld this information from the public arena. This makes a mockery of the Hippocratic Oath and the validity of psychotropic drugs being used to treat mental illnesses and puts people’s health and lives in danger.

3.3 We believe that the definition of mental disorder and the consequent conditions for compulsion are unnecessarily wide-ranging, and with the introduction of compulsory treatment in the community, no provision for capacity testing, no joined up thinking between the Draft Mental Health Bill and the Mental Capacity Bill, no opportunity for gene testing for “poor metaboliser” status, and lack of resources for implementation of therapeutic Care Plans, we see that the currently drafted Mental Health Bill fails, quite dramatically, to achieve a balance between individual rights and personal or public safety concerns.

4. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient, and clear? Are there any important omissions in the Bill?

4.1 We believe the introduction of non-residents and compulsion in the community to be unnecessary, unworkable, not efficient, nor clear.

4.2 Clinical supervisors must be qualified to assess if a person meets the conditions for compulsion in order to be able to keep under review if the conditions continue to be met. It is totally inappropriate that determination of clinical supervisor status be qualified in the regulations.

4.3 Compulsion should only be possible, other than in an emergency, if two doctors certify that the patient suffers from a mental disorder, satisfying the conditions.
Omissions

4.4 Not including capacity testing so that patients, who have capacity, can determine their own care and treatment regimes for their own, self determined recovery (could we ever envisage compulsory homeopathic treatment for example?)

4.5 Not including important consent to treatment powers and safeguards; such as abolition to consent to medication, removal of emergency treatment safeguards regarding psychiatric medication and allowing tribunal authorisation of “generic” care plans in the absence of consent.

4.6 Not interfacing the Mental Health Bill and the Mental Capacity Bill and in particular so that people can produce Advance Directives/Statements.

4.6 Not including the concept of “treatability”, or care and treatment being of benefit to the patient. We believe that all mental health care and treatment must be of therapeutic benefit for the patient and this should be reflected in conditions within the Draft Mental Health Bill.

4.7 Not enabling people to have a gene test to determine “poor metaboliser” status.

5. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft Bill?

5.1 No, the Mental Health Bill should be re-drafted.

5.2 No, it is totally inappropriate that any person can request for any one else to be examined and assessed.

5.3 No, there will not be enough resources, within Mental Health Services, to implement the care plans, particularly with the increasing number of people, from the current level, that will come under compulsion, if the Draft Mental Health Bill is introduced.

5.4 There are not enough Mental Health Professionals in the workforce, nor services, to implement the measures contained in the Bill.

6. Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

6.1 No, the safeguards against abuse are not adequate.

6.2 However, we welcome the right to independent advocacy and believe this to be an important advance in ensuring that our voice is heard and our rights protected. However we believe that independent advocacy is under-funded, and that more money will have to be directed towards advocacy posts, in order to ensure that all people with severe mental health problems, including in the community, can access a mental health advocate when needed.

6.3 We welcome, with some reservations, as mentioned above, the role and responsibility of the Mental Health Tribunal.

6.4 No, it is totally inappropriate that any person can request for any one else to be examined and assessed. This will lead to abuses and further stigma and discrimination of people with mental health problems.

6.5 The Bill abolishes the existing right of patients to an independent, binding, second-opinion concerning the appropriateness of the medication they are forced to take.

6.6 The broad definition of what constitutes a hospital leads to a correspondingly broad list of places where citizens may be held down and given medication by force.

6.7 It will be too easy in practice for consultants to by-pass the protective scheme set out for ECT.

6.8 There should be gene testing of people who may be poor metabolisers of psychotropic drugs and before they are given any further psychotropic drugs. These are people that appear to be very sensitive to drugs, and suffer from severe and adverse effects, and toxicity, and who will have inherited drug breakdown enzymes, which do not work. Failure to do this will result in professional malpractice in terms of a medical drug intervention causing a patient’s condition to deteriorate, causing acute pain and suffering and even death.

6.9 Many safeguards against the poor or inappropriate use of compulsion have been abolished as mentioned above. In addition the Bill: revokes the powers of a patient’s nearest relative; provides that the guidance in the Code of Practice may be qualified; abolishes the statutory duty to provide long-term after-care; revokes the discharge powers of NHS bodies and local authorities; may endanger professional independence; does not provide for an independent, standalone, Mental Health Commission.
6.10 Tribunals should continue to have a discretionary power to discharge people from compulsion. The Bill should provide that a Tribunal must release a citizen from detention unless it is satisfied that clear grounds, which Parliament has determined, justify depriving a citizen of her or his liberty are met. It is a matter of concern that a tribunal may authorise a person’s further detention for up to eight weeks when it has just determined that s/he does not satisfy the relevant conditions for compulsion.

6.11 A patient’s spouse or partner should retain their existing power to object reasonably to admission to hospital.

6.12 It should be clear from the legislation, that a care plan presented to a Tribunal would include the statement, that identified treatments will only be given with the patient’s consent (subject to an emergency treatment clause).

6.13 Mental Health Practitioners, that are co-ordinating the care and treatment of patients, should not be to put into the role of “policing” community treatment orders, nor be involved in any part of the assessment and sectioning process, as this will destroy any therapeutic relationship with their client.

6.14 People with mental health problems are fully aware that the Government, in the Draft Mental Health Bill, has given far more, and far reaching, and unnecessary, powers to groups of mental health professionals, then ever before, and rather than enhancing and protecting our rights, they have even removed some. This is totally unethical.

7. Is the balance struck between what has been included on the face of the draft Bill, and what goes into Regulations and the Code of Practices right?

7.1 No the balance is not right and some of these issues have been covered already above.

7.2 The principles should go onto the face of the Bill.

7.3 Some important regulations, like who has the power to assess and compel a person to compulsory treatment, should be specified in the face of the Bill.

8. Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

8.1 No as the Bill does not refer to the Mental Capacity Bill or to common law powers.

8.2 Users of mental health services believe they too have a fundamental right to be able to benefit from the new Mental Capacity Bill, in terms of being able to produce Advance Directives/Statements. As it stands at the moment, the Mental Health Bill will trump the Mental Capacity Bill and bar any user of mental health services, who is under compulsion, from being able to utilise key parts of the new legislation. This would be a travesty.

8.3 The rights, and safeguards, should be the same for people under the Mental Capacity and the Mental Health Bills.

9. Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

9.1 No the Draft Mental Health Bill is not in full compliance with the Human Rights Act and the issues have been covered already, above.

9.2 The Mental Health Act for England and Wales must meet the requirements both of Human Rights legislation and the recommendations of the Council of Europe.

10. What are likely to be the human and financial resource implications of the draft bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

10.1 We believe the human and financial resource implications of the draft bill will be much higher than the Government and society can afford.

10.2 We believe that implementation of the Mental Health Bill, as it stands, would bring mental health service provision down onto its knees, in particular due to increases, that will be seen, in the number of people under compulsion, and the inability of the system to implement the care plans, which are additionally, not backed by adequate mental health services and resources.

10.3 We believe community treatment orders should never become a part of mental health law and that the money saved would be better invested, in developing a Mental Health Services that is fit for the 21st Century.

10.4 The Bill will take much needed money away from developing therapeutic mental health services and will result in more people remaining and becoming severely mentally ill. Lack of resources will prevent what we believe to be mandatory, for the recovery of people with severe mental illnesses, and that is a mental health service provision shift, away from medical model dominance, towards a more balanced holistic
model. Holistic mental health resources need to be available throughout the NHS, within primary and secondary care, and most importantly within the community as well as in the hospitals. This would vastly reduce the burden of suffering and the financial cost to society, as the service would enable prevention, reduce re-admissions, and promote long term recovery. Mental Health problems are caused by genetic predisposition as well as stress. Stress from the mind will affect brain biochemistry, which in turn will affect the mind. Stress can be caused externally, for example, difficulties related to money, homelessness, work and relationships. Stress can also be generated within the mind, due to adverse life experiences, causing conflicts, confusion and traumas. To become mentally well these stressors need to be minimised through practical support for environmental stresses, talking therapies for internal stresses and a combination of treatments such as medical drugs, homeopathy, nutrition and massage, for overall mind and body healing, as well as well as enabling (not controlling) care and support structures, to promote self confidence, self esteem, to enable nurturing relationships to be developed and to facilitate meaningful occupation. It is mandatory that a person is given all the tools to enable their recovery such as being able to understand mental illness, the effects of stress and coping strategies and being able to choose a holistic treatment that supports their own individual needs, of which drug treatment, may or may not be, one of them.

10.5 Further research is required to assess the realistic likely impact of the proposals, on people who use the service, in terms of therapeutic benefit, and the workforce, in relation to numbers, recruitment, morale and to the types of services available. However it would be more prudent to carry out this research from a set of proposals, whose starting point, is one that keeps compulsion to a minimum, that protects and enhances human rights and provides for a holistic mental health service, which is delivered in an ethical manner.

October 2004

Witnesses: Mr Richard Brook, Chief Executive Officer, Mind, Ms Kay Sheldon, representative of Mindlink, Mind’s service user network, Ms Lindsay Foyster, Director, Mind Cymru, Dr Anneke Westra and Mr Roger Keeling, No Force, examined.

Q209 Chairman: Good morning and thank you very much for making the time to come and give evidence to the Committee. These are quite short sessions and the aim is for there to be an exchange of questions and answers rather than statements to be made. So I hope that you will be content not to make opening statements, because we have only an hour at the most for this session. I will ask you very briefly to introduce yourselves in a moment, but can I remind you that this is a public evidence session and that everything that is said will be recorded. You will be sent a copy of the Hansard that is prepared as a result of the meeting and you will be free to make small textual corrections, but not to alter the substance. Could I ask you to introduce yourselves, please? Could we start with you, Mr Keeling?

Mr Keeling: My name is Roger Keeling. I am a user of mental health services and I am a founder member of No Force, which is a network of users of mental health services set up to protest against the Draft Mental Health Bill.

Q210 Chairman: I should say that we are grateful to all of you particularly for your written submissions, which have led to your being asked to come here today. Dr Westra?

Dr Westra: My name is Dr Anneke Westra. I am a lifetime user of mental health services and I have also co-founded the No Force campaign, which is to provide a direct user voice regarding certain concerns about the Draft Mental Health Bill. Could I quickly say one thing? On behalf of all users of the No Force campaign, I would like to thank you for inviting us to give oral evidence to you today—particularly as, since 1748 when the first user group, the Lunatic Friends Society, was established, this is the first time that people with severe mental health needs have been able to express ourselves directly to Parliament.

Q211 Chairman: That is very good news. Thank you for that. Mr Brook?

Mr Brook: I am the Chief Executive of Mind. My name is Richard Brook. I am afraid that we only go back to 1946.

Q212 Chairman: Not 1748!

Mr Brook: No, I am afraid not. Mind is a mental health charity, as I think you are aware.

Ms Foyster: I am Lindsay Foyster and I am the Director of Mind Cymru, which is Mind’s presence in Wales.

Ms Sheldon: I am Kay Sheldon. I am a user of mental health services and I have direct personal experience of being detained under the current Mental Health Act. I am also co-chair of Mindlink, which is the service user network of national Mind.

Q213 Chairman: Can I remind each of you that there are a number of middle-aged men on this Committee, all of whom are challenged in their hearing. So, despite the existence of the microphones, can I ask you all to speak up, please, because it makes a huge difference to us. This question is mainly directed at Mind, though we would obviously be interested in the views of the service users. Mind have submitted that a set of guiding principles should include a requirement that treatment and care should be provided in the least restrictive and least invasive manner compatible with ensuring the health and safety of other people. Can you give examples of where you think the balance between the least restrictive alternative and
safety for the public needs clearer guidance, and also perhaps you might tell us where you think it operates badly now and how it could be improved?

Mr Brook: I am happy to start, if that is okay. I think that the question is interesting, because it starts with an assumption that people with mental health problems potentially may be dangerous or may be significantly more dangerous than any other group or part of our community. If you look at our evidence, you will see that we submit evidence which says clearly that that is a very questionable assumption. Moving on from that, when I became Chief Executive of Mind three and a half years ago, one of the major positions in mental health policy at the time was that we needed good policy, good practice and good legislation. In a sense, we have seen some good policy come through. The issue around practice—which we will come back to in a minute—is a real issue. Legislation was, if you like, the third leg of that stool. In terms specifically of your question, you do not have to go much further than the many inquiries that occur after tragic events happen in mental health services: the statutory inquiries where, sadly, you see people harming other people. When you look at the results of those inquiries, I think that you will find that it is not about the powers of the current legislation being deficient; it is about the failure to provide a good service to people in those situations. The sorts of things you see are administrative failures, lack of care planning, lack of talking between different parts of the service—all the things that some of us are very familiar with, not only in mental health services but also in social care generally. The suggestion is that somehow we can get this better by amending the legislation. In terms of the question how it can be improved, what we need to see, particularly in this Act, is a much better assumption that, when people come and seek help, they will get help—even if they do not require compulsory treatment. One of the things I know you have already heard about is the issue in the draft Bill of the responsibilities in terms of what you do under the assessment process, but no requirement to do anything if people do not meet the grounds for compulsion. So something about better services; better administration of services particularly around assessment; something about better understanding of what happens to people as they move in and out of mental health services; something about better risk assessment guidance; moving away from this idea of discrimination, particularly trying to promote a concept of reducing stigma in society; and also a more realistic understanding of the risks of mental health compared with other risks. We have to remember that drink and dangerous driving is more dangerous in some senses than mental health. The whole point of this is that we create a situation in considering mental health where we perceive risk as much higher than it is. That is not to diminish the fact that sometimes there is risk and we need good services to deal with that. You also asked about the least invasive treatments. Again, there is a slight misconception there in the sense that we often see that as ECT or psycho-surgery. Actually medication is an invasive treatment, and forms of care can also be invasive. I know that Kay may want to say a little more from her experience about how she sees that as invasive. Lastly, you ask how it can be improved. One of the real concerns for many mental health charities, especially for Mind, has been a lack of any understanding of some of the other things related to what will happen with this legislation, particularly around the code of practice. Some of you may be aware that Mind is challenging the current code of practice. We are party to proceedings in the House of Lords. Interestingly, the Court of Appeal determined that the current code of practice should be adhered to more strictly than Ashworth Special Hospital was adhering to it, and should be the driving principles behind it. It is very interesting that Ashworth have appealed that decision, without the Government intervening to stop it. One of the real concerns at Mind, therefore, is that a lot of the things we are being asked to take on trust here about some of the things that will happen are not there for people to see. For service users in particular, the mental health system is a very scary system. Engaging that, where compulsion might be used without an understanding of the issues via the code of practice, is a real issue.

Q214 Chairman: Can I ask Mr Keeling and Dr Westra if they would like to say anything about the balance between invasiveness and the need for compulsion in certain cases?

Dr Westra: No Force believes that compulsion should only ever be given when someone is at risk of harm to themselves or others. Under those circumstances, we believe that the least restrictive procedures should still come into play. If that person has capacity, they should still be able to determine what care and treatment they need. If the person does not have capacity, they should be able to determine it through advance directives and statements.

Q215 Lord Rix: My flatfooted question is addressed to Richard Brook. It seems to me that the answers to the questions and your submission indicate that you dislike literally every aspect of this Bill. At a seminar I chaired yesterday at the Royal Society of Medicine for the Intellectual Forum on Learning Disability, which was about capacity, consent and advocacy—and the participants were mainly psychiatrists, clinical psychologists, social workers, advocates, et cetera—they seemed to echo your sentiments totally. However, they sang the praises of the Mental Capacity Bill, or rather its aims and objectives, but they also sang the praises of the Scottish Mental Health Act, which they claimed was about mental health, whereas this Bill is about detention rather than about mental health. Would you care to comment on that?

Mr Brook: I would, although my colleagues may also want to comment. I think that you are right. There are some good things in this Bill. If you look at our submission, although it is quite hard to find
Chairman: It might be helpful if we slightly broadened this and then had more of a discourse, and perhaps Ms Munn could put a question that she has in mind.

Q216 Ms Munn: Dr Westra has already said very clearly what No Force’s view is around issues of compulsion. Perhaps I can ask the representatives from Mind, given that you admit that there is a role for compulsion in treating those with mental disorders, how would you like to see a Bill ensure that it is only given in what you consider to be appropriate cases?

Mr Brook: The experience of being under compulsion is probably one of the most traumatic experiences you can experience in the UK inside the healthcare system. Your rights are taken away; your ability to be yourself. So our view is that it should only be as a last measure. In our submission to you we explain that, whilst we have some concerns about the definition, particularly around what are called the “exceptions”—alcohol and drugs—we broadly could accept the current definition as proposed in the Bill, but only if the conditions for compulsion are significantly tightened. We set those out in our submission. They are around a test of capacity or impaired judgment. It is about therapeutic benefit, and the patient being much clearer than the current suggestion of appropriateness. We are unhappy about the higher threshold for people who are a danger to others: this idea of protection against significant risk, which I think you have already heard evidence on. We also believe—and do remember this is what Mind is saying—that there should be more power given back to professionals, which is quite an unusual position for us to be taking, in determining how people are treated within the system. We think that there is a lack of discretion in this new Bill which means that people will be driven to make certain decisions, contrary to where we are. I do not know if Lindsay or Kay want to add to that?

Ms Sheldon: I would just reiterate how frightening it is to be sectioned, and how that can have such a lasting impact on your life.

Q217 Baroness McIntosh of Hudnall: I would like to follow that up, if I may, and to ask Ms Sheldon about her experience of being sectioned under the present Act and what she perceives to be the potentially greater risk that would pertain to her, or people like her, if the Bill that is before us now were to become an Act. Also, what additional level of anxiety—which we are very conscious has been expressed to us by a number of people—is present in people such as yourself. Ms Sheldon, who might become, I was going to say “victims”—but whatever is the appropriate word—of the powers that this Bill brings forward?

Ms Sheldon: I have been sectioned a number of times and certainly have been seen as a non-compliant, revolving-door patient; but, from my perspective, the problem was not with me but it was with the services not listening to what I was saying my needs were and also not providing the services that they said they would. I cannot see that would change under the new Bill. The new Bill frightens me even more, simply because of the proposed Community Treatment Orders. I have no doubt that I would have been put on a community treatment order if they had been available under the new Act, and I would be very afraid of the services. I would not trust them. I would basically do all I could to disengage. I would also be very concerned about the impact it would have on my family. I am married and I have two children. To feel that my husband had the added pressure to have to police me would be quite worrying.

Dr Westra: With the No Force campaign, a lot of users put forward their concerns. They said, “What we are saying is we understand that mental health legislation guides policy development, which in turn guides its implementation in everyday practice, which then finally impacts upon people with severe mental health needs who are receiving care and treatment”. Many users of services feel oppressed and abused by the manner in which they are treated within mental health services and find the system to be controlling, paternalistic, punitive and detrimental to their well-being and quality of life. They say they feel that they are being treated as subhumans, where psychiatric symptoms are dealt with and severe adverse reactions and mental distress ignored. Many describe the experience as like being in prison, where they feel trapped and have no choice on what care and treatment they would like in order to recover, even as a voluntary patient and in the community. All the users I have ever talked to over the last six or seven years particularly do not agree with compulsion in the community and, to be honest, they are literally terrified of it. In Russia in the mid-20th century, political dissidents were incarcerated in psychiatric hospitals and forced to take psychotropic drugs. In the early 21st century, this Government proposes to coerce people into taking psychotropic drugs in their own homes, through fear of detention. We see no difference in these examples, in terms of the Government using psychotropic drugs either in hospital or at home as a means of social control.
Q218 Chairman: Would not some people rather be at home taking drugs than detained in a hospital?
Dr Westra: What we firmly say is that compulsion should be used as a very last resort and only if a person is a serious danger to harm themselves or someone else, and then they must be in hospital. If they are in the community under compulsion and are at severe risk of harm to themselves or others, they may commit suicide or, even worse, perhaps a homicide. Remember, however, that thousands and thousands more people with mental health problems may commit suicide rather than be a danger to someone else. As we know, it is mythical that people with severe mental health problems contribute a lot of violence to the society.
Chairman: This was Mr Brook’s point earlier.

Q219 Mr Prosser: I can well understand the fear that, by concentrating on the compulsion issue, it tends to cloud the whole subject. I take the point of the iceberg very clearly. Purely from a practical point of view, however, how in a Bill do we deal with a patient who has capacity and whose ability to make decisions is not impaired, but who is clearly seriously mentally ill and clearly a danger to his or herself, let alone to other people? It is one thing to say it must be a last resort. I think that we would all agree with that as a phrase, but how can the Bill remedy that?
Mr Brook: The issue there is the Bill can remedy that by ensuring that it is much clearer about the small number of cases where that would be required to happen. Our argument is not about the fact that sometimes compulsion may be needed. This is an argument that has raged long and wide in Mind over many years. Ultimately, our position has been that compulsion may be needed but, at the moment, many more people than even 10 years ago are receiving compulsory treatment. I do not think the world has got that much madder in the last ten years, and I do not think it is going to get that much madder in the next 10 years. The difficulty we have is that legislation and the nature of the definitions and conditions in the legislation will drive people’s situations. One of the things that really concerns us is something which is called defensive practice. If you put an onus on to people who are genuinely trying to engage in a healthcare model to protect the public, they are very frightened of the newspaper headlines on the Monday morning. I am sure that you have already heard evidence about this and you will continue to hear evidence. We are creating a system where people feel more concerned about what might happen, how it might happen, and how they might be seen as players in that, rather than addressing the real concerns of users of the service, such as you heard from Anneke and Ken this morning. Our real problem is that we are creating a system where people have to respond in a certain way, rather than respond in a way driven by the sorts of criteria you are setting out.

Q220 Mr Howarth: Could I probe Dr Westra’s point? I think she conceded that there are some cases where, either for the protection of the person who is displaying symptoms themselves or the public, certain actions are regrettably necessary. I want to explore where the boundaries of that might be. I suppose there will be some cases where physical harm is potentially present, either to the person themselves or to some member of the public. What about in a case where somebody, through compulsive behaviour, is harassing some other person? Would you think that was a protection issue, or is that something that should be dealt with by some other means?
Dr Westra: I think the harassment issue is—

Q221 Mr Howarth: I mean extreme harassment.
Dr Westra: I think that with extreme harassment, a bit like with violence, you get groups of people in all societies who are violent. You get more violence from drunken adolescents, spurned spouses, and bad drivers than you do from people with mental health problems. So we should be looking—

Q222 Chairman: Forgive me for interrupting, Dr Westra. Mr Howarth has asked you a very significant question, in my view, and I just want, for the benefit of the Committee, to refer it to the Bill. Under clause 9(4) of the Bill, one of the conditions necessary before somebody can be compulsorily detained under the provisions is “for the protection of other persons”, and it is stated in those terms. Those are the words. Somebody who is being harassed might be suffering quite severe psychological damage, even if the harassment is being done at a distance, for example through persistent text messages or emails. There is plenty of evidence of that kind of thing. From your viewpoint, is it defensible at all that people should be detained in circumstances like that under a Mental Health Act?
Dr Westra: I think our position would be to say no, but there need to be other mechanisms put in place to deal with that situation.

Q223 Chairman: Can you help us a little further towards those other mechanisms, bearing in mind that there are civil procedures, for example for harassment, which can be used and which sometimes result in people being committed to prison for contempt of court?
Dr Westra: One would envisage using perhaps a civil procedure and then the person being diverted into the mental health system. Also, if there were holistic mental health services in the community, with the appropriate care and treatment options for people, which they could access at the earliest possible stage, I believe that would decrease the numbers of people who may end up very disturbed and harass other people. I would quickly like to point out that there are statistics that people with severe mental health problems are abused and harassed much more than the general public are by them. So we need the protection.
Q224 Chairman: Would that be the same in Wales, for example, Ms Foyster?
Ms Foyster: Our view is that it is much better to engage with people and to draw them into providing appropriate services that will meet their needs, and that we do not go down the line of just overly protecting the public. Certainly in Wales, policy does not take that as its primary focus. It looks at the mental health needs of people as its primary focus, and we would want to see legislation that is compatible with that, quite clearly. Where we have been talking about the threshold for people who are at risk to others, we would want to move from that low threshold of protection of another person—which is very broad—to look at having a threshold that is around significant risk of harm, which makes that clearer.

Chairman: Mr Howarth, do you want to come back on your harassment point?

Q225 Mr Howarth: To be honest, I am not entirely clear as to where we stand on this. It has just been said that the whole thing needs to be dealt with at an earlier stage. I am sure we would all agree with that. The fact is though that some people will arrive at a place where they compulsively believe that they have a right, by whatever means—whether it is through texts, whether it is through physical presence—to impress their view of somebody on them. In those circumstances that can become intolerable. Yet you do not seem to believe that there can be any solution to that problem, other than potentially through civil action.

Ms Foyster: We are saying that criminal law is there for such cases, if people meet those criteria.

Q226 Laura Moffatt: I am very interested in what is being said here and I was originally going to talk about the difference between trying to struggle with the issue of capacity and, if we had a capacity-based Bill, would that cure things or would it make for more difficulty. But this last bit of evidence has been interesting me most sincerely, I have to say, because I was the victim of someone who was deeply unwell.

To my great sadness, at the end of it—I was not thinking about service users would feel less stigmatised by?

Mr Brook: That is absolutely right. Perhaps the thing that needs to be focused on here is the difference between the mental health problem and the criminal activity or civil activity. One of the questions you have to ask is when should mental health legislation override all our responsibilities as normal human beings to behave in normal, appropriate ways in society. The problem for us is that we think that threshold in the proposed Bill, under this issue of protection, is too low—in the sense that if somebody is doing the sort of harassment that Mr Howarth referred to, there are criminal ways of dealing with that. As they go through the criminal process, if there is a determination that they have a severe mental health problem, then there is remedy through that criminal process or harassment legislation. The issue is that you have to get that level higher for people with mental health problems. In terms of what you are saying in relation to the sorts of services, I do not see that as a legislative issue; that is a service issue about the right sorts of services for people to be helped. The majority of people in those situations—obviously I do not know your exact personal circumstances—want help. That is where we lose track of that so much.

Laura Moffatt: Sadly in this case not. It would be a mistake to assume that there were not services available for this young man, because that was not true.

Q227 Mr Howarth: Do you believe the police and the Crown Prosecution Service, or whatever, are better equipped to make a judgment in a case like that than mental health professionals?

Mr Brook: I think that mental health professionals can make an assessment on that basis. What we are arguing in terms of the debate this morning is that the threshold is too low to allow people to enter the mental health service under compulsion. We are not saying it is an either-or situation. It could be both situations. But the difficulty is, if you use the protection—

Mr Howarth: I think that we were saying it is an either/or situation.

Q228 Chairman: Can I intervene and ask you what I think may be a helpful question? I would like a snap answer to this, if you can give it. It is rather like the question, “What is the most important thing in your life?” where a snap answer might be very revealing. If you were faced with the choice between Mental Health Act detention and being imprisoned under civil procedures for contempt of court, which do you think service users would feel less stigmatised by?

Dr Westra: Prison.

Ms Sheldon: I am also a Mental Health Act commissioner and I have heard service users say that they wished they were able to serve their prison sentence rather than being sectioned.

Dr Westra: I know as a user, and talking to other users, that the mental health system really feels very oppressive, controlling, paternalistic, and we have no freedom to choose our own care and treatment—even though we are, like all of you here, completely with capacity. We are being told what to do and not able to choose for ourselves what we want in terms of care and treatment. So it is very much like being cornered and totally oppressed, and coercion blocks therapeutic intervention. You need to be enabled to carry out your own treatment decisions, to try to make yourself recover from mental ill health.

Chairman: Ms Munn, and then I will ask Dr Stoate to broaden the discussion a little further.
Ms Munn: Where I am struggling with this discussion is with issues around people involved in criminal activity, not because they have any intent to be involved in criminal activity but, because of their situation, they are doing something which they perceive in a completely different way. Perhaps I can give an example. Many years ago when I was a social work student, and mental health was not a speciality I dealt with a great deal subsequently, I was working with a young man who was at that point compulsorily detained but had, prior to being detained, been arrested for jumping on somebody’s car—because of some belief that he had which related to that. I went with him and he went through a court procedure and was convicted of this offence. It felt completely wrong to me that he should be convicted of an offence when he had not set out to engage in criminal activity. The beliefs he had, because of his illness, led him to do this. I could not see that that was right. My question is, if people are behaving in a way which is criminal in terms of our laws but they are doing it because of their illness, what should our response as a society be? What should we do to be? What should our legislation have in place to deal with that situation? That is the crux of the matter. Again, it is not about somebody being harmed. There was not a risk to him; there was not a risk to anybody else; but it was criminal activity.

Q229 Chairman: A fundamental question, Dr Westra.
Dr Westra: When you look at that situation, you have to look at the other side of the coin. The other side of the coin is, if you were that person, if you were a user of mental health services, if you had a mental illness, and you realised that if you became ill and your behaviour became . . . Users of mental health services are terrified of compulsion. They are terrified of being in hospital. They are terrified of drugs. They are terrified of ECT, and they are terrified of the way they are treated so dreadfully by the system, because they are looked at in terms of symptoms of their mental illness, which are then treated with drugs. They are not looked at as a person. You do not, in hospital, get to talk about why you have become ill, why you are distressed. You do not get support on how to alleviate those problems. So people with a mental illness are terrified if they see that the threshold for compulsion can get so low that their behaviour—

Q230 Ms Munn: I am not decrying any of what you say. I am trying to get to what, in an ideal world, should happen to a person in the circumstances I described?
Mr Brook: My view is quite clear: that person should enter the criminal system, because they have committed a criminal act. The issue is the way that is resolved. It seems to me that, possibly in the situation you had, the disposal and the nature of that disposal was inappropriate for that person. However, there are some assumptions if you go down the mental health route. First of all, you are making assumptions of guilt. Clearly, in your case of someone who is jumping on a car, there is no doubt about that. But often people need to be clear what things have or have not happened. I am not sure that the mental health system is set up to determine whether people have committed the offences that people sometimes think they have. There is a whole issue around that type of concept. Secondly, there is a responsibility issue. We cannot have it both ways. If there is a capacity issue in terms of mental health, there is also a capacity issue in taking responsibility for people’s actions. I think that service users accept and understand that, and perhaps sometimes feel more strongly about that than some of us who are not suffering from mental ill health. I think that is the reason why they say things about—

Q231 Chairman: Here we have a conceptual issue about the whole of the criminal justice system, have we not?
Mr Brook: Absolutely.
Chairman: If people are saying they would rather be convicted of a criminal act than be compelled under the mental health provisions, then you are envisaging that people can be convicted of a crime which they do not perceive to be a crime and which they do not intend to commit. To the lawyers around this table that is a somewhat alien concept.
Ms Munn: Or even to the non-lawyers.

Q232 Dr Naysmith: It also carries the implication that you are being treated better under the criminal justice system, and I do not think that is true at the moment—or do you?
Dr Westra: Can I give you one example? When someone is under a compulsory section, we do ward forums every month on all the wards of the local psychiatric hospital. The biggest thing that patients say continually—there are two things. One is that they get nervous about being told to go home on leave because they know they are about to lose their bed, and they are not well enough to go home. Secondly, the biggest thing is that they do not get fresh air. In prison, you can get fresh air every day. Under a section, people can quite easily spend two or three weeks without being able to get one nurse to take them out of the building to get fresh air. The treatments, drug interventions, are so invasive and intrusive, particularly for people who cannot break the drugs down, that it feels like torture; and it is not heard. No one listens to them. Being in a psychiatric hospital is not what people imagine it to be. It is very oppressive and quite torturous at times.
Dr Naysmith: I think that a lot of people have heard what you have had to say today.
Chairman: Can we broaden it a little now?
Dr Stoate?
Mr Brook: This is such an important and crucial part of the Bill. I just want to test it to destruction, using your framework about exactly what the Bill can and cannot do. A friend of mine was a victim of De Clerambault’s syndrome, and many of you will know what that is. It is where a person with mental health problems has a very firm delusion that they...
are deeply in love, usually with their nurse, their doctor or their psychologist. In this case it was a psychologist. This person was hounded for two years by the patient, who stood on the doorstep every single day, spending all day outside their house, following them in the car, and absolutely harassed this person, almost to the destruction of his marriage and his life. The question remains, and it has not really been answered yet, is that grounds for compelling somebody to be in hospital or is it a police matter? The police would say that the person has not been physically threatened; there is no actual criminal act in being in love with somebody. So the police really could not do much, and the civil law was very wanting on the issue. Clearly the person had a mental health problem. We have not tested to destruction whether that is grounds for compulsion or not—because that, to me, is the heart of the Bill.

Chairman: If we were the Home Affairs Committee of the House of Commons we would probably have an array of service users in front of us, saying that prisons are the worst places in the known world, where you get absolutely no help whatsoever and all you get is 20 minutes’ fresh air in an enclosed yard every day. Your very telling evidence has made the hair on the back of our necks tingle a little bit, because of some conceptual issues that have been raised. I think that is the point you are making, is it not?

Dr Stoate: It is, and the fact that we keep hearing that 25% of prisoners have significant mental health problems which are pretty much largely ignored. I think that with this particular person, had they been simply put in prison for harassment, it would not have even begun to address the problem.

Q234 Chairman: I would like to ask Mr Keeling, because I know that he has been trying to get in as well. Would you like to make some comments on this discussion?

Mr Keeling: There is a sort of myth that violence is associated with mental illness. If you look at the population, there is a certain number of people who are violent and some of those people, 20 or 25% of them, will suffer from mental illness, and some people who are mentally ill will be violent; but if you concentrate on that intersection of mentally ill people who are violent, then you are not dealing properly with the problem of violence in society and you are not dealing properly with the problem of mental illness in society. This Act, the Mental Health Act, should be split into two Acts, in my opinion. There should be a sort of social control Act for controlling dangerous people, and there should be a Mental Health Act which would be mental health. It would be about providing a therapeutic environment. You cannot have a therapeutic environment where the function of the staff is to detain you and to compulsorily medicate you. When I have been in mental hospital, I cannot talk truthfully to people because what I need to do is to make sure that I am not punished, by having the various nasty things thrown at me. This Mental Health Act could be very good, as long as the compulsion elements are either taken away or contained. There is a capacity Bill which says that if people have capacity they can make their own decisions. Somebody with capacity should always be able to refuse medical treatment but, under the Mental Health Act, they cannot. It overrides the capacity Bill.

Q235 Tim Loughton: This clearly goes to the nub of the whole issue of this Bill, and some of the practical examples that colleagues have brought up are interesting. In the United States, if you commit a traffic offence, for dangerous driving or speeding usually, you are often given the option: either you are fined or maybe go to gaol, depending on the severity of the offence, or you can go to a driving retraining class for however many weeks it may take. Could the same sort of principle be applied to some of the examples we have heard here, whereby somebody who was harassing in some way—which could be construed as being a result of mental disorder—could be offered the option either that they will be prosecuted under the legal system or they will have to face up to the fact that they may have a mental health problem and be subject to assessment for that and, if appropriate, would then...
have to go on to some form of treatment? They would retain the option. This would not be compulsion at that stage. If they refused to do that and had the capacity to refuse it, then it becomes a criminal matter and would be prosecuted in that way. Could we set up some sort of mechanism where you get that division between where it is legally prosecutable or somebody being able to opt in, taking ownership of their mental health problem, and then getting treatment, as a substitute? Or is that too simplistic?

**Mr Brook:** Yes and no. I will give you a very straightforward answer, because it is the whole issue that we are talking about. One of the things we have to do is get the assessment process right. This comes back to the concept that when you assess someone for a mental health problem you have a responsibility to deal with them, even if they are not in need of compulsion. That would start to address some of these long-term issues because, in a sense, people move away from that situation. In the case that Dr Stoate described, to me, two years of that sort of harassment does move into the significant risk issue. It is not significant physically, but it is significant risk to the whole person. If someone is banging on my door every morning for two years, I think that would make me feel rather unwell. I think that the law does have an intervention role at that point. What you have to get right—and you are absolutely right—is at what threshold do you set it? The argument we are making today is that the threshold as it is legislatively set out at the moment is too low. If someone has too much to drink in the pub tomorrow night and picks up his car keys, there is no compulsion to remove those car keys from that person. They go off and do what they want—which could be a real tragedy. It seems to me that, if we cannot do that in relation to people who drink too much, what are we doing in terms of people with mental health problems at that same threshold? It has to be a significant threshold. There are implications if you drink and drive. We all know about those. There should be implications if you have a mental health problem and you do certain things: that is where you get into possible detention or possible criminal activity. But we have to get that gap between protection and significant risk much clearer. If you are a psychiatrist on a Friday night, with someone in a situation which is not at significant risk but one of protection, you are likely to detain them—even if they did not need to be detained—with the consequences that my colleagues have talked about.

**Dr Stoate:** That is my point. Provided we get all these things right, you will be happy with the principle?

**Mr Brook:** Yes, we have accepted that. It is in our submission.

**Hywel Williams:** I was struck by the choice between being mad or bad, and everyone choosing “bad”, as it were. Is that your philosophical position or is it because of your critique of the mental health services as they are now? Clearly you have very well worked-out reservations about the system as it is.

**Ms Foyster:** It is about hearing what service users have to say. It is taking direct evidence from people, and recognising the stigma that is attached and the experience that people have. They come away from experiences of detention very frightened. They are then faced with not getting adequate support for recovery. It is very difficult, as you have already heard from Kay, to enable people to feel that they can re-engage with the services. So it is directly taken from people’s personal experience of the system.

**Chairman:** We are going to move on. We do not have much time left: in fact, we are over time. I will ask Mr Hinchliffe to deal with the issue about tribunals. We will deal with this briefly, if we may. I should say that we have had a lot of evidence about tribunals and we have received more, including from the chairman of the tribunals, who have real misgivings about the proposals in the Bill.

**Mr Hinchliffe:** It has been invaluable, having a user perspective this morning. I would just like to differ slightly with Dr Westra in terms of the historic nature of your evidence. The Health Committee, certainly four years ago, took evidence from users in our mental health inquiry—and Dr Stoate confirms it.

**Dr Westra:** I do apologise!

**Mr Hinchliffe:** What I want to ask you is this. In your evidence, you give a very positive view, and Mr Brook has mentioned the positive view of most of the witnesses, in terms of the proposals in the Bill on the tribunals system. I am interested in particular in your views of how these proposals differ from the current system; what your criticisms are of the current system, and in particular I note that, in Mind’s evidence at paragraph 5.16 on page 28, you are talking there about the need to include lay member representation. Do I assume from that that the lack of lay representation on the current system is a factor and, if so, how is that impacting upon the operation of the system?

**Ms Foyster:** Shall I lead in terms of what we see as the problems with the system as it operates at the moment? We think that there are major problems at present because of delays, poor administration and, in relation to that, poor traceability on any individual if the process fails, if there are delays, and why those delays take place. Many service users report that hearings do not take place within the timeframe that is currently required. That is an additional issue in Wales, in terms of the coverage of
Invasive Treatment

The most common invasive treatment used is medication, either as an injection or, more often, in an oral form. Whilst I accept there is a role for medication in mental health (I take it myself from time to time), I believe there is a profound concern. In terms of the other issues that service users report to us about the current system, the lack of advocates—which is something that is addressed within the current Bill—patients find the process intimidating and are unable to present their views, and also to have their views taken on board by medical advisers. You mentioned the fact that Mind would like to see the tribunal panel opened out to include lay members. We feel that, because of the input from the expert panel member—which is the medical input—you do not then have to have a clinical member on the tribunal. That could be opened out to non-clinical, bringing in the more social aspects. We feel that is very important. Bringing in the lay view from the service user, carer or family member would also be very much welcomed.

Q241 Mr Hitchinlife: Do I gain the impression from what you are saying that you believe that the current system is perhaps too medical model focused, and the lay representation would include the wider social perspective? Secondly, looking at your current criticisms, one is in relation to delays and the administration of the system. How do you feel, with the additional demands of this new system, we will overcome those same kinds of problems?

Ms Foyster: Although we welcome the new arrangements and we do recognise the resource implications, particularly in terms of the numbers of people needed—there will be more tribunals meeting, given that everyone has to have one after 28 days, which we welcome—and taking the point about widening out to include the social aspect, then one of the other major criticisms of the current situation is that there is a lack of support and a lack of a holistic package in terms of discharge, which is one of the other duties of the tribunal. We feel that would be addressed more with the widening-out perspective on the tribunal.

Mr Brook: We have collected together some real service users’ views of their experiences on the tribunals, both for our legal advice line and our information line. We could submit those to you.

Chairman: Would you? Because we are running out of time, or because we have given you more time than was intended, we would be very grateful if any of you or your organisations wished to add anything as a result of the questioning today. You can assume that we have read the written materials which you submitted, indeed in the case of No Force that is why you are here today in particular—so it is additional material we would be grateful for. The sort of thing you have just mentioned, Mr Brook, would be helpful. I know that you have not all said everything you wish to say, but you have said a great deal. I think I speak on behalf of the whole Committee. You have given us very valuable evidence and indeed have taken us, as I have already put it twice, to the conceptual rather than the legislative—which is good for our grey matter anyway. Thank you very much indeed for attending.

Supplementary memorandum from K Sheldon (DMH 377)

Following on from the session of 10 November at which Mind and No Force were giving evidence, as one of the witnesses I have decided to take up Lord Carlile’s offer to submit further information on some of the issues discussed during the session. I believe Mind are also submitting extra information, but I am submitting this evidence as an individual having been subject to compulsory powers on numerous occasions. As well as being based on my own personal experience, the evidence is also informed by contact with thousands of other service users, particularly in my roles as a mental health advocate, a reviewer with the Healthcare commission and a Mental Health Act commissioner.

Invasive treatment

The most common invasive treatment used is medication, either as an injection or, more often, in an oral form. Whilst I accept there is a role for medication in mental health (I take it myself from time to time), the unwanted effects associated with all forms of medication (including newer ones) are often intolerable and greatly impair the quality of life of the people being prescribed them. It is still unclear how psychiatric medication actually works and is prescribed with the aim of eradicating all psychiatric symptomology as defined or detected by a psychiatrist. The result of this “blunderbuss” approach is that numerous extremely unpleasant unwanted effects are frequently experienced by patients. Three that I would particularly highlight are:

- An inability or a significantly reduced ability to experience pleasure. This is a very common effect which is frequently not recognised by clinicians. It is often misdiagnosed as depression or apathy but is qualitatively different from both these emotions. Having experienced this feeling of anhedonia from several drugs, I cannot emphasise strongly enough just how debilitating and pervasive this feeling, or lack of feeling, is. You just exist. There is no point in being alive. I suspect that many service users use illegal drugs, drink excessive amounts of alcohol, overeat and sleep excessively to escape the horror of anhedonia. The feeling of anhedonia disappears within days of stopping the medication.
— The second effect is feeling tired and without energy. This is also different from depression and apathy, and indeed anhedonia. Clinicians do not take this very common side-effect seriously, seemingly believing that it is a small price to pay for the obliteration of psychiatric symptoms. Very few service users would concur with this.

— An excruciating feeling of inner restlessness characterised by an inability to keep still (akathisia). This side-effect can only be described as torture. Again it is often overlooked, not taken seriously or misdiagnosed by clinicians—agitation, anxiety, overactivity, pacing. It is proven factor in suicidal behaviour: I would rather be dead than suffer akathisia and I am lucky to be alive.

There are numerous other unwanted side-effects, some of which respond to anti-side-effect medication, unlike the three mentioned above. Incidentally, the medication prescribed for side-effects such as shaking, stiffness, drooling etc is highly addictive. On several occasions it has taken me several weeks to wean myself off on a literally crumb-by-crumb basis.

A colleague of mine recently told me that she was advised not to come off lithium carbonate as she would relapse within six months. She ignored this advice, and it’s not the fact that this happened four years ago and has she not “relapsed” in this time that had the most impact on me, but her comment that she would willingly have relapsed “just to spend one day off lithium and its appalling side-effects”.

In time, I have no doubt that the forcible administration of medication will be viewed as a violation of human rights: liberty and security of person; cruel, degrading treatment; even torture.

There needs to be much more emphasis on other approaches to managing and coping with the whole range of mental health issues which should be recognised as valid alternatives to medical interventions. Many service users—survivors—have had to develop their own strategies for surviving and thriving, often without, even against, the support of the mental health services. Service users should be actively encouraged and supported to develop their own strategies. In turn, staff working in the services should be empowered and trained to engage in this more holistic approach which focuses on individual autonomy.

The most acceptable and effective care plan that I have ever had, is the one I devised myself.

COMMUNITY/NON-RESIDENT TREATMENT ORDERS

As I said last Wednesday, there is no doubt that I would have been subject to this type of order if it had been available under the current act. I was viewed as a revolving-door, non-compliant chronic patient. If I had been subject to compulsion in the community I would have done everything I could to disengage from the mental health services, including taking my own life.

The fact that people become “revolving door” is the due to the inadequacy of the services. Simply compelling people to take medication/live in a certain place/do certain activities is short-sighted and inappropriate not to mention intrusive and de-humanising.

The role of carers is important but should not be over-emphasised. This partly to ensure that the service user’s right of self-determination is not encroached and partly not to place an inappropriate—often intolerable—burden on the carer and wider family unit.

The example that a non-resident order would be appropriate for someone whose kindly parent would like to look after him or her at home is wholly misplaced. Firstly, parents or carers can look after their relative or friend at home now. The reason that this often breaks down is lack of support and follow-up by the services. It seems almost that the compulsion element is really about compelling the services to continue to be involved. It seems strange that an individual can have their civil rights curtailed to ensure that the mental health services to their job!

On Wednesday, a great deal of time was spent discussing the example of a person harassing another person to the extent of the other person being seriously affected by this. We went round in circles but the key point the witnesses were trying to get across was that, not that it would have been inappropriate to “section” the perpetrator, but that the threshold for using compulsory powers must be much higher than is proposed.

I gave the example of the horrendous two year harassment campaign that I was subjected to by a psychiatric nurse. The point which I failed to get across was that there was very little that the law could effectively do about it. The perpetrator was not unwell, just simply a very unpleasant person. She should not have been, and was not, subject to the Mental Health Act. If a person with a mental health problem committed the same degree of harassment as this nurse, should they be subject to compulsory powers? I think not, as this would be unequal and discriminatory.

There are very many people in low and medium secure mental health units who have committed minor crimes (many of them not even prosecuted) largely due to their mental health problems. If the same crimes had been committed by someone without mental health problems, he or she, at the very most, would have completed a short custodial sentence. Most would not have been prosecuted or would have been given a warning, a fine or community service etc.

Patients languish in secure units for months and years. This cannot be a fair or humane state of affairs. They are, in effect, being punished for being mentally ill.
Compulsion is being used more and more to inappropriately control people and as a substitute for inadequate and inappropriate services. The proposed Mental Health Bill clearly—overtly even—seeks to extend this.

The need for an effective interface between the health service and the criminal justice system is just one example of where services for people with mental health problems require more development and improvement. However, the current inadequacies of services, together with a reaction to a few non-representative high profile cases (which seems contrary to the Government’s desire for evidence-based practice!), cannot be allowed to inform the development of mental health legislation. It is fundamentally wrong, unethical and in breach of human rights.

People with mental health problems, particularly those of us with severe and/or ongoing difficulties, do not need legislation that increases even further the levels of discrimination and marginalisation we face in society.

On one hand we are being told that we are “experts by experience”, that our opinions should be at the heart of mental health policy and practice and yet our views about legislation that will have a profoundly detrimental effect on our civil liberties and human rights are repeatedly given little credence. We need to be listened to and to have our cause championed.

November 2004

---

**Supplementary memorandum from Mind (MGHB 400)**

Attachment 1: Note on medication issues to the Pre-legislative Scrutiny Committee on the revised draft Mental Health Bill.

Attachment 2: Research findings on coming off psychiatric medication

Mind has some research in progress which suggests doctors do not always have good judgement about who can safely stop taking their drugs, something which has serious implications for the proposal for non-resident orders.

---

**ATTACHMENT NO 1**

**Difficulties reported by service users in their experience of Mental Health Review Tribunals.**

The following are not in any particular order and we cannot quantify the relative numbers of service users (and their families and friends) who have raised these issues. Mind has records of calls to the Lawyers’ Support Line, records of calls from mental health advocates and the collective experience of the team to inform us.

1. Delay—the waiting time for a hearing once applied for is often extremely stressful land frustrating. Although recent case law requires Section 3 hearings to take place within eight weeks, many service users and practitioners report that this is simply not happening. Section 2 hearings must be listed within seven days and these frequently result in other cases being delayed at the last minute.

2. Adjournments—these may occur because administrative staff have not asked for reports from other parties or have not obtained the reports in time or have mislaid them. There may be listing problems with other cases. Staff may be unable to find tribunal members who are available within the correct time scale. RMOs frequently decide to discharge a patient at the last minute on the day of a tribunal hearing. Consequently many applications are withdrawn at the last minute. This leads administrative staff to intentionally list more cases than can actually take place. When applications are not withdrawn some cases get pushed off the list and the process has to start again. This is a very common complaint.

3. Many service users and their families report difficulties in identifying legal representatives. They have little opportunity to identify who is “good”. Rarely do people have any choice, particularly outside the cities, and it is becoming increasingly hard to find mental health lawyers with the spare capacity to take on new cases.

4. People report a variety of experiences in the quality of the representation they receive.

5. The medical advisor used to be paid extra money to see the patient before the day of the tribunal. For the last few years this has changed and they now receive a fixed fee. This means that patients are usually interviewed on the day of the tribunal. This adds stress to what is already a very stressful day; it impedes the service user’s ability to communicate effectively and may limit the appearance of any recovery and often leads to the advisor not being in possession of the correct or full enough facts about the person’s history.

6. Reports are very common of medical advisors not listening to service users, not reading their notes, or failing to bring the notes with them. They frequently mix up one person’s notes with those of another person. Many service users feel inaccurately portrayed by medical advisors.
7. Plucking up the courage to contradict professionals in the tribunal setting is often extremely difficult. The service user may lack confidence and be afraid of alienating staff with whom they have to live in close contact. The tribunal setting is adversarial and essentially formal. This is by its nature a difficult environment for patients to function effectively. Being medicated, tense and in an unfamiliar situation in front of a panel of strangers does not give service users the best chance to present themselves in the best or most accurate light.

8. Many users and representatives report difficulties in obtaining expert reports. This leaves patients less well supported than they could be, and often results in delays (see above). Legal aid funding restrictions and delays in authorising instructions also frustrate both service users and lawyers.

9. Service users fear antagonising their RMO by requesting a tribunal.

10. The burden of proving that a person is no longer so unwell that they require detention under the Act now lies on the Tribunal. However, the standard of proof required to discharge this burden is set at the relatively low level of balance of probabilities. Two issues arise. First, how does one measure whether the evidence is sufficient to prove on balance that a person is not well enough to merit discharge? And second, many service users and their lawyers feel that the tribunals should have to be satisfied to a much higher level than on balance to merit ongoing detention.

11. Tribunal administration is notoriously bad. Lost faxes, mislaid reports, lack of co-ordination between admin team members, staff turn over, lack of a person with “ownership” of the case all create a feeling that patients are white water rafting through a chaotic system, when they need order, responsibility, clear guidance and accountability.

12. The last major group of complaints relates to aftercare arrangements. Conditional discharges depend on satisfactory arrangements being put into place and many people report difficulties at this stage. Families say they are not consulted, listened to or supported or involved. Service users feel the same plus the added deep frustration whilst their detention is extended as they wait for apparently faceless and unaccountable professionals to put together whatever package the tribunal has identified. No one has a duty to implement delayed discharge arrangements in a timely fashion. This is a major problem for all involved and needs to be addressed.

13. Aftercare arrangements that have been made often fail to materialise causing dreadful anxiety and leading to slower recovery or even deterioration of people’s health. Many people complain that when discharged they are suddenly left with no support.

**ATTACHMENT No 2**

Note on medication issues to the Pre-legislative Scrutiny Committee on the revised draft Mental Health Bill.

**Background**

During 2003–04 a team of service user consultants developed and carried out a piece of research for Mind about people’s experiences of attempting to stop taking psychiatric drugs. The final report is in preparation, but the preliminary report, which contains the main findings, is attached for information.\(^{29}\) The findings have relevance to the work of this committee as they show that people can do well without medication even when doctors advise against coming off. This short note summarises some of the key findings.

**Findings**

The findings are based on quantitative research with 204 people and qualitative research with 45 of those people, all of whom had tried to stop taking psychiatric drugs, successfully or otherwise. This summary gives the findings that concern people’s decision to come off and their success in doing so, not the process of withdrawal.

1. When asked how well or badly psychiatric drugs had worked for them, one fifth replied that they had been mainly helpful and a similar number said they had been mainly harmful, with the rest assessing them as somewhere in-between.

2. When asked how much choice they had had in taking psychiatric drugs, nearly one third answered that they had been compelled to take them on at least one occasion. Only just over half had ever felt they had had a free choice.

3. The most common reason for wanting to come off drugs was not liking the adverse effects. The next most common was not liking the idea of being on them long-term.

4. One in 12 people decided to try to come off against the advice of their doctor. This rose to a quarter of people on mood stabilisers or antipsychotics.

5. A quarter decided to come off without involving their doctor in the decision. This rose to two in five for people on mood stabilisers or antipsychotics.

6. Nearly three quarters of people who tried to come off a mood stabiliser succeeded, compared with just over half of the people trying to come off an SSRI antidepressant or an antipsychotic. And yet people on mood stabilisers were much more likely to be discouraged from trying to come off them by their doctors than people on SSRIs.

7. Nearly half the people we interviewed were no longer on any psychiatric drugs. Of these, nearly a quarter hadn’t taken a psychiatric drug for 10 years or more.

8. Those who are attempting to come off psychiatric drugs rate people who do not have a role in prescribing drugs as most helpful—people such as therapists and other service users. Doctors are seen as least helpful.

9. People attempting to come off antipsychotics are particularly likely to find doctors unhelpful. Four fifths who sought help from a psychiatrist said they were unhelpful or made things worse.

10. Compared to their patients, doctors were seen as:
- more likely to see the drugs as beneficial
- less concerned about the adverse effects
- less likely to understand the desire to live without them
- more likely to doubt the ability of the patient to manage without them (especially mood stabilisers and antipsychotics)
- less likely to value alternative and complementary strategies and sources of help and support
- more likely to under-estimate the difficulties of withdrawal (especially from SSRI and SNRI antidepressants).

11. People who tried to come off their drugs against their doctor’s advice and people who decided to come off without involving their doctor were as likely to succeed as people who had their doctor’s approval and involvement.

12. When asked about the benefits of having come off psychiatric drugs, people most commonly said: better mental ability, feeling more alive, having taken back power and control, the reduction of side effects, and feeling good about managing without drugs.

Discussion

It is common for people to stop taking psychiatric drugs for good reasons. This research suggests that doctors do not always have good judgement about who can safely stop taking their drugs—those who came off against their doctor’s advice did as well as those who had their doctor’s agreement. This has implications for the proposal in the Bill for non-resident orders, which presupposes that doctors can make these judgements. If these proposals are made law, it will be even more difficult for people to choose to try to stop taking drug treatments and more people will be taking drugs unnecessarily to the detriment of their health and wellbeing.

December 2004

Memorandum from Rethink (DMH 192)

1. INTRODUCTION

Rethink, formerly known as the National Schizophrenia Fellowship, is the charity for people who experience severe mental illness and for those who care for them. We are both a campaigning membership charity, with a network of mutual support groups around the country, and a large voluntary sector provider in mental health, helping 7,000 people each day. Through all its work, Rethink aims to help people who experience severe mental illness to achieve a meaningful and fulfilling life and to press for their families and friends to obtain the support they need.

Rethink is an active member of the Mental Health Alliance and supports the submission which the Alliance has made to the Committee. For this reason, we have chosen to focus in particular on four specific issues. Our response to the 10 questions asked by the Committee is set out as an annex to this paper.

As England’s largest provider of voluntary sector mental health services and largest membership charity for people with severe mental illness, Rethink would welcome the opportunity to give oral evidence to the Committee, especially on the issues which we have highlighted below.
The four specific issues are:

— Access to care, including help in a crisis.
— Planning for the future—the use of advance statements.
— The rights of carers.
— Practical issues in implementing new mental health legislation: inequalities in application and resource pressures.

Our response is set out as follows:

1. Introduction.
2. An overview of the legislation and a summary of Rethink’s recommendations.
3. Our detailed comments on four specific issues.
4. Our response to the 10 questions asked by the Committee.
5. Rethink’s research into confidentiality and choice for service users and carers.
6. Some recent cases which illustrate high-risk situations, and the factors which might have made a difference.

This report has been written by Mary Teasdale, Head of National Advice Service, Vanessa Pinfold, Research Manager and Mike Took, Policy Officer, with input from users and carers within Rethink.

2. Overview of Legislation and Summary of Recommendations

2.1 The Issues

At present, mental health care is difficult to access and highly stigmatised. People are frequently turned away when seeking help at early stages, only to become so ill that a use of compulsory treatment is considered. Those developing a psychosis typically get no specialised help until 12 to 18 months after clear signs and symptoms. Those developing more common mental health problems may never receive specialist help.

As a result, half of all people developing a psychosis receive a compulsory section as their first experience of specialist mental health care: far from being a last resort, compulsion is at present the main resort for many. Such treatment is traumatic and may poison future relationships with professionals. It is estimated that 60% of people admitted to psychiatric hospital are lost to follow up care. The existence of powers to compel individuals to accept treatment against their will without matching powers for individuals to secure the help they need has distorted mental health care. Resources are disproportionately skewed to funding secure care, acute care and compulsion, and away from early intervention which can make the most difference.

The problem with mental health care is that, overwhelmingly, people cannot get effective help when they need it. A new Mental Health law should tackle this problem.

2.2 The Revised Draft Bill

Rethink supports the analysis of the Mental Health Alliance of the revised draft Bill. In particular, we regret the emphasis within the Bill on risk, and the disproportionate attention on a small number of people, who are deemed dangerous. We would draw the Committee’s attention not just to the question of dangerousness, but the provisions within Part III of the Bill where the threshold for compulsory treatment through the criminal route is far lower than the civil route. This could easily lead to further stigmatisation of people with severe mental illness.

This emphasis is to the detriment of thousands of people with severe mental illness and their families who want mental health law to help them access the help and support they need. A central platform of Rethink’s policy throughout this period has been the need for a right to access help when it is needed. We would particularly commend the Mental Health Alliance’s proposals in this respect.

In addition, the wide powers which are created by the Bill offer great dangers of both misuse and misinterpretation. This is particularly true in the future if mental health funding is in crisis.

2.3 Rethink’s Priority Areas: Summary

As stated above, Rethink has identified four areas of particular concern. In the following pages, we set out the rationale behind these concerns and propose a series of recommendations.
These can be summarised as follows:

1. Access to Care
   - Rethink wants a similar duty to that provided for in the new legislation in Scotland, which means that the relevant authorities must respond to requests for mental health needs assessments. We also want written reasons to be provided if the request is refused.
   - We also want duties to be imposed on the authorities to provide adequate care and support services, including specialist services for older people, adolescents and mother and baby units.
   - We want an equivalent provision to Section 117 of the 1983 Act.
   - If a new stage is to be inserted into the pathway to compulsion, the draft Bill should spell out the details clearly. It should also ensure that there is full consideration of the patient’s social circumstances.
   - We want an equivalent right for carers to that described in Section 13 para 4 of the 1983 Act.
   - The current range of rights available to the Nearest Relative should be allocated to the Nominated Person.

2. Use of Advanced Statements
   We want the care planning process to ensure that the patient is offered an opportunity to draw up an advance statement and be provided with any support required, and that the Statement should be regularly reviewed and stored with the crisis plan:
   - There should be an obligation on the mental health services to take the advance statement into account in every respect and to provide written reasons if the statement is not implemented as requested.
   - The tribunal should take full account of what is stipulated in an advance statement.

3. Carers’ Rights
   - The identity of the carer, as well as the “nominated person” should be specified in the advance statement, which should also specify what information is to be shared and with whom. If there is no advance statement, for example when people are experiencing a “first episode” of mental illness, the Nominated Person role should default to the carer, using a default hierarchy as in the new Scottish legislation.
   - A duty to be placed on Trusts to consult carers during the patient’s treatment and when discharge plans are being drawn up.
   - Clear guidance on information exchange that takes account of the needs of the carer role.
   - An absolute duty to be placed on Trusts to respond to a carer’s request for an “examination”.
   - Carers to have the right to seek a patient’s discharge and to have a voice at a tribunal hearing.
   - Recognition of a carer’s right to advocacy and clarification of the “nominated person”, carer and advocacy roles, before, during and after hospital.
   - A duty placed on the Trust to demonstrate that the least restrictive and invasive options for the patient’s care have been considered.
   - Provision for monitoring the new arrangements and implementation of the mental health carer role.
   - Patients to have the right to seek a patient’s discharge and to have a voice at a tribunal hearing.

4. Implementation
   - The Code of Practice should have the same legal force as the Act.
   - The Code of Practice and regulations that will support the legislation should be written with stakeholder consultation, and should be examined by Parliament alongside the Bill.
   - We believe that there should be at least two years between Royal Assent to the Act and its implementation, to ensure that sufficient staff have been recruited and adequately trained, with the input of patients and carers)
   - Clarification within the draft Bill over who are the various “appropriate authorities” which will be supporting aspects of the draft Bill eg the regulation of the AMHP.
   - We believe that comprehensive monitoring and recording systems should be requirements within the legislation, for example, decisions regarding the examination and assessment processes should be documented, and written reasons given if examination is not carried out when requested, or the provisions in advance statements are not implemented.
3. **Key Issue 1: Access to Care**

3.1 *The problem*

The right to access timely and appropriate care and treatment is essential for maintaining mental health and promoting recovery. The 1983 Mental Health Act did not provide rights to care and neither does the draft Bill. This is a particular issue for Rethink because access difficulties are so commonly reported by our members, people using our services and our staff.

Our experience, surveys and research show the difficulties that people affected by mental health problems / psychosis have in getting access to care and treatment. Our “Better Act Now” survey (1999) showed that 35% of people seeking help had been turned away, and 25% when seeking hospital admission. In addition:

- 91% of respondents asked for new legislation to provide a right to a hospital bed when assessed as needing one; and
- 69% called for a legal right to adequate care and treatment.

Our most recent surveys in 2003 reported similar experiences relating to access to care both in time of “crisis” and for routine care and treatment. Service users were asked how long it took to seek help for their mental health problems / psychosis. One in four reported being denied access to the help they sought from mental health services when their problems were developing, irrespective of diagnosis or length of illness.

Figure one: How long did it take you to get any sort of help from mental health professionals when your mental health problems were first developing?

![Chart showing access times](chart.png)

The problems of accessing “the system” however are not limited to first experiences of seeking help. Our latest service user survey found that in the last three years, more than one in four people (28%) reported being turned away when they sought help from mental health professionals. The most common difficulties in accessing help were (n = 1785):

- Long waiting times for appointments with psychiatrist, GP, Community Psychiatric Nurse (CPN), social worker (26%).
- Unable to access help out of hours (12%).
- Lack of facilities and funding for services locally so appropriate help is unavailable (12%).
- Difficulty accessing members of your own care team (particularly problems with telephones) (8%).
- Personal difficulties in asking for help particularly when unwell (6%).

The government’s National Service Framework for Mental Health says that all service users on the Care Programme Approach (CPA) should be able to access help 24 hours a day, 365 days a year. However, 19% of service users in our psychosis group and 29% with other diagnoses, reported that they did not know where to get help out of hours—even in an emergency.

Carers were asked in 2003 to describe their frustrations with mental health services and over half of all carers (56%) cited an access related issue (n = 1451). The most commonly cited frustrations were:

- 30% shortage of adequate services locally for service users;
— 16% the difficulties of accessing help in a crisis; and
— 14% difficulties accessing mental health professionals.

Getting access to help is especially difficult when symptoms of mental illness have suppressed the service user’s awareness of the fact that they need it. These problems may result from—

— lack of resources;
— lack of understanding that the patient’s judgement has been affected by his or her condition;
— insufficient liaison with carers; and
— a crisis focussed approach towards implementing the current legislation.

This is why Rethink has asked for a right to care and treatment since the reform process began.

3.2 *Strengths of 1983 Act in access to care*

The Mental Health Act 1983 includes some provisions which are intended to facilitate access to care and services—

— the involvement of the Approved Social Worker (ASW) allows for consideration of the patient’s social circumstances and need for services. The ASW has a background and training in social work, is independent of the clinical staff and is employed by a local authority. It will be possible for the ASW to determine whether compulsion can be avoided by providing social support and other services to meet the patient’s needs.

— Section 13 para 4 provides carers, through the “nearest relative” provisions with the right insist on a response from the mental health services if a crisis seems imminent. The local authority can be required to direct an ASW to consider whether the use of compulsion may be necessary. Carers only use this right as a last resort, when it has proved impossible to access help any other way. In Rethink’s experience it has frequently averted potential tragedies by ensuring a response from the mental health services. Written reasons must be provided if an application for hospital admission is not made. The ASW must take the views of carers and other relevant circumstances into account.

— Section 117 provides for free aftercare, for as long as it’s considered necessary, for patients who have been detained under treatment orders.

3.3 *Bill Provisions*

In Rethink’s view, the draft Bill misses the opportunity to provide patients and carers with the rights they have asked for, and removes some of the important strengths of the 1983 Act.

In contrast to the Mental Health (Care and Services)(Scotland) Act 2003, the draft Bill does not place a duty on the authorities to respond to requests for patients and carers to an assessment of mental health needs. In addition, the fact that the Approved Mental Health Professional (AMHP), who replaces the ASW in the draft Bill, will not necessarily come from a social work background means that insufficient consideration may be paid to the patient’s social circumstances and options for care and treatment other than compulsion. The current element of independence may well be lacking, especially if the AMHP is employed by the same trust as one or more of the doctors.

The absolute right for families to require an assessment is also missing from the draft Bill. Instead, the Bill has created a new stage in the process leading to compulsion. Any person (eg a carer, the police, a doctor or nurse) can contact the “appropriate authority”, presumably the local mental health trust, and request that they decide “whether all of the appropriate conditions (for compulsion) seem to be met in a patient’s case”. This is a new stage which would determine whether “examination” by an AMHP and two doctors can take place. Neither the draft Bill nor the Explanatory Notes specify who will make this decision or what qualifications or experience they would have. It could be anyone from a clerical officer who has been given a screening brief, to the team leader of the local community mental health team. There may be no consultation with the carer (see section below on Carers’ Rights).

In the draft Bill, provision of free aftercare has been limited to six weeks, for all patients discharged from compulsion, and we understand that there is no duty on the authorities to provide this. This compares poorly with the duty imposed by section 117 of the 1983 Act to provide free aftercare until a multi disciplinary decision is made that it is no longer necessary. Rethink is aware from experience and the relevant research that engagement with services is crucial if recovery is to be achieved. Having to pay for basic necessities like prescriptions and perhaps day-care would be a major disincentive.

3.4 *Recommendations*

Rethink Recommends:

— Rethink wants a similar duty to that provided for in the new legislation in Scotland, which means that the relevant authorities must respond to requests for mental health needs assessments. We also want written reasons to be provided if the request is refused.
— We also want duties to be imposed on the authorities to provide adequate care and support services, including specialist services for older people, adolescents and mother & baby units.
— We want an equivalent provision to Section 117 of the 1983 Act.
— If a new stage is to be inserted into the pathway to compulsion, the draft Bill should spell out the details clearly. It should also ensure that there is full consideration of the patient’s social circumstances.
— We want an equivalent right for carers to that described in Section 13 para 4 of the 1983 Act.
— The current range of rights available to the Nearest Relative should be allocated to the Nominated Person.

4. **Key Issue 2: Planning for the Future: The Use of Advanced Statements**

4.1 **The problem**

Research indicates that the use of advance statements or crisis planning can facilitate improved levels of engagement with services and positive patient attitude to self (Sutherby et al 1999), results in lower rates of compulsory admission to hospital under 1983 MHA (Henderson et al 2004), though not all studies have shown clear benefits for patient outcomes (Papageorgiou et al 2002) and varied models and practices have been highlighted. The Mental Health Foundation project on advance directives is also producing useful materials to support their use through research carried out in Bradford.

Rethink is aware that many service users would like to set out their views and preferences when well about treatment, proxy decision making, information sharing and practical arrangements to be made during a period of illness, in a comprehensive advance statement drawn up after recovering from an episode of illness, which would have some authority. We know how carefully people who have recovered from an episode of illness have set out their wishes, including their experience of specific treatments and details of what sort of information they would wish to be shared with carers or others and what information they want to keep confidential. In Rethink’s experience, there are several schemes promoted by NHS trusts to address this issue: crisis cards (eg Harrow, Lewisham); joint crisis plans (Henderson et al 2004); advance statements (Hertfordshire, Hull and East Riding, Bradford, East Gloucestershire) and user/carer forums are developing their own tools (eg East Kent advance directives). However, we also know that those who have attempted to use this mechanism at times of crisis have found that their advance statements have been ignored by the professionals, who currently have no obligation to take them into account.

4.2 **Bill provision**

There is some provision for advance directives in the Mental Capacity Bill, which attempts to regularise and clarify the existing common law rules on advance refusals of treatment. Rethink believes that people should be enabled to plan for future episodes of incapacity through advance statements. But neither advance directives (advance refusals) nor advance statements (advance expressions of wishes) are mentioned in the draft Mental Health Bill. We believe this is a vital omission and a missed opportunity to modernise law and practice in a way which would protect the patient’s true individual autonomy.

We also note that the Nominated Person’s role ceases when the patient is no longer to be under compulsion (Part 8 Chapter 1 Clause 242). Presumably, another appointment is to be made should the patient become subject to compulsion at a later date, and when judgement may well be impaired. This is obviously likely to reduce the element of continuity which currently exists through the Nearest Relative arrangements in the 1983 Act. We believe that the appointment of the Nominated Person should be made in accordance with the preference stated in the patient’s Advance Statement. This is more likely to result in the involvement of someone who is aware of the patient’s previous history which could be vitally important . Professionals come and go; many people complain to Rethink about the lack of continuity in their care.

4.3 **Recommendations**

Rethink Recommends:
— We want the care planning process to ensure that the patient is offered an opportunity to draw up an advance statement and be provided with any support required, and that the Statement should be regularly reviewed and stored with the crisis plan.
— There should be an obligation on the mental health services to take the advance statement into account in every respect and to provide written reasons if the statement is not implemented as requested.
— The tribunal should take full account of what is stipulated in an advance statement.

This would also reduce the confusion likely to result from the proliferation of roles in the two draft Bills. Clause 9 of the Mental Capacity Bill allows for a Lasting Power of Attorney, which includes authority to make personal welfare decisions and an Independent Consultee. In addition to the person carrying out this
role, a patient could also have someone providing day to day care, and another appointed as “nominated person”, and also an advocate. It appears to Rethink that little thought has been given as to how these arrangements would work in practice. But an advance statement could clarify the patient’s views and preferences made at a time when judgement is not affected by symptoms of mental illness.

5. **Key issue 3: Carers’ rights**

5.1 The problem

Perhaps more than any other mental health organisation, Rethink’s experience shows the difficulties which carers have in achieving recognition of their role and respect for their views. The 1983 Act did not originally mention carers, as the concept was barely recognised in UK law when it was drawn up. But considerable advances have been made since. This includes the Disabled Persons (Services, Consultation and Representation) Act 1986, the Carers (Recognition and Services) Act 1995, and the Carers and Disabled Children Act 2000. The Government introduced “A National Strategy for Carers” in 1999. There is also a requirement in Standard Six of the National Service Framework for Mental Health, 1999 that some information is shared with carers. We believe that the draft Bill is out of keeping with these advances.

Carers must have the right to be heard, if vital pieces of information are not to be lost to the assessment process. It is also essential that carers’ health, safety and well-being are protected and that information essential to enable them to continue their supporting role is not denied to them. In the words of the Framework, Standard Six, “Caring about Carers”,

“The families of individuals with severe mental illness may have to contend with demanding behaviour, extra financial burdens, restrictions upon their social and family life, and occasionally a risk to their own safety.”

Rethink believes that the provisions of the draft Bill should be consistent with the approach of the Framework and the government’s National Carers Strategy. Carers are often perceptive observers of the patient’s behaviour, and aware of the subtle signs that precede a further episode of illness. If there is any likelihood at all of harm to others, they are also the people who are most at risk. Yet the vital information which they can provide will be lost if consultation with them does not take place.

For many years, Rethink has provided carers with general information and education about mental illness and support and advocacy for those that need it. In recent research carried out by Rethink and the Institute of Psychiatry into Information best practices in mental health—professionals supporting carers, we developed a comprehensive conceptual model, which emphasised the difference between general and personal (sensitive) information in particular in mental health. Barriers to engagement for mental health carers cause enormous distress to individuals—both patients and carers, and with carefully applied principles many of the barriers can be easily overcome without removing the rights of patient autonomy or impinging on the human rights of carers (as is currently the case in many cases) (see appendix 1 attached).

We found that only 20% of the confidentiality and information sharing NHS and social service policy documents submitted to the research team contained reference to carers and practices of sharing information with carers, though professionals report that they need policy guidance and codes of practice to guide their decision making on this subject. Service users feel that professionals lack understanding of the confidentiality rules with only 12% of our sample (168) being routinely asked to provide consent to disclose.

“Concerns I had were treated as irrelevant and never followed up. Medical team felt patient was fine and taking medication. Months later he relapsed. So much distress could have been avoided” (Carer)

5.2 Strengths of current provisions

The 1983 Act recognises the importance of carers and gives them, through the “nearest relative” provisions, the following rights:

- To require the local social services authority to direct an Approved Social Worker (ASW) to carry out an assessment of a patient to decide whether or not he or she needs to be compulsorily admitted under the Act (section 13 paragraph 4).
- To apply for admission to hospital (sections 2, 3 and 4)
- To be informed of an admission for assessment (section 11(3))
- To be consulted before a section 3 admission for treatment and to block the admission if he or she objects (section 11(4)) (though this objection can be overridden by a court displacing him or her and appointing a substitute—section 29).
- To seek to discharge the patient from (a) either an assessment or a treatment section or (b) guardianship (section 23).
- To be informed of a patient’s discharge (section 133) and to be involved in aftercare planning (chapter 27 Code of Practice) unless the patient objects.
These rights were part of the carefully thought out checks and balances designed to give the family some powers to counterbalance those of the professionals, which could be used in the interests of both patient and carer. In practice, many carers are unable to exercise these rights because they are not aware of them and there are no statutory arrangements for them to be provided with this information.

5.3 Bill provisions

Rethink supports the change from “nearest relative” to “nominated person” provisions but the draft Bill strips away most of the existing rights of “nearest relatives”. By contrast, the professionals are given far more discretion than they have at present, which would, if the draft Bill were enacted, allow the carer, family and friends to be marginalised. We do not believe that effective decisions can be made unless the carer’s views are obtained. We also know that in terms of “supporting the carer”, involvement at this stage is essential to promoting better long term outcome for the carer.

The draft Bill (Part 2, Chapter 2, Clause 14, para 1) states that “The appropriate authority must, if requested to do so by any person, determine whether all of the relevant conditions appear to be met in a patient’s case.”

Para 2 provides that “before making any determination, the appropriate authority must consult with . . . (b) any carer of the patient . . . subject to Clause 12 and if practicable,“

Clause 12 states that “where a person is required by any provision of this part to consult a person in his capacity as a carer of the patient” (para 1) . . . “The person may not consult the carer without first ascertaining the patient’s wishes and feelings about his consulting the carer in pursuance of the requirement in question (unless inappropriate or impracticable)” (para 2).

Para (5) stipulates that “If a person determines that it would not be appropriate to consult the carer, he must not do so and, accordingly, the requirement ceases to have effect”.

In Rethink’s experience, most patients approaching crisis will not agree that someone who has been trying to persuade them to accept help should be consulted. Also, symptoms like paranoia are often focussed on those closest to the patient. So a patient, when unwell, could veto consultation with the carer despite accepting the carers involvement when well, which will make it impossible for the appointer to know the carer’s perspective of the situation and to gain important information without which a full assessment would not be possible. Rethink does, however, support the decision of a patient made when well, eg in an advance statement. We believe that in the process of modernising mental health law, little consideration has been given to the effect of the changes on the day to day problems which carers experience in trying to access care and treatment for someone whose symptoms have suppressed their recognition of their need for help. Nor has there apparently been any consideration for the human rights of carers, particularly to the need for “reciprocity”. There also seems to be little rationale behind the differing arrangements described for consultation with or notification of nominated persons and carers.

5.4 Recommendations

Rethink recommends:

— The identity of the carer, as well as the “nominated person” to be specified in the advance statement, which should also specify what information is to be shared and with whom. If there is no advance statement, for example when people are experiencing a “first episode” of mental illness, the nominated person role should default to the carer, using a default hierarchy as in the new Scottish legislation.

— A duty to be placed on Trusts to consult carers during the patient’s treatment and when discharge plans are being drawn up.

— Clear guidance on information exchange that takes account of the needs of the carer role.

— An absolute duty to be placed on Trusts to respond to a carer’s request for an “examination”.

— Carers to have the right to seek a patient’s discharge and to have a voice at a tribunal hearing.

— Recognition of a carer’s right to advocacy and clarification of the “nominated person”, carer and advocacy roles, before, during and after hospital.

— A duty placed on the Trust to demonstrate that the least restrictive and invasive options for the patient’s care have been considered.

— Provision for monitoring the new arrangements and implementation of the mental health carer role.

— The value of the partnership between users and carers to be recognised.
6. **KEY ISSUE 4: IMPLEMENTATION OF THE DRAFT BILL IN PRACTICE: INEQUALITIES AND RESOURCE PRESSURES**

6.1 *The problem*

The success of the draft Bill depends largely on the people who will apply it—mental health professionals, and the training they receive to apply both the legislation and codes of practice. As highlighted in a recent article about the Mental health Act in Scotland (Darjee and Critchton, 2004) new legislation does not in itself provide improvements in clinical care or resources, much depends on the implementation of complex procedures and in Scotland, as in England, concern remains over the application and availability of sufficient resources, implementation and training to deliver improvements in mental health care on the ground.

Inequalities in mental health care provisions are major issues that recent reforms have been actively targeting, including the introduction of the national Service Framework to set standards of care. For example research has shown that expenditure and resource allocation in mental health varies widely with under spend occurring more frequently in deprived areas, but not in the four-inner city London health authorities (Bindman et al 2000). Application in the use of the Mental Health Act 1983 is also known to vary widely based on geography, gender and ethnicity (see studies commissioned by Department of Health reporting in 2000 eg Churchill et al 2000; Audini et al 2000; Thornicroft et al 2000; Peay et al 2000). One of these studies explored the attitudes of professionals with responsibilities under the MHA 1983, the authors concluded:

“The study offers some possible explanations to account for practice variation between individual practitioners and between professional groups. These include individual differences; differences in the way ‘facts’ and law are selectively perceived, interpreted and re-interpreted in relations to patients’ mental states, their records and other data; differences in the perceived level and appropriateness of availability resources . . . the study further observes that even law which is clearly expressed may evade consistent application, particularly where it is at variance with the objectives practitioners deem it necessary to pursue and where decisions are subject to either no, or to delayed, regulation” (Eastman (2000) Shaping the new mental health act: key messages from the department of health research programme).

Rethink believes the application of the Mental Health Act needs careful monitoring and regulation, and professionals also need comprehensive training, including on-going professional development sessions, that involve user and carer trainers. In terms of resources, we believe that mental health has received inadequate levels of investment, despite recent increases, and calls for greater transparency in the allocation and tracking of resources.

We are aware of the current difficulties with the tribunal system where scheduled tribunals are cancelled at the last minute because professionals are unavailable, reports are delayed and in some cases tribunals have been double booked.

6.2 *Bill provisions*

We are concerned about the availability of the resources needed to administer the new legislation, for training the staff who will be involved in implementing it, and to delivering of the care plans agreed by the tribunals.

Applying the legislation: The draft Bill includes some details on the additional staffing and other resource requirements necessary to apply the legislation, for example the numbers of additional psychiatrists required by 2007, and also the independent advocates. We would question these figures and ask how they have been derived. Staffing levels in secondary mental health care are extremely low in many areas, with recruitment problems reported in acute in-patient settings, community mental health teams and similar difficulties in primary care. There are problems in implementing the current mental health legislation due to inadequate staffing 20 years on; will this new bill receive additional resources to prevent these shortfalls affecting continuity of care and application of best practice across England and Wales?

Training and Supporting Staff

A key concern in Rethink is the increased level of professional discretion written into the draft. There are many “get-out” clauses in the draft Bill describing how professionals will action “as appropriate”, and “if practicable”, or appoint a nominated person who is “suitable and eligible”, or apply policy “if practicable” and how they will consider patients views and feelings “where possible”, without mention of capacity. These terms are too loose and the drafting is very vague in places. Reliance on the Code of Practice to provide guidance on application is unsatisfactory when so much more professional discretion is provided in this draft Bill compared to the 1983 Act without many of the safeguards (as outlined above).

We believe that it will take a considerable time to recruit the extra staff needed, and either train or retrain them to apply the new law and exercise this level of discretion, so that the new provisions will be applied with fairness and consistency.
Resourcing the Care Plans: The draft Bill does not seem to take into account the role of available resources in the use of compulsion—how will a tribunal approve a care plan if the resources to action this plan are unavailable? The Annex to this document which refers to some of the cases recently brought to Rethink, mentions two young people, both from BME backgrounds, who took their own lives by jumping from the tower block accommodation in which they had been housed. Would the tribunals approve care plans involving such accommodation? If they felt unable to do so, how would they attempt to influence local authority policies on the allocation of public sector housing?

Non-residential orders (more commonly known as “community treatment orders”—(CTOs) are provided for in the bill, building on evidence from abroad and experience of using supervised aftercare (Sections 25A–J) in England and Wales. Rethink questions the application of CTOs as proposed within the bill without equal rights of access to treatment and advocacy services. The limitations on the right to advocacy services is inadequate.

In Scotland the Mental Health (Care and Services) (Scotland) Act 2003 provides the right of access to advocacy services for all service users. Rethink is concerned with the increased emphasis on medical interventions, and the reduced role of social workers, and thus social interventions in the care and treatment of people with mental health problems. As CTOs are framed as an alternative to hospital admission, they are likely to be drug focused as this is the one intervention that can be effectively enforced. They are also likely to extend compulsions powers to a wider group than is medically necessary placing pressures on professionals and services whilst infringing individual human rights.

6.3 Recommendations

Rethink Recommends:
— The Code of Practice should have the same legal force as the Act.
— The Codes of Practice and regulations that will support the legislation should be written with stakeholder consultation, and should be examined by Parliament alongside the bill.
— We believe that there should be at least two years between royal assent to the Act and its implementation, to ensure that sufficient staff have been recruited and adequately trained, with the input of patients and carers.
— Clarification within the draft Bill over who are the various “appropriate authorities” which will be supporting aspects of the draft Bill eg the regulation of the AMHP,
— We believe that comprehensive monitoring and recording systems should be requirements within the legislation, for example, decisions regarding the examination and assessment processes should be documented, and written reasons given if examination is not carried out when requested, or the provisions in advance statements are not implemented.

7. PART 4: RESPONSE TO THE COMMITTEE’S QUESTIONS

1. Principles

Rethink regrets that a full set of Principles do not appear on the face of the Bill, as they do in the Mental Capacity Bill, and in the Mental Health (Care and Treatment) (Scotland) Act 2003. They are instead to be included in the Codes of Practice as a guide to decision makers. These professionals will have discretion to “disapply” the principles if they believe it would be appropriate to do so.

We believe this unacceptable position has come about because of the acceptance of the principle that patients should be involved in decision making “whenever possible”, while allowing it to be set aside if treatment is felt to be necessary. This problem should be addressed by making patients’ involvement in decision making subject to mental capacity. Rethink believes that the legislation should acknowledge the fact that during an episode of mental illness, symptoms can substantially affect a patient’s judgement and temporarily change the views and preferences the person holds when well. The patient should be enabled to exercise true individual autonomy through a comprehensive advance statement drawn up during the care planning process.

We believe that the principle of reciprocity is particularly important. Nobody should be compelled to accept treatment which is not of benefit to them and good quality services which meet the patient’s needs should be provided.

In our view, the draft Bill should start by setting out guiding principles as the new Scottish legislation does, including one which relates to respect for carers.
2. Definition of Mental Disorder

In Rethink’s view, the loose definition in the 1983 Mental Health Act has been replaced by a further vague definition. It is not clear to us what difference the insertion of the term “functioning” makes. We believe that the explicit exclusions for drug and alcohol dependency and sexual deviance should be carried over from the 83 Act into new legislation. We are very concerned about the combined effect of the new, broad definitions, the removal of the exclusions in the current legislation and the introduction of “non-resident orders”. All of this could result in a significant increase in the use of compulsion.

We are particularly concerned about the provisions for Part 3 patients, as the conditions for remand or committal for medical treatment are significantly broader than the conditions which apply to Part 2 patients. We are afraid that this might result in the excessive use of non-resident orders in order to reduce the prison population.

In Rethink’s view, an assessment of the patient’s capacity to make valid decisions should be part of the process leading to compulsion. As well as this being an ethical approach, it is in keeping with that of the Mental Capacity Bill.

We also believe that treatment given under compulsion must be of benefit to the patient in accordance with the principle of reciprocity.

We are concerned that the rise in the threshold of “harm to self” described in the draft Bill could encourage a crisis focussed approach to the use of compulsion, as many people have experienced under the current legislation. Raising the threshold will increase risk. Rethink is aware of many cases where the degree of risk has been underestimated, with tragic results.

We believe that the requirement that “medical treatment is available which is appropriate in the patient’s case” could prove to be a loophole in the new legislation, like the current “treatability” condition. What will the tribunal do if a specialist treatment is needed (eg a secure bed or an adolescent bed) but is not available? Will this mean that compulsion cannot be used?

3. The Balance between Human Rights and Risk

In Rethink’s view, the draft Bill increases stigma by still overemphasising risk rather than health needs and reduces the rights of relatives to safeguard their mentally disordered family member. A major flaw which runs through the draft is its failure to recognise that the patient’s individual autonomy must be safeguarded by implementing his or her views and preferences expressed while well, not during periods when judgement has been distorted by symptoms of mental illness.

The draft Bill also makes some fundamental shifts in the relationship between the state, the family and the individual patient—

— A major change from the approach of the 1983 Act is contained in the fifth condition of Clause 9, which stipulates that medical treatment must be available which is appropriate to the patient’s case, but with no requirement that it must be of therapeutic benefit. It is not clear what this means; we think that some professionals may interpret “appropriateness” to refer to the presence of risk to others.

— As the Approved Mental Health Professional (AMHP) may come from a nursing rather than a social work background, and the decision as to whether “examination” will take place is to be made by an unspecified person within the relevant authority, we believe this may result in insufficient consideration of the patient’s social circumstances and alternative options to compulsion.

— Rethink generally supports the replacement of the “nearest relative” by the “nominated person” provisions but is concerned that the existing rights given to the “nearest relative” (eg to apply for admission, to discharge and to require the local authority to direct an Approved Social Worker (ASW) to assess) have disappeared and the sum total of the rights which may be available to carers through the “nominated person” provisions are significantly reduced in total. This means that some of the careful checks and balances built in to the 1983 Act have been lost. We believe that the human rights of the family have been diminished as a consequence. Rethink’s National Advice Service receives many requests for help from carers who are desperate to get access to appropriate care for a relative who is in crisis but has no awareness of their need for treatment. Sometimes using this right is the only way to achieve a response from the professionals. The right to request an examination is a watered down version and it is not clear who will deal with it within the “relevant NHS body”, what experience or qualifications they would have and in what circumstances “examination” would be allowed. We also believe there may be a conflict of interest—the person who decides whether the conditions appear to be met may be influenced by whether a bed is available.

— Mental health professionals have been given far more discretion than they are able to exercise under the 1983 Act or even the previous draft Bill.
The draft Bill reduces professional accountability. For example, there is no obligation on the person who “examines” a patient (Part 2 Chapter 2) and decides that further assessment is not appropriate to provide an explanation to the person who requested the assessment. By contrast, the 1983 Act provides for written reasons to be provided to the “nearest relative” who asked for the assessment if no application is to be made).

4. Efficiency/Omissions

While Rethink recognises that the 83 Act was in need of modernisation, particularly because of its incompatibility with the Human Rights Act on some points, we believe that the main problems associated with it were linked with the way it was operated in practice; the same concern applies to replacement legislation. A further problem was the way it was often interpreted by professionals—for example the failure to consider the nature of mental illness as well as the degree. This often meant that the deteriorating patient was made to wait until crisis point before intervention could take place. So how the draft Bill would work in practice would depend on the training and monitoring of the professionals applying the legislation, whether the necessary resources were in place and whether they believe in its provisions.

We also believe that there is a gaping hole in the proposed arrangements which will inhibit the process of assessment, particularly in relation to risk. We do not believe that either “examination” or “assessment” can be carried out effectively unless there is an obligation to consult with carers. Yet the draft Bill requires the professionals to “ascertain the patient’s wishes and feelings about consulting the carer” without regard to the effect which symptoms of mental illness may be having on the person’s wishes and feelings when well, and not to consult the carer if it is deemed “not appropriate”. (Part 2 Chapter 1 para 12). This ignores the effect which mental illness has on dynamics within family relationships.

In most cases, the carer will have been attempting to persuade the patient to seek help, while the patient is convinced that he or she is not unwell. So there is likely to be a significant disagreement between them, and the patient will not wish the carer to influence the examination or assessment. Also, symptoms like paranoia are usually focussed on close relatives. In fact, carers are often perceptive observers of the patient’s behaviour, and aware of the subtle signs that herald a further episode of illness. If there is any likelihood of harm to others, they are also the people who are most at risk. For these reasons it is essential that the professionals consult with carers and utilise the information they have to offer.

In our view, consultation with carers is of particular importance in the black and minority ethnic context, as people from this group are known to be disproportionately diagnosed with schizophrenia and subjected to compulsion. This is probably because the patient’s attitudes, lifestyle, or religious beliefs are mistakenly regarded as evidence of psychosis. The patient’s family will have an intimate knowledge of the person’s views, beliefs and behaviour when well, but this information will not be available if consultation with them does not take place.

5. Institutional Framework

The concerns which we have expressed in the past have not been allayed.

— We are still worried about the concept of a tribunal which combines the roles of imposing compulsion and reviewing orders.

— We are afraid that the problems associated with the current Mental Health Review Tribunal system, including unacceptable delays, will beset the proposed tribunal.

— We do not favour single member tribunals in any circumstances. A legal Chair considering what might be perceived as a simple fact still has to understand the interpretation of that fact, which may call for the experience of others.

6. Safeguards

The proposed safeguards need to be strengthened.

We are particularly concerned about the dangers involved in the use of restraint. Some Rethink members have lost relatives following its use. Glen Howard, a section 3 patient, died after restraint was used by the police in order to return him to the ward where he had been detained. We believe that the draft Bill increases the likelihood of such incidents since patients on non-residential orders will have to be removed to a hospital setting in order that medication can be given by force At the moment there is no consensus as to good practice in the use of restraint.

Access to independent advocacy should not be limited to those under compulsion. Earlier provision of advocacy during the examination stage could be vital in gaining access to care and treatment in order to avoid compulsion, ie it should be provided from the start of the examination rather than later, from the start of assessment under compulsion.
The nearest relative’s right to discharge has been removed in the draft Bill, as well as the right to require a local authority to direct an Approved Social Worker to assess whether an application for compulsion might be appropriate (section 13 para 4). Clause 14 of the draft Bill gives the right to any person to “ask for” examination to be arranged, while the authorities have discretion as to whether they will respond, is much weaker. In our view carers must be given similar rights to those which were allocated to the “nearest relative” in the 1983 Act.

We believe that children should always receive care and treatment in appropriate settings and from suitably trained and qualified professionals with the necessary expertise. In Rethink’s view, new legislation should impose a specific duty on the authorities to ensure that appropriate services are available for children and adolescents. We note that this is one of the requirements of the new legislation in Scotland.

7. Balance Between the Face of the Bill and Codes/Regulations

As we have said in relation to the Principles, we strongly believe that a full set should be on the face of the Bill rather than in the Codes, as is the case with the new Scottish mental health legislation and the Mental Capacity Bill.

We also believe that important subjects like the circumstances in which it might be right to consult the carer despite the patient’s opposition, should be described as a provision in the draft Bill and not the Code of Practice.

On the whole, the draft Bill’s frequent use of “get-out” terms like “appropriate” and “suitable”, without explanation or qualification, leaves much to guidance to be provided in the Codes of Practice which may not have the same status as the Act. It is also difficult to assess the likely impact of the draft Bill which leaves so much detail to other documents which we have not seen. For example, Part 2 Chapter 1 Clause 12 para 4 states that consultation with a carer is subject to the patient’s wishes and feelings, which should be sought “unless inappropriate or impractical”. The Explanatory Notes expand on this issue, but do not mention whether there is to be further guidance in the Codes.

Other important matters, for example which group of patients are considered suitable for compulsory assessment in the community, are to be left to regulations rather than made explicit in the Act (see paragraph 66 of the Explanatory Notes.

As the draft Bill confers no private rights on individuals but relies on imposing duties on the relevant authorities, challenging professional actions or failures will be mainly through the process of judicial review, which is rarely a practical prospect for patients and their carers.

8. Integration with Mental Capacity Bill

Our main concern is that although there is some provision for Advance Directives in the Mental Capacity Bill, neither advance directives nor advance statements are mentioned in the current draft Mental Health Bill. We believe that it is vital that the draft Bill should enable the patient to set out their views and preferences about treatment, proxy decision-making, information sharing and practical arrangements to be made during any further period of illness, in a comprehensive advance statement drawn up after the person has fully recovered from an episode of illness. The care planning process should ensure that the patient is offered an opportunity to do so and given any support required, and that the advance statement should be regularly reviewed and stored with the crisis plan.

There will be considerable scope for confusion if the draft Bill is enacted as it stands. Clause 9 of the Mental Capacity Bill sets out the role of a Lasting Power of Attorney, which includes authority to make personal welfare decisions. In addition to the person carrying out this role, a patient could also have someone providing day to day care, and another appointed as “nominated person”. It appears to Rethink that insufficient thought has been given as to how these arrangements would work in practice.

9. Compliance with the Human Rights Act

Rethink believes that the shape of this draft Bill was largely determined by two conflicting aims—the wish to appease the public’s fear of the risk posed by people with mental illness, a concern largely generated and fuelled by the tabloid press, and the need to address some of the arrangements under the 1983 Act which are not compatible with the Human Rights legislation. We believe that in addressing these aims, insufficient consideration has been given to the needs of people with mental illness and their families, particularly the need for a right to prompt access to care and treatment when necessary. If compulsion is necessary, there must be a reciprocal right to treatment which is of therapeutic benefit and to good quality services which meet the patient’s needs. We also believe that carers’ human rights have been overlooked in the second draft Bill.

Many of those who are eventually subjected to compulsion lose awareness of their need for care and treatment as they move towards a mental health crisis and deny that they have any form of mental health problem. So those closest to them, usually family and friends, have to press for the help they need. In many
cases these people are the patient’s greatest safeguard. The 1983 Act recognised this crucial role in accessing help for those who had lost the capacity to ask for it themselves, and also in resisting the use of compulsion, and gave important rights to a family representative described as the “nearest relative”.

These rights were part of the carefully thought out checks and balances designed to give the family some powers to counterbalance those of the professionals. But the current draft Bill has stripped away most of this and the sum total of the rights allocated to the “nominated person” and the carer are significantly less than those available to the “nearest relative” under the current Act. By contrast, the professionals have been given far more discretion then they have at present, which would, if the Bill were enacted as drafted, allow them to marginalise or eliminate the involvement of the carer, family and friends.

This is possible because the “appointer” of the “nominated person” is generally required to accept the service user’s choice of appointment, provided the patient is thought to be capable, made at the very time when compulsion has just been ordered. In most cases, the carer will have been attempting to persuade the service user to seek help, when the user is convinced that he or she is not unwell, so there is likely to be a significant disagreement between them. The patient may veto consultation with the carer, which will make it impossible for the appointer to know the carer’s perspective of the situation and to gain important information without which a full assessment would not be possible.

Have the policy makers considered what will happen if the person providing the substantial and regular care does not agree with decisions made by the “nominated person”? Is it fair that someone should be discharged into the home of a carer who is to provide security, food, support and encouragement without information which they have a reasonable right to know, including the date of discharge? Some carers may decide to relinquish the role if this information is denied.

It is to be expected that the 1983 Act does not mention carers, as the concept was barely recognised in UK law when it was drawn up. But considerable advances have been made since, including the requirement in Standard Six of the Mental Health National Service Framework 1999 that some information is shared with carers. They must also have the right to be heard, if vital pieces of information are not to be lost to the assessment process. It is also essential that carers’ health, safety and well-being are protected and that information essential to enable them to continue their supporting role is not denied to them. In the words of the Framework, Standard Six, “Caring about Carers.”

“The families of individuals with severe mental illness may have to contend with demanding behaviour, extra financial burdens, restrictions upon their social and family life, and occasionally a risk to their own safety.”


Rethink is extremely concerned that insufficient thought and planning has gone into the actual implementation of this draft Bill, despite its long course of development in recent years. In too many places, the draft Bill directs practitioners to the Code of Practice, which is yet to be written. However, in commenting on the draft Bill it is also vital that all interested bodies can assess these proposals alongside practice guidance for implementation and in too many places our reading of the draft Bill leaves us with major doubts over the practicalities of introducing these measures within current resource levels for mental health.

Key concerns for Rethink include the application of legislation and quality of service provision. Underpinning any new legislation must be a substantial training programme for all mental health professionals and support staff in the statutory, private and independent sectors. Levels of knowledge and understanding of the 1983 MHA are still poor and variable across different professional groups/sectors and this translated into variations in application. Safety for professionals, patients, carers and members of the public in the application of legislation is a key concern: Will tribunals have sufficient resources? Will agencies (including the emergency services) enforcing the application of non-residential treatment orders be properly resourced and trained? How will the management of risk assessment and restraint be more effectively supervised and monitored in both residential and non-residential order settings to prevent accidental deaths? Will appropriate feedback mechanisms to ensure effective communication of decisions and actions regarding application of the new legislation between multi-agency staff, patients, carers and other involved parties be introduced? How will the therapeutic relationship between professional and patient be affected by the introduction of a new legal framework and what measures and processes will be in place to inform users and carers of their rights—other than planned advocacy services which will need substantial increased funding to meet demand?

Inequalities in application of the current mental health act are well documented, contributing in part to variations in the quality of service provision across England and Wales. Despite reforms to drive up standards in mental health care, mental health enquiries continue to highlight problems within the system: poor communication between agencies and individuals; inappropriate service placements; poor record keeping; insufficient resources locally to provide comprehensive package of care; professional incompetence or lack of staff support and supervision. Without substantial increases in the level of resources, we do not believe that the new legislation will address current failures.
The human implications of this draft Bill for patients, carers and professionals are far reaching. As our submission emphasises we do not feel the right balance has been found to promote improvements in quality of life for patients and their families/friends, whilst balancing the rights and responsibilities of the public. There is little mention of therapy and the therapeutic benefits of mental health treatment under the Mental Health Act. The introduction of non-residential treatment orders, with likely increased levels of compulsion, will impact on all groups and in particular those patients from Black and Ethnic Minority Communities who are known to subjected to higher levels of compulsion under the current Act. Alongside voluntary organisations such as Rethink, professional bodies are also afronted by proposals in the draft Bill and with recruitment and morale difficulties ridding mental health services this draft Bill looks set to increase pressures on an already strained system.

October 2004

Memorandum from Hafal (DMH 161)

“Hafal empowers people with severe mental illness and their families to achieve a better quality of life, to fulfil their ambitions for recovery, to fight discrimination, and to enjoy equal access to health and social care, housing, income, education, and employment”—Hafal’s Mission Statement

“This is not what patients and families want. We know there is a need for a legal framework but it has to be balanced fairly. The state has no right to compel people to undergo treatment if it is not also prepared to give them legal rights to a choice of treatments which they can seek voluntarily”.—Peter Davey, Chair of Hafal.

1. About Hafal

Hafal (meaning “equal”) is a patient- and carer-led organisation working with people with severe mental illness and their families in Wales. Many of Hafal’s membership of 612 have extensive personal experience of the Mental Health Act 1983. Hafal operates over 60 projects across Wales providing a range of services for people with severe mental illness: these include employment/training projects, supported accommodation, resource centres, club activities, befriending schemes, advocacy and carers’ support services. Over 600 people use a Hafal service every day. In addition Hafal campaigns vigorously through research and publications to remove the stigma and isolation associated with severe mental illness.

2. Summary of this Response

Hafal acknowledges that there are some improvements on the 2002 draft particularly those relating to the conditions for Community Treatment Orders and the treatment of offenders. However, there remain fundamental weaknesses in relation to:

— incompatibility with Welsh policy and the current state of services in Wales;
— the scope for extending use of compulsion to new groups;
— the lack of rights for carers;
— the lack of reciprocal rights to treatment.

Everybody understands that compulsion is needed as a last resort, mainly to ensure the safety of those who become seriously vulnerable because of their illness. But compulsory treatment is a distressing and highly complex business which for obvious reasons damages the trust needed between doctor and patient. The draft Bill is also significantly more complex than the 1983 Act making it difficult for patients and families to comprehend the process. The Government has missed an opportunity to engage in a dialogue with patients—the real experts who understand how severe mental illness affects people—with a view to reducing the need for compulsion by ensuring early, effective treatment.

Hafal is a member of the Mental Health Alliance and shares their general concerns about the Bill: we have not attempted to repeat these here but rather we reflect on specific issues for our members in Wales.

3. Compatibility with Welsh Policy and Services

We are especially concerned that Wales simply has not got the infrastructure to support this legislation. The Commission for Health Improvement has reported that Wales’ services are less developed than those in England. Very little of Wales’ National Service Framework has been implemented and there is no clear timetable for implementing many of the required standards. Wales has an acute shortage of psychiatrists and other key human resources; psychology services are also seriously under-resourced.

Implementation of this Bill, which requires a marked increase in Tribunals, would have the effect in Wales of diverting already scant resources away from timely and effective services into the management of the legal process: this in turn would mean more people deteriorating to the point where compulsion was necessary.
While Hafal will campaign to ensure that regulations and the Code of Practice for Wales are attuned to Welsh Policy and Services the suggested primary legislation sits very poorly with the Assembly Government’s own Strategy which promised empowerment and choice to patients and families.

Hafal is also concerned that the Bill does not take account of the Welsh language which should be used in all aspects of the administration of new legislation where patients or families prefer this.

Hafal is concerned that the increased bureaucracy which the Bill would create will be especially difficult to accommodate in Wales in particular in rural areas.

Hafal would like to highlight the Mental Health Act 2003 introduced by the Scottish Parliament. Their legislation was developed in careful liaison with patients and other interested parties. Though there remains some controversy there is nevertheless a degree of consensus in Scotland about the way forward. Of course the National Assembly cannot make law as the Scottish Parliament can but Wales’ devolution settlement only makes sense if Westminster makes laws which work in Wales: without radical change this Bill will not work in Wales.

Hafal is a member of the Wales Alliance for Mental Health which shares the broad concerns expressed above.

4. **Scope**

Hafal is concerned about the scope for the use of compulsion. The 2004 draft is little improved on the 2002 version in this respect because new groups will inappropriately come under the scope of the legislation including those with substance misuse problems and people with personality disorders for whom there is not a clear course of treatment.

The Government has made much of the “closing of the loophole” concerning the very small number of people with a personality disorder whom the Government believe should be detained without having committed an offence. Hafal has always believed that this matter should be addressed through separate legislation: a Mental Health Bill should be about health. The confusion of these two separate issues will result in continuing misunderstanding and prejudice in wider society and distrust and distress for patients and families.

5. **Carers**

The Nearest Relative loses rights which they held under the 1983 Act: in particular they may be excluded from key rights such as the power to seek discharge because new provisions for the Nominated Person replace the previous rights of the Nearest Relative. In particular one of the key benefits of the Nearest Relative provisions in the 1983 Act was the ability it gave carers to resist the imposition of compulsion in the first instance: this vital safeguard is largely compromised in the proposed Bill. Hafal recognises the right of patients to choose people to advocate for them but this can be addressed at the same time as retaining rights for carers to be engaged as key parties in their own right. The proposed limited rights for carers to be informed and consulted are insufficiently rigorous being subject to qualifications of appropriateness and practicability. The role of the carer could also be assisted by full integration of advance directives into the legislation which might often be used by patients to nominate carers.

6. **Reciprocal Rights**

Hafal’s recent survey of patients and families indicated that their highest priority for new legislation was to establish a right to treatment. This would be a counterbalance to compulsory treatment which is understood by patients and families to be a necessary last resort.

Reciprocal rights are frequently argued for as “compensation”—offering something in return for the invasion of individual rights which compulsion necessarily involves. This is a valid argument but Hafal’s members seek legal rights to treatment for much more concrete reasons. Typically patients and families who seek help at the early stages of illness receive too little help too late: subsequent deterioration frequently leads to the use of compulsion. It is staggering to note that 50% of people with psychosis find compulsion their first experience of specialist care. More than a third of patients who are treated under the 1983 Act have previously been refused treatment which they sought voluntarily. Long experience tells our members that the quality of support (if any) when it counts at the early stage never matches the methodical and relatively consistent application of legal compulsion (which of course will always also win the case for resources).

Rights to early treatment would create a more humane and cost-effective service, steering patients quickly towards recovery and social integration and reducing the need for compulsion. Extending rights to aftercare treatment following discharge (beyond the suggested very limited requirements over six weeks) would also assist patients in making a successful recovery and avoiding relapse.

Reciprocity of this sort was initially recommended in the Richardson report “Review of the Mental Health Act 1983: Report of the Expert Committee” (DoH 1999). Hafal does not see why this principle should be abandoned.
7. *Improvements in comparison with the 2002 draft Bill*

(i) *Community Treatment Orders*

Hafal’s members have not opposed in principle the idea of compulsory treatment being provided other than through detention in hospital: their concern was that such arrangements should not extend compulsion but rather offer an alternative to hospital treatment. Hafal therefore welcomes the restriction of CTOs to those who have previously been admitted to hospital but we believe this should be made clear within the body of the Bill, not left to regulations, and we remain very concerned that CTOs may still be used on patients where previously no compulsion would have been applied. Hafal also believes that the powers to limit behaviour of those subject to CTOs should be defined and confined mainly to treatment compliance.

(ii) *Compulsion in Prison*

Hafal welcomes the withdrawal of the proposal for compulsory treatment within prisons.

(iii) *ECT*

Hafal welcomes the further restrictions on use of ECT.

8. *Evidence*

Hafal has conducted a Survey, including specific questions on mental health legislation, of over 300 patients, carers, and staff: Hafal’s response is based on this Survey and the extensive experience of members, clients and staff. A full report of the Survey is available on request from Hafal.

Hafal is willing to give evidence in person if requested and we have an expert panel of patients and carers for this purpose.

Should the Committee (or individual members) visit Wales Hafal members would be delighted to welcome them to our innovative project at St. Fagan’s, Cardiff where support is provided to both patients and carers demonstrating successful management of severe mental illness within the community.

*October 2004*

*Witnesses: Mr Cliff Prior, Chief Executive Officer, Mr Mike Took, Service User and National Policy Officer, Ms Elaine Barnes, Carer, Ms Mary Teasdale, Advice Service Manager, Rethink, Ms Jo Roberts, Service User, and Ms Vicky Yates, Carer, Hafal, examined.*

**Q242 Chairman:** Good morning. Thank you very much for coming. I should declare an additional interest. I have already declared an interest as a trustee of a charity called Rekindle, which is a mental health charity based in Mid Wales. In fact, Rekindle has a part management agreement with Hafal, which manages part of its services for it in Newton, Powys. Welcome. We have a lot of time and carer-led. As you will know from the evidence is recorded. You will be sent a transcript of the recorded evidence in due course. Please feel that you can make textual amendments to transcripts; but you cannot make amendments of substance. Not everybody will be able to answer every question—there are six of you. I think you share a commonality of interest, being a brother and sister organisation.

**Mr Prior:** I am Cliff Prior. I am Chief Executive of Rethink, the charity for people affected by severe mental illness in England and Northern Ireland.

**Ms Teasdale:** I am Mary Teasdale and run Rethink’s advice service, which means I have day-to-day contact with users and carers and an overview of the sort of problems affecting them.

**Mr Took:** Mike Took; I am Policy Officer for Rethink I experienced mental illness in 1985 and was detained under the Mental Health Act, but I have been well since then, and I have run a carers’ group since 1987.

**Ms Barnes:** My name is Elaine Barnes. I am a carer from Sheffield. My son is currently detained under the Mental Health Act. I also work for Rethink as a Service Manager, managing the carer services.

**Chairman:** We are particularly interested in the views of service users, including carers; and if other witnesses could slightly defer to those, we would be grateful. We will start with Lord Carter.
Q243 Lord Carter: We have had evidence from Rethink that it wants to place a duty on authorities for adequate care and support services, including certain specialist services. How would you define “adequate”, and would a statutory, but vaguely defined duty simply invite unnecessary litigation and legal costs?

Mr Prior: Can I put this in the context of why we feel this is such an important measure? The main problem with mental health services at present is the difficulty that people in the early stages of a mental illness, and their friends and families, have in accessing help. Research suggests an average of 12 months’ delay for people with first onset of psychosis before specialist help. A lot of people try to get help during that period and are turned away. Carers, even more frequently, are denied help. As a result, for half of the people with first onset of psychosis, a compulsory section is their first experience of care. Compulsion at the moment is the main resort, not, as has been mentioned earlier, the last resort for people with severe mental illness. It is traumatic and dangerous and poisons future therapeutic relationships, and it is a personal tragedy for every single person who is sectioned. There are nearly 50,000 uses of compulsion a year. We feel that the Bill should try to tackle that problem. In our surveys, 70% of people put a legal right to adequate care and treatment as their number one priority for their needs the right help and I use all mechanisms to battle on a daily basis to get the right help for my son. Without me being very vocal—and may I say I am very bossy—my son would not be in the position he is, whereby he would be leaving the secure unit he is currently in, because I am very clear that he needs the right help and I use all mechanisms to make sure that the statutory service provides the right care to the needy.

Ms Roberts: I am going to reiterate some of the points that Cli

Chairman: And a lawyer.

Ms Yates: I do not think that came into play too much because with the passion and the pain that was involved in discovering that my daughter was suffering from this terrible illness, I was in such shock that the legal knowledge went out of the back window, and my gut reactions as a carer and as a mother took over. I think that it is absolutely essential that we look at this as an individual concept: people need to have a basic treatment plan. We ought to be asking for written reasons if no treatment plan is forthcoming.

Q245 Chairman: Can I turn this to Ms Barnes, because she may be able to link with this. You come from a different part of the country, which is why I want to broaden it. Do you feel that if there was a statutory obligation, along the lines of Lord Carter’s question, to provide adequate care and support services, and something like the educational statementing procedure, that that would help you as a carer?

Ms Barnes: It certainly would do. In Sheffield I have to battle on a daily basis to get the right help for my son. Without me being very vocal—and may I say I am very bossy—my son would not be in the position where he is. I found my way to a GP in a psychiatric hospital for the first time and that was a delusional mindset and then it needs to be picked up and dealt with very, very quickly. My GP did not pick it up. That is no criticism of her, because it was quite well masked, but we do need access to specialist services.

Ms Roberts: I work in a forensic unit, Llanarth Court, in the women’s services, and 90% of those ladies will tell you that they knocked on every door that was available for possibly two or three years, and did not get any help; and then something sensational happened and they were sectioned under the Home Office. We need early intervention. It is okay to talk about compulsion orders, but if we can get early intervention in, then compulsion orders will be reduced. There needs to be a legal right to early intervention, I feel, on behalf of the service.

Q246 Chairman: Can you give a percentage of the women in the unit where you work that you think might have been saved from sectioning?

Ms Roberts: Possibly 90%. I do not have statistics, but I would say, talking to them, 90% of the ladies went knocking on doors, and help was not available.
Q247 Mrs Blackman: Is that about a capacity issue, that there are not sufficient psychiatrists, or is it about the system not working well enough and that the GPs and other professionals do not pick up the issue and refer on; or is it a bit of both?

Ms Roberts: It is very much both.

Mr Prior: It is also to do with the way the current legislation is couched. At the moment, if somebody meets certain criteria, they can be subject to compulsion by a mental health service, at which point the mental health services have to provide very expensive intervention, with secure beds and so on. It skews the whole mental health system down towards the end of failure. Some people become so ill that a compulsory section is needed. That is where all the resources have gone. More money has gone into mental health services in England and Wales over the last few years, but disproportionately it has gone into yet more secure beds. We still have very little resource at the first end. If we have a balanced Mental Health Act, which, whilst it keeps powers to compel people who become very ill, also gives powers for people who are less ill in the earlier stages—to compel services to be provided—then we are much more likely to get a more balanced arrangement in mental health services and the resources deployed more where they can make most difference, ie earlier on, where people can be saved from this terrible decline; and for individuals themselves and for their families watching this happen, battling and unable to get any help until people have become so desperately ill that the only resort left is to have them literally sometimes dragged kicking and screaming into hospital. It is a terrible thing to happen to anybody or any family, and we really ought to have a more balanced mental health programme.

Q248 Lord Carter: Your evidence is compelling, but is the problem that there is not a means of appeal so that the problem of access can be dealt with? If there were a duty in statute, it would have to be clearly defined, and you could be placed in some sort of appeal system with litigation and legal costs.

Mr Prior: I agree that one does not want to introduce extended powers that require tribunals and appeals and so on, and that is why we think the extended powers on the compulsory end go too far and cut far too much resource in, in that process. At the moment, people do not even have a first right, let alone a right of appeal. At the moment, whilst there is a maximum time limit I should have to wait for a hip operation or for a referral to a heart surgeon, there is no such time limit and no such right in terms of access to a mental health service, even though the consequences both for the individual, and the vast cost to the state, are in many ways much greater. A first right is what we are seeking. We have it in other areas of public welfare. We have it for homeless people. We have it, although unfortunately with no appropriate time limits, on doing it, under the Community Care legislation, but we do not have it in mental health care. Part of the reason why mental health care is so distorted towards dealing with failure is because the legal powers are there for that end and they are not there for the other end.

Q249 Baroness McIntosh of Hudall: I would like to pick up the question of the two cases that Ms Barnes and Ms Yates have talked about—their own examples. Would I be wrong or impertinent in assuming that both the patients were young? Were they under the age of 18, either or both of them, when the symptoms began to appear?

Ms Yates: Yes, in my case she was under the age of 18.

Q250 Baroness McIntosh of Hudall: In relation, firstly, to diagnosis, and, secondly, to treatment, is the issue about diagnosis and the reluctance to diagnose or to be clear about treatment specifically more difficult in relation to people who are below the age of consent, and, secondly, is their treatment noticeably different? Do you have any observations on what is in the Bill about the treatment of young people under the Bill?

Ms Yates: Obviously, the issue of diagnosis is extremely sensitive. When you are being told that your 16-year old child has schizophrenia, it is a challenge for the profession to deal with that in the most humane way possible. I can honestly say that it was probably the most shocking thing that has ever happened to me, to hear that word in relation to my daughter. I actually have a photograph of her. I bring this photograph to show you what a beautiful girl she is and how sad it is for me to know that for her she cannot accept that diagnosis. She knows she has a mental illness, but she will not accept that it is schizophrenia. As she says to her consultant, in the gentlest of ways—because she is the gentlest person in this terrible thing to happen to anybody or any family; you do not know the damage you do with legal costs. Of instances. Whilst one can understand that legal powers are there for the other end. If we have a balanced Mental Health Act, which, whilst it keeps powers to compel people who become very ill, also gives powers for people who are less ill in the earlier stages—to compel services to be provided—then we are much more likely to get a more balanced arrangement in mental health services and the resources deployed more where they can make most difference, ie earlier on, where people can be saved from this terrible decline; and for individuals themselves and for their families watching this happen, battling and unable to get any help until people have become so desperately ill that the only resort left is to have them literally sometimes dragged kicking and screaming into hospital. It is a terrible thing to happen to anybody or any family, and we really ought to have a more balanced mental health programme.

Q250 Baroness McIntosh of Hudall: In relation, firstly, to diagnosis, and, secondly, to treatment, is the issue about diagnosis and the reluctance to diagnose or to be clear about treatment specifically more difficult in relation to people who are below the age of consent, and, secondly, is their treatment noticeably different? Do you have any observations on what is in the Bill about the treatment of young people under the Bill?

Ms Yates: Obviously, the issue of diagnosis is extremely sensitive. When you are being told that your 16-year old child has schizophrenia, it is a challenge for the profession to deal with that in the most humane way possible. I can honestly say that it was probably the most shocking thing that has ever happened to me, to hear that word in relation to my daughter. I actually have a photograph of her. I bring this photograph to show you what a beautiful girl she is and how sad it is for me to know that for her she cannot accept that diagnosis. She knows she has a mental illness, but she will not accept that it is schizophrenia. As she says to her consultant, in the gentlest of ways—because she is the gentlest person you will ever meet in your life—“you doctors, you people; you do not know the damage you do with your labels”. I think she sums it up there. I am really glad that you focused on that question, because this is something I raise whenever I am asked to talk about the expert carer’s point of view. This is something that is very ham-fistedly handled in a lot of instances. Whilst one can understand that professionals would not want to rush to apply labels which are so very damaging, and will become more damaging if this Bill becomes law, it is also very important to have some kind of input to monitor, and to give the best possible drugs that are available. Unfortunately, my daughter ended up taking Seroxat, which was a disaster. She was then put on Soefen, which was a disaster. She was then put on Seroxat, which was a disaster. She was then put on Seroxat, which was a disaster. She was then put on Seroxat, which was a disaster. She was then put on Seroxat, which was a disaster. She was then put on Seroxat, which was a disaster. Unfortunately, my daughter ended up taking Seroxat, which was a disaster. She was then put on Seroxat, which was a disaster. She was then put on Seroxat, which was a disaster.
which her care was managed was largely as a result of a strong, robust dialogue between me, the family, and the care team. I despair of a situation where, if this Bill becomes law, my role in that process and dialogue will be reduced.

Q251 Chairman: Was she there as a genuinely voluntary patient, or did she fall straight into the Bournewood gap?
Ms Yates: Could you elaborate on the Bournewood gap?

Q252 Chairman: It is not a fair question. I know somebody who could elaborate on that in some detail.
Ms Yates: Did she lack capacity? At times, yes, she did. It was a moveable feast. Sometimes she seemed to be more knowing than the psychiatrist and other times she clearly did lack capacity.

Q253 Chairman: Was she under a form of non-statutory compulsion in reality or not?
Ms Yates: Well, that is very difficult to answer because when they did get to the stage of threatening to use their compulsory powers, my response was, “well, no; she is not a danger to herself and she is certainly not a danger to others; and I can take care of her clinical needs”. What label you want to put on it, I am not sure.

Q254 Chairman: I think we understand that quite clearly. Ms Barnes, do you want to add anything?
Ms Barnes: Yes, some of my experience is very similar to my colleague, but my son became ill around the age of 14. I knew immediately there was something wrong with him, partly because I was a youth worker, working with youths with behavioural problems. My GP was very clear there was something wrong, partly because we had built up a very positive relationship with her over the years, as patients. When we were referred to the child adolescent services, they more or less blamed me for my son’s behaviour, as opposed to seeing that my son was genuinely not well. So I then went and battled with the service in many ways for them to recognise that this was something serious that needed to be taken seriously by the professionals. It was not picked up, and it was two years after my son attempted to commit suicide, that the service picked up that he was actually ill. It was at this point that we were sent out of Sheffield because of the complaint I had lodged against various members within the services. They decided I was too much for them to handle basically. We went to Nottingham, and he received the right care that he needed; but by then his mental illness had developed into schizophrenia. He was then put, at the age of 16, on Risperidone, but that medication did not help him. We have had years of backwards and forwards into the mental health system, which is why he is currently in a secure unit.

Following from what my colleague has said, working with family members is really important— I cannot stress that enough. Without me, my son would have been in a far worse place than he currently is. I just want to add something else: from the black and minority ethnic community. I am very concerned that currently we are over-represented under the current Mental Health Act and under the current draft Bill I am even more fearful as to what might happen to people like my son, and myself as well. I am very concerned about this.

Chairman: I will take the next questions from Mr Hinchliffe, Mrs Browning and Lady Barker as a group, and then ask for responses. Mary Teasdale may be able to help us from the carers’ perspective in a moment.

Mr Hinchliffe: In a sense, Elaine Barnes has taken us exactly to the area that I wanted to ask her about. You may have heard in the earlier session that I referred to the Health Committee’s inquiry about five years ago into the mental health services. One of the things that struck us and disturbed us was the way in which, as you have stated, the black community was grossly over-represented within the mental health system. I recall visiting a private secure unit in Yorkshire that was full of young black men from London, locked up there with, frankly, not a lot of hope of being returned to the communities they came from. How do you feel that this legislation could be made more culturally sensitive to address the issues you have just touched on about the black community?

Mrs Browning: Can I ask you about primary care, and the interface when somebody comes directly into contact with primary care services—the carer and the person with a mental health problem. We know that the Government is introducing a national framework for mental health, and early intervention is at the heart of that. In my own constituency in Devon we are having a battle with mental health services because people have been split into “core” and “non-core”. If you are non-core and you present to a GP, you will be jolly lucky if you even get a referral through a community mental health team within 20 weeks. I have a lot of support for what you are requesting here. I think that the terminology will need to be tweaked to make it suitable to go into the Bill, but the principle of having an assessment and the right to support services as a statutory matter, I support. I am very concerned at what we are hearing today. It seems to me that that at the first port of call at primary care—and I am not making a criticism of GPs, but a lot of GPs do not have the expertise or the resources themselves to be able to deal in practice with somebody. If people are not going to get their support at primary care level, and end up under a section order, or straight into a hospital, how do you think we need to re-organise those first visits and those first interfaces with the health service to ensure that people are enabled to get further up the system while they are still in the early stages? We have heard today of mothers battling, and of people waiting two years until they are sectioned. Is there not something fundamentally wrong now that really needs to be addressed now; and is that outwith this Bill and to do with health provision generally?

Baroness Barker: You are clearly people who have done your utmost for your relatives, and you are at one with your relatives and what their best interests...
are. Where do you think the balance lies for professionals when there is a disagreement between the patient and their families? Secondly, adding to David Hinchliffe's question, what could be done to make this Bill better for carers from black and minority ethnic communities, because I was very struck by your comment, Ms Barnes, about suddenly becoming part of the problem rather than the solution in the eyes of the professionals.

Q255 Chairman: Could I ask you first to deal with part of Lady Barker’s question and Mr Hinchliffe’s question about greater cultural sensitivity, and also how this can be interfaced with help for carers?

Ms Barnes: In terms of the BME carers, I do not feel that there is a simple answer to that question, partly because I am one person and I do not represent the whole of the black and ethnic minority community United Kingdom—just to be very clear about that. I work very closely with a lot of BME carers in Sheffield, and I am very fortunate that they do come to me because they feel they can identify with me. I gather that the route into this system, whilst it is very similar to white care, is quite traumatic because often they are going through the police in order to get access to services. Once that access is through the criminal justice system, the barriers are there for a lot of carers; and they are reluctant then to engage with any professional. Even with good intentions, the barriers are there, so we need to look at the route by which carers come into the system. In terms of how we engage, there is a lot around training professionals to understand carers’ experiences. I deliver training to a lot of professionals, and I do not see many consultants or doctors in the training sessions, partly because they are a bit too busy. From my point of view, I am also very busy, as a carer, and I have taken the time to do a lot of things, despite my busyness. I think somehow they need to take the time to also listen to our experience and find out what is helping from our point of view. I think that this needs to be mandatory. I am sorry to use that word, but I do feel that it should be mandatory.

Ms Teasdale: I agree with Elaine Barnes. Access is such a difficult problem for families that we produced a fact sheet called Getting Help in a Crisis—in which we go through all the options that people can try in order to try and get a relative into the system. It starts obviously with access to the GP, but a lot of GPs will respond to a carer by saying, “unless your relative comes to see me directly, there is absolutely nothing I can do”. The Government has tried to block this gap by setting up early intervention, but, again, you may well need a referral into early intervention. There are a number of steps you could take to try and get into the system, but, as we have already heard, that can take a considerable time. The ultimate step under the current legislation is by using section 13(4) of the 1983 Act, which gives the nearest relative, as defined in the Act, the right to require an approved social worker to assess the situation to see whether compulsion might be needed. At the moment, this is a right that the nearest relative, who is often the carer, has, and it is an absolute right. We are worried about the fact that under the draft Bill this right disappears, as do practically all the rights of the nearest relative. Under the draft Bill, anyone can ask the appropriate authority, which is presumably the Mental Health Trust, to respond to a request for assessment. We do not know who makes the decision under the draft Bill, and whether that assessment is going to take place by being passed on to the approved mental health professional. It is not clear at all. The duty is to respond to a reasonable request, but at the moment we do not know what would constitute a reasonable request. There are a lot of questions there, but the general change in the Bill is that the rights that currently are invested in the family by the 1983 Act mainly disappear.

Q256 Mr Hinchliffe: On that specific point, you are uneasy about that right, which was also there in the 1959 Act, before the 1983 Act, being removed. However, would you accept that in some instances the nearest relative has been very uneasy about having that role foisted upon them; and that therefore some relatives would disagree fundamentally with the point you have just made?

Ms Teasdale: I do not think they would disagree fundamentally. It is absolutely clear that the better applicant is the approved social worker, as the code of practice says; but we are talking about a last-resort situation. If you have a relative whom you know is bent on suicide, or you are in that sort of crisis situation, that right under section 13(4) sometimes saves the day and prevents a real tragedy. It is absolutely right that families would much prefer the situation to be dealt with in a very different way, but as a last-resort option we are really worried about it being used.

Q257 Chairman: Mrs Browning asked a big question about the very big issue of primary care. Anyone who has had experience of looking closely at the primary care health system would state at the outset that GPs’ reactions to different situations are extremely variable, from the admirably imaginative and focused to the opposite end of the extreme, to which I will not apply adjectives. It is a policy issue really, Mr Took; and I was going to turn to you for your answer to Mrs Browning’s important question.

Mr Took: It is well recognised that GPs are not generally specialists in mental health. Research in 1993 into depression found that only half of GPs picked up people with depression. Add a matter of good practice, having a mental health specialist on tap within the GP practice is the best way ahead, and certainly GPs appreciate having that specialist mental health expertise close at hand. That is the solution to the problem, and it already happens in many areas.

Q258 Chairman: Certainly in Wales a number of general practices have mental health professionals, some of whom are professional clinical psychologists working as part of the practice. It is very much a minority of practices, but some do. As
a group, do you have a view as to whether that is effective in clinical terms, because if it is effective in clinical terms it is bound to be cost-effective because it happens at the first gateway?

Mr Prior: Clearly, this is a big area of problem. If you take a condition, a diagnosis of schizophrenia, the average GP only sees a person with first onset of schizophrenia every year to two years, so they are not building up expertise. It is a difficult job for GPs. We have to recognise that. Various service measures help. Gateway workers are being introduced in primary care in England, and they are mental healthcare specialists in the primary care setting, which is an excellent move. Early intervention services are supposed to be becoming set up, although the progress is much slower than was originally hoped for, to provide somewhere much more positive and youth-focused for a GP to refer somebody to, because part of the difficulty is a reluctance of GPs to refer on for specialist help, when they know that the only specialist help on offer is some terrible over-crowded, run-down adult psychiatric ward. That is not the place where you want to send a very vulnerable young person. Although service measures like that are important, and there are wonderful initiatives like the Yes Scheme in Plymouth in your own county, they only get there if they are backed up by duties. It is wonderful that the present Government is investing in those services, but the Mental Health Act will probably last for 25 years and there is no guarantee that all future governments would invest in those services. Unless there is something like a duty of assessment, a duty of this first response, to drive the balance of service provision towards that early engagement end, we are greatly concerned that the pattern of the last Act and the Act before it drives the care down to the end of failure, when people are already desperately ill, will be repeated again over the next 25 years. It is mainly a service response, but a duty to respond to a reasonable request for an assessment and to provide the appropriate services would help to drive that service provision and make sure it stays when times get tough and cuts are being made.

Q260 Mrs Browning: The statutory right to assessment would be something that a carer or a patient could ask of a GP at that first port of call; we are not just talking about assessments when there is some dispute about the diagnosis or the medication. We are talking about the first step here, where that right to assessment would be there from the beginning. Is that what you are asking for?

Mr Prior: Yes, and one would always hope that 99 per cent of people would never have to exercise a right, but the fact that the right was there would drive service provision to be available in the first place, and a better response.

Ms Yates: I would agree with that. One of the problems we have in Wales, which links into the primary care point, is that we have a set of national service standards, but they are not in place at the moment, and we do not have a care programme approach that is up and running in all parts of Wales—it is very patchy. To a certain extent, we are way behind England in terms of our services. That obviously impacts on the primary care thing as well because the way we see the care programme approach is in working in close liaison with the primary care centre. There is a lot of work to be done here, and it would be very useful if this Bill could focus on the very, very interesting issues we are talking about today, which is about how to improve health services, and not become obsessed with this thing about compulsion and risk management and keeping the Home Office happy.

Q261 Lord Carter: On the question of carers, there have been two Acts of Parliament, one under the Conservative Government, the Carers and Recognition of Services Act, and then the Carers Act, which has only just reached the statute book. Do you have any experience of the operation of the first Act, which has been on the statute book since 1995?

Ms Yates: Yes, I have got an experience; I have got my own experience. Whilst I was statutorily entitled to a carer’s assessment, I was not told about it; I certainly did not receive it, and I have not to this day. So whilst we have legislation in place, in Wales the difficulty is that we do not have a developed service and infrastructure to deliver on the legislation.

Chairman: We will move on now specifically to Wales, bearing in mind that there is separate secondary legislation required for Wales to large order.

Q262 Hywel Williams: Specific to Hafal, you say very strikingly in your evidence at 3.6 that without radical change the Bill will not work in Wales. Can you tell us a little bit about that in terms of the infrastructure you have already referred to? I am also interested in the rurality questions, particularly in terms of Community Treatment Orders. I am concerned about the language issue as well, and in addition the policy in Wales seems to me to be different from the policy in England. I do not know if you can answer all of those, but I would be interested in your views.
Ms Yates: Thank you so much for that. To put it into context, this Bill is predicated on the idea that there will be greatly improved services. Let us go back to the beginning. The problem we have in Wales is that we do have a national service framework comprising eight standards, and it is actually a very good document, based on good standard principles of equity, empowerment, effectiveness and equality; but it is not in place. We have not even been given a date for when it will be in place. We do not have in place the care programme approach. I am sure you are aware of how that works. It has been working well in England for ten years now. As you can see, we are way behind there. We have been given a date for the implementation of the care programme approach of December 2004, but I think that is extremely unlikely—it is unworkable and unachievable, and is some way off. Also in Wales we have severe workforce difficulties. There is a dearth of psychiatrists. We have something like 20% vacancies. It will be very difficult indeed to administer this new legislation, because it is estimated that it will take a minimum of 70 extra psychiatrists to administer this new system. Those are resources that will not be going towards early treatment, which is a great shame. In Wales, we are awaiting an Audit Commission baseline survey. They are going to report on the current state of services in Wales. All the indications are that it will reflect the view that Wales is very far behind.

Q263 Chairman: We have generally cottoned on to your view; you could not have made it clearer.

Ms Yates: I would move to England!

Q264 Chairman: Ms Yates and Ms Roberts, are you able to address Mr Williams’s specific point on rurality? It may be useful to reflect upon whether in the unit where you work, Ms Roberts, there are female patients who may well be mothers themselves, who are having to come a long way from rural areas for their treatment, having been compelled to be patients in that unit.

Ms Roberts: Visiting is very difficult because we take ladies from all across Wales. Visiting is very, very important, especially to mothers. We try and make that as accessible as possible, because we have to do risk assessments on visits as well, which makes it a little more difficult. We are the only female forensic unit in Wales at the moment.

Q265 Chairman: You are in Cardiff.

Ms Roberts: Llanarth, Abergavenny.

Q266 Chairman: So you are three hours’ drive from Llandudno, for example, on a good day.

Ms Roberts: At least—on a good day. It takes me on a good day, just from Bridgend to get to Abergavenny an hour and a half. It has taken me to go 50 miles four hours.

Q267 Chairman: That is from south-west Wales to south-east Wales.

Ms Roberts: Yes. There is undoubtedly a problem for rural Wales. We have a population that is widely distributed. We have a lack of specialist services, and what services there are tend to concentrate on the urban areas. There are large proportions of places like Ceredigion and Powys, Pembrokeshire and Gwynedd that are not adequately served. We are seeing an increase of mental illness in the farming community, following all the stresses and strains of the last couple of years; and the infrastructure is simply not there.

Q268 Chairman: Are they not served by Chester, Wrexham, Shrewsbury, Hereford and Bristol as well? Should one not be realistic about that provision? I know none of it is in Wales, apart from Wrexham.

Ms Roberts: There are provisions, but when you are thinking about the lay of the land, how wide it is in geographical terms, and how spread out the population may be, there is a difficulty of access to services if you are not in the urban parameters.

Q269 Hywel Williams: You referred to the very progressive way that mental health services hopefully will develop in Wales. Is that consistent with the way this Bill seems to see the world in terms of emphasising detention and dangerousness and all those issues?

Ms Yates: That is an absolutely question for Wales. No, I do not think this Bill is compatible with the National Service Frameworks, because National Service Frameworks 1 and 2 emphasised the need to address the issue of stigma. National Service Framework 2 specifically states that we should encourage user and carer involvement in care plans and treatment et cetera. In my opinion, this Bill will set the course of stigma back a 100 years in terms of user and carer involvement. There are some good provisions with regard to users, and we are quite happy and at ease with the notion of users being able to appoint their own nearest relative/carer, whatever label it will be. That is fine. However, in terms of reducing the role of what was the nearest relative, which will become the carer/nominated person—that will represent a significant decrease in the ability of that person to take a robust and meaningful role in the care and treatment of their loved one. Let us make no mistake about that. There is a veneer of patient autonomy in this legislation but, if you scratch away, it is very thin indeed. I am not sure whether the people who drafted this Bill—if we could somehow—

Q270 Chairman: They are in the room and they are listening to every word you are saying. I can assure you.

Ms Roberts: I would like to bring in there the rights of the user, and that is where the Advance Directive comes in. If somebody is well, they can sit down and plan their care and treatment and who they want as their nominated representative, whether it be a
carer, a member of the family, or an advocate, a solicitor. Service users are not stupid; they know what treatment and care they want and need.

Q271 Baroness Finlay of Llandaff: I was interested to hear that you have less resistance to the community compulsion than other people who have made representations to us. I wondered if that was because of the rurality or because of the lack of effective services in Wales.

Ms Roberts: If community orders come into effect, as long as basic treatments and care can be delivered in the community, then it has obviously got to be a better option than hospital.

Chairman: We are coming to Wales and having a session there. Can I now come on to an issue about carers.

Q272 Baroness Pitkeathley: We have had some very powerful testimony from carers this morning, and indeed Rethink’s own record on research and promoting issues of carers is a very proud one; but I want to link my question with the question raised by Lady Barker earlier. We have heard today about very good, clear and powerful relationships between carers and users, but since caring itself takes place within a pre-existing relationship, and that relationship by its very nature is variable and can be of different kinds of quality, how do we enshrine this valuing of carers in a bill, taking into account the different types of relationship in which caring takes place?

Mr Prior: We have a real difficulty with things as set out in the draft Bill. When somebody in the family or a close friend becomes severely mentally ill, the position of the carer is difficult. There are bound to be tensions. Paranoia, if that is involved in the illness, tends to settle on the people closest to you; so it is likely to be the person who is providing most care and support. Currently, the Bill states that at the point of considering a compulsory section, the AMHP must ask the individual whether they want the carer involved—at that point. There could not be a worse point to be asking that question. The carer is probably called for to help in an emergency. Clearly, if compulsion is being considered, the service user does not want the services, so they are unlikely to be terribly happy that somebody in the family has called them in. They are most likely to be most ill, and they are most likely to have lost the capacity to make decisions that they would want to have made had they been well at the time. Once the service user says “no”, the professionals then cannot consult the carer, and consequently cannot hear the history. There is no previous professional involvement at this stage; it is purely the family involvement, and they cannot hear it. It is an extraordinary and bizarre state of affairs, and it is then repeated at each point of change through the process. Clause 12 repeats—you have to ask again, do you want the carer involved; do you want the carer involved; do you want the carer involved? Nothing could be more designed to poison family relationships than this process. If the Bill were to recognise the concept of capacity or impaired decision-making, then one of the judgments made at the point of considering compulsory assessment would be, “does this person have the decision-making capacity to decide whether their carer should be consulted, or to decide at this point who their nominated person should be?” If they do not, there need to be default arrangements, as in the Scottish legislation, for example. Later on, when the individual has recovered some capacity, some decision-making ability, that is the time to ask, “if you have a relapse, who do you want involved in your care; who do you want to represent you; do you want your carers consulted?” That would be recorded in an advance statement that would then be used in any subsequent care.

Ms Teasdale: Our research department has looked at the reasons why professionals often do not involve carers. In summary, it is because of lack of training. They often lack the skills and the confidence to involve carers. Quite frequently, they complain that they do not have enough time to work with carers as well as users, because of the pressure they are working under. There is a lot of fear too. They worry about boundaries. They sometimes do not understand confidentiality policies, and training on confidentiality is rarely very good. They worry about the damage that involvement with carers might do to their therapeutic relationship with their client. There is of course still an overhang from RD Laing and a lot of worry about abusive carers. Nobody would argue that they do not exist, but we must not allow that worry to block valuable information from the majority of carers who are doing their best to access care on behalf of their relatives.

Q273 Baroness Pitkeathley: Could I ask a supplementary question? There are people who say that asking a carer for that kind of information, in defiance perhaps of the wishes of the user, is a denial of human rights. How would you react to that?

Ms Teasdale: Our research department again has done a great deal of work on this issue, and there is going to be a published report with some really practical suggestions not too far ahead in the future. Basically, like treatments and other issues, it is something that needs to be negotiated in advance. Professionals need to be trained to understand the role that carers can play, and carers with any degree of experience become very astute observers of what is going on. They can recognise when someone may be heading for another episode of mental illness. It is essential that a good alliance be set up between user, carer and the professionals so that they can find the right ways forward, so that distinctions can be made between different types of information that is shared. Most carers do not want to know the sort of personal issues that might be raised by a user in the course of consultation, maybe about intimate things like sexual history or dynamics within the family; but there is information that they would have a reasonable right to know, and without which they cannot do a very effective job of supporting.
Q274 Mrs Browning: In the Bournewood case, which the Chairman mentioned, the carers were denied access to the patient on the grounds that the psychiatrist said that, if they were admitted to the hospital, he might want to go home with them; but the European Court judgment found that actually depriving him of access to those carers was an infringement of his human rights and liberties. Bearing in mind those sorts of excuses on the part of doctors to deny carers access at a very critical point, right at the beginning when it actually matters, do you agree that the Bournewood judgment will require a statutory change?

Ms Teasdale: Hopefully. What we would really like to see is good leadership and guidance within the Trusts. At the moment, there are not many policies that relate to carers and how to work with them. It is essential that there is some forward development on this. Part of the problem is the whole concept of carers. It has been a bit late in being recognised in the legal framework. Hopefully, the Mental Capacity Act will do something about this, but it is an area that needs to be looked at closely. We have a national strategy for carers; we have Standard 6 in the NSA framework, but we do regard what is in the draft Bill as a step backward in terms of carers. It might well increase risk, which is one of the things that the draft Bill seeks to deal with.

Q275 Mr Howarth: The bullet points in the submission are very helpful. Is there not at the moment a difficulty in that the values that the mental health professionals apply are very often different from the values that a carer applies, and that sometimes they collide? If that is the difficulty, how can you resolve that in any legislative way?

Mr Prior: I am sure that is part of the difficulty, and culture barriers do come out as a major part of the current problem. If the Bill includes rights for carers to be consulted at various stages, rights that should not be overridden by consulting the user at the point where the user lacks the capacity to make a proper decision about carer involvement, then carers can force the change in professional culture. They have the right to demand and say, “you have not talked to me”. The Bill confuses quite different sorts of involvement of carers. There is informing carers about the individual’s condition and treatment—“your son is being taken to this hospital under this legal provision”; and there is listening to carers about what they have observed about the individual—“can you tell us if they have been depressed for long; have they talked about suicide?” They are important things that currently could be just blocked completely. Then there is the issue of consulting carers about their caring role—“what support do you need to help this person?” Different decisions may apply for different people. It may be appropriate to listen but not to tell in some circumstances.

Q276 Mrs Blackman: Carers UK provided us with a submission, and they gave an example of a family with an adult son who had been sectioned and was being released from hospital. The family had two minors. The son had been violent prior to his treatment, and the mum was desperate to see the care plan because they were frightened, and they were pointing out that this was a clash of the carer’s human rights and the patient’s, the service user’s, human rights. How would you square that? Would it be on the face of the Bill or in the code of practice?

Mr Prior: It should clearly be on the face of the Bill. The Scottish Act has a respect for carers on the face of the Act. We can see no reason not to have a respect for carers on the face of the Bill. The case you give is a clear example of where carers have a very, very good reason to need to know what is happening. There are plenty of other circumstances. As Mary has said, not all carers are perfect. Some carers are terrible, and there are circumstances where people should be formally removed from caring for somebody. The current Act allows for that and the new Bill should allow for that in extreme circumstances, but we should not let extreme circumstances dominate practice, any more than the fact that some doctors are terrible and need to be struck off by the GMC says that we should have a power to disregard what doctors say if the user does not like it. We have to get these things in balance. The great majority of families are desperately trying to do their best—and sometimes not trying very well because they just do not know; they are not provided with the information to do the job very well.

Ms Yates: Can I come in with one very short point—and I will be short! You talk about respect for carers. I am not entirely sure that this Bill does show respect for carers because without somebody in the process, whether it be carer, nearest relative, nominated person—whatever label we end up with—without the firm right to challenge detention where appropriate or to challenge potential treatment, and to veto detention, then all this so-called respect for carers is “aye, Mary Martin”.

Q277 Lord Rix: I must declare a personal interest in this next question on advance statements. I am sitting next-door to the Chairman of the Scrutiny Committee of the Mental Capacity Bill, and I was a member, and most of the time the Chairman kept asking me to ask questions on advance statements, probably because at my great age I am more likely to need them than anyone else! Given that it is not always possible for the person to foresee the circumstances, when advance statement or refusal of treatment might well become necessarily, why do you believe they should be included in this draft Mental Health Bill, and should they be given a binding or advisory status? Already, Jo Roberts has talked warmly, but rather briefly, about advance decisions.

Ms Roberts: On an individual level, I think the advance directive would be ideal. I have been living in the community for ten years. I have recently had a new psychiatrist, and she said to me last week, “your care plans have not been re-assessed for 10 years”. My needs have changed drastically over those 10
years. Also, I have my own ideas about care and treatment of my illness; I have my own views on how I should be treated; and they should be legally binding as well. I think it would be something positive.

Mr Took: In the first episode of mental illness, it is quite unlikely that the person will have prepared an advance statement. The advance statement comes into play when a person is well enough, after an episode of illness, to make one. It is an important principle that what a person says when they are well should be taken into account when they are unwell. The need to put it in legislation is, will the professionals take account of what the patient has said? That is our worry. An advance statement would be made and would just be cast aside. We are arguing that if it is put aside, because there may be unreasonable requests—maybe treatment in the South of France, which is not appropriate—but the reasons should be recorded by the professionals.

Q278 Lord Carter: I am not clear about your evidence where you argue for the provision of advance directives to be in this Bill. They are there in the Mental Capacity Bill: are you suggesting that if, somebody has capacity but is subject to mental health problems, that somehow the provisions in the Mental Capacity Bill that lay down the requirements for advance directives cannot be met? You could surely use that provision for any advance Directives you wish to make.

Mr Took: I think there is a distinction between advance directives that are centring on refusal of treatment, and advance statements that are about expressions of wishes. I know that the Making Decisions Alliance is pressing for advance statements in the Mental Capacity Bill, but advance statements are not covered in either Bill. We want the patient’s expressions and wishes to be fully taken into account.

Q279 Lord Carter: I am sure you are familiar with the recent Burke judgment, which is being appealed by the GMC for clarification. That has changed the view, at this stage anyway, regarding the ability to require treatment, which you cannot do under an advance directive—you can only refuse treatment. Have you given any thought to the implications of that?

Mr Prior: The answer is, not in detail. We have certainly given consideration to the overlap with the Mental Capacity Bill. Many people subject to a Mental Health Act would also come within the remit of a Mental Capacity Act. At the moment the Mental Health Act is drawn up on different principles and does not recognise the concept of capacity, and does not use it, for example, in choice of nominated person or decisions about whether you want your carer involved, and things of that kind. This will mean that professionals will have to run two parallel systems with different principles, different decision-making tribunals and different consultees, nominated persons and so on. It is a recipe for error, chaos and expense and so on. The other thing we would say about advance statements is that they are not just about treatment. They are a way, when you have a fluctuating condition, as most serious mental illnesses are, of being in control of your life when you are not in control of your life. It is a way of reclaiming some of what is lost. We know that for long-term recovery, having that sense of control over your life is so important; the institutionalisation is what destroys people’s chances of recovery at the moment—the loss of self-esteem and so on. You can deal with practical problems: you can stop yourself losing your accommodation by specifying who you want to look after your flat and pay your bills; you can stop all sorts of problems about pets, who is going to feed them; who is going to look after your dependants—very practical, real-world issues; issues that are important in terms of culture and religion, which come up hugely from people in ethnic minority communities, specifying dietary and religious needs. In all sorts of ways they just help in what is a very traumatic and difficult experience of being under supervision by making the experience that little bit better, that little bit more ethical, humane, and recovery-focused—“here is my plan for my future”.

Q280 Lord Carter: There are provisions in the Mental Capacity Bill for a lasting power of attorney. Would they help?

Ms Teasdale: One of our concerns is that with these two Bills running alongside in terms of development, it leaves the user in a very confused position because there are so many different roles in the individual—

Q281 Chairman: And us!

Ms Teasdale: Absolutely. To be honest, I think we would all agree that insufficient thought has been given by the Bill drafters about how these arrangements would work together, how the lasting power of attorney would—

Lord Carter: They do come from different departments.

Q282 Chairman: We do have a problem with different departments, and this is something that Lord Carter has raised not just here on several occasions but far and wide. Have Rethink and Hafal done any work as to what will be needed in the gap between the Mental Capacity Bill becoming an act and the Mental Health Bill becoming an act, which is likely to be a gap of three years, or more than three years given the resource implications—for example, if you just look at tribunals? Would you please let us have your thoughts?

Mr Prior: We would certainly do it, but we would suggest that, if the Bill as drafted were passed, the gap would be more like 30 years, and that is the situation we are having to consider at the moment.

Chairman: That is a helpful answer in the sense that it highlights the issue. The Committee would be grateful to you if you could find the time to give us some more help on that problem. We have expert advice on the issue, but it is becoming more than just
Supplementary memorandum from Hafal (DMH 413)

At this late stage in your scrutiny of the Draft Mental Health Bill we hope you will consider one further piece of evidence. As service users in Wales we have grave concerns about the scope and conditions for compulsion which the Draft Bill proposes. These matters have been addressed in Hafal’s original submission. However, here we want to focus on one specific issue: reciprocal rights. The following evidence has the full support of Hafal but is also expressly the view of the undersigned.

The Need for Reciprocal Rights

1. In their review of the Mental Health Act 1983 the Richardson Committee was clear about the importance of introducing reciprocal rights. We agree with their diagnosis. Reciprocity within mental health legislation is the key to creating a humane and effective framework to support people with a mental illness. Reciprocal rights would give us back our dignity because the law would be based on agreement between government and patients: both would be required to act in a particular way at a particular stage of an illness; responsibility and obligation would be shared; and it would reduce the stigma of mental illness because the legislation would be seen by all as a genuine result of negotiation between government and patients.

2. Reciprocal rights would ensure access to early treatment. From our own experience we are convinced that this would prevent much suffering, improve safety for all, and significantly reduce the need for compulsion which the Bill so emphatically focuses upon. We believe that a new Mental Health Act should incorporate:
   — A core statement of principles on the face of the Act which opens with a new principle of law: compulsion which compromises a patient’s rights must be balanced fairly with legal rights to treatment and care.
   — A stipulation that Codes of Practice are based on that balance between compulsion and patients’ rights.
   — A right to assessment on request within a set time.
   — A further right to defined treatment and care including access to a psychiatrist when a basic threshold (for example the occurrence of delusional behaviour) is reached—a threshold well short of that required for compulsion to be applied.
   — Improved rights to aftercare following discharge.
   — Mechanisms for legal rights to be increased over time by the Secretary of State in England or the National Assembly in Wales—for example, statutory timescales for the assessment of patients could be reducible and specific new rights to care and treatment made legally enforceable.

3. It is crucial to stress the importance of reciprocal rights in Wales where we have a sound and empowering strategy agreed between patients and the Welsh Assembly Government but where progress has yet to be made on developing services to match. Already we have seen the potential impact of the new Bill on services: the key focus of mental health workforce planning in the Assembly was previously to improve community services; now workforce planners within the Assembly Government have been forced to redefine those priorities to accommodate the requirements for compulsion which the Bill may introduce. Legal rights to treatment would rebalance those planning priorities, ensuring services are put in place where they are needed—in the early treatment of a mental illness.

4. The Draft Mental Health Bill is a lost opportunity to improve treatment and care, improve safety for all, and give people with a mental illness the rights they deserve. By creating law with reciprocal rights at its core, the opportunity for positive change could instead be seized.

Matthew Butcher—former service user and Hafal Trustee
Linda Biaggi—service user and Hafal Trustee
Richard Lawson—service user and Hafal volunteer
Rod Morgan—service user and Hafal volunteer
Christine Mead—service user and Hafal volunteer
Emma Norton—service user
Jo Roberts—service user and Hafal staff member
Keith Rogers—service user  
Darryl Stevens—service user  
Richard Timms—service user and Hafal volunteer  
November 2004

Supplementary memorandum from Hafal (DMH 414)

Having followed the evidence taken by the Joint Committee we have developed some specific recommendations on one important area of the Bill which we hope may be helpful.

Balancing Carers' and Service Users' Convention Rights

Under the Mental Health Act 1983 the nearest relative is identified in accordance with s 26. A person who is a relative and who is providing or intending to provide substantial care will go to the top of the list, so the carer is nearly always the nearest relative, and is entitled to exercise the rights and powers which go with that role. This represents a fair balance of responsibilities and rights necessary to sustain a role that is often arduous, painful, and open-ended.

What are the nearest relative’s rights under the 1983 Act?

— Only nearest relatives and approved social workers have the power to apply for the exercise of compulsory powers, whether for assessment, treatment or guardianship. Hafal would argue that the power to apply for compulsory admission should be confined to the Approved Mental Health Professional, as the use of the power to apply for detention could cause divisions within the family.

— The right to be consulted when an ASW is considering compulsory admission. This consultation role has been defined by case law in 1986 to mean “a genuine invitation to give advice, and a general consideration of that advice”. This right provides a floor of entitlement, which promotes a real and robust process of family involvement at a critical stage on the route to possible compulsion. This right should be retained.

— The right to have one’s wishes taken into account in relation to detention for assessment (s 2). Although there is no power to block detention for assessment, the nearest relative must be told of their right under s 23 to order the discharge of the patient.

— The power to discharge under s 23 is exercised by giving 72 hours notice to the hospital. Unless within that 72 hour period the patient is certified by his or her psychiatrist to be a danger to self or to others they must be discharged. If the psychiatrist blocks discharge by issuing a barring certificate, the nearest relative can then apply to a Mental Health Review Tribunal for the issue of danger to self or others to be independently determined.

— The right to veto compulsory powers in relation to detention for treatment under s 3. Only if the nearest relative’s objection to detention is unreasonable can s/he be displaced. If the patient is already detained for assessment, the detention for assessment continues until the county court hears the displacement application.

Hence, under the 1983 Act, the family’s role (where there is one) as the primary locus of care within the community care system is recognised in the nearest relative provisions which provide the main protection against medical misjudgement and potential misuse of state power.

The Proposals in the Bill

The Richardson Committee heard legitimate concerns that current law does not allow a patient the right to apply for displacement and replacement of an unsuitable nearest relative. These concerns were reinforced by the case of JT v United Kingdom (2000) where the European Court of Human Rights held that it was a breach of the right of respect for privacy that JT had no right to seek displacement of her mother as nearest relative, when the mother was living with a man who had abused JT. The Richardson Committee responded to these concerns by recommending the removal of the nearest relative altogether, to be replaced by the nominated person, who would have significantly fewer rights. The decision in JT v United Kingdom could have been complied with by simple amendment of the 1983 Act entitling the patient to seek displacement of an unsuitable nearest relative, without abolishing the important powers and rights which go with the nearest relative role. Hafal would have been in favour of this.

Under the Bill carers have rights to be consulted in their capacity as carers, but the only person with rights to challenge compulsion before the Mental Health Tribunal (other than the patient) will be the “nominated person”. The Bill abolishes nearest relatives’ rights to object to compulsory admission for treatment and to direct discharge of a patient who is not dangerous to self or others. Whilst under the 1983 Act the carer will almost automatically be the nearest relative, the carer will not necessarily achieve nomination as nominated person under the Bill. This is potentially very divisive within families and could damage relationships as the
situation is envisaged where the carer bears responsibility for care, but does not even have the powers of the nominated person, limited as they are. The nominated person will not be appointed until after the patient has been subject to compulsion, too late to influence the decision.

RECOMMENDATIONS

1. In order to ensure that patients and their families do not lose rights at an important stage of the process of compulsion, the nominated person should have the rights of the nearest relative to order discharge, and to apply to the tribunal for discharge. In the recent case of *HL v United Kingdom* (2004) (Bournewood) the European Court of Human Rights emphasised the importance of nominated persons acting as defenders of the rights of mentally incapacitated patients. In *R(MH) v Secretary of State for Health and the Mental Health Review Tribunal* [2004] EWCA Civ 1690 the Court of Appeal emphasised the important role played by the nearest relative in upholding mentally incapacitated service users’ rights.

2. In identifying the nominated person the following system of preferences should be employed. Priority should be given to a person nominated by the service user when capable and identified in an advance directive. If there is no nominated person, the default position should be based on the current nearest relative system, modified to take account of the case law recognising the rights of gay partners. In the probably rare case that this produces someone whom the service user considers unsuitable or who has abused the patient in the past, the service user should be able, with leave, to seek displacement of the nominated person.

In European Convention on Human Rights terms the service user’s right to respect for privacy under Article 8 can be maintained whilst ensuring that s/he does not lose the protections which may come from a family member (in the loose sense) being able to exercise rights under Article 5 on her or his behalf to challenge detention or compulsory treatment.

*Vicky Yeates*
Hafal Mental Health Carers’ Forum

*Bill Walden-Jones*
Chief Executive, Hafal

*November 2004*
Wednesday 17 November 2004

Members present:

Baroness Barker  Mrs Liz Blackman
Lord Carlile of Berriew  Mrs Angela Browning
(Chairman)  Mr David Hinchliffe
Lord Carter  Mr George Howarth
Baroness Cumberlege  Tim Loughton
Baroness Eccles of Moulton  Laura Moffatt
Lord Mayhew of Twysden  Ms Meg Munn
Baroness McIntosh of Hudnall  Dr Doug Naysmith
Lord Rix  Mr Gwyn Prosser
Lord Turnberg  Dr Howard Stoate
Hywel Williams

Memorandum from the Sainsbury Centre for Mental Health (DMH 107)

The Sainsbury Centre for Mental Health (SCMH) is an independent charity working nationally to improve mental health services through research, development and training. Our knowledge of how services operate informs this submission on the draft Bill. It covers those issues on which we have specific evidence for the Committee.

In addition to these concerns, SCMH is a core member of the Mental Health Alliance and fully endorses its submission.

1. Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

1.1 The principles underlying any piece of legislation that deprives people of their liberty must be clear and binding. Placing them in a Code of Practice that can be over-ridden in emergencies is not, in our view, sufficient.

1.2 The Government has rightly stated that values lie at the heart of good mental health practice (Woodbridge and Fulford, 2004). The values underpinning the draft Bill are in many ways contradictory. The Explanatory Notes, for example, state that it should reflect “modern patterns of care and treatment for severe mental illness”. Yet the Bill focuses strongly on the medical, rather than social, dimensions of treatment despite the many advances in the latter in recent years.

1.3 The Government also states that it sees the draft Bill as strengthening safeguards for patients—yet in many aspects the safeguards are weaker than those which currently apply, such as the power of professionals over the appointment of a nominated person and the failure to include advocates at the examination stage.

2. Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the Community adequate and sufficient?

The Definition of Mental Disorder

2.1 The draft Bill’s definition of mental disorder is much broader than the 1983 Act, which made specific reference to the nature and type of the disorder and which had clear exclusions of drug and/or alcohol misuse, promiscuity, sexual deviance and immoral conduct.

2.2 This may lead to mental health legislation being used on people who do not have a mental illness. This could turn many people away from using drug and alcohol services, for fear of compulsory treatment. Using the mental health system to treat such people will also block entry for people with severe and enduring mental health problems.

2.3 We recommend that specific exclusions be made within the definition of mental disorder. These need not exclude people who have co-existing mental health and other problems, regardless of the person’s “primary diagnosis”.
THE CONDITIONS FOR COMPULSORY TREATMENT

2.4 The criteria for compulsory treatment in the draft Bill are worryingly open to interpretation. While clause 4, for example, ensures that patients must be treated without resort to compulsory powers where it is possible to do so, clause 7 modifies and, in some cases, removes the basic principle of treating people outside compulsory powers. It places no burden of proof on professionals that compulsion is necessary. Any people who fall into this category will have to fight an uphill battle to demonstrate that their level of dangerousness to others has reduced.

2.5 Section 9 (8) modifies these criteria further, stating that a potential “substantial risk” is to be treated as a part of the determination of whether all of the above criteria have been met. The notion of substantial risk is difficult to establish. Many studies have shown that risk assessment is frequently an imprecise science (Morgan 2000). Practitioners tend to over-estimate risks and are often risk averse in their approach. The term “substantial risk” could lead to a culture of excessive caution. The nature of the risk, its severity, likelihood and consequences should be more clearly specified.

2.6 Most people who experience mental health problems function normally in their communities. Though they are symptomatic, they continue to live without support from the mental health system. Since we know that using the mental health system can lead to social exclusion (SEU 2004), its use should only be enforced if an individual is disordered and not functioning well within their social system. We recommend that the issue of function be specifically addressed within the conditions.

2.7 The stipulation that treatment should be appropriate and available is not enough of a safeguard. We endorse the Mental Health Alliance policy that there should be a test of therapeutic benefit for treatment imposed under the Act. We suggest that treatment be defined as “clinical and/or social interventions that are likely to be of therapeutic benefit to the individual concerned”.

NON-RESIDENT ORDERS (NROs)

2.8 A system similar to that used in Saskatchewan, Canada, should be considered for non-resident orders in England and Wales.

2.9 Non-resident orders should only be applied where there is clear evidence that they would reduce the need for repeated compulsory admissions to hospital. There are two key principles: that people are treated in the least restrictive setting possible; and that the use of NROs should on balance benefit the life of the individual by preventing the regular use of more restrictive treatment settings.

2.10 Both principles are in the end for the judgement of clinical and professional social care staff. These judgements should be made more secure through the approval of a qualified social care professional to the course of action proposed and through a binding Code of Practice.

2.11 One of the conditions for a non-resident order is that the treatment is available. It should also be accessible, for example in terms of time, location and language. There should be an obligation on the service provider to ensure that the person can attend (e.g. funding a taxi, offering it at a time so that they can continue to work).

2.12 We also note that existing guardianship provisions, though under-used, are sufficient for most people leaving hospital who need a more structured approach to their treatment. They offer people treatment without the immediate threat of being taken back to hospital if they do not comply. They should be considered as a part of any new Act as an alternative to NROs for some people.

RACE EQUALITY

2.13 The current Mental Health Act is not implemented equally among ethnic groups. African and Caribbean people face a disproportionate risk of being placed under compulsory powers and of receiving coercive treatment within them. This discrimination can be explained only in terms of the stereotyping of Black people in our society (SCMH 2002).

2.14 Although action is being taken on this issue, racism will remain a real threat in mental health services for the foreseeable future. It is vital that a new Act includes a specific provision for race equality and for monitoring its use among different ethnic and religious groups. It should also specify that any care or treatment under the Act is provided in a culturally sensitive manner and environment. Without these specific safeguards, Black people are likely to continue to stay away from services.

3. Does the draft bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

3.1 The draft Bill does not, in our view, balance these two concerns. There is a significant risk that the proposals in the Bill, and the message it sends out more widely, will strongly contradict what the Government is trying to achieve in tackling the stigma of mental illness and promoting inclusion among those who experience it. The draft Bill is incompatible, for example, with plans to help more people with mental health problems to get into work, education and training.
3.2 Advances in the treatment of personality disorders are providing therapeutically beneficial treatment options for this group. Additionally, it is now possible to detain people who have committed violent crimes for as long as is necessary. Extra powers are not, therefore, needed. There is a risk that the draft Bill would bring many more people with personality disorders into the ambit of compulsion with no evidence that it would either benefit them or protect others.

4. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient, and clear? Are there any important omissions in the Bill?

A Right to Assessment

4.1 The absence of a right to be assessed for mental health needs is a major omission from the draft Bill. Homicide inquiries frequently discover that tragedies have followed a patient’s (or their carer’s) requests for help being ignored.

4.2 While waiting times across most of the NHS continue to fall, delays in getting access to psychological therapies remain prohibitively long. The new Mental Health Act is an historic opportunity to tackle this inequity. A legal obligation on services to assess people’s needs and to provide the treatments they require as quickly as possible would also be an important means of helping services to become more patient-centred.

Advance Statements

4.3 There is no provision in the Bill for advance statements: a missed opportunity to be rued in years to come. Advance statements allow practitioners and service users to make plans in advance for future relapses. They also reflect the growing value of patient choice in health care. Establishing reference to or consultation with these plans would help to create a sense of control for service users at a time when they have little or no control over their lives.

4.4 Advance statements are now being implemented in Scotland under their new Mental Health Act. Their experience of putting advance statements into practice will be invaluable for England and Wales.

Aftercare Arrangements

4.5 The proposals for aftercare in the current draft represent a major loss of service. The suggestion that services need only be provided for a six week period reflects a lack of understanding of the process and delivery of an adequate care plan. Where someone has been subject to formal powers for many months it is important that services facilitate a programme of support for them to return to a satisfactory quality of life. This often takes time.

4.6 If a person has to be placed on a waiting list for aftercare, anything provided after six weeks would need to be paid for. This could lead to people dropping out of services. We suggest that aftercare be provided for as long as is necessary—subject to the review of the care plan by the multi-disciplinary team.

5. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft bill?

Access to Advocacy

5.1 We welcome the creation of a new role of Independent Mental Health Act Advocate. We are disappointed, however, that access to advocacy is not proposed until after the examination stage. This leaves some of the most vulnerable patients without access to an most important source of support at a critical time.

5.2 It is also vital that sufficient resources are made available for this service. Providing a decent level of support to the 25,000 people who are treated compulsorily each year requires a significant number of highly skilled people. It is vital that the new service is not “poached” from existing voluntary sector provision of advocacy services.

Care Planning

5.3 The draft Bill gives little guidance about what constitutes a care plan. Mental health services currently use a Care Programme Approach (CPA) to plan a person’s care. Implemented properly, the CPA has many benefits, including the involvement of the patient and their carers, and its broad coverage of social as well as health issues.

5.4 It is important that people treated under the new Act are offered full CPA care plans. Without them, we risk creating a two-tier system as well as causing confusion for staff and service users alike—especially for those who move between voluntary and compulsory care plans.
9. Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

9.1 There is a risk that some aspects of non-resident orders could clash with the Human Rights Act. In particular, the requirement people must live in a certain place, without providing financial assistance to do so, and the proposed powers for the police to take people from their homes (in some cases without a warrant).

10. What are likely to be the human and financial resource implications of the draft bill? What will be the effect on the roles of professionals?

STAFFING CONCERNS

10.1 We are very concerned about the staffing implications. Overall, the powers in the draft Bill make it highly likely that more people than currently would be brought under compulsory powers. The necessary safeguards and procedures also increase the amount of work each case of compulsion will entail; while the creation of non-resident as well as hospital care for those under compulsion will make the system more complex to manage. These factors combined will have an enormous effect on staff time as well as changing radically the way some teams work.

10.2 There remain major gaps in the understanding of the impact of the proposals in the draft Bill on mental health workers. Three of these are noted below. They must all be fully explored before any legislation is allowed to pass through Parliament.

APPROVED MENTAL HEALTH PROFESSIONALS (AMHPs)

10.3 The creation of AMHPs could be problematic in the short term. The existing shortage of ASWs will be exacerbated by the need to train them in the new role and the likely wastage from that process of those nearing retirement. That will place the greatest pressure on nursing staff, for whom the transition to AMHP status will require considerable training, and whose former roles will need to be back-filled.

10.4 Longer term, the loss of the ASW could also have a major impact. As a professional grouping with a clear identity, ASWs act as a peer group, providing support to one another in making decisions and maintaining a different perspective to that of health professionals. This is an important safeguard for patients and indeed the wider public. The new AMHPs will come from many different professions and have varying lines of accountability and regulation. They will need a lot of support to remain independent, develop a common approach and establish a professional identity.

EFFECTS ON COMMUNITY TEAMS

10.5 The creation of non-resident orders will have a dramatic impact on community mental health teams. The brunt of enforcing NROs could fall on assertive outreach teams, who work with the people other services find it hardest to engage.

10.6 These teams, recently established across the country, work on the basis of encouraging people to comply with care plans voluntarily. Much of the value of assertive outreach, indeed, is in building the confidence of clients and helping them get back to an ordinary life. Imposing compulsion in these circumstances could damage those relationships and undermine the basis on which services are currently provided.

NON-DANGEROUS OFFENDERS

10.7 The Draft Bill suggests a new model of dealing with non-dangerous defendants and offenders in the courts. This proposes that persons can be remanded in hospital (as under the 1983 Act) or in the community. This has the benefit of offering a less restrictive alternative for some people. There is a risk, however, that community teams will lack the skills to support people remanded in the community, or that doing this will divert resources from other groups of service users.

Key recommendations

— The definition of mental disorder must have exclusions.
— The conditions for compulsion must be more clearly defined and should include function and therapeutic benefit.
— Non-resident orders should be used in more limited circumstances, with extra safeguards, and should provide accessible services.
— The Act should promote race equality and incorporate ethnic monitoring of its usage.
— There should be a duty of assessment on services.
— Assessments should consider all of a person’s circumstances, not just their medical condition.
— Advance directives should be recognised and respected wherever possible.
— Aftercare should be provided free of charge for as long as it is needed.
— Advocacy should be available from the outset and must be fully resourced.
— Care planning under the Act should always be under the CPA system.
— The impact of the draft Bill on mental health staff and teams must be better explored and understood before any legislation is passed.

To discuss any of these issues further, please contact Andy Bell, Director of Communications, on 020 7827 8353.

REFERENCES

Sainsbury Centre for Mental Health 2002, Breaking the Circles of Fear London: SCMH
Social Exclusion Unit 2004, Mental Health and Social Exclusion London: ODPM

Memorandum from the King’s Fund (DMH 269)

We are grateful for the opportunity to submit comments to the Scrutiny Committee. The King’s Fund is an independent charitable foundation working for better health and health care, with a special focus on London. We carry out research, policy analysis and development activities, working on our own, in partnership and through development grants.

The Fund is a member of the Mental Health Alliance, the grouping established in 1999 to comment on the Government’s proposals to reform the Mental Health Act 1983. We support the views set out in the Alliance’s submission to the Scrutiny Committee.

Without repeating the Alliance’s views, there are some issues we believe are particularly important, and we comment on these below. Our comments are informed in particular by the findings of our major Inquiry into London’s mental health services, published in 2003, London’s State of Mind. These demonstrated that although good mental health services exist, there are still serious problems facing many people with serious mental health needs who are being failed by the present system, including those who are subject to mental health legislation.

What should a new Mental Health Act do?

The Government is clear that “The purpose of mental health law is to protect patients and others from harm that can arise from mental disorder” (Improving Mental Health Law: Towards a new Mental Health Act, Summary, September 2004). New legislation is certainly needed to update the Mental Health Act 1983, partly to reflect changes in practice and partly to address breaches of human rights legislation. Unfortunately the Government has followed traditional thinking about mental health law. It should have started from the premise that patient and public protection is best served not just by measures taken in certain limited circumstances when a patient becomes seriously ill, but by setting out duties to provide good care from an early stage of illness. This it fails to do.

The Bill therefore starts from the wrong perspective. Rather than tackle issues of patient care and support, it focuses on risk and dangerousness. At a time when the Government is promoting the cause of patient choice, the Bill introduces new powers to restrict choice for some patients living in the community, even when they have the capacity to make decisions for themselves.

Similarly, the Bill does little to support the Secretary of State’s assertion that he wishes to ensure the NHS is genuinely a health not an illness service, and that everything should be “geared towards preventing illness”.

In adopting this approach, the Government is missing a real opportunity to introduce powers and duties that would tackle the wider issue of public health mental health. For example, it fails to introduce a right to an assessment of mental health needs—not just an assessment for compulsion at a point of crisis—and to have assessed needs met. At the same time, the Bill removes the specific Mental Health Act 1983 duty on authorities to provide aftercare services following discharge from compulsion until they are no longer needed.

We know that earlier intervention and consensual aftercare would mean that fewer people would reach a stage where they could become a danger to themselves or others, and that, as a result, compulsory powers would be required less often.
COMMUNITY-BASED TREATMENT ORDERS

One of the most controversial aspects of the Bill is the introduction of community-based treatment Orders. The Committee will be aware that powers already exist under the Mental Health Act 1983 for extended leave and guardianship, together with supervised discharge powers that were introduced in 1995. All of these allow for a patient to be in the community under some form of restriction or obligation. We believe it would be a useful for the Committee to explore with the Department of Health and mental health professionals why these current provisions are not widely used and why the Government does not consider them adequate to deal with the problems of patient and public safety.

In addition, the Committee may be aware of the considerable literature that has been published over the last 20 years or so on the introduction of community-based Orders around the world (primarily from Australia, New Zealand and the United States). The findings from studies in this area suggest that there is still considerable uncertainty on whether community-based orders are effective and in what circumstances. Again this may be a fruitful area to pursue.

Our analysis suggests such Orders may work for a small number of people when they are backed by well developed community support services. But the research also suggests that if there are good community support services then introducing community-based Orders makes little or no difference to outcomes. In other words, it appears that it is the services that are crucial rather than the Orders.

One area that does concern us is the impact these Orders may have on the overall levels of compulsion with the system. This is a topic that does not appear to have been researched in any depth and at present we do not know how many more people might be subject to compulsion under a community-based Order system, compared to the number subject to compulsion at present. The Government has said that it is not its intention to increase the number of people under compulsion. But along with other critics of the Bill we have real worries that patients who are not now subject to compulsion may find themselves drawn into the system. We are currently undertaking a small study into this area based on similar systems in other countries and hope we may have some findings to submit to the Committee before it reports next March.

WORKFORCE

There are significant resource issues linked to the Bill, the most evident being the apparent shortage of staff to ensure the new procedures are properly implemented. The main groups involved are consultant psychiatrists to participate in Tribunals; community psychiatric nurses and other community staff to monitor people living in the community under a compulsory Order; and the new statutory advocates.

The Committee will be aware that similar (though not identical) new legislation has already been passed in Scotland and will come into effect in 2005. A Scottish National Mental Health Services Assessment of March 2004 concluded that “There are not enough staff to make the Act work, especially psychiatrists, mental health officers and advocacy workers . . . The Review Team found that . . . there will be difficulties in implementing [the Act] and significant changes and developments will be needed”.

Such problems are also very likely to be met in England and Wales. According to the Department of Health’s own figures (NHS Workforce Vacancy Survey, March 2004), there are significant vacancy rates in England among consultant psychiatrists (9.6%, that is 334 whole time equivalents, the largest percentage shortfall among any group of medical staff), yet it estimates that the new legislation will need an additional 130 psychiatrists (page 134 of the Explanatory Notes to the Bill). The Tribunal arrangements set out in the Bill would be impractical without this significant increase.

There are also shortages of psychiatric nurses, with the Department of Health figures showing community psychiatric nurses with 1.9% vacancies (235 wtes) and “other psychiatry” nursing staff with 4.7% vacancies (1,282 wtes) in England. The Department of Health estimated need for the Bill is for an extra 110 nurses. Should the Bill become law then community psychiatric nurses would have a major role in monitoring whether people subject to compulsion in the community were adhering to their care plans.

On top of this, there is the introduction of a right to statutory advocacy. While welcome, this will involve the recruitment and training of a whole new category of staff. The Department of Health estimates 140 will be required for England and Wales. Even assuming that the number of people under compulsion remains broadly the same after new legislation is passed as today (there were 46,900 detentions under the 1983 Act in 2002–03 in England alone according to the Office of National Statistics Bulletin 2003/22), this would seem to give each advocate an impractical workload.

While we are aware of the Government’s plans to meet the workforce implications of the Bill, we are not convinced this has been properly thought through.
POSITIVE ASPECTS OF THE BILL

However, let us conclude on a positive note—the Bill does contain some welcome provisions, including the right to statutory advocacy, the change from the nearest relative to a nominated person and a more regular Tribunal system. We hope that the Committee will be able to build on these aspects and recommend amendments to the Bill to produce something that will help create a modern mental health system that encourages early intervention and supports those with mental health problems, thereby creating a service that protects patients and the public alike.

November 2004

Witnesses: Ms Angela Greatley, Chief Executive, Mr Malcolm King, Programme Leader, Sainsbury Centre for Mental Health, Mr Niall Dickson, Chief Executive, and Mr Simon Lawton-Smith, Senior Policy Adviser, Mental Health, King’s Fund, examined.

Q283 Chairman: Good morning, thank you very much for attending the Committee this morning. Would you please note this is a public evidence session. The transcript will be produced and made available on the internet after about a week. If you would like to make any textual corrections to the draft of the transcript, please do—but textual corrections only, please, not of substance. We have about three-quarters of an hour for this session. Hopefully we can dispense with an introductory statement and move straight on to questioning if that is acceptable to you—other than inviting you to introduce yourselves, if you would, please.

Mr Lawton-Smith: My name is Simon Lawton-Smith. I am the Senior Policy Adviser in Mental Health at the King’s Fund.

Mr Dickson: I am Niall Dickson, the Chief Executive of the King’s Fund, and, until last year, Social Affairs Editor for the BBC. The King’s Fund has a longstanding interest in mental health, including having done two major inquiries into mental health in London. We have ongoing policy work in this area, among many others.

Ms Greatley: My name is Angela Greatley. I am Acting Chief Executive of the Sainsbury Centre for Mental Health, which is a research development and training organisation in mental health and mental health services.

Mr King: I am Malcolm King. I am Programme Leader for the Sainsbury Centre for Mental Health. I lead on workforce leadership. I am a social worker by background.

Q284 Chairman: Thank you. You can take it that anybody who asks any questions, at least will have read your submissions, and could I congratulate you on the conciseness of all of them. Mr Dickson, the King’s Fund, along with many others, has expressed a clear preference for a radical new Act focusing on rights, care and support of service users. Given your view that the draft Bill we are considering does not achieve this, is it your view that it might be preferable to take the Mental Health Act 1983 as a basis and try to amend it, rather than attempt to improve the draft Bill?

Mr Dickson: The first thing to say is that there are obviously good things in this Bill as well as bad. We, in particular, are very keen on the automatic right to tribunal—although we have worries about the staff implications of that. We are very excited by statutory advocacy—although we are concerned that it is not going to kick in early enough in the Bill as it currently is. We like the change, for example, from “nearest relative” to “nominated person”—although, again, we have worries about the powers of that. So it seems to me that there are really good things in this Bill that one would not want to lose. We have a big concern about the need to have the principles set out on the face of the Bill, as I believe many people have already said to you: that sets the tone and we believe it will also prevent amendment by the Executive. I think that is really important, that those principles of autonomy, reciprocity and compulsion as a last resort should all be there right on the front, on the face, of the Bill. Having said all that, do I believe this is really the task? I think it is the task of this Committee to make this Bill better. The community of people who are concerned with this legislation have been waiting rather a long time to get something, and I think they would see the job of this Committee to make this Bill better rather than going back to 1983. But “no Bill” is certainly better than a bad bill.

Q285 Chairman: We have had evidence that there is a 25% shortage of all posts in Wales (taking Wales as a microcosm of the whole country for this purpose). Is that a general picture?—without being too particular about the numbers. If so, do you see the proposals in the Bill and their effects on manpower as being remotely realistic over a measurable time frame?

Mr Dickson: We have really very serious concerns, not least, of course—and this does tie in with another concern we have about the Bill—that all the Department of Health’s figures, as I understand it, are based on the idea that there will be no increase in compulsion. Certainly, as far as tribunals are concerned, the history—if you judge by the history—has been very poor, and it would be an absolute tragedy if we had a good piece of legislation and we did not have the time scale or the resources in order to do it. There are enormous pressures on mental health services around the country. The Government are training more doctors, but, of course, it takes a long time to produce one; they are training more community psychiatrists, of course, the new mental health practitioners that are envisaged do not arrive overnight either. I think we have really quite serious concerns about the Government’s figures—and I do not know what the figure is but I think they produce £70 million as their
figure for it. We have not done a health economic estimate of all this but our view would be that these are serious under-estimates and there is a real danger that if we go ahead with this without having the proper planning for manpower then the Bill itself or the Act itself will be undermined and will cause more problems.

Q286 Chairman: Let us see if Sainsbury’s—if I may call you that—would like to add anything to that, and then I will call Dr Naysmith.

Ms Greatley: We are seriously concerned about the implications for staffing with the new legislation. That, I think, is both in terms of implementing this Bill if it becomes an Act but also the effect on other services, because, of course, where compulsion is involved it may mean that the staff who are available will be drawn into that area of work and clearly will be less able to undertake the kind of work we all want to see in implementing the rest of the national service framework, for example. We have looked at the most recent vacancy figures for psychiatry, for instance. The recent figure is 9.6%; there are something over 3,200 posts in psychiatry and there are something like 2,860 people in post. If we add the most conservative estimate that is made for the requirements of the Bill, there will be problems in meeting that. I should perhaps add that an overall estimate for the implementation of the Capacity Bill adds another 350 staff overall perhaps, of whom a number—maybe 25—are psychiatrists. I think we need to think of those two together. I wonder if my colleague would like to comment about Wales. My colleague is actually working in Wales at the moment.

Mr King: I have been doing some work in West Wales and I have just been asked by the Welsh Assembly Government to do some across the whole of Wales. My experience of the medical situation in Carmarthenshire is that there are three locums in post, there are two vacant posts. Most of the consultants are working 56 hours a week on average, which means they are doing a week and a half just to catch up. So there is a real shortage of expertise around the medical issue. Going on from there, there is a big shortage of social workers and psychiatric nurses. In Wales, over 50% of nurses over the next five years are to be retiring, therefore who is going to replace them over the next five years?

Ms Greatley: These are England and Wales figures together.

Mr King: They are.

Chairman: And you have already highlighted, Mr King, the nurse problem in Wales.

Q287 Chairman: Please do. I have noticed some Welsh interest on my right as well.

Mr King: I have been doing some work in West Wales and I have just been asked by the Welsh Assembly Government to do some across the whole of Wales. My experience of the medical situation in Carmarthenshire is that there are three locums in post, there are two vacant posts. Most of the consultants are working 56 hours a week on average, which means they are doing a week and a half just to catch up. So there is a real shortage of expertise around the medical issue. Going on from there, there is a big shortage of social workers and psychiatric nurses. In Wales, over 50% of nurses over the next five years are to be retiring, therefore who is going to replace them over the next five years?

Q288 Dr Naysmith: The Sainsbury Centre argues that there have been many advances in the social dimensions of treatment in recent years, but that that draft Bill is heavily skewed, as you point out, in favour of the medical forms of treatment. Could you tell us what these advances in the social dimensions of treatment to which you refer are?

Ms Greatley: There is a greater awareness now of the importance of the contribution of social care, of course, to how people are better supported in the community, but I think more recently the importance of employment for people with mental health problems; the importance of good housing—moves like Supporting People to enable people to live in their own independent accommodation. Our fear with the proposals in this Bill is that, because most of the definitions of treatment still rest around medical treatment, there is, in a sense, in potential legislation a diminution in the importance of what we know to be the kinds of measures that will help people not only live the lives they want to live in the community but to recover and be the contributing members of society which they want to be.

Q289 Dr Naysmith: You are not talking there about the use of drugs versus the use of so-called talking therapies and psychology?

Ms Greatley: We are talking about the availability across the board. For those who want to take medication and for whom it is effective, we absolutely think that is the right thing—although, of course, in line with NICE Guidelines and so forth. For many people, though, that is only acceptable if they have access to talking therapies. There are currently not available the targets for mental health waiting times that there are in other parts of the health service, so there are very long waits in many parts of the country for talking therapies, but we are also concerned with housing and employment and people’s ability to enjoy an ordinary life.

Q290 Dr Naysmith: Is there anything in the draft Bill that will stop these treatments happening, or prevent these treatments?

Ms Greatley: One specific I want to draw to people’s attention is that throughout the Bill there is a discussion about care plans, quite rightly, and the adequacy of the care plans. It is our view that, where a care plan is devised, it should be consistent with and become integrated with the current care-programme approach that applies to people in mental health service, and that care-programme approach specifically requires consideration of these social issues and life-domain issues (if I may use that rather inelegant term).

Q291 Dr Naysmith: In fact, if this is implemented it could help the kind of things you are talking about.

Ms Greatley: If it were implemented in a way that the care plans were integral with the care-programme approach, and not merely medical treatment and medication plans—which is what we fear in this Bill—then it could actually be very positive.

Q292 Hywel Williams: You referred to some figures around the shortage of psychiatrists. Are these England and Wales figures?

Mr King: England and Wales.

Ms Greatley: These are England and Wales together.

Q293 Chairman: I think the Wales figures are higher.

Mr King: They are.
Q294 Lord Rix: The Sainsbury report recommends at 2.3 that the current broad definition of mental disorder has to be linked to specific exclusions, otherwise legislation may be used on people such as alcoholics, and I would like to include here, of course, people with a learning disability who do not have a mental illness. Is not the problem that the opposite is happening now? We have had evidence that welcomes the exclusion relating to alcohol misuse in the definition of mental disorder, as the exclusion in the 1983 Act seems to have excluded people with a dual diagnosis from the protective and often life-saving provisions in that Act.

Ms Greatley: We are certainly in favour of a tightening of the current definition by adding exclusions. These would include alcohol, drug misuse, and, indeed, people whose behaviour is disorderly or not acceptable. We do not believe that people for whom that is the only problem should have anything to do with the mental health legislation. Mental health legislation is about the terms in which we deal with people who need compulsion. We do accept that people who have co-existing or co-morbid (as they are called) conditions that involve mental health and other problems certainly would be subject to the Act. Our own view is that the reason people are excluded at the moment is that the commissioning and provision of services suitable for people with substance abuse problems and mental health problems is still, frankly, not good enough and therefore it is used as a way of rationing the availability of services.

Mr King: I was an approved social worker for a number of years and I had to assess under the exclusion in the 1983 Act seems to have excluded people with a dual diagnosis from the protective and 14. Hopefully I am quite skilled in mental illness, but not autism; so I could not go ahead with the assessment because I did not feel I had the necessary skills to decide whether this person needed to be admitted or not.

Q295 Mrs Browning: Could I pick up on this question of these specific exclusions. If we could just take the adult population with a diagnosis of Asperger’s syndrome who very frequently come into contact with mental health services, very often mis-diagnosed by mental health services and the autism not recognised. I wonder what your view would be about Asperger’s syndrome in this context, because a lot of people with Asperger’s come into contact with mental health services because there has been an event which has triggered a certain type of behaviour. Very often, at the base of that, we find that it is because they are not actually receiving an adequate package of care and support that is supporting the autism, in terms of their lifestyle and their wellbeing, and it is that which triggers the behaviour that brings them into contact. I wonder what your views are on that particular grouping.

Ms Greatley: Our organisation does not deal with Asperger’s, autism or learning disabilities, except to say that it is our view that people for whom that is their only difficulty—substantial as it is for many—should not be caught in this mental health legislation.

Mr King: I was an approved social worker for a number of years and I had to assess under the Mental Health Act a young lad with autism who was 14. Hopefully I am quite skilled in mental illness, but not autism; so I could not go ahead with the assessment because I did not feel I had the necessary skills to decide whether this person needed to be admitted or not.

Q296 Chairman: Are you implying that is a general issue? Because it is very, very important.

Mr King: Yes, I think it is.

Ms Greatley: Yes, I think that would be our view. But we have to say that there are other organisations much more expert on the best way of dealing with those issues.

Q297 Mrs Browning: In terms of assessment, very often with adults we would welcome the input of social services as opposed to mental health. Very often it is a group decision from all interested expertise. In the example you have just given us, were you saying you felt it was more appropriate for somebody with a mental health qualification to make that assessment?

Mr King: No. I was saying that I think it needed someone with specific training in autism to do that.

Chairman: I would like to move on to a question Dr Stoate is going to start with, which has already been flagged up in an answer that has been given. This is a very big issue.

Q298 Dr Stoate: Thank you, my Lord Chairman. I am actually a practising GP as well as a Member of Parliament and obviously I am particularly concerned about Community Treatment Orders because I have a particular interest about care in the community for mentally ill people. We have heard, as you know, a lot of evidence from a lot of witnesses who seem very strongly opposed to Community Treatment Orders and to compulsory treatment in the community. Certainly Simon Lawton-Smith seems to have echoed that from the King’s Fund, that the people he spoke to did not find it helpful, and yet the Sainsbury Centre has expressed support for Community Treatment Orders based on the Saskatchewan system. I would like to ask what the benefits are in the Saskatchewan system. If there are such benefits, how are you going to sell those to the other people who have given us evidence that these would not be helpful?

Ms Greatley: I welcome the opportunity to make these points clear because I am aware that this is a hugely important part of the proposed legislation. We are aware from the Sainsbury Centre that Government have a view that there should be
services that are based on the principle of the least restrictive alternative. We therefore assume that there will be an exploration of how that principle might be carried through. We understand entirely and absolutely support the service users who are saying that, with the current definition and the current conditions, any kind of non-resident order could effectively be a long-term measure for keeping people in the community continually on some kind of restriction and having the requirements, whatever, applied with the non-resident order. Our view has been that there are jurisdictions—Saskatchewan is one we have mentioned, and in New Zealand—that have had a much longer experience of using these kinds of orders. If the definitions and conditions are sufficiently tight and if these non-resident orders were used only for a very small group of people—revolving door, as they are sometimes called—we think there is an argument for further exploration. We certainly do not suggest any one particular model to you now as being appropriate for Britain just to pick up and implement—it needs a great deal of further work. But I think we have to have an assurance that there is a way. Frankly, if the gateway to get into this legislation is as wide as we fear, then we think the way out could be extremely narrow for people on non-resident orders. That I think is the problem. George Szmukler’s evidence from the Institute of Psychiatry in King’s—again, a commendably short piece of evidence, I think—talks more about the assessment of what has happened in England and other jurisdictions and again talks about this tiny group for whom, with sufficient work and research, it might be a helpful adjunct.

Q299 Dr Stoate: Tony Zigmond from the Royal College of Psychiatry, when asked this very same question, was adamant that he was opposed to them. He said, that if you have compulsory treatment orders for people with mental illness, you are discriminating against them, because it will be the only medical model where that type of order was applicable. You could not, for example, have a compulsory treatment order for somebody who has renal failure or somebody with diabetes or somebody with heart disease, so why should you have a community treatment order for somebody with mental illness? It is discriminatory in the extreme. That is certainly the Royal College’s view. Ms Greatley: We think that argument has a great deal of strength to it. Our own view is, of course, that there is a missed opportunity in this legislation for something that we might call advance directives. If people have the opportunity to say when they are well what they would accept when they are unwell, we think that could be a very powerful way of dealing with this.

Q300 Chairman: I should tell you we have had 100% representation in support of advance directives.

Ms Greatley: Yes.

Q301 Chairman: Without exception.

Ms Greatley: In our view, the use of any kind of agreed treatment order in the community would be infinitely preferable to any imposed order, but, whatever happens, the gateway to get people out has to be much broader. People are going to be caught in these for years, we think, as it stands.

Mr Dickson: I am not sure that the analogy with physical illness in that particular instance is right, because, of course, you do not have compulsory orders for hospital for physical illness either. But I think there is a danger with the Bill as currently constituted that these orders are used too often. The Government are saying that these would only be used in very limited circumstances, and yet, as Angela said, of course the gateway into them... So there has to be a danger that they are used too often; that they are used for people who would otherwise not be under compulsion; that people do not get off them when they should—there is a real issue there for people about “once you are on...” and I think Genevera Richardson’s lobster pot was a good analogy or that of a valve which you go through and you cannot get back out—and I suppose they may even be used for people who should actually be detained and supported in hospitals because hospitals are under enormous pressure. I think there are real dangers. We have not shut the door entirely to the idea. I think we would probably feel more comfortable if they were not in the Bill, but if they are going to be in the Bill then it is a question of getting the criteria right and restricting. Saskatchewan appeals—and I entirely endorse it because it is an ideal model—because it does appear to restrict both in terms of the history of the patient and being clear about the impaired judgment being an issue before these orders are used.

Q302 Lord Carter: As you know, there are provisions for advance directives in the Mental Capacity Bill which is in front of Parliament at the moment. There is unlikely to be a new Mental Health Act for some time now because of the time scale of our report and the legislation. Would you suggest that we should be attempting to amend the provisions for advance directives in the Mental Capacity Bill, which, as I say, is before Parliament and we have the chance to do it and to meet your concerns? Why can we not use the provisions which are already in the Mental Capacity Bill to meet your concerns?

Ms Greatley: We are in entire agreement that the time when we will have a Mental Capacity Act and we will not have a new Mental Health Bill is a time of maximum confusion potentially. I suppose we have always said we should use that as an opportunity, but in this case I think it is not going to be a very helpful one. If the provisions for advance directives could be put in the capacity legislation.—
Q303 Lord Carter: They are there now, of course. Ms Greatley: Absolutely.—in a way that means they can also go in the Mental Health legislation, because we are worried about the incongruence, if you like, between the way that they appear in the two pieces.

Q304 Lord Carter: What changes would you need to make them, as you say, congruous? Ms Greatley: For instance, if you have people who are under compulsion under this mental health legislation, we have to be sure that the arrangements for the advance directive in advance of the period when they are under compulsion, are operating in a way that staff are able to operate both. It is that sense: the confusion between what an advance directive means under one piece of legislation coming so far in advance of the other, could be the period at which staff find it very difficult. We have a very big training job to do for staff in mental health trusts. Some of them, of course, will be dealing with clients who may be in and out of the different jurisdictions, if you like. To have clarity about what would be said in this legislation at this stage would be very helpful.

Q305 Hywel Williams: Could I take you back to the Saskatchewan model. You say at 2.11 of your submission that they should be “accessible, for example in terms of time, location and language”. I would like to ask you about two of those issues. In terms of rural areas, it has been suggested that non-resident orders would be particularly appropriate because that would avoid residential care at a remote location. There is also the contrary argument that day care facilities or day treatment facilities would also be remote. Do you have any observations on this in terms of the provision in Saskatchewan? Ms Greatley: I think, again, we have to go back to the principle point, that, if an order is going to be made that someone has to have certain conditions attached to the way they live in the community, we have to be sure that the resources will be sufficient to enable them to meet those conditions. I think the rural question is an absolutely strong one. That would suggest that, unless we have the resources to pay, for instance, for a taxi for someone to go to a day hospital, that can provide care to support them at home, if it is needed, it will not be possible to implement any system of non-resident order.

Q306 Dr Stoate: This clearly has implications for the equity of availability throughout England and Wales. I would like to turn to the language issue. The legislative context in Canada, and particularly in Quebec, is somewhat different, and there is a difference, of course, between Wales and England, and thus we have the Welsh Language Act which says that Welsh and English should be treated on the basis of equality. Again referring to non-resident orders, how appropriate would they be, do you imagine, in terms of the situation such as we have in Wales, where the provision through the medium of Welsh is very scarce indeed in respect of equity of treatment for Welsh speakers as compared to English speakers?

Ms Greatley: In a sense, the argument has been made, because if one cannot provide a service for people which is culturally and linguistically acceptable then it cannot be something which we can compel people to use. I am concerned equally for young African and Caribbean men in some of our inner cities who may be compelled to meet certain conditions and to use services that are not appropriate or acceptable to them. That is equally difficult. In both of those situations there are issues where we have to be sure that there is going to be sufficient capacity to provide in the proper way before we can even contemplate going down this road.

Q307 Chairman: Could I offer, arising from Mr Williams’s question, a comparison that has just been put in front of me. Ontario has approximately the same population as Northern Ireland—slightly smaller—about 1.5 million, and it has community treatment orders. I am informed that Ontario imposes about 90 CTOs a year, of an average duration between three and six months. That would be the equivalent of about two to three per year for each United Kingdom team. That, apparently, is the Ontario experience factually. Do you have optimism that that will be the level of imposition of these orders in England and Wales or not? Mr Lawton-Smith: It is a very interesting question about the level of use of these orders. The King’s Fund is actually undertaking a piece of research at the moment on the use of the orders in various administrations around the world. We are particularly interested in trying to find out the numbers of people who are subject to compulsory treatment, whether in the community or in hospital, following the introduction of this sort of system, a community-based treatment system. The evidence is very difficult to unpack at the moment because the data is not good; however, I think our initial findings would suggest that there is certainly a very varied usage of orders. In some of the American states where it has been introduced, it is hardly used at all; in others it is used quite radically. In the example you gave of Ontario there seems to be quite a mild amount of use. I think it is simply not a question that it is possible to answer at the moment about the likely impact on numbers. We are fairly certain though—as I think is everybody who has given evidence to your Committee so far—that the danger of a significant increase in compulsion and the numbers of people under compulsion is there, unless there is a significant tightening of the definitions and the conditions as they stand at the moment.

Q308 Chairman: Might you be able to supply us with at least a preliminary analysis of information collected from around the world on the use of them after this meeting? Mr Lawton-Smith: I would be very happy to do so. To be honest, it might be January before we can put together anything sensible.
Q309 Chairman: That will do very nicely.
Mr Lawton-Smith: I am very happy to do so.
Chairman: Thank you very much.

Q310 Baroness McIntosh of Hudnall: This may be another question that it is impossible to answer, so forgive me if it is. I am just listening to what you are saying about capacity within the mental health services. You have talked about and we have heard evidence from others about the current lack of capacity where there are vacancies; in other words, there is the willingness to recruit but there is apparently a difficulty in recruiting people into these services—at all levels, it would seem. I would like to ask two questions, if you can answer them. The first is: What do you think is currently discouraging people from applying to or from taking up the training that would allow them to apply to fill those vacancies? Secondly, if this Bill or something very like it were enacted, do you think that would help or hinder the recruitment of mental health professionals?

Mr Dickson: I think this is all related to how mental health is regarded within the wider health system. I think it was David Owen who created mental health as a priority within the National Health Service and it is rather a long time since he was Minister of Health—which shows that not all government priorities actually have an impact. The truth is that the mental health world has consistently suffered from... under-investment... under successive governments and its reputation in the wider world—not least, I have to say, sometimes because of media coverage—has been that it is not deemed an attractive and exciting place in which to work. For that reason, it has been difficult. Of course, we have had wider shortages of health staff in all the major professions across all specialties, but it is the Cinderella specialties where it has been difficult to recruit both the numbers and quality of staff, and mental health is a classic example of an area which has been not given the prominence or support that has been needed. To go on to your second point: Will this Bill help? I think it goes back to the point I said yesterday that he reckons there are quite a few psychiatrists who have case loads of 300 people. I just wondered what would be the implications of psychiatrists actually having a realistic case load and concentrating on severely mentally ill people. Would some patients actually lose out because of that, or could their needs be met by others?

Ms Greatley: Certainly, we have been doing a great deal of work around the changing role of psychiatrists, and acknowledging—and this is much supported by the College and others—that there are ways in which one can use the expertise of psychiatry in a much more pointed and focused way. My question, I suppose, if I were talking with the President of the Royal College, would be: If people have case loads of up to 300, I wonder whether some of those people are getting any kind of service already? Therefore, we can only exacerbate that problem by any changes here that we cannot resource properly. I think one of the difficulties is that the moves within workforce development to develop the role of psychiatrists, to bring in other professionals are working, but they are working fairly slowly. I am not sure that by the time it is anticipated this Bill would come into force we will actually have tackled those difficulties, because we have this reservoir, if you like, behind, of unmet problems.

Mr Dickson: I think this is also going to be compounded by the Working Time Directive in the consultants’ contract which will probably mean that people will do fewer hours and still be faced with these ludicrous levels of case work.

Q311 Baroness Cumberlege: We are where we are. I appreciate what Mr Dickson has said about the shortage of mental health staff. I particularly want to concentrate on psychiatrists because I was told by the President of the Royal College of Psychiatry yesterday that he reckons there are quite a few psychiatrists who have case loads of 300 people. I just wondered what would be the implications of psychiatrists actually having a realistic case load and concentrating on severely mentally ill people. Would some patients actually lose out because of that, or could their needs be met by others?

Q312 Baroness Eccles of Moulton: Continuing the question of the availability of manpower, but taking it from a slightly different angle, it is well known that over the last number of years the division of time between office work (paperwork, et cetera) and time available to spend, as it were, working directly with patients, has shifted very much towards the paperwork end. I heard the other day of somebody whose work load is now two-thirds paper, one-third actually with the clients, whereas ten years ago it was the reverse of that. Do you think that the measures in the Bill are going to make this situation worse? If so, is there anything we can do in our recommendations to help stop the drift or maybe even reverse it?

Mr Lawton-Smith: If I may try to answer that. I am not sure I am completely competent to answer that question but, in terms of the administrative burden on clinicians that this Bill will impose, I am not sure I can immediately see that the quality of the work they have to do will change significantly, but what there will be is more of it. There will be a significantly increased number of tribunals, for example. I think it is undoubted that the work load will go up. If that work load is two-thirds paperwork, one-third talking to patients, then it will go up in proportion. I guess, I do not see anything in this Bill that will actually ease the paperwork—but I would like to qualify that by saying that I have not actually looked at the Bill for that purpose.
Ms Greatley: Might I add a comment on your second point. I realise that the purpose of this Committee is to look at the legislation. However, if we consider overall the investment in the growth of mental health services, it has been only about half of the investment in health and social care generally. Our own research last year showed, real terms, about 1.6 for mental health when it was at least double that for other health and social care services. The particular aspect that worries me is those aids and assistance to people that could come from a better developed technology system. Mental health is light years behind the rest of health and social care in investment in technology. Some of us may look at technology and think, “Is that going to ease my burden?” but in the long term, of course, it will. The recording of important information and the keeping of care programmes—perhaps this Committee would be able at least to comment—unless that happens, it will be even more difficult to implement this Act.

Q313 Chairman: We have not had a paper from anyone in informatics in mental health. It might be helpful—you are both distinguished policy bodies—if you could give us some help on informatics before we get to the way in which information is shared, then it would I think be of assistance to the Committee’s deliberations.

Ms Greatley: Absolutely.

Q314 Laura Moffatt: We keep thinking we are getting to the crux of it, but clearly capacity within the service is truly the basis of why people are very cynical about what this Bill is all about. Could you say a little bit about what I believe will then pile on the pressure for the existing psychiatrists, and that is the increasing medicalisation of those who are being treated in primary care at the moment, who may well be pushed into the psychiatrist’s office rather than being kept within primary care, which may well add to all these problems we are now facing.

Ms Greatley: If I may go first and Simon may want to add something as well. From our own research, the development, for instance, of the national service framework in relation to primary care provision is still relatively slow in terms of being able to get the kind of primary care support that would at least contain the move into secondary care. One of the worries that we have about these proposals is that, with the conditions being so broad, many more people may be propelled early on into secondary care, particularly with a less well developed primary care service than we would all like to see, which I think is going to distort the resource questions as well and can only add to those difficulties.

Mr Lawton-Smith: I was involved, with the people with whom I used to work, the Mental After-Care [Service] Association, in the first national survey of primary care in mental health. This was about three or four years ago. That found that many GPs around the country—and they were very self-aware of this—had severe difficulties with the increasing number of people presenting with mental health problems, which has increased broadly in the last 14 or 15 years from about 15% of the people who present to about 30%. Many of them did not feel skilled to undertake the necessary assessments or prescribe the right treatment or make the right referrals, so there were great difficulties there. Having said that, you have to accept that there is now an increasing number of counsellors within GP practices to whom patients may be referred and I was also very struck by the Minister Mr Ladyman’s assertion the other day that the NHS was going to be about being able to prescribe Tai Chi and skiing, which were two of the things mentioned. I think that is a very important point to make. I believe that what primary care is able to offer people who use mental health services and who go to primary care for their mental health support is actually expanding over what is available today and certainly what was available a long time ago. We still have a difficulty with the fact that many people are simply prescribed pills—there is a big issue around that—but I think I would be slightly optimistic that in the future we will have a more appropriate social model of care treatment available to people than we do now.

Mr Dickson: I think there is a growing recognition within medical practice that the menu needs to be rather wider than it currently is. Part of the problem is the time factor: General Practitioners feel they are under enormous pressure of time to get through the appointment, and, of course, reaching for the prescription pad is a way of quickly ending the appointment. But I think that is changing and I think the General Practitioners are becoming more aware. The Government’s choice agenda and pushing this idea of personalised care combined with the new GMS contract will, I hope, encourage more practices to offer a wider range of services, which will mean that General Practitioners do not reach for the prescription pad as the first resort and do consider some of the talking therapies and some of the other things we have been talking about.

Chairman: We will have to move on now. Mr Loughton and then Mr Hinchliffe: perhaps you could both put points and then we will take some responses.

Tim Loughton: I think the notion of Tai Chi and skiing, particularly simultaneously, is slightly worrying. We may end up shifting the problem from mental health to orthopaedics! I think we are all agreed about the resource problem, the fact that the Bill just will not work if you do not have the people on the ground to put it into action. Could we try to quantify that, though. The Government have said a lot and started to do a lot about setting up new innovative community services—intervention teams, crisis resolution, et cetera, et cetera—which on the face of it sound good, though in practice have all too often been at the expense of core services. Have you done some calculations in terms of the level of investment you think is required, firstly, to bring us up to speed with what we need now, so that we do not have the consultants with 300 clients on their books, and to be able to enact the terms of the
Bill? The King’s Fund particularly has recognised the need, as we all agree, for early intervention. Have you done some calculations in terms of what that degree of proper early intervention would actually save, in terms of man hours later on where it becomes a more acute problem? So some more detailed figures around the acute versus the preventative investment arguments.

Q315 Mr Hinchliffe: Angela Greatley will recall that, when the Health Committee looked at mental health a couple of years ago, when she was involved as an adviser, we were very struck by the marked differences from area to area in the ability to prevent admissions to hospitals of people with mental illness. I am also struck, when we look at the different procedures used in sectioning patients, that there are very marked differences from area to area—and that is not to say that some areas have more people who are mentally ill, because I do not think they do, quite frankly. Does the Bill in any way address these differences, these inequities, or could the focus on this Bill actually make them more marked?

Mr Dickson: The short answer is no, we have not done those calculations. I think there are two separate issues here. One is the state of the mental health services as a whole and the inability of the mental health services to meet need in spite of extra investment which has gone in. Then there is the particular question of the additional demands which will be made by the Bill as currently constituted. It is crude, but our crude system is that the current figures produced by the Government are not realistic, particularly because we do not believe the Hinchliffe report. The problem is—and I think you raised that plenty of services in the community at the moment are under-resourced. If a Bill is introduced which imposes compulsory treatment on a small number of people, then it is likely that the resources that are in the community will be focused on those people and there will therefore be fewer resources for others in the community.

Q317 Chairman: I presume if I asked you the question as to whether mental health provision funding should be ring-fenced, we would get a unanimous answer.

Mr Dickson: I do not know; we have not consulted on the matter. My general view is not in favour of ring-fencing because I meet too many different sectional interests who all want to ring-fence, and then it becomes utterly meaningless and there is no level for local discretion at all. So, generally, in principle, I am not in favour of ring-fencing. But that view may not be shared by my colleagues.

Ms Greatley: I would have had some ring-fenced investment in new services. But, overall, I think Niall makes a very good point. We all know there are demands across the system. Might I comment very quickly? Unfortunately the calculations are not possible to do yet about the cost of implementation because of the broad difference, as Niall has said, between the estimates of the numbers of people likely to go through and therefore the demands on the system. But, be assured, we should continue to look at that. On the area differences, we are aware of inequities currently. We just looked at the implementation of guardianship under the current Act and it is very different across the country—just one little bit at which you can look and say it is already happening in so many areas. In relation to resources, if it would help the Committee, our research into early intervention in psychosis services did have some calculations about the potential. We could supply that afterwards.

Chairman: We are certainly very much in favour of early intervention. Mrs Blackman and finally Mr Hinchliffe and then we will have to draw this to a close.

Q318 Mrs Blackman: We have talked about inequity of resource distribution, but have you done any research around differences in good quality practice? I am aware that in so many of the fields I look at there is exemplary practice and poor practice. You must have some kind of observations to make around that particular issue. Is there anything in the Bill that can help drive up practice where it is not so good?

Mr King: I probably worked with 50 or 60 different teams over the last year in England, Wales and Scotland. The problem is—and I think you raised this—that it is about local issues. Local resources are different in every area. In my view, crisis teams and intervention teams are being staffed by people from community teams and from in-patient units, and therefore the skill level, the experience, is being diluted from in-patients and some HTs to staff crisis teams or intervention teams, which has caused problems in working with patients in the other teams. I think every area is different. Some areas have good working practices, but they have the resources; some are not because they do not have the resources. Crisis teams are supposed to work 24 hours: a lot are not because of resources used.
Q319 Chairman: I think the answer to Mrs Blackman’s question is probably that the Bill does nothing to deal with that issue.

Ms Greatley: It is a difficult question. I am tempted to start with “I would not start from here if I wanted to get there.” I think that is very serious and I entirely support the points Niall made earlier about the conception of this Bill being entirely ill-designed to support the development of a move away from in-patient care. I do not think that any of the proposals in it are going to help in that direction, and, if I may say, I agree: I think it is a great pity.

Mr King: Yes.

Q320 Mr Hinchliffe: I want to ask what is probably a very unfair final question, but I will ask it nevertheless. I sometimes do sessions with health service managers and one of the most interesting debates we get into is when I put to them the question of devising a local service which has no hospitals. Imagine a mental health service with no hospitals. If we had that—and some of us believe we actually could have that—how would this measure before us differ? What would the focus be in a service without a hospital?

Supplementary memorandum from Sainsbury Centre for Mental Health (DMH 394)

THE USE OF IT IN MENTAL HEALTH TRUSTS

The Audit Commission report, *Information and Data Quality in the NHS* (April 2004) found:

- In a sample of six mental health trusts, five received the lowest possible rating on patient information data entry quality (cf 20 out of 49 acute trusts);
- The proportion of “non-acute” trusts with documented procedures for clinical coding was 24% (cf 72% for acute and 42% for PCTs);
- Only one quarter of non-acute trusts met national standards for staff training and support in information systems (cf one half of acute trusts).

It concluded: “The approach to data and its quality appears to be particularly weak in mental health trusts.”

The Commission for Health Improvement (now Healthcare Commission) report, *What CHI found in mental health trusts* (December 2003), rated trusts it had reviewed on a scale of 1 (little or no progress) to 4 (excellent) on a number of issues. For use of information, 18 trusts scored 1; 13 scored 2; one scored 3 and none scored 4.

Sainsbury Centre for Mental Health report *Acute Care 2004* (forthcoming) surveyed ward managers across England. It found:

- There is computer access for all staff in 81% of wards.
- Internal e-mail is available to all staff on 61% of wards (though this varies from 30% in one region to over 80% in another).
- One quarter of wards routinely use electronic CPA for managing patient care (varying from over 50% in one region to less than 10% in another). Where it is used, bank and agency staff are rarely given access.
- Training in computer use is given to all staff in 16% wards, some staff in 81% and none in 3%.

EVIDENCE ON THE ECONOMICS OF EARLY INTERVENTION IN PSYCHOSIS (EIP) SERVICES

The SCMH publication *A Window of Opportunity*: a practical guide for developing early intervention in psychosis services (2003) concluded:

- Schizophrenia is estimated to cost the NHS more than £1 billion every year.
- Adding the costs of human suffering, informal care, lost output (eg worklessness) and premature mortality the cost of schizophrenia can be calculated to be £9.8 billion.
- EIP services are estimated to cost approx £5,000 per client per year.
- The average incidence rate of schizophrenia (ie the number of new cases each year) is approx 15 per 100,000 population.
EIP services work with people in their first three years of psychosis, so for an area with a population of one million, the cost of EIP would be £2.25 million a year.

Across England, this would equate to around £110 million, or 1.15% the total cost of schizophrenia.

Done properly, with sufficient investment, early intervention can eventually reduce the £9.8 billion cost by:

- Reducing the length of time people wait for the necessary treatment (currently between 12 and 18 months in many cases);
- Reducing the likelihood of expensive compulsory hospital admissions by dealing with the problem before it becomes too serious;
- Helping the person keep in work or education, making them less likely to fall into the poverty-illness cycle;
- Making complete or partial recovery more likely over the longer term (though this remains unproven).

November 2004

Supplementary memorandum from Kings Fund (DMH 448)

DRAFT MENTAL HEALTH BILL 2004

When we gave oral evidence to the Parliamentary Scrutiny Committee on the Draft Mental Health Bill last November the Committee asked how many patients might become subject to a community-based treatment Order.

One figure cited was that of Ontario (population 1.5 million, similar to Northern Ireland) with around 90 Orders per year. However, as far as England and Wales are concerned, as Jennifer Rankin of IPPR has pointed out, “the likely impact remains extremely contested, as Ministers argue it will have an impact on 300–600 people and campaigners suggest it could affect 50,000”.

At the committee hearing we said that we were undertaking a review of the use of community-based Orders and would let you have our preliminary findings so that if necessary you could take them into account in drafting your report to Ministers. I am therefore setting out our preliminary findings in this letter. I should emphasise that we are still collecting data and intend to publish a more comprehensive report later this year.

“Revolving door” patients

The Department of Health has said that “revolving door” patients are its main target for community-based Orders. These are patients who are hard to engage and persistently fail to comply with community treatment, which in turn leads to multiple admissions to hospital (McIvor 1998). As yet the Department has not estimated how many people may fall into this group.

We have received three estimates of the number of “revolving door” patients:

(i) no more than 15 patients per trust providing mental health services, producing a total of some 1,500 people in England and Wales (Bowers 2004, personal communication);
(ii) a build up over five years to around 25 people in each of 100 local mental health services England (ie the old health districts), giving 2,500 after five years (Sugarman 2005, personal communication); and
(iii) an estimate of 25 to 50 in the Borough/Primary Care Trust of Lambeth, London (Bell 2005, personal communication). That works out at between nine and 18 per 100,000 population, which if, in the unlikely event it were reproduced across England and Wales, would produce a total between around 4,700 and 9,340 people. In reality Lambeth has a very different socio-demographic make-up from most other PCTs across England and Wales, and current levels of hospital detention under the 1983 Mental Health Act are twice as high in London as any other part of the country. Based on this, a truer national figure based on the Lambeth estimate may therefore be between 2,000 and 4,500 people.

Mentally disordered offenders (MDOs)

Home Office Minister Paul Goggins (19 January 2005 oral evidence to the Parliamentary Scrutiny Committee) has indicated that he wishes in the Bill to “provide the widest possible range of disposals for the court . . . we estimate there may be 200 or 300 people who at any one time might be liable to this kind of treatment in the community, all of these people, if they were not being safely managed and treated in the community, would either be in prison or in hospital.”
Current use of compulsory community treatment powers in England and Wales

Many people already live in the community subject to the powers of the Mental Health Act 1983. Primarily this covers those under guardianship (Sections 7 and 8), detained patients who are granted leave of absence (Section 17), and those who are subject to supervised discharge (Section 25, as amended in 1995).

The draft Bill is expected to replace guardianship and supervised discharge arrangements, and may also impact on people under leave of absence. Transitional arrangements have yet to be finalised, but it seems reasonable to assume that those currently subject to guardianship (950 people in 2003) and supervised discharge (610 people in 2002-03) will be transferred to community-based Orders. If so, some 1,500 people would be placed on Orders in England and Wales as soon as the necessary arrangements and procedures were in place.

Leave of absence numbers are not collected centrally and we are currently undertaking an exercise to try to obtain figures from each Mental Health Trust.

Evidence from other jurisdictions

We have looked at selected literature from around the world (mainly the United States, Canada, New Zealand and Australia), and have spoken to a number of organisations and individuals from those countries.

In presenting the findings from this work, it is important to recognise the very real limitations.

First, no single definition of community-based treatment Orders exists.

Second, there are significant differences between community-based Order systems both within and between countries—for example within the United States (Ridgely et al 2001). For example, thresholds for compulsion vary between jurisdictions; some have identical criteria for inpatient and outpatient commitment, others have different thresholds; sometimes a judge authorises an Order, sometimes it is the responsibility of a psychiatrist; the length of time that Orders may be imposed also varies; some Orders combine in-patient and out-patient treatment; some allow the enforcement of treatment in the community, and others do not.

Third, an enormous range of factors influences the extent to which orders are used. These include how the law is interpreted; the attitude of psychiatrists and other staff about using the Orders, and the approach of judges making the Orders; the conditions that have to be satisfied before compulsion can be imposed; the socio-demographic make-up of populations; the availability of hospital beds; the types and range of treatments and the availability of community-based services to support patients subject to the Orders; and the clinical diagnosis given to patients.

For this reason the data we have collected should be treated with great caution in terms of estimating either the number of Orders made, or the patients who may be subject to Orders, in England and Wales. It should also be noted that some patients from other jurisdictions were subject to more than one Order over time; some of the data goes back to the 1990s; and some of it is based on estimates.

The data we have drawn up are set out in the Annex to this letter. These show that, in the jurisdictions we were able to look at, there was a massive variation in the number of people subject to Orders ranging from 1.7 to 52.8 per 100,000 population. The figures tend to be lowest in Canada and the United States and highest in Australia and New Zealand.

Translating these parameters to the population of England (49.2 million) and Wales (2.9 million), this might suggest that across England between about 840 and 25,980 people will become subject to community-based Orders; and across Wales between about 50 and 1,530 people will become subject to community-based Orders—a total of between about 890 and 27,510 people in England and Wales. This is obviously such a wide range as not to be very helpful beyond underlining the uncertainty of what is being proposed.

The mean figure for all jurisdictions (using only the most recent figure from those jurisdictions with more than one data entry, a data set of 10 items) is 21.7 per 100,000 population. If England and Wales sat at this mean, this would suggest some 11,300 people in England and Wales would be subject to a community-based Order. It should be noted that with this relatively small data set of 10 items, any new data received might change the mean significantly, and therefore the estimated figure.

We are now looking at whether there is a correlation between use of community-based Orders and certain specific conditions for compulsion set out in each jurisdiction’s legislation. The aim is to see whether the conditions set out in the draft Mental Health Bill might place England and Wales at the higher or lower end of the range of use of Orders.

A separate estimate (Dawson 2003, personal communication) is based on the average of figures found in New Zealand, New South Wales and Victoria. This suggested about 1 in 2–3,000 of the total population was on a community-based Order at any one time, a range of between 33–50 per 100,000 population. This would mean totals of between 17,190 and 26,050 in England and Wales, although Dawson suggests the figures would turn out to be substantially lower in the UK because here there is less support for Orders among community mental health professionals, longer inpatient stays and less well developed community facilities.
Rising use of community-based Orders

Whatever the jurisdiction or actual number of Orders, the pattern is that the use of Orders, when introduced, rises over time. For example in New York State, in the first year there were more than 400 Orders, but over the first four years the average was 735 each year (New York State, 2001, 2004). In Victoria, Australia, between 1993 and 2000 the number of patients treated on community treatment orders rose from 1,255 to 2,260, an 80% increase (King’s College, London, 2004). In New Zealand the number of people receiving community-based Orders rose from an estimated 1,207 in 1998 to 1,769 in 2003 (New Zealand Ministry of Health, 2005).

Reported under-usage of community-based Orders

The literature suggests that community-based Orders are not being used as much as they might be, or as much as anticipated.

A study of eight States in the USA (Ridgeley et al 2001) found that outpatient commitment laws were seldom used. It cites New York officials initially estimating that 7,000 individuals would be placed on outpatient commitment orders under Kendra’s Law (passed in August 1999), but by September 2000 only 235 involuntary outpatient petitions had been filed.

Two studies (Torrey and Kaplan 1995, Allen and Smith 2001) point out that in the United States not all administrations use the powers they have with any regularity; of the 40 or so states with powers of outpatient commitment, more than half invoke the law infrequently. In Texas the involuntary outpatient commitment law is rarely used (Mental Health Association in Texas 2004). In Saskatchewan physicians use community-based Orders sparingly (O’Reilly et al 2003). A Canadian report (Centre for Addiction and Mental Health, 2000) states that community-based Orders have been instituted in a limited fashion in the United States and hardly at all in Canada, and where they exist, they are reported to be poorly understood and under-used.

The various reasons suggested for this low uptake in the USA include civil rights opposition to community-based compulsion; unwilling professionals; doubts about judging how dangerous people may be; lack of community-based services; and poor understanding of the legislation and commitment criteria.

An Australian study (Rolfe, 2001) identifies an increase in work for clinicians as a deterrent and cites an example of a local service that restricted Orders to 20 at one time because of resource constraints.

In Israel (Ajzenstadt 2001) it is reported that some psychiatrists have refused to carry out what they see as a police function, and a lack of community treatment facilities means psychiatrists rarely impose Orders on people in some regions of Israel.

Interview evidence

So far we interviewed 10 individuals here with an interest in the Bill, including consultant psychiatrists, a Chief Executive of a Mental Health Trust and a service user. One interview question focused on the number of people who may become subject to compulsion under the Bill, using a Likeart scale:

“What effect do you anticipate that CTOs will have on the overall number of persons subject to compulsory treatment—a significant increase, a mild increase; no change at all; a mild decrease; a significant decrease.”

Four interviewees responded that there would be a significant increase, four a mild increase, one an increase followed by a reduction in numbers over some years, and one thought there would be no change. Many expressed concern that there would be inadequate services to provide people subject to compulsion in the community with the necessary care and support.

Preliminary conclusions

In reaching our preliminary conclusions about how many people might become subject to community-based Orders in England and Wales, we are acutely aware of the limitations of the data, the variations between different types of community-based Order and the many reasons why they are used to different degrees. Our estimates should therefore be treated with great caution.

Bearing that caveat in mind, our preliminary conclusions are as follows:

1. If the draft Bill as it stands becomes law, the introduction of community-based Orders in England and Wales will lead to an increase in the total number of people subject to compulsion.

2. If England and Wales fall within the parameters of use of Orders from elsewhere around the world, then this would suggest that anywhere between about 890 and 27,510 people could become subject to community-based Orders. If England and Wales sat at the mean, based on data collected, this would suggest around 11,300 people in England and Wales would be subject to a community-based Order.
3. If those currently subject to guardianship and supervised discharge are transferred to community-based Orders, around 1,500 will be placed on Orders when the new law comes into effect; the figure will be higher if people on leave of absence are also transferred.

4. If Orders are imposed strictly only on the so-called “revolving door” patients, as the Government intends, then the number of people who may become subject to Orders is likely to be between 1,500 and 4,500.

5. There is likely to be between 200–300 mentally disordered offenders placed on community-based Orders from within the criminal justice system.

6. The number of people on community-based Orders will most likely increase each year.

7. There will be significant variations in usage of orders between different parts of England and Wales.

8. There will be fewer people placed on community-based Orders than meet the legislative conditions for such Orders.

I am aware that many of these conclusions are necessarily tentative but hope they are helpful. Please let me know if you would like to discuss our preliminary findings.

I am sending a copy of this letter to Rosie Winterton, Minister for Health and Paul Farmer, Chair of the Mental Health Alliance.

Niall Dickson
February 2005

REFERENCES


Centre for Addiction and Mental Health, Canada (2000) Community Treatment Orders: ethical practice in an era of magical thinking, based on Community Treatment Orders: the ethical challenge of coercive care, Psychiatry Roundt, December 2000


Mental Health Association in Texas (2004), http://www.mhatexas.org


Rankin (2004), Developments and trends in mental health policy, institute for public policy research, November 2004


Personal communications
Bell, Stuart, Chief Executive, South London and Maudsley NHS Trust, 10 January 2005

Bowers, Len, Professor of Psychiatric Nursing and Head of Research, University of London, 21 December 2004.

Dawson, John, Faculty of Law, University of Otago, New Zealand, 22 December 2003.

New Zealand Ministry of Health, 10 February 2005.

Sugarman, Philip, Medical Director, St Andrew’s Group of Hospitals, UK, 27 January 2005.
NUMBER OF COMMUNITY-BASED ORDERS AND NUMBERS OF PEOPLE SUBJECT TO COMMUNITY-BASED ORDERS PER 100,000 POPULATION

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Population</th>
<th>No of community-based Orders</th>
<th>No of people under CTOs per 100k pop per annum</th>
<th>People under CTOs per 100k pop per annum</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otago, NZ</td>
<td>180,000 (1996)</td>
<td>269 (av 50 pa)</td>
<td>27.7</td>
<td>259 (av 48 pa)</td>
<td>26.6</td>
</tr>
<tr>
<td>New Zealand</td>
<td>4,000,000 (2003)</td>
<td>43</td>
<td>c1,700</td>
<td>42.5</td>
<td>2003 snapshot</td>
</tr>
<tr>
<td>New South Wales, Australia</td>
<td>6,687,000 (2003)</td>
<td></td>
<td>c2,600</td>
<td>38.9</td>
<td>2003 snapshot</td>
</tr>
<tr>
<td>Victoria, Australia</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>1994</td>
</tr>
<tr>
<td>Victoria, Australia</td>
<td>4,645,000 (2001)</td>
<td></td>
<td>7,500 (av 577 pa)</td>
<td>12.4</td>
<td>Nov 1990–2003</td>
</tr>
<tr>
<td>Victoria, Australia</td>
<td>4,645,000 (2001)</td>
<td></td>
<td>2,260</td>
<td>48.6</td>
<td>2000 snapshot</td>
</tr>
<tr>
<td>Victoria, Australia</td>
<td>4,917,000 (2003)</td>
<td></td>
<td>c.2,600</td>
<td>52.8</td>
<td>2003 snapshot</td>
</tr>
<tr>
<td>Western Australia</td>
<td>2,000,000 (2004)</td>
<td></td>
<td>c.200 at any one time</td>
<td>10</td>
<td>2004 snapshot</td>
</tr>
<tr>
<td>Toronto, Canada</td>
<td>2,400,000 (2004)</td>
<td></td>
<td>c.480 (av 144 pa)</td>
<td>6</td>
<td>Dec 2000–31 March 2004</td>
</tr>
<tr>
<td>Ontario, Canada</td>
<td>12,260,000 (2003)</td>
<td>900 (av 292 pa)</td>
<td>2.4</td>
<td>635 (av 206 pa)</td>
<td>1.7</td>
</tr>
<tr>
<td>New York State</td>
<td>18,976,000 (2001)</td>
<td></td>
<td>3,678 (av 735 pa)</td>
<td>3.8</td>
<td>Nov 1999–Nov 2004</td>
</tr>
<tr>
<td>Israel, Jerusalem and South Districts</td>
<td>1,380,900</td>
<td>326 (av 81.5 pa)</td>
<td>5.9</td>
<td>208 (av 52 pa)</td>
<td>3.8</td>
</tr>
</tbody>
</table>

1 Dawson and Romans 2001.
7 King’s College, London; Evidence submitted to Joint Parliamentary Committee on the draft Mental Health Bill (2004), 26 October 2004.
15 Arizona Department of Health Services, personal communication 28 January 2005.
Memorandum from Mr David Hewitt (DMH 21)

Note:

David Hewitt is a solicitor, and a partner in Hempsons, where he specialises in mental health law (and in particular, in the impact of the ECHR on the Mental Health Act).

For the last five years, David has represented NHS bodies and health care practitioners. However, for 13 years prior to that he represented mental health patients and their families.

Since 1995, he has been a member of the Mental Health Act Commission. He is also on the editorial board of the Journal of Mental Health.

This submission is made in a personal capacity.

1. Is the Draft Mental Health Bill rooted in a set of unambiguous principles? Are these principles appropriate and desirable?

1.1 The Draft Mental Health Bill seems to be motivated by two distinct, even contradictory, desires: to create new rights while also addressing the perception that the public believes itself to be at risk.

1.2 The Government has not given a proper explanation of why a new Mental Health Act is necessary. Even before the new Draft Mental Health Bill, the Green Paper, the White Paper and the 2002 Draft Bill suggested six motivating factors:

(a) There is a need to up-date the principles upon which mental health law is based. The elimination of the Approved Social Worker (“ASW”) will undermine one of the key principles of the Mental Health Act 1983 (“MHA 1983”): balancing the ‘medical’ and the ‘social’ models of mental illness.

(b) MHA 1983 no longer reflects the way mental health services are delivered. If more patients are cared for in the community, that may be because there are too few beds for them. The Government has failed to explain why this reason makes it necessary to make the changes it has proposed.

(c) MHA 1983 has failed to protect patients and the public. This reason is at the heart of the proposals. However, although it has asserted as much, the Government has not explained how the lack of a broad definition of “mental disorder”, for example, or the presence of the “treatability test” have placed the public in danger. In fact, most of the (many) inquiries of recent years suggest that there are other reasons for patient suicides and homicides, reasons that the Draft Mental Health Bill does not address.

(d) Professionals have an inadequate knowledge of mental health legislation. Why does it require a new Mental Health Act to cure this deficiency? Wouldn’t the answer be to provide more and better training on the existing Act? The one group of professionals that does receive specialist training in mental health—ASWs—will see its role weakened under the next MHA.

(e) MHA 1983 has a too narrow conception of “treatability”. See below.

(f) The introduction of the Human Rights Act 1998 has created new obligations. There is nothing in the ECHR to require all decisions to apply compulsion to be taken by an independent judicial body. Nor would the ECHR appear to require a broader definition of “mental disorder” or “relevant conditions” that are themselves broad and abolish the “treatability test”.

1.3 The Government need not introduce a new Act; it could make all the truly necessary changes by amending MHA 1983. It did so before, when it introduced Supervised Discharge and reversed the burden of proof in MHRT proceedings.

References:

1 Department of Health, Reform of the Mental Health Act 1983: Proposals for Consultation, November 1999, Cm 4480.
2 Department of Health and Home Office, Reforming the Mental Health Act—Part I: The new legal framework, December 2000, Cm 5016-I; Department of Health and Home Office, Reforming the Mental Health Act—Part II: High risk patients, December 2000, Cm 5016-II.
4 Green Paper, para 1.3.
5 Green Paper, paras 2.5-2.7; White Paper, para 2.6 and Executive Summary, para 4.
6 White Paper, Foreword, Executive Summary, para 2, and paras 1.14 & 1.15, 2.6, and 2.13 & 2.14.
7 Green Paper, Para 2.8; White Paper, para 1.14 and 2.6.
8 See para 2.2, below.
9 White Paper, paras 2.9, 3.8 and 5.1, and Executive Summary, para 7; Draft Mental Health Bill 2002, Consultation Document, para 2.2, Annex, and Partial Regulatory Impact Assessment, Option 1, number 1.
10 Mental Health (Patients in the Community) Act 1995, c 52.
11 Mental Health Act 1983 (Remedial) Order, SI 2001 No 3712.
2. Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the community adequate and sufficient?

2.1 The definition is unquestionably broader than the one in MHA 1983. It does seem wide enough to cover epileptics and drunks. It might also cover those who have sustained traumatic damage to a fully developed brain (who are not caught by the current Act).

2.2 The Government believes psychopaths are escaping detention because they can’t be treated.\(^\text{12}\) It is wrong. If MHA 1983 is correctly applied, there are few circumstances in which those suffering from mental disorder (as currently defined) cannot be “treated”:\(^\text{13}\)

(a) The current definition of “treatment” is very wide,\(^\text{14}\) and it is preserved in the Draft Bill.\(^\text{15}\)

(b) The definition has been widened by the courts,\(^\text{16}\) so that now, its purpose “may extend from cure to containment”.\(^\text{17}\)

(c) These widenings have been sanctioned by the European Court of Human Rights.\(^\text{18}\)

2.3 Third Condition: Due to a shortage of resources, compulsory treatment has long been confined to those who suffer from serious and enduring mental illness, which they often manifest by harming or neglecting themselves or endangering others. Now and for the first time, compulsion will be confined to such people as a matter of law.

2.5 Fourth Condition: this says that a patient will be subject to the fewest restrictions consistent with his/her needs. However, it won’t apply in the case of an adult “who is at substantial risk of causing serious harm to other persons.”\(^\text{19}\) This exception is justified neither by fact or experience, nor by the Government’s own rationale.

2.6 The Fourth Condition and the proposal for “non-resident” compulsion could be seen as examples of the “least restrictive alternative” principle.\(^\text{20}\) This is how the Government would like them to be seen. In its over-view document it says: “The intention of allowing patients to be under formal powers in the community is to provide greater flexibility to practitioners so that the principle of least restriction can be put into effect”.\(^\text{21}\) However, in the White Paper, the Government noted that under MHA 1983, “powers to require compliance with treatment are linked to detention in hospital”. This, it said,

“does not [ . . . ] support the processes of individual care planning that are needed to ensure that compulsory treatment will result in good health outcomes for patients and reduced risk. At the moment clinicians have to wait until patients in the community become ill enough to need admission to hospital before compulsory treatment can be given. This prevents early intervention to reduce risk to both patients and the public”.\(^\text{22}\)

The Government could be accused—not, perhaps, for the first time—of trying to appeal to two different, even antipathetic, constituencies.

3. Does the Draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

3.1 The definition of “carer” may not be sufficiently precise to avoid confusion or argument.

3.2 Even when selected without controversy, a patient’s carer might come into conflict with his/her Nominated Person (“NP”). There would appear to be nothing in the Draft Bill to indicate how any such conflict is to be resolved.

3.3 The Draft Bill purports to compel the sharing of information about patients who are subject to compulsion. However, it provides no new powers—or protections—in that regard and (particularly in the case of the police) may raise expectations it cannot fulfil.

---

\(^{12}\) White Paper, paras 1.15, 3.3 & 3.5, and Executive Summary, para 2; Draft Mental Health Bill 2002, cl 2(6), and Consultation Document, para 2.11 and Annex.

\(^{13}\) David Hewitt, Treatability Tests, Solicitors Journal, 4 October 2002, pp 886 & 887.

\(^{14}\) MHA 1983, s 145(1).

\(^{15}\) cl 2(7).


\(^{17}\) Reid v Secretary of State for Scotland[1999] 1 All ER 481.


\(^{19}\) cl 9(7).

\(^{20}\) See, for example: MHA 1983, s 3(2)(c); Department of Health, MHA 1983 Code of Practice, March 1999, para 1.1.

\(^{21}\) Department of Health, Improving Mental Health Law, September 2004, para 3.35.

\(^{22}\) 2000, Cm 5016-I, para 2.14; emphasis added.
4. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient, and clear? Are there any important omissions in the Bill?

4.1 The Draft Bill of 2002 contained detailed and robust safeguards for compliant, incapable patients who were not subject to compulsory powers.23 Those safeguards have been omitted from the 2004 Draft Bill. The Government says this is because they have been shifted to the Mental Capacity Bill, but that is not so: the Mental Capacity Bill does not provide for the appointment of a NP for such patients,24 nor does it give them the right to a care plan25 or to apply to a tribunal.26

4.2 Following HL v United Kingdom, this deficiency must be addressed. The common law does not provide a lawful basis upon which incapable patients can be admitted to hospital.27 In fact, the safeguards that the European Court of Human Rights (‘ECtHR’) held to be necessary to comply with ECHR, Article 5—and which it found to be lacking in the common law—resemble those set out in the 2002 Draft Bill.28

6. Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

6.1 The proposals concerning ECT beg at least two significant questions:
(a) Is the requirement for consent (in the case of a capable patient) motivated by concern over the efficacy or effects of ECT? If so, is it appropriate that ECT may be administered to in-capable patients without their consent? Is it appropriate for ECT to be administered at all?
(b) Why are capable patients fit to refuse ECT but not anti-psychotic medication?

7. Is the balance struck between what has been included on the fact of the draft bill, and what goes into Regulations and the Code of Practices [sic] right?

7.1 It is unfortunate that so much has been left to documents that have not yet been published. For example:
(a) It is not possible to comment conclusively upon proposals for the appointment of the NP without knowing whom the relevant regulations will “disqualify” and why.29
(b) There are several areas of mental health practice in which staff are in need of clear, comprehensive guidance. One of those areas is seclusion. However, there is no indication that such guidance will be provided in the Code of Practice.

9. Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

9.1 The ECtHR has declined to give a definitive interpretation of what it means to be of “unsound mind”.30 Nevertheless, it should not be assumed that every use of compulsion on a person who is thought to meet the new, broad definition of “mental disorder” will comply with ECHR, Article 5(1)(e).

9.2 The Draft Bill would diminish the force of the Code of Practice. It provides that the Code may be dis-applied in certain circumstances31 or in the case of certain patients,32 and that hospitals and practitioners need only “have regard” to it.33 This represents a very different view of the status of the Code than the one put forward by the Court of Appeal in the Munjaz case.34 The Court held that the Code must be respected unless there was “good reason” for departing from it. The Code must have such force, the Court decided, so that the interventions it covered could be said to be “prescribed by law” and so comply with ECHR, Article 8. If the Code is stripped of such force, there is, once again, the prospect of challenge under the HRA 1998 (and not just in respect of the practice of seclusion).

---

23 Draft Bill (2002), Part 5.
25 Draft Bill (2002), cl 129-134.
28 Ibid, para 120.
29 Draft Bill, cl 232(4)(a).
30 Winterwerp v The Netherlands (1979) 2 EHRR 387.
31 cl 1(4).
32 cl 1(6).
33 cl 1(2).
34 R (Munjaz) v Mersey Care NHS Trust; R (S) v Airedale NHS Trust [2003] EWCA Civ 1036.
9.3 At first sight, the proposals for the appointment of the NP seem sensible. However, a patient’s choice of NP may be disregarded by the AMHP if the person chosen is “unsuitable”. The Draft Bill does not suggest that this loaded word will be explained, or that guidance as to “unsuitability” will be given, in rules, regulations or the Code of Practice. It gives the AMHP far too great a discretion; so much, in fact, that there might be a breach of undertakings the Government gave to the ECtHR.36

October 2004

Memorandum from Ms Lucy Scott-Moncrieff (DMH 304)

INTRODUCTION

I have been representing detained patients at Mental Health Review Tribunals since 1979, and my experience therefore pre-dates the coming into effect of the Mental Health Act 1983 and the universal availability of Legal Aid for Tribunal representation. I have specialised in representing mentally disordered offenders detained in secure hospitals, but I also have long standing experience of representing patients detained in local, open, hospitals under Part 2 of the Mental Health Act 1983.

I am the Managing Partner of Scott Moncrieff Harbour & Sinclair (www.scomo.com) a legal aid practice with over 20 fee earners undertaking mental health work. For nearly 20 years I have been a member of the Law Society’s Mental Health and Disability Committee, and am currently the co-chair of the Committee. However, this submission is made in a personal capacity, and not in my capacity as a partner of Scott Moncrieff Harbour & Sinclair or as co-chair of the Mental Health and Disability Committee.

SUMMARY

In answering the Committee’s questions I have explored the difference between what I understand to be the intentions of the Department of Health and the Home Office, and the consequences that will actually flow from some of the provisions in the draft Bill. I am particularly concerned that those promoting the legislation seem to be unaware of the complexities involved in the care and treatment of people with mental disorders, with the result that the proposed legislation will probably not achieve its intended result in many cases. The very strong impression I get from reading the draft bill and the accompanying notes is that it has been drafted by theorists with very little knowledge of mental disorder or of the practice of psychiatry in this country.

1. Is the Bill rooted in a set of unambiguous principles? Are these principles appropriate and desirable?

The principles underlying the Bill are not articulated, and therefore have to be deduced from the provisions within the Bill.

(a) The first principle that can be deduced is that a person who has a mental disorder shall be treated (in relation to the care and treatment of that mental disorder) as if s/he lacks capacity to make decisions, even when s/he does not lack capacity (see clauses 9, 16, 199). The principle is not all-encompassing: capacitous patients retain autonomy if their mental disorder is below a certain (poorly defined and inconsistent) threshold of seriousness, and a capacitous patient continues to have the right to make decisions in relation to certain sorts of brain surgery and non-emergency ECT. (See clause 178)

(b) The second principle that can be deduced is that people with mental disorders charged with, or convicted of, criminal offences shall not only lose their right to liberty, but shall also lose their right to bodily integrity, regardless of the any risk that their mental disorder may pose to their own health or safety or to the protection of others (see clauses 96, 116 etc)

(c) The third is a rather hazy and inconsistent principle relating to the use of compulsory powers in the community. Paragraph 66 of the explanatory notes makes it clear that the only people who can be compulsorily assessed in the community without an immediately preceding admission to hospital are “revolving door” patients “who are prone to relapse on discharge and hence get into a cycle of admission and discharge from hospital. “The government’s assertion that compulsory powers are not meant to “catch” people who are not currently subject to detention under the 1983 Act suggests that there may be an underlying principle that only “revolving door” patients should be subject to compulsory community treatment. Such a principle would be rational, as one can assume that patients who do not require regular, frequent admission to hospital are treated satisfactorily under the current scheme of voluntary community treatment. However, if this is a
principle, it is not reflected in the provisions of the Bill, which make it perfectly possible, indeed likely, that people who are currently treated informally and who will never be ill enough to need in-patient treatment, will be put on community treatment orders.

The apparent safeguard offered by the tribunal having to approve the community treatment plan will not offer any real protection in many cases. If it is clear to the Tribunal that the person needs to be in hospital, it seems unlikely that it will refuse to make a treatment order just because the available treatment is not as good as it should be. The Tribunal’s powers will be more valuable when non-resident orders are being contemplated, but the likelihood is that compulsion will provide an alternative to high quality community care, as people who are well enough to leave hospital will probably accept community treatment voluntarily if it is good enough.

**Proposals**

(i) The principles in cl 1 of the Mental Capacity Bill and s 1 of the Mental Health (Care and Treatment)(Scotland) Act 2003 (“the Scottish Act”) should be imported into the draft Mental Health Bill.

(ii) Non-resident treatment orders should only be available if the patient fits the definition of a “revolving door” patient; which should be tightly defined (for instance, requiring three compulsory admissions of more than six weeks within 18 months). Such an order would automatically lapse after 12 months.

2. **Is the definition of mental disorder appropriate and unambiguous?**

The definition appears to be circular, and is not attached to any clinical definition.

The definition in s 328 of the Scottish Act is markedly more clear cut, and is linked to clinical diagnosis, which seems appropriate for a piece of legislation intended to provide a framework for the compulsory treatment of mental disorder.

The government seems keen not to have any exclusions from the definition under the draft Mental Health Bill, but even if the Bill keeps in the exclusions in s.328(2) of the Scottish Act, there is still much greater clarity in this definition, and it also assists in interpreting the relevant conditions under Cl 9 of the Bill.

**Proposal**

The definition in s 328 of the Scottish Act, with some, all, or none of its exclusions, should replace the definition of mental disorder in the Bill.

3. **Are the conditions for treatment and care under compulsion sufficiently stringent?**

It all depends where you start from.

(a) If one takes the situation of a person with mental disorder who has capacity to make his/her own treatment decisions, the conditions seem too wide. Nothing in the conditions set out in cl 9 require the people carrying out the assessment to consider whether compulsion is appropriate. The issue of appropriateness simply relates to treatment, and so long as the clinician considers that there is appropriate treatment for the disorder (ie treatment for mental disorder provided under the supervision of an approved clinician, including nursing, care, cognitive or behaviour therapy, counselling, other psychological intervention, habilitation and rehabilitation (cl 2(7)), and that the appropriate treatment is available, s/he does not have to consider whether it is appropriate to compel the person to accept the treatment. It is also the case that where the relevant conditions in cl.9 have been established, the provisions in clauses 16 and 38 mean that the clinicians have no choice but to make the person with the disorder subject to compulsory powers, and clauses 36 and 45 mean that the MHRT has no discretion to discharge the person. See example 1.

This is in stark contrast to the 1983 Act, and the Scottish Act where both the doctors and the Tribunal have a discretion as to whether to use compulsory powers. See for instance ss 36, 44, 57, 64 of the Scottish Act and ss 2, 3, 4, 5 and 72 of the 1983 Act.
Proposal

Either:

(i) amend cl 9 so that the relevant conditions include a condition that compulsion and/or detention in hospital are necessary, appropriate and proportionate in all the circumstances; clauses 16 and 38 to ensure that the existence of all the relevant conditions would authorise the use of compulsory powers but not compel them; and clauses 36 and 45 to give the Tribunal an overriding discretion to discharge the patient even where all the relevant conditions are met; or

(ii) adopt the equivalent proposals in the Scottish Act.

(b) On the other hand, if one is looking at the cl 9 conditions from the point of view of a person who lacks capacity, it may be said that the conditions are not wide enough. There is, at the moment, an overlap between some of the provisions of the Mental Capacity Bill and those in the Mental Health Bill in relation to treatment for mental disorder for people who lack capacity. I think it is quite likely that it will be found necessary to exclude the authorisation of treatment for mental disorder (as defined in cl 2 of the Mental Health Bill) from the provisions of the Mental Capacity Bill (to prevent chaos, if for no other reason). A situation would then arise whereby people who lacked capacity but who met the “need for medical treatment” threshold under cl 9 would be precluded from receiving necessary treatment unless they also met the suicide, self harm, serious neglect of self, or protection of others, criteria.

Proposal

Either:

(i) add a “best interests” condition for people lacking capacity (which would mean, of course, that the Government would have to bite on the bullet and acknowledge that the appropriate criteria for the use of compulsory powers in the case of people who lack capacity are different from those which relate to people who have capacity); or

(ii) adopt the criterion in the Scottish Act that states that compulsory powers cannot be used unless the person’s ability to make decisions about the provision of medical treatment is, because of the mental disorder, significantly impaired (see ss 36, 44 and 57). This would allow all decisions to be made using the criterion of best interests, which is the appropriate criterion for people who lack capacity.

(c) Cl 9(7) requires a person to be made subject to compulsory powers even if s/he consents to treatment, so long as s/he meets the various other conditions and s/he is “at substantial risk of causing serious harm to other persons”. This provision is, presumably, intended to “catch” people with dangerous personality disorders. However it seems likely that it will also catch many long-term, stable, capacitous, consenting, patients in the community as well as people with dementia and/or learning difficulties who are not currently subject to any compulsory powers. See examples 2, 3, 4 and 5.

Proposal

Either:

(i) delete cl 9(7); or

(ii) amend cl 9 generally to make the duty to section a discretionary power; or

(iii) adopt the compulsory powers criteria in the Scottish Act, as set out, for instance, in ss 36, 44 and 57.

(d) The criteria for compulsory treatment for those in the criminal justice system are astonishingly wide, so much so that it is difficult to see how a HRA challenge, on grounds of lack of proportionality, could fail.

Defendants can be remanded on bail or to hospital for mental health reports to be prepared (this is probably a good thing), but whilst on remand they can be made subject to compulsory powers regardless of their capacity and regardless of any evidence (or any lack of evidence) of risk to self or others (see cl 96). I have been told that the government disputes this, and I note that cl 86 allows the court to obtain a mental health report and to specify, if it chooses, that a risk assessment must be included in the report. Clearly this makes it possible for those making mental health orders to do so on the basis of risk to the patient or others. However, as far as I can see (and I am perfectly prepared to accept that I may have missed something crucial in these rather impenetrable provisions) it does not make evidence of risk a precondition for making a mental health order, nor does it insist that a risk assessment must be carried out before a mental health order can be made.
Proposal

Either:

(i) the requirements of cl 9(4) (risk threshold) must be added to the compulsory treatment provisions in Part 3 of the Bill; or

(ii) the criteria for compulsory powers contained in the Scottish Act should be looked at to see if they provide a more appropriate framework.

4. Are the provisions for assessment and treatment in the community adequate and sufficient?

I agree with the Law Society’s evidence on this.

5. Does the draft Bill achieve the right balance between protecting the person or the human rights on the mentally ill on the one hand, and concerns for the public and personal safety on the other?

I agree with the Law Society’s evidence here.

6. Are the proposals contained in the draft Mental Health Bill necessary, workable, efficient and clear? Are there any important omission in the Bill?

“Necessary”

To decide if the proposals are necessary one has to look at the ills they are intended to address and then consider if the proposals will address those ills. As the provisions for compulsory powers in the community and for a much increased role for the Tribunal are the greatest changes from the 1983 Act, I will concentrate on those matters.

(a) It is clear that the intended extension of compulsory treatment in the community is an attempt by the government to address public anxiety about people with mental disorders. These anxieties probably fall under three main headings:

(i) “Dangerous and unpredictable people with mental disorders are roaming the streets because the law cannot deal with them until they commit a crime”.

It is true that there are dangerous and unpredictable people at large who cannot be arrested as they have either not yet committed a crime or, even if they have, there is insufficient evidence to arrest them. However, if such a person also has a mental disorder, the power already exists to detain that person until s/he is safe to go back into the community. The tragedies that occur when professionals misassess risk or do not have the resources to offer treatment will not be cured by extending compulsory powers, but by improving resources and training. Also, if someone is dangerous and unpredictable, s/he will not be rendered less so by making him/her subject to compulsory community treatment: s/he needs to be contained until s/he is safe and then offered high quality support to help him/her stay that way. Assertive outreach is already available and could be expanded without changing the law.

In any event, the new proposals will not help in the way apparently envisaged, as doctors will still be able to refuse to use compulsory powers, on the ground that no suitable treatment is available. See examples 6 and 7.

(ii) “The streets are full of mentally ill people who are quite clearly not getting the help that they need”

The 1983 Act allows people with mental disorder to be detained in the interests of their own health and safety, and “health” includes mental health. Many of the “care in the community” people who are so visible are people who would have been in hospital in the days of the large asylums, and they could have been detained there if necessary. The law is still available but the facilities and resources are not. Most people with mental disorders have the same desire to be settled, comfortable and content as the rest of society, and if they are offered services and facilities that meet these objectives (which means that they have to be high quality, tailor-made, and respectful of autonomy, personal choice and human dignity), they are likely to accept them. There is nothing in the Bill to suggest that the new compulsory powers will lead to an improvement in facilities and resources that could not as easily be achieved by simply improving facilities and resources. See example 8.
Proposal

Improve the provision of high quality community care, including the development of very small, local, community hospitals intended for crisis admissions of a day or so, either voluntarily or under compulsion. Develop community homes for people with low-level chronic mental disorder who are not capable of living well on their own, and offer tolerant and non-judgemental support without expecting major changes or improvements in lifestyle.

(iii) "Tribunals have to release people even when they know they are dangerous"

The 1983 Act requires that a person with mental impairment or a psychopathic personality disorder is entitled to be discharged if he is untreatable, regardless of dangerousness. However, treatability has been defined so widely that it is almost impossible for a patient to be discharged on this basis unless the clinical team really want to get rid of him/her. A person is considered to be treatable if the core disorder can be treated, or the symptoms of the disorder, or the manifestations of the symptoms. For instance, a person with an anti-social personality disorder, characterised by impulsivity and aggressivity would be treatable if his/her underlying disorder were ameliorated so that s/he no longer felt so angry, or, even if the underlying disorder remained unchanged, s/he would be treatable if s/he learned anger management techniques that prevented him/her lashing out, or, even if that did not work, s/he would be treatable if skilled nursing observation allowed him/her to be contained or restrained before someone got hurt.

What is far more problematic, in the 1983 Act, is that Tribunals do not have enough powers in relation to mentally disordered offenders who have been put on restriction orders; they can only recommend transfer to another hospital, rather than being able to authorise it, as the Home Office can. This is to a considerable extent, an historical anomaly. When the 1983 Act was being planned, there were very few (maybe only one or two) medium secure units, and it was not considered at all unusual for special hospital patients to seek to be discharged to suitable community placements, as it was accepted that local general psychiatric hospitals could not provide a suitable service. Therefore the ability to discharge, which had previously been lacking, was a very considerable addition to the Tribunal's powers.

Over the last 20 years or so, the development of medium secure units has been very significant, and with that development has come a widely held view that special hospital patients should almost always be transferred to a medium secure unit as a prelude to the possibility of discharge. This creates major problems in moving people on from special hospitals, as medium secure units are a scarce and expensive resource, and the funding arrangements create perverse incentives for PCT's to drag their feet in making suitable arrangements for their special hospital clients. However, even if all the practical arrangements can be sorted out, the transfer cannot take place without the agreement of the Home Office, and the Home Office is entirely capable of holding up transfer for years. It has a shocking record of decision-making; it has no people working for it who are qualified to make risk assessments, and yet it frequently and routinely rejects risk assessments made by professionals and substitutes its own over-estimation of risk. Even when the Tribunal rejects the Home Office's view and recommends the transfer to medium security that is being made by the clinical team, the Home Office is under no obligation to accept the Tribunal's view and can insist on much further work being done before it will consider granting permission.

There are a number of consequences that flow from the shambles of the transfer system for restricted patients. The patients concerned are the first to suffer, as they are not only kept in excessively secure conditions, but the delay in transfer increases, sometimes by years, the length of time that they are detained before their return to the community. These delays then have a knock-on effect, as the patients become bed-blockers, preventing the admission of seriously mentally disordered prisoners, who may have to wait years to be admitted and who will therefore have more intractable problems when they are finally admitted.

The draft Bill was an opportunity to bring things up to date and give the tribunal the same powers as the Home Office to authorise, or even order, transfer and leave. It would be consistent for these new powers to be given now as the Tribunal is being given the power to reserve similar decisions to itself in relation to some non-restricted patients. However, it seems that the Home Office couldn't resist the temptation to maintain, and even try to increase, its stranglehold over restricted patients.

Proposal

Give the Tribunal the same powers as the Home Office in relation to restricted patients.

(b) Another perceived ill, intended to be righted by the Bill, is the disruption that is occasioned when a person has to be admitted to hospital for treatment as compulsory powers are not available to allow them to be treated while remaining in the community. But there is very little in the Bill that
would reduce this disruption, and a great deal that would make disruption more likely and make it more likely that compulsory powers would be used on people who never had needed, and never would need, in-patient treatment for mental disorder. See examples 9, 10, 11 and 12.

Proposal

Scrap the non-resident treatment provisions and develop small community hospitals, either NHS or independent, that would be authorised to take detained patients and which would offer a community service to people recovering from an acute episode of illness. Compulsory treatment could still be imposed and sections could be renewed while the person remained at the community hospital, but when the person was allowed home on leave, the compulsory powers would expire when the section lapsed, up to 12 months later.

(c) The extension of the tribunal’s remit is intended to offer protection from arbitrary detention, and to ensure that detention is accompanied by appropriate care.

The case of HL v UK has established that many people are currently being unlawfully detained. The Bill will not improve this situation; many of these people will not be detainable as their treatment needs are not being provided “under the supervision of an approved clinician”, as required in cl 9. If the definition of an approved clinician is widened to include, for instance, GP’s or nurses, then the scope of compulsory powers will be widened to include anyone who is receiving treatment from such people. Also, even if they are receiving treatment under the supervision of an approved clinician, they can only be detained if they are in an establishment authorised to take detained patients, which most places caring for the elderly are not. There is nothing in the Bill or in the Mental capacity Bill that deals with these arbitrary and unlawful detentions.

Proposal

Residential care for people with mental disorder who may lack capacity (for instance, elderly people with mental disorders and people with severe learning difficulties) should be upgraded to allow them to care for patients who may need to be detained from time to time, without disruption.

“Workable and efficient”

The system to impose and regulate the use of compulsory powers is complex and bound to be very expensive. It may be workable if there enough people to work it, but is unlikely to be an efficient use of resources as it will probably be dealing with people who are receiving perfectly satisfactory voluntary treatment at the moment, and, in any event, the Tribunal’s options are likely to be so limited, in many cases, as to make a hearing rather a big waste of time and money. This happens under the current system as well, of course, but the new system is going to be so much more extensive that the waste will be proportionately greater. It would be a different story if there were extra resources or treatments that the Tribunal could insist were provided, but if these were available it probably wouldn’t be necessary to use compulsory powers.

I have great difficulty in seeing how these provisions can be introduced. At any one time there are thousands of people subject to compulsory powers under the 1983 Act, and many thousands more receiving treatment for mental disorder (as defined in cl 2 of the Mental Health Bill) voluntarily. As things presently stand, many of those current subject to compulsory powers under the 1983 Act will have to be discharged as soon as the Mental Health Bill comes into force because they lack capacity: if their treatment can be authorised under the Mental Capacity Bill, it cannot be provided under the Mental Health Bill (clause 9(5) provides that compulsory treatment cannot generally be imposed under the Bill if it can lawfully be authorised else how; for instance, by the consent of the patient with capacity or the consent of the carer of a patient who lacks capacity). Many others who are presently receiving voluntary treatment will have to be made subject to compulsory powers, either as resident or as non-resident patients, and all those currently subject to compulsory powers in hospital will have to have care plans prepared to come into effect on the day that the legislation is introduced. It is difficult to see how there can be two systems running side by side, so there may have to be a switchover from one day to the next, and an enormous number of care plans and treatment orders will have to be authorised by the Mental Health Tribunal within the first few weeks of the implementation of the new Act. Not only will this initial avalanche of cases have to be dealt with in addition to any new patients coming into the system, but it will also create a bulge in Tribunal cases that is likely to take a number of years to dissipate, as decisions will be made, in many cases, for a standard length of time, and these will then need to be renewed at more or less the same time.

It is a very different situation from the time when the 1982 and 1983 Acts replaced the 1959 Act. For a start, the Tribunal system was already in existence under the 1959 Act and although the 1982 and 1983 Acts brought in changes, they were changes to the powers of Tribunals and the rights of patients, rather than to the underlying structure. What is now being proposed is not only a radical shift in the grounds for the use of compulsory powers, but also a completely different Tribunal system, and completely different Tribunal powers and responsibilities. In effect, a “Big Bang” approach is being adopted which is bound to be enormously disruptive, and it is being imposed upon a group of people who are, surely, entitled to expect as little disruption as possible.
Even if their needs were not seen as paramount, it is difficult to see how the hospital and community professionals who are required to engage with this process will be able to do so while at the same time providing satisfactory mental health services to their patients.

I understand that the transitional arrangements for the implementation of the Scottish Act have not yet been finalised or published, but they are likely to be much easier to organise as the use of compulsory powers under the Scottish Act is discretionary, whereas the use of powers under the Bill is non-discretionary.

What I find completely inexplicable is the way in which the Government has, apparently, paid no attention to what is happening in Scotland. I am sure that I do not understand the full inwardness of the Scottish legalisation but on the face of it it appears to have found a way forward that seems far more in keeping with the recommendations of the Richardson report, and with the requirements of the ECHR and the HRA. The proposals are, mainly, comprehensible, consistent, and based upon principles which many of us on this side of the border would applaud. It would appear that the Scots authorities have a human rights sensibility, and a sensitivity to the needs and rights of their vulnerable people, that the English and Welsh authorities simply lack.

"Clear"

The Bill is ridiculously unclear and will be a source of litigation that will keep the Mental Health Appeal Tribunal in full-time work for years.

"Omissions"

In terms of important omissions in the Bill, I would, once again, refer to the Scottish legalisation, and in particular ss 1, 2 and 3 (principles); s 23 (child sensitive services); s 24 (mother and baby units); ss 25, 26 and 27 (rights to services); ss 36(4)(b), 44(4)(b), and 57(3)(d) (impaired judgment condition for compulsory treatment); ss 36(5)(b)(ii), 44(4)(d)(ii) and 57(3)(c)(ii) (threshold for the protection of others is “significant risk to the safety of any other person”); ss 125, 126, and 220 (requiring notice of transfer to be given to patients and giving patients an opportunity to appeal to the Tribunal to challenge the transfer); s 130 (setting a threshold of significant risk to the health, safety or welfare of the person or a significant risk to the safety of any other person for the use of compulsory powers in relation to a person charged with, or convicted of, a criminal offence); s 193 (allowing a Tribunal to discharge a restriction order or transfer a restricted patient; s 240 (allowing patients with capacity to consent to treatment in certain circumstances); s 259 (legal right to advocacy for all, not just sectioned patients); ss 264 and 268 (allowing the Tribunal to order a patient’s transfer from conditions of excessive security); s.276 (requiring that valid advance directives must be had regard to); s 278 (imposing a duty to mitigate the adverse effects of compulsory measures on the relationship between parent and children)

Proposal

Import these provisions from the Scottish Act.

7. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft Bill?

I agree with the written evidence given by the Law Society.

8. Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

I agree with the Law Society and Mental Health Alliance in what they say.

9. Is the balance struck between what has been included on the face of the draft Bill and what goes into regulations and the Code of Practice right?

I agree with the written evidence of the Law Society.

10. Is the draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17th July 2004)?

I agree with the written evidence given by the Law Society. I also attach a copy of an article I wrote recently for Legal Action on this subject and the related issues created by the case of HL v UK.
Proposal

Where a person with mental disorder has the capacity to make treatment decisions and refuses treatment, or a person with mental disorder lacks capacity to consent to treatment, any treatment for mental disorder, as defined in clause 2 of the Bill, can only be given in accordance with the provisions of the Bill, and cannot be authorised under common law or under any other statute.

11. Is the draft Mental Health Bill in full compliance with the Human Rights Act?

I agree with the written evidence given by the Law Society.

12. What are likely to be the human and financial resource implications of the draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effect of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

I agree with the evidence given by the Law Society.

Concluding proposals

The initial intention of reforming the Mental Health Act 1983 was to create mental health legislation “fit for the 21st Century”.

At the time that those words were spoken, it was clearly contemplated that the 21st century would be more prosperous, more tolerant and more free than the 20th century, and that people with mental disorders would benefit through increased respect, increased autonomy, improved treatment and more resources.

The reality, mainly as a result of the events of 11 September 2001, has been a century characterised by fear, anxiety, risk-aversion and increased intolerance of some minority groups, including people with mental disorders. As a result, the draft Mental Health Bill is considerably more restrictive than the 1983 Act, and offers few benefits to patients, particularly when one takes into account the significant amendments of the 1983 Act that have taken place since the coming into effect of the Human Rights Act 1998.

In view of the enormous cost of the new legislation (which I suspect has been significantly underestimated in the Government’s impact assessments as a result of the discrepancy between what they say they are trying to do and what the Bill actually proposes), and the real risk that it will cause chaos and damage in the lives of vulnerable people, I wonder whether an alternative approach should be considered.

We have the very great advantage of knowing that most of the Scottish Act is going to be introduced in April 2005 (with the remaining tranche being introduced in May 2006). The Scottish Act is introducing compulsory treatment in the community, which has been a major driver of this Government’s activities in promoting a reform of the 1983 Act, and it will be possible for us to see how that pans out in Scotland over the next year or so. If it seems to work well (and surely 12 months would be long enough to see this) we could then adopt many or most of the Scottish provisions, which are far less draconian than those in the Bill, and which would, I believe, be far more acceptable to both service users and professionals.

One of the most attractive aspects of the Scottish legislation appears to be that the Mental Welfare Commission in Scotland has taken on the role currently undertaken by hospital managers under the 1983 Act. I am not quite sure how this is going to work, but it potentially provides a layer of full-time professional staff who can make some decisions on discharge and treatment, while still allowing the person subject to compulsory powers to apply to the Mental Health Tribunal. This could easily be a way to deal with the overwhelming resource implications in the proposals in the draft Bill.

At the same time as monitoring the Scottish legislation, the Government could ask a volunteer mental health NHS Trust to engage in a simulation of the provisions in the draft Bill (for which, of course, it would have to be paid). A date would be set for the purported implementation of the draft Bill, and the volunteer trust would then have to undertake all the assessments, determinations, preparations of care plans, reviews etc that will be required under the draft Bill. The Tribunal office could take on staff to organise the imaginary Tribunal requirements that would be called for by the actions of the volunteer Trust, and could have a pool of notional Tribunal Members who would have to be organised to deal with the hearings.

While all this is going on, the government could also mount a campaign to get registered mental nurses and registered learning disability nurses who have left the profession to come back in to the system, allowing care homes and hostels to register as independent hospitals authorised to take detained patients. Probably if one such place opened in each Trust’s catchment area, the need for non-resident treatment orders could be almost eliminated.

An experiment of this sort, over 12 months or so, would give the Government a much better idea of the practicability of its proposals, as well as the resource implications.

At the end of both of those processes, it might find that the most appropriate way forward was to gradually introduce reform of the 1983 Act—perhaps starting with an extension of compulsory powers to allow some patients detained in hospital to continue to be subject to compulsory powers when they move out of hospital (for a fixed period). This could be accompanied by an extension of the Tribunal’s powers.
Once those changes had been bedded in and evaluated, reform of the composition of the MHRT could be introduced if further reform were thought necessary. This would have the added advantage or preserving the very considerable body of case-law that has developed, particularly since 2 October 2000. Indeed, at the time of writing this, I know of at least two judicial reviews, which, if successful, will require amending legislation long before this Bill has any prospect of becoming law, which shows that the 1983 Act is already in a state of satisfactorily permanent revolution.

Examples

1. Imagine a divorced couple with a young child. The child spends the week with his mother and is meant to go to his father at weekends. The mother is not a smoker; the father is. The mother knows that smoking is not only bad for the father’s health, but also that her child is at considerably increased risk of contracting childhood respiratory ailments such as asthma or bronchitis if he spends time with a smoker. She therefore contacts the appropriate authority (under clause 14 of the Bill) and requests a determination whether all of the relevant conditions for compulsory treatment appear to be met in her ex-husband’s case. The assessment takes place, and the examiners decide that all of the relevant conditions in clause 9 are met—the patient is suffering from mental disorder (nicotine dependency); the mental disorder is of a nature or degree as to warrant the provision of medical treatment (there is no requirement that it should be of a nature or degree to warrant the provision of compulsory medication treatment); “medical treatment” is defined in Section 2 as “treatment for mental disorder provided under the supervision of an approved clinician and . . . includes . . . Cognitive therapy, behaviour therapy, counselling or other psychological intervention”. The father is not willing to accept any of this on an out-patient basis, and therefore he will need to be brought into hospital so as to be available for this treatment, which will, necessarily, have to be given under the supervision of an approved clinician; it is necessary for the protection of the patient from serious self harm, and serious neglect of his health and for the protection of other persons that medical treatment be provided to him; and he is not willing to give up smoking, so the treatment cannot lawfully be provided to him unless he is subject to the provisions of the Act. (Alternatively, the Doctors could decide that his smoking is at substantial risk of causing serious harm to his child, and therefore compulsory powers must be used, whether or not he is willing to consent to the proposed treatment). Having made their determination that the father meets the relevant conditions, the examiners have no choice but to make him subject to compulsory powers, either as a resident or as a non-resident patient, for an assessment (Section 16 sub-sections 3, 4 and 5).

If the father then applies to the Mental Health Review Tribunal to be discharged from his liability to be assessed, the Tribunal can only discharge him if it is satisfied that not all the relevant conditions are met. (Clause 36(3)). If the Tribunal is satisfied that the relevant conditions are still met, it can either make an order authorising his medical treatment, or it can make a further assessment order. It has no power to discharge him from the use of compulsory powers if all the relevant conditions are met.

If all the relevant conditions continue to be met (that is, the father is unable or unwilling to give up smoking) the clinical supervisor then has an obligation to apply to the Tribunal for a treatment order (Clause 38(1) and (2)) and if the subsequent Tribunal determines that all the relevant conditions are still met in the patient’s case it must make a treatment order or a further assessment order. It has no discretion to discharge the order.

This means that once the initial request for an assessment has been made, there is an inevitability about the subsequent actions that have to be taken. The Doctor could probably agree to carry out a non-resident assessment of the father, so long as he cooperated, but if the father continued to smoke (either wilfully or through lack of willpower) the Doctor would have little option but to bring him into hospital. If he applied for a Tribunal during the assessment period, claiming that the conditions where not met because he had successfully given up smoking, the Tribunal would probably have to accept that nicotine dependency is not so easily broken, and therefore the relevant conditions were still in place. It would be able to make an order that his assessment should continue as a non-resident patient, but he would have to be closely monitored and if he started smoking again he would have to be brought back in.

2. An elderly woman with dementia and fluctuating capacity lives willingly in an independent hospital registered to take detained patients (it used to be called a registered mental nursing home). The place is well run and the care of the patients is managed by the staff and the local community psychiatric team for the elderly, under the supervision of a consultant psycho-geriatrician. It has been agreed that it is very beneficial as to be available for this treatment, which will, necessarily, have to be given under the supervision of an approved clinician; it is necessary for the protection of the patient from serious self harm, and serious neglect of his health and for the protection of other persons that medical treatment be provided to him; and he is not willing to give up smoking, so the treatment cannot lawfully be provided to him unless he is subject to the provisions of the Act. (Alternatively, the Doctors could decide that his smoking is at substantial risk of causing serious harm to his child, and therefore compulsory powers must be used, whether or not he is willing to consent to the proposed treatment). Having made their determination that the father meets the relevant conditions, the examiners have no choice but to make him subject to compulsory powers, either as a resident or as a non-resident patient, for an assessment (Section 16 sub-sections 3, 4 and 5).

If the father then applies to the Mental Health Review Tribunal to be discharged from his liability to be assessed, the Tribunal can only discharge him if it is satisfied that not all the relevant conditions are met. (Clause 36(3)). If the Tribunal is satisfied that the relevant conditions are still met, it can either make an order authorising his medical treatment, or it can make a further assessment order. It has no power to discharge him from the use of compulsory powers if all the relevant conditions are met.

If all the relevant conditions continue to be met (that is, the father is unable or unwilling to give up smoking) the clinical supervisor then has an obligation to apply to the Tribunal for a treatment order (Clause 38(1) and (2)) and if the subsequent Tribunal determines that all the relevant conditions are still met in the patient’s case it must make a treatment order or a further assessment order. It has no discretion to discharge the order.

This means that once the initial request for an assessment has been made, there is an inevitability about the subsequent actions that have to be taken. The Doctor could probably agree to carry out a non-resident assessment of the father, so long as he cooperated, but if the father continued to smoke (either wilfully or through lack of willpower) the Doctor would have little option but to bring him into hospital. If he applied for a Tribunal during the assessment period, claiming that the conditions where not met because he had successfully given up smoking, the Tribunal would probably have to accept that nicotine dependency is not so easily broken, and therefore the relevant conditions were still in place. It would be able to make an order that his assessment should continue as a non-resident patient, but he would have to be closely monitored and if he started smoking again he would have to be brought back in.

2. An elderly woman with dementia and fluctuating capacity lives willingly in an independent hospital registered to take detained patients (it used to be called a registered mental nursing home). The place is well run and the care of the patients is managed by the staff and the local community psychiatric team for the elderly, under the supervision of a consultant psycho-geriatrician. It has been agreed that it is very beneficial for the patient to be allowed to do some cooking, which has always been a great pleasure to her, but it is also accepted that she must be supervised as she can be forgetful about lighting the gas when she has turned it on, or about leaving pans of fat on a high flame. It is decided that she has to be made subject to compulsory powers as she would be at serious risk of causing substantial harm to others (fire or explosion) if she were not supervised; the supervision and the rest of her care is provided under the supervision of an approved clinician; she is suffering from mental disorder of a nature or degree as to warrant the provision of medical treatment; appropriate medical treatment is available and her consent (when capacitious) or her compliance (when lacking capacity) are irrelevant as she meets the higher risk threshold. While she lacks capacity she could be discharged from the provisions of the Bill and treated under the provisions of the Mental Capacity Bill, but she would have to be re-sectioned as soon as she regained her capacity.
3. A young man with autism lives at home with his family, but attends a day centre several times a week. He has no sense of personal danger, and no road sense, so he can’t go out on his own because he might cause an accident. When he is at home his parents always go out with him and when he goes to the day centre one of the day centre staff will often go out with him, to help him learn to cope with the traffic, shops, crowds etc. The day centre is run as part of the NHS community psychiatric service, under the overall supervision of a consultant psychiatrist. Everyone agrees that the time spent at the day centre is extremely important for the young man’s social and personal development, as the day centre provides opportunities for social interaction in controlled circumstances that could not be provided by his parents. If the draft Mental Health Bill comes into effect in its present form, this young man will have to be made subject to compulsory powers—he has a mental disorder; it is of a nature or degree as to warrant the provision of medical treatment to him (care and habilitation under the supervision of an approved clinician); the treatment is necessary for the protection of other persons (other road users); the treatment is available and appropriate, taking into account the nature or degree of his mental disorder and all other circumstances in his case; and his consent, or compliance, or the consent of his carers is irrelevant, as he would be at substantial risk of causing serious harm to other persons (other road users) if he were not receiving treatment.

4. A patient suffers his first schizophrenic breakdown and attacks a member of his family. He is admitted to hospital for compulsory assessment as he is so ill, and the Tribunal subsequently authorises a resident treatment order. He improves significantly, and is discharged home on a non-resident treatment order. He is completely compliant with medication, which both he and his doctor agree that he will need for many years to come to prevent a further breakdown. Neither his doctor nor the Tribunal can discharge him from his non-resident order, as he meets the higher risk threshold and therefore his consent/compliance are not grounds to discharge. The only way for him to be free of compulsory powers would be for his doctor to agree to a medication-free trial, to see whether he has recovered and no longer needs medication. This may be a dangerous course to take, because if he does suffer a further breakdown it will not necessarily be the case that resumption of medication will bring him back to the same level of health. It would also, almost certainly, require him to go into hospital for the drug-free period, which would be disruptive.

5. A ten year old boy with Attention Deficit/ Hyperactivity Disorder is extremely disruptive at school, affecting the concentration and enjoyment of the other children in his class. His local education authority has a policy of integrated schooling for children with special needs, so there is no prospect of him going to a special school or a special unit.

The parents take him to a child psychiatrist, who recommends Ritalin. The parents say that they first of all want to try behavioural methods and an additive free diet, but the head teacher of the boy’s school says that he will have to exclude the boy unless there is an almost instantaneous improvement in his behaviour and attitude. The psychiatrist takes the view that, to protect others, he should ensure that the boy takes Ritalin straight away. He considers that the meeting he has had with the boy is sufficient to allow him to prepare a care plan, and he considers that the assessment that has taken place amounts to a voluntary assessment. He therefore applies to the Mental Health Tribunal for a non-resident treatment order. The Tribunal agrees that Ritalin is an appropriate treatment, although it also recognises that dietary changes and behavioural methods may be effective. However, in the short term, they believe that its in the boy’s best interests to remain at school, and it therefore agrees to a two month treatment order, hoping that if the parents are successful with the behaviour modification and dietary changes, that the boy can be discharged from the order after two months.

6. A man with a diagnosed anti-social personality disorder is referred for an assessment by the police, who are afraid that he may be a danger to the public, although all his brushes with the law have arisen from his dishonesty and his use of alcohol and street drugs. He is admitted to the local locked ward for assessment, but it quickly becomes apparent that he will not co-operate with local services, and as the locked ward is for short-term admissions only, the staff from the local medium-secure unit are called in to see if they could offer appropriate treatment in long-term security. They confirm that he has a treatable disorder, but does not really consider what level of risk he poses because they are able to conclude very quickly that they cannot offer him suitable treatment, as their unit can only offer a service to people with personality disorders if the individual concerned is willing to co-operate and not be too disruptive, which this person is not. The relevant condition of appropriate available treatment is therefore not met, and the man cannot be made subject to compulsory powers.

7. A predatory paedophile is coming to the end of a long sentence for sexual offences against children. The authorities are alarmed, as, despite prolonged counselling and regular attendance on sex offender treatment programmes, he still does not really accept that his behaviour was harmful, and therefore they believe that he is likely to re-offend. They ask for an assessment from Broadmoor, in the knowledge that his release date is not until just after the Bill is to be implemented. Broadmoor agrees that he is still dangerous and that there are treatment programmes available which might reduce the danger. There is an immediate vacancy, so they will take him straight away as his reported behaviour and attitude establish that he has a personality disorder amounting to psychopathic disorder under the 1983 Act, that is to say, he fits within the definition of antisocial personality disorder........failure to conform to social norms relating to lawful behaviour; reckless disregard for the safety of others; and lack of remorse. The fact that his personality disorder manifested itself through predatory paedophilia would not preclude his detention.
8. A middle-aged man has schizophrenia, the positive symptoms of which have burnt out, leaving him emotionally flat, socially uncaring and unable to work or look after himself properly except in a hand-to-mouth way. He begs to get money for his one pleasure, drink, and when he is not begging he is wandering about, dishevelled and smelly, talking to himself. He goes into prison from time to time, and is also admitted to a psychiatric ward from time to time after being brought into casualty when he has fallen over and banged his head. They clean him up and dry him out and try and find him some place to go, but they do not keep him in for long because they only have in-patient facilities for acute admissions, elderly people and people with challenging behaviour. When he leaves he goes to the bed and breakfast that has been found for him, but is soon asked to leave, because of his drinking. He meets the criteria for compulsory powers under the Bill but he also meets the current criteria for detention under the 1983 Act, and that does not help him as there are no suitable facilities for him. If the Bill has become law by the next time he is admitted from casualty, he could be put on a non-resident treatment order, with a condition that he stay at the place that they find for him, and that he does not beg or drink alcohol. However he will probably continue to beg and drink, because he knows nothing else and has no other options that he can cope with, and he will probably be asked to leave the accommodation because he is breaking the rules. The only option is to re-admit him to hospital (which he does not need) or discharge him from the order, which is where we started.

9. A man is a “revolving door” patient, who falls within the group of those who can be compulsorily assessed in the community without an immediately preceding admission. He is compulsorily assessed (somehow) and his psychiatrist considers that a non-resident treatment order should be made. The matter goes before the Tribunal, and the client says that he has seen the light, he realises that he needs medication and he is willing to take it. He reaches the basic risk threshold for the protection of others, but not the higher risk threshold of substantial risk of causing serious harm to others. He can, therefore, only be made subject to compulsory powers if he is not consenting. Under the 1983 Act, if a detained patient says to a Tribunal that he or she will accept treatment voluntarily or remain in hospital as a voluntary patient, the consultant psychiatrist will very often say that although he accepts that the patient means what he says, he believes that the patient’s willingness to comply will not last for long, and therefore it would be best if the person remained detained. However, the draft Mental Health Bill doesn’t seem to accommodate this kind of longitudinal assessment—if the patient is willing to accept treatment voluntarily, not all the relevant conditions are met and he is entitled to be discharged. It would therefore be necessary for the psychiatrist to tell the Tribunal that he believed his patient was lying when he said that he would accept treatment voluntarily. This is not likely to benefit the therapeutic relationship.

10. A woman is suffering from depression, which is causing her to become angry and erratic with her family, including her young children. She goes to her GP who offers her anti-depressants, but she says that she doesn’t want to take anti-depressants and would like to try and find another way of dealing with her depression. The GP refers her to a consultant psychiatrist, and she has a consultation with him. He believes that counselling will help, but he also feels that she should take anti-depressants, particularly as her children are beginning to show signs of anxiety as a result of her erratic behaviour. She continues to say that she is not willing to accept anti-depressant medication, and the consultant accepts that she has the capacity to make this decision. Nonetheless he decides that she reaches the threshold for an assessment. The depressed woman doesn’t understand the implications of agreeing to an assessment, and therefore does agree to it, so a voluntary assessment is carried out in the community, and it is decided that the relevant conditions are met and that a non-resident treatment order must be applied for. It is applied for, and the Tribunal has to make the order because she meets the relevant conditions and it has no discretion. This woman therefore, finds herself subject to compulsory powers although she has no previous history of in-patient treatment and her illness is not serious enough to justify a hospital admission.

11. Her sister, who has been living with her and helping to look after the children, also becomes depressed. It is suggested to her that she might benefit from anti-depressants, but she is so shocked at what has happened to her sister that she is not prepared to co-operate with any informal assessment. The GP whom she has consulted believes that the relevant conditions may be met in her case and feels duty bound to refer her for a determination under clause 4. Although the psychiatrist doesn’t believe that her illness is severe enough to justify in-patient treatment, he has no choice but to admit her for a compulsory assessment, because she does not fall within the group of people who can be given a compulsory assessment in the community without an immediately preceding hospital admission and she is not willing to co-operate with a voluntary assessment. She is therefore admitted to hospital for assessment, and immediately applies for a Tribunal. When she appears in front of the Tribunal she says that although she doesn’t want to take medication, she will take it because she doesn’t want to be put on a compulsory treatment order. The Tribunal believe that she will take her medication and therefore discharge her, and she returns home as a notionally free individual, who has actually been coerced into taking medication against her own wishes.

12. A woman has bi-polar affective disorder. She usually has insight into her need for medication, but sometimes she loses her insight, stops taking her lithium and becomes increasingly elated to the point where she is not sleeping, staying up all night playing loud music until her neighbours complain. Under the Bill she couldn’t be put on a non-resident treatment order when she leaves hospital on the next occasion, as she would be consenting to treatment and so all the relevant conditions wouldn’t be met. If the CPN went round and thought she was getting high, it might be possible to impose a compulsory community assessment on her, as she was a “revolving door patient”, but if the doctor managed to persuade her to take her medication he would have to discharge her from the compulsory assessment, as she was consenting, and if he did not
manage to persuade her, she would have to be taken to hospital anyway to be compelled to take the medication. There is no reason to think that she would go quietly for this. Also, once the medication had been given, it would be unlikely that she could go straight home as lithium does not work instantly and she would be upset at what had happened, and would probably need to be observed for a day or so, at least.

November 2004

Witnesses: Mr David Hewitt and Ms Lucy Scott-Moncrieff, solicitors, examined.

Q321 Chairman: Ms Scott-Moncrieff and Mr Hewitt, thank you for coming to give evidence this morning. Ms Scott-Moncrieff, you have given evidence before, which shows how lucky the Committee is to have you back again; Mr Hewitt, you are very welcome and can I congratulate you on your new Law Journal articles, the first one of which I have circulated the Committee because of the clarity of the picture it presents and the explanations. So thank you for those.

Mr Hewitt: It is edifying to know that somebody reads them.

Q322 Chairman: If we may, we would like to move straight into questioning rather than inviting you to make an opening statement, except that we have met Ms Scott-Moncrieff before so she has introduced herself once and she does not need to do it again. Mr Hewitt, would you introduce yourself very briefly?

Mr Hewitt: Yes, my name is David Hewitt, I am a solicitor and a partner in Hempsons Solicitors; until very recently I was for nine years a member of the Mental Health Act Commission.

Q323 Chairman: I think you have worked on, as it were, both sides of the litigation over the years, have you not?

Mr Hewitt: I have, and possibly even in the middle if you include the Commission in that.

Chairman: Mr Prosser, I think you are going to start this.

Q324 Mr Prosser: Mr Hewitt, on the question of least restriction No Force, Scoop and others have told us that the threshold for protecting the safety of others and the health of others is set too low in the Bill. Given that those with mental disorders are not always conscious that they have a problem, do not always perceive that there is a problem, would you say that the level set in the Bill is about right and, if not, how would you set it and how would you define it?

Mr Hewitt: I think there is this differential in the Bill, as it is now drafted, between those who are thought to present a risk simply to themselves and those who are thought to present a risk to others, and I think the differential is such that you could see a change between the current draft of the Draft Mental Health Bill and the 2002 draft as being evidence that the main purpose of the draft is public protection. Certainly, the relevant conditions would make it easier to apply compulsion to a person if he or she presents a risk to others, than if the only risk is to him or herself. It is worth bearing in mind of course that the 1983 Act contains no such differential test, in essence no greater self risk is required to justify detention than risk to the public. So in that context you could see this change, I think, as being motivated by the desire not to protect the public but to keep patients out of hospital unless it is absolutely necessary. The problem is that the other relevant conditions rather give the lie to that, but certainly as far as concerns this particular one of the conditions, that would be possible. My own view is that I have not seen in the documents that the Government has prepared to accompany the Draft Bill a justification for having that differential test, unless it is to protect the public, unless it is out of the perception that the public fears itself to be at risk.

Q325 Chairman: Ms Scott-Moncrieff, can I ask you possibly to widen the answer to the question to deal with any legal difficulties that you feel we might find practitioners like yourselves facing in the context of the test as described in Mr Prosser’s question?

Ms Scott-Moncrieff: The difficulty for me is that it does not actually talk about the protection of the public and their health and safety, it just talks about the protection of the public, and that could be from all sorts of things. It could be from harassment, from annoyance, from irritation, from financial hassling—all sorts of things come under the heading of protection—and it is not at all clear that those sorts of things would be restricted. It is the same use of language as under the 1983 Act; there it simply talks about the protection of the public as well, but there are other constraints under the 1983 Act—the protection has to justify treatment in hospital, for instance, whereas it does not under this Act, and there is a much narrower definition of the medical treatment that has to be available to the person. It has to be medical treatment under psychiatric supervision, whereas under the current proposals there is a very wide definition of protection, i.e. it covers anything, as far as one can see. There is no need that the person has to be given hospital treatment to protect the public and there is no need even that the treatment has to be given under the supervision of a psychiatrist; it could be given under the supervision of a psychologist. So it is enormously wide, and that seems to me to be extremely problematic. If I were being asked to suggest an alternative I would, as I think I have said in my written submission, propose the Scottish definition, where they talk about the safety of the public. That is much more straightforward, is it not, because it leaves out all the social irritant side of things and so on, so the safety of the public seems to me to be a good and clear definition where protection of the public just is not and will lead to endless arguments.
Chairman: Mr Howarth?

Q326 Mr Howarth: I can understand exactly where you are coming from and some of the client groups that we spoke to have made more or less the same point in the last week. Do you not accept that there are some types of behaviour that, while they might not physically threaten somebody, can make their lives miserable? You used the word yourself, harassment: there is a spectrum of harassment from something that is irritating through to harassment that can make people's lives intolerable.

Ms Scott-Moncrieff: Yes.

Q327 Mr Howarth: How would you deal with that more serious end of the spectrum of harassment?

Ms Scott-Moncrieff: That kind of behaviour is well recognised in the criminal law—particularly recently with ASBOs and so on, and the stalking legislation—so one of the things that this Act does, is it have quite flexible provision for people who are charged with or convicted of criminal offences, and it seems to me that if somebody's behaviour reaches that criminal threshold, then if the decision is to have a mental health disposal, well, fine, that seems to be the way to do it, but to bring in as it were a mental health threshold as well, where somebody could be sectioned for behaviour for which they could not be arrested, as it were, seems to be discrimination. There are plenty of provisions for diverting people from custody and diverting people from the court system, if they reach the threshold of criminal arrest, and those provisions no doubt will be able to continue.

Q328 Chairman: Forgive me for interrupting, but do you mean what you are saying, because the threshold for criminal arrest is pretty low?

Ms Scott-Moncrieff: Yes.

Q329 Chairman: Are you in favour of a mental health diversion, possibly through compulsory powers, even where the threshold of arrest has been reached—for example by a low level of assaults on police officers or thefts from business premises?

Ms Scott-Moncrieff: One of the things that I think is important is to disentangle criminal justice from mental health. People with mental health problems are citizens and are responsible for their actions unless found not to be, and, if they are doing things that break the law or appear to break the law, then let us recognise that and, let us acknowledge that. Because we live in a humane and civilised society, that does not mean that they necessarily are going to be punished in the way that somebody who perhaps has greater responsibility for their actions should be, but let us clarify the difference between a criminal act—which certain sorts of harassment and annoyance would be, aggressive begging or whatever it might be—and then what you do about that criminal act, rather than conflating them as this legislation appears to be trying to do.

Q330 Mr Howarth: Have we not traditionally taken the view that while the act of one person and the act of another person might be the same in effect, the things that drive them to it have been entirely different? For example, in the case of a mentally disordered offender there is a compulsion to do which is not necessarily acquisitive or vindictive, it is quite separate. Have we not historically felt that that was something that was a mental health problem and should be dealt with in that way, rather than a criminal problem?

Ms Scott-Moncrieff: Absolutely, I am not saying if somebody has a schizophrenic breakdown they have to be arrested and taken to court; I am not saying that at all. We have the provisions for the police now to take people who appear to be mentally distressed, who very often may be behaving in a way that is, you know, verging on breach of the peace or whatever it might be, taking them to hospital—I am not saying that you should not be able to do that, but the way that the question was put to me was that somehow mental health legislation ought to have a different threshold to criminal legislation, and it seems to me that you ought to be trying to use the same thresholds to ensure that you are not discriminating against people's mental health problems, and making them subject to compulsory powers where their behaviour does not reach any kind of criminal threshold. One of the difficulties—and I have done a lot of work with mentally disordered offenders, obviously at the higher end of the market rather than the community end of the market—about the conflation between the criminal justice system and mental health is that all the safeguards under criminal justice, like for instance proving a case, are completely dissolved. Most psychiatrists have no particular understanding of the difference between evidence and proof, for instance, or suspicion and proof, or suspicion and guilt, and somebody can be suspected of behaving in a particular way and, out of compassion, possibly, or for various reasons, they are not arrested and charged with an offence. It is assumed that they did what it is that they are alleged to have done, and they may say “I did not do it”, but that is denial, is it not, we are going to keep you in hospital, and so on, and so forth. Very dangerous situations arise where people are shut into the psychiatric services without any of the safeguards of the criminal justice system, Obviously, criminal justice is about protecting the public but it is also about protecting the accused individual.

Q331 Chairman: Mr Hewitt, do you want to add anything on thresholds?

Mr Hewitt: Yes, just to make the point that if there is a problem in dealing with people who present a problem to the community, that difficulty arises it seems to me, not because the threshold is to high or too low in a particular case, it is because of other conditions, other criteria and conditions, such as for example the treatability criteria. Experience shows us that there is never really any difficulty in having people who present the kind of risk that you describe
who also suffer a mental disorder being admitted to psychiatric care, the difficulty lies with other aspects of that, including the treatability of the condition.

Chairman: Mr Hinchliffe?

Q332 Mr Hinchliffe: I wanted to press Ms Scott-Moncrieff on her comments on the criminal justice versus the mental health system. It struck me in some instances that people in the criminal justice system are not enabled to get the kind of help that they could possibly get in the mental health system. You talked about the harder and more serious end of offending, but if we look at the less serious exhibitionist, for example, it has always struck me as rather odd that exhibitionists—the closet flasher perhaps—could do with some help possibly, rather than the kind of punishment that would arise from the criminal justice system. Would you accept an argument for that kind of level of offending to be more geared to our mental health legislation as opposed to criminal justice?

Ms Scott-Moncrieff: There is no reason why that could not happen.

Q333 Mr Hinchliffe: But it does not happen.

Ms Scott-Moncrieff: It does not happen, but that is to do. I would suspect, with lack of resources rather than lack of provision, either in mental health legislation or voluntarily. I do not really work with people like that, so I do not know to what extent people would accept treatment voluntarily, but certainly if treatment were available and they had been arrested and convicted then they could be compelled to accept treatment, if treatment were there. Yes, of course, I agree. I would like to see much more provision for mentally disordered offenders of all sorts; I think there is rotten provision at the moment and there should be far more of it.

Chairman: Can we move on now and take fairly shortly, so that we can give time to the next question, the second of the questions of which you were obviously notified? Lord Rix?

Q334 Lord Rix: In your submission, in paragraph 13, you say: “The definition of the Scottish Act with some, all or none of these exclusions should replace the definition of mental disorder in the Bill”, but the Scottish definition includes persons with learning disability; why do you consider that learning disability, without any attendant mental illness, should constitute a mental disorder for the purposes of this Bill?

Ms Scott-Moncrieff: It is partly to do with language, is it not? I do not think that learning disability is a mental disorder, but there are arguments to say that other forms, like personality disorder, would also not fit within mental disorder in terms of mental illness. So I think one has to go beyond the words and look at the purpose of the legislation, and as I was saying with the criminal justice provisions, it is not just about protection of the public, it is also about protection of individuals; and if people with learning difficulties were taken out of the provisions of the Mental Health Bill, the current Act or any new Act, then, for instance, the availability of hospital orders for people who have been convicted of offences would not be available to them. That seems to me to be unfortunate; it would be very unfortunate, they would be stuck in prison. You might have to have special units in prisons, or something like that, but that would be very unfortunate.

Q335 Lord Rix: Could not a clause be put in the Bill which would cover that point?

Ms Scott-Moncrieff: I think that the way to do it is to keep people with learning difficulties within the definition, but to put in all sorts of other restrictions, as with the current Act, where mental impairment has to include abnormally aggressive or seriously irresponsible conduct, and compulsory powers can only be used if somebody needs to be in hospital under the care of a psychiatrist, all these kinds of provisions. Equally with the Scottish legislation, they have got people with learning difficulties, learning disabilities in there, but they have also got all sorts of other provisions—the person has to need to be in hospital, and so on and so forth—and it has to be for the safety of the public or for the health and welfare of the individual, and I think there are also provisions in there for families and carers to be able to challenge compulsory powers if they can look after the person at home, which, of course, we have got in the 1983 Act; because so long as a person is not a danger to themselves or others then their family can discharge them.

Q336 Lord Rix: Would you not consider that the hurt that is caused to people with learning disabilities and their family and carers—people who, literally, just have a learning disability full stop—by the fact that they are referred to in the Mental Health Act—is it not worth considering their feelings when it comes to legislation?

Ms Scott-Moncrieff: It is something that you obviously know much more about than I do because I do not particularly work with people with learning difficulties. It seems to me that, yes, to put any group of people at fear of compulsion when they should not be is very, very damaging, particularly people who are already vulnerable and disadvantaged and have low status in society, and so on and so forth. So to make them feel that there is yet another thing that they might be subject to. I think is very significant, but nonetheless I think the protections that are offered under Part 3 of the Act should not lightly be done away with.

Lord Rix: No.

Q337 Mrs Browning: Can I just pick up on that? You acknowledge that learning disability is not a mental disorder; it seems somewhat bizarre to group them in with a mental disorder when quite clearly they have not got one, rather than trying to construct a package of checks and balances that will help us avoid, perhaps, some of the more high profile cases we have seen involving people with learning disabilities. I am very concerned that you feel that just by giving them a diagnosis that they do not have
that opens up the door to misdiagnosis across a whole range of disabilities. I just wonder if you think that is a potential danger.

Ms. Scott-Moncrieff: It is such a muddle with this Act and the Mental Capacity Bill, because what you have got is a complete confusion. This Act covers people with capacity; and without capacity; with mental illnesses; with personality disorders; and with learning difficulties. The Mental Capacity Bill is only meant to deal with people who lack capacity, but there is nothing to say that it has to be limited to people with learning difficulties; it could equally apply to people with schizophrenia who lack capacity, for instance, or certainly people with certain personality disorders who lack capacity. So it would be perfectly possible to construct something separate, a separate package as it were, for people with learning difficulties or people with developmental disorders, but if they are going to have the same safeguards—I share the views of a lot of people that the safeguards in here are not particularly adequate, but there are certainly a lot of them—then what you would be having is a parallel system of safeguards for some people under the Mental Capacity Bill, for instance. But at the moment the Mental Capacity Bill does not authorise detention. If people with learning difficulties were going to be covered entirely by the Mental Capacity Bill, then you would have to have a system within the Mental Capacity Bill for authorising detention and for reviewing detention, so as well as your Mental Health Tribunals you would have your Mental Capacity Tribunals.

Q338 Chairman: Can we ask Mr Hewitt if he has the same view or a different view on the issue raised by Lord Rix?

Mr Hewitt: I have a similar view and it is a point that Lucy made, and that is that however we regard people with a learning disability the fact is that as a consequence of the European Court of Human Rights decision in the HL case it is going to be necessary to devise some sort of framework whereby they can be admitted to hospital and given safeguards. That may be under the new Mental Health Act or it may be under the Mental Capacity Act, my preference I think would be for the Mental Health Bill. Alternatively, of course, it may be possible to devise a third piece of legislation which would give them those protections, but however we see those people, some sort of framework will have to be devised.

Lord Rix: I would accept that.

Mrs Browning: I would accept too, we all know the struggle over the HL case in trying to work out which is the most appropriate vehicle, but I do not think that is resolved by taking a group of people, people with a learning disability, and giving them a new diagnosis which clinically they do not actually have.

Chairman: Can we pause there—we have had a lot of debate about this issue and I think it is reasonably clear what the views are—and ask Baroness Barker to deal with the next of the notified questions?

Q339 Baroness Barker: Thank you. Last time you were with us, Ms Scott-Moncrieff, we had an interesting discussion about what should be in the Bill and what should be in the Code of Practice and that is when we were talking about principles. I return to similar territory here because given the constraints on resources which you and particularly the user groups who we saw last week talked to us about, is there any point in having the reciprocal right to mental health assessment and services on the face of the Bill? If you think there is a point to that, what would you expect to see in the Code of Practice?

Ms Scott-Moncrieff: I am not sure if I am the right person to answer this, but I will do my best. The compulsory treatment provisions in here are meant to be last resort, and it is meant to be where voluntary treatment cannot be provided, for one reason or another. I think the impression that a lot of people have got, is that it is going to become much more a matter of first resort, and then only resort, in the sense that resources are going to be shunted into looking after people who are necessarily subject to compulsory powers and there is going to be less available for everybody else. One of the relevant criteria for compulsion is that there are available resources; that there is appropriate treatment available for somebody, and therefore it is going to be perfectly possible for people to be subject to compulsory assessment and then subject to the initial examination and then not put under compulsory assessment because there are no resources available. I am not aware that there is going to be any way of keeping those statistics, and identifying the areas of unmet need, and it is rather a roundabout way of doing it. If you have a provision on the face of the Bill that people are entitled to ask for services, even though they may not be entitled to get services—in the same way that you can do with community care; people are entitled to ask for a community care assessment and the assessment may be, yes, you need this, that and the other but we cannot afford to give you any of them—then this would be quite interesting information, it seems to me, for those who are meant to be making provision, and it will also, of course, feed into the whole issue of the circumstances in which people are not being given compulsory treatment because there is no availability of resources. I do think it is very important, therefore, that people should have the right to ask for that; without necessarily thinking that they are going to be subject to compulsory powers. As for how the Code of Practice would deal with it, the legislation allows anybody to trigger a compulsory assessment so presumably anybody should be able to trigger a voluntary assessment.
Q340 Chairman: Mr Hewitt?
Mr Hewitt: My concern would be that, if there were a specific right to services in connection with people who have been under compulsion or who are under compulsion, that might have the effect of diverting funds away from services provided for informal patients, and it seems to me that that would be running contrary to a desirable intention in mental health services, and that is to favour informal treatment where possible and to discourage formal treatment. My other point would be that I am concerned that so-called section 117 patients under feasible form of advance directive? treatment where possible and to discourage formal I become so ill again that they want to give me ECT running contrary to a desirable intention in mental patients, and it seems to me that that would be compulsion, that might have the e

Q341 Chairman: Can I just move to another subject which I think you may be able to help the Committee on particularly and that is about advance directives? As a matter of law and as a matter of legal practicality—which may not always be quite the same thing—do you believe that fairly prescriptive advance directives are something that we ought to be taking closely into account, by which I mean, for example, advance directives covering the refusal of a narrow range of severe treatment such as ECT and psychosurgery—which is at one side of the balance—and on the other side have regard to directives which might impose a different set of obligations upon clinicians?
Mr Hewitt: I think this is a subject that is likely to cause a great deal of difficulty, largely because it is hard to see on the face of it how advance directives, which give some indication of the patient’s choice and attempt to make that binding, could co-exist with a system that depends entirely upon compulsion. It seems to me a rather strange situation. There was discussion in the previous session about the possibility of either using or amending the proposals in the Mental Capacity Bill, and it seems to me that those proposals are predicated upon an entirely different notion, and that is the standard notion of consent in general medical treatment. Compulsory mental health treatment, as I am sure the Committee is aware, is not that type of treatment, so it seems to me that although there may be some room for advance directives in psychiatric care, certainly where patients come out of hospital having ceased to be detained or subject to compulsion, the scope for them is in fact rather limited.

Q342 Chairman: If you take the simpler example of a patient with a history of mental illness who says “If I become so ill again that they want to give me ECT without my consent, I refuse”; do you think that is a feasible form of advance directive?
Mr Hewitt: It is difficult in the case of ECT. I think my point would be that it rather depends on why compulsion is thought necessary in the future event. It may be thought necessary—and I appreciate it may be different with ECT—in order to protect the public, for the safety of other persons. In those circumstances it is hard to see how the advance directive could be allowed to take precedence. If the only threat the patient is thought to present is to him or herself, I can see the argument for that; we are back into the sort of capacity territory that was canvassed by the Richardson Committee.

Q343 Lord Carter: I was going to give the same example, but in fact in a different way, because of course under the Mental Capacity Bill the physician can take into account a change of circumstance, so that the person in fact, if they were redoing it, might change their mind. You could have somebody who had given refusal of ECT but the physician could perhaps argue that the circumstances have changed so much that, if he knew how it would help the patient, therefore he would be prepared for them to give the ECT.
Mr Hewitt: As somebody who advises doctors in these circumstances I can say that one of my first questions is can you be sure that when they created this advance directive, first of all, they were capable and, second, that they anticipated the precise circumstances that have arisen? Maybe on occasions that is a bit of a get-out for hard-pressed doctors.
Lord Carter: Exactly. Thank you very much.
Chairman: This has been a short session, and we are very grateful to you for the clarity of your submissions and your answers. Thank you very much indeed, we do appreciate your help.

Memorandum from the Making Decisions Alliance (DMH 230)
— Significant amendments are needed in both Bills to address inconsistencies, potential confusion, and inappropriate use of either Bill for people who could be affected by both.
— Safeguards to address the Bournewood case and meet the European Court’s ruling should be contained in the Mental Capacity Bill but widened to include other groups who lack capacity to consent to being in hospital, residential care or nursing homes.
— The Government should complete its consultation on safeguards to meet the European Court’s ruling in Bournewood in time to allow amendments regarding those safeguards to be incorporated into the Mental Capacity Bill.
— Guidance from Government is urgently needed to cover Bournewood type situations that may arise prior to primary legislation being passed that incorporates the necessary safeguards.
1. The Making Decisions Alliance (MDA) is a coalition of national and regional disability and older people’s organisations that came together in 2002 to campaign for the introduction of mental capacity legislation. The current membership of the MDA is listed below.

2. Many of the member organisations are also members of the Mental Health Alliance (MHA) and we are broadly supportive of the MHA’s submission to the Joint Committee. Of particular concern to the MDA are the issues raised in the MHA’s response to Question 8 posed by the Committee concerned with integration between the Draft Mental Health Bill and the Mental Capacity Bill (MCB). We view this as an extremely problematic area, particularly in light of the recent European Court ruling on the Bournewood case, and would urge the Committee to consider these issues very carefully. In summary these are:

2.1 Different philosophies and procedures underlying the two Bills yet the same individuals may find themselves subject to both.
2.2 The failure of both Bills to adequately provide the safeguards necessary to meet the European Court’s ruling on the Bournewood case.
2.3 Inconsistencies in the level of safeguards between the two Bills for people who lack capacity that are being treated with ECT.
2.4 The potential for confusion and inappropriate use of the MCB to detain and compel people with mental disorders to receive treatment without clear safeguards.
2.5 The potential for confusion for practitioners as to which piece of legislation to use, what is in an incapacitated person’s best interests, and the least restrictive alternative, taking into account significantly different definitions of the latter in the two Bills.
2.6 Discrimination against people with mental disorders who have advance refusals of treatment which can be over-ridden where they apply to the mental disorder but must be respected if they apply to a physical disorder.

3. The MDA is particularly concerned about the implications of the European’s Court’s ruling on the Bournewood case and the recent announcement that the Government will be carrying out a consultation on how best to address this issue. While the MDA fully supports the principle of a consultation process we are very concerned that the timing of this may prevent it being addressed in the MCB. The MDA believes that the MCB is the more appropriate Bill for inclusion of the safeguards to address the Bournewood ruling. This is because the European Court’s ruling primarily concerned the unlawful detention of Mr L, as opposed to the treatment he received. Thus the situation could equally as well apply (and almost certainly does at present) to people who lack capacity to consent and are detained in hospital for treatment for physical illnesses and people who lack capacity to consent and are detained in residential care or nursing homes, particularly people with dementia. Although we recognise that adults with mental disorders who lack capacity to consent are a particularly important group, and our amendment to the MCB reflected this, we would ideally like to see the safeguards necessary to meet the European Court’s ruling on the Bournewood case applied to this much broader group of people. These safeguards include:

3.1 Clear conditions and assessment process for the safeguards;
3.2 Clarity concerning the duties of the responsible clinician and the availability of a second opinion from someone with the relevant clinical expertise concerning the person’s illness and/or lack of capacity to consent;
3.3 Notification and appointment of a representative for the person (independent advocacy);
3.4 Preparation, approval and procedure for review of a care plan;
3.5 Procedure for resolving disputes, including applications to the Court of Protection

4. We would also draw the Committee’s attention to the fact that neither Bill is likely to become law in the immediate future and therefore there is an urgent need for guidance to be issued on how any situations comparable to the Bournewood should be handled in light of the European Court’s ruling before being addressed in primary legislation.

For further information please contact the MDA co-chairs:
Richard Kramer, Turning Point, 020 7702 2300, Richard.Kramer@turning-point.co.uk, or Toby Williamson, Mental Health Foundation, 020 7802 0332, TWilliamson@mhf.org.uk. Information is also available on the Making Decisions Alliance website: www.makingdecisions.org.uk

**Members of the Making Decisions Alliance**

- Action on Elder Abuse
- Addavoice
- Age Concern England
- Alzheimers Concern Ealing
- Alzheimer’s Society
- Beth Johnson Foundation
Carers UK
The Centre for Policy on Ageing
Cloverleaf Advocacy
Consumer Forum
The Down’s Syndrome Association
Foundation for People with Learning Disabilities
Headway
Help The Aged
Horsham Gateway Club
Independent Advocacy Service
Kent Autistic Trust
Leonard Cheshire
Mencap
The Mental Health Foundation
Mind
Motor Neurone Disease Association
The National Autistic Society
North Staffordshire Users Group
The Oaklea Trust
Patient Concern
POPA
The Relatives and Residents Association
Respond
Rethink
St Clements Patients Council
Scope
Sense
Skills for People
The Stroke Association
Turning Point
United Response

Memorandum from Mencap (DMH 268)

Thank you for giving Mencap the opportunity to respond to the Joint Committee’s consultation. As the UK’s leading learning disability charity representing people with a learning disability, and their families and carers, we are pleased to be a part of this extremely important consultation.

Mencap is an associate member of the Mental Health Alliance (MHA) and as such we fully endorse their submission to this Committee. We are also a core member of the Making Decisions Alliance which has been working on the related Mental Capacity Bill. Our answers to the questions below all have the necessary caveat that, like all people giving evidence to this Committee, we do not yet know what will be in the final Mental Capacity Act and this creates difficulties in making definitive judgments about both Bills. However, we welcome and support the reform of mental health legislation.

Given the response you have received from the MHA, our submission concentrates on the core issues for people with a learning disability associated with this Bill, namely, the need for the Bill to concern only people with a mental illness (question 2), the need for the Bill to be first and foremost a health and social care Bill (question 3), the need for the Bill to be understandable (question 4) and the need for the Bill to work with the Mental Capacity Bill (question 8).

Mencap’s stance on the Draft Mental Health Bill is based firmly on a human rights perspective. The detention of someone against his or her will is a serious breach of their fundamental human rights and should only be allowed in the most limited of circumstances. It is of particular concern to people with a learning disability because, regardless of whether they actually lack mental capacity or not, things are often done for, or to, them against their expressed or unexpressed wishes.
It also has to be noted that people with a learning disability have for too long been subject to inadequate and discriminatory practices when trying to access all aspects of health and social care services including mental health services. This is despite clear evidence, as outlined in the Government’s Valuing People White Paper, that people with a learning disability are more likely to have mental health problems than the general population.\(^3^7\) The lack of access to the same quality of preventative care and services often leads to the development of more serious mental health conditions.

**Q2. Is the definition of mental disorder appropriate and unambiguous?**

The Draft Mental Health Bill defines mental disorder as “an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain”. This broad definition undoubtedly gives the potential for serious over inclusion of people with a learning disability simply because they have a learning disability. The Draft Mental Health Bill explanatory notes (page 11) confirm this stating “examples of mental disorder include schizophrenia, depression or a learning disability”.

A learning disability is not a mental illness. Mencap believes that it is fundamentally wrong for someone with a learning disability to come under mental health legislation unless they also have a mental illness. If such a broad definition of mental disorder is to be used, then it is essential that this be combined with extremely tight conditions and limitations. As such, we firmly support the Royal College of Psychiatrists’ recommendation that the final Bill should include the exclusion condition ‘impairment of intelligence’. If this is not included, then the definition of mental disorder in the final Bill would include almost all people with learning disability, who would then be liable to compulsion at any time they declined medical treatment (including education and training).

Such an approach is likely to lead to:
- The inappropriate detention of more people with learning disability
- The growth of institutional care (in stark contrast with the Government’s stated aims in Valuing People)
- The increased stigmatisation of people with a learning disability
- The exacerbation of existing confusion about mental illness and learning disability
- Increased fear among people with a learning disability about voluntarily accessing mental health services and hence a likely decline in early preventative treatment

**Q3. Does the Draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?**

While a balance clearly needs to be struck between the rights of the individual and public safety, Mencap believes any future Mental Health Bill must be first and foremost a health and social care Bill and not a criminal justice Bill. We do not believe the Draft Bill has got this balance right yet. The Committee has already heard evidence that treatment for mental illness nearly always begins with someone telling a doctor or psychiatrist that they think they have a mental illness. As such, neither someone with a mental illness nor the community in which they live is best served by a law which prevents this interaction or drives people away from seeking the help they need.

As well as further stigmatising people with a learning disability and creating unhelpful and unnecessary apprehension among those people with a learning disability who do have a mental illness, it may well have knock on effects for the treatment of other illnesses. As Mencap’s Treat me right! report demonstrated, people with a learning disability are already the least likely group to seek or receive appropriate medical care and treatment.\(^3^8\) The last thing that is needed to improve this already dire situation and to encourage more people with a learning disability to seek medical help is the message (however wrong in reality) that they could be locked up simply for having a learning disability.

We are particularly concerned by clause 9, sub-section 4, of the Draft Bill which states that it is necessary that medical treatment be provided to the patient:

(a) For the protection of the patient from—

(i) Suicide or serious self-harm, or

(ii) Serious neglect by him of his health or safety, or

---


\(^{38}\) Treat me right! Better healthcare for people with a learning disability, June 2004.
Mencap believes that the threshold for protecting the patient under (a) is acceptable but that the threshold for protecting other persons under (b) is too low. We are very concerned that people with a learning disability who might be displaying challenging behaviour—behaving noisily or being a nuisance for example—may fall foul of this condition. We believe that the threshold for the protection of other people should be raised.

Q4. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient, and clear? Are there any important omissions in the Bill?

While endorsing what the MHA has said in response to this question, we would simply like to highlight that experts with many years experience in the mental health field are having great difficulty understanding the complexities of this Draft Bill. As the Mental Health Act Commission said in its evidence to this Committee: “The likelihood of the Bill being misapplied is greatly increased in proportion to the opacity of its construction. Mental health law must be accessible to persons without legal qualifications for it to be effective.” People with a learning disability will have great difficulty attempting to understand this piece of legislation. We are grateful that the Government has produced an accessible version of the Draft Bill and recognise that the full Draft Bill’s complexities are, to some extent, a necessary evil. However, we feel that the need for this Bill to be widely understood adds weight to the argument for there to be clear principles on the face of the Bill. The introduction of clear principles in the Mental Capacity Bill did assuage some of the initial fears held by people with a learning disability about that Bill. We feel similar clear principles on the face of the Mental Health Bill will have a similar effect.

Q8. Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

Mencap feels that it is wholly unsatisfactory to be trying to assess whether the Draft Mental Health Bill is sufficiently integrated with the Mental Capacity Bill when we do not yet know precisely what will be in the Mental Capacity Act. At the time of writing, it seems unlikely that the Government consultation following the European Court of Human Rights Bournewood judgment H.L. v United Kingdom will be finished by the time the Mental Capacity Bill has completed its passage through Parliament. We are concerned that if Bournewood is dealt with under the Mental Health Bill, it could be two years or more before appropriate legislation is finally on the statute book.

Wherever the Bournewood issue is dealt with, fundamentally, the rights and safeguards should be the same under both Bills. The current provisions in the Mental Capacity Bill are woefully inadequate and, in our opinion, will not prevent another ‘Bournewood’ type situation. The following safeguards must be put in place to protect the estimated 50,000 patients who may be affected by the Bournewood ruling:

— A care plan which is subject to independent review
— The appointment of a Nominated Person who would be consulted about treatment and discharge and who could apply to the Court of Protection
— Access to the Court of Protection together with no-strings legal aid
— Access to mental health/legal/independent advocates as appropriate who should also have an automatic right to apply to the Court of Protection on the patient’s behalf
— Special authorisation for ECT and serious non-emergency treatment should also be required before approval of the treatment plan is given.

Clearly, even when the issue of informal incapacitous patients has been properly dealt with, there is going to be considerable scope for overlap between the two Bills and for psychiatric patients to be subject to both regimes—a fact which is likely to cause confusion and dilemmas for professionals and service users alike. However, we feel this is a reflection of the complexities of the issues involved rather than poorly considered legislation.

Thank you for giving Mencap the opportunity to contribute to this consultation and we hope you find our response helpful.

November 2004

39 Memorandum from the Mental Health Act Commission, 12 October 2004, p1.
Witnesses: Mr David Congdon, Head of External Relations, Mencap, Mr Richard Kramer, Director of Policy, Turning Point and Co-Chair Making Decisions Alliance, Mr Jonathan Coe, Chief Executive POPAN (Prevention of Professional Abuse Network) and Chair of the Association of Mental Health Advocates (Making Decisions Alliance) and Ms Henrietta Marriage, Head of Mind Legal Unit, Member of AMHA, (Making Decisions Alliance), examined.

Q344 Chairman: Good morning, and thank you for attending on behalf of the Making Decisions Alliance and Mencap. This is a fairly short session; we are constrained by events in the House of Commons on Wednesday morning around about noon, so if you do not mind we will omit any introductory statements. Can I say to you at the outset that these proceedings are recorded, you will be sent a transcript of what is recorded and also it will appear on the internet in about a week. You can correct the text to make sure that what you said is accurately recorded, but not the substance. We are very grateful to you for your submissions, which we are really seeking is a situation that says that, if someone only has a learning disability, they should not fall foul of the compulsory procedures in the Bill, because that is really the essence of this Bill. Why do we say that? We say that because too often in the lives of people with a learning disability they have things done to them or for them, things imposed on them, with or without their actual technical consent—"It would be best for you, we know what is right for you". I think we would accept, of course, that the Mental Capacity Bill will go some way to improve that situation, but in terms of mental health legislation a lot of people with a learning disability fall foul of the current law; even more would fall foul of the current law if they were not detained informally, as was the case in the famous or infamous Bournewood judgment. It seems from the evidence that, in practice, the distinction between whether someone actually gets sectioned or not is not always absolutely clear, and what does happen is you do find people with a learning disability, particularly where it is difficult to provide suitable services and maybe social services cannot provide for them, the health service steps in and they end up accessing psychiatric services. What we want to see is an exclusion where a person only has a learning disability—and of course a third do have a mental illness problem, and they should fall within the normal rules of the powers. But we were also concerned, as came up in the evidence session, about the very low threshold. If you have a wide definition of mental disorder—and it is wide—then as other witnesses have said you need very tight conditions. The condition of protection from harm of others means absolutely nothing; people with a learning disability, maybe being a bit agitated, maybe causing a problem in the street, but not seriously harming someone, could fall foul of the legislation, and we are seeking to avoid that. So we have tackled this particular piece of legislation very simply from a human rights aspect.

Q345 Mrs Browning: Mencap are very clear that they believe it is wrong for somebody with a learning disability to come under mental health legislation unless they have a mental illness as well. You have heard the previous discussion and you can see that there is quite a lot of overlap now in the advice the Committee is being given in respect of learning disability. First of all, in terms of protecting people with learning disability when they may come into contact with the criminal justice system, and also this question of protection of people for learning disability where, on the one hand, it does look as though they might benefit from the protection of the Act, except that we have just heard from the previous evidence that, in order to come within the umbrella of the Act, in some areas where protection might benefit them we would then have to say quite specifically that they have a diagnosis of a mental disorder which they clearly do not have. I just wonder if you could elaborate on the evidence that you have already sent us as to how you see this Act protecting people with learning disability, and what are the dangers for people with learning disability from it?

Mr Congdon: Thank you very much. There has been a long history of confusion between what is a learning disability and what is a mental illness, and a learning disability being a lifelong condition it cannot be cured. Indeed, people with a learning disability in particular find it offensive if they are said to have a mental health problem or a mental illness. That is probably the easy bit to say. I was struck very much by the discussion just now, and I think we would certainly accept that we would not wish to see people with a learning disability penalised via the criminal justice system because of any change to the Mental Health Bill, but we believe that could be overcome and indeed we were looking at other evidence from other people who I think took a similar view in some of the written evidence. What we are really seeing is a situation that says that, if someone only has a learning disability, they should not fall foul of the compulsory procedures in the Bill, because that is really the essence of this Bill. Why do we say that? We say that because too often in the lives of people with a learning disability they have things done to them or for them, things imposed on them, with or without their actual technical consent—"It would be best for you, we know what is right for you". I think we would accept, of course, that the Mental Capacity Bill will go some way to improve that situation, but in terms of mental health legislation a lot of people with a learning disability fall foul of the current law; even more would fall foul of the current law if they were not detained informally, as was the case in the famous or infamous Bournewood judgment. It seems from the evidence that, in practice, the distinction between whether someone actually gets sectioned or not is not always absolutely clear, and what does happen is you do find people with a learning disability, particularly where it is difficult to provide suitable services and maybe social services cannot provide for them, the health service steps in and they then end up accessing psychiatric services. What we want to see is an exclusion where a person only has a learning disability—and of course a third do have a mental illness problem, and they should fall within the normal rules of the powers. But we were also concerned, as came up in the evidence session, about the very low threshold. If you have a wide definition of mental disorder—and it is wide—then as other witnesses have said you need very tight conditions. The condition of protection from harm of others means absolutely nothing; people with a learning disability, maybe being a bit agitated, maybe causing a problem in the street, but not seriously harming someone, could fall foul of the legislation, and we are seeking to avoid that. So we have tackled this particular piece of legislation very simply from a human rights aspect.

Q346 Mrs Browning: Could I just quickly come back on that? In the event of somebody with a learning disability having an episode of very challenging behaviour, which can very often be triggered by a specific event rather than by some form of mental aberration, there clearly has to be some action taken because they might well not be a danger to other
people but they could very well be a danger to themselves when they are in such a state. How do you see that type of situation being managed, because it was actually that specific type of event that triggered the Bournewood matters?

Mr Congdon: The crucial thing, you are absolutely right, when something happens is dealing with the situation absolutely appropriately and understanding the needs of the individual. If the needs of the individual are understood, particularly if someone knows the individual, they are much better placed as to whether that behaviour was triggered by a specific event, which you have quite rightly alluded to, or whether there is some deep underlying mental illness problem which needs to be dealt with. The difficulty if you rush straight in as it were and invoke the sectioning powers, or indeed the informal admissions under the Mental Health Acts, is that it is a denial of the person’s liberty at that point in time and they may end up in a completely inappropriate setting. So the crucial thing is to try to get people involved who understand that individual and get to the root cause of the problem, and deal with the situation appropriately. Very often, those isolated outbursts of challenging behaviour can be sensibly dealt with if you get to the underlying cause of the problem, which may be a change in their circumstances.

Chairman: I am going to ask Lord Carter to broaden the issue out so that the discussion can be as general as possible, and then Mr Kramer I think you wanted to say something.

Q347 Lord Carter: I think in a sense you have answered the question about the relationship between the mental capacity legislation and the mental health legislation and how it affects people with a learning disability, but in a general sense it would help the Committee to know—and I am sure you are aware of the situation—what will happen next March or April when there will be the Mental Capacity Act, which could be amended almost certainly in the Lords—if it is amended at all—to deal with the Bournewood gap? We are hoping that will happen, and if the Government does not bring forward amendments I think other people might attempt to help them, and, of course, the 1983 Act will be on the statute book and we will not have a Mental Health Act for, say, two years or more. In general terms how does that relationship between the mental capacity legislation which will be on the statute book, and the Mental Health 1983 Act which is on the statute book, affect people with learning disabilities?

Mr Kramer: The intention is for the Bill, hopefully, to become law next year and then there will be a two year period of implementation, so until 2007, so that does provide further room for manoeuvre to get the relationship between the Mental Health Bill and the Mental Capacity Bill correct. There are a number of problems, I think; there are very different philosophies and values underlying both Bills yet someone could be subject to both. There is the issue that you raised in terms of Bournewood and the failure really of both Bills to address and to meet the gaps in Bournewood. Then there are some particular concerns about how clause 6 of the Mental Capacity Bill could be used to restrain someone, and could be used to restrain and compel people with mental disorder to receive treatment without clear safeguards, and linked to that is the concern that there is a lack of treatment safeguards in the Mental Capacity Bill and that will have an impact in terms of the relationship with the Mental Health Bill. So there are a number of problems around how the two will interact in practice, particularly I think, around clause 6 which could allow someone to use force where necessary to prevent harm to the individual, and in doing so allow people to be admitted, to hospital to receive treatment for their mental disorder when they pose a risk to themselves, even if they object to that admission. That issue, I think, needs to be particularly resolved.

Q348 Lord Carter: That is a general point but can you help us by specifying how in fact people with learning disabilities will be particularly affected by this overlap of the legislation?

Mr Kramer: There is the concern in terms of how the Bournewood gap will be addressed and we think that people with a learning disability who are, to use the phrase, long-term incapacitated should have safeguards provided under the Mental Capacity Bill. So that is one point and that directly affects people with a learning disability. We also think there is a risk that a person with a learning disability who may have an additional mental health problem, who is in hospital on a voluntary basis, if their condition then deteriorates and they want to leave against clinical advice, the Mental Capacity Bill could be used to keep them in hospital without any of the safeguards under the Mental Health Bill. That is also a cause of particular concern, not just for people with a learning disability with additional mental health problems, but all people.

Q349 Lord Carter: Just on that point, does the 1983 Act help somebody in that situation that you have just described?

Mr Kramer: The problem will still be the same, because, if you are looking at the relationship between the Mental Capacity Bill and the Mental Health Act 1983, you could still be left in the position of somebody being restrained to protect themselves, even if they are objecting to that admission.

Q350 Ms Munn: It has been suggested to the Committee that there should be an additional condition at clause 9 in the draft Bill, which is the clause that deals with the conditions under which examination, assessment and treatment can take place, that a person should have impaired decision-making by reason of their mental disorder. Would that be something that you would welcome? Would that help with the kind of problems we are talking about?

Mr Kramer: This is something that the Making Decisions Alliance does not necessarily have a formal position on, but we support the line taken by
the Mental Health Alliance in terms that there need to be extra criteria, as you have described, where you are looking at significant impairment, understanding that that is a different threshold to capacity that is in the Mental Capacity Bill. The Mental Capacity Bill definition I think is based on cognitive functioning and impaired judgment and is more looking at disturbances of a person’s emotional perception, and we have been persuaded by the evidence of the Royal College of Psychiatrists that we need to have a relative approach, looking at risk in relation to this issue, because somebody who may be contemplating suicide may have capacity under the Mental Capacity Bill definition, but still may have impaired judgment and it is imperative that the clinician’s best practice and right to intervene is still preserved.

Chairman: Would either of the other witnesses like to add anything at this stage?
Ms Munn: That sounded like a yes, and no really.

Q351 Chairman: Yes, it did. Ms Marriage?
Ms Marriage: Not really, no, I think that has covered the point for us.
Chairman: Do you want to return to that question?

Q352 Ms Munn: I suppose this comes to this whole area about how we deal with people who lack capacity and dealing with Mrs Browning’s point about where they should rightly come in the legislation, and indeed Lord Rix’s point about people’s feelings about how they are dealt with. I do not have a fixed view on it, but it seems to me that this might be a way of dealing with some of that issue if there was a clause which said it had to be by reason of mental disorder rather than by reason of capacity.

Mr Congdon: It is an attractive proposition, but I am not sure it necessarily solves the absolute problem. From Mencap’s point of view we have not got an absolute sort of stand on principle as to which piece of legislation should be used to deal with the situation as described. We are happy to go along with the view that the Mental Capacity Bill could be suitably amended to deal with it, providing all the necessary safeguards are in place, but I suspect that that needs some pretty significant changes to the Mental Capacity Bill. The difficulty we all have is that both Bills are quite difficult for people to understand all the details and all the ramifications, and because of the timing that Lord Carter mentioned, in a way that makes it even more difficult for people to understand. We think there is certainly a pressing need to deal with those issues that could arise and ensure the two Bills do provide the equivalent safeguards, because it is the safeguards that are absolutely crucial. There will be, sadly, occasions where compulsory powers have to be used, and the issue where they are used is can you actually challenge the use of those powers? The Bournewood case was a situation where effectively compulsory powers were used but could not, under the law as existed, be challenged. Ironically, once Mr L was sectioned, he was released because there was a challenge made, and I think that is the crucial point; when the state imposes compulsory powers—and there will be people, sadly, with a learning disability who will have those powers imposed on them—ensuring that it can be properly challenged. That in a sense is why we are actually keen, coming back to the exemption point, that, if we could then prove that the only reason they were sectioned was because they had the learning disability and not a broader mental illness problem, that would be an opportunity to get them released from the section’s compulsory powers.

Ms Marriage: What is interesting about this part of the discussion is it raises the issue of what has gone into the draft capacity legislation and what has not. Our concern is that there were provisions put into the 2002 version of the draft Mental Health Bill which would have provided certain safeguards for people lacking capacity in this situation—I believe it was clause 5—and some of those safeguards, for example, would have included other general safeguards that were in the Bill, for example the ability to access mental health advocates, the role of the nominated person, the right for a tribunal to review continued detention and treatment plans and so forth. The problem that we have is that those terms have not been transferred into the capacity legislation, there is just a blank page that does not respond to the issue at all. Even more complicated than that—and we had a brief word before we came in this morning—and comparing notes—it is really quite scary in a way that the whole role of the tribunal system and the role of the nominated person under the Mental Health Act, which are all considered to be fundamental to human rights safeguards for people who are detained, whether they lack capacity or not, is not something that has been moved into a separate piece of legislation which covers both without it. So you have a very difficult situation. If I was the mother of somebody who lacked capacity, as things stand, and I was asked whether I would rather that person was admitted to hospital under the provisions of the capacity legislation or under the provisions of the mental health legislation as proposed, there are lots of things about the mental health legislation which would provide my son or daughter with protections which simply are not there in the Mental Capacity Bill. We have a real problem with this and it is something which is not very easy to resolve. The things that have been canvassed in conversation are should people who are detained under capacity legislation and treated under those provisions in some way have access to the tribunal system so there is a proper review? It seems to me that that is completely unworkable, so then what you look at is you are looking at transferring the role of a tribunal in reviewing detention and treatment under the Mental Health Act into, perhaps, the Court of Protection, and that raises a whole other tranche of issues about how you do that. There is a further problem which I think is a very practical problem, because, if you have not got a nominated person and you have not got a Mental Health Act difficulty under the capacity legislation, and you are forced and your family are forced to take proceedings in the Court of Protection where there is no automatic
Joint Committee on the Draft Mental Health Bill: Evidence
Ev 305

17 November 2004 Mr David Congdon, Mr Richard Kramer, Mr Jonathan Coe and Ms Henrietta Marriage

right to non means-tested legal aid, how are those people going to perform that role? This is a really complicated area and we do have huge concerns about it.

Chairman: Would you like to come back on that, Ms Munn?

Q353 Ms Munn: Just very briefly. I take all the points you are making about the safeguards that kick-in under the compulsory orders et cetera, but I just want to add in one further issue which I hope does not complicate it a great deal more. I met with service users in my constituency last Friday and one of the points that they were making quite forcefully to me is that there are serious implications for people of having been subject to a compulsory order. Having the safeguards is fine and what you are saying is at least if they are subject to a compulsory order there are safeguards, I certainly would not want to disregard the implications for any person, whether they are a person with a learning disability or a person with a mental health problem of actually being subject in the first place to compulsory orders.

Mr Coe: I think that is a very good point and the point that we are wanting to focus on is that under the Capacity Bill the provisions outlined in clauses 5 and 6, which are about restraint and, to an extent, treatment, do not give you any access to a tribunal. We think the proposals in the new Mental Health Bill are good in terms of having tribunal-ordered treatment, but in theCapacity Bill some of the same actions can be undertaken but with no immediate recourse to any form of help, no advocacy, no nominated person and only a secondary, after the fact, access to the Court of Protection. We fully take your point, but the same provisions almost can be used in one and not the other without the same level of protection. I think there is a whole range of issues about the stigma and some practical, legal implications of having been under section, and I do not under-estimate those at all, but they are made worse by not having proper access to redress and to ways to avoid that happening in the future.

Q354 Mrs Blackman: I wonder if you could elaborate on what sort of role there ought to be for advocacy for a person who lacks capacity?

Mr Coe: We wanted here to draw a parallel again between the two Bills. We are very supportive of the proposals in the Mental Health Bill around the establishment of independent Mental Health Act advocates, the specific functions that are outlined there are useful, but I think there are some difficulties there and we want to see some amendments made, particularly in relation to instant access to records, for example. We think the provisions around the right to meet need to be strengthened so that there is a clear right to meet in private, which was in the 2002 draft but removed in the current version. However, in relation to the Mental Capacity Bill what we have ended up with is rather than having a kind of two-pronged safeguard, with nominated person and advocate as in the Mental Health Bill, we have ended up currently with a situation which is a kind of hybrid of the two. So the Government has proposed the introduction of a kind of new term that they have invented called the independent consultee, whose role has kind of shifted in the course of the Bill going through Parliament and it now is much more in line with what we would take to be the ordinary functions of an advocate; we support those developments. There is still some question about whether or not that person fulfils roles which are not part of advocacy—we are in discussions on that at the moment—but what you have not got is the dual safeguard of nominated person equivalent and independent Mental Health Act advocate equivalent, so it is somewhat in between. The overriding issue here is about the potential difficulty of developing two separate but parallel services, independent consultees. IMHA advocates, with potentially different levels of funding and different ways of being developed in terms of its practical implementation. What we would like to see is for local advocacy services—who are in the best position we think to actually run both these services—to be centrally involved in developing both of them, but they do need to both be advocacy.

What we do not want to end up with is a situation where a person is already in the local community working with their advocate with whom they are familiar, and if there are capacity issues to have to have somebody else come in and take on the independent consultee role, and yet another person to come in if the Mental Health Act is used, the independent Mental Health Act advocate. So what we want to see is all of these things being joined up and I think there is a real danger with these two Bills that that is not going to happen.

Mrs Blackman: Can I just come back on that?

Chairman: Yes, of course.

Q355 Mrs Blackman: Advocacy services are relatively unregulated so can we have confidence that they will be able to deliver their services which are regulated by the state?

Mr Coe: That is an excellent question. Membership of the Association of Mental Health Advocates is very clear that there needs to be proper accountability of advocacy services, there needs to be proper standards, there needs to be an agreed national code of practice, there needs to be proper training standards and local services, as well as individual advocates, need to be held to account to those standards.

Q356 Chairman: We are on to the resource issue inevitably.

Mr Coe: There is clearly a resource issue, but one of the ways through this, we think, is by pulling together the proposals in the two Bills in the form first of all of an agency which is, as in Scotland, geared to supporting these developments, so in Scotland it is called the Advocacy Safeguards Agency and we are talking about the Standards Agency here. I think that would be a very useful way forward and, again, in terms of the resources, independent consultees are attracting at the moment I think £6.5 million worth of funding and I think it is £400,000 in Wales, and then for IMHA advocates
a figure of £5 million had been outlined so far. We heard from the King’s Fund earlier that the estimate of 140 advocates is very low and we can absolutely share that, we think that is an absolutely vast underestimate and think it is actually close to 50,000 uses of the Mental Health Act each year. 140 times 50,000, it does not take much to see that that is not going to work very well, there needs to be a greater allocation of resources. However, this is all going to be helped and you will actually make economies of scale if these two things are pulled together. The point on regulation, I think, is that there needs to be much greater attention paid to this and certainly in the advocacy world I know there are all sorts of developments coming through now which are going to pay much more attention to standards.

Q357 Lord Carter: This whole area is obviously extremely complicated. Would you agree that in practice practitioners will be using the codes of practice much more than they will ever look at the statute? I believe the draft Codes of Practice for the Mental Capacity Bill have in fact been produced; have you had a chance to look at them and, if the Codes of Practice for the Mental Capacity Bill were properly drafted, would that help the practitioner through this extremely complex situation?

Mr Kramer: The codes of practice as currently drafted do not sufficiently look at the inter-relationship between the Mental Capacity and Mental Health Bills.

Q358 Lord Carter: Could they?

Mr Kramer: They need to because there are some—

Q359 Lord Carter: They will have to, will they not?

Mr Kramer: They will have to. We have raised particular problems with clause 6 of the Mental Capacity Bill and that will need to be addressed because it will be unclear whether people could be detained, their liberty restricted, under the Mental Capacity Bill or the Mental Health Bill. That is one issue that needs to be addressed, as does the use of treatment safeguards.

Ms Marriage: I was just going to mention something on the status of the codes in both pieces of legislation, and there is a law resulting from the Court of Appeal last year in the case of Munjaz which suggested that trusts’ ability to defer from what is recommended in the Code should be limited to circumstances which are extraordinary. There were some assurances forthcoming from the Department of Health following the judgment that guidance would be brought forward suggesting that that should be the case, and that there would be provision made in the new draft Mental Health Bill to ensure that the judgment was reflected. Unfortunately, neither draft Bill does reflect those changes and it seems to me that one problem is the practical reality of how your law-making is going to be put into effect on a day to day basis, then you have to make sure that those codes have to be adhered to, unless there are exceptional circumstances and for one reason or another they justifiably cannot. To leave out of the face of both Bills any statutory provision to give that teeth and force indisputably to both codes on the one hand, whilst also at the same time continuing to legislate and put more and more of the detail into the basket of the codes of practice, is really quite a dangerous thing to do.

Q360 Chairman: Can I ask a question now that is really aimed, I think, at Mencap, about crisis management, situational crises in the lives of people with learning disabilities? Often what happens at the moment is that under section 2 of the 1983 Act people are admitted when they are disturbed and disruptive to a hospital, partly with the purpose of avoiding police detention which, it is perceived, might exacerbate the disturbance and disruption which they are going through at the time. Mencap’s evidence seems to suggest that we really should leave it to the police and could result in more people with learning disabilities at moments like that finding themselves in police cells, or possibly remanded in custody to remand prisons for extended periods, which is not something which instinctively I would wish to visit, for example, on someone living in South Wales who might find themselves in Cardiff Prison for a few weeks.

Mr Congdon: If that was implied in any way in the evidence, it certainly was not the intention because that would clearly be a very undesirable outcome. There will be situations, as you rightly say, where there is a crisis facing a particular individual, they are causing a lot of disruption and difficulty—hopingly this does not occur too often but it will occur from time to time. I would acknowledge that. The issue is under what basis legislation should say you actually need to be formally sectioned under the Mental Health Act as opposed to any other action taken. We are not saying that just because someone has a learning disability, under no circumstances should they come anywhere near any of the provisions under the Mental Health Act; if they were behaving really, really badly, risking serious harm to someone else, the chances are they probably have got a mental disorder at that point in time, and certainly at that point in time for some of them assessment may well be appropriate. The crucial thing, if that assessment then takes place, is getting to the heart of what that difficulty is. If the difficulty was simply something triggered it, as I was saying earlier, the sooner they are discharged from that section and appropriate provision is provided, the better. Sadly, too often what happens with people with a learning disability is that an episode like you have described happens; something has got to be done and so they do get sent to a psychiatric assessment unit. They may or may not get a diagnosis of learning disability and mental health, but because there is nowhere else for them to go, they are a bit hit challenging to services, they will be discharged from the section and they will remain there informally. There was a very good case reported by the Ombudsman earlier this year in Wakefield where a woman ended up in a psychiatric assessment unit, mainly because no one could
actually provide for her, she was discharged from the section, no one else wanted to provide for her and she remained there eleven years and no one got her out. So from that point of view we are trying to build in the safeguards to ensure that if someone ends up being detained, either formally or informally, there is a means of challenging and remedying the situation.

Q361 Chairman: So there is a Bournewood canyon. Mr Congdon: That is a very attractive term. I think there is, there are a lot of people in a situation where they end up being informally detained, either initially or after a while, and no figures are published on the number of informal detentions on that basis. That is why we take such a strong line on trying to ensure that there is that general definitional safeguard, if it is only a learning disability they should not be sectioned, and having a higher threshold. That would benefit a lot of people, the higher threshold, we are trying to ensure that people are not unnecessarily sectioned but in no way are we wanting to create a situation where they are unnecessarily caught up in the criminal justice system.

Q362 Lord Rix: I have kept quiet up to now in case of being accused of bias, but I would just say that Brian McGiness, our great guru on this, submitted a suggestion which might well cover this particular gap in the legislation, in the current draft Bill clause 157(a): “Where it is alleged by or on behalf of any person with a disability or disorder of mind or brain who is being assessed or treated in hospital for that disability or disorder, other than under the provisions of Parts 1 and 2 of this Act, that the person’s choices and best interests are not being respected then the person shall have the right to a Tribunal; the right to a named person; the right to an advocate and to come within the ambit of the CHAI...” et cetera. Would you see that as being a sufficient safeguard?

Mr Congdon: That is a very useful question because we did not, when we were talking about Bournewood answer the question what would you do about the Bournewood canyon as you put it. Mr Chairman. Bournewood is seared on my soul; I had been with Mencap very few weeks when it first arose back in 1998, and there were differing views how to deal with it. There was an understandable desire to avoid having maybe up to 50,000 people sectioned who were not currently sectioned and may be unnecessarily sectioned, but at the same time to provide the safeguards. Therefore, what we were saying then and are saying now, which is really encompassed in the sort of amendment that Lord Rix was outlining, is in a situation where someone has been informally admitted, if anyone is unhappy with that, whether the individual, the parents, the carers or the advocate that we were talking about just now, then all the formal powers and protections that are currently provided in the mental health legislation should come into play so that then you have the opportunity to say why is this person here, they do not need to be here, because that was what the gap was; the gap was the inability to challenge and have due process, so we would very strongly support that sort of measure.

Q363 Chairman: The last word to Mr Kramer.

Mr Kramer: I think the safeguards need to be addressed, first of all, in the Mental Capacity Bill, so there is a time factor there that needs to be addressed, secondly, there need to be safeguards around admission, and Part 5 of the Mental Health Bill provides a blueprint for the safeguards needed around the care plan, review of care plan, second opinion, an advocate, proper information, but there also need to be safeguards around review. The Government have indicated that we do not necessarily need safeguards around review because of the Human Rights Act and that provides some form of appeal to the court system. I think it is very important that legislation sets out the procedural safeguards around review as well so that carers, as in the Bournewood case, know exactly what process they need to take if they want to challenge an informal protection.

Chairman: Lord Carter, finally, finally.

Q364 Lord Carter: Is it the problem that you have actually highlighted in your answers for the Government in attempting to deal with it, that on one reading there are not that many people involved, on another reading there could be a very large number of people involved and the resource cost could be very considerable. This is a problem that I know the Government are having to grapple with; have you any idea how many people would be involved?

Mr Kramer: We have been struggling on this, but it is a larger number than the Government thought because the European Court ruling was on detention.

Chairman: If the question had been in a courtroom it would have been stopped as a comment, but we are allowed comments. I am going to have to say Order, Order, because we are losing our quorum, I am afraid. Can I say thank you to the survivors from the House of Commons for bearing with us; we have to have two MPs here or two Members of the House of Lords, at least two members of either House, so we are no longer quorate. Can I informally, therefore, thank you very, very much for your very clear submissions, for the clarity of your evidence and for attending here today. We would have wished it to be longer, but thank you.
Joint Committee on the Draft Mental Health Bill: Evidence

Wednesday 1 December 2004

Members present:

Barker, B.
Carlile, L. (Chairman)
Carter, L.
Eccles of Moulton, B.
McIntosh of Hudnall, B.
Mayhew of Twysden, L.
Murphy, B.
Pitkeathley, B.
Rix, L.
Turnberg, L.

Mrs Liz Blackman
Mrs Angela Browning
Mr David Hinchliffe
Mr George Howarth
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Hywel Williams

Witnesses: Dr Brian Jacobs, Child Psychiatrist, and Dr Patrick Byrne, Adolescent Psychiatrist, South London and the Maudsley NHS Trust, examined.

Chairman: Welcome, Dr Jacobs and Dr Byrne. Before we start our session, we have welcomed to the Committee a new member, Baroness Murphy, who will now make a declaration of interests.

Baroness Murphy: My interests are recorded in the psychiatric units in your care, over the last three or four years for example. I am a Fellow of the Royal College of Psychiatrists, Visiting Professor to the Psychiatry Department at Queen Mary University of London in an honorary capacity, and a recent UK Adviser in Mental Health to the WHO. It is perhaps also relevant that I am a former Vice-Chair of the Mental Health Act Commission.

Q365 Chairman: You met us only last week, Dr Byrne, and we are grateful to you for coming and putting up with us again. May I remind you that this is a public evidence session. A transcript will be produced and will be available on the internet after about one week. If you wish, you will have the opportunity to make textual corrections, not substantial corrections. You both come from child and adolescent mental health services—CAMHS, as they are usually called. Do you think that the proposals in the draft Mental Health Bill, particularly to widen the criteria for diagnosing mental disorder, will affect CAMHS significantly? In particular, do you think that the proposals will lead to an increase in the compulsory admission of children and young people?

Dr Jacobs: My Lord Chairman, I work in a residential unit for young people aged 12 to 18, so this part of the Act is of great importance in my clinical practice. It is my view, very clearly, that the change in the definition of mental disorder and the revision of the conditions for compulsory treatment will undoubtedly lead to an increased number of compulsory admissions. It therefore applies much less to my population at present. I think that the redrawn Act will, over time, inevitably lead to the same conclusions that Dr Byrne is expressing: that I, or my successors, will be put under pressure to use it more.

Q366 Chairman: Has there been a significant increase in the number of children being admitted to psychiatric units in your care, over the last three or four years for example?

Dr Jacobs: No. There has overall, over the past 10 to 15 years, been what I regard as an inappropriate reduction in the number of children’s in-patient services, and there is evidence from research to show that there are both insufficient children’s beds and insufficient adolescent beds.

Q367 Baroness McIntosh of Hudnall: Dr Jacobs, you said that you have only used the provisions that are available to you under the 1983 Act twice in your recent practice.

Dr Jacobs: Since 1986.

Q368 Baroness McIntosh of Hudnall: Have there been occasions in that time when you would have liked to use provisions that were not in that Act which would have allowed you to compel treatment, but you could not because the Act did not allow it?

Dr Jacobs: I think the honest answer to that is no. A slightly longer answer is that I have come near it once or twice. It has been in circumstances where the amount of restriction of liberty that I have had to impose on a child, because they were at risk to themselves, has begun to creep up into 30 or 40 hours. It is very rare that that happens. That makes me quite uncomfortable, because it starts putting the staff at potential risk. I have been in a position where I would have had to discharge the patient inappropriately or try and section them in a way that I was not quite comfortable with.

Q369 Baroness McIntosh of Hudnall: Could I be clear whether that was to do with the application of your clinical judgment within the normal range that you would expect, or was it that the Act, as it is currently drafted and the Act that we are using at the moment, was insufficiently flexible, or too flexible perhaps, to allow you to make the judgment that you would have liked to make?
**Dr Jacobs:** I am sorry to give you a complicated answer again.

**Q370 Baroness McIntosh of Hudnall:** Please do.  
**Dr Jacobs:** The difficulty is in balancing up the potential problems in trying to override a parent’s reticence for their child to be sectioned versus the long-term issues for that child—that they probably have a mental illness that they will have for decades, and that one wants them and their family to be properly engaged with mental health services. So it may be appropriate to do something that, in the short term, feels inappropriate.

**Q371 Chairman:** Can I ask one of you to tell us what you mean by restrictions on liberty? Are you talking about a member of staff being in the room with the patient 24 hours a day?  
**Dr Jacobs:** No. Restriction of liberty, under the Children Act—and this is from memory—essentially means that, if a nurse blocks a doorway with their body, or does anything to prevent a child having free egress, they are restricting that child’s liberty.  
**Dr Byrne:** My Lord Chairman, may I offer a note of clarification about your previous question about trends and admission? I think that the picture is very sharply different with the adolescent age group from the younger age group. As Dr Jacobs has pointed out, the 1983 Act is very rarely used under 12, but the position is very different with teenagers. In our unit the admission rate has increased about two and a half times since 1990. That is not all compulsory admissions; part of the reason for it is because we are promoting easier access and we are reducing length of stay, so that we can treat more patients—in line with the National Service Framework. The overall trend in admissions under the Mental Health Act with adults has doubled since 1983, and I think that the picture is quite similar with teenagers in the middle to upper age range.

**Q372 Chairman:** So it is consistent with adults?  
**Dr Byrne:** Consistent with adults, yes.

**Q373 Chairman:** Can I ask you a particular question which I know has concerned some members of the Committee, as a result of what we were told on our visit last week? Is the use of cannabis by young people having a measurable or noticeable effect upon admissions?  
**Dr Byrne:** It is having a noticeable effect upon admissions. It is quite difficult to answer the question whether there is a net increase in the incidence of new cases of psychosis under the influence of cannabis but, in those young people who themselves are vulnerable to severe mental illness of a psychotic type, their symptoms are provoked and made more severe by concomitant use of cannabis. We pursue a very strong policy with young people who are having their first or second episode of mental illness to be completely abstinent from cannabis, because of this potent effect.

**Q374 Chairman:** Is there any other commonly used substance that has such an effect on teenagers?  
**Dr Byrne:** Not directly in the same way. Alcohol usage has its own very particular deleterious effects, but they are not the same in quality as cannabis.

**Q375 Baroness Eccles of Moulton:** Is it so then that nicotine has no effect on increasing the incidence and severity of psychosis?  
**Dr Byrne:** No. Nicotine addiction does not have any direct relationship to psychosis at all.

**Q376 Baroness Eccles of Moulton:** So any parallel that is made between cannabis and nicotine in your sphere is not valid?  
**Dr Byrne:** Nicotine addiction is a very serious problem for the group of young people I work with, mainly because of its effect upon their physical health. Withdrawing from nicotine does have minor effects upon temperament and conduct, and it sometimes is a bit of a point of tension in our unit—people who want to smoke and need access to smoking areas—but it is not in any way a major problem in the mental health field. It is more the effects upon the physical health of young people.

**Chairman:** I am going to draw a veil over the nicotine issue now, because I was trying to test something slightly different and we are moving into other possible legislation. Does anybody want to ask one or two short questions about the cannabis issue?

**Q377 Lord Carter:** I am not clear. I think you said that if somebody was mentally ill with psychosis or whatever, and they took cannabis, that made the symptoms worse. Is there any evidence that people without mental illness who take cannabis have become mentally ill?  
**Dr Byrne:** Yes, there is evidence from the Swedish conscript study, which looked at a very large number of young men who were conscripted into the Swedish army and found that the exposure to cannabis was dose-related to the vulnerability to a later breakdown with psychosis. When they looked at the number of young men who had broken down with a schizophrenic illness in later life, they found that the likelihood of that occurring was quite strongly related to the frequency of consumption of cannabis. So the risks do seem to be beginning to be quite clearly defined. However, there is not anything in the Bill about this, is there?

**Q378 Chairman:** I share your concern about these questions and I started this hare running—but it is nonetheless an important issue, in broad general terms.  
**Dr Byrne:** Agreed.  
**Chairman:** I think that it is in order, because it affects the number of potential admissions under the Act.

**Q379 Mrs Browning:** Dr Byrne, in your opening remarks you said that the wider definition of the Bill would be likely to result in more in-patients in this age group. Could you be a little more specific? Under which categories of mental health headings do you see it as more likely that this age group would come...
in as in-patients? For example, are we looking at more eating disorders? How would you subhead that?

**Dr Byrne:** I think that it is a general risk. I do not think that it is specific to particular mental conditions. The definition in the draft Bill is a very general and quite vague definition. It provides, if you like, a broad gateway into compulsory care. My chief concerns are that, first, in the age group that I work with, the peak time for unruly, boisterous, difficult behaviour is the mid to late teens to early adulthood. Second, it is also the peak time for substance misuse—as members were asking about—particularly cannabis. Therefore, practitioners who are faced with assessing young people for the possibility of compulsory admission, under the rules laid down by this Bill, will find a very wide net that they have to trawl through. That is a very considerable concern to me. The second concern is that we have been working very hard to develop mental health services for adolescents which are accessible, which young people will find they want to use. We have been trying to bring down the delay before young people with serious mental illness reach care, and we have achieved that in one of our community adolescent teams in Croydon. The widening of the gateway in the increase in compulsory admissions is likely to create a negative climate for adolescent mental health services, and to make them far less attractive to young people. We really need to be treating their problems early, offering them good-quality services, rather than relying upon a widening of the need for compulsory admission.

Q380 **Lord Rix:** What percentage, over the years, would you say that people have been referred with a dual diagnosis of learning disability and mental illness? With this broad definition, how many more people with learning disability—pure and simple, not with a mental illness—do you think will mistakenly be referred to you?

**Dr Byrne:** I would say that about 10 or 15% overall of the referrals in the services that I have been seeing would have a learning disability. At the current time, in our in-patient service, there are dedicated services for those who have a very low IQ—in other words, severe learning disability—and who we therefore do not admit; but we do not discriminate against other young people who have mild to moderate learning disabilities. Again, I think that the lack of exclusion criteria in the draft Bill does leave the conditions wide open to misinterpretation of some of the challenging, difficult behaviour, of young people with learning disability. It does run the risk that maybe practitioners who are less well informed about learning may very well overuse the draft Bill.

Q381 **Mr Hinchliffe:** We are obviously concerned as a Committee with the statutory framework. Dr Byrne implied a moment or two ago that the use of the law is often as a consequence of the inability to prevent, at the lower end of the scale, a person having to move into more secure facilities. Can you give any examples of where you see services that might prevent a youngster ending up in hospital, or where compulsion might have to be used? Can you point to situations where such services are prevented, rather than going further into the system?

**Dr Byrne:** In the adolescent team in Croydon, which has been set up with the express purpose of trying to reduce the use of in-patient beds by providing accessible services in a high street location and having outreach services in local schools, they have been able to lower the threshold for people coming in for informal care. The expenditure from that team on admissions of young people to my unit—which was quite a worry to me—has reduced over the past three years by £1.3 million. In other words, they are showing that they are able to care for young people with severe mental health problems at home, with support at home, without the necessity to admit them to hospital. So I think that we do have good examples of practice which show that that kind of work can be done.

Q382 **Mr Hinchliffe:** Do you feel that this legislation could in any way be shaped to encourage the greater development of that kind of provision?

**Dr Byrne:** We need to have a Mental Health Act which has a statement of principle at the beginning that the welfare of people with mental health problems is the greatest value and aim of the legislation. It should have a clear statement that—

Q383 **Chairman:** In the Act?

**Dr Byrne:** Yes, that informal treatment, voluntary treatment, is the *sine qua non* of services, and that should be our major duty—to ensure that services are delivered as far as possible in an informal and accessible way, and that compulsion is seen as very much the last resort.

Q384 **Chairman:** Before we move on to the next issue, can I ask you to give us a fairly brief answer to an important question, which is the placing of under-18 year-olds in adult wards? Is it ever appropriate? Would you like to keep a range of flexibility, so that some, albeit possibly rare, 17-year-olds can be placed in adult wards, or do you think that it is something that should be excluded as a matter of principle?

**Dr Byrne:** In principle it should be excluded, because of the risks of placing a young person in what I would call a developmentally inappropriate setting. However, the operation of that policy is very much dependent upon resources. The distribution of adolescent in-patient beds round the country is very patchy, and there are parts of the country—particularly the north-east and the north-west—where there are too few beds, and local clinicians will find themselves really hard-pressed sometimes to provide an acute admission directly into a dedicated bed for a young person. I agree with the principle completely, and we need to keep young people under 18 out of adult psychiatric beds, but whether it can be achieved in different localities is very much a resource question.
Q385 Tim Loughton: Dr Byrne, that is a question of resources driving appropriateness of the service. Do you think, however, that in principle there should be part of the Bill which guarantees an appropriateness of service for younger people, as certain evidence previously has suggested, so that resources will have to be developed in order to meet that appropriateness rather than if it just happens to be available at the moment? Is that desirable and, in practice, is it workable, albeit only with a drastic increase in the resources?

Dr Byrne: I am not a commissioner of health services, and I think that a commissioner would find that a difficult question. Would it work in practice to mandate purchasers of health services to ensure that that policy was carried out? I would tend to agree with that, although I have reservations about making the pattern of commissioning accord with the letter of the law. I think that local health commissioners need some flexibility. I would hate to think that they achieved it by stealing money from cancer services, for example. In principle, I would agree with it. However, I am not sure that you achieve quality in mental health services by legislating for those things to take place. That is probably a personal reservation of mine.

Q386 Tim Loughton: Is not the problem at the moment that for somebody who is inappropriately admitted to an acute ward—and there are suggestions that something like two-thirds of adolescents end up in that way—there is no comeback for them or their carers to say, “Hold on, this is not appropriate. I require more appropriate accommodation”? If there were part of the Bill that said that every endeavour has been made that appropriate accommodation is provided, they would have some legal back-up to force that position.

Dr Byrne: I find your argument very convincing, and I would certainly support it. I think that it is a scandalous situation and it does need to be addressed. If Parliament thought that was the best way to solve the problem, then I would certainly support it.

Dr Jacobs: I think you could deal with that under the Lord Rix’s question? I would think that about 30 to 40% of my admissions have learning difficulties. We need—do not take profound, or where there are accompanying, very severe physical difficulties, because we are not equipped to do so. There is a real problem, which you will be aware of; namely that at the moment there is only one hospital in the country, up in Northumberland, that can cope with those patients. Do I think that there would be miscalculation and abuse under the present redrawing? Yes, I think that there probably would, over time.

Chairman: Can we now turn to an important issue about risk of serious harm?

Q387 Mrs Browning: In respect of this legislation, and 16 to 18 year-olds who may be subject to compulsion under this legislation because they are deemed to be a danger to other people, the Mental Health Act Commission has expressed concern that the standard of decision-making is at odds with the decision-making set for this same age group by the Children Act 1989. I wonder what your comments on that would be, and whether you think that the Commission is being too cautious there.

Dr Jacobs: No, I do not think that the Commission is being too cautious. It is striking that in this Bill there is no mention of the paramountcy of the needs of the child or young person, I think that the Bill would be improved, and the thinking of practitioners would be improved, were they required to hold that principle in mind. I think that, for 16 to 18 year-olds, the issue of serious harm to others should be tempered by that principle.

Q388 Ms Munn: Paramountcy of the child is obviously within the Children Act but, as soon as other considerations come in, there is a conflict. When a child has committed a very serious crime—I am not talking about a child with mental illness but who perhaps has murdered somebody, or whatever—you might say that the paramount needs of the child were not met by being locked up; that, nevertheless, there were other considerations. Would you not see that as being a problem, if there were a risk of serious harm? My personal view is that would be in a very small number of cases and, if it were the case, is there not some other way of dealing with it—without having the paramountcy principle?

Dr Jacobs: Section 25 of the Children Act essentially allows for that situation, where children are having to be kept in secure accommodation because of their threat, either to themselves or to others. They can end up in that situation under the directions of a judge. I think that provides a better route for the non-mentally ill population who find themselves in that predicament, because the judge will have to weigh up the risks to society against the risks to the young person.

Q389 Ms Munn: What would the parallel be for a child who was deemed to pose a risk of serious harm because they had a mental health disorder? How would you deal with that within the Bill?

Dr Jacobs: I think you could deal with that under the proposed Bill in any event. I do not see that you need—

Q390 Chairman: Forgive me for interrupting, but I think I understand you, Dr Jacobs—and this could be very important—to be saying that children who fall within that category, which is a descriptive rather than a diagnostic category, are better dealt with under the Children Act and the general law, rather than the specific law dealing with mental health. Is that right? Is that what you are saying?
Dr Jacobs: I think what I am saying is that if they clearly have a major mental illness and that is what is driving their violence, then they are better dealt with under the Mental Health Act. However, in a situation where they do not have a serious mental illness, as at presently drawn, then they are better dealt with under the Children Act.

Q391 Ms Munn: I entirely accept section 25 of the Children Act and how that works. What I am trying to get at is what would that look like—not in any detailed, technical terms—with regard to the Mental Health Bill as opposed to what there is currently. How would that be generally expressed?

Dr Byrne: One of the difficulties here is, in a sense, the privileging in the Act of violence or serious harm. I think that this is probably part of the Mental Health Act Commission’s concern. They are looking at the 16 to 18 age group and picking up on the anomaly that the draft Bill defines adulthood, if you like, as 16-plus for the purposes of the Act, but the Children Act creates a facilitating legal environment for young people who are suffering significant harm up to 18. We therefore have an area of overlap. In a way, the Children Act is casting a searching light on this draft Bill, because of the way it promotes the welfare of the child and the risks to the child. The balance in the draft Bill seems to be going towards the idea that that, “If you have a mental health problem and you are a child, then we are perhaps not so worried about the paramountcy of your welfare. What we are really worried about is the public order issue—the serious harm to others”. Because of the imposing of that kind of thinking throughout the Act, we create this little window of anomaly among 16 to 18 year-olds where they clearly may be dealt with very differently under the two forms of legislation—with the draft Bill making it much easier for a young person to be compulsorily detained between the age of 16 and 18, with fairly poorly defined mental disorder and very few exclusion criteria. I think that is probably the concern of the Mental Health Act Commission and it would also be my concern. I would worry about my teenagers being out on the street, maybe misbehaving or maybe being intoxicated, and falling into this system and being assessed in this way. I would be very concerned, as a parent.

Chairman: I think that was a particularly clear piece of evidence in answer to Ms Munn’s question, and I am sure that we are grateful for it. Can you give us numbers nationally about the number of 16 to 18 year-olds who would fall into the descriptive category of risk of serious harm to other people?

Q392 Lord Mayhew of Twysden: Substantial risk.

Dr Jacobs: Very substantial.

Chairman: Very substantial?

Dr Jacobs: Twenty-five per cent of teenagers get into trouble with the law because of delinquency. If you assume that only a quarter of those or less have any violence associated with what happens, you are talking about a large number of youngsters.

Q393 Chairman: We are talking about ill-directed violence as well as well-directed violence.

Dr Jacobs: We are talking about teenagers getting drunk.

Q395 Lord Mayhew of Twysden: But the Bill talks about “substantial risk”. I do not quite know what that adds, but we ought to remember that it says “substantial risk” and not, I suppose, fanciful or one in a hundred.

Dr Jacobs: The problem is as you have just summarised it. I do not know quite what that adds. The problem is that it becomes a very flexible meter in different people’s hands.

Q396 Chairman: If you, as a psychiatrist, were asked to judge whether somebody posed a significant risk or a substantial risk, would you know the difference between them?

Dr Byrne: We would struggle probably.

Chairman: Can we move on, after those very helpful answers, to an issue relating to tribunals?

Q398 Lord Carter: Should considerations a tribunal has to take into account differ where an application is made in relation to a child under the Children Act 1989 and the draft Bill? Because of the imposing of that kind of thinking throughout the Act, we create this little window of question, so my apologies if I stumble with it. To try to compare the procedures under the Children Act and to envisage how the draft Bill would work in practice is quite a challenge. However, there are aspects of the draft Bill which are very welcome, in particular the issue of safeguards for young people and clearing up some of the anomalies about the consent, particularly the ability of the child to refuse treatment. Let us take an under-16-year-old who is unwilling to accept treatment but the parents are agreeable to offering treatment. We call this “working under parental authority” and at the moment, where this seems appropriate, we use the Children Act. These proposals seem to me to bring with them some benefits, in that to rely entirely upon parental authority sometimes gives rise to worry and anomalous situations—because of the quality, let us say, of the parent’s relationship with the child. Introducing a review system, whereby such a child could have their treatment reviewed by a tribunal, seems to me to be in keeping with the Human Rights Act and a step in the right direction. In that sense, there will be a kind of commonality, a crossover point, between the Children Act and the Mental Health Act, which I should imagine we would work out in practice and develop, with the Code of Practice, the right way of doing that. It seems to me to be, partly at least, a step in the right direction. The other situation is one which comes back to some of the issues we raised in the answer to the last question. Say you had an over-16-year-old, who previously,
under the Children Act, could be treated under parental authority, if that were felt to be desirable, or you had the choice of a Mental Health Act order—I am starting to think that the situation might be a little more confused here. As Dr Jacobs rightly pointed out, if the concern were antisocial or violent behaviour associated with emotional difficulties, and there was a substantial risk of running away, putting the young person at risk, a section 25 order under the Children Act would probably be less stigmatising than a compulsory order under the Mental Health Act. So I think that I have probably confused myself as well as you!

**Q399 Lord Carter:** You have mentioned the importance of the Code of Practice in this area. I am sure you would agree that this is an area where the practitioner requires a pathway through this, to show them how to handle these situations. Is that right?

**Dr Byrne:** We really do not know what it is going to be like in practice, do we? The practitioners involved with the 1983 Mental Health Act, rightly, become dominated by the needs of adults—because our sector is a small one compared with the adult sector. However, if we have more overlap between the two jurisdictions, I think that we will need to have more and better trained personnel going on these tribunals, who know about children and about teenagers and their development, and who know about the Children Act. Up till now, I do not think that has been seen as a very important point in training people to go on tribunals.

**Q400 Lord Carter:** There will not be a new Mental Health Act for two or three years. For the period from next spring, for two or three years, you will have to work with the Mental Capacity Act, the Children Act, and the Mental Health Act 1983. That is right, is it not?

**Dr Byrne:** Yes.

**Q401 Laura Moffatt:** Dr Byrne, thank you very much for meeting with us at the fantastic unit that we saw. We were seriously impressed.

**Dr Byrne:** Thank you.

**Laura Moffatt:** I am wondering if I could take that argument a little further? You said that the child and adolescent sector is a tiny proportion of the overall mental health services. Therefore, we instantly become alarmed to the fact that, if we are to do as you suggest, and make sure that there are people on tribunals who understand children—and we know that children’s organisations are calling for that—clearly, there will not only be a professional shortage but, with the expansion of the tribunal service that we expect, there will be extra pressures. How do you see that working? Who do you expect will be willing to contribute and wanting to sit on those tribunals—and will there be enough of them?

**Q402 Chairman:** Even if they do not want to sit on the tribunals, will there be enough of them?

**Dr Jacobs:** I would anticipate that there will be a severe shortage to start with, if which, if the right incentives are created, will gradually rectify itself.

**Q403 Laura Moffatt:** What is the right incentive?

**Dr Jacobs:** Presumably it is about recognition in people’s job plans, negotiation with trusts that this is appropriate, encouragement through training—a whole lot of things that will make people more interested in becoming involved in this. However, I do think that it will take time. It is very important. I agree with Dr Byrne. The biggest messes I have found myself in, in my career working in an adult mental hospital, are when those who know how to apply things in a crisis in adult services find themselves butting up against other forms of legislation, the issues of children and parental responsibility, and—everything else—getting themselves, and us, into an absolutely awful tangle with social services. The two systems do not mesh nicely, even today. So I am sure that it is important to build those things.

**Q404 Chairman:** As CAMHS psychiatrists, have you had extensive dealings with mental health review tribunals? Please correct me if I am wrong, but I have the slight feeling that you are more comforted by the process carried out by judges under the Children Act and have more confidence in that procedure—which is a judge-alone procedure with a strong and sometimes slow adversarial element—as compared with Mental Health Review Tribunals, which are quicker and perhaps have a less adversarial element.

**Dr Byrne:** In my sector that is not true, because we use the 1983 Act significantly—as I said, 10 to 15% of admissions. Compared with my adult psychiatric colleagues, I am less involved in tribunals, but it is a regular thing. I was in one two weeks ago and also in the previous month. Over the years, therefore, I have had a fairly consistent experience of tribunals. On the whole, we have generally found the experience quite positive. Often we have found that lots of issues are clarified before the tribunal comes up, and the whole process of independent advocacy also helps our young people to sort out what their aims and objectives are. Of course, occasionally there are very difficult, problematic cases; but we do have some experience of them. It is different with younger children.

**Dr Jacobs:** As I said, my experience is very much less. However, on both occasions we have been really grateful to the tribunal. I feel that it has been an entirely appropriate forum for the child’s rights to be properly considered and, on at least one of those occasions, one of the reasons that I used the section was because I was not completely convinced that the parent was in a position—because they were so worried about their child—to act in the best interests of the child. As a psychiatrist, I personally thought that child needed compulsory treatment. The child was arguing very coherently—this was a rather intelligent 12 year-old girl—that this was not necessary, and she needed to have somebody completely independent to hear it. The mental
health tribunal provided that opportunity very well. I am pleased to see Part 6 in the forthcoming legislation, which talks to that and provides those safeguards for children. I think that they are very important.

Q405 Hywel Williams: Perhaps I could ask Dr Byrne about the synergy between the Children Act 1989 and this draft Bill. If my memory serves me, in the Children Act, when consideration is being given to bringing children into care, there is a list of considerations which include race, age, gender and, interestingly for me, language and culture. In your experience, are the tribunals suitably aware of those sorts of considerations when they are looking at young people? Do you envisage that would be the case in the future? Could you attract people into an extended tribunal system who would have that sort of expertise?

Dr Byrne: I thought you were going to ask me whether I thought that the draft Bill’s provisions met that sort of test—which is the question I would have preferred. My experience of tribunals is not so extensive that I would wish to go on record and make a massive generalisation about them.

Q406 Chairman: Answer the question you would like to answer. Mr Williams will accept it!

Dr Byrne: Thank you, my Lord Chairman. In my opinion, the Children Act is a well worked-out piece of legislation. What I particularly like about it are the precise definitions of the welfare of the child and of significant harm. Over the years, I have seen children’s workers working together very well on those issues. Even when it goes to court, there is a very precise theme that everyone has to adhere to. With mental health legislation, unfortunately, we have not got there, and this Bill does not take us there either. Faced with those very careful considerations that children’s workers have to look at when deciding on significant harm, the kind of criteria we are planning to use here in the draft Mental Health Bill are so much vaguer and more poorly defined, and so much more difficult to test in practice. Coming back to your point about tribunals, although they are hardworking and worthy people, I think that they will struggle with this Bill to put it into practice and to meet the standards that we have seen set with the Children Act.

Q407 Chairman: I think that we would all like to congratulate Mr Williams on an excellent question, because you have given us a very important answer. May I add a very short supplementary to that? Do I understand you to be saying that you would welcome on the face of the Bill some principles specifically relating to the position, and especially the welfare, of children?

Dr Jacobs: Yes.

Dr Byrne: I would agree, yes.

Q408 Lord Carter: If you did have the principles on the face of the Bill, would you agree that the use of the term “paramount” in the Children Act would lead to problems if it were used in the Mental Health Act? Referring to the welfare of the child, yes. However, if you said that was paramount in mental health considerations, would that not create more problems than it solved?

Dr Jacobs: I do not think that it would. We know that failure to treat serious mental illness early actually produces long-term damage. It seems to me that, in terms of strictly medical, serious mental illness, it would work together. In terms of some of the other things that are in the Bill, it would help resolve some of the potential human rights concerns within it.

Q409 Dr Naysmith: Dr Byrne, you have talked about the principles affecting the Children Act and this Bill, saying that the draft Mental Health Bill is much vaguer, much less specific and much less useful than the Children Act. Why do you think that is? Is it something intrinsically to do with the subjects, or is it just different, sloppier legislation?

Dr Byrne: There are intrinsic difficulties in the field. As a psychiatrist, it is sometimes a source of frustration that the definitions in our field are not as precise as, say, surgery or general medicine. We do not have proper tests that look into people’s minds and which can define things in an objective way. We rely on talking to people, often to find out what their problems are. All these things do sometimes lead to difficulties of definition. Putting that difficulty aside, I think that there is a lack of precision in the draft Bill with regard to the nature of mental disorder. Other jurisdictions, other countries, have gone for more precisely defined definitions which, for example, even include lists of the common symptoms that you find. With such powerful legislation, I do think that the civil liberties of people with mental health problems need to be more respected and there need to be more precisely defined exceptions to this rather broad gateway. That is my general concern.

Q410 Dr Naysmith: So you believe that it can be improved?

Dr Byrne: I do believe that it can be improved. There is a lot of good in the draft Bill. I think that it would be improved by a more precise definition of mental disorder, and we need to look again at the exceptions to do with learning disabilities—which Lord Rix has pointed out. We need to look again at the whole issue of drug use, and not create situations where we will create confusion for practitioners faced with emergency situations, where they have legislation which is difficult to understand, vaguely defined, and hard to put into practice.

Q411 Baroness McIntosh of Hudnall: I just want to develop Dr Naysmith’s point a little. Very early in your evidence you mentioned that there was an insufficient concentration in the way the Bill is presently drafted on the welfare of the patient. You implied, though I do not think you said, that was because there was a concentration on the risk element, to the detriment perhaps of those broader welfare concerns. If the Bill were to specify a more
articulated definition of mental disorder, in the way that you have suggested, would that deal with those concerns? Would it then be possible for practitioners not to feel, as it were, trapped into collecting up people on the basis of, perhaps, a generalised sense of risk—in the way that I think you have suggested might be the case if it were left unamended?

Dr Byrne: There are two ways you could go. One would be to make the definition more precise and restrictive, to correspond more closely to definable criteria which would cross over to the training of people who are making the assessments. Therefore, you would reduce the danger of what we would call false positives—dragging people into the system who really ought not to be there—or you could define more clearly what the exceptions are to a broad definition of mental disorder. I do not know what is the best way to do that, but I think that both issues need to be looked at.

Chairman: That may lead us neatly to the next issue about care plans.

Q412 Laura Moffatt: I am glad to say that we have been given some background information on the whole issue of care plans and the use of care plans. Could you talk us through how it works in practice and how it would work in the future?

Dr Jacobs: In practice—and it probably applies to both of our services—there are multidisciplinary meetings, usually involving education and, if social services are involved or can be involved, with either their interest or the family’s permission or both, then a multidisciplinary approach is undertaken. Is it effective? We have done research that shows that, of the recommendations at discharge, over a population of 150 children from eight different units—four adolescent and four children’s—only 10% had all the recommendations fulfilled a year later, and 25% had none of them fulfilled. I think that, if there were just to be a requirement that the planning should happen, then it is an empty piece of work. If, on the other hand, this were to be given teeth and some way of looking at it to see whether or not they had been fulfilled, it could be extraordinarily helpful for these very disturbed and needy youngsters.

Q413 Chairman: Dr Byrne, your unit has a school, which has done some very good, indeed pioneering, work over the years. Is it the only unit with a school? Does having a school in your unit make it significantly easier for you to engage in the educational side of planning future care?

Dr Byrne: Thank you for your kind remark about the school. It is a very excellent school and it is one of the biggest in the country, because it also serves Dr Jacobs’ unit, the eating disorders unit, and shortly we will be opening a 10-bedded forensic adolescent unit too. So the school is going to expand. There are 44 or 45 adolescent units round the country, and about half to two-thirds have a school. Those which do not have them have to make some alternative arrangements. The school is a hospital school, particularly set up to deal with young people with mental health problems. It is a great asset and it is also an opportunity to develop training and good practice in meeting the special needs of young people and children with mental health disorders.

Q414 Mrs Blackman: Should care plans with a more integrated approach also embrace 16 and 17 year-olds?

Dr Byrne: They certainly should. We have to bear in mind that the care programme approach, which is a framework for planning the care of people with mental health problems, particularly at the point where they are discharged from hospital, is very well established in adult services. In CAMHS round the country we have been making great efforts to modify and apply the care programme approach, particularly to adolescents. In our unit we have been using it for three years now, and it means that we talk the same language as adult services when young people get to the age of 18 and we hand them over.

The range of needs which is listed in the CPA forms, which we go through with every patient, includes education, daily living skills, finance, housing—in other words, a holistic approach to the needs of the patient. We are certainly taking that very seriously in CAMHS and are trying to push it forward and widen the application round the country.

Q415 Mrs Blackman: Young Minds is a little more doubtful about including education in care planning. It sees it as something quite separate and as an obligation on services to provide, as opposed to something that is compulsory. What is your take on that?

Dr Byrne: I am surprised to hear that. I had not picked that up in the evidence which I have read. One cannot help but emphasise that education is one of the key needs for young people. For young people who develop mental health problems, some of their chief handicaps in life accrue from the fact that they lose educational opportunities; they miss out on schooling for long periods of time; and, at the point where they need to be reintegrated into school, they encounter stigma and other difficulties. In terms of care plans, therefore, it is an absolutely vital part of it, and we spend an awful lot of time in our unit—

Q416 Chairman: I must say that I had not read Young Minds’ submission in that way. My impression was that they were emphasising education, though in a particular way. I can see the room for misunderstanding, however.

Dr Jacobs: I concur with what Dr Byrne is saying. It applies even more with my younger patients. It seems to me that education is still extremely important in the adolescents, but it is not just narrowly drawn education. One might also be thinking of vocational skills as they get older. I think that it needs to be thought of flexibly, but it is a very important component. The other thing that came from some of the research was that the needs post-discharge for youngsters were often in the education and social domain—even more strongly than they were in the narrow mental health domain. So these are very important areas, but we should not plan empty.
Mrs Blackman: I may have misinterpreted slightly what Young Minds were saying, my Lord Chairman, but nevertheless I think that the answers were very good.

Q417 Chairman: They were very helpful. I was not criticising you at all, Mrs Blackman. Far from it. Can I thank you both for being so helpful to us, now and last week. Do you want to add a coda?

Dr Jacobs: I want to add a couple of points. There are things that I have slight doubts on but which have not been covered at all by the questioning.

Q418 Chairman: Please do.

Dr Jacobs: The first one relates to the relevant conditions. The fourth condition is that “medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part”. I am not a lawyer, but I wonder whether lawyers might argue that, for children under the age of 16, and indeed under the age of 18, it could lawfully be provided under the Children Act and therefore the Mental Health Act should not be applied at all. I do not know whether that is a serious consideration or whether it is not, but somebody ought to think about it.

Q419 Chairman: I have already asked one of our expert advisers, Professor Fennell, to think about that. Thank you.

Dr Jacobs: The second is the issue of psychosurgery in relation to children who have epilepsy that is leading to mental health difficulties. That is a well-known path. A child may present with a picture that looks as though it is autistic but is actually driven by an epileptic focus. The question is, should that be subject to the issues in this Act, because of psychosurgery, or is it a physical condition that ought to be dealt with under ordinary medical issues? Again, I do not know the answers, but it does not seem to me that I have seen anyone comment on that.

Chairman: You have just made our two expert advisers busy over the next week! Thank you for answering so clearly the answers that have been put—and one or two that have not been put, which you have answered in a most constructive way.

Memorandum from YoungMinds (DMH 64)

YOUNGMINDS IS A MEMBER OF THE MENTAL HEALTH ALLIANCE AND ENDORSE THE ALLIANCE EVIDENCE. WE BELIEVE THAT THE 2004 DRAFT MENTAL HEALTH BILL IS THE WRONG APPROACH TO TAKE. NEVERTHELESS OUR THREE MAIN PROPOSALS FOR CHANGES SPECIFIC TO CHILDREN ARE SUMMARISED ON THE FIRST PAGE. WE WOULD LIKE TO SUBMIT ORAL EVIDENCE AND SUGGEST THAT A SESSION BE DEDICATED TO CHILDREN’S ISSUES.

SUMMARY PAGE

Prevent under 18s being detained on adult wards

The Committee has heard from the Mental Health Act Commission that about 260 young people are detained on adult psychiatric wards each year. This is a substantial proportion of all young people detained under mental health law. Echoing many commentators, the Commission stated that “it is becoming clear to everyone that this type of admission is inappropriate.”

The government argues that levers of service management should be used to create enough adolescent beds for all adolescents who need to be detained, freeing up adult beds. Nevertheless the law could be used here. We propose:

— A duty on strategic health authorities and primary care trusts to provide enough age-appropriate psychiatric wards for detained adolescents.

Meet family and educational needs

Children compelled under the Bill will have ongoing educational and family needs, as well as aftercare needs. Many compelled adults are parents, who have family needs. Meeting these needs are important to a patient and his/her recovery. We would like this to be addressed on the face of the Bill so that it is more likely to happen. We propose:

— Care plans be required to provide for family needs of patients who are parents or children, for the educational needs of children, and for aftercare needs.

1 First oral evidence session, 21 October 2004.
2 Placed among strangers, Mental Health Act Commission.
Empower a capable teenager to make decisions

As part of the Mental Health Alliance, YoungMinds believes that people who are capable of making their own decisions should be empowered to do so. That applies when considering someone’s capacity to decide in the context of their mental illness; but it also applies when considering the maturity of a child. We suggest that this is required by the child’s ECHR right to private and family life in this context. We propose:

— A Gillick/Fraser “competent”3 child should be empowered to make his or her own decisions to the same extent as an adult.

INTRODUCTION

YoungMinds is the national children’s mental health charity. Our members are children’s professionals concerned about mental health, from teachers to psychiatrists. We provide services to professionals, managers and parents as well as campaigning work.

The Bill as a whole

YoungMinds is a member of the Mental Health Alliance. We endorse the Mental Health Alliance submission. YoungMinds believes that the 2004 Draft Mental Health Bill is the wrong approach to mental health law. Our main objections (and these address the Committee’s questions 1, 2 and 3) are:

— It is too much about safety and not enough about treatment.
— Resources will become more focussed on dealing with people under compulsory powers rather than providing early intervention.
— Users and professionals are worried about the potential for a large increase in the use of compulsion, and the difficulty of ever being released from compulsion.

Or technically:

— The criteria for compulsion (section 9) are still too broad.
— The criteria combine with a widened definition of “mental disorder” which will cover a large number of young people with behavioural problems (known as “conduct disorder”) whose behaviour would not meet the threshold for diagnosis (with “personality disorder”) in adults.
— There is no statement of principles comparable to those in the Mental Health (Care and Treatment) (Scotland) Act 2003 (section 1 (3)), nor those in the Children Act 1989 (section 1 (3)). For example, both of these begin with a statement that the wishes and feelings of the young person must be considered.

We would prefer the government to take a much more liberal approach, comparable to Scotland and most other comparable jurisdictions, as well as its own original Review of the Mental Health Act 1983 chaired by Professor Genevra Richardson.

Nevertheless, the rest of this paper proposes amendments to the 2004 Draft Mental Health Bill. We focus on issues that are specific to children in mental health law.

POSITIVE POINTS

There are two respects about children in which the 2004 Draft Mental Health Bill is an improvement on the 1983 Act.

Firstly, the safeguards for children treated under parental consent (Part 6) are very welcome (but see our proposals for empowering competent children).

Secondly, parental responsibility is considered throughout, and this is welcome.

ENSURE CHILDREN ARE DEALT WITH BY CHILDREN’S SPECIALISTS

The clinical supervisor, AMHP, advocate and Tribunal members should all be specialists in children when the patient is a child. In practice the most important factor is that young people under compulsory powers should be admitted to specialist adolescent wards, where they are also more likely to get adequate education, work with families, and protection. The Mental Health Act Commission has found a instances of children on adult wards being seriously assaulted or offered illegal drugs under threat.4

3 The House of Lords decided in the Gillick case (All England Law Report 1983, volume 3, page 402) that a child was capable of giving consent if he was capable of understanding what was proposed and of expressing his own wishes.

There are insufficient age-appropriate in-patient facilities which can take young people on section, and they are under no obligation to take young people under compulsion. A third of admissions of mentally ill young people are inappropriate admissions to adult psychiatric or paediatric wards.

The United Nations Convention on the Rights of the Child, article 37 (c) states that “every child deprived of liberty . . . shall be separated from adults unless it is considered in the child’s best interest not to do so.”

**Duty on health authorities**

We propose:
- A duty on health authorities (see summary) to provide age-appropriate accommodation.

This would help ensure that young people are treated in age-appropriate facilities, and be similar to the Mental Health (Care and Treatment) (Scotland) Act 2003, section 23. In practice, groups of Primary Care Trusts would have to commission facilities jointly.

**Consultation by adults’ specialists of children’s specialists**

Even in an adequately-resourced system, there will still be rare occasions when young people are admitted to adult facilities, for example in an emergency. So we propose:
- Wherever young people are admitted to adult wards (or paediatric wards) in violation of this duty, the law should require the clinical supervisor to consult a children’s clinical specialist.

**Definitions of Bill personalities**

In Scotland, the Mental Health (Care and Treatment) (Scotland) Act 2003, section 233 requires the Mental Welfare Commission for Scotland to compile a list of designated medical practitioners. Subsection (3) requires that the list includes child specialists. We propose:
- Definitions of all Bill personalities should distinguish between those qualified to act in relation to children and those qualified to act in relation to adults.

**Meet Family and Educational Needs**

A young patient has educational needs. The knowledge that educational opportunities are being missed can be very counter-therapeutic, and reduce a young person’s potential even after a full recovery. The right to education is enforceable under the European Convention on Human Rights.

Family is central to the lives of any child or anyone with parental responsibility. The mental health of parents and children are closely related. A child whose parent has very poor mental health has a 34% chance of having a mental disorder. As parental mental health improves, the figure falls, to 5% for the healthiest. The relationships between parental mental health and children’s mental health include a mentally ill parent finding it harder to provide the care that he or she might want to (for example during an episode of psychosis); a child taking on caring responsibilities for a mentally ill parent; and in rare cases, a parent’s mental illness resulting in child protection concerns. Mentally ill children are also harder to care for than well children, so families may need extra support.

No care plan is complete without consideration of the family needs of patient who is a parent or a child; nor the educational needs of someone who is still in education, or would be if it were not for their mental illness. (This should of course be an obligation on services, rather than treatment which the patient or his/her family is forced to accept. Education is included in the Bill’s definition of “treatment”.)

It will not be possible for clinical supervisors to make these parts of assessments and care plans, so they will need the help of appropriate professionals. We propose:
- A duty on hospital managers, where the patient is a child or has parental responsibility, to ensure assessment of family needs, and to ensure that appropriate provision is included in the care plan.
- A duty on hospital managers, where the patient is a child, to ensure appropriate educational provision (unless the child is past school leaving age and has left education other than because of his/her mental illness).

Both should be on the face of the Bill. The Code of Practice for the 1983 Act provides that family needs must be assessed but services are rarely provided.

---


6 The Mental Health of Children and Adolescents in Great Britain, Meltzer et al, Office of National Statistics, 2000. “Very good mental health” means a score of 12/12 on the General Health Questionnaire (GHQ); “very bad mental health” means 0/12, Egs of GHQ items: whether someone worries, feels useful and enjoys daily activities.
EMPOWER A CAPABLE CHILD TO MAKE TREATMENT DECISIONS

With the Mental Health Alliance, YoungMinds believes that people who are capable of making their own decisions should be empowered to do so. So it should not be possible to compel someone unless a criterion of lack of capacity or impaired judgement is met, as in Scotland. For example, if someone is in danger of death due to anorexia, their judgement would probably be seen as impaired. However, this also applies to children who are mature enough to make treatment decisions.

Many children are capable of understanding the treatment that is proposed, weighing it in the balance, and coming to even major decisions. That is, they are “Gillick” or “Fraser” competent, see above. Unless they prefer to leave it to their parents, they should be allowed to consent to, or refuse, treatment to the same extent as an adult. However, the government proposes to leave the common law position in place for children under 16. This would mean that a parent can consent “on behalf of” a capable child, albeit with the new and welcome safeguards.

ECHR article 8 provides a right to private and family life. It can be argued either that the family right empowers a parent to decide; or that the private right empowers the child to decide. We believe that the competent child’s right to private life should take precedence in this context. We propose:

— A competent child should be empowered to consent to, or refuse, treatment to the same extent as an adult.

Memorandum from the Children’s Legal Centre and the National Children’s Bureau (DMH 194)

This submission from the Children’s Legal Centre and the National Children’s Bureau draws attention to the need for mental health service planners and providers of services to children with a mental illness to take further action to safeguard and promote their welfare. In particular service providers should recognise the need to establish:

— specific criteria for the protection of children during their time as an in-patient;
— a clear policy on issues of consent and confidentiality; and
— a framework for multi-disciplinary service planning for individual children.

INTRODUCTION

The Children’s Legal Centre is an independent charity which takes an active interest in law and policy as they affect children, and provides both legal information helplines and direct representation through its legal practice unit. The Centre receives funding from the Community Fund, the Children’s Fund, the Home Office and the Department of Health. It has a particular interest in the development of mental health legislation as a result of its involvement with a local adolescent psychiatric unit. It also recently received a small grant from the Nuffield foundation to examine the implications for children of the Draft Mental Health Bill 2002. The report from this project has already been sent to the Select Committee.

The National Children’s Bureau (NCB) works to identify and promote the well-being and interests of all children and young people across every aspect of their lives. It encourages professionals and policy makers to see the needs of the whole child, and emphasises the importance of multi-disciplinary, cross-agency partnerships. We also believe that children and young people themselves should play an active role in developing the policies which affect them.

PRINCIPLES AND WELFARE CONSIDERATIONS

The Children’s Legal Centre, in their report on the 2002 Draft Bill, criticised the failure of the Draft Bill 2002 to include welfare related principles, (as contained in the Children Act 1989 and the Adoption and Children Act 2002), in those clauses related to the treatment of children. Those principles, which include the welfare checklist and, particularly, the paramountcy of the best interests of the child and the right of the child to express his view and wishes and have these taken into account according to his age and maturity, are also missing from the new Draft Mental Health Bill. These principles are regarded as fundamental to the safeguarding and promoting of children’s welfare.

The omission of child welfare principles from the 2004 Draft Mental Health Bill is to be regretted and the Children’s Legal Centre and the National Children’s Bureau recommend that these be included on the face of the Bill.

CONSENT, CAPACITY, COMPETENCE AND CONFIDENTIALITY

These issues present mental health service providers with considerable problems. If the proposals in the Draft Bill are included, there are 9 possible routes by which consent to treatment may be given for children, which are subject to various, but not always consistent, criteria. They are:

— consent by a child over 16 years old, which is permitted;
— consent by a Gillick competent child under 16, which a parent may not overrule;
— consent by a person holding parental responsibility for a child over 16, where that child lacks capacity under adult criteria;
— consent by a person holding parental responsibility for a child under 16, where that child is Gillick competent and refuses treatment;
— consent by a person holding parental responsibility for a child under 16 who lacks the competence or capacity to consent;
— the use of compulsion under the Mental Health Act 1983;
— the use of the inherent jurisdiction of the High Court to overturn refusal of consent to treatment by either parent or child;
— the use of care proceedings under the Children Act 1989, where it is believed that the child is at risk of significant harm as the result of the parent’s refusal to consent. Once an interim care order is granted, the local authority may provide consent as a parental responsibility holder; and
— the use of “protected child” status under the Draft Bill.

In determining whether the appropriate consent has been given, the clinician needs to work with both the child and, possibly, both parents, all of whom may have differing views. Balancing interests and rights can be problematic in the light of the absence of criteria for reaching decisions.

One problem frequently faced by clinicians is the difficulty of obtaining rapid legal advice and intervention to prevent the inappropriate removal of a child in situations where the use of compulsory Mental Health Act powers is not appropriate. In this context the proposal in the new Draft Bill to create a “qualifying child” status would appear to add complexity to an already confused scenario.

The Children’s Legal Centre and the National Children’s Bureau recommend that consideration be given to clarifying the issue of consent, in particular the setting of legislative criteria for consent given by children and when and in what circumstances consent by children, or lack of consent, can be overridden.

PROTECTION OF CHILDREN RECEIVING IN-PATIENT CARE

In its report on the 2002 Draft Bill, the Children’s Legal Centre criticised the lack of measures to protect in-patient children not subject to compulsory powers. There are two aspects to this problem.

First, although the Code of Practice states that children should only be placed on adult wards in exceptional circumstances, Placed amongst strangers (MHAC 2003) states that 62% of children admitted under compulsion were placed on such wards between 1999 and 2001. This may be the result of the shortage of in-patient and emergency care but, as the law applies to children of any age, even a very young child could be so placed. To date, background checks for staff on adult wards have not been to a standard comparable to those for children’s wards, nor are the antecedents of patients checked.

Second, the role of the CHAI in Part 10 Draft Bill 2004 needs to incorporate the protection of children receiving voluntary as well as compulsory care, using the standards within Getting the Right Start, the NSF for children in hospital. Otherwise there is possibility that one group of in-patient children will receive a lesser standard of inspection than another. This accords with the duty in s.48 (2) (e) Health and Social Care (Community Health and Standards) Act 2003, which requires the CHAI to safeguard and promote the welfare of children as part of its function.

The Children’s Legal Centre and the National Children’s Bureau recommend that:
— background checks for staff on any adult ward admitting children should be completed to the standard required for children’s wards;
— all health agencies should be accountable for the protection of children affected by the use of compulsory powers, as required by the Children Bill 2004; and
— the role of CHAI within the Draft Bill 2004 should incorporate the protection of children receiving voluntary care as well as those receiving compulsory care, using the criteria within the NSF for children in hospital.

REVIEWS

Article 25, UN Convention on the Rights of the Child requires regular reviews for children placed in institutional care. The Children’s Legal Centre and the National Children’s Bureau recommend that the Draft Bill should incorporate provision for statutory reviews for children receiving in-patient mental health care.

INTEGRATED CARE PLANS FOR CHILDREN

The Draft Bill 2004 makes no provision for integrated service planning for children and their families.

First, there is no power within the Draft Bill for children subject to compulsory powers to be assessed either for special educational needs or for children in need services, and no powers to compel either education or social services to undertake such an assessment.
Second, looked after children reviews incorporate health and education plans for each child. However, there is no similar provision to incorporate the views of other agencies for children subject to compulsion, let alone for those receiving voluntary treatment. Such children will have had significant disruption to their lives, affecting their schooling and ability to cope in the community, which would be eased by good planning and adequate resources.

Third, the discharge proposals in Clause 53 are not helpful. On leaving hospital, some children go home, either with or without support, some may have no home to go to and need housing. Often, decisions are left until the last minute, requiring immediate action to ensure that a child is not left homeless as a result of inter-agency disputes. Powers related to discharge should also take account of the provisions for “qualifying children” under the Leaving Care (Children) Act 2002.

Parents subject to Mental Health Act powers

The separation between adult and children’s sector services is likely to increase with the development of Children’s Services Authorities. Planning for families when a parent is suffering from severe and/or chronic mental illness may become more difficult, with serious consequences for the children. It is important for legislation to be framed in such a way as to ensure that the separate sectors collaborate in this area.

The Children’s Legal Centre and the National Children’s Bureau recommend that NHS trusts should have the powers to request and obtain assessments of children either for SEN or for services under s 17 Children Act 1989.

December 2004

Memorandum from Barnardo’s (DMH 315)

INTRODUCTION

Barnardo’s is the UK’s leading children’s charity, with 359 projects across the UK. Each year we work with more than 100,000 children, young people and families, providing a range of services, from SureStart to support for young people leaving care.

Our commitment to working with children and young people in greatest need means that many, if not most of the children and families we work with have experienced or are experiencing some degree of mental distress. As a consequence we have a wealth of experience of supporting children young people and families to become or remain emotionally healthy. In addition to this, we also provide a range of more specialist services, including therapeutic projects for children and young people who have survived abuse.

CHILD CENTRED WORKING

Barnardo’s is concerned that the Draft Mental Health Bill 2004 continues to enable the compulsory treatment of children and young people, and yet fails to incorporate child welfare principles that have underpinned children’s services since the passage of the Children Act 1989. The bill as it stands does not take into account crucial elements of child welfare legislation relevant both to children and young people subject to compulsory treatment, and to children and young people whose parents or carers are subject to compulsion.

Under the Children Act 1989, children in need are supported through a care planning process which places great emphasis on the wishes, views and feelings of the child concerned, and draws on the expertise of professionals from a range of disciplines. Children subject to compulsion under this bill, and children whose parents or carers are subject to compulsion, should be entitled to the same quality of care planning.

Further, this bill fails to reflect Clause 11 of the Children Bill 2004, which creates a new duty binding all NHS Trusts to co-operate in safeguarding and promoting the welfare of children:

“ensuring that

(a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and

(b) any services provided by another person pursuant to arrangements made by the person or body in discharge of their functions are provided having regard to that need.”

We feel that it will be impossible for NHS and independent mental health care providers to comply with the duty under Clause 11 of the Children Bill, without employing a far more child centred and multidisciplinary process than is envisaged by the Draft Mental Health Bill.
Barnardo’s would like to see:

- Child welfare principles included on the face of the bill.
- A care planning process that reflects best practice under the Children Act 1989 and the meets the requirements of the Children Bill 2004, with children’s views wishes and feelings at its core.

**Child Centred Structures**

Barnardo’s believes that in order to provide child-centred care and treatment, professionals involved in the assessment and planning process, as well as Tribunal members, must have specific expertise and experience in working with children and young people.

We feel it is essential that where a child or young person is assessed at least one of the assessors is professionally trained in child development and/or child psychiatry. Children and young people are not adults in miniature; a “normal” emotional state or reaction for a 10 year old would perhaps be symptomatic of severe emotional disturbance in a 20 year old. We are mindful that Clause 3 allows for Local Authorities to stipulate specific competencies for approved clinicians and mental health professionals, but feel that this is not a sufficiently robust mechanism to ensure that where children and young people are assessed for compulsory treatment the process is age appropriate and child centred.

Likewise, given the enhanced role of the Tribunal, responsible for approving care plans as well as detention and discharge, it is essential that Tribunal composition reflects the necessary expertise in children and young people’s mental health and emotional development. Inclusion of expert panel members should not be at the discretion of the Tribunal, rather it should be a statutory requirement where the Tribunal is considering the care and treatment of a minor.

Whilst welcoming the focus on safeguards for patients under the new bill, Barnardo’s is concerned that these safeguards will remain inaccessible to many children and young people being treated in inpatient settings. All children and young people in receipt of inpatient psychiatric care are extremely vulnerable, not least because many continue to be inappropriately placed on adult wards. Consequently, statutory safeguards should be extended to all children and young people in inpatient settings, not simply those subject to compulsory treatment.

Barnardo’s would like to see:

- Consideration given to the drafting of a separate CAMHS chapter for the bill, in order to ensure that the structures outlined are appropriate as they apply to children and young people.
- Involvement of professionals with expertise in child development and/or child psychiatry as a statutory requirement where children and young people are being assessed, detained, treated or discharged.
- Statutory safeguards extended to all children and young people in receipt of inpatient psychiatric care.

**Young Carers**

Barnardo’s feels that the bill fails to take into account the needs of children and young people whose parents are subject to compulsion. As the bill stands, such children and young people will either have no rights at all in regard to their parent or carer, or a potentially highly inappropriate range of rights where they meet the definition of “carer” employed in the bill.

Children and young people who do not provide “a substantial amount of care on a regular basis”, or who do provide such care yet are under 16 will have no right to information about or input into their parents experience of treatment under this bill. In sharp contrast to this, young people over 16 providing “a substantial amount of care on a regular basis’ will have a wide range of rights, the exercise of which might do irreparable damage to an otherwise positive parent/child relationship.

Barnardo’s would like the bill to include a right to information for all children and young people whose parent or carer is subject to compulsory treatment. These children and young people should be entitled to basic information about the nature of the mental health problem being experienced by their parent or carer, the role of statutory services in supporting people with mental health problems, opportunities to input into the care and discharge planning process and any support that is available to them in coming to terms with the experiences of their family.

Clearly, such a right can and should be subject to an assessment of specific family circumstances, including age and development of the child concerned and the nature of the family network, but the fundamental principle should be one of entitlement to information.

Barnardo’s is concerned that the definition of carer employed in the bill may lead some young carers to become involved in their parent or carers assessment, treatment and discharge in a way which is profoundly damaging to their family relationships and thus to their own experience of being cared for. We would like
to see a more careful consideration of any safeguards which may be necessary to ensure that the carers rights set out in the bill are not exercised in a manner which causes harm to vulnerable young people eager to provide their parent or carer with support.

Additionally, it is essential that families where parental mental health is an issue are able to access the widest possible range of support. In order to achieve this aim, the bill should acknowledge the new duty under Clause 11 of the Children Bill 2004, and stipulate that where appropriate, practitioners engaged in assessing or treating adult patients should request assessments under s17 of the Children Act 1989, or any other legislative provision linked to accessing support for vulnerable children and young people.

**Barnardo’s would like to see:**

- A right for age appropriate information for all children and young people whose parent or carer is subject to compulsory treatment.
- Further consideration of family safeguards needed where a young person meets the definition of “carer” set out in the bill.
- A clear link between the bill and holistic child focused assessments under the Children Act, Children Bill etc, in order to ensure that the needs of children and young people are not overlooked where their parent or carer has mental health support needs.

December 2004

**Witnesses:** Mr Gavin Baylis, Senior Policy Officer, and Mr Gul Y Davis, YoungMinds; Ms Nancy Kelley, Principal Policy Officer, Barnardo’s; Ms Christine Daly, Social Policy Adviser, Children’s Legal Centre, examined.

**Q420 Chairman:** Welcome. We are not asking for introductory statements, as I think you have been told. In a moment, you might like to introduce yourselves briefly. Unfortunately, we are under pressure of time, not because of anything that we would wish to limit but because of pressure on the parliamentary timetable, particularly Prime Minister’s questions which are a popular spectator sport towards the end of the morning and, indeed of course, a very important parliamentary occasion. The evidence is recorded and you will have the opportunity to correct the record for textual purposes only. It should appear on the internet within about one week and you will receive copies. Would you like to introduce yourselves?

**Mr Baylis:** I am Gavin Baylis from YoungMinds. I did not mean to suggest that educational needs should not be protected. That was exactly the opposite of what I was trying to say.

**Ms Kelley:** I am Nancy Kelley, principal policy officer in Barnardo’s UK.

**Mr Davis:** My name is Gul Davis.

**Ms Daly:** Christine Daly from the Children’s Legal Centre.

**Q421 Dr Naysmith:** Under the draft Bill a competent child under the age of 16 can refuse treatment but this can be overruled by a parent. There are safeguards under the draft Bill but do you think these safeguards are strong enough or can you suggest any other safeguards that might be required?

**Ms Kelley:** Barnardo’s would feel that the safeguards in the Bill are very welcome but the key issue is that the safeguards are age appropriate. As members of the Committee will know, we would like the tribunal to have specialist members with experience of child development in order to make sure that reviews and approval of care plans are informed by an understanding of children and young people’s needs. That would equally apply to the safeguards around advocacy. My background includes specialist legal advice to mental health advocates and, in my experience, it is those cases involving children and young people which a generic mental health advocate would find most complex, most difficult to deal with. From our perspective, the importance is that the safeguards in the Bill are tied into some specialism around children and young people’s needs, experiences and other legal frameworks relevant to children and young people.

**Ms Daly:** We have heard the previous representatives speak of the best interest principle with some enthusiasm. What we would welcome is the introduction of that principle to govern decisions about children in general within the ambit of the Bill which would then make tribunals’ roles simpler and indeed clinicians’ roles simpler. There would be a common standard and I think we would all welcome that as a principle within this.

**Q422 Dr Naysmith:** You were all listening to the previous session and you heard the comparison of the Children Act with these proposals. Do you agree that there are some benefits in the clarity in the Children’s Bill?

**Ms Daly:** Absolutely. Where we have looked at the previous draft Bill and this draft Bill, we have consistently argued for the introduction of the welfare check list which is found in section one of the Children Act. It was particularly welcome to hear clinicians impressed by the value that this would offer them.

**Q423 Chairman:** You mean the previous witnesses?

**Ms Daly:** Yes. That was very welcome indeed to us.

**Mr Davis:** I am not a lawyer in any sense, when you talk about check lists or the balance. It is a very complicated issue. Should a child be able to overrule his parents? Should the parents be able to say what happens to a child? How does that work? It is so
specific to the child. For instance, there are many children that are very impressed by their parents. The clinician needs to encourage them almost to be able to have a voice. On the other hand, you can have children suffering from almost the opposite. They do not feel safe. They have not had the boundaries. They feel out of control, in which case sometimes it is very important that parents overrule them. If you want to rely on clinicians to decide, fine, but clinicians have a lot of variability. All of you will have gone to see your doctor and decided there are some doctors you think are good and some that are bad. When you have lack of clarity in the legislation about the requirements, you are leaving so much to discretion when it is such a complicated issue for children and such an important one, because children need to feel safe.

Ms Munn: I am very interested in repeating the welfare check list from the Children Act into the Mental Health Bill because one of the issues that is in the check list, for those who do not know, is that we should have regard to the child’s wishes and feelings. One of the reasons that is very clearly there is that workers generally and adults generally do not pay enough attention to children’s wishes and feelings. It is very clear that that needs to be there. There is an expectation that adults generally say much more readily what they want. Do you think that would be helpful in emphasising that, within this area of work, that should be a requirement to get to the issue of wishes and feelings at least?

Q424 Chairman: Perhaps we can throw in another phrase there in addition to the question which might be best answered by Ms Daly. Would the introduction of such a check list into the mental health legislation cause legal difficulties?

Ms Daly: I come from a social services background so I have worked with both the Mental Health Act and the Children Act. It is like working in two different worlds with different languages, it is that difficult to translate from one to the other. Our enthusiasm for introducing this type of concept is to give a consistency of experience for children as they are dealt with by the law. It seems to me personally to be indefensible that that does not happen. I have worked in both worlds and I cannot understand why. It is visceral. In terms of the complexity of the law, I have not heard an argument against it and certainly in discussions within the Centre it is supported by the lawyers.

Mr Baylis: YoungMinds is a member of the Mental Health Alliance and I wanted to make a connection with the principles that are being asked for by the Alliance on the face of the Bill and the similarity between the principles needed for the Bill as a whole for all patients and the welfare check list for young people. It is the same basic set of needs. They need to be slightly different for young people but it is the same motivation behind that.

Q425 Lord Rix: Can I refer you to the recently Bournewood case in the European Court of Human Rights where it was held that the 1983 Act failed to safeguard the rights of incapacitated patients who did not refuse treatment for mental disorder. How can it be certain that a child is actually consenting to treatment as opposed to not resisting the treatment? What safeguards, if any, are available for children who fall into the Bournewood category of patients?

Ms Daly: My recollection is that was an Article 5 breach. Underlying a lot of our concerns about the Bill is the fact that it does not address the issue of children who are “informal” patients. We argued originally that all children should receive access to advocacy services irrespective of their legal status.

We have experience of representing children in a psychiatric unit through that advocacy scheme. We provide back-up legal advice to the scheme when required. We have had more business from “informal” rather than formal patients because of the need for those children to have a voice that is heard. I think you would be looking at the whole spectrum of children so irrespective of the question of capacity you would pick them all up through that type of system. I think that is where we have to start.

Ms Kelley: From our perspective, the point you have raised is an argument in favour of importing the Children Act welfare principles into this Bill because the idea that as a routine matter of course you would be incorporating and looking for wishes and feelings of children and young people—well, we are primarily talking about older young people here, largely able to express their views, wishes and feelings if they are given the opportunity to do so in an open environment. From our perspective, it would be that read through into the Children Act that would begin to ensure that children and young people are able to give meaningful feedback and make meaningful choices about their care and treatment.

Q426 Chairman: We have had a lot of evidence at past meetings about the need to coordinate the mental capacity legislation and the mental health legislation. This morning we have had a clear message from all our witnesses to co-ordinate the mental capacity legislation, the mental health legislation and the general children’s law legislation. Is that a yes from all of you?

Ms Daly: Yes.

Ms Kelley: I feel that is potentially something that will have to happen because we have talked quite a lot about the 1989 Children Act; we have not talked particularly about the 2004 Children Act, which imposes a new duty on NHS trust strategic health authorities to discharge their own ordinary duties with regard to safeguarding the welfare of children. From our perspective, it is not only a matter of it being desirable that there is some link between the new Mental Health Act and the Children Act. It is necessary.
Q427 Chairman: It is absolutely clear that many children who are suffering from mental illnesses are highly intelligent, well capable of understanding what is happening to them if it is explained and capable of making a serious contribution to their own futures. Is there a programme for at least attempting to explain to them what their rights are, what is likely to happen to them and how to have some understanding of the law, rather than merely patronising them by authority?

Ms Daly: As far as I know, the only people who have done extensive work on this are YoungMinds. Where we are engaged, we do training with staff but we are starting to look at developing direct work with young people who are seeking advocacy, including those young people who have a degree of learning disability, which is particularly interesting because there is a huge communication agenda. That hits you like a brick when you encounter it. I think there is a very good case for introducing a UK-wide—certainly England-wide—measure for dealing with this as a programme and setting standards. One hates to mention it, but a looked after child under the Children Act has an automatic right to an advocate and enormous experience is held within certain voluntary sector organisations about explaining those rights. We know how to do this. There is expertise out there. Many organisations do very good programmes.

Lord Rix: Can I welcome what you have just said very warmly? I am sitting next door to the chairman of the Scrutiny Committee on both the Disability Discrimination Bill and the Mental Capacity Bill. He will agree with me. I am certain—I hope he will—that the thing that has been plugged in all three Bills as far as evidence is concerned is the need for reasonable, properly funded advocacy services. At the moment, the Government are, without question, resisting this. The stronger you can make your statement in this regard the more I would welcome it.

Q428 Baroness Barker: Many of you were here earlier on this morning when we had a very clear exposition from our previous witnesses about clause 9(7) of this Bill and section 11 of the Children Act and the way in which people who are aged 16 to 18 are going to be potentially treated very differently under children’s legislation and this legislation. Given the rights and responsibilities that young people do have from the age of 16, do you think 16 is the right age at which the clauses of this Bill should apply?

Ms Daly: No. I think it is unnecessary, which I think is what the previous evidence suggested. As I understand it, the objective of clause 9(7) is to permit the detention of people who pose serious risk but who are not otherwise necessarily detained in order to provide medical treatment—ie potentially consenting 16 year olds who pose a risk. As evidence this morning suggested, section 25 of the Children Act 1989 was written precisely to deal with these sorts of circumstances. It already exists. I do not really see how having this provision adds anything. It potentially confuses the matter. I would raise the age to 18.

Ms Daly: I absolutely agree. Health authorities can make applications for secure accommodation orders.

Mr Davis: Although the technical terms are difficult for me, the immediate thought when you talk about advocacy is that it is wonderful to have the principle and I would support absolutely that everybody should have the right for an advocate but my personal experience of advocacy is that there are not any teeth. They are often quite intimidated by the doctor’s system and there is nothing is disempowering as approaching an advocate and seeing that they are really unable to do anything. A lot of the points I wanted to make are not in the questions that you are asking but one of the main points is about what happens. When you are a kid, or an adult for that matter, and you are mentally ill, you are very distressed, especially as a kid. Mental illness is even harder because you are not just dealing with the mental illness. Emotionally and cognitively you are not developed. How do you help someone? The answer is that the knowledge is out there about how to help people with mental illness, how to help with emotional problems. It is not implemented and, if I could argue for anything within this legislation, it is not just about the right for advocacy or the right for this or that. It is somehow ensuring that the quality of treatment actually occurs. One of the important points you have to understand is there is a really wide net here for compulsion. If you are looking at positive outcomes, what creates a positive outcome is a sense of partnership. When you have a mental illness, to get over it, you are going to have to take some very difficult steps and face very difficult things. If it is psychosis, it may mean taking horrible medication. It may mean stopping taking substances that are very addictive. If it is obsessive compulsive disorder, it means doing things that scare you a lot. If you have somebody saying, “You will do it” and throwing you into a situation that you are not buying into or you are feeling powerless, the important point is empowerment, to help people feel that they can buy into it and that they want to do it. The minute you make it compulsive or make somebody an in-patient, what you are doing is reducing the chances of them getting better. The minute you become an in-patient, there is a massive loss of power, dignity and self control. That is why community outcomes are so much better because people maintain all those elements of choice. If you are leaving a really wide net to compel people, the last thing you want to do is, by making a lot more people detained, reduce the chances of being able to help them effectively. The reason it is important to have very strict criteria and a very clear principle that informal treatment and treatment in the community should be much preferred is because it is much more effective. People relax and get better a lot quicker. If you are going to detain people, you have to think very carefully about how you do that, maintaining people’s sense of empowerment, dignity
and choice. Moreover, you have to make sure that what you are saying is going to happen for them is occurring on the ward.

Q429 Chairman: Understanding absolutely what you say—that was a very valuable contribution, if I may say so—you will have known quite a lot of service users and talked to them as friends over a period of time. Would it be right that some of them feel safe, at least for short periods, because their autonomy has been removed from them, albeit that they want their autonomy back but, for the time being, the safe haven is more comforting for them; or is that wrong in your opinion?

Mr Davis: It is not wrong but it is not just kids. There are so many prisoners in prison that do not feel safe outside of prison. There are so many people that feel so out of control and there is so much of a lack of boundaries and structures that they almost need to be contained. That was my original point about whether children should make decisions above parents. It is such a complicated issue but it is not solved by keeping people in physical containment; it is about doing the work that is needed to help them feel safe. You have to ask yourself what needs to be in place to best do that work. Is it that, instead of doing that work, we are putting people in institutions and containing them through law or is the law enabling the clinicians that know how to help those children have those boundaries within themselves to do that work.

Q430 Chairman: Returning to Lady Barker’s question, do I understand you to be saying something along these lines: that having legal definitions put to you does not help you at all? What you are looking for is the best possible outcome which is going to make you an autonomous person, not in a hospital but at home or preferably in your own home if you are approaching adulthood?

Mr Davis: Absolutely. You should be very careful about widening the remit for compulsion or admitting people as in-patients because generally it reduces the effectiveness of treatment and encourages relapse for all the reasons I gave about not having that sense of partnership. Therefore, it is important that you have clear definitions for why people should be detained. Secondly, if you are going to detain people, the main focus should be how do you do that while maintaining people’s dignity so that you are not reducing people’s chances of getting better, and how do you use the law to make sure that what is going on, on the wards or in the detained community setting, is what should be happening, because there is a great big theory gap. You go on to the wards; you are looked after mostly by people who have no training whatsoever. There are no psychologists to see you. Psychiatrists see you once every six months. It is about can you use this Mental Health Act to improve the care of detained people and can you make sure that detention in itself does not reduce the chances of people recovering and staying well.

Chairman: This is a helpful phase in the evidence and I wonder if there is any other member of the Committee who would like to put some specific questions to Mr Davis, who is on a roll of very eloquent evidence at the moment.

Q431 Baroness Pitkeathley: Have you any idea about how you ensure this treatment takes place? If you were organising it, how would you ensure that what goes on on the ward is what the people on the ward need?

Mr Davis: If you make legal requirements for audits so that it is not just a case of someone being detained; therefore it is up to clinicians and nurses to get on with it and that is where the legal detention ends until a tribunal, where they say, “Are you well enough to be discharged? Are you not?” and the answer is, “No, you are not.” Therefore, you go back. You are getting somewhere by saying that the tribunals have to okay care plans, but what it means is having a system where you can monitor: is this treatment occurring, not just because nurses or doctors are saying it is happening, but involving service users and advocacy in regulation assessments of what is happening on the ground. If you can use this legal framework to make a requirement with sanctions if it does not happen that people get the care they need when they are detained, I think that would be a tremendous improvement in mental health quality.

Q432 Laura Moffatt: It must be an issue of variability because last week a couple of members of the Committee were at a child and adolescent in-patient unit which appeared to us to be superb, with lots of contact, lots of professionals, people trained. It seems to us it is the variability issue that is so crucial to this whole debate. There were a lot of YoungMinds leaflets there which I thought were superb. What work is going on to map out where the best and the worst units are? I think that would be very helpful to us.

Mr Davis: I cannot say that I have done any work on that.

Mr Baylis: YoungMinds has done several research projects looking into in-patient care. Almost certainly a unit would not have been comfortable inviting you there unless they were very confident about their care. We spend a lot of time interviewing young people and professionals, asking what they needed and wanted. One of the things that came out particularly strongly was that the experience of admission and compulsion is very frightening. Sometimes for young people this can be the first time they have lived out of their family home. Other young people have much more disruptive backgrounds but more information and preparation for admission would make things a lot less anxiety provoking.

Q433 Mrs Blackman: How might the Bill improve practice?

Mr Davis: A lot of the focus is on what happens when somebody is compulsorily detained and what mechanisms can you put in place to make sure that
(a) the care plans that are being drawn up for that person are suitable and (b) that they are actually being implemented. If that can be a requirement for some sort of evidence to be shown, not just from the doctor or the nurse, that these treatments are occurring and how they are going, a regular review, I think that would be a very useful requirement within the law. You ask why in-patient services are so variable. You were talking about violence. I would argue that 90% of violent incidents, whether in adolescent units or adult units, are nothing to do with mental illness. If you ask a nurse, they would say, “They have an illness. It is badness”, but I would argue differently. I would say you could take 100 people—we could take you lot—and put you on a ward where you feel disempowered. You have lack of choice; you have lost your dignity; you feel you have no say, that there is nothing you can do. You are having unreasonable decisions put on you. Especially if in your past the way you resolve those situations was from getting into a fight, you would have an incident. Are people mad and dangerous because they are mentally ill or are they simply responding normally to a very disempowering situation which is why community care is very important? Compulsion in the community must be carefully done, not to undermine all the benefits of the community which are about the maintaining of dignity, making sure that there are appropriate care plans and that they are being implemented, not just relying on doctors to sign and say they are, but having other avenues like carers, patients themselves, advocacy, monitoring how things are going, would be a very useful introduction if you are going to detain people. The previous person said that you should make a declaration to say—

Q434 Chairman: We are returning to putting principles on the face of the Bill.

Mr Davis: He said that on the face of the Bill it should say that informal detention is preferable and I think that is very important because it is the best way of getting the best outcomes.

Q435 Baroness Eccles of Moulton: There is one aspect of detention which is probably worth pursuing and that is if the young person is seen to be in a state where they are either at a threat of doing serious harm to themselves or to the public. How do you equate the need to be able to have that person under some sort of control with the disempowerment aspect?

Mr Davis: I see them as contradictory. I do not think there are any circumstances where you should allow especially kids to hurt themselves. The message you are sending to a kid is, “Go on, get on with it. OD on heroin. Commit suicide. You are just attention seeking” or whatever. What you are basically saying is, “I do not care”. The message that has brought that kid to that point is, time and time again, that they do not care. I am not saying you should just let kids get on with their disruptive behaviour, but I am saying you have to think about how to show them that you care and help them. There are lots of clinical studies about how to do that. It can be done but I am in no way arguing for you to let people who are very ill and vulnerable get on and destroy themselves or others. A lot of the focus on this Bill is about the safety of the public. I need to remind people that 99% of violent crime is committed by sane people. You should be much more scared of the person sitting next to you. The media has not helped. We are scared of mental illness because it does not make sense and it is out of control. You have to be very careful that you are not allowing innate human fear to drive this Mental Health Act when it should be evidence based.

Q436 Baroness Barker: One of the things I wanted to ask you was about parents and children and parents being able to override decisions. You were talking about treatment in the community. When we went to talk to some carers, not of children particularly, they took a very different view about community treatment. Under this Bill, the right to choose a nominated person enables people who have mental health problems to have a much wider choice about the person who may wind up making decisions or having an influence in decisions in their life, rather than people to whom they are directly related. We found on some of our visits last week that there was a feeling that sometimes children or young people make bad choices. I would like to know what you think about that. What do you think within this whole dynamic of parents and children the legal framework ought to be?

Mr Davis: The whole thing is so complicated. For some kids it is very important to help them stand up against domineering parents. For other kids it is very important that they get the message that the parents do care about them. In my experience, when I first became ill, I had a very bad family situation. I wanted to be fostered. I wanted a new mum and dad. It was completely crazy. I thought the only solution to my problems was to start again, change my name, get rid of my lisp and have a new mum and dad. Because my parents were not cooperating with the doctors, instead of dismissing it as crazy, they went along with it. I had to tell my parents I wanted to be fostered and my parents said yes. That was extremely damaging because what I needed was for my parents to say, “No. I want you” because they were workaholics up until I became ill. If you have kids that are very angry with their parents, they could choose anybody to be their nominated person. On the other hand, if you do not allow kids to do that, you could have really unhelpful parents that are the cause of the problem and some really helpful people that the kid could rely on and stop it. I do not know how you solve it.

Q437 Baroness Eccles of Moulton: You know or have met more people in that situation than we have. On balance, what do you think? Is it better to give people a wider choice or not?

Mr Davis: All I could recommend is that you speak to people who have studied this and think about it carefully.

Chairman: We have your paper and you have put a lot of thought into that. We will read that with care.
Q438 Mr Hinchliffe: In YoungMinds’ evidence there is a recommendation that there ought to be a duty on health authorities and PCTs to provide enough age appropriate psychiatric wards for detained adolescents. I wonder whether that is a view shared by Christine Daly and Nancy Kelley?

Ms Daly: We felt that the Children Act with the new duties to safeguard and promote the welfare of children would lead in that direction and would even permit action to be taken against authorities that did not have those adequate facilities in place. You can also add to that the new duties of the CHAI, who also are required in their inspections, to look at safeguarding and promoting the welfare of children and the NSFs. There is a range of provisions coming on stream which a failure by a strategic health authority, a primary care trust, could leave open to possible judicial review.

Q439 Mr Hinchliffe: What you are saying is that, in your opinion, this does not need to be written into the Bill?

Ms Daly: At this stage, it does not. A little bit says, “Not a prayer of getting it past anybody.” You would not get that in anyway. Let us use the new powers productively and work with them.

Q440 Mr Hinchliffe: Do you concur, Ms Kelley?

Ms Kelley: Yes. On principle, we agree absolutely with YoungMinds that there is a need to ensure that all children get age appropriate treatment. Our perspective is that that is what section 11 of the new Children Act will do. More broadly than that, what I would wish the Committee to consider is that this Bill was originally drafted long before the Children Act 2004 was even thought of and that there is a real urgent need to look at this Bill again in light of the new duties in that Act.

Q441 Mr Hinchliffe: Mr Baylis, would you like to respond to that point? It is your evidence that suggests we need to address this specifically.

Mr Baylis: Christine knows a lot more about the legal technicalities. In the code of practice under the 1983 Act it was envisaged that only exceptionally would people be admitted to adult psychiatric wards and that has simply not been the case.

Q442 Mr Hinchliffe: How common is it?

Mr Baylis: You heard from the Mental Health Act Commission a few weeks ago that 260 young people every year are being admitted to adult psychiatric wards. It is a substantial proportion of all young people who are admitted under detention and it is a very real problem. The Government feels that it can be done just through the performance management tools of inspections and so on. Those tools have been available for all this time and it has not happened.

Q443 Mr Hinchliffe: Mr Davis in his evidence a few moments ago said, “Community outcomes are so much better”. As a Committee we will want to underline in legislation the ability to achieve those outcomes. I wonder whether we need to look more carefully at the way the legislation is framed in terms of what he suggested because I am very conscious that we concentrate specifically on the hospital side without looking at that very valid point that he made. Would you like to expand on that?

Mr Baylis: I agree. If people can be treated adequately in the community, obviously that is much better. If services can intervene much earlier, that also is ideal. This is about the situation where that fails.

Mr Hinchliffe: I appreciate the point but we are probably talking about two separate things here and it is my fault if we are getting confused. What I am trying to say is: do you feel, in view of Mr Davis’s comments about community outcomes, it is possible to write into legislation of this nature the ability to deliver those community outcomes so that we are not concentrating all the time on the hospital elements of this legislation?

Chairman: To deliver those outcomes in the community.

Q444 Mr Hinchliffe: That is right.

Mr Baylis: The Mental Health Alliance believes, if someone is ill enough that they need to be treated compulsorily, they are ill enough to be treated in a hospital. If someone could be treated in the community, they are not likely to be ill enough to need to be treated—

Q445 Chairman: Is that a logical answer? Why should there not be a patient who requires some form of compulsory treatment but who can be treated in the community subject to their complying with that compulsory treatment?

Mr Baylis: It could happen in exceptional cases, but the danger is that, if community treatment is allowed with the very wide criteria that we have, there is a possibility of a huge increase in compulsion.

Q446 Chairman: If Mr Davis is right and community outcomes are of great value, subject to safeguards for example in the code of practice, why on earth not?

Mr Baylis: It is much better for people to be treated in the community. The problem is that you may also get far more compulsion under the draft Bill. That is the danger of a widened definition and the lack of an implicit criterion of being able to find the hospital bed to treat someone in, which you have in the 1983 Act.

Mr Davis: When you maintain someone’s sense of dignity, choice, self respect, partnership and ownership of the treatment, because they are going to have to sustain things which are going to be very difficult, your outcomes are much improved. There is such a broad definition of mental disorder. You could round up every delinquent child and section them and treat them in the community. That would not be beneficial unless (a) you have thought about how to do compulsion in the community without undermining that sense of independence and responsibility and (b) I think it is very important that you restrict and make very clear what sort of kids should be detained. If you ask any psychiatrist, diagnosing an illness in a kid is virtually impossible.
It is not clear what mental illness a kid has until really they reach virtual adulthood. It was only recently they agreed that kids could suffer with psychosis. What a kid is ill with is very hard to nail. If you are going to say, “We are going to detain you and keep you in the community. We are not sure what your illness is and, by detaining you, we are removing that sense of power” that could be damaging. On the other hand, if you can use it to say, “This is a treatment programme. If you comply with it you can stay in your home” I think that would be useful.

Q447 Lord Carter: To come back to the principles being on the face of the Bill, which I think almost all our witnesses have agreed to, we have also spoken a great deal about the welfare of children and the evidence of Mr Davis is extremely compelling. The definition in the Children Act is that the welfare of the child shall be paramount. If you look at the 2004 Act, functions are discharged having regard to the need to safeguard and promote the welfare of children. That is not a duty. “Having regard to” is not the same as having a duty to promote. You can see how hard it is when we try to advise the Government on the wording of these principles and how they can meet the patient centred requirement, which we all understand and sympathise with, and the law.

Ms Daly: The point is so well made. I am also aware when I talk about the Children Act and the paramount welfare principle there is a caveat that allows, in certain circumstances, the best interests to be disregarded. It is when there are particular circumstances where the child poses a danger to other people. In that case, the local authority may disregard the welfare criterion.

Q448 Tim Loughton: Can I come back to the disempowerment point Mr Davis was making? I think his last comments might have disempowered the clinical professionals we heard from earlier. What I am fascinated by is if the numbers subject to compulsion were to remain the same after this legislation, which most of us suspect they will not, and your point that one of the biggest problems is the sense of disempowerment of young people when they are subject to that compulsion in a hospital or whatever, if they are subject to compulsion and Community Treatment Orders in the community, would young people feel the same sense of disempowerment as they would in a hospital and therefore be just as less likely to react well to treatment as they do in a hospital? Is there a desirability about compulsion in the community over compulsion in general?

Mr Davis: There are many more good examples of good practice in the community than you will find in in-patient care. That is generally because in-patient care is very disruptive, far from being a healing environment in which to get better. I am not talking specifically about CAMH services. I am talking about in-patients across the board, adult and children services. My gut feeling is that, wherever possible, you should be treated in the community, but it is not rocket science. It was in one of the documents submitted to you that lots of people ask for help but do not get it. If the people who asked for help were given that help at that stage, they would have a sense of control, autonomy and partnership. Their illness would not be so acute. They would be treated in the community and they would be less likely to relapse and get better quicker. All the effort has to be directed at, when people come for help voluntarily, giving it to them effectively and voluntarily in the community. The more you can concentrate on that the fewer people you will have to detain. For those you do have to detain, I think it is about how you implement detention while hopefully giving, in some senses, that sense of choice, empowerment and dignity and, secondly, once they are detained, how do you make sure that the care you have agreed for them to have is happening so that they have the best chance of getting better. If that was the structure of the Mental Health Act in terms of priority, it would save a hell of a lot of money. Hospital care and detention are very expensive. A revolving door is very expensive as well as being a human tragedy. It makes me so angry because when you do get the right treatment, when you are lucky enough to have the few professionals coming together to give you the right treatment, you can get better.

Q449 Chairman: It puts it into stark relief if I refer to my own experience as a parent here. One of my children who is now happily much better and an adult, as a teenager, was referred by a general practitioner to a general adult psychiatrist in an expensive private unit at vast cost to an insurance company. It was three to four months before we realised that she was being inappropriately treated and very heavily sedated with inappropriate drugs. She was then transferred to a National Health Service unit specialising in child and adolescent mental health services and, within a few months, became a great deal better and started on the road to recovery that Mr Davis has just been referring to. Is it a common experience that psychiatrists who specialise in general adult psychiatry have an inappropriate and disproportionate input into CAMHs before CAMHs gets there? Is that a general problem and, if so, is it something that is being addressed satisfactorily?

Mr Baylis: It is certainly the case in certain circumstances. For example, if I am a 16 year old and I turn up in A&E after taking an overdose, the chances are the first mental health professional I meet will be someone specialising in adults. It is something that children’s mental health services at the moment are not able to do, to provide enough cover to meet that need. If there is an emergency admission, it is far more likely that I will be admitted to an adult unit rather than a children’s unit because there are not many children’s units which take emergency admissions like that.

Ms Daly: From the work we have looked at, there is a long history of failure to work up the age to which child psychiatry should go. It has tended to relate to school leaving age. The Audit Commission
identified a range of ages from 14 up to 20. The view we have is that it should be up to the age of 18. Then you can dovetail with other provisions and services much more easily to secure the support systems that you need. Generally speaking, it can be a lottery. It depends on where the child is, who they see, where the resources happen to be sited. It is not about a systematic, thoroughly thought through, thoroughly understood response to the needs of children and young people.

**Mr Davis:** What you said about the private care very much interests me. I do not know if any of you are involved in the Government’s decisions about how to run the NHS, but it should ring a lot of alarm bells. In my personal experience and from what I have heard, once you start to move into the private sector quality really goes down because either they charge you a hell of a lot more to provide you with the same care as you would get in the NHS so that they can make a profit; or they charge you the same price as you will get in the NHS but cut lots and lots of corners in terms of quality. They have no reason to get you better because so long as you are there they have the guaranteed income. It is all about presentation and packaging.

**Q450 Chairman:** They have their ethical duties.

**Mr Davis:** Ethics and business do not really wash together.

**Q451 Chairman:** I was not making a point about private health care.

**Mr Davis:** I was making it though because it is relevant to some degree. More and more mental health services are being provided that way. In terms of kids, you have just heard about the numbers treated on adult psychiatric wards and that really answers your question about a significant number of people. I was once a 14 year old on an adult ward, so it certainly happened to me.

**Q452 Baroness McIntosh of Hudnall:** This leads me to probably a rather crude and insensitive question given the quality of the evidence we have had. There has been a lot of talk about how much better the service would be if it were possible to guarantee the kind of attention that Mr Davis has said that young people—and I would say adults as well—deserve when they come forward with severe mental health problems. We did not get a chance to question our clinician guests earlier, but what we have heard from other witnesses is that there is a severe problem in recruiting and retaining mental health professionals. This is something to do, it would appear, with the culture into which people are coming when they take on these jobs. Is it your view—I do not address this question to anyone in particular—that with the best will in the world it is possible to meet the standards that you are quite rightly suggesting this Bill should aspire to if it is not possible, just in numerical terms, to recruit the people to provide the services?

**Ms Kelley:** It seems to me that several of the questions the Committee have posed have been about how you create a continuity of care beyond compulsory treatment into the community. From our perspective, some of that is about integrating the systems particularly that deal with children. It is about integrating the 1989 Act so you are working from a multidisciplinary basis and a continuum up and down which children and young people can pass. Your point about recruitment is of course absolutely well made. It applies equally well to social care. As an agency that employs a great number of social workers, what Barnardo’s has found is that being able to offer our social workers an opportunity to work in that kind of multidisciplinary environment, where they are working across a continuum rather than being required to do just sharp end interventions, has meant that our recruitment and retention is significantly better than in the statutory sector. I think the two things connect providing a much more flexible continuum of care for children and young people and will attract professionals who want to work holistically and who want to commit to effective community care for vulnerable children and young people.

**Q453 Baroness McIntosh of Hudnall:** Can I ask you to tell us in what way you think the Bill could be amended to make it clear that that kind of cross-disciplinary approach to dealing with mental health issues could be effectively strengthened? You have talked about read across from this Bill to at least two others and probably several more that you have not yet thought of but specifically within this Bill can you see what it needs to say that strengthens that argument that you have just put to us?

**Ms Kelley:** I have some suggestions but I am not so competent a lawyer as to do the read across of four Bills at once. One of the issues is the basic one about making explicit the connection with the 1989 Children Act because then you are automatically framing this in terms of a system that works in that way. Some other issues would be around looking at confusing terminology in this Bill. The use of the words “care plan” in this Bill is extremely confusing for those of us who work in the Children Act. The care planning process is different and the care planning process for the Children Act, in our view, is preferable. There could be some very straightforward things about making it very clear that, when you are saying care planning for a child subject to compulsory treatment, you mean the same kind of thing as care planning for a child subject to a Children Act order, a multidisciplinary, regularly reviewed, advocacy based way of working. Those kinds of concrete connections are going to link in the same way of working across a continuum of care.

**Mr Davis:** It is no wonder that you have problems in recruiting. I think I am referring more to adult care here than children care but, just as I said in-patient care is not a healing experience for a patient, if nurses come in and find that they are not able to do the work that they want in terms of holistic care but are just giving out tablets and filling in forms, is it surprising that they do not stay? When you say, with the best will in the world, given these problems can we do anything about it, would you be saying that if it was your son, daughter or husband? You would say, “Address the cultural issues that mean people
are not wanting to work there, that are causing the recruiting crisis because my son deserves to get better”. Every child or adult under psychiatric care is somebody’s husband, wife or child. The best nurses are the ones who think: how would I deal with it in that situation? You have to keep that in your heads. It is one in four and it could directly affect your lives if it is not sorted.

Baroness McIntosh of Hudnall: There is a practical matter about what the Bill can say.

Chairman: Perhaps Barnardo’s and the others might like to consider this further and write to us.

Lord Mayhew of Twysden: Mr Davis said there should be an audit and sanctions for failure to achieve what has been willed by the Act. I can understand the audit but perhaps you would write to us about your ideas as to what the sanctions could practically be.

Q454 Baroness Murphy: I wanted to raise the issue of the coordination of the Mental Health Act and the Children Act again. Would it be helpful to put into the Act a part which specifically refers to treatment of children and young people? It almost seemed to me that in the 1983 Act it was rather a mess and it was not dealt with separately. Would it be helpful to have a separate part as we have for the criminal justice effects of the Bill?

Ms Daly: We would be delighted to see a part in the Act that addressed children, including those in the criminal justice system who have been sadly neglected by us in this morning’s discussion but about whom we have profound concerns. We have not talked about the education and special needs aspects of this agenda. A child who is “statemented” will at least have a right to the service. A child who simply is assessed as needing some support may lose that when the financial circumstances change and that may be in the control of the school and not the local education authority. At the risk of frightening the horses, one might suggest perhaps that any child for whom in-patient care is considered, and certainly for whom compulsion is considered, should have a Children Act assessment and an education assessment.

Chairman: I have a sense that we have covered all the issues that we intended to cover this morning through the whole of the evidence that we have heard. I apologise that we have not been able to deal in detail with all the questions we had in mind but we have to finish now. Can I thank you all very much for coming and giving your evidence this morning? It has been extremely helpful, as with the previous witnesses. All members of the Committee should look at the Select Committee on Delegated Powers regulatory revision memorandum to the Joint Committee and in particular the introduction and the part dealing with clause 1.

Supplementary memorandum from Barnardo’s (DMH 419)

ADDITIONAL EVIDENCE ON INTEGRATING THE CHILDREN ACTS 1989 AND 2004

Barnardo’s believes that the Draft Mental Health Bill represents a unique opportunity to establish integrated services for children and young people by linking mental health and child welfare legislation. The new duty to have regard to children’s safeguarding and welfare under s11 of the Children Act 2004 is an important catalyst for statutory change in this area, and we urge the Committee to recommend that the Draft Mental Health Bill be revised in light of this duty.

Integrating the work of health and social care services is essential to ensuring that children, young people and families get the support they need when they need it rather than being left to lurch from crisis to crisis, or navigate the chasm between health and social services alone. This integration is particularly needed in light of the fact that many children and young people in contact with mental health services have multiple vulnerabilities, and may already be in contact with social care services when they enter the mental health system. Nowhere is this more apparent than in the experience of looked after children, who are commonly unable to access any mental health support in the community and are disproportionately represented in the inpatient population where they are at risk of their hospital bed being seen as a replacement for their home.

CHILDREN AND YOUNG PEOPLE SUBJECT TO THE DRAFT BILL

“We need: sensitivity; efficient communication between services; help to open up a wider variety of therapies and options; broader crisis management and more focus on positives. Everyone should have a personal healing plan; we need to feel that we are in control and can get ourselves better”17

Examination

Barnardo’s believes that decisions about care and treatment of children and young people should be taken in the context of a wider assessment that considers the child’s own resources as well as the support available from family, friends and community. Examination and assessment under the Draft Bill has an almost exclusively clinical focus and whilst this clinical assessment is clearly central, without an understanding of the family context or of the range of services available to the child and family in the community, such a process will be incomplete and may lead to decisions that are not in the best interests of the child.

A child or young person who may be in need of mental health services under the Draft Bill is likely to be a child in need under s17 of the Children Act 1989, and thus entitled to social care support for themselves or their family.

S17(10)

For the purposes of the Part a child shall be taken to be in need if:

(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;
(b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
(c) he is disabled.

Barnardo’s believes that clause 14 of the Draft Mental Health Bill should be amended to ensure that where the appropriate authority is arranging an examination of a child or young person under cl 14(3), the list of persons to be contacted should include the Local Authority, for the purposes of triggering a parallel assessment under s17 of the Children Act 1989. Such a parallel assessment is already explicitly provided for under s3(d) of Schedule 2 of the 1989 Act:

3. Where it appears to a Local Authority that a child within their area is in need, the authority may assess his needs for the purposes of this Act at the same time as any assessment is made under:

(a) The Chronically Sick and Disabled Persons Act 1970;
(b) The Education Act 1981;
(c) The Disabled Persons (Services, Consultation and Representation) Act 1986; or
(d) Any other enactment.

This parallel assessment would serve two principal functions. Firstly it would ensure that a child or young person’s needs are considered holistically, reducing both the risk of inappropriate use of mental health legislation and the risk of a child in need being left without support. Secondly, it would ensure that where a child or young person is treated as an inpatient, liaison with the local authority can begin at the point of examination and continue throughout admission and treatment, enabling care planning to extend into discharge planning and community support.

Community treatment orders

The Government has made it clear that community treatment orders are primarily intended for use with “revolving door” patients and consequently the assumption is that these will not be commonly used for children and young people. However, this possibility is not excluded from the Bill, and indeed there might be sound welfare considerations that militate in favour of treating children and young people as “non-resident patients”. Given this, Barnardo’s feels it is essential that determinations at examination stage cl 16(4), and determinations relating to residency made throughout the care planning and approval process, are made with reference to a s17 assessment of the child and family as outlined above. We believe it is impossible to make a decision about the best location for a child’s care without a well rounded understanding of their family environment.

Care Plans

The care planning process set out at cl 31 of the Draft Bill is unidisciplinary; the only statutory requirement is that all “medical treatment” is recorded. Barnardo’s believes that this is inadequate and a missed opportunity to work across organisational boundaries. Where a care plan relates to a child or young person, the process should be multidisciplinary and linked to the well established care planning process under the Children Act 1989 and/or a Pathway Plan under the Children Leaving Care Act 2000. Maintaining links with family, friends and community can play a key role in enabling children and young people to recover from experiences of mental distress, and move out of inpatient care in a safe and supported way. A clinical care planning process which doesn’t acknowledge the importance of life outside the hospital is
missing a key part of a child or young person’s recovery; Barnardo’s would like to see social work input into care plans under the Draft Bill, and co-ordination between care plans drawn up under the Draft Bill, care plans drawn up under the Children Act 1989 and care pathways under the Children Leaving Care Act 2000.

Given the fact that a child, their nominated person or their parent can apply to the tribunal for discharge from compulsion at any time, it is essential that these health and social care planning processes are linked and concurrent. Where a Tribunal is considering discharging a child or young person, community and social support networks should already be in place to avoid delayed discharge and failure to support vulnerable children and young people in the community.

**YOUNG CARERS**

*Family focused assessment and reviews*

“Two people arrived and sat by my mum and dad. They did not introduce themselves to me even though I was in the same room. I heard them talking about my mum. It was as if I was invisible. I was glad when they went.”

Family focused assessments and reviews are essential to good decision making and the provision of effective services both to the person subject to compulsion, and to their family. This is particularly relevant in relation to new powers to issue compulsory treatment orders for people living in their own homes. Assessments and reviews under the Bill must take into account the strengths and vulnerabilities of a patient, their family and their community. A purely clinical assessment of the patient alone cannot achieve this.

Barnardo’s believe that where a family member is being assessed for compulsory treatment under the Bill, the assessment should include a social work element which takes into account the views, experiences and feelings of children and young people in the family. This could be achieved by having a clearly multidisciplinary assessment process and retaining the social work emphasis of the Approved Social Worker role in the new role of the Approved Mental Health Professional.

*Family Support under s17 Children Act 1989*

“Before my mum went into hospital, it felt like we were hiding and keeping the situation in our family, locked away. When she went into hospital, it was like an explosion. There were lots of people around us. I felt frustrated and confused.”

Barnardo’s believes that children and young people whose family members are subject to compulsion may well be in need of support for themselves and their families. We feel that where a family member is being assessed for compulsory treatment under the Bill, consideration should be given to initiating an assessment under s17 of the Children Act 1989; a “child in need” assessment. At a minimum, we feel assessment under s17 is essential where a community treatment order is under consideration.

**WHAT BARNARDO’S WOULD LIKE TO SEE**

— A CAMHS chapter in the Bill.

Barnardo’s feels that the Bill should be restructured to insert a chapter dealing specifically with children and young people both as patients, and as young carers. Not only will this enable drafting to reflect the specific needs and vulnerabilities of children and young people, it will also support integration of mental health legislation with the Children Act 1989, and enable mental healthcare providers to deliver on their new duties under s11 of the 2004 Act.

— Integration of the Draft Bill and the Children Act 1989 for child patients.

Barnardo’s believes that vulnerable children and young people will be best served by a system that integrates the expertise and support that health and social care services offer. We would like to see the Draft Bill amended to require parallel assessment and care planning processes under the Draft Bill and the Children Act 1989.

— Integration of the Draft Bill and the Children Act 1989 for young carers.

Barnardo’s believes that where a family member is assessed under the Draft Bill, consideration should be given to whether a parallel assessment under the Children Act 1989 would be of benefit to the family. An assessment under s17 should always take place where non-residential treatment is under consideration.

Historically, the divide between mental health services and social care has meant that many vulnerable children, young people and families have been left without support, have been subject to inappropriate interventions, or have simply been unable to get services to work together to provide the services they need. The passage of the Children Act 2004 and the publication of the Draft Mental Health Bill offers an opportunity to bridge this divide, and create a multidisciplinary model of care that will lead to better outcomes for children in contact with mental health services.
ADDITIONAL EVIDENCE ON YOUNG CARERS

Barnardo’s works with hundreds of young carers across the UK, many of whom care for parents or family members with mental health problems. We believe that the families these children and young people are part of can be positive, nurturing environments, and that parents with mental health support needs can be excellent parents.

In 2001, the Census identified 149,942 young carers in England and Wales. Studies suggest that nearly a third of these children and young people are caring for a family member, commonly a parent, with mental health problems.18 Caring for a family member with mental health problems can place enormous strain on children and young people and is associated with lower attainment at school, poor physical health, and risk to the long term mental health of the child or young person in question. Barnardo’s feels it is absolutely essential that young carers have access to age appropriate information, advice and support and that the family as a whole can access services that help them to thrive. The Draft Mental Health Bill 2004 presents an excellent opportunity to secure these aims.

CHILDREN ACT 2004

The Children Act 2004 makes it clear that children’s welfare is everyone’s business. S11 imposes a new duty on, amongst others, Strategic Health Authorities, Special Health Authorities, Primary Care Trusts, NHS Trusts and Foundation Trusts to have regard to the need to “safeguard children and promote their welfare” when they are discharging their normal functions:

“Exercise of this duty will require agencies that come into contact with children to recognise that their needs are not always the same as adults ie that they are children, and vulnerable, as well as being patients, offenders, or people who use local amenities.”

Explanatory Notes to the Children Act 2004

There is an urgent need to review the Draft Mental Health Bill 2004 against this requirement to have regard to children’s safeguarding and welfare, particularly as it applies to young carers. As the Bill stands, there is a risk that children and young people will either be left with no rights and safeguards at all, or with an inappropriate range of rights and responsibilities under the new legislation.

DEFINITION OF “CARER” USED IN THE BILL

The definition of “carer” is set out at clause 301(1):

“carer” means a person who:

(a) provides or intends to provide a substantial amount of care to the patient on a regular basis;
(b) does or intends to do or did so otherwise than;
   (a) by virtue of a contract of employment;
   (b) as a volunteer for a voluntary organisation; and
(c) has indicated that he wishes to be considered for the purposes of the Act as a carer of the patient.

There is no age threshold placed on the definition of “carer” in the Draft Bill. The explanatory notes indicate that “carer” should be read as consistent with s1 of the Carers and Disabled Children Act 2000, which restricts the “carer” to “individuals aged 16 or over”, but this threshold is not apparent on the face of the Draft Bill.

As a consequence children and young people who provide a substantial amount of care to a family member will potentially be able to exercise the full range of rights afforded to “carers” under the Draft Bill. This would apply both to the relatively small numbers of children and young people who are sole carers, and to the far larger numbers of children and young people who provide support alongside other family members.

The rights accorded to carers under the Draft Bill include, but are not limited to:

— the right to request an assessment cl14(1); explanatory notes state that “normally” the person requesting an assessment “would be a carer”;
— the right to be consulted about assessment cl14(2)(b), care plans cl31(4)(d), community or residential orders cl14(6)( c ).

This range of rights is restricted in the Draft Bill by a requirement that the patient’s “wishes and feelings” be taken into account cl12(2) and a power to exercise discretion about carer involvement cl12(4). Despite these safeguards, this remains a deeply unsatisfactory statutory framework for supporting families and ensuring that children and young people are safeguarded. Under the Bill, children and young people will either have the full range of carers’ rights, or no rights at all.

No child or young person should be left in a situation where they are forced to request an assessment of a parent or carer; the potential damage to family relationships is incalculable. At the same time, all children and young people need age appropriate information about their family member’s illness and treatment, whether they qualify as a “carer” or not, and assessment for compulsory treatment can only be meaningful where it takes into account the circumstances of the whole family.

**WHAT BARNARDO’S WOULD LIKE TO SEE**

---

**A CAMHS chapter in the Bill**

Barnardo’s feels that the Bill should be restructured to insert a chapter dealing specifically with children and young people both as patients, and as young carers. Not only will this enable drafting to reflect the specific needs and vulnerabilities of children and young people, it will also support integration of mental health legislation with the Children Act 1989, and enable mental healthcare providers to deliver on their new duties under s11 of the 2004 Act.

---

**Clarity of definition**

The definition of carer in the Bill must be clarified to ensure that children and young people are not left in a position where they are expected to exercise a wide range of rights that may ultimately damage both their well being and their family relationships. Barnardo’s would like to see the definition of “carer” restricted to over 16s, in line with the Carers and Disabled Children Act 2000. We would also like to see additional safeguards for 16 and 17 year olds designed to ensure that they are not forced to take on this statutory role as a result of isolation and lack of support. Alongside this, we feel all children and young people whose family members are subject to compulsion should have rights to information, family focused assessments and family support.

---

**A right to information**

“I feel as if I had more information about my mum’s illness at the time, it wouldn’t have been so difficult for me. I might have understood why she cried so much and why she said and did such strange things. I might not have worried so much that I would become like her”

Barnardo’s believes that children and young people need a statutory right to age appropriate information about their family members’ illness, treatment and care needs. A right to information is an essential component of supporting children and young people to understand and cope with their experiences. These rights to information shouldn’t be contingent on a child or young person meeting the definition of carer in the Draft Bill, or any other definition of carer.

---

**Family focused assessment and reviews**

“Two people arrived and sat by my mum and dad. They did not introduce themselves to me even though I was in the same room. I heard them talking about my mum. It was as if I was invisible. I was glad when they went.”

Family focused assessments and reviews are essential to good decision making and the provision of effective services both to the person subject to compulsion, and to their family. This is particularly relevant in relation to new powers to issue compulsory treatment orders for people living in their own homes. Assessments and reviews under the Bill must take into account the strengths and vulnerabilities of a patient, their family and their community. A purely clinical assessment of the patient alone cannot achieve this.

Barnardo’s believe that where a family member is being assessed for compulsory treatment under the Bill, the assessment should include a social work element which takes into account the views, experiences and feelings of children and young people in the family. This could be achieved by having a clearly multidisciplinary assessment process and retaining the social work emphasis of the Approved Social Worker role in the new role of the Approved Mental Health Professional. A holistic assessment of the family would enable professionals to identify children and young people who have significant caring responsibilities and ensure that these children are offered the support that they need.

---

**Family Support**

“Before my mum went into hospital, it felt like we were hiding and keeping the situation in our family, locked away. When she went into hospital, it was like an explosion. There were lots of people around us. I felt frustrated and confused.”

---

Barnardo’s believes that children and young people whose family members are subject to compulsion may well be in need of support for themselves and their families. We feel that where a family member is being assessed for compulsory treatment, consideration should be given to initiating an assessment under s17 of the Children Act 1989; a “child in need” assessment. At a minimum, we feel assessment under s17 is essential where a community treatment order is under consideration.

The passage of the Children Act 2004 and the publication of the Draft Mental Health Bill provide a clear opportunity to bridge the divide between child and family support and mental health services, moving towards a system that offers continuity of care for families, rather than fragmented interventions that target individuals. Barnardo’s hopes that the Committee will feel able to recommend changes the Draft Bill to secure this continuity of care and protection for all children and young people who live in families touched by mental distress.

ADDITIONAL EVIDENCE ON MENTAL HEALTH TRIBUNALS

Barnardo’s welcomes the enhanced role of the Tribunal in the Draft Bill as an important step towards protecting children and young people in inpatient settings and ensuring they are able to access the quality of care they need. However, it is difficult to see how a Tribunal will be able to make robust, child-centred judgements about the suitability of compulsory treatment, the content of care plans, or appropriate discharge without specialist knowledge of children and young people’s development. Without a specialist member, the extra safeguards inherent in the proposals for the new Mental Health Tribunals (MHTs) will not be equally extended to children and young people. Barnardo’s would like the Committee to recommend an amendment to the Draft Bill requiring all Mental Health Tribunals considering the care and treatment of minors to sit with two members, one of which should have specialist experience of child development from a health or social care perspective.

TRIBUNALS UNDER THE DRAFT BILL

The Tribunal system set out in the Draft Bill envisages a far broader role for the MHT than is currently performed by the Mental Health Review Tribunal in relation to patients detained under the Mental Health Act 1983. In addition, some children who are inpatients but not detained under the Act (cl207 “qualifying patients”) will also have recourse to the MHT.

Both as regards orders for assessment and for treatment, the Tribunal is charged with determining:

- Whether the “relevant conditions” for compulsion are met cl 45(2).
- Whether a person needs further assessment, or whether a treatment order is appropriate cl 45(5), cl 45(6) et seqq.
- Whether the care plan is appropriate cl 46(2), including the issue of resident versus non resident treatment cl 46(4).
- With non-resident orders, what the conditions of the order might be, and what is necessary to protect the health and safety of the patient “or other persons” cl 46(6).
- Where discharge from an order is appropriate cl 56.
- Where a patient should be placed on a non-resident order.
- Where a deferred discharge is necessary because “no plan has been prepared. . . .of the post discharge services to be available” and this is likely to lead to a relapse in the two months post discharge cl 63(2).
- Whether to authorise ECT for use on under 16s cl 186(3).

For children and young people qualifying for extra safeguards under clause 207 the Tribunal role includes:

- Approval of care plans for qualifying patients that are not approved by the medical expert cl 211(6);
- Permission to refuse a request for a care plan review cl 216(2);
- Approval of a request for a care plan review where the clinical supervisor has refused cl 216(4);
- Dispute resolution re: care plan reviews cl 217;
- Applications for discharge cl 218.

Children and young people are not adults in miniature; they may express serious mental distress in a way that is very different from an adult, equally they may express everyday emotions in a way that appears extreme when judged against an adult standard. In addition to this, many children and young people in contact with mental health services have experienced trauma and deprivation, which renders the task of identifying a “normal” response far more complex for someone without specialist knowledge or experience.
CONSTITUTION OF THE MHT

The MHT will consist of a President and “other members” as appointed by the Lord Chancellor (cl 4 and schedule 2). The qualifications for the President are to be set out in rules by the Lord Chancellor, qualifications for other members are as follows:

- “legal members” must have seven years PQE;
- “clinical members” must have “knowledge or experience of the treatment of mentally disordered persons”;
- “other persons” must have “knowledge or experience of the provision of mental health services”.

Panels will be selected by the President, and can include 1, 2 or 3 members; where a single member panel sits, it must be a legal member.

Decisions about treatment regimes, care plans and discharge have a significant and often long-term impact on the lives and life chances of children and young people; the Tribunal in the Draft Bill might leave a mental health lawyer with sole responsibility for making these decisions without the benefit of any contextual knowledge of child development, the range of social support available or the extent to which children and young people can be resilient. Research into children’s representation in public law proceedings indicates that lawyers commonly feel ill-equipped to work with children and young people as clients; there is no reason to suppose that even the most eminent of mental health lawyers will feel any more confident dealing with distressed children and young people at Tribunal.

This need to ensure multidisciplinary membership in light of the expanded role of the Tribunal was clearly identified by Sir Michael Leggatt in his review of the Tribunal system:

> “These new responsibilities could scarcely be carried out by a body which does not include someone with medical qualifications. We therefore welcome the move away from the consultation suggestion of a single-person tribunal, and the proposal that the MHT should include a member with a clinical background”.

In practice, the structure of the new Tribunal is designed to allow discretion for the President to set up multiple member panels where appropriate. To impose a statutory duty to include a child specialist where a Tribunal is considering the care or treatment of a minor would be simply to acknowledge that this is an instance where such multiple membership is always appropriate.

As it stands, the draft bill already requires specialist expertise where the applicant is a restricted patient (Schedule 2, cl 4(6)) in recognition of the particular challenges presented. Cases involving children and young people are no less challenging, and children and young people deserve no less protection. The number of cases involved is comparable, even taking into account the additional number of children and young people qualifying for safeguards under cl 207:

- During 1999–2001 1,082 children and young people were detained under the 1983 Act.
- During the same time period, more than 1,469 patients were detained under the Act subject to restrictions.

WHAT BARNARDO’S WOULD LIKE TO SEE

- Specialist Tribunal members for children’s cases

Barnardo’s believes that the Draft Bill should be amended to insert a statutory requirement that Tribunals considering the care and treatment of minors must include at least two members, one of whom should have expertise in child development either from a health or social care perspective. The President of the Tribunal should further stipulate that the legal member in such cases should have expertise in public law as it relates to children, in addition to mental health law.

- Training in child development and child protection for Tribunal members

Barnardo’s would like the duty placed on the President of the Tribunal to ensure appropriate training for members’ clause 6 of schedule 2 to include a specific requirement that all Tribunal members are given basic training in child development and child protection.

---

23 Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation in England 1993–94 to 2003–2004, Department of Health, HMSO, Statistical Bulletin SB 69/2004. Admission of patients to mental health facilities (including patients detained under the Mental Health Act 1983, Statistical Directorate, National Assembly for Wales. Neither set of figures covers patients detained under s46 of the Act, who are also subject to restrictions on discharge.
The extended remit of the Mental Health Tribunal in the Draft Bill has the potential to ensure that more children and young people in inpatient settings are able to secure their rights and access appropriate treatment and aftercare. However, this additional protection will be illusory unless Tribunal composition reflects the expertise necessary for making good quality, child-focused decisions. Barnardo’s asks the Committee to recommend the Draft Bill be amended, creating a Tribunal capable of offering equality of service to the vulnerable children and young people who come before it.

Nancy Kelley
Principal Policy Officer

January 2005
Wednesday 8 December 2004

Members present:

Barker B.
Lord Carlile of Berriew, L. (Chairman)
Carter, L.
Cumberlege, B.
Eccles of Moulton, B.
Finlay of Llandaff, B.
Mayhew of Twysden, L.
McIntosh of Hudnall, B.
Murphy, B.
Pitkeathley, B.
Rix, L.

Witnesses: Professor Nigel Eastman, Consultant Forensic Psychiatrist and Professor of Law and Ethics in Psychiatry and Professor Tony Maden, Professor of Forensic Psychiatry, examined.

Q455 Chairman: We are extremely grateful to you, Professor Eastman and Professor Maden for coming. Your reputations have travelled here well ahead of you. Could I just remind you formally that this is a public evidence session and that you will have the opportunity to make textual corrections to the transcript, but only textual. A transcript will be produced and be available on the internet after about one week. Although this room looks as though it has a very good microphone and loudspeaker system, it does help if all witnesses speak up rather clearly, please. We have a session which is targeted to run until about 10.35, quite a short session. I would ask you, if you would please, simply to identify yourselves and if you are willing then to go straight to questions. If you would like to make very short introductions then please feel free to do so, though, of course, this is intended to be a question and answer session rather than a paper session. Professor Eastman, do you want to introduce yourself?

Professor Eastman: I am Nigel Eastman. I am Professor of Law and Ethics in Psychiatry at the University of London. I am Head of Forensic Psychiatry at St George's Hospital Medical School and I am a consultant forensic psychiatrist in the National Health Service working in medium security for about 50% of my time, I also have community patients. I should declare, perhaps, also, two other things. One is that I am Chair of the Law Committee of the Royal College of Psychiatrists, and that Committee was responsible for drafting the White Paper response and the first draft Bill response but not this Bill response. Also I should say that I was co-chair of a think tank that the Department of Health funded and sponsored pre-Richardson, that was with Dr Jill Peay of the LSE, and that was published as a book.

Q456 Chairman: Thank you very much. Professor Maden?

Professor Maden: I am Tony Maden, I am Professor of Forensic Psychiatry at Imperial College and the Clinical Director of the Dangerous and Severe Personality Disorder Service within West London Mental Health Trust.

Q457 Chairman: Thank you very much. Can I start by asking you if in your respective views there are significant differences between the draft Bill's proposals for dealing with mentally ill persons concerned in criminal proceedings and current provisions for that group of people under the 1983 Act?

Professor Eastman: We have agreed how we will do this, so I will go first on this one. It has been implied that there are not many differences and that it looks much like the existing Act. I do not agree with that, I think there are substantial differences which reflect the overall tenor of the Bill in Part 2 but actually go beyond the tenor of Part 2. The good news is that certainly the College and I think that it is simpler than the present arrangements and so in terms of process and procedure I think it is better. However, all of the Part 3 Orders are, I note, based on very, very loose criteria, even looser than those in Part 2 of the Bill. All they require essentially is that it is appropriate that the person have medical treatment, that it is warranted, and that treatment is available. If I am invited, I will say what I think about that but, in summary, I think it is far too broad, it is even broader than in Part 2. Of course the treatability criterion for personality disorders, psychopathic disorder and mental impairment have gone by virtue of a common definition of mental disorder. Secondly, there is no section 38, which is the Interim Hospital Order. I think that is a loss for reasons which I will explain, if people ask me. Of course, treatment is very broadly defined in this Act, as it was in the 1983 Act, and I note particularly the GMC's response to this, which is that it argues that what is being suggested is not really medical treatment in some regards, in terms of education and training. There is also no risk or health criterion for discharge from a restricted Mental Health Order, as it would be, as there is under the current Act for a restricted Hospital Order. There is the extension of the use of the Hospital and Limitation Direction, which is now the Hospital Direction, to all people with mental disorder. I think that presents some opportunities but many dangers. Of course, as a doctor you cannot recommend a Hospital
Direction, you can only recommend a Mental Health Order and then the judge decides not to follow that and go elsewhere. I have nearly come to the end of my list. I am interested to note that the Restriction Order evidence can be from a clinical supervisor, although in relation to making the basic order that has to be recommended by two medical practitioners. Finally, of course, the courts determine the care plan initially, about which I had grave reservations, and linked to that I think there is absolutely no logic to the Home Office retaining its power over the transfer of patients between different hospitals and different hospital units when the core of the care plan which the tribunal operates is the location of the care plan. In summary, those are my readings of the differences between the 1983 Act and the proposed Bill.

Q458 Chairman: If I can only very slightly caricature the views presented to us by one chief constable, they are that the provisions of this Bill would give him a welcome opportunity to take dangerous people off the streets, whether they had committed criminal offences or not. Do you think that is a caricature of the Bill? If it is not, do you think it is acceptable for that to be the effect of the Bill? 

Professor Eastman: I think, with respect, that goes beyond Part 3 of the Bill and I was dealing just with Part 3 where there is a conviction or a magistrates court, they think the person has done it. However, I think the caricature is largely correct. My own approach to mental health law is that there should be as much congruence with common medical law as is possible and therefore as much separation as possible from criminal justice provisions. I think that, if you broaden discussion out to the issue of civil detention, which, I think, is what perhaps the officer has in mind, then clearly the extraordinary broadening of the criteria within Part 2, combined with a lack of exclusions and the lack of discretion to apply orders, both for the clinicians and the tribunal, I think, not only invite it, they almost infer it automatically.

Q459 Chairman: Can I just return to something you said about care plans being in the hands of the court. You expressed a strong antipathetic view towards that proposal, could you just give a main reason for expressing that view so it is on the record?

Professor Eastman: Because my experience of courts, with all due respect to senior judges, is that they have relatively little exposure, infrequent exposure, to the detail of treatment. They simply accept recommendations or not, that there should be a hospital disposal. The detail they are not usually interested, in or experienced sufficiently to adjudicate on, even with expert assistance. By comparison the tribunal is a very different animal. That is the reason, combined with the fact that there is not even a duty for the judge to consult an expert from the Panel.

Q460 Chairman: My final question on this is do you think that a sentencing court ought to be required rather than permitted to appoint a member of the Expert Panel to report if the court is considering a Hospital Order?

Professor Eastman: I think I have just answered that and the answer in my view is yes.

Chairman: Thank you. That is very clear.

Q461 Baroness Murphy: This follows well, because I think Professor Eastman you have touched on this already. Reviewing previous Government proposals, both of you have suggested that the inclusion of public protection issues in mental health legislation is problematic. Professor Maden, I am going to quote you, if I may, “a new and coherent strategy for high risk individuals led by the criminal justice system, with psychiatry in a secondary supporting role” is what you are calling for. I wonder if you can tell us more about how you see the proposals in the draft Bill playing into your concerns on that?

Professor Maden: I think the proposals in the draft Bill do not meet my concerns but in a sense one could ask why should they? After all it is mental health legislation which is meant to set out circumstances in which compulsory treatment may be appropriate, it is not meant to be a complete strategy for dealing with dangerous people. I think the concerns are well illustrated by the chief constable quoted earlier. I think there are unrealistic expectations on some sides. Mental health services will not be solving the chief constable’s problem of dealing with dangerous people and I would suggest that as a chief constable that is his primary responsibility. I think, if one was to put in dangerous mentally disordered people, then we would be closer to being able to work together. I think the risk with the draft Bill as it stands is that it takes away a lot of the existing barriers or gatekeeping functions that the old Mental Health Act allowed. On the one hand, that is a good thing and I support the broader remit without strict exclusions, for example, untreatable personality disorder, addictions, drug and alcohol problems; on the other hand, if that gatekeeping function goes, what is going to be put in its place? I have seen no sensible discussion within the Department of Health of how the mental health services will guard against the wholesale transfer of prisoners, for example—most of whom have a mental disorder—straight into health service beds. Now that is not going to happen but the way in which it is not going to happen is not at all clear at the moment. I know that goes beyond the draft legislation but it is an important contextual concern.

Q462 Baroness Murphy: Picking that up, if I may follow up, you have both written in other papers about the wrong profession being asked to take on the wrong role?

Professor Maden: That is correct. If one looks at this in an international context, we are probably the only country that sees mental health services as
taking the lead in dealing with psychopathy, dangerous severe personality disorder. I am not sure that we are right and all the others are wrong.

Professor Maden: Yes.

Q465 Chairman: Professor Maden, I would just remind the Committee that in a very recent ministerial answer in the House of Commons it was said, if my memory serves me correctly that 90% of prisoners have some kind of mental disorder.

Professor Maden: That is correct. I think this is an extremely difficult area but a crucial distinction is between mentally ill and mentally disordered. I think that a lot of the confusion arises when people blur those categories.

Q466 Dr Stoate: You used the term mentally disordered.

Professor Maden: I did say mentally disordered, that is correct. The mental disorder, of which we are talking, is personality disorder or psychopathy most commonly and the problem is that the definition, for example, of anti-social personality disorder in the DSM American classification is virtually synonymous with habitual criminality, and it is not satisfactory. People tend to proceed when they are doing research, such as the ONS study in prison, as if “Oh, well, we know it is not entirely satisfactory but we will do our best” and I think that leads potentially to some very misleading results and conclusions. The step I would like not to follow is that because a person is both dangerous and suffers from a mental disorder then the lead in their management should necessarily be taken by mental health services. It may be that as in most countries the lead for dangerous people with psychopathy is taken primarily by the criminal justice system with mental health in a willing, enthusiastic, supportive role but nevertheless supporting the criminal justice system. The difficulty often is that those mental disorders do not respond readily or rapidly to treatment. The problem in simple terms is that, once you have taken them into the hospital, how do you ever get them out because the same risk indicators that led you to admit them in the first place will still be there five or 10 years later. The nature of psychopathy and the gold standard for measuring psychopathy is that it does not change so the same psychopathy score that results in your admission will still be present 20 years later and that poses a massive dilemma for a health service operating primarily on the basis of risk in its release decisions.

Professor Eastman: Could I add that within the 90% there is a group of mentally ill people who do not need to be in hospital. They are the equivalent of those in the community who are treated by primary care or secondary care, if you like, within the home which is the prison so you have both groups of people who do not need to be in hospital.

Q467 Ms Munn: I just want to raise some issues around the whole concept of treatability which may have led to a view that it was not helpful for it to be in the Bill. Three things. Firstly, treatability, whether somebody can be deemed to be treatable or not, has been or could be or may have been used for a reason for mental health services not to work
with somebody, that is the first issue. Secondly, our knowledge and understanding of mental health generally changes, what might be deemed to not have been treatable 20 years ago might be treatable now or might be treatable in 20 years’ time. Thirdly, this whole issue about personality disorder. It is a long time since I had any experience of working very close to mental health services but people said, “A personality disorder by definition is not treatable, therefore these people are not our concern” and, again, that issue linked back round to is it just another reason not to work with somebody who has some needs in that area?

Professor Maden: In my view treatability has to go as a criterion for whether compulsion could be used within mental health services because I believe it has been used in the way that you describe to refuse effectively to offer services of any sort. Psychiatrists grossly misuse the treatability criterion in the 1983 Act, in order not to provide even voluntary consensual services to people with that diagnosis, so it has to go. That is not to say that problems do not follow from removing it. As to the question of whether treatment has improved, the situation is that now we know more about the use of psychological treatments to reduce risk of offending behaviour in sexual and violent offenders. I think I am quoting the Zito Trust evidence, it is now well established that cognitive behavioural treatment can reduce risk in sexual and violent offenders, and that includes a lot of offenders with personality disorder. Having said that, so far it has not been established that that same treatment can be effective in people with established psychopathy so the severe end of the spectrum. The jury is still out on that I guess but, if I was asked to say “yes” or “no” today, I would say that no, those techniques on present evidence do not produce the same reduction of risk in the most severe personality disorder offenders. In a way that treatment of violence and offending risk fits very poorly within a mental health model because the most seriously ill people, the most seriously disordered people are least likely to benefit from the psychological intervention. It seems to me the way forward would be in the use of powers of compulsion more widely for people with personality disorder to establish compliance within services but not necessarily admission to hospital.

Q468 Chairman: Can I just interpret that. Does that mean that you are in favour quite strongly of the compulsory community option?

Professor Maden: Within the Bill in general?

Q469 Chairman: Yes.

Professor Maden: Absolutely, I think it is the single most important positive element.

Q470 Chairman: I am glad I asked you that question because you have given a very clear answer to it.

Professor Maden: And it will have massive ramifications for the management of mentally disordered offenders who are not subject to restriction orders at the moment where the lack of compulsory community treatment delays their discharge and in future the ability to impose the discharge will allow them to move through the system more quickly.

Q471 Baroness McIntosh of Hudnall: I think some of what I want to ask has been clarified by the answers to Ms Munn’s questions. Could I be absolutely clear about one thing. You have made a distinction between mental illness and mental disorder. Would I be right in thinking that all those who suffer from mental illness to some extent exhibit mental disorder but that not everybody who has a mental disorder is mentally ill? Would that be a fair summary of how you make that distinction?

Professor Maden: That is correct, and I apologise on behalf of psychiatry for the confusing terminology. It is convention to regard everybody with any diagnosis at all as mentally disordered, and that includes the two main groups for these purposes of the mentally ill and those with a personality disorder. Some mentally ill people have a personality disorder as well.

Q472 Baroness McIntosh of Hudnall: Yes. I think this is rather an important bit of clarification because I want to ask you whether the Bill sufficiently makes it clear what the distinctions are between different kinds of mental disorder as you have now elucidated them?

Professor Maden: It seems to me that the Bill deliberately opts out from that and says we are not going to say anything about mental disorder but leave it to the professionals to sort out, and that includes professionals within mental health and within criminal justice. There is ahead a massive—battle may be the wrong word—heated discussion and argument to be had within the profession if it remains as it is because it is asking the professionals to sort out a lot of very difficult issues that certainly they have not sorted out yet.

Q473 Baroness McIntosh of Hudnall: Do you think that the Bill can be amended in its current form so as to unpack some of that and make it less subject to interpretation at a later stage by professionals?

Professor Maden: Certainly it would be desirable that there should be some guidance.

Baroness McIntosh of Hudnall: Desirable it unquestionably would be but is it possible?

Q474 Chairman: You are not a legislator are you?

Professor Maden: Yes.

Q475 Chairman: I can rescue you from a very difficult question, not that you need rescuing.

Professor Maden: In fact one of my guiding principles is not to step outside the area—

Q476 Chairman: It does raise an issue about the problem of the Committee not knowing what is in the Code of Practice because it does not exist yet. Professor Eastman?
**Professor Eastman:** I take your point but I think the problem is not in the definition of mental disorder, it is in the lack of exclusion clauses and the lack of tight gateways thereafter. I would not tinker with the mental disorder bit, I would do something to the rest of it. Can I just say one thing generally about the code which the Chairman just referred to. I believe there is a presumption on the part of the Department of Health, even the Home Office, that sensible people, be they clinicians or tribunal members, will behave sensibly and that there will be a sort of values-based approach to it. You may have heard this term already. I think that is inadequate because I think you need legal constraints and sufficient legal definitions in order to restrict the way in which the Act is used. My Lord Chairman, I will be stopped if I should not go on, but I would like to give an answer to the question about treatability because my answer is rather different from Professor Maden’s. I think the first thing about treatability is that it depends what you mean by treatment and treatability. I think Professor Maden and I may have a slightly different notion of treatability because I would not equate it with the reduction of offending behaviour, and he will tell me if I have got his view wrong. That is the first point. The second point is that I think therapeutic benefit to the individual is of crucial importance in terms of protecting the boundary of what is the business of mental health professionals. I am not at all against protecting the public, of course not, but it must be in conjunction with some benefit to the individual that goes beyond simply stopping them offending. If you adopt a definition of treatability which is simply the reduction of risk or the avoidance of offending, that means that locking somebody up is treating them; I would not adopt that approach. The final thing I would say in relation to the issue of developing science, if I can put it that way, is I absolutely accept, and I am very encouraged, by the work that is being done in this area in relation to personality disorder. However, as Professor Maden has acknowledged, firstly, it is pretty early, secondly, is it general to PD and, thirdly, is it going to work with the highest risk people and are you not going to end up with the snake pits that I am so concerned about, if you like, of untreatable people there in hospital long term? The point I would make finally in this bit is that I think you should have law that follows science, in other words you create the law once you have the science, you do not hope you are going to get the science and create the law to match it.

**Chairman:** That is the common complaint about the 1983 Act, is it not, amongst clinicians, that the medical concepts and the legal concepts are so far from one another.

**Q477 Mrs Browning:** Could I bring you back to the first question that was asked here and the point Baroness Murphy made about Professor Maden’s statement and the need for a strategy with the criminal justice system in the lead then supported by psychiatry. I have concern in trying to square that with the fact that, quite rightly, it has been said that a lot of the detail in this Bill was triggered by two particular cases, the Stone case and the Clunis case. If that is the case then how would what is presented to us here fit in with what Professor Maden has said is his objective with his strategy? I cannot see that it would have been the criminal justice system in the lead in either of those two cases in identifying what might have happened with those two individuals and how they would present and then psychiatry coming in afterwards. If you had future cases like that, it would surely be psychiatry that would be in the lead in identifying them and the criminal justice system coming in secondly. I cannot quite square how what is in this Bill is in any way going to present or identify such cases in the future if the lead is taken by the criminal justice system?

**Professor Maden:** I think it is difficult to work too much on those two examples because my own view would be that, irrespective of changes in legislation, the Clunis scenario would be most unlikely to happen again because of the changes such as the care programme approach et cetera. I am not sure that the problem with either Clunis or Stone was the legislation. I should add further that I have never seen an inquiry into the Stone case and I am not sure that there were inadequacies in Stone’s management. Obviously it had a terrible outcome but personally I have never seen an inquiry that described the inadequacies in Stone’s case.

**Q478 Chairman:** The Stone case is still subject to litigation in the courts.

**Professor Maden:** That is correct and I think a homicide inquiry was conducted but has not been published. There is a lot of gossip in the mental health community about what it says.

**Q479 Chairman:** I do not think we should speculate.

**Professor Maden:** Precisely not.

**Q480 Chairman:** For the reason I have just given, if you do not mind terribly.

**Professor Maden:** I would not accept that either of those cases necessarily reflected inadequacies in mental health legislation, firstly, and therefore it would be a bad test of the draft Bill to ask whether or not it would have solved those two problems because I do not think they were due to inadequacies in the law in the first place. Secondly, in cases such as Michael Stone, the reality is that most of their dealings with mental health services are through the criminal justice system. Essentially that was the role of mental health services in that case, it was largely working in support of the criminal justice system, but that could have been done better. I do think that in the cases of people who are personality disordered, it is unrealistic simply in terms of numbers. If 70, 80, 90% of prisoners have a personality disorder, we are never going to have a situation where the health service is able to meet that kind of chronic, intense demand. I think one of the important deficiencies from all the documents I have seen is any discussion of how the
health service will meet the new demand that results from removing the treatability criterion from personality disorder.

Q481 Mrs Browning: Could I just pick that up. Did you say 70 to 80% of prisoners have a personality disorder as opposed to a general mental health problem?

Professor Maden: Yes, because the definition is virtually synonymous with criminality. If you encounter them in court you would call them common criminals; if you encounter them in the psychiatric clinic, you would call them people with a personality disorder.

Q482 Chairman: 70 to 80% is at the lower end of the estimates.

Professor Maden: That is correct. I should say, in the original survey by John Gunn and I did of the prison system we did not bother to count personality disorder because we knew the answer before we started. We knew that there was no way the health service was going to take on that burden, so what was the point of going to the trouble of counting it.

Lord Carter: Continuing on the theme of risk, which you have mentioned: in 1999 the Home Office called for the development of new and better models for assessing risk in psychiatric patients and offenders. How are patients currently assessed for risk and have there been significant improvements in the methods used in recent years? In other words, have the Home Office proposals of 1999 had any effect?

Q483 Chairman: Can I ask Professor Eastman if he would like to deal with that first and then anything hanging over from the previous set of questions.

Professor Eastman: We agreed that Professor Maden would do this one first but I will go first, partly because he works in the vicinity he does work in. I think we have dealt with this to some extent already but essentially it seems to me that what has changed, and is changing, is the introduction of what are called actuarial methods, which are methods of assessment of individuals based on populations. These have certain strengths against clinical methods which, of course, are based on the individual. However, I think my concern would be that there is over-reliance, particularly amongst legislators, upon what can be hoped for, or expected, from actuarial methods, because they have substantial weaknesses in relation to the individual and to the type of clinical variables that doctors and other mental health professionals are concerned with when they are trying to manage risk. I would be very cautious, I would say that things are improving and I would be the first to say they have not been good enough in the past. But I think it would be wrong to put great store by substantial improvements in risk assessment being on the horizon, so to speak. Can I just add one other thing which is—and I apologise for this phrase—there is a phrase “positive predictive value”, which is about of the people you predict are going to do something, how many of them go on to do it? Underlying this, and looking at risk assessment tools in relation to this, are issues of sensitivity and specificity: is the tool sensitive in picking people up and how specific is it in picking up the right people? Now I will not go into stats but you have to have very high sensitivity and specificity in order not to end up locking up a huge number of people to stop one event, and the reason for that is because the base rate of serious violence is very low, and that is the nub of it. Shall I go back to the other question? I think the answer to the Member’s question about Stone and Clunis is this: I largely agree with Professor Maden, I think they are slightly different types of cases. I think that in relation to Clunis, there was a paper by Rumgay and Monroe in the British Journal of Psychiatry about five years ago which looked at a whole series of homicide inquiries, took their findings at face value and found that in only a very small percentage of cases was it thought that the event could have been predicted. However, in quite a high proportion, over 60%, they thought it could have been prevented within existing legislation, and could have been prevented by earlier intervention. It is about services, it is not about prediction. Now, I think that is particularly relevant to Clunis. In relation to Stone, I think that the important issue to lay on the table, if you like, is the criminal justice system’s use of the discretionary life sentence, or lack of use of it. I gave evidence to the Home Affairs Select Committee in relation to the DSPD proposals some years ago now, and in front of me Mr Boateng said the problem is that judges will not make enough life sentences. In fact, the Home Office’s own paper at that time said that the judges made a life sentence on 2% of occasions when they could make a life sentence, including in relation to people with personality disorder. That rather starkly, if you like, puts the issue. What I said to the Select Committee then, which was rather incautious of me, was that lots of psychiatrists and other mental health professionals in hospitals were saying that the Government essentially were saying “We cannot get the judges to roll over, so let’s get the shrinks to roll over”.

Q484 Lord Carter: If we continue with the actuarial point that you have made, the Mental Health Alliance argue that there is no reliable way of assessing risk for people who have committed no offence and that, statistically, it would be necessary to detain between 2,000 and 5,000 people unnecessarily in order to prevent one single homicide. Is that right?

Professor Eastman: I think it depends what you are concerned with when they are trying to manage risk. I would be very cautious, I would say that things are improving and I would be the first to say they have not been good enough in the past. But I think it would be wrong to put great store by substantial improvements in risk assessment being on the horizon, so to speak. Can I just add one other thing which is—and I apologise for this phrase—there is a phrase “positive predictive value”, which is about of the people you predict are going to do something, how many of them go on to do it? Underlying this, and looking at risk assessment tools in relation to this, are issues of sensitivity and specificity: is the tool sensitive in picking people up and how specific is it in picking up the right people? Now I will not go into stats but you have to have very high sensitivity and specificity in order not to end up locking up a huge number of people to stop one event, and the reason for that is because the base rate of serious violence is very low, and that is the nub of it. Shall I go back to the other question? I think the answer to the Member’s question about Stone and Clunis is this: I largely agree with Professor Maden, I think they are slightly different types of cases. I think that in relation to Clunis, there was a paper by Rumgay and Monroe in the British Journal of Psychiatry about five years ago which looked at a whole series of homicide inquiries, took their findings at face value and found that in only a very small percentage of cases was it thought that the event could have been predicted. However, in quite a high proportion, over 60%, they thought it could have been prevented within existing legislation, and could have been prevented by earlier intervention. It is about services, it is not about prediction. Now, I think that is particularly relevant to Clunis. In relation to Stone, I think that the important issue to lay on the table, if you like, is the criminal justice system’s use of the discretionary life sentence, or lack of use of it. I gave evidence to the Home Affairs Select Committee in relation to the DSPD proposals some years ago now, and in front of me Mr Boateng said the problem is that judges will not make enough life sentences. In fact, the Home Office’s own paper at that time said that the judges made a life sentence on 2% of occasions when they could make a life sentence, including in relation to people with personality disorder. That rather starkly, if you like, puts the issue. What I said to the Select Committee then, which was rather incautious of me, was that lots of psychiatrists and other mental health professionals in hospitals were saying that the Government essentially were saying “We cannot get the judges to roll over, so let’s get the shrinks to roll over”.

Q484 Lord Carter: If we continue with the actuarial point that you have made, the Mental Health Alliance argue that there is no reliable way of assessing risk for people who have committed no offence and that, statistically, it would be necessary to detain between 2,000 and 5,000 people unnecessarily in order to prevent one single homicide. Is that right?

Professor Eastman: I think it depends what you think of the stats of the tests or the methods, and I have said something about that already. You can play with them but you would have to have far higher stats, if you like, for the tools, better tools than I think we have got, and I will be interested in the list of questions for today talked about risk assessment tools being significant. I would say “Are
they adequate?” and “Are they adequate in public policy terms, in terms of locking people up to stop events?”. 

Q485 Lord Carter: Is it not correct that the number of cases of homicide committed by mentally ill people who have been released from treatment is much less than the number of murders which are committed by murderers who have been released and kill for a second time?

Professor Eastman: I do not know that statistic but I would believe it. I will say one other thing which is that there was a good paper by John Gunn and others, I forget whom, two or three years ago, which demonstrated that there has been no increase in the number of homicides committed by the mentally disordered.

Chairman: If you will allow us, Professor Maden, I am going to take a couple more questions from Members and then ask you if you would do a wind up on this section.

Mr Howarth: We have talked about the degrees of risk and how to assess them and so on, it seems to me from the public’s point of view there are two kinds of risks that we are talking about. There is the risk, predictable or otherwise, that somebody might go on and do something very violent, obviously including killing somebody. There is the risk, also, that somebody might, by their behaviour, target somebody and make their life an absolute misery. In those sorts of cases, how do you weight the importance of that in terms of how they should be dealt with?

Chairman: Can we have Lady Barker’s question and then will we return to you, Professor Maden?

Q486 Baroness Barker: Returning a little bit for a moment to the actuarial methods, can you tell us some of the assumptions that are included in the actuarial methods? In your opinion, does that in any way reflect the over-representation of some minority populations in mental health services?

Professor Maden: I suppose I am known, certainly by my detractors, as the country’s foremost enthusiast for risk assessment with a degree of standardisation but I would disagree slightly with Nigel. The current state of the science is that the best way of looking at risk is by structured clinical judgment. It very firmly says that actuarial methods are not the best way of looking at risk. What we know about the statistics ought to inform clinical judgment but it ought not to replace it in any way. I think the findings on that are absolutely unequivocal, that structured clinical judgment is where it is at risk assessment, you need to know the actuarial background but the actuarial stuff is not better. Yes, if you look at things in actuarial terms in a very straight forward way, the fact of being of Afro-Caribbean origin is statistically associated with over-representation amongst violent offenders ergo the man who walks through your door, if he is Afro-Caribbean origin, is at high risk of violence. It is not nonsense, it is dangerous nonsense and we should not subscribe to it. If I could return to the risk assessment, I think it has improved tremendously over the last 10 or 15 years and within general psychiatric services there has been a transformation of the general approach to risk to the point where one would say that at the moment general psychiatric services probably have too much concern.

Q487 Chairman: Would that include the kinds of issues that Mr Howarth was referring to?

Professor Maden: I have not forgotten the question. I will come back to it shortly. I think the main element of that risk assessment is not so much in the technicalities of the business but a simple awareness that things can go wrong and we ought to think about the circumstances in which they may go wrong and we ought to plan for the unexpected. That was missing from mental health services at the time of Clunis to a degree which was irresponsible; it is no longer missing. Some services spend a lot of time thinking about what may go wrong in terms of risk and they spend a lot of time planning for it. We could still do more because what we have not done is to adopt some of the procedures for structured clinical judgment that are commonplace in Canada. HCR 20 is the main one, it is used in some forensic units in this country but in my view it is not used enough in forensic services to support our clinical judgment. There have been big improvements and we are heading in the right direction. The question from Mr Howarth was a good one because it points up the complex nature of risk. We are not dealing with a single dimension in which you can say the risk is 60%, we are dealing with, on the one hand, the risk of homicide and on the other hand, the risk of harassment, and on another you may be dealing with less serious categories of violence. The task of the professional faced with risk assessment is to take into account all those risks and to formulate a management plan and which cannot be reduced to a unified scale of “This is a high risk person therefore you have to do this”.

Q488 Mr Howarth: Some of the patient groups that we have talked to have taken the view that those sorts of cases where there has been harassment, violence or even worse should be dealt with in the criminal justice system and that mental health considerations should be quite separate. The word that was used was because somebody commits a crime, it is “stigmatising” them to deal with them as a mental health issue and some have even gone so far as to say that they would rather have a prison sentence than treatment. How do you feel about that?
**Professor Maden:** I do not think it is an either/or situation. I think the general assumption must be that when people break the law, the law takes its course and that the disposal at the end of that process may well be influenced by whether there is mental disorder. Leaving aside trivial offences and diversion at an early stage there, I think in general it is not an either/or question. Mental health professionals ought to work more with the criminal justice system but mental health services are not a substitute for the criminal justice system. They cannot do that job of examining and testing the evidence and determining guilt and giving a very public statement of what has happened in the case of that the criminal justice system is designed to do.

**Professor Eastman:** Could I say Psychiatrists are not a predictive substitute for the criminal justice system, whilst clearly, if an offence has been committed, the person can be charged. I do think that one should take account of psychological damage, not just physical damage, in assessing the risk the patient poses and determining detention or compulsion on that basis. The difficulty with this Bill is that it goes beyond all of that and suggests that mental health professionals can predict a whole range of events before they happen, as Professor Maden has described. I have to say I largely agree with almost everything he has said, not everything he has said but the last few remarks.

**Q489 Lord Rix:** Mine is a two part question but as both parts concern treatability I think they do go together. The Royal College of Psychiatrists has recommended that the inclusion of a criterion of “impaired decision making” on the grounds of mental disorder. What would the implications of such a criterion be for the application of the Bill to patients with Dangerous Severe Personality Disorders who up to now have been considered untreatable? The second part of my question is as learning disability is considered to be untreatable, should it also be considered a mental disorder or sometimes Asperger’s Syndrome can be associated with a learning disability problem in that it has to be recognised that learning disability is considered to be untreatable, should it also be considered a mental disorder or should it be excluded in the putative list which is favoured by Professor Eastman unless there is an allied mental illness? Would not impaired decision making sweep the majority of people with a learning disability within the curtailage of this draft Bill?

**Professor Eastman:** I will take the first point first. Impaired decision-making is a softer concept than incapacity. It includes evaluative disorder, if you like, not just cognitive disorder, so it includes the effects of depression, for example. It is also the case that the threshold, even for the finding of incapacity through the courts, has been lowered substantially over various cases so, for example, Ian Brady was found to lack the capacity to refuse feeding, and he had a personality disorder. It seems to me therefore that there is not a necessary conclusion that people with severe personality disorder retain capacity. Some may; some may not. The second point relating to that, I suppose, is that, of course, a finding of incapacity does not mean to say you have to treat it. It is the gateway into treating without consent if there is then therapeutic benefit. As regards the learning disability issue, my latter point becomes relevant again, because just because you find that somebody lacks capacity, and a learning disabled person may or may not lack capacity, that does not mean to say you therefore have to intervene and override. Indeed, the Mental Health Bill is not based on the assumption that you lack capacity therefore you intervene and override. I think I would approach Lord Rix’s question in that sort of way. Perhaps I can add a general comment, which is that the difficulty with learning disability is that there is quite properly a wish to normalise the lives of people with learning disabled conditions, and I absolutely approve of that. The question then becomes, if their normality is going to be prison is that still the right normality? There I start to have some difficulty in relation to moderately severe learning disability because I start to worry about humane disposal and so on. I think there is a difficult issue there.

**Q490 Mrs Browning:** My question is very similar to Lord Rix’s but specifically focuses on the interpretation of this in respect of, for example, people with a diagnosis of Asperger’s Syndrome, rather a different grouping of people who might well (and already do) fall foul very often of misunderstanding by psychiatrists in terms of their ability to make decisions, not necessarily because they cannot but because of the nature of their communication disorder at the time, particularly at a time of stress. I just wonder whether I could ask you whether you have any concern about whether that particular grouping of people with an AS diagnosis would fall foul of a mis-diagnosis of personality disorder.

**Professor Maden:** That certainly is possible. There is a real diagnostic issue about some types of personality disorder overlapping with Asperger’s Syndrome, so it is not a straightforward matter. The risk criterion would hopefully deal with that problem in that it has to be recognised that sometimes Asperger’s Syndrome can be associated with a very high risk of violence to others, partly because there is a lack of empathy. That is rare within the condition but it does occur, and certainly one encounters within high security hospitals more than the normal representation of people with Asperger’s Syndrome because of their dangerous behaviour. I think the draft bill deals with that issue by insisting on the risk criterion for detention.

**Professor Eastman:** I think there is a problem with it though, because the risk criteria are set at incredibly low levels. For many it is protection of others, but from what and at what level and how likely and so on? But even for the so-called dangerous group, where there is supposed to be a substantial risk of serious harm, I am not convinced it is that high a threshold. The Chairman will correct me if I am wrong but from my own experience of the courts and decisions on what “substantial” means, it simply means “having substance and more than trivial”. Therefore, “a substantial risk of serious harm” means a bit of risk of serious harm. I think there is a real issue about catching all sorts of people, including people with
Asperger’s, within this bill by virtue of this extraordinarily low threshold, and the lack of exclusions, the lack of a therapeutic benefit test and so on, which relates also to Lord Rix’s question about learning disability.

Q491 Mrs Browning: Could I add a caveat to that because, although there will be behaviour management treatments, there is no cure, of course, for the underlying condition of Asperger’s Syndrome, and therefore I can see that that grouping could well fall foul of this legislation in a way that was not intended?

Professor Eastman: Neither is there a cure for personality disorder and yet this Bill is substantially dominated by the concept of personality disorder. I would even say that this is a Bill where the DSPD tail is wagging the general mental health dog. Mrs Browning: That is very helpful. Thank you.

Chairman: One of you talked about therapeutic intervention as opposed to cure in an earlier remark and perhaps we should bear that phrase in mind. There is a quite separate but important issue I would now like to deal with.

Q492 Baroness Eccles of Moulton: This question relates to the use of civil powers for preventative detention. Quite a lot of what is contained within it has already been touched on. If it is not going to be too confusing could I possibly ask the main question first but, before you answer, refer to something in the preamble which I think might be quite helpful to have a view on for the very sharp request for your view in the main question? The main question is that the Mental Health Act Commission among others have raised concerns about the potential use of civil powers for the preventative non-therapeutic detention of patients judged to be at risk of causing harm to others. The specific question is, in your view when is it justified to use civil powers of compulsion in this way? If I may could I refer back to the quote from the Law Society which says that various homicide inquiries overwhelmingly show that it is a lack of resources, information and communication that causes care and treatment to break down in such a way as to increase the likelihood of a tragedy? The question there is, obviously, if those resources and information and communication could be greatly increased, which is a question of general resources within the service, would this possibly affect the degree to which compulsion would be needed in the community?

Professor Eastman: I referred the committee to the paper by Munroe and Rumgay which looked at homicide inquiries and found essentially what you are saying and what the Law Society is saying. I actually think that the marginal contribution of law to national mental health, and even to public protection, is very small indeed potentially. It is all about services. The reason why the Government hopes that there is a way of predicting who is going to be risky is that it is cheaper than preventing it by virtue of therapeutic intervention which breaks the chain of causation. It is not that you can predict if somebody is going to kill somebody; it is that you intervene for their mental health care, and one out of goodness knows how many would have gone on to kill but you have intervened. That is my answer to that question.

Q493 Chairman: That is one of the most concealed Exocet missiles I have ever come across, if I may say so, Professor Eastman, but you have waited an hour to deliver that.

Professor Eastman: I only just thought of it. The answer to the formal question 4 on our list, which we agreed that I would deal with first of all is that, in my view, you should never use civil powers for preventive detention where there is no therapeutic benefit. Here I do have something I prepared earlier, so to speak. My reasons for this are first because you should have respect for ethical principle and the separation of mental health care from criminal justice. I have said this already but it is a means of protecting not just professionals but also future patients, because if you contaminate mental health professional activities, eventually it will have a knock-on effect with future patients. Secondly, I think it is unworkable, because you cannot predict who is going to do it. You would have to lock up lots of people—and which risk are we talking about?—and we have been through a lot of that already. It is also the case that if somebody is untreatable, if there is no therapeutic benefit, hospital is the wrong place for them. There are people who are untreatable and who are dangerous and who are on a life sentence in prisons, and prisons are very good at dealing with people who are of that sort. It is also unworkable because if you cannot change the risk, it is unworkable in that sense, and you end up with the snake pit I have already described. One of the major issues though is that what it will do is frighten patients away from services, and I know you have had this said to you by quite a lot of people, because I have read some of the transcripts. What that point lights up is that this Bill, and the whole process of reform, are driven by the wrong model. They are driven by the individual case scenario model rather than by what I would call the public health model. The public health model, which is how the rest of medicine thinks, if you like, is: look at aggregates; look at the whole population of patients and potential patients, the whole of services, see how they operate, and have services, and in this case the law relating to services, designed with regard to all of that. If, for example, it is the case that you have, let us call it, somewhat draconian wide powers and they would have stopped Fred from killing Freda on Friday, that is great, but it is useless if it has an aggregate effect that is the reverse. The College’s evidence, for example, I think, is that this is not only unworkable law, because of the resources; it is also ineffective law, or likely to be ineffective law, because it will not deliver what the Government wants it to deliver, for that sort of reason.
Q494 Baroness Eccles of Moulton: Do you think there are any useful recommendations we could make which would mean that the lack of resources as referred to by the Law Society could be practically enhanced?

Professor Eastman: That is a huge question. This is a sneaky response first of all, but one of the difficulties is that the more compulsion you have, the less restriction on compulsion you have, the less pressure there is on services to produce proper services. If you did not have a Mental Health Act, if you had to persuade people into psychiatric hospitals, would we have the sorts of hospitals we currently have with the sorts of resources we have? I suspect not. The same must apply when you think about community treatment orders and so on. It is a huge question because it is a political question: how do you encourage government to put more resources into something which is still a Cinderella service? I think it will become even more of a Cinderella service under this bill because what it will do is pull psychiatry further away from the rest of general medicine than it is already and, if you like, stigmatise the practice of psychiatry (in the case of my discipline of medicine) and it will have an overall long-term bad effect in those terms.

Q495 Lord Carter: To be absolutely clear, if you have a person who is untreatable but who has a condition in which there is evidence that other people with that condition have been violent in the past, are you saying you would only be able to deal with that with extra resources?

Professor Eastman: I think that, if you had somebody under the present Act who was like that, the treatability test under the present Act, interpreted in a case called In Reid and the Secretary of State for Scotland in the House of Lords, is such a low treatability test already that, in the vast majority of cases the power exists in law to detain in hospital somebody of the type you are describing. I think somebody of that sort would be detained. And I agree with Professor Maden: I think we have moved a long way since Clunis. In a sense this Bill is almost anachronistic because it reflects an era we hopefully have moved on from.

Q496 Chairman: Out of courtesy to the next group of witnesses we must move on. Do you want to say something finally, Professor Maden?

Professor Maden: I think this is the only point on which Nigel and I really do disagree. I think that certainly the use of civil powers for preventive detention of patients judged to be a risk is justified when the risk is high enough. I think psychiatry has always done it in the case of people with mental illness without thinking. One would not ask the question if a dangerous schizophrenic patient were before one whether this was one of the 10% who was resistant to treatment. One would detain them to prevent risk to others. There is a lot of discussion around how one decides on that risk but the principle that one must in some circumstances detain people, even though at we do not know how to treat them, because of risk to others is entirely sound and has always been followed by psychiatrists.

Chairman: You will be aware that the oral evidence sessions are only a part of our deliberations and we have had a great deal of written evidence on these issues. We are extremely grateful to you both for coming and giving us such valuable evidence today. You have admirably concentrated, if I may say, volumes of opinions in a very short time and that is just what we were looking for. Thank you both very much.

Memorandum from Revolving Doors Agency (DMH 324)

INTRODUCTION

This document is the consultation response to the Draft Mental Health Bill 2004 (the Bill) from Revolving Doors Agency. Revolving Doors Agency is a member of the Mental Health Alliance.

THE AGENCY

Revolving Doors Agency works with people who are in crisis. Our clients have mental health problems and have come into contact with the criminal justice system—generally through arrest or imprisonment. The Agency offers practical and emotional support to this client group through its Link Worker Schemes. The schemes help clients engage with support services to resolve problems such as homelessness, poverty and drug addiction which contribute to their offending behaviour.

What we learn from our practice is shared with other charities, Government and local service providers. Our research into the client group, carried out in conjunction with partners such as the London School of Economics and the Institute of Psychiatry, demonstrates levels of social exclusion among this group and effective ways of helping them. This approach enables us to link policy, practice and research in order to highlight client need and an appropriate response.
CONSULTATION RESPONSE

1. Increasing Crime—Inadvertent Consequence?

Section 2(5) provides a very broad definition of “mental disorder”. Such a definition will allow many Revolving Doors clients to be diagnosed with a recognized “mental disorder”, who are currently excluded. For example, one third of Revolving Doors clients are assessed by Link Workers as having a yet undiagnosed personality disorder. Most of these clients would now fall within the section 2(5) definition of “mental disorder”. This move is welcomed. However, the broad definition of section 2(5) does not address the separate problem that many Revolving Doors’ clients face gaining access to appropriate mental health services. While section 9(3) provides that the conditions for examination and assessment include this requirement in the form that such action is necessary for the protection of the patient or others from suicide, self-harm or serious neglect, there is no comparable requirement under section 116. This may have the inadvertent consequence of suggesting that committing a criminal offence is the quickest and most effective way to gain access to mental health services.

93% of Revolving Doors clients were in contact with no services, when referred to one of our Link Worker Schemes, despite the fact that 34% of referrals need to see a GP; 23% were sleeping rough; and 99% were unemployed. All Revolving Doors clients suffer from some form of mental illness, whether diagnosed or undiagnosed. With this reality in mind, throwing a brick through a police station window, for example, may seem a shortcut route to assessment and examination and, potentially, treatment. Desperate clients should not be led to feel that committing a criminal offence is the only way to draw attention to their mental health problems. Providing a positive right to assessment and examination in the community would avoid this problem.

2. Mental Health Orders: Discrimination

Article 6, European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) provides everyone with a right to a fair trial and Article 7, ECHR provides that no one shall be found to be punished for an act or an omission with is not an offence in law. Under section 114(2), to be eligible as the subject of a Mental Health Order, the court need only establish that the person did the “act or omission constituting the offence” and, therefore, the court does not establish whether the defendant had the mental element (mens rea) for the offence. With the exception of strict liability offences, not establishing the mental component of the offence prevents the founding of the defendant’s guilt. Following Article 6(2), ECHR, the defendant is presumed innocent until proved guilty and, therefore, cannot be held to be criminally responsible for the offence.

Despite the fact that the defendant is not found criminally responsible, the conditions for compulsory mental health treatment applied under Part 3 are less rigorous than those applied to patients who have not been charged with an offence (contrast s116 and s9). In s116, all of the provisions in section 9(4) relating to risk to self or others are absent. We favour that the same criteria should be applied throughout the Bill as in Part 2, Chapter 1, section 9. As neither those falling within Part 2 nor Part 3 have been found guilty of an offence, any difference in criteria for compulsory treatment seems to lack rationale and be a potential breach of human rights law.

A further point of discrimination may be found in a comparison of the application procedures for a medical treatment order (section 39) and a mental health order (section 115). Under section 39(5), the obligations placed on the applying clinician to give reasons for his recommendations are much more extensive than those demanded by section 115. Section 39(6) demands that the applying clinician must consult the patient (his parents, if under 16), his nominated person and carer. There are no comparable obligations under section 115, providing a wholly unsatisfactory level of patient involvement in the process.

3. Applications to Mental Health Tribunals and the Courts—Part 3

We welcome the increased use of Mental Health Tribunals in Part 2. However, under Schedule 2, section 4, panels can comprise only one person which, when combined with the increased powers of those tribunals, places a heavy burden of responsibility on that individual which may be vulnerable to abuse or weak judgment.

Under Part 3, the court makes the decisions regarding assessments, examination and treatment. Following section 86(4), the court may require a clinician to prepare a mental health report. It is not an obligation. Neither is preparing a risk assessment [section 86(5)]. We are concerned that there is limited scope for the role of a mental health professional under this arrangement. Revolving Doors recommends

3 p 41.
4 p 46.
that a court should be obliged to hear the evidence of a multi-agency panel of mental health experts. This would allow a comprehensive appraisal of the patient’s needs to be made and enable the court to reach a fully informed conclusion.

4. **Community Sentence Framework**

   As the patient is not found criminally responsible by the court, no conviction or sentence are imposed. Consequently, it is logical that those subject to section 120(1)(b) cannot be given a community sentence while on a mental health order. However, the new Community Sentence Framework (Custody Plus/Minus—Part 12, Criminal Justice Act, 2003) has been designed to ensure that vulnerable people who would currently be imprisoned and released without condition, are awarded a sentence with a short prison sentence followed by community-based support. This is intended to ensure that offenders are linked into community services on release. There is a need to ensure that the more holistic service provision approach provided under the Community Sentence Framework is not denied to those subject to a mental health order. For this reason, it must be clearly specified in the Bill or accompanying Code that a non-resident Mental Health Order is to be enforced by the Community Mental Health Teams.

5. **“Impracticable”**

   A general point of concern is the use of the language of practicality. It is highly subjective and poses a series of difficulties for the agencies that will be working with the patients—eg section 228(1)(c) “Urgent Removal to a Place of Safety”. In addition, the use of subjective language provides an inadequate defense for the human rights of the patient, particularly Article 5 of the ECHR—eg Section 11 where the mental health professional does not have to consult with the parents of a patient aged under 16 if “it would be impracticable to do so”. Clear minimum standards must be included in the Codes of Practice to ensure that the human rights of patients are protected.

6. **Advocacy**

   Much valuable work has been done with our client group through advocates and arrest referral teams based in police stations. Where a police station or psychiatric hospital is a “place of safety”, we suggest that specialist mental health advocacy provisions are available on arrival.

   Also, the Mental Health Alliance estimates that 2,000 people are currently involved in advocacy work for this client group. The Bill makes provision for 140. We are concerned that this is an unrealistic figure to cover England and Wales and more resources should be dedicated to ensuring this is an effective service. The Bill could also make provision for minimum standards of training for advocates.

   **December 2004**

---

**Memorandum from the Zito Trust (DMH 174)**

**INTRODUCTION**

1. The Zito Trust is a mental health charity which was established in 1994 following the publication of the independent inquiry into the care and treatment of Christopher Clunis, who killed Jonathan Zito in 1992. The Trust’s principal activity is to provide a support and advice service to victims or potential victims of mentally disordered offenders, particularly in cases of homicide or violent assault. The information obtained from this service informs the Trust’s lobbying and research activities. A number of books and reports have been published over the years reflecting the Trust’s concerns about the implementation and delivery of community care services to the severely mentally ill/disordered. The Trust has also commissioned academic and clinical research into the relationship between mental disorder and violence. Monthly bulletins are posted on the Trust’s website (www.zitotrust.co.uk) which record cases, inquiries and incidents reported in national and local media. The Zito Trust was founded by Jayne Zito OBE (Patron) and Michael Howlett (Director).

2. The Zito Trust supports the Governments proposals contained in the new Draft Mental Health Bill and in doing so will focus this memorandum on the following three discrete areas:
   - the rights of victims of mentally disordered offenders;
   - services for people with severe personality disorders; and
   - non-compliance with treatment in the community.
VICTIMS OF MENTALLY DISORDERED OFFENDERS

3. Primary victims of mentally disordered offenders (MDOs) are those who have been killed, attacked, threatened or who are at risk. Secondary victims are those who have been bereaved by a homicide, or otherwise affected as family members or relatives. Currently victims of MDOs do not have the rights enjoyed by victims of prisoners regarding simple information concerning the date of release from prison and any conditions attached etc. Measures contained in the Domestic Violence Crime and Victims Bill will address this anomaly and extend similar rights to victims of restricted patients only. The Zito Trust asks that these rights be extended to all victims of violent and sexual offences, regardless of whether a restriction order has been applied.

4. There are currently no provisions in the Draft Mental Health Bill which would provide a structured system to engage victims proactively with a view to reducing risk. The word “victim” is not mentioned anywhere in the draft Bill.

5. There should be a statutory duty on professionals working with MDOs to liaise with victims or potential victims in order to improve their assessment of the risk of harm. If the MDO’s previous history discloses an identifiable, future victim who might be at risk by the clinical decision-making process, that victim should be consulted and informed during the process. Currently, the defence used for not engaging the victim at all is patient confidentiality and the public interest criterion for breaching patient confidentiality is rarely applied. “Patient confidentiality”, “public interest” and “need-to-know” are urgently in need of statutory clarification. The new Mental Health Tribunals should also have a duty to take evidence from identifiable and interested victims or potential victims when considering applications for discharge by MDOs. The tribunals should be obliged to keep all parties informed about proceedings and to allow victims legal representation and to have victim impact statements treated confidentially, if desired.

6. NHS Mental Health Trusts and PCTs providing mental health services should be required by new legislation to appoint named advocates responsible for assessing the needs and concerns of victims and potential victims, and to ensure that multi-disciplinary teams responsible for care planning have this information made available to them. These appointments could be made in the same way a patient’s keyworker is allocated.

7. Where physical or verbal threats have been made by an individual to a member of the public, the relevant mental health trust or PCT should be required by law to inform the victim or potential victim whether the individual is a patient undergoing psychiatric care and, if so, what further action will be taken. In cases of homicide the MDO should forego all rights to withhold consent to the disclosure of information to proper and interested parties, such as inquiry panels.

SERVICES FOR PEOPLE WITH SEVERE PERSONALITY DISORDERS

8. The Trust believes the proposed new definition of mental disorder is appropriate and will permit NHS services to be provided for patients with personality disorders who have hitherto been denied them under the current treatability criterion. The purpose of treatment with this core group should be to reduce the risk of offending and to reduce recidivism, and this purpose should be made explicit. Until we can provide effective interventions for the very young to prevent the onset of conduct disorders in adolescence, we must provide services to those who are regularly legally classified as having psychopathic disorder, who most often have a criminal history, and who are told they are untreatable.

9. The Government’s proposals will affect only those who are at serious risk of suicide, self-neglect or harm to others and only where treatment is clinically appropriate. While inevitably many mental health trusts will say they have no clinically appropriate services for this group of patients, the development and progress so far of the D&SPD Programme (Dangerous and Severe Personality Disorder) at four pilot sites indicate that treatments are available and effective, particularly cognitive behavioural therapy (CBT), in reducing risk and recidivism. As Maden et al state in their article in The Journal of Forensic Psychiatry and Psychology (Vol 15 No 3 September 2004 375–390): “The empirical evidence on CBT is now so advanced that, as well as knowing that it is effective, we have estimates of just how effective it is in a range of offenders.” The authors quote outcome data which demonstrate reduction of sexual and violent recidivism by approximately 50% following short courses of CBT. It is expected that the multi-disciplinary teams working with this group of patients will be led by new clinical supervisors who are not necessarily psychiatrists. Given general psychiatry’s unwillingness to engage with these patients, this new development is to be welcomed.

It is essential, in our view, that we do not lose the opportunity to provide the legislative framework for the treatment of severe personality disorders as they have treatment needs which should be met.

NON-COMPLIANCE WITH TREATMENT IN THE COMMUNITY

10. In its 2001 report Safety First, The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) published the following key findings:

— About 25% of all suicides in the UK have been in contact with mental health services in the year before death. This represents about 1,500 cases per annum. About 20% of these suicide victims were non-compliant with medication in the month before death.
— Around a third of all perpetrators of homicide have a diagnosis of mental disorder based on life history. Nine per cent of all perpetrators in England and Wales have been in contact with mental health services in the year before the offence. Sixteen per cent of these recent contact cases had been discharged from psychiatric inpatient care within three months of the offence. Almost 25% of the recent contact cases were non-compliant with drug treatment in the month before the offence.

These figures refer to cases where the outcome is tragic. In the majority of cases dealt with by The Zito Trust, where there has been a breakdown in community care services, non-compliance with medication (often in conjunction with alcohol and/or street-drug abuse) is the most common feature. The Trust believes that the Government’s proposals for treatment and care under compulsion will address many of the problems posed by non-compliance and that they strike the right balance between patients’ rights and public safety.

**Conclusion**

11. Since the publication of the Clunis inquiry in 1994, there have been over 150 independent inquiries into homicides committed by people in contact with mental health services. Many of the findings are familiar: the breakdown in communication between agencies; poor risk assessment; non-compliance with medication; the absence of NHS services for personality disorders, and little or no face-to-face contact with individuals in the community. The number of suicides already referred to should cause policy-makers and critics great concern. In addition there are the unquantifiable and unreported cases involving people whose lives are made miserable by systemic faults in the provision of health and social services. The Zito Trust believes that mental health legislation needs to reflect the complexities of the modern era where the principal focus is on caring for vulnerable people with a wide range of different needs in the community. Contrary to some critics of the Government’s intentions, The Zito Trust believes the principles enshrined in the new Draft Mental Health Bill are directed at keeping people out of hospital for as long as possible, but which necessarily include powers and measures to deal with problems before they become crises. It is in this respect that we believe the Government has delivered on its promise to balance the rights of the patient with the safety of the public.

October 2004

**Memorandum from Nacro (DMH 156)**

**Summary**

Nacro welcomes:
— The new definition of mental disorder.
— The conditions set for the provision of compulsory treatment.
— The provisions for assessment in non-residential settings.
— The decision not to introduce compulsory treatment in prison.

Nacro remains concerned about:
— The over-emphasis on compulsion.
— The mechanism for dealing with “high risk” patients.
— The complexity of the Bill.
— The proposals relating to the provision of ECT.
— The apparent lack of appreciation of the major increase in resources required, without which the Bill will be unworkable.

Our full response follows.

**Nacro’s response to the Call for Evidence by the Joint Committee on the Draft Mental Health Bill**

**Introduction**

1. Nacro, the crime reduction charity, is dedicated to making society safer. Nacro believes that responses to offenders with mental health problems should focus on their care and treatment, rather than punishment, while recognising that there can be difficulties in balancing the needs of the individual and safeguarding the interests of the community.

2. Nacro’s Mental Health Unit has been working with national and local agencies in this field since 1990. Our evidence to the Joint Committee reflects our interest in the overlap between mental health and criminal justice issues. We have concentrated on responding to the questions set out by the Joint Committee, where relevant to our concerns. As background, we attach our response to the 2002 Draft Mental Health Bill.
Question 1

3. Nacro welcomes the grounding of the Draft Bill on general principles to underpin the provisions of the new legislation, and endorses the basis for those principles as set out in Clause 1.

Question 2

4. Nacro favours the new broader definition of mental disorder. We believe that for many practitioners, such as those working in the criminal justice system, it will be easier to understand. From our work, we are aware that many criminal justice practitioners believe that the exclusions in the 1983 Act are invoked to exclude “difficult people” from services. The broader definition and removal of the exclusions may result in improving access to services for mentally disordered offenders (MDOs).

5. We endorse the raising of the threshold of risk to self and are generally satisfied that the “relevant conditions” for compulsory care and treatment are set at a sufficiently high level to avoid unnecessary compulsion. We see no justification, however, for the exception in Clause 9(7), relating to those considered a substantial risk to others. The assessment process in relation to all patients will involve determining whether they would comply with treatment voluntarily, for the purposes of the fourth condition, and in all cases it will be necessary to consider the whole picture. The inclusion of the exception appears to be an artificial mechanism for attempting to deal with a particular category of “high risk” patients. Such patients must still satisfy the other conditions in order for compulsory powers to be imposed and we think the exclusion clause is likely to lead to confusion in the application of the conditions or to a two-tier assessment process. We do not think concerns relating to provisions for “high risk” patients, which were expressed in response to the 2002 Bill, have been adequately addressed.

6. We welcome the provisions which will allow some patients (both offenders and non-offenders) to undergo assessment in non-residential settings in the community, rather than in hospital. We hope that the provisions allowing remand on bail for the preparation of reports will reduce the use of remands in custody by the courts. We would, however, favour the inclusion in the Draft Bill of criteria governing whether assessment in the community should be permitted, rather than the proposal to define categories of patients in regulations (Clause 15(2)). At present, the basis on which patients will be deemed suitable for assessment in the community remains unclear.

7. We particularly welcome the decision not to introduce the use of compulsory treatment in prison. We understand this position could change if the standard of healthcare in prisons became comparable to that in the community. However, we regard prison as a wholly inappropriate environment for the provision of compulsory treatment and would remain opposed to such a change.

8. We remain unconvinced by the arguments in favour of compulsory treatment in the community. According to the launch of the Draft Bill on 8 September, the measure is intended to deal primarily with “revolving doors” patients. Such patients frequently lead chaotic lifestyles and need the support of services which can work with them on an intensive basis, such as the Revolving Doors Link Worker scheme. Service models, such as assertive outreach, prison in-reach and crisis teams, have made a real difference, enabling MDOs and patients in the community to engage with services on a voluntary basis. Where such approaches are unsuccessful and a patient’s condition deteriorates to the point where compulsory treatment becomes necessary, it will not be possible for treatment to be provided without recourse to a return to hospital. We appreciate the merits of making the process of returning patients to hospital less cumbersome. However, we think the emphasis should be on ensuring that intensive services are the norm in all areas, rather than, as at present, only patchily available and inadequate to meet demand. If such resources were in place, the need for compulsory treatment would be likely to be substantially reduced.

Question 3

9. We welcome the improved safeguards for patients but remain concerned that there is an over-emphasis on compulsion and “high risk” patients, which perpetuates the myth that mentally disordered people are dangerous when, in reality, only a tiny minority could be so categorised.

Question 4

10. The Draft Bill remains extremely complex and difficult to follow, which is likely to make implementation problematic. Whether the proposals will be workable in practice will depend primarily on two factors. The Code of Practice will need to be drafted in a clear and straightforward manner, making clear what needs to be done, and by whom, to implement the new provisions. Also the proposals in the Bill will require considerable additional resources both in terms of services to support the provisions for compulsory assessment and treatment and in terms of personnel and support for the vastly increased role of the Tribunal. We believe the resources required for the Tribunal have been grossly underestimated and this could throw the viability of the Bill into jeopardy.

5 http://www.revolving-doors.co.uk/link_worker.asp
Question 6

11. We welcome the increased focus on legal rights and protection for children and young people. We think that, where children and young people are to be treated on a compulsory basis, or as “qualifying patients”, it is crucial that their care should be supervised by a specialist in child and adolescent mental health. We think regulations should stipulate that only in exceptional circumstances would it be acceptable for a non-specialist to supervise a young person’s care. Resources must be provided to ensure a sufficiency of appropriately trained and experienced clinicians and mental health professionals.

12. Professional opinion about the use and efficacy of ECT is divided. It is not universally accepted that its use is advantageous. We do not believe that ECT should ever be given to patients capable of consenting, without their consent. The patient’s autonomy and right to consent should be respected and emergency grounds should not be used as a means of overriding a patient’s will where consent has already been refused. Where patients lack capacity, ECT should only be given where this has been authorised by the Tribunal (or the High Court), even in an emergency. The assessment of whether a patient satisfies any of the emergency conditions is a matter of clinical judgment and not one on which all professionals would agree. It is not, therefore, justifiable to remove the safeguard of authorisation by an independent body.

Question 7

13. As indicated above (paragraph 6), we think the criteria governing whether assessment and/or treatment is to be provided in the community should be included in the Bill, rather than by way of categories of patients defined in regulations. In other respects, we think the balance between what is contained in the Bill and what will be included in the Code and in regulations is about right.

Question 9

14. We have reservations about compatibility with the Human Rights Act in relation to the power allowing police to enter premises without a warrant and the provisions for “high risk” patients.

Question 10

15. In our view (see paragraphs 10 and 11), the proposals in the Bill have major implications in terms of human and financial resources. Shortages of personnel and resources already exist, especially in psychiatry and in the availability of community services, such as outreach teams. In some areas, patients have to wait a considerable time before they can be assigned to an appropriate team. This has adverse repercussions for patients awaiting discharge from hospital and for patients struggling in the community with inadequate support. It can lead to decisions which are resource, rather than needs, driven. We know of areas where assessments are delayed, pending identification of a bed, and we are concerned that lack of resources in terms of in-patient facilities, may result in an inappropriate and under-resourced use of compulsory treatment in the community, rather than in hospital.

16. The Bill’s proposals will add a considerable burden to existing demands. The Government’s estimates of increases in professional staff do not appear to be realistic or to take account of drop-out rates, part-time working and retirement. More thought needs to be given to recruitment and retention of staff across the range of relevant disciplines.

Nacro’s response to the Draft Mental Health Bill published June 2002

INTRODUCTION

Nacro welcomes the opportunity to participate in the process aimed at producing a new Mental Health Act. The existing Act (the Mental Health Act 1983) has proved a generally sound piece of legislation. However, it was designed for a time when hospital-based care and treatment were the norm in the psychiatric services and, since this is no longer the case, it is long overdue for reform. Over the last decade, the focus of psychiatric services has moved increasingly towards community-based services and patient centred issues, such as capacity, and new legislation is needed to reflect these major changes.

In responding to the Draft Bill, Nacro’s particular concern is with how the proposed legislation would serve mentally disordered offenders (MDOs). Various studies and surveys over the last decade or so have shown that a significant proportion of both remand and sentenced prisoners are mentally disordered, while the number of offenders who are recognised as being mentally disordered before or while they are being dealt with by the courts has also risen. The way in which the legislation impacts on this section of the population is therefore, in our view, of considerable importance.

Our response to the Draft Bill is in three main parts. First, we set out our general comments on the Draft Bill and the consultation process. In the second part, we respond to the points in the Consultation Document accompanying the Draft Bill. We have not attempted to respond to all the consultation points but have reserved our comments for those points which we believe are particularly relevant to MDOs. In the third part, we set out our views in relation to specific matters in the Draft Bill where these have not already been covered in earlier comments.
GENERAL COMMENTS

Process

We have a number of general concerns about the Draft Bill, the first of which relates to the consultation process. The initial review of the Mental Health Act undertaken by the Expert Committee chaired by Professor Genevra Richardson was subjected to considerable pressure to achieve completion within a short timescale. Having done so, the Expert Committee’s Report was published in November 1999, alongside the Green Paper Reform of the Mental Health Act 1983—Proposals for Consultation. Despite that initial urgency, the White Paper Reforming the Mental Health Act did not appear until December 2000 and it has taken a further two and a half years for the Draft Bill to be produced.

Notwithstanding this protracted process, consultation on the Draft Bill is now again subject to unseemly haste. The Draft Bill has been published without warning and with a consultation period precisely timed to coincide with the summer months during most of which Parliament will be in recess and MPs and others will be away. This seriously curtails the opportunity for proper consultation and hampers organisations which normally consult widely among staff and members or through a committee structure.

Incomplete Bill

The consultation process is further invalidated by the fact that the Draft Bill—as stated in the consultation document—does not include everything which it is intended should be in the Final Bill to be introduced to Parliament, thus preventing a full public debate about all of the proposals. It is difficult to be anything other than worried about what else will emerge. Given that mental health legislation goes to the heart of individual liberty and public well-being, this is a very serious concern.

Drafting

We are extremely concerned at the poor quality of the drafting of the Bill, which has frequent cross-referencing back and forth, making it excessively, and unnecessarily, difficult to follow. It makes already complex legislation into something virtually incomprehensible. We believe this is a serious flaw and, if it is not put right, the resulting legislation is likely to be almost impossible for practitioners to apply when it finally comes into force. This is likely to lead to Judicial Reviews which will be lengthy, and during which patients may be detained erroneously and will be subject to continuing anxiety and uncertainty.

We are similarly concerned about what the Code of Practice will look like if it is required to clarify ambiguous or poorly drafted statute—by definition the Code should be easily understood by the range of professionals involved in enacting the legislation and should be free of ambiguity or unnecessary detail.

Definition of mental disorder

Nacro favours the new definition of mental disorder, which is broader than that contained in the Mental Health Act 1983. We recognise the concerns expressed by some service users and practitioners about the new definition but we believe that for others—eg those working in the criminal justice system—it will be much easier to understand. We also hope that it will prevent many MDOs, who are currently excluded from services and assessments because they do not meet the criteria under the current Act, from being excluded in future.

General principles

We wholeheartedly support the inclusion in the Draft Bill of the general principles which are to underpin the provisions in the new legislation. However, we are very disappointed at the following gaps in those principles:

— there is no principle of reciprocity;
— there is no right of access to a mental health assessment;
— the Green Paper principle “Informal care and treatment should always be considered before recourse to compulsory powers” has been excluded; and
— there is no principle with regard to patient capacity.

We think that, if the inclusion of the general principles in the new legislation is to have any real meaning, these omissions must be remedied.

**Tribunal system**

We favour the proposals which provide for greater scrutiny of the imposition and maintenance of compulsory powers by the new Mental Health Tribunal—though we have considerable doubts about whether these improvements can be achieved (see Resources page 00 below). We are also pleased to note that the Draft Bill recognises the need for there to be two separate tribunal mechanisms: one to deal with decisions about care and discharge and the other to deal with appeals (the latter being the responsibility of the new Mental Health Appeal Tribunal). We do have some reservations about the proposal for Single Member Tribunal Sittings and these are addressed in response to the consultation points below (page ??).

**Assessment**

We particularly welcome the improvements in the arrangements for assessment which will allow patients (both offender and non-offender) to undergo mental health assessment in non-residential settings in the community, rather than requiring them to be detained in hospital. In the current system, mentally disordered offenders are often excluded from relevant services and resources because they carry the label “offender”. We are concerned that this may remain a problem but we are hopeful that the new arrangements will be beneficial in terms of reducing the use of remands in custody for offender patients.

**Compulsory treatment in the community**

Although we welcome the provisions facilitating assessment in community settings, we remain fundamentally opposed to the concept of compulsory treatment in the community. We take the view that those who are sufficiently disordered to warrant treatment on a compulsory basis are also sufficiently disordered to require detention and treatment within a hospital environment. We would argue that those who are non-compliant with medication and fail to co-operate with other aspects of care and treatment are the least suitable candidates for compulsory treatment in the community, since they frequently fail to turn up for appointments or to keep appointments scheduled at their own place of residence. In cases where this does not apply, it is difficult to see why compulsory measures would be needed.

There is a risk that the use of the resources of various agencies to trace individuals who failed to comply with compulsory orders would be disproportionate and would act adversely on the delivery of services to the majority of patients who can be safely and effectively maintained at a reasonable level of functioning within the community, without resort to compulsory measures.

There are legitimate reasons—such as side effects and personality clashes—why people may sometimes not wish to take medication or to co-operate with certain aspects of their care plan. We believe that the way to deal with this is to work intensively with such individuals in order to gain their trust and to achieve treatment goals which are in their own interests. The aim should be to work with patients to achieve a satisfactory level of functioning, not simply to use their concerns as a trigger to initiate compulsory powers. The service model of assertive outreach, prison in-reach, and crisis teams has made a considerable difference to working with MDOs and we are concerned that the emphasis on compliance will undermine this good work and may lead people to disengage from services and move away.

We are disappointed that the emphasis in respect of community treatment is on compulsion. We strongly believe that the emphasis should be on properly resourcing comprehensive community mental health services, so that the risk of patients’ conditions deteriorating to a point where compulsory treatment becomes necessary is substantially reduced.

**Part 3: Patients concerned in criminal proceedings etc**

The provisions in this part of the Draft Bill are largely unchanged from those in the existing Mental Health Act. There has been no substantial research to indicate whether the existing provisions work well or to identify what deficiencies, if any, there are. The systematic review9 of the existing provisions which was undertaken around the same time that the Expert Committee conducted its wider review of the 1983 Act found:

- an almost exclusive emphasis on quantitative data that, in isolation, do not provide an adequate basis on which to judge the effectiveness of existing legislation;
- most research has been opportunistic, with research questions arising from the available data rather than from careful consideration of what questions should be asked;
- research designs often result in no more than a descriptive analysis of the use of the legislation itself or of the resources associated with those provisions: to judge the appropriateness of the legislation itself, research needs to be more clinically driven;
- there has been relatively little research at all on Part III compared to other provisions of the existing Mental Health Act; and

Dealing with dangerous people

The White Paper published in 2000\(^\text{10}\) separated out the proposals in relation to high risk patients, including the very small group—designated as dangerous people with severe personality disorder—who pose a high level of risk of serious harm to others. Personality disorder is an extremely complex mental health issue, which poses difficult questions about diagnosis, care, treatment, management and risk.

Nacro had previously welcomed the programme of research to find better more exact ways of assessing risk and dangerousness (and parallel research to identify effective responses to those so assessed). In the absence of conclusions from that research, risk assessment remains a far from exact science, hardly a sound basis for indefinite detention\(^\text{11}\). In respect of public safety, we are concerned that the Government may be making a serious error in equating offending behaviour with a higher risk of future violent or dangerous behaviour. As Nacro showed clearly in its publication Risks and Rights,\(^\text{12}\) previous behaviour or offending does not, of itself, accurately predict future risk.

We are dismayed that in the Draft Bill there is no distinction between this high risk group and mentally disordered people generally, adding weight to the public perception that all mentally disordered people are dangerous and leading to widespread concerns that compulsory powers may be applied and maintained inappropriately as a result of wrong diagnosis or inaccurate risk assessment. The alarm of people who fear that they may inappropriately be made subject to coercion under a new act is a serious cause for concern. In our view, this lack of research reflects the fact that insufficient attention has been paid to the provisions relating to MDOs. We have no confidence that the status quo is now largely being maintained because it represents the optimum procedure for dealing with MDOs. We would urge that high quality research on the working of this Part of the new Act should be initiated without delay, so that in future Government will be properly informed about how well the arrangements work and decisions about any necessary changes can be made on the basis of proper research evidence.

Approved Mental Health Professionals (AMHPs)

We do not object in principle to the role of the Approved Social Worker (ASW) being extended to other mental health professionals provided that they are properly trained and qualified with the emphasis on the range of skills, knowledge and experience they would need in order to qualify for approval, so as to provide a social care—as opposed to medical—perspective on cases. We think it is essential that AMHPs should be capable of maintaining their independence when considering cases with their medical colleagues and that the need for mental health professionals and clinicians to reach independent conclusions should be

---

\(^\text{10}\) The White Paper comprised two parts: “Part I—The new legal framework” and “Part II—High risk patients”.

\(^\text{11}\) At the launch of the consultation paper Managing dangerous people with severe personality disorder on 19 July 1999, Professor Jeremy Coid indicated that, using positive prediction value (PVD) correct predictions were only likely in 7 out of 10 cases and, using negative prediction value (NVD), the rate fell to 6 out of 10.


emphasised. There is also the question of accountability, which becomes even more of an issue, as in many cases both AMHPs and their medical colleagues will be employed by the same Trust. We would expect the Code of Practice to continue to give strict guidance on the issue of complicity and would wish to see this aspect of the process being monitored by the new health care inspectorate.

Patients lacking capacity

We also welcome the inclusion of proposals in relation to the informal treatment of patients not capable of consenting (Part 5 of the Draft Bill), which seek to resolve the “Bournewood Gap”.

Resources

The proposed new legislation, particularly in the context of the new Mental Health Tribunal, will necessitate considerable additional resources. The existing tribunal system is already under severe strain and the new Tribunal will have additional powers and responsibilities requiring yet more personnel and resources.

We see no reason to dispute the statement by the Royal College of Psychiatrists and the Law Society\(^\text{14}\), which estimates that 600 additional psychiatrists will be required to service the new tribunal system alone. We do not believe an adequate pool of sufficiently trained and qualified staff exists at the present time and the training of new psychiatrists is a lengthy process.

We would like to suggest that the running of the Tribunals should be funded by a source other than the Department of Health, since it is a judicial process and not a function of patient care. Arguably, as a judicial process, there would be greater justification for it to be financed by the Lord Chancellor’s Department. This would also emphasise the independence of the Tribunal.

As indicated above (Compulsory treatment in the community, page 3), we believe the emphasis should be on avoiding the need for compulsion, whenever possible, through the provision of properly funded and resourced, comprehensive mental health services.

If the new legislation is to be fully effective on implementation, the matter of resources must be addressed and clear commitments regarding funding and resources will need to be spelt out.

OUR VIEWS ON THE ISSUES HIGHLIGHTED FOR CONSULTATION

As indicated in our introduction, we are concentrating primarily on those issues which relate to MDOs, though we are also commenting on some of the broader issues which we think will also have an impact on offenders. In each case, we include the heading of the consultation issue and the relevant paragraph number from Chapter 3 of the Consultation Document.

Scrutinising the proper application of the Act—Para 3.5

We support the proposal for improved scrutiny functions. In our view, it is essential that these functions—including visits where there is concern about a patient’s care—should also apply in prison settings so that MDOs in prison would receive the same protection as other patients.

Protecting children with serious mental disorders—Para 3.10

We welcome the proposal to extend the legal rights and protection of young people, enabling those of 16 plus to take decisions without parental consent, but we believe the issue of consent to treatment should be considered separately from the provision of treatment. We would not be happy if the fact that the Draft Bill treats those aged 16 or 17 as adults were allowed to undermine delivery of treatment to them through Child and Adolescent Mental Health Services (CAMHS).

We think the Bill should include a specific focus on the needs of children and young people. In particular, the regulations concerning approved clinicians and mental health professionals should ensure that those working with children and young people have relevant training and experience in relation to child and adolescent mental health services.

Respecting the legal rights of patients and health care workers—Para 3.17

We believe that the balance in the current framework needs adjusting and agree that the proposal in the amended provisions appears to strike the right balance. However, we believe there should be greater emphasis on mechanisms other than the courts for dealing with complaints (though the courts will necessarily remain a point of recourse where other arrangements for dealing with complaints have failed).
Focusing on individual needs, removing exclusions—Para 3.24

We see no need for specific exclusions to be contained in any new Mental Health Act. We take the view that the existing exclusions have on occasion been used to exclude people from access to mental health services they needed, especially in the case of those with mental health problems who also have problems with substance misuse. The purpose here is not to suggest that substance misuse on its own is a mental disorder but to ensure that the definition of mental disorder is not used to exclude those with co-morbidity from services so that they fall into the gap between mental health and substance misuse services. Comprehensively funded services are required and these must also cater for alcohol misuse. There is a tendency for both substance misuse and psychiatric services to concentrate on drug misuse and overlook the problems caused by alcohol misuse. Proper application of the conditions governing compulsion should provide adequate safeguards to prevent inappropriate interventions.

Para 3.25

We note that the “relevant conditions” quoted in the Consultation Document are not identical to those set out in Clause 6 of the Draft Bill. In the Draft Bill, sub-section 6(4)(a) dealing with high risk patients excludes the requirement that treatment cannot be provided unless the patient is subject to the provisions of the Act. We see no justification for this exclusion and we are concerned that the conditions as drafted will result in an unjust, two-tier process of assessment. If this is an attempt to cater for dangerous people with severe personality disorder, we believe it is flawed and will not provide a satisfactory solution. As indicated above (Dealing with dangerous people, page ?), we believe there should be a new separate jurisdiction to deal with this group.

We are also disappointed that the condition included in the Green Paper: “that the care and treatment proposed for the mental disorder and for conditions resulting from it, is the least restrictive alternative available consistent with safe and effective care” has been removed from the conditions and believe this should be restored in place of the fourth condition included in the Draft Bill.

Sharing information to improve patient care—Para 3.32

We believe that information sharing between agencies is crucial to the effective management of MDOs, to ensure that patients get the care and treatment they need. We believe that this is the case not just where compulsory treatment is being considered but also as a general principle in relation to the delivery of mental health services. Better communication between agencies would lead to better quality care and reduce the likelihood of a deterioration in a patient’s condition to the point where compulsory treatment became necessary.

We welcome the proposal to include a statutory duty to co-operate in the sharing of information and believe this should apply just as much to the care planning process as to issues of risk management and assessment. In our view, clear guidance on information sharing protocols is essential and must be backed up by active mechanisms to ensure that these are adopted and used appropriately at a local level. There will be a substantial cost—in respect of the training, the development input and the changes to information recording systems that are required—and resources will need to be made available for this.

Better care for prisoner patients—Para 3.42

We believe that the right to a mental health assessment (see General principles above, page 0) should be enshrined in the new Act and should also be extended to prisoners, whether sentenced or on remand.

We are concerned, however, that assessment should not take place in inappropriate settings. If assessments are to be conducted in prisons, this should only be in a properly resourced health/assessment centre.

We have welcomed the spirit of Changing the Outlook, a Strategy for Developing and Modernising Mental Health Services in Prison15 because we recognise that there will always be some offenders whose offence[s] warrant a prison sentence and whose mental health needs do not warrant care and treatment in hospital but do nevertheless require some input while the person is in prison. For prisoners who are compulsorily detained and treated in psychiatric hospital but who then return to prison, the Bill should specify a statutory requirement for care planning during the remainder of their sentence and after their release.

We believe strongly, however, that prison is not an appropriate setting for the provision of compulsory treatment and that where treatment of a prisoner on a compulsory basis becomes necessary that individual must be transferred to hospital.

15 Department of Health, HM Prison Service and National Assembly for Wales (2001) Changing the Outlook, a Strategy for Developing and Modernising Mental Health Services in Prisons London: Department of Health (The Head of Nacro’s Mental Health Unit is a member of the Expert Group on Mental Health Care in Prisons chaired by Professor Louis Appleby).
For prisoners whose assessed treatment needs do not bring them within the criteria for compulsory treatment, there is, in our view, a need for the Bill to specify what should happen to them. First, we think the Bill should require that offenders believed or suspected to be suffering from mental disorder should be assessed by approved clinicians and approved mental health professionals. This assessment (probably through prison in-reach, as currently being piloted in a number of prisons) should be wider than simply assessing whether compulsory treatment is needed. Where compulsory treatment is not needed but where there are identified mental health needs that would benefit from support and treatment in the widest sense, this should be provided by community based mental health services working alongside the relevant prison staff (again probably through prison in-reach, as currently being piloted in a number of prisons). The aim should be to ensure there is continuity of care for such prisoners while in custody and after their release.

**Mental Health Tribunals—Single Member Sittings—Para 3.49**

We are prepared to accept that a single member tribunal would normally be sufficient for uncontested cases and this would alleviate some of the pressure on the tribunal system. However, we are uncomfortable about the possibility of single member tribunals in any other circumstances as this would remove the checks and balances provided by the full tribunal structure. Who, for example, would decide whether an application related to a “simple matter of fact”? We think that the pressures on the tribunal system—which are already considerable and which are likely to increase under the new system—would make it tempting to use single member sittings as a matter of expediency rather than appropriateness and we are concerned that they should not be used as a result of financial or administrative pressures, regardless of the suitability of individual cases. On a practical level, it is likely it would be necessary for the single member to obtain views from members of the Expert Panel and, in that event, potential savings in terms of time and costs would be significantly reduced.

**Information for victims—Para 4.2**

We agree that there is a distinction between clinical information relating to the care and treatment of a patient and information concerning detention and release under the Mental Health Act. We support the proposal that victims of mentally disordered offenders should be entitled to receive relevant, clearly defined information concerning the detention and release of patients who have committed serious violent or sexual offences. Clear guidance on exactly what information could be released, in what circumstances, and to whom, should, in our view, be included in the Code of Practice.

**Criminal Procedure (Insanity) legislation—Para 4.3**

We are disappointed that the intended new provisions for amending existing insanity legislation have not been included in the Draft Bill so that we are unable to comment on them.

**Providing care for patients on community orders—Para 4.4**

We are totally bemused by the suggestion that patients subject to compulsion may be charged for the provision of services that they need. This is unprincipled, unethical and would be a further incentive to people to seek to avoid involvement with the mental health services, thereby potentially putting themselves and others at greater risk.

**Compulsion simultaneous with a prison sentence—Para 4.7**

We see no reason for a change to the situation which currently obtains under the Mental Health Act 1983.

**Specific Comments on the Draft Bill**

In this section, we comment on specific issues arising from the Draft Bill where these have not already been covered by comments made earlier.

**Part 1: Introductory**

**Clause 1: Code of Practice**

The Code of Practice needs to be consistent with, and complementary to, other relevant codes. Currently there appear to be operational differences between the latest Code of Practice for the 1983 Act and that for the Police and Criminal Evidence Act 1984, particularly with reference to section 136 of the 1983 Act.

**Clause 2(8)**

We would like clarification about the regulations covering “approved clinicians”. It would be helpful to know who would qualify. For example, we think there should be routes available making it easier for forensic medical examiners (FMEs) and general practitioners (GPs) with appropriate knowledge and experience to obtain approval.
Part 2: Examination, assessment and treatment
Chapter 3: Assessment
Clauses 17 and 18

We welcome the introduction of a 24 hour time limit for applications to be registered and the reduction to seven days of the period during which non-emergency patients must be admitted.

Part 3: Patients concerned in criminal proceedings
Chapter 1: Remand
Clause 61(4)

We welcome the reduction from six months to 16 weeks of the maximum overall period during which a patient may be remanded for assessment.

Clause 62(1)

We also welcome the extension to the magistrates’ court of the power to remand for treatment. (We must comment that the drafting of subsection (2) and of Clause 66 is so complicated as to make it virtually impossible to determine to whom the measures would apply.)

Clause 75(2)

We trust that patients who wished to obtain their own independent medical report would be eligible to apply for legal aid for this purpose.

Chapter 2: Orders and directions
Clause 77(4)

We welcome the requirement that courts must consider a care plan before making an order for compulsory treatment.

Chapter 3: Transfer to hospital
Clause 92(2)

We think this will make it easier for the transfer of mentally disordered prisoners to hospital for assessment to be effected because it will only be necessary to show that the individual is suffering from mental disorder and nothing further.

Clause 96(6)

We welcome the reduction from 14 to seven days for the transfer period for remand prisoners and wonder whether a similar reduction could not also apply to sentenced prisoners, for whom the period is 14 days (Clause 94(6)).

Chapter 4: Applications and references to the Mental Health Tribunal

Clause 102 entitles restricted patients, under Part 3 of the Draft Bill, to make an application to the Mental Health Tribunal. It is understood that Clause 42 provides access to the Tribunal for unrestricted patients, who are subject to compulsory powers under Part 3, but this has not been set out clearly. The Bill must make it clear that unrestricted Part 3 patients can apply to the Tribunal.

Clause 106(2)

We welcome the requirement to refer the cases of patients recalled to hospital to the Mental Health Tribunal within seven days.

Part 4: Medical treatment
Clause 118(2)

We are most concerned at the provisions allowing the use of electroconvulsive therapy (ECT) without a patient’s consent. We take the view that ECT should never be administered to any patient who retains capacity without that patient’s consent and that there is no justification for overriding this principle in an emergency.
Part 6: Powers of entry, conveyance and detention

Clause 143

This appears to be a new power enabling the police to enter private property in an emergency without a warrant. We wonder what evidence there is that such a power is necessary and that in such cases it has not been possible for the police to gain access under common law? We are concerned about the possibility that this power may be used simply to avoid the trouble of obtaining a warrant and of the potential for violation of human rights.

Clause 144

We welcome the power facilitating the movement of patients from one place of safety to another which should mean that patients originally taken to the police station can be moved, if appropriate, to another more suitable setting.

Conclusion

There are some aspects of the Draft Bill which we are particularly pleased to see, especially the introduction of care plans, the measures facilitating remands for assessment in non-custodial settings, and closer scrutiny of the management of cases by the Mental Health Tribunal.

Nevertheless, we remain extremely disappointed at the continuing focus on compulsion in the community with the resultant increased involvement of the police which will be required where patients fail to comply and have to be conveyed to hospital. We believe this will have a detrimental effect on patients’ engagement with community mental health services. We are also concerned that there is to be no separate jurisdiction for dangerous people with severe personality disorder.

Whilst we are not opposed in principle to the extension of the current role of ASWs to other mental health professionals, we do have concerns about the possible implications of this. Social care and housing are key aspects of the successful maintenance of mentally disordered people within the community. We would not wish to see any reduction in the commitment of social services and housing departments as a result of a reduction in the statutory responsibilities of local authority staff, thus leading to even greater emphasis on a medical model of care.

In our view, therefore, there are still extensive flaws in the Draft Bill and we would urge strongly that these should be remedied before the Bill is placed before Parliament.

12 September 2002

Witnesses: Ms Ethel Samkange, Director of Link Worker Schemes, and Mr Nick O’Shea, Director of Development, Revolving Doors Agency, Ms Sue Kesteven, Policy Development Manager, and Ms Lucy Smith, Research and Information Officer, Mental Health Unit, Nacro, and Mrs Jayne Zito, Patron, and Mr Michael Howlett, Director, the Zito Trust, examined.

Q497 Chairman: Thank you for attending this morning. You are quite a formidable array of well-known and distinguished people, and I apologise on behalf of the committee for keeping you waiting. You will be aware that we are under a degree of pressure because of events, particularly in the House of Commons, that occur round about noon on a Wednesday, so we have at the most an hour to deal with the questions that you have had notice of and any supplementaries. I am going to ask you to identify yourselves briefly for the record in a moment. I hope that you will be content to go straight to questions. If anybody wants to make an introduction they are free to do so but please make it extremely short. As you heard when the other witnesses started to give evidence, a transcript will be produced appearing on the internet within about one week. You will be given the opportunity to make any textual corrections only that you wish to make to the draft text of the transcript. Jayne Zito, shall we start with you?

Mrs Zito: My name is Jayne Zito. I am the widow of Jonathan Zito, murdered by Christopher Clunis who has been referred to today numerous times. I am the founder, along with Michael Howlett, my Director, of the Zito Trust. We support victims of community care failures.

Mr Howlett: My name is Michael Howlett. I am Director of the Zito Trust, which was set up in 1994. Before that I was in a management position with the Special Hospitals Service Authority which ran Ashworth, Broadmoor and Rampton high security hospitals, and before that I worked in a therapeutic community for adolescents and young offenders.

Ms Smith: I am Lucy Smith. I am a Research and Information Officer in Nacro’s Mental Health Unit. Nacro is a crime reduction charity.

Q498 Chairman: I should say that Ms Kesteven and I have known one another for a large number of years. Mr O’Shea: I am Nick O’Shea. I am Director of Development for the Revolving Doors Agency, which is an agency that provides support for people who have serious mental health problems but not
those which are severe and enduring, so the majority of our clients would not come anywhere near being sectioned under the current Act.

Ms Samkange: Good morning. My name is Ethel Samkange. I am Director of Link Worker Schemes for Revolving Doors Agency.

Q499 Ms Munn: I particularly want to put questions initially to the Zito Trust. You heard earlier the discussion we had about treatability and some of the issues I raised with the previous witnesses. As I understand it, the Zito Trust support the exclusion of treatability as a necessary condition underlying the use of compulsory powers because it will allow patients with personality disorder to be subject to compulsory powers. An alternative view which you heard articulated is that it is unethical to detain people in hospital if there is no clear benefit to their health. Can I ask you to comment on this issue and put forward your views in relation to this?

Mr Howlett: If I may set it in a little context, when we started the Zito Trust we did not have that much thought about personality disorder and treatability until, as has already been referred to, the Michael Stone case in 1998 and a long contact with Michael Stone’s sister before the first trial. Obviously, I do not want to talk about the legal issues because there is an appeal under way, but what emerged from that first trial was that psychiatrists—and this was probably known to many people but not to us—had historically stopped treating people with personality disorder, not across the board 100% but in many cases, and the theme that emerged out of the discussion and debate following the trial was encapsulated in a letter by the then Home Secretary to The Times, who pointed out that in 1984, one year after the 1983 Act came into being, 14% of people with so-called psychopathic disorder were being treated in NHS facilities, but 10 years later the figure was under 3%. We have already heard from Professor Maden the extent to which psychiatrists are now using that treatability criterion to get them off the hook in terms of rejecting people with personality disorder from NHS services, and I have some sympathy for the position that general psychiatrists find themselves in because of the way that psychiatry has developed along an increasingly medical model in that they are not able, particularly with the resource issues that we have, to offer much beyond medication as the base-line treatment, and, of course, personality disorder generally does not respond to medication. There are a number of families who have come to us through our support and advice service and said, “I have got a young son or daughter of 17, 18, 19, 20 who has been diagnosed as having a personality disorder” by a psychiatrist and has been told there is nothing that can be done; they are untreatable under the current legislation”, and the question is always put to us, “What services are there for people?”. There are a few therapeutic orientated services around but they are very patchy, and the answer is basically nothing. We feel that the treatability criterion as a loophole should be excluded from the current legislation so that people can be brought into NHS and other services having had an assessment of their needs.

Q500 Ms Munn: Can I clarify one issue because, as I understand it, there is some evidence which you cite that some cognitive behavioural therapy can be effective for some people, and the evidence that particularly Professor Maden gave was that he believes that there is greater treatability perhaps than had been thought in the past but that those that had the most complex and severe personality disorders were the least likely to respond to that treatment. Is that your understanding and how does that affect your view?

Mr Howlett: Yes, I think it is. Having been quite negative about the availability of services for people with personality disorder, the situation is changing as we speak. The Personality Disorder Network has been set up and that involved 11 pilot sites in mental health NHS trusts offering therapeutic orientated services and they are using an eclectic model based on cognitive behavioural therapy, dialectical behaviour therapy, psychotherapy and psychological therapies to improve the social functioning and the skills of people who have poor impulse control and anger management. It is a stepped programme and it is in response to a publication which we do not hear very much about from the National Institute of Mental Health, which is an implementation guidance which drives this Personality Disorder Network and it is called Personality Disorder: No Longer a Diagnosis of Exclusion. There are some positive signs, and, of course, I agree with Professor Maden’s observations about the very severe end of psychopathy that treatment does not work at the moment. There is a question mark about what we should be doing with people who are described as dangerous and having a very severe personality disorder who would score very highly on the Hare psychopathy levels that we heard about this morning.

Q501 Chairman: On this issue of dangerousness can I ask if any of the other witnesses would like to contribute anything at this stage?

Ms Kesteven: From Nacro’s point of view I might just say that when the 2002 draft bill was put forward we expressed disappointment that the original idea of having separate legislation to deal with this small group of dangerous, severely personality disordered people had not been pursued. That was an idea that was put forward in the Home Office proposals on managing this group of people in 1999 and it was argued that there should be separate legislation to deal with that group and that it was not really appropriate to attempt to deal with them in general mental health legislation. Having said that, on the issue of the treatability clause we would support a lot of what Professor Maden said this morning. We think there are treatments available for people who have personality disorder. There are psychological interventions, for example, which may not cure the condition, if you want to put it that way, but which
Q502 Tim Loughton: Can we look at the whole subject of the conditions for compulsion and the differences between criminal and civil patients? The Revolving Doors submission said that “this may have the inadvertent consequence of suggesting that committing a criminal offence is the quickest and most effective way to gain access to mental health services”. Can you give some evidence for that, because we have also heard service users in previous submissions almost unanimously saying that they would prefer to be held under the criminal justice proceedings than be subject to compulsion under mental health legislation. Do you think that is a fair assessment of what people think?

Ms Samkange: I think there is a real issue about access to services and the use of compulsory treatment because I feel (and this was something that the two professors touched on) that there should be more of an emphasis on preventative intervention. Most of the clients that we are working with are very chaotic. They have serious mental health problems, which means that they do not fit into the criteria set by mental health services of suffering from severe enduring mental health problems. These are the clients that cause the police, people working in the courts and the prison services the most concern, but these are people who, through their level of social dysfunction, have not been able to access services and this is their first point of contact. I think the use of the compulsory treatment order would be counter-productive for our clients.

Mr O’Shea: The definition of “mental health” and also “mental treatment” within the bill is very broad. What this does is to re-open, in theory at least, the fact that a number of our clients who at the moment just want to engage with services, as Ethel has outlined, would find that their first way into these services is that compulsory way. Because our clients are so chaotic what we have discovered is that they are not dangerous in the same way as these very high end people. They are not going to go out and kill somebody. You can work with these people over a long period of time, but that is about engaging them over a long period of time and working with them, whereas it is the coercive element, if that is the first way in which they are going to go into the service, which will undo an awful lot of the work that we have done with them to get them to engage with services voluntarily.

Q503 Tim Loughton: Do you think there is a perverse incentive here for people to attack somebody or to commit some other criminal activity in order to get access to mental health services that they are simply divorced from?

Mr O’Shea: We have clients who have thrown bricks through police windows or mugged people outside police stations in order to get help from services, be it drugs services, be it alcohol services. There is some quite well documented evidence which I do not have here about how particularly in London the quickest way to get things like rehabilitative services for drug or alcohol usage is through the criminal justice route. Yes, there are examples of where that has happened and people have committed fairly minor crimes (although serious enough, obviously, for the individual victim) that have then led to them being engaged with those services.

Tim Loughton: And you think this Bill will make it worse? There is some interesting anecdotal evidence that, if you live in Gloucestershire, the best way to get dental treatment is to go to prison where the waiting time is two weeks rather than in excess of six months.

Chairman: I think that question should be suppressed in Gloucestershire.

Q504 Tim Loughton: Are you saying that the same is applicable to mental health services from sufficient number of your clients to justify that?

Mr O’Shea: Potentially. The thing that we find very worrying about this Bill is that because it is so broad, and because the treatments that you can then offer are again very broad, it gives that scope for it. Although in practice I accept that we have a limited number of services out there, and we have already spoken about the dearth of those services, and although in practice it may not be possible to give everybody a compulsory treatment order this law makes it theoretically possible and therefore you have a law which opens up lots of possibilities which will then be directed by services and codes of practice, whereas my understanding was, and I am no lawyer, that the law had to leave as little room for doubt as possible and say, “These are your gateways. This is the way in, and that is it”. Because this is so much broader it could happen that, yes, you commit a fairly minor crime and you find yourself in front of a magistrate who says, “Okay, I think you have got a mental problem”, and then on the word of the GP or two practitioners you then find yourself on a compulsory treatment order which, because you do not have to go into hospital, you can have at your home, and therefore that frees up an awful lot more resources. Having worked for the Home Office I know that one of the biggest problems they have is the level of mental health problems in prison; they are very concerned about it. Judges in our experience are very keen to offer alternative sentences. There is a lack of community punishments out there which are going to help with a drug or alcohol problem or a mental health problem and on the face of it this bill provides an opportunity for a judge to say, “Okay: compulsory treatment order. Off you go”, whether those services are there or not to back it up. It could happen under this legislation.
Q505 Mrs Browning: In relation to that group of people who see that they can trigger the services they are otherwise denied through this type of action, on the converse side of that how many of those people end up as suicide cases as a result of not accessing appropriate support and treatment? 

Ms Samkange: There is a high incidence amongst our client group of attempts to self-harm or commit suicide, but to date we have not had any clients that have committed suicide. 

Ms Samkange: There is a high incidence amongst our client group of attempts to self-harm or commit suicide, but to date we have not had any clients that have committed suicide. 

Q506 Baroness Eccles of Moulton: I am having a certain amount of difficulty in distinguishing between, amongst your client group, who you would define as treatable and who you would define as untreatable. If there is a voluntary potential patient who presents, say, at A&E and says, “I have a problem”, how is it then decided whether they have a treatable problem or an untreatable problem? 

Ms Samkange: Our clients will turn up in most cases at A&E or be arrested and be seen by a forensic medical examiner. They are a group of clients that have been assessed to death and have never actually had any meaningful intervention in the community. The response that they get in most cases is that they do not fit the criteria for mental health services; therefore they get nothing. They do not fit the criteria for drug and alcohol services; they get nothing. The GP finds it very difficult to contain their needs. They do not respond as well as other clients to medical interventions. What have we found helps is having a flexible therapeutic approach which engages with the client on a voluntary basis, which goes back to the basics and looks at what they lost out on in their formative years and builds up their capacity to be able to cope and live in the community as well as make effective use of the services that are around. 

Q507 Baroness Eccles of Moulton: Could criteria be created that would then mean that they were not rejected, that there were criteria that they would fit? 

Ms Samkange: Yes. This is one of my concerns about the bill, that there should be this preventative model in there and that it should not be focused mainly on medical treatment and other psychological treatment; it should look at the needs of people who find it difficult in the first instance to engage in services and work within set structures. 

Q508 Chairman: Forgive me for interrupting you, but arising from that we have three organisations here giving evidence with a wealth of experience in dealing with problems coming straight from members of the public, from members of the community and dealing with people who have various difficulties who are living in the community, much of the time at least. You heard, if you were here earlier, the difference of opinion between Professor Eastman and Professor Maden about the concept of community treatment orders. Can we find out from you with your extensive community involvement briefly what your views are about community treatment orders with these two sub-questions: first, should they exist, and, secondly, if so, how extensively would you expect them to be used? 

Mr Howlett: We are in favour of community treatment orders. This is partly because we have acquired a lot of evidence of people who are difficult to engage with services in the community, who are creating problems for their families or members of the public, who have stopped taking their medication. There is a high degree of non-compliance in the cases that we know of, the homicide cases and to a larger extent of course the suicide cases. Suicide rarely gets a mention in terms of forensic mental health issues, of course, but we should remember that about 1,500 suicides are committed every year by people who have been in contact with mental health services. About 20% of them have stopped taking their medication in the period leading to the suicide, and I am talking about a matter of months. There is similar non-compliance in cases of homicide, with about 40 or 50 a year committed in this country by people who have been in recent contact with mental health services and who have stopped taking their medication. Community Treatment Orders are obviously controversial but they are applied in jurisdictions all over the world. We believe that this Bill presents an opportunity, looking at it from a positive point of view, to engage those people in services who would otherwise be difficult to manage and to treat. Part of the problem is a resource problem. When people talk about patient rights and keeping them out of hospital, it is actually very difficult to get into a hospital at the moment. We have a lot of families who are really struggling to access services and they are in despair. They are extremely frustrated. Whenever they call the community mental health team they are told that there is nothing they can do until something happens and their best option is to call the police. When they call the police they are told there is nothing they can do. 

Q509 Chairman: We understand this issue; you make your view clear. 

Mr Howlett: With community treatment orders we see them as a positive benefit for keeping people out of hospital and engaging them with services where they might not otherwise engage. 

Q510 Chairman: Can we ask for Nacro’s view on that? 

Ms Kesteven: We are opposed to orders for compulsory treatment in the community. We are concerned by the emphasis in this Bill on compulsion and we think that compulsory powers should be used as a matter of last resort. The sorts of clients that Revolving Doors have been talking about very often have very chaotic lifestyles. They need a high degree of support, as has been indicated, from a variety of perspectives, not just from a mental health perspective but also help more generally in accessing services such as housing benefit and so on. In our view these are the types of people who are the most
unsuitable candidates for compulsory treatment in the community. Non-compliance with medication and a failure to co-operate with aspects of care and treatment are not a recipe for a successful management structure in the community and we think that people who are so disordered or so mentally ill that they need compulsory treatment require that treatment to be provided in a hospital environment. We understand the views of those who think that there is a problem in getting people into hospital, but, in our view, this is not an issue for legislation; this is an issue for resources because one of the key problems is that there is a lack of resources in terms of community mental health services in existence at present. The services provided are variable and patchy. In some areas they are very good; in other areas they are not very good. A lot of these people need much more help than perhaps just a visit from a key worker once a week or once a fortnight. If the resources were provided to give a comprehensive structure of assertive outreach services, crisis teams and so on, we think that it is far more likely that it would be possible to engage with service users on a voluntary basis so that they could be helped to maintain their lives in the community without the use of compulsion and you would only then be talking about a smaller number of people whose illness might deteriorate to the point where compulsory treatment in hospital became necessary.

Q512 Chairman: But how does the Bill in any way exclude voluntary involvement? There seems to be evidence from some witnesses who have given evidence to us in writing that the introduction of community treatment orders is the inevitable consequence of somebody having a disorder which might fall within the definition of the Bill. Is it not right to suggest that many of them would remain within the voluntary ambit anyway?

Ms Samkange: Our concern is that it is not clear because there is such a broad definition. My understanding is that once they hit the point where they are in the criminal justice system there are so many reasons as to why they can fall into a compulsory treatment order—it can be through the substance misuse route (most of our clients have dual diagnosis); it can be through the serious mental health problems that they can have. We have heard today from the professors that they feel that about 80% of the people who have mental health problems in prison suffer from a personality disorder. I think that is very alarming because we hear that the public perception of personality disorder is immediately linked with dangerousness and this does not apply to our clients. We welcome the fact that there is an acknowledgement that people who suffer from personality disorder need some intervention but on the other hand it also should be acknowledged that these people are suffering from symptoms within that disorder, such as anxiety or depression, which can be treated and help them to live a better life in the community.

Q511 Chairman: Mr O’Shea and Ms Samkange, if you look at the matter from the viewpoint of somebody who has perhaps the stark options of being detained compulsorily in hospital, possibly finding themselves in the criminal justice system because there is no other way of dealing with them, or a compulsory community treatment order, is not the community treatment order with the cooperation of carers in perhaps a smallish group of cases an attractive option for the client?

Mr O’Shea: We would be very clear about this, that this is not for our clients. That is the bottom line. I was very interested to see the principles which were at the beginning of the Bill, which talk about including people and making sure that voices are heard and that compulsory treatment is the last resort, whether that is in the community or residential. However, interestingly, those principles are not lawful because they are going to form part of the code of practice and basically go out of the window when you get to section 3. To me, if you are going to have principles, you are going to have principles and they are going to go through the bill or they are not. What happens is that once you commit a crime suddenly the risk element goes away and the last resort, in that there is no other option for you to engage with, has to be force because you are refusing to engage. This group want to engage but those services are not there for that to happen. What this Bill is suggesting is that the way ahead is to say, “As soon as you have committed a crime let us compulsorily treat you”. I would make it very clear that this is not for our clients at all.

Q513 Baroness Barker: One of the changes in the proposed legislation from previous Acts is that treatment following a period in hospital should be limited to six weeks. How do you think that is going to affect some of the issues you have been talking about in relation to the people that you work with?

Mr O’Shea: Is that question for us?

Q514 Chairman: If you can answer it. If not, please think about the question and drop us a note afterwards.

Mr Howlett: May I add a point about community treatment orders? I do believe that they are the inevitable consequence of de-institutionalisation. In 1954 we had 154,000 NHS psychiatric beds in this country. Now we have 33,000. That is 0.66 per 1,000 of the population. The other point I would like to make is that the current Mental Health Act has guardianship and supervised discharge orders have been introduced in recent times. It would be a shame to lose those, as this bill does, because they provide flexibility.

Q515 Chairman: You would not want to hark back to the fifties, would you?

Mr Howlett: Oh, no, I am not saying that; absolutely not. We are firm believers in community care.

Chairman: Can we now switch to a very important issue? I know it is of great importance to the Zito Trust.
Q516 Baroness Pitkeathley: I would like to turn to the issue of victims and address this initially to the Zito Trust but I am also interested in the views of the other witnesses. As you point out, there is no mention of the victim in the Bill and no suggestion about engaging with the victim. As I understand it, you want all victims of violent or sexual offences to have the rights which victims of prisoners currently enjoy to simple information about the date of release from prison and any conditions which are attached to it and so on. What information, if you could be very specific, concerning mentally disordered offenders would you want released, under what circumstances and to whom? Conversely, and I emphasise that I am also interested in the views of other people about this, what information should not be released?

Mrs Zito: We have been giving evidence to the Department of Health now for 10 or 11 years with regard to the experiences of victims of mentally disordered offenders and the experience of being a socially excluded group from mental health policy. What we are seeking through this legislation is a recognition of the circumstances and the experience of being threatened or assaulted or, if a homicide occurs, being bereaved by someone who is ill or who is disordered. The consequences of being ill or disordered at present mean that the victim’s right to information is restricted because of patient confidentiality. As soon as an offender becomes a patient we have no rights to information regarding their discharge from hospital, a special hospital or a local hospital, or, if the offender is transferred to another hospital, has lesser restrictions or is moved back into our community. Further to that, if a victim is a member of the community and has been threatened or assaulted, if a criminal charge is not brought against that offender with no restrictions, we are not entitled to information with regard to any discharge of that offender to a hospital or whether that offender has been admitted to hospital in the first place. That is the experience of victims on a variety of assaults or threats or very serious experiences of violence or even homicide. We are seeking to address the balance in terms of rights to information. We request that we have rights to information about whether an offender has been admitted to hospital, whether that offender has been charged with an offence and admitted to hospital, whether that offender is going to be discharged from that hospital and whether that offender is going to be discharged with restrictions attached to their discharge. In order to achieve restrictions to that discharge or whether or not an offender should be admitted to hospital in the first place, we believe—and there has been much discussion taking place today about accurate risks assessments and predictors of risk—that the failure to engage with victims in terms of enhancing accurate risk assessments and accurate risk management is very much restricting the accuracy of the information that clinicians receive about the offending behaviour of the patient, whether that patient be a relative of yours or a member of the public or a patient in a hospital. There is a continuous failure, and homicide inquiries have continuously told us this, to engage with victims of mentally disordered offenders and therefore there is a failure to enhance the risk assessment process because we are not engaging in important information that victims should have. Say, for example (and it is an example that I use continuously), you have a neighbour who has been threatening to kill you for months. You have phoned the mental health services. They have told you that there is nothing they can do unless that individual actually acts in a violent way. You know your neighbour has had access to mental health services before but they are refusing to engage with you as a member of the public and they are refusing to engage with that individual who is your neighbour. You are advised to inform the police. The police also tell you that there is nothing you can do. What we are requesting is that there is a duty placed on the mental health professional team to engage with that individual member of the public, whether they be a carer or not, to undertake an assessment of what kind of behaviour they are experiencing by that member of the public in order to enhance the risk assessment process. What is occurring at the moment is that assessments are being made in isolation. You present yourself to a mental health professional who will take a picture of the risk. Then you will present yourself to the police and the police will have a different picture of that risk. You will then present to housing and housing will have another picture of that risk. You will present to your carer and they will have a different picture, and I will present to you as a victim and a member of the public and there is no coherent strategy or duty to gather information from those professionals and from third parties who we identify as victims and who are critical to the risk assessment process that is undertaken at present.

Q517 Baroness Pitkeathley: So your emphasis is as much on gathering information as on giving information to victims, or indeed potential victims?

Mrs Zito: Yes, it is. I think it is very important that victims, whether they are carers or third parties, are recognised as having crucial information in the risk assessment process. At present and for the past 10 years that we have been engaged with victims our experience and the experience of the families who come to us is that we have been completely overlooked to the point of being ostracised by the mental health professional teams. The Domestic Violence Crime and Victims Bill has made recommendations and we very much welcome that the Home Office have sympathised with victims of mentally disordered offenders to give information to victims of restricted patients regarding discharge, so now I will be able to know whether Christopher Clunis is going to be discharged. I will also now have the opportunity to make representations if there are any risks associated with that discharge and I will be entitled to know what those restrictions are on his discharge and when he is going to be discharged. We know that many offenders who represent high levels
of physical and violent risk to members of the public or carers or to other staff or patients do not receive restriction orders as part of their mental health disposal, and we are concerned that victims of those patients who do not receive restriction orders will again be excluded from the right to information dependent on the status of the offender as a patient.

Mr Howlett: Can I add a point about victims? I think you asked who should collect the information or carers or to other staff or patients do not receive restriction orders as part of their mental health Initially it should be the community mental health teams working within the mental health trusts. And disposal, and we are concerned that victims of those patients who do not receive restriction orders will example from this week, very briefly, is that a man has been threatened with his life by somebody he knows and he knows he suffers from manic depression and has had many hospitalisations over the years. This person went to his house on Sunday and urinated against his door and left him a calling card. There was the same reaction from the police. The reaction from the community mental health team was, “Why are you calling us? This has got nothing to do with you. We refuse to talk about any patients that may be under this trust”, and he is petrified.

Q518 Chairman: Can I stop you for a moment because you have identified two problems? One is the collection of information which may help in a risk assessment. The other is the provision of information to victims, and they are rather separate issues.

Mrs Zito: Yes, they are.

Q519 Chairman: Taking the first of those issues raised by Lady Pitkeathley, the collection of information from victims and their families in relation to risk assessment, who should collect the risk? What agency should collect the risk and in what form, and does it include, for example, the victim or the victim’s family having the right to attend mental health tribunals?

Mrs Zito: Our recommendation is that the victim should have a right or legal opportunity to make representations to a Mental Health Review Tribunal, but our concern pre-empts whether or not an offender has been detained and whether or not a mental health tribunal is appropriate for that offender. We are also concerned about offenders and people who are ill within our community or who are disordered within our community where there is repeated threatening behaviour, so where the victim has experience of behaviour that will enhance the risk assessment that takes place. That, we have been informed by the professors this morning, is improving. We feel that that risk assessment process cannot improve adequately unless all information is gathered by all parties. We believe there should be a duty on the PCT and the community mental health trust to appoint an independent advocate as part of the multi-disciplinary team to engage in gathering information which will feed into that multi-disciplinary process.

Q520 Chairman: Can I ask the other witnesses if they would like to comment on that tranche of evidence?

Mr O’Shea: I would back the point about expanding services that Jayne Zito has made. The two things that I would say are that I think it is important to remember that this is again a very high end group and once again this Bill has some very vague and broad definitions. The other thing is that it is a very fine balancing act between risk and stigmatisation. I would refer you to the latest Exclusion Unit report on mental health which says that the biggest thing that would prevent people from accessing services voluntarily and engaging with them at a time before things got serious was stigma. If it is not done properly and it is just a broad brush approach, “Yes, this is it”, that would increase that stigmatisation undoubtedly.

Mrs Zito: My experience in terms of the training that we offer mental health practitioners is that victims are not at the forefront of mental health practitioners’ thinking. Their duty is to their patient and the autonomy of that patient and the least restrictive option to that patient. For them to consider victims as part of enhancing a process for that individual in terms of accessing treatment is a very difficult concept for mental health professionals to engage with. It is not a statutory part of their training programme. I think that many clinicians that we gather evidence from very much see the evidence which comes from the patient as being foremost in terms of the importance of the information coming from the patient. It is at the forefront in terms of the assessment that is being made. If you look at the Royal College of Psychiatrists’ response to MAPPA, multi-agency protection panels, and their guidance in terms of sharing information, it makes it very clear that sharing information should only happen if an alternative cannot be found to the treatment of that patient with MAPPA. I think that the autonomy of the patient is at the forefront of the thinking and the engagement with the victim is secondary to that, and the thinking is that victims belong in the criminal justice system. Victims of mentally disordered offenders do not belong in the criminal justice system. We belong in the Department of Health as well, and the Department of Health—and excuse me if I should not be saying this—have continuously, and I think it is a psychological response, that, used the word “victim” in terms of association with somebody who is ill which is again increasing stigmatisation. We do not want to increase the stigmatisation of a patient by calling ourselves victims. What we want to do is enhance the treatment that they receive because of our experience, not exclude them from society or from
our communities. I think that the Department of Health and the medical profession that we engage with have found that very difficult to understand. We can both belong within the community but we both have needs which have to be addressed, and we have information that is vital to the treatment and the care of an individual who is ill.

Q522 Mr Howarth: I think probably we would all accept the general principle that there should be confidentiality between doctors and patients. There should be the presumption that in normal circumstances personal information should not be transmitted to others. On the other hand I think there is great merit in your argument that in the sorts of cases you are describing there ought to be some mechanism by which that information, for safety purposes if for no other reason, should be made available to a limited number of people. The difficulty I foresee, and maybe you can help me, and I think you have partly answered it, is, where do you set the threshold? How do you trigger the point where you say, “Right; in this particular case it is reasonable to pass on information to proper people”? That would presumably be a very difficult exercise to go through.

Mr Howlett: In cases of giving information it is quite clearly laid out in the Domestic Violence Act which received Royal Assent recently, but in terms of collecting information I can understand the concerns about patient confidentiality because members of the public may make spurious calls to community mental health teams. Every call should be taken seriously initially, enough for someone to carry out some kind of assessment of the situation in order to see whether it is appropriate to release more information, particularly if somebody feels that they are at risk of harm. I would also include psychological harm because we have a lot of people who are extremely distressed in the community.

Q523 Chairman: That comes back to your earlier point, Mr Howarth. Can I ask finally if any of the witnesses have any comments to make about the continuing role of the Home Office under the Bill, bearing in mind that we have heard evidence criticising the fact that under the draft Bill the Home Secretary retains the exclusive power to authorise transfer and leave in the case of patients under restriction orders, and it has been suggested to us that this leaves a clear anomaly whereby tribunals can order the discharge of somebody from a restriction order but cannot order the essential precursors to discharge to enable them to make a full assessment? Do any of you wish to say anything about that or is that a question which is really outside your respective scopes?

Ms Kesteven: We do not feel strongly that the executive power should be taken away from the Home Office. Clearly there are issues about the scope of the Mental Health Review Tribunal and the fact that it cannot order that leave or transfer be initiated. There are some benefits in the Home Office having an overall view of restricted cases because we are only talking about restricted cases. It is a very small number and it does relate to the patients who present the greatest risk to others. Rather than necessarily taking away the executive power it might be helpful if the tribunal could make statutory recommendations about leave or transfer. My understanding is that the tribunal can make recommendations but they do not have any statutory force at present and it is not proposed that they should do in the Bill and perhaps that is a change that might be advantageous.

Q524 Chairman: Really this is not in your area of work, is it, because you are not dealing with restricted patients?

Ms Samkange: No.

Q525 Chairman: Do you want to add anything, Mrs Zito or Mr Howlett, on this point?

Mr Howlett: Only that I have read the evidence of Professor Richardson about this point and it may be instructive for the Committee when they go to Wales next week to know that there was a homicide inquiry, the first of its kind published in Wales, into a man called Paul Khan, who was a restricted patient.

Q526 Chairman: This was very recent, was it?

Mr Howlett: Very recent, yes. The inquiry found that a number of rules were broken. The Mental Health Review Tribunal stipulated that he must go into 24-hour staffed care but the hospital concerned needed to cater for a remand prisoner in Cardiff Prison, so they put him into another hospital which did not have 24-hour staffed care and the Home Office was not informed. The Home Office was not informed about a number of other matters, including the fact that the patient went missing rather than attend an outpatients’ appointment. I wondered whether removing the executive powers of the Home Office, as suggested by Professor Richardson, might not give the tribunal more direct engagement with all the issues that crop up with restricted patients. I do not have a strong feeling about it but I did have a reservation about her proposal that they would have an advisory role instead and am not quite sure what that would consist of. That is the only observation I have to make about that point.

Q527 Baroness McIntosh of Hudnall: I really feel there is one question I would like to ask the Trust as we have a unique opportunity here. One of the previous witnesses in the earlier session said quite specifically that the initial imperative to reform the mental health law was two specific cases, one of which is the case of your husband, Mrs Zito, and what happened to him. What I want to ask you, and I do not know whether the other witnesses would have anything to contribute to this, relates to whether you believe that had this Bill been law at the time of your husband’s death it is likely that the outcome would have been different. I know that is a very difficult question; I am sure, however, that it is one that you must have thought about in thinking
about how you would like to see the law reformed. I wanted to ask it particularly in relation to the fact that the earlier witnesses did say that in their view—and I think it was Professor Eastman particularly—it was not the law that was the problem on that occasion but the way in which the individual in the case was managed and that, therefore, because that has changed, the particular circumstances are unlikely to recur. To repeat my question, do you think that the reform of the law that is proposed in this Bill would make any significant difference, or what significant difference would it make to the circumstances that you faced 12 years ago?

*Mrs Zito:* I can refer, and I hope Michael will help me with this, to the proposal for Community Treatment Orders. When my husband was murdered there was an inquiry called the Ritchie Inquiry into the care and treatment of Christopher Clunis, and Jean Ritchie referred specifically to a group of individuals called the Special Supervision Group that Christopher Clunis would be identified under if he was under a special heading. These were individuals such as Christopher Clunis who were highly dangerous, recognised as being dangerous and known to services as being dangerous when they were ill. He suffers from paranoid schizophrenia; he does not suffer from personality disorder. He was non-compliant with treatment. I remember when the police came to my house in the days after the murder of my husband they told me that his drawers were full of medication, that he was not taking his medication. He was non-compliant with medication, he was transient and he was dangerous. He was identified by Jean Ritchie as falling into a category where there is a number, and the numbers have been used today, of individuals who are recognised as being within this profile. I believe and the Trust believe from the evidence we collect from other families where homicides have occurred and very serious assaults have occurred that have not been mentioned here today, that individuals like Christopher Clunis should not be hospitalised for a lifetime because of that profile, that they should have a right to live in our communities with appropriate support and with appropriate legislation to ensure that they take their treatment so that they can live safely within our communities. We believe very strongly that the Community Treatment Orders proposed within this legislation would support individuals who fall into that profile.

*Mr Howlett:* Can I add something to that? For instance, Christopher Clunis saw 43 different psychiatrists in five years. I do not think that will happen today, but there have been 150 homicide inquiries since 1994 and they continue to take place. They are not as high profile but there are real concerns about people living in the community who do pose a risk and who are not compliant. Professor Jeremy Coid, a forensic psychiatrist working in London, wrote at the time, Let us not delude ourselves that this is a one-off event. There are other people like Christopher Clunis out there and we need to make sure that we can engage them in services before something terrible happens.

*Q258 Chairman:* I have asked the staff just now to obtain for us if possible a short note on the Paul Khan case for our visit to Wales next week, partly because it has been mentioned in evidence, and I was reminded thus of it, and partly because it is extremely recent. The report was published, I think, only last week or possibly the week before, as recent as that. Thank you for that; we will be assisted by that. We are going to have to finish. Can I say thank you to all the witnesses. You have provided us with a great deal of food for thought and very good material. We are grateful to you for your written submissions.
Wednesday 15 December 2004

Members present:
Carlile of Berriew, L
(Chairman)
Eccles of Moulton, B
Finlay of Llandaff, B
McIntosh of Hudnall, B
Rix, L

Mrs Liz Blackman
Mrs Angela Browning
Mr David Hinchcliffe
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Mr Gwyn Prosser
Hywel Williams

Memorandum from Ms Jane Hutt, AM, Minister for Health and Social Services, Welsh Assembly Government (DMH 312)

I am very pleased to have this opportunity of providing evidence to the Joint Committee on the draft Mental Health Bill. The National Assembly for Wales considered the draft Bill at its Health and Social Services Committee and David Melding the Chair of that Committee is also responding to you. This response conveys my views on behalf of the Welsh Assembly Government and reflects the views of stakeholders in Wales.

1. Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

Whilst a clear set of principles are not included within the Bill, the Bill attempts to achieve the same intention by providing for a Welsh Code of Practice which will set out the general principles to which decision makers must have regard and the Code will also provide guidance on good practice.

2. Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are provisions for assessment and treatment in the Community adequate and sufficient?

I am concerned that the definition of mental disorder has been drafted very broadly. This would be acceptable if it were to be combined with appropriate exclusions. For instance, in Wales I established a Learning Disability Advisory Group to advise me on implementing the All Wales Strategy on Learning Disability. They have advised me that they have serious concerns that the definition encompasses people with learning disabilities and could lead to unnecessary and inappropriate detentions. They point to the existing legislation that people with mental impairment may only come under the remit of the Act if it associated with “abnormally aggressive or seriously irresponsible conduct”. Whilst this terminology is not perfect it has allowed a needs-based approach for the use of the Act for people with learning difficulties.

I welcome the improvements that have been made to the drafting of the conditions from the 2002 drafting, however, when combined with the wide definition of mental disorder I remain unsure as to whether they are yet sufficiently stringent to prevent inappropriate usage. I prefer the drafting contained in The Conditions in Scotland (Mental Health Care and Treatment) (Scotland) Act 2003.

I welcome the fact that the Bill breaks the automatic link between compulsory treatment and detention and allows patients to be helped in the setting most appropriate to them. However, I will wish to make sure in Regulations and the Code of Practice that compulsion in the community is not inappropriately used resulting in an increase in compulsion. I would wish to ensure that such non-resident patients receive appropriate interventions, which will have workforce implications (see question 10).

3. Does the draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand and concerns for public and personal safety on the other?

The number of people from whom society needs protection is very small, and I recognise that the UK Government have sought to protect the human rights of this particularly vulnerable group and that there is inevitably a fine line to be drawn between protection of the public in general and rights of individuals. It is important that the balance is struck according to clear evidence of risk to public and personal safety, rather than concern about that risk. I welcome the proposal that people with personality disorders will now not be prevented from receiving treatment under compulsion where that is necessary and appropriate.
4. Are the proposals contained in the draft Mental Health Bill necessary, workable, efficient and clear? Are there important omissions in the Bill?

The policy intent behind the Bill is clear; however, Welsh stakeholders have made the point that they consider the drafting of the primary legislation as excessively complex, containing as it does over 300 clauses. It could prove to be administratively very difficult to apply.

5. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft Bill?

The proposal to transfer the functions of the Mental Health Act Commission to the Commission for Healthcare Audit and Inspection (the Healthcare Commission) is welcomed. However, it is essential that the Healthcare Commission recognises in its operation the legitimate differences between England and Wales and that appropriate arrangements are established between the Healthcare Commission and Health Inspectorate Wales to ensure maximum benefit to patients and carers.

The new Tribunal system and Appeals Tribunals are welcome but have major workforce implications that are dealt with in Question 10.

6. Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

I welcome the safeguards contained in the draft Bill in respect of children, advocacy and aggressive procedures. The safeguards for children are consistent with the Carlile Report that we issued in March 2002, which covered safeguards for children in the care of the NHS. I remain concerned that there are no safeguards for repeated malicious requests for assessment under the draft Bill, as this currently allows anyone at any frequency to make such a request.

Whilst I welcome the Nominated Persons provision, I think consideration should be given to retaining the specific rights of the Nearest Relative that are contained in the existing legislation.

7. Is the balance struck between what has been included on the face of the draft Bill, and what goes into Regulations and the Code of Practices right?

Health and social services are devolved matters in Wales and therefore as much of the detail as possible should be contained in the Regulations and the Code of Practice rather than the primary legislation. I believe more could be contained in the Regulations and Code of Practice. As drafted the National Assembly does not have a great deal of scope to shape the legislation in the light of Welsh policies and service infrastructure. For instance, although it would be difficult, as Home Office functions are not devolved, more scope could have been incorporated for the Welsh Assembly to define relevant conditions.

8. Is the draft Mental Health Bill adequately integrated with the Mental Capacity Bill, (as introduced in the House of Commons on 17 July 2004)?

There is clearly a complex inter-relationship between the two pieces of legislation. Consideration will need to be given as to what changes are needed to either or both due to the judgment in HL v UK Government (The “Bournewood” case). However, the rights and safeguards contained in two Bills are different which will be confusing to users and carers.

9. Is the draft Mental Health Bill in full compliance with Human Rights Act?

I have taken no independent legal advice on the issue of Human Rights Act compliance.

10. What are likely to be the human and financial resource implication of the draft Bill? What will be the effect on the role of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

This draft Bill is a complex piece of legislation that makes it difficult to accurately predict the resource implications with any great accuracy. Although it is the policy intention of the UK Government that compulsion will not increase, should it do so the resource implications could increase disproportionally due to the safeguard provisions.

With regards to workforce within Wales we have vacancies against establishment in all professional groups working in the field of mental health: nursing, social work, psychology, psychiatry etc. This is particularly severe in psychiatry where we currently have 21% of posts either vacant or covered by locums.
We are as part of modernising mental health services and planning towards implementation of this draft Bill, seeking new ways of working for our existing workforce as well as planning and developing our future workforce to meet the emerging challenges.

Nonetheless we have very real concerns that the workload of psychiatrists will become exclusively focused upon statutory duties. The Chair of the current Mental Health Review Tribunal has advised me of her concern about the feasibility of furnishing the new Tribunal with sufficient members for them to operate. The draft Bill will result in many more hearings of the Tribunals as well as a likelihood that each sitting of the Tribunal will take longer due to additional responsibilities (such as considering the statutory care plan). Thus a large number of additional members will be required for the Tribunal. As far as the medical members of the Tribunal are concerned, this will impact on the availability of psychiatrists to act as members of the expert panel: this panel is itself critical for operation of the Tribunal and if not available could give rise to human rights issues.

Further there is a real danger that the statutory requirements of the draft Bill could reflect from the strategic intent contained in our Mental Health Strategy and National Service Framework by tying up resources in the legal process for the few resulting in the needs of the many suffering. It is possible that this could result in people seeking compulsion to obtain services and having the paradoxical effect of making services and the public more at risk.

Finally, it is important that we do not overlook the considerable implications for training staff in health and social care. Tribunal Members and the voluntary sector will all need to understand the draft Bill when enacted as well as the Regulations and Code of Practice. These all have major implications for professional practice and the necessary training will be considerable and must be properly planned.

October 2004

Witness: Ms Jane Hutt, Assembly Member, Minister for Health and Social Services, Welsh Assembly Government, examined.

Q529 Chairman: Ladies and gentlemen, before we formally start this session I would like to thank our hosts at the National Assembly for their help in organising this meeting; this meeting is a procedural first. Never before has a joint committee of the House of Commons and the House of Lords taken formal evidence in the Welsh Assembly. We are into our third month of oral evidence hearings in Westminster on the draft Mental Health Bill; in the course of those hearings we have heard from many Welsh stakeholders alongside their English counterparts, we have also received numerous written submissions from Welsh stakeholders and today we are very much looking forward to exploring more deeply the Welsh views on the draft Mental Health Bill. Can I start by giving a very particular welcome to Jane Hutt, a member of the Assembly, who is the Minister for Health and Social Services in the Welsh Assembly Government? As you are the first witness, Minister, can I start as I am going to with every witness by reminding everyone that this is a public evidence session; a transcript in English will be produced and will be available on the internet after about one week. It will be open for textual but not substantive correction. Can I also say to all witnesses who are waiting, please speak into the microphones and speak up when you come to give evidence so that we can hear every word, though I must say this is a better committee setting than we usually use because the room we usually use is very large and in which areas (if any) would you expect the Welsh Assembly to exercise its discretion to make regulations which differ significantly from arrangements in England?

Ms Hutt: Thank you very much. I am very pleased that you are giving this scrutiny and coming to Wales to hear our views. Thank you.

Q530 Chairman: The regulations and the codes of practice under the draft Bill, as you know, have yet to be published, but one of the clearest things about this draft Bill is the reality of devolution. Could you indicate to the Committee which principles you consider should be adhered to when the National Assembly for Wales drafts secondary legislation, and in which areas (if any) would you expect the Assembly to exercise its discretion to make regulations which differ significantly from arrangements in England?

Ms Hutt: Thank you very much. I think the issues relating to the principles are very important and, of course, they have been laid down in general in terms of the three points of involving the patient in decision-making and through decision-making ensure that they are open and fair decisions, and also...
that intervention is on the basis of least restriction. I envisage that these will be adhered to in our approach to secondary legislation, but, of course, we need to underpin this by Welsh needs and circumstances and indeed the Welsh policy framework. That rests within our Adult Mental Health Strategy and indeed our Adult Mental Health National Service Framework; just to mention the Adult Mental Health Strategy, that was published in 2001 and the title of that strategy was Empowerment, Equity, Effectiveness and Efficiency, and those are the principles which we would want to underpin secondary legislation, particularly looking at the issue of empowerment, empowering our service users and their carers. We also, as you know, have a statutory obligation to promoting equality of opportunity in the Government of Wales Act which is key, and we will obviously come on to issues around the equality of Welsh and English language and also the different structures in relation to health and social care. If I could just address your issue beyond that, in terms of those are principles that would underpin our secondary legislation, but if we look at issues where they may be variants or differences or where maybe we want to seek the opportunity for differences and variants, what I would say at the outset is that we would like as much as possible to be left for secondary legislation. Because we are responsible for health and social care and we have underpinning the National Service Framework and strategies, we do want to ensure that as much as possible is left for our discretion in terms of the opportunities for clinical staff, and other health professionals, relating to mental health professionals, recognising that there are concerns, if this does extend in relation to CPNs and other health professionals, relating to independence in the examination process. We also recognise that there are issues around the opportunities for multi-disciplinary working in terms of the opportunities for clinical staff as well as those of the social work profession. We would also want to be looking at who could be, in addition to psychiatrists, clinical supervisors. Those are areas which have been raised with us, but I think the major issue and concern does relate around the impact and use of compulsion, and we do feel, as I said in my written submission, we are in favour of exclusions, and you will know that I have referred to the Scottish legislation in this respect, but in terms of the use of compulsion what I want to seek as Minister is as much flexibility through secondary legislation for areas in the Bill that affect both the rates and the use of compulsion in Wales.

Q531 Chairman: Forgive me for interrupting you, would that include the use of Community Treatment Orders; and perhaps you would indicate in the context of the answer you have been giving, given the widely divergent evidence this Committee has had about even whether there should be Community Treatment Orders, let alone what they should be, what categories of people with mental illness would you like the National Assembly to define as suitable for Community Treatment Orders?

Ms Hutt: We would seek regulatory power through our secondary legislation for that very issue. You are receiving evidence about this in terms of should there be that route in terms of non-residential; we obviously recognise that there is an issue around the revolving door type of patient and concerns as far as that is concerned, but we would certainly want to have the opportunity in terms of secondary legislation, to consult widely as to how we would deliver on that regulation.

Chairman: Thank you. Mr Hinchliffe.

Q532 Mr Hinchliffe: I wanted, Minister, to pick up your point about the approved social worker role. I personally broadly agree with what you are saying, but one argument against what you are saying and in favour of the way the Bill suggests we should go is that increasingly we will see a much closer working relationship between health and social care and the possibility that certain roles like CPN and social worker may get much closer together. Do you not see that 10 or 20 years down the line we may have a very different professional person in front line mental health than those we have now?

Ms Hutt: Yes, and I think that is where the approach to workforce redesign is crucial, and I am sure we will go on to that in response to further questions, because we are modernising and it is a key action in our National Service Framework to modernise and redefine the workforce; indeed, in Wales we have chosen to have health and social care closely linked. Our local health boards are co-terminus with our unitary authorities for health and social care and we have health, social care and well-being strategies under statute that the partners have to develop, so I can see the progression in terms of that direction. I think it is the issue relating to independence and the role that obviously you are teasing out in relation to the approved social worker, and I think that through secondary legislation we have the opportunity to actually consult more widely. I do not think this is something we should be rushing to, we want the flexibility within the Bill to really root and branch
Chairman: Mr Williams.

Q533 Hywel Williams: (Through the interpreter): Thank you very much, Lord Chair, and good morning, Minister. I wanted to raise a specific matter with you regarding Community Treatment Orders. I have a concern about rural areas in Wales where it will be more difficult to implement these; would you see these being implemented differently in Wales compared, for example, with urban areas in England where there are actually no resources so there will be inequality or inequity in terms of the choices of treatment available to people in rural Wales?

Ms Hutt: Again, it does go back to those key principles of empowerment, equity, effectiveness and, indeed, in terms of our obligations in the Welsh Assembly Government to equality and promoting equality of opportunity, and recognising in terms of equity that that is where our National Service Framework and the implementation of it is key in order for us to be able to have appropriate services for people in rural areas. I know this is something we will move onto in terms of implementation of our National Service Framework and the Care Programme Approach, but it is clear that the rurality of Wales as well as the language issues will have to be taken into account if we are to deliver on that.

Chairman: Mrs Blackman.

Q534 Mrs Blackman: If I could just push you a little bit more about the answer you gave to Lord Carlile about Community Treatment Orders, why are you so much more positive about the use of Community Treatment Orders? A lot of the evidence we have taken is either completely opposed or certainly extremely sceptical; why are you so convinced that they have a place and they will meet your key principles?

Ms Hutt: I think what I was being positive about was the opportunity to actually influence it through secondary legislation. We are concerned about Community Treatment Orders and indeed that has come back to us from our stakeholders; I apologise if I did not make it clear that what I was concerned about is that we have an influence, if they are to progress through the legislation and through the Bill, on how they should be implemented. Clearly, this is an issue where there are great concerns about equity and empowerment.

Q535 Mrs Blackman: Would you like to just elaborate a bit on the concerns that have been put forward?

Ms Hutt: It is concerns about, for example, the use of appropriate support and treatment, what is appropriate. That does come back to the issues which I touched on earlier about the compulsion and whether there are exclusions that can actually ensure that we have respect and recognition of what kind of treatment would be available, but I think it does go back to the concerns that have been raised by stakeholders. On the other hand, there is an issue around the fact that we do have people who potentially are losing out on treatment if they do not have the opportunities which, hopefully, the Bill will address, but it is a matter of concern from stakeholders and I am sure you have already had quite a few comments. The supervision is key and also the risks to patients in terms of increased use of compulsion, particularly in relation to Community Treatment Orders.

Q536 Chairman: On a day when two trains carrying Members of this Committee to Cardiff happily arrived early, could you give us an estimated time of arrival of the Welsh Code of Practice and draft regulations, please?

Ms Hutt: Clearly, there are parts of it where we would have to be in tandem because we are already starting work in terms of mapping out the parameters of a Welsh Code of Practice and the direction of it, but I will have to work with my colleagues in the Health and Social Services Committee and the Assembly to deliver on the timetable for implementation. We are concerned about the timetable because we know that we want to consult widely, we want to deliver a Welsh Code of Practice and in terms of secondary legislation we will need to have time to consult. We already have processes in terms of open Government for full consultation and, indeed, in terms of a timescale for implementation we want to deliver on our National Service Framework to ensure that our services are robust, because there is a concern as you know, Lord Carlile, from stakeholders and indeed from the professionals and myself as Minister that, unless we have our services fully in place and our workforce expanded, then we will have difficulties and there will be concern that there will be more use of compulsion than if we were really up to speed in terms of delivery of our services at the time of implementation. 2007-09 is nearer than we think.

Chairman: I am sorry?

Ms Hutt: 2009 is nearer than we think.

Q538 Chairman: What, for the Code of Practice in draft and the draft regulations?

Ms Hutt: In terms of actually delivering we will have to deliver in terms of the Bill as it emerges.

Q539 Chairman: Can I be absolutely clear—I am not going to abandon a barrister’s habit of a lifetime and indeed, Mr Lawlor, your official, knows my habit very well of occasionally asking quite specific questions—can we have a clear answer to the question when you expect to have draft regulations and a draft Code of Practice, and did you really mean to give the Committee the impression that it is 2009?

Ms Hutt: No, I apologise for the 2009. Ultimately, we will be ready for the commencement with our Code of Practice.
Q540 Chairman: So that could be a year and a half down the line.

Ms Hutt: Obviously, in terms of the timescale I understand we are talking about 2007, that is what the Department of Health has told us in terms of commencement.

Chairman: That is what they have told you, Mr Loughton.

Q541 Tim Loughton: On the draft Code of Practice can I just be sure about the mechanics of it all? We are told that we are not going to get the draft Code of Practice until the actual Bill is produced, whenever that may or may not be in the future. What input have you got into the Department of Health in London to influence that Code of Practice on the basis that you are saying that you are going to have to be all reactive or partly reactive to whatever is produced in London as to then producing your own version of that Code of Practice? How widely is the Department of Health consulting you proactively at this stage, or are you just waiting until you get what you are given and then will have to adapt it accordingly for your own Welsh version. How do you envisage this actually happening, because your timetable is going to be that much more squeezed if you are waiting on London?

Ms Hutt: We are certainly working in tandem with the Department of Health in terms of the development of the Code of Practice and obviously in relation to the whole timescale of the Bill. We have project leads in both the Department of Health and the Welsh Assembly Government who have been working on the draft Bill and indeed the previous draft Bill that came forward for pre-legislative scrutiny. There is no question that we are already mapping out how we would see a Welsh Code of Practice; I am partly giving evidence to you to encourage you to try and seek as much flexibility as possible in terms of the parameters and the principles of our Code of Practice here in Wales and indeed the secondary legislation, but we will have to deliver in time for commencement and we will have, as far as I am concerned, as much freedom as we hope we will gain as a result of as much of it being left to secondary legislation as possible, and the Code of Practice of course will be the guidance to implement that. That is something where, as far as you are concerned, you might want to have more on the face of the Bill; we want to have more opportunities for flexibility in secondary legislation and the Code of Practice.

Q542 Tim Loughton: Do you think we should be better informed by you giving us some indications of your likely Code of Practice before we get one in London? Should this be more of a two-way street with this Committee?

Ms Hutt: I hope I have given you some indication. You have had a lot of written evidence from other stakeholders as well as myself of our concerns about the draft Bill, but also you have had evidence about our strategy, our approach, our powers and responsibility in relation to our Adult Mental Health National Service Framework and strategies. I think you have also had evidence from me that we are interested in evidence coming forward about the use of exclusions in terms of impacts on the power of compulsion; I have already mentioned one area of concern about the approved mental health practitioner and we can go through the whole process of compulsion step by step and say these are our views, if that would be helpful—and I have given you two examples—but basically that the Welsh Code of Practice will have to be in line with the primary legislation is clear, it is how it reflects Welsh needs, circumstances and policies that we would want to see. I do not think there is more that you need to know at this stage except what I am hopefully giving you in terms of our policies and our Welsh circumstances.

Q543 Tim Loughton: It is not clear whether that differing Code of Practice is going to be based on the problems you have with the capacity you are able to offer and some suggestions that mental health services in Wales are a few years behind, or whether it is going to be based on some suggestions that you can do it rather better than the likely Code of Practice from London is going to suggest. Are you tailoring it because of the inadequacies of the service as it stands at the moment in Wales, or are you going to tailor it because you think you have a completely different approach that will be rather better?

Ms Hutt: No, this is about collaboration between the Welsh Assembly Government and the Department of Health. As I have said, we welcome the fact that there is new legislation, the Act has to be reformed, but we are concerned to ensure that Welsh circumstances and needs are reflected in the Bill, principally through secondary legislation, that is the evidence I am giving. In terms of the way forward, it is based and underpinned on not just the principles that have been laid out in the Bill but also on the principles of our mental health National Service Framework and strategy. We have to take into account our workforce, we have to take into account the readiness of our services, and that is key, but I think you will recognase that the evidence that is coming forward is also about the basic principles of this legislation in relation to compulsion and in relation to the equity and empowerment issues of service users. It is basically a combination of improving the legislation on an England and Wales basis—that is why I am giving evidence today—but specifically for Wales, and ensuring that we have as much flexibility as possible in our secondary legislation. The result of devolution is that we have that power within secondary legislation to shape things to meet our circumstances, but basically the primary legislative powers are what is going to be the key driver of this Bill.

Chairman: Mr Williams, do you want to raise any other issues briefly about the codes of practice before we move on to a question about the Care Programme Approach?

Q544 Hywel Williams: (Through the interpreter): Thank you very much, Lord Chairman. There are a number of questions arising in my own mind, but I
would like to ask a very general question of you rather than go into too much detail here. Bearing in mind the complexities of having a different Code of Practice in Wales to that in operation in England, and the differences between implementing the service framework, did you give any consideration to giving pressure for having a separate Bill for Wales? If you did consider that, what was your opinion on that?

Ms Hutt: In terms of answering your first point, what we need to do in the Code of Practice is to involve Welsh stakeholders in the development of our Code of Practice, that is the way we work in Wales, involve them in it before it is finalised. It would be unusual to produce the Code of Practice at such an early stage in the process. I am sure you would recognise that as a Committee anyway, but in terms of this Bill there is clearly a function to Part 3 under the Home Office; we have to recognise that in terms of our opportunities it comes through secondary legislation and the Code of Practice.

Chairman: Thank you. Lord Rix.

Q545 Lord Rix: My question is not about the Code of Practice, but we were going to hear evidence later on from the Welsh Nursing and Midwifery Committee, and unfortunately they are not now going to give us that evidence. They refer to the Bill and suggest “that the removal of existing exclusions contained in the new Bill is an erosion of the public’s protection, and may not be compatible with the Human Rights Act. Removal of these exclusions effectively broadens the grounds for compulsion”. Would you agree with that statement?

Ms Hutt: I think I have raised already, Lord Rix, the concerns we have about the powers for compulsion and I have already in written evidence said that we are attracted to the exclusions that have been identified in the Scottish legislation, so we do have some sympathy with that and that is why I gave my response as I did.

Q546 Lord Rix: Can I go one step further? Obviously, I am referring to learning disability; as you know, learning disability is swept into this Bill by all the accompanying papers which we have had, but I am of the opinion that people with learning disability should not be in the Bill unless they have a mental illness as well, therefore they should come under these exclusions. I feel very strongly about this; would you agree with the exclusion of people with learning disability without the additional problems of mental illness?

Ms Hutt: Certainly, that view has been expressed to us very strongly by our Learning Disability Implementation Advisory Group, which has obviously drawn reference to the existing legislation which relates to people with mental impairment, that they only come under the remit of the current Act if associated with abnormally aggressive or seriously irresponsible conduct. The only other point I would make in this context is that within the new legislation we need to be also careful that people with learning disabilities do not then fall within the criminal justice system if they do not have protection, so that is my concern about the exclusion in relation to the Scottish Act. From the criminal justice aspect of this new Bill we have to protect people with learning disabilities from that eventuality and we need to ensure that we get the right treatment and support for people with learning disabilities.

Chairman: Lady McIntosh.

Q547 Baroness McIntosh of Hudnall: Minister, we have begun to touch on the issue that I wanted to raise with you already, but we have had submitted to us some evidence, certainly opinion, to the effect that mental health services in Wales are being provided on some rather outmoded models. Indeed, we have been told that practice in Wales and policy is less evolved than it is elsewhere in the UK; therefore the implication is that extra safeguards—if this is true—would need to be in place to ensure that the Code of Practice was developed to make sure that a Care Programme Approach was fully implemented and resourced. Can I ask you first of all whether you agree that mental health services in Wales are behind, both in terms of their modelling and their delivery and resourcing? If you do agree can you tell us why the Care Programme Approach is not fully implemented yet and whether or not the implementation of the National Service Framework in Wales will eliminate some of those differences that we now see between Wales and England?

Ms Hutt: Thank you very much, Lady McIntosh. In fact, part of this is historical and perhaps I can focus particularly on the Care Programme Approach since it is a key action in our National Service Framework. If we go back, the Care Programme Approach was introduced in England in 1991 and then through Building Bridges in 1995 guidance came through with strengthening guidance in 1999; in Wales, just to give you the historical picture, in 1998 the guidance first was initiated in terms of the Care Planning Process and then in 2002, through our National Service Framework, this Care Programme Approach became a key action and, in fact, this month (December 2004) we are expecting all our local health boards to deliver with their partners on the Care Programme Approach in Wales. So historically we were behind, pre-devolution, we had extensive consultation around our Adult Mental Health Strategy which led to our National Service Framework, which we feel is a robust National Service Framework, we have just had a review of it and the Audit Commission has done a baseline review for us. We also have appointed a new Director of Mental Health Services in Wales, again the first ever appointment of such a professional in the Assembly, so we are making progress in order to deliver, and through performance management we have a service and financial framework and we also have our National Service Framework key actions, so the Care Programme Approach should be delivered in 2005 across the whole of Wales, it should be in place. Performance management of course will be key and that will be done through our three regional offices of the Health and Social Care Department in Wales. As far as implementing our
National Service Framework is concerned, there is huge enthusiasm backing it, it is a priority of the Welsh Assembly Government, it is a priority of the National Assembly for Wales and mental health is quite at the forefront of the political and public agenda in terms of improving services. We are investing more as an Assembly Government into Adult Mental Health Services and, clearly, our stakeholders are engaged in the implementation of it—they co-chair our Implementation Advisory Group—but our concern I think is that we deliver on our National Service Framework and that in terms of priorities and investment that is our focus—in terms of workforce development, workforce redesign, improving services that has to be our focus, and I am confident as Minister that we are on line to deliver our National Service Framework.

Chairman: Can I just link this with a question that I know Ms Moffatt wants to ask because I think the two tie together very well?

Laura Moffatt: They certainly do. Minister, I am very interested in what you are saying about the aims and objectives of getting to the point with the Bill or the Act, whatever it looks like, where the Welsh Assembly will be able to respond properly, and in your written evidence and in your evidence now you are talking about the changing roles of those professionals involved in that whole process. We know that there are acute shortages of staff, particularly in Wales—in fact, I believe the situation is more severe in Wales than it is in England—and I wondered if you have given thought to how you are going to reach that establishment and what impact will that have on reaching the goals that you have been talking about today if you have not got, particularly, psychiatrists in place and other professionals to be able to deliver the service?

Q549 Baroness McIntosh of Hudnall: I do not want to labour this point because I can see that it is difficult and I do not doubt the goodwill and intentions that are expressed in what you have said, Minister, and in what you have submitted in your written evidence, but do you feel that there is a danger, given that we are being told that you are already in Wales somewhat behind in the delivery of these new mental health strategies, that the implementation of the Bill will put such pressure on your services that there is a danger that you will fall as it were further behind? I am sorry to put it in that rather uncomplimentary way but I am just trying to feel for whether there is a real danger of an active disadvantage growing out of the relationship between this Bill and your own strategies.

Ms Hutt: Certainly that is the major concern that has been expressed by our stakeholders, that it is the impact on delivering or National Service Framework and also the ability of the workforce in terms of delivery, because in terms of the use of compulsion we understand that if there is a 10% increase in the use of compulsion, it could lead to a 20% increase on their statutory duties in terms of the workforce. Clearly if we have the National Service Framework implemented—and can I just say that key actions relate to not just the Care Programme Approach but crisis resolution and home treatment as well as all of the issues relating to prevention and mental health promotion and tackling stigma—if all those are in place, then I think it would be a better balance in terms of the implications of the Mental Health Bill in terms of implementation. That is the dilemma for me as Minister in terms of how I respond to you, in good faith, in terms of yes we need to modernise, yes we need reform in terms of the Mental Health Act we have now, but we in Wales have got to deliver on improving mental health services and have that in place. I think that is where we go back to have we the opportunity in our Code of Practice and secondary legislation to help achieve a balance in terms of delivery.

Chairman: Mrs Browning.
Q550 Mrs Browning: Thank you. You mentioned up to standards within the Barnett formula and then the implementation of this Bill post 2007. I just wonder how you are seeing this in terms of actually filling these vacancies, which seem absolutely essential. I know there is a national shortage, particularly of psychiatrists, but is it the case that it is that lack of policy and strategy being in place that puts people off applying for posts in Wales and therefore you need to really step up the timescale in which you implement something that is attractive, or are you looking at other ways of actually recruiting the people who you will need on board to help you develop that strategy and to implement it. If I could just add a supplementary to that, within that framework and that strategy and the need to recruit, how focused are you on the need, particularly in psychiatry, for specialisms within the field of mental health? I am particularly focused on the lack throughout the country and the very patchy and sporadic expertise we have in psychiatrists who also have an expertise in autism. I just wonder how you are focusing on those specialisms because it seems to me you have a pretty big mountain to climb there.

Ms Hutt: We do not see it as a mountain, we see it as a challenge and as a priority, that is the key for me as Minister. I have outlined already, and I will not go over it again, how we are putting into place our National Service Framework key actions, the service and financial framework, and health boards have to deliver not just on Care Programme Approach but crisis resolution and home treatment, so in terms of moving forward I believe we are going as fast as we can. Recruitment and retention is key; we have expanded for example our SPRs (specialist registrars) in psychiatry in order to grow our workforce in Wales, but also in terms of recruitment and retention we have just invested more into, for example, our Child and Adolescent Mental Health Strategy, and that in itself is having an impact on recruitment and retention because we are making progress in that respect. Turning to the needs in terms of sub-specialisms, interestingly, in Wales we are ahead of the UK in developing an Autism Strategy, which you might be aware of, and that Autism Strategy is going to guide the way in very similar terms to a National Service Framework about autism services across Wales. However, that does not just relate to health, of course, it relates to social care, education and all the other aspects of the lives of people with the autistic spectrum disorder syndrome. So we are up for it all in terms of timescales, recruitment and retention, investment, priority and recognising sub-specialisms like autism.

Chairman: Mr Prosser.

Q551 Mr Prosser: You have told us you are confident of meeting your National Service Framework requirements but, at the same time, you have listed some of the challenges, some quite large challenges that you have to meet. Are you confident that you can meet all of those challenges and come up to standards within the Barnett formula? Secondly, and specifically, with regard to the shortage of psychiatrists and other staff, to what extent is the requirement and the quite understandable requirement that new recruits should have linguistic skills in Welsh a barrier to your recruitment programme?

Ms Hutt: Both points touch on a couple of issues relating to resources; for example, our budgetary estimates for not just implementing our Adult Mental Health National Service Framework but also the implications of this new Act which, although we anticipate in 2006–07 will cost £3.8 million in addition, and certainly we are seeing as large a consequential as we can in terms of the Barnett formula from the Treasury and the Department of Health, there is an issue about how we deliver twin track—preparing for the new legislation and delivering the National Service Framework. That is our responsibility, it is hugely challenging and I realise that has had an impact in terms of the Bill—you want to scrutinise the Bill and see how we can improve the Bill, and I have talked about principles and practicalities in terms of my evidence. In terms of the equality of the Welsh and English language, which is our statutory commitment and framework, I am sure you will hear from the Welsh Language Board that we have a Welsh language healthcare unit within the Assembly where we are promoting the opportunities, and indeed bilingual Wales, the Iaith Pawb, is all about how we promote the opportunities. It is a very important aspect, but it is not necessarily the key issue for recruitment and retention because it is not necessary to speak Welsh in order to work in Wales, but obviously linguistically and in terms of quality services we want to encourage as many Welsh speakers as possible, not just psychiatrists but through all of the professions. Indeed, that is what we are driving to in our Welsh language policy. I would say that recruitment and retention has to be about investment, and I have talked about that already, I will not go over it, and we need to ensure that every aspect of our services are provided bilingually where appropriate.

Chairman: Dr Naysmith.

Q552 Dr Naysmith: I listened very carefully to what you had to say to Lady McIntosh in describing the various milestones that were reached, in most cases, a few years after they had been reached elsewhere. You say that mental health services and your National Service Framework are now very much a priority for you and for the Assembly, but what you did not do was explain why things were happening a little bit later in Wales than they were elsewhere. Do you have any explanation for that?

Ms Hutt: Dr Naysmith, I think I did give some explanation of the historical situation in terms of pre-devolution.

Q553 Dr Naysmith: You did, yes.

Ms Hutt: For example, the Care Programme Approach did not emerge in terms of the planning process as early as in England; also, in terms of the
consultation we had for the Adult Mental Health Strategy, that was when the Assembly came into being and we did have widespread and extensive consultation to get what we felt was the best strategy for Wales and the best National Service Framework for Wales. Indeed, our involvement of users and carers in our planning and indeed in the implementation of our National Service Framework, the appointment of our new Director of Mental Health Services, has all positioned us very well to provide good mental health services in Wales and we want to get it right for Wales.

Q554 Dr Naysmith: Would it be fair to say that because you are taking a little bit longer over the process you expect to produce a better result at the end?

Ms Hutt: We would hope we were getting the right result for Wales. It is very challenging, it is a priority, along with cancer and cardiac—and there are obviously huge challenges in Wales in terms of health, we have high levels of poor health in Wales which has had an impact—and also we have started from a very low base in terms of, for example, our older estate, our Victorian hospitals. We are now replacing all of those and we are moving forward, but it is at a pace where we feel that what has emerged from this in terms of our policies and our involvement through the devolution process will result in robust and good mental health services.

Chairman: Mr Williams has an extremely brief final question.

Q556 Hywel Williams: (Through the interpreter): Thank you very much. This is a yes or no response to this one really: do you predict that in the Code of Practice there will be a right for people to be assessed through the medium of Welsh?

Ms Hutt: Certainly.

Q557 Chairman: Actually, that was a trick question because I have a final question to ask you really. Can you give us any examples of where you have actively chosen to differ from English strategy?

Ms Hutt: In terms of mental health or other aspects? We certainly have not gone down the route of foundation hospitals and of course we are moving to free prescriptions shortly. We have variances according to Welsh needs and circumstances, and policies.

Q558 Chairman: Thank you very much. Thank you, Minister, very much, for bearing with our questions, dealing with them so efficiently and for working at the high speed which is always imposed on this Committee because there is so much material we have to face. We are very grateful to you for taking the time to prepare clearly so carefully and to speak to us today. Thank you.

Memorandum from the Health and Social Services Committee National Assembly for Wales (DMH 389)

REPORT BY THE HEALTH AND SOCIAL SERVICES COMMITTEE

DRAFT MENTAL HEALTH BILL

Background

1. On 14 October 2004 the Health and Social Services Committee considered the Draft Mental Health Bill published by the UK Government on 8 September for pre-legislative scrutiny. The Committee invited those organisations in Wales that gave evidence on the previous Draft Bill in September 2002 to do so again. Copies of the written evidence submitted in advance of the meeting are appended to this report, together with the minutes of the meeting.
2. The organisations represented were:
   — Association of Directors of Social Services;
   — HAFAL;
   — Mind Cymru;
   — Royal College of Psychiatrists;
   — Royal College of Nursing.

The Law Society was also invited to the meeting, but had not been able to accept.

Consideration of Evidence

3. The Committee focused its examination of the Draft Bill on the changes from the Draft Mental Health Bill that was published in 2002 and the extent to which the new draft met the concerns raised then.

General Principles

4. Written evidence from the Royal College of Psychiatrists addressed the question of whether the Draft Bill was rooted in a set of unambiguous principles. They recommended a number of issues that the Bill should address specifically as principles. Hafal supported this view.

The Committee’s Conclusion and Recommendation

   — The Committee took the view that the principles underlying the Draft Bill should be set out clearly. The current draft, as with the 2002 draft, was not compatible with Assembly policy.

Conditions for Compulsory Treatment

5. All of those who gave evidence took the view that the revised definition and associated conditions would result in increased levels of compulsory detention. New groups would come under the scope of the legislation inappropriately, including those with substance misuse problems and people with personality disorders, for whom there was no clear course of treatment.

6. In their written evidence, the Royal College of Psychiatrists said that any new Act must not have an adverse effect on voluntary (consenting) patients. This could occur because patients who are under compulsion will have first call on the limited resources. This view was supported by Hafal, who felt that the Bill would not help people who sought treatment voluntarily in the early stages of mental illness.

Committee’s Conclusions and Recommendations

   — The definition of mental disorder was too broad and needed to be qualified by exclusions.

   — The emphasis on compulsion would draw heavily on resources resulting in less scope for early therapeutic intervention where this was sought voluntarily. The right of people to have voluntary treatment needed to be given equal status.

Treatment Orders in the Community

7. In their written evidence Hafal had been particularly concerned about the loss of carers’ rights. It felt that carers would no longer have powers to seek the discharge of patients and they were effectively excluded because new provisions for the Nominated Person replaced the previous rights of carers. Vicky Yates, a carer who gave oral evidence to the Committee felt that carers would have all the responsibility and none of the rights. She believed the new legislation would put pressure on carers to ensure patients did not breach conditions, which could be seen as part of the coercing process and would have an adverse effect on the caring relationship.

8. Hafal also raised concerns that under Clause 14(1) any person could request the Local Health Board to carry out an assessment of a mentally disordered person. This could lead to malicious or mischievous requests.

9. Mind also raised concern that the nominated person was entitled only to be “consulted” and had no powers to discharge a patient under compulsion. They felt that the nominated person should have the same powers as the nearest relative under current law and should retain the right to block the patient’s admission. Mind took the view that it was unlikely that people who were well enough to be in the community and not in hospital would need compulsory treatment. It could be difficult to break the cycle of compulsory treatment where treatment was shown to be effective and removal of compulsion could put the patient at risk.
10. The Royal College of Psychiatrists told the Committee that, although the Draft Bill provided for compulsory treatment in a health care setting, it did not contain enough detail about how this might be achieved. In its written submission, it recommended that the rights and safeguards should be same under the Mental Capacity Bill and the Mental Health Bill.

Committee’s Conclusions and Recommendations

— The role of the nominated person would be weaker than that of the current “nearest relative”. This needed to be addressed, as did the role and rights of carers. The Committee recommended that the Joint Parliamentary Committee be asked to look at the roles of the nominated person and carers in the cycle of assessment and treatment.

— The concerns about compulsory treatment raised by the Committee in 2002 had not been addressed. These related to the criteria for applying compulsion and how compulsory treatment would be given in the community.

— Clause 14(1) was open to abuse in people making malicious or frivolous requests for assessment. It was recognised that this clause was probably intended to protect the rights of families and carers, but its intention needed clarification.

— There is potential for people being trapped in a cycle of incidents of compulsion. Compulsion should be a temporary measure only.

— It was important that the provisions and terminology of the draft Mental Health Bill and the Mental Capacity Bill currently before Parliament should be compatible.

Effects on Professional Roles

11. In their written evidence, the Royal College of Nursing said that the Approved Mental Health Professional may require a different view, possibly a conflicting one, from that of the actively caring nurse, patient or manager and there were clear implications for the therapeutic role. The role needs to be clarified. They supported this in their oral evidence with the view that moving the focus from a therapeutic, caring relationship to one of compulsion could be extremely damaging.

12. The Association of Directors of Social Services was disappointed that the Approved Social Worker role had not been retained. The Bill did not take account of the increasing integration of health and social care and the aims of the National Service Framework. Mind expressed grave concerns at the loss of independence resulting from the creation of the Approved Mental Health Professional. The current Approved Social Worker was seen to have a level of independence because he or she was not normally employed by the NHS. Service users had been extremely concerned by this proposal.

13. The Royal College of Psychiatrists highlighted the current shortfall in consultant psychiatrists in Wales, where there are 40 vacancies. It estimated that 30 more psychiatrists would be required in addition to filling the vacancies, if there were to be no diminution in services for patients not subject to detention.

Committee’s Conclusions and Recommendations

— The provisions in the Bill for compulsion could damage the therapeutic relationship between the patient and health care professionals.

— It would not be appropriate for the role of the Approved Social Worker to fall to a professional in the health service.

— If the number of people receiving compulsory assessment and treatment were to increase under the Bill as predicted it would be necessary to recruit more psychiatrists.

Other Resource Implications

14. In their written evidence all of the organisations expressed concerns about implications for resources, both staffing and financial. The Royal College of Nursing and the Association of Directors of Social Services expressed the view that mental health services were already under-funded and that the requirements of the Bill would exacerbate the problem.

Committee’s Conclusion

— The additional costs that would be associated with providing more tribunals and advocacy were noted, although evidence on this had not been discussed.
**Effects on Welsh Mental Health Services**

15. Hafal expressed the view that the provisions of the bill would increase the stigma attached to mental illness.

**Committee’s conclusion and recommendation.**

— The Bill should seek to reduce, rather than increase, the stigma associated with mental illness. The Committee recommended that the Joint Parliamentary Committee address this issue in detail when it scrutinises the Bill.

David Melding AM
Chair
November 2004

**Witnesses:** Mr David Melding, Assembly Member, Chairman, Health and Social Services Committee, National Assembly for Wales; Ms Kirsty Williams, Assembly Member, Health Spokesperson (Liberal Democrats), National Assembly for Wales; Mr Rhodri Glyn Thomas, Assembly Member, Health Spokesperson (Plaid Cymru) National Assembly for Wales, examined.

**Q559 Chairman:** Can I welcome our next group of witnesses? Can I just say this to our next group of witnesses—and this applies to anyone else who is going to give evidence partly in English and partly in Welsh, I have been asked to say that it would be helpful for the interpreters if you did one language per answer as it were; I know you know the way the system works here much better than we do. Could I ask you to introduce yourselves, starting first with Ms Williams?

**Ms Williams:** Good morning, my name is Kirsty Williams, I am the Assembly Member for Brecon and Radnorshire; I am a member of the Health and Social Services Committee, I speak on behalf of the Liberal Democrats and, in the first term of the National Assembly, when we looked at the first draft Bill, I was chairman of the Health Committee at that time.

**Mr Melding:** Good morning, I am David Melding, I am a member of the Conservative group in the Assembly but I am not the health spokesman, though I am the chairman of the Health and Social Services Committee here.

**Q560 Chairman:** Thank you for your written submissions and correspondence.

**Mr Thomas:** (Through the interpreter): Rhodri Glyn Thomas, I am the Plaid Cymru spokesperson on health and social services and while my colleague, Leanne Wood is on maternity leave, I am also the Plaid Cymru spokesperson on social justice.

**Chairman:** Thank you. Meg Munn.

**Q561 Ms Munn:** Good morning. You will have heard the evidence given by Jane Hutt about what she sees as the advantage of not having the principles set out on the face of the Bill, in that it gives the opportunity for greater flexibility within Wales in developing your own Code of Practice, but in the written evidence that you have submitted to us your Committee took a clear view that the principles underlying the Bill should be set out clearly within the Bill, and in fact you go so far as to say the current draft was not compatible with Assembly policy. Can I have your comments on this issue about flexibility and the benefits as opposed to the negatives of having the principles on the face of the Bill?

**Mr Melding:** First of all, can I confess a certain naivety about primary legislation because we are a secondary legislative body—insofar as that is a coherent concept—so it is perhaps not so easy for us to pass fine judgments on to what extent a piece of legislation can omit the basic principles and leave them to some other mechanism like a Code of Practice. It seemed to us rather strange that you did not have the principles informing a very comprehensive piece of legislation—certainly by the number of clauses it has—without those principles being explicit, and that was the view of some quite senior witnesses who spoke to us. There is an element of contradiction in our approach because in urging principles to be written into the Bill the principles may be rather antipathetic to what we would want and as we would see practice developing in Wales; so there was an approach from some people who gave evidence that, if this was going to be a bad Act, we would want as much scope as possible to improve it in Wales via secondary means, insofar as that is possible.

**Mr Thomas:** (Through the interpreter): Just to add a few points, Chair, I think that, even if the principles of the legislation are clearly written on the face of the legislation, they should be actually implicit in the legislation and I do not accept therefore that a Code of Practice in itself would be sufficient to enable Wales to develop the kind of service for people who suffer mental health problems that is actually required. We as a Party have actually fought for separate legislation for Wales because of the specific needs in Wales and because of the nature of the service in Wales. We have heard of the problems with the National Service Framework in Wales and also, of course, there is the rural element in Wales where it would be very difficult to offer treatment in the community, which is actually in the legislation. Also, there is the special case of the Welsh language and, despite the fact that the Minister can say quite
definitely that we can certainly offer a service in Welsh, I am not aware that it is possible to do that in many places in Wales, and, in order to offer that service fully in Wales, I think we would need to have much more variation from the legislation in England than we could ensure through the Code of Practice.

Q562 Ms Munn: To go on to talk about one of the key issues around the Bill, which is around compulsion, you have expressed concerns about the levels of compulsion that might be involved but also, particularly, you have mentioned those with substance misuse problems and people with personality disorders for whom there is no clear course of treatment. One of the most interesting areas that we have had big discussions about is around people with personality disorders and whether, in fact, in the past there has been tendency by some psychiatrists to use that label as an excuse not to provide services—indeed, we have had some level of admission that that has been the case. What I would like to know really is whether that is an issue that you have discussed and come to a view about in terms of actually providing services for people who previously, perhaps, have not received those services, and whether that is then needed to be done compulsorily or not?

Mr Melding: I think the view the Committee took—and certainly it was strongly emphasised to us in evidence—is that the reason for giving compulsory treatment in mental health law is that they have a mental health condition. There may be other factors associated with behaviour, and in the explanatory notes some very vague concepts are used like sexual deviation, promiscuity, addiction to substances for instance. In a dual diagnosis sense you may have that present, but it seemed to us strange to have such a wide definition of what would be a mental disorder; it would need a mental disorder as well, some people would argue, for that the Bill would actually contradict the European Human Rights Act.

Ms Williams: The Committee's main concern is on issues around compulsion that we have focused on and it came from the evidence that we received, that, if somebody were ill enough to be subject to compulsion, then they should be in hospital—that is with regard to compulsion in the community—but also there were concerns that, given that the definitions were so broad, it would lead to a broadening of the categories of people who might fall into this trap. The issue of compulsion also might lead to people being trapped in a long term predicament of being in compulsion whereas it was seen desirable by the evidence that we received that compulsion should be only a short term measure, and that under this system potentially people could be trapped for almost a lifetime in a cycle of compulsion. With regard to specific personality disorders, the Committee did not actually hear any specific evidence on that but there was a general feeling, both in 2002 when we took evidence and indeed this time, that the Bill perhaps concentrated too much on a potentially small number of people who might fall into that category rather than the broader number of patients who would need treatment, and the issues around compulsion then would potentially stop people from seeking treatment at an early stage and also divert resources away from the majority of people needing mental health services to be focused very much on the few.

Chairman: What you have just said has produced mind waves from Lord Rix who I feel sure has a question to follow that up.

Q563 Lord Rix: Indeed. You recommend specific exclusions from the Bill rather than a tightening of conditions for the use of compulsion; would those exclusions from the evidence you have taken include people with a learning disability without additional mental health problems?

Mr Melding: I do not think it was actually put to us directly but I am sure I can infer justifiably from the evidence that we received that we would exclude people with learning disabilities unless there was an accompanying mental disorder.

Q564 Lord Rix: Thank you very much.

Mr Thomas: (Through the interpreter): I noted that Lord Rix asked this question to the Minister also and I would agree with him entirely that the definition of mental disorder within this particular draft Bill would mean that there would be people who do not have any mental health problems but do have special needs in terms of personality problems who will be drawn into this also, and this element of compulsion will be placed upon them. The Law Society in Wales has suggested that the broadness of that definition of mental disorder would mean that people's fundamental rights would be undermined, and that there is a danger that the Bill would actually contradict the European Human Rights Act.

Q565 Mrs Browning: Similarly to Lord Rix, people with autistic spectrum disorders would come into the same category, although we all acknowledge that they can of course have a mental disorder on top of that. A lot of our deliberations have touched on the Bournewood judgment which specifically involved an individual with an autistic spectrum disorder, and we await the Government's recommendation on that, but could I just ask you—and I asked the Minister this—you are going to produce a national framework for autism in Wales, which I think is absolutely wonderful, but have you thought about the resources, not just for psychiatrists and in-patients, which is what I asked the Minister, but also resources in the community, because a lot of support in autism and keeping autistic people out of mental health services is actually providing the right package of support, and it involves things like housing and social services support. Have you looked at what you think should be done in terms of resources there?
Mr Melding: May I start, Lord Carlile, by declaring an interest. I am trustee of Autism Cymru. I think that needs to be made clear. We very much welcome the decision of the executive here to form an autism strategy—I understand it will be the first anywhere—but I think it is fair to say that we have been slightly disappointed that it has taken a little while, it has been about two years in gestation, I think, but that may be a meagre comment because it is innovative and there is not any practice to emulate. The Committee will, I think, want to look at the actual strategy when it is produced and I think if in an analogous way I can compare it to the Adult and the Child and Adolescent Mental Health Strategies, one of the main criticisms we had was that there were no dedicated resources attached to it in addition to current practice, it was more or less passed on to the commissioning bodies as something to inform their future commissioning, whereas I think in England there was more readiness to top slice monies. We felt, if you are really going to prioritise something you need, certainly in the short to medium term, something as vigorous as that, otherwise you may not shift commissioners very much from their current practice. I would say my experience of autism services, certainly in South Wales, is that they are very under-developed. Insofar as they exist it is because you have a psychiatrist who also happens to be interested in autism, rather than someone who is appointed as an expert in autism and, whilst they often become experts, that is not necessarily why they were appointed initially. That is a weakness, I think, but you could say that of quite a lot of services and the Government of course quite fairly could say that that is one of the reasons they have a strategy because they now need to improve.

Q566 Chairman: Forgive me for interrupting, but can I just pick up a point? As somebody who represents a rural area, Ms Williams, would you say that the problems Mr Melding has highlighted from Cardiff, which is an urban area, are sometimes squared in the remoter rural areas of Wales where there is a great shortage of specialists in almost anything, let alone the autism spectrum?

Ms Williams: Absolutely, and I think that would be in true in terms of autism services, and it is certainly a huge concern for mental health organisations delivering services and representing patients in rural areas with regards to this Bill as well. There simply is a real fear that the problems experienced in urban areas will be squared in rural areas because there is even more difficulty in recruitment and retention of staff often in rural areas, because the opportunities for wider practice and promotion and progression in your career are more limited in a rural area, so it is much more difficult in rural areas, often, to have access to services of a type that may be available in some of the urban and more highly populated areas.

Mr Thomas: (Through the interpreter): Just to add to that—and I agree with what David and Kirsty have said—I would give one warning regarding the autism strategy: that is at present being discussed internally and is not going out to be consulted upon until next Spring, so we are not really clear at present what the content of the strategy will be. In principle it is a good thing and there are many good suggestions being made, but will they actually be included in the paper which will go out to consultation? We will have to wait and see. I would also say that part of my constituency is a rural area, and I have an additional problem in Carmarthenshire which is the provision for Welsh speakers. If there is a general problem in terms of offering a full provision for people who suffer from autism, that problem is huge for Welsh speakers. I have had a great problem in ensuring fundamental rights for school pupils who suffer autism, to get the full provision through the medium of Welsh, despite the fact that there is a bilingual education policy in the area. I know there is a problem with numbers, but I think there is a responsibility to provide fully through the medium of Welsh as well as through English, in a county which is a bilingual county such as Carmarthenshire and in Wales which is supposed to be bilingual.

Chairman: If the strategy has the gestation of an elephant at least it will be as obvious as an elephant when it appears. Mrs Blackman?

Mrs Blackman: Can I just make an observation; I am chair of the All Party Group on Autism in Westminster and we had an excellent presentation of the very holistic approach that is taken by Rhondda Cynon Taf. Yesterday I attended a Welsh Children’s All Party Group where there were representatives from Powys who were presenting their work on autism; they are next door to each other but what they had not done was joined up and shared best practice. That is the same in England as it is in Wales, there is some good practice out there but it does actually need a bit more joining up. Let us hope this strategy does that.

Q567 Chairman: Is anybody going to disagree with that trenchant and completely coherent view? Mr Melding: No.

Chairman: Mr Hinchliffe.

Q568 Mr Hinchliffe: You heard me ask the Minister a question about your position on approved social workers and probably I should declare, as you may already be aware, that I used to be an approved social worker, and it is quite a pleasure to read politicians saying nice things about social workers, it does not happen very often in my experience. What I wanted to press you on in relation to the evidence that you have put forward is do you have reasons, experiences and specific evidence to lead you to believe that professionals other than approved social workers—and we are talking here primarily of health professionals—might be more willing to section people than approved social workers? Are you suggesting that they could be led by a psychiatrist or a GP more easily, perhaps, than an approved social worker? If you are, what is your evidence?
Mr Melding: I do not think we received evidence on that specific point, although we received evidence from all who did comment on the role of the approved social worker that that should be retained, and that it was a robust element in the sense of the team that was dealing with very difficult issues on compulsion that someone from social care and with obvious interests in the person’s reintegration into society and the community was there. We were not convinced, despite explanatory notes saying that there would nearly always be a social worker, that there was a reason to move away from that model. I am not quite sure how predictive legislation is meant to be, but to talk about what might happen in 20 years seems somewhat speculative and I do not think you can hold up legislation just on one issue like that and say we had better put it in just in case; presumably you could amend it at some future point. I think the precautionary approach is appropriate; if I was in your position of dealing with primary legislation—because of course we are not—I would want to see evidence. It was not obvious to us and certainly witnesses such as the ADSS were very concerned about this although, in fairness to this draft, they did note that at least the power of appointment was back with the social services authority, so that was welcome.

Ms Williams: Certainly when we heard from the service users and carers there was that concern, that this Bill did have a very strong focus on medical aspects of mental illness rather than a more holistic approach, and the service users and carers all felt very strongly that the approved social worker did allow for a certain independence that might not be there if that was also taken up by a medical professional, somebody who was employed within the NHS structure who did have working relationships with other people within their local NHS. It was seen as an element of independence to have somebody from outside the NHS providing that role, who perhaps was looking at that service user in a more holistic way, rather than just focusing in on the medical needs and the treatment needs of that person. That was a strongly held view by all service users and care representatives that we heard from, although I must say that we did not have any specific evidence that would suggest that people would be more likely to be sectioned, but there was a very strongly held perception and view.

Q570 Ms Munn: I am a little concerned about this view because David Hinchliffe said earlier that there is a general moving together of health and social services, and certainly in the city I represent we have a Mental Health Trust and the social workers and the community psychiatric nurses actually do work for the same organisation, so this issue of independence which you are identifying here does not exist in fact in many of the services in England now. But I would also take the view that what we are striving for is for all mental health professionals to be dealing with people with mental health difficulties holistically, and, if you actually look at the roles that a community psychiatric nurse takes as opposed to a social worker, my contention would be that those have come much, much closer together with the nursing aspects of the community psychiatric nurse perhaps being a minor element as opposed to the general support element of their role, and that that overlaps considerably with what a lot of social workers do. While there may be some benefits therefore in having people with different professional training which leads to that, I really cannot see why there would be too much of a concern about having all professionals acting on some issues the same and taking a holistic view. Surely the way you deal with that is by having good practice guidelines and inspection of standards and the way people are operating, rather than relying upon structures which are, frankly, becoming outmoded to deliver those?

Mr Melding: I accept that you can have a more constructive interpretation of what is proposed and of those circumstances, although I do note that in the explanatory notes the assumption still seems to be that this person will be the mental health social worker. The point about authorities working more closely together is clearly an important one, and the policy in Wales is the same as in other parts of Britain, that that has to happen, and I do not think anyone thinks, in the team that is responsible for the care of an individual, that we would see such dramatic divisions or the nurse not playing a more expansive role, if that is appropriate. So I do not see any block on the way these teams evolve, and, if joint working mechanisms become even more closely integrated in terms of budget-holding and all the rest of it, then we would welcome that, but I think the general view of the Committee was that if the approved mental health professional is a social worker, that sends a very clear message to society in general and we did not want to move away from it. We felt that if practice leads us there eventually, then perhaps you could review it then, but at the moment it would say something that we are not ready to say or that indeed we do not think should be said by many people, and there was a very generally held fear—I am not saying it was more than that—that it would be a retrograde step.

Ms Williams: (Through the interpreter): Thank you very much, Lord Chairman, I would agree entirely with the need to develop a team ethos and to have this holistic principle established very clearly, but although we have not received any direct evidence
Chairman: That nicely brings us to a question Dr Naysmith was going to ask.

Q571 Dr Naysmith: It is interesting what has just been said, and really this question has been asked and answered already, but since it is such a trenchant question I will put it to you and see what reaction we get. The Welsh Nursing and Midwifery Committee has stated that the Welsh National Service Framework has hardly been implemented yet in Wales and they also told us in written evidence that mental health services in Wales are 10 years behind those in England and that the service is still largely reliant on Victorian institutions as the “hub” of care delivery. Do you agree with that and, if you do, how does this affect the ability to implement the Bill?

Mr Melding: I am not quite sure whether we are 10 years behind or whatever, but I think we are in a position of seeing a major change in legislation at a time when we are trying to develop the basic care model for mental health. It is difficult to think how the legislation might affect that in a very constructive way, it would seem to be better to implement these important changes and then have a stable situation in terms of the care model and then review the legislation, but we are in a position where we legislate for England and Wales and that is where we are at the moment. In terms of acute care, the situation of the hospital stock is really very poor. My last visit a couple of months ago was to a hospital for adults, with 20 beds or so, and I just asked “Are there any children or adolescents currently being treated?” They were very embarrassed, the person looked at the chairman of the Trust, but they had to answer the question as it was such a direct one, and there were two adolescents at that time being treated in that adult hospital. That is not uncommon in Wales.

Q572 Chairman: Would you wish to ban it in Wales?

Mr Melding: I think it is completely unacceptable, and most people would say that, but it still happens, and if it happens then the fact that we promise that it will not happen in three or four years is pretty weak. Four or five years ago we closed down one of the main acute hospitals in this part of Wales, and that hospital had been designed as a TB hospital; it had particular problems with observation because of the way it was constructed—it was for the reverse of observation, to give lots of people air in a private way—in the 1930s. That was closed, quite rightly, in the end because the Royal College of Psychiatrists would not permit their members to practise from there, but we had not prepared new facilities so we then had the current hospital in Whitchurch, which is a Victorian one, being over-used and that has to be modernised as well. We still do not have the replacement units from the closure of the Sully Hospital (the one I am referring to) and I think that is part of the problem, our services really are not fit for purpose for modern mental health care.

Dr Naysmith: We will be visiting Whitchurch this afternoon so we will wait and see for ourselves.

Chairman: Given the good Gladstonian principle of self-flagellation, leaving aside the 10 years point—which is perhaps pejorative—I think all those of us who function politically in Wales know that it is very easy to raise money for certain subjects in health care, like scanning machines and almost anything connected with children, as a reality of life—and it is perhaps unfashionable to say so but I think it needs to be said—but it is extremely difficult to raise money in the voluntary sector for unattractive health care provision like mental health, and elected politicians are naturally prone to the effect of public pressure. Do you think that is a reasonable statement and, if so, how are you going to redress it?

Dr Naysmith: That is not just true in Wales, that is true everywhere.

Chairman: Yes, but I function politically in Wales so I am merely putting the Welsh viewpoint. If that is, as Dr Naysmith says, true everywhere, how are you as the Welsh Assembly Government going to redress that balance so that whether you are one month or 10 years behind, given your diversity and rurality in the Principality, you are able to do what everyone must require which is to meet need. Do you want to start, Mr Thomas?

Mr Thomas: (Through the interpreter): Thank you very much. May I say clearly in the first place, that we are not the Government of Wales, we are
actually the opposition parties, the Minister is the Government of Wales and we live in hope. Lord Chair. Perhaps the situation will improve when that happens, but I think you are quite correct to say that it is very difficult to get interest and financial response from the public to services and provision for people who suffer mental health problems, this stigma is still around and society in general wants to push the problems to the sidelines, hoping that we can ignore the situation. I think there is a responsibility on politicians of every party to try and educate people about the needs and to look at mental health problems in the same way as we look at physical health problems, and that we are willing to respond in the same way. In terms of where we are now, in terms of the National Service Framework at present, the fears I have, looking at this draft Bill before you, is that the dependency of the draft Bill on the National Service Framework means that, because the service in Wales—and we can debate how many years behind we are—is significantly behind, and in terms of recruitment problems we have in Wales and the specific problems we have with regards rurality and rural communities and the landscape of Wales, the compulsion will put, on top of the National Service Framework that it will be impossible to catch up. The nature of this draft Bill will make the situation much worse in Wales and rather than actually catching up I am afraid we will actually be falling back because of the pressure put to bear on the National Service Framework which is already deficient. We have a double problem, therefore, Lord Chair, in trying to get people’s support financially and in terms of empathy with mental health problems, and also the problems we have in terms of our National Service Framework.

Q574 Chairman: Do you want to add anything, Ms Williams?
Ms Williams: I take a very pessimistic view and I do not think that elected politicians will change unless we enjoy the benefits of non-elected politicians, and therefore you do not have to worry about the public and playing to them in that sense. One of the concerns is that we have got limited resources here in the National Assembly for Wales, the question of Barnett was raised earlier and there are lots of things that health spending can be spent on. The evidence that we received was very concerned that implementation of this Bill in Wales would take money away from implementing our National Service Framework, it would divert resources, our meagre resources, and, although the Minister says and has said consistently since 1999 that mental health services were one of the top three priorities for herself, we are three or four years into our Child and Adolescent Mental Health Services and only now, in year four, have we seen the first ever dedicated resources going into that service. The real problem I think with this Bill is that it will take money away from what we are trying to implement in Wales.

Mr Melding: Can I just say something on the issue of stigma and information? I do not think the public are obdurate and bloody-minded about mental health, it is that there has been a lack of leadership and perception. Also, people are vulnerable to mental health illnesses; 25% of the population will have a diagnosable illness that should be treated. I am the only politician I know of in this Assembly who has acknowledged that he has suffered depression and anxiety in the past, and it is difficult I think to speak candidly about these things. Until politicians can provide role models or give some leadership about how we should talk about mental health issues, I think we always will have a danger when it comes to looking at compulsion and the threat that some very ill people might pose if they do not receive treatment, but we do need to get across the more positive message about how effective therapeutic and drug treatments can be and how much hope there is for people who have suffered ill health. This is ill health, people do not ask for it, it is a vicissitude of life, it occurs, people get it. I hope I am not pre-empting you, Chair, but at some point I would have something to say about the codes of conduct and how the Committee might deal with secondary legislation in terms of the timetable. I just say that now in case we run out of time very soon.

Chairman: Lady McIntosh, and then we will return to that point—unless that is the point that Lady McIntosh is going to return to.

Baroness McIntosh of Hudnall: It is not, Chairman, I will be as brief as I can. I just wanted to say that I do agree very much with what Mr Melding has just said about the necessity for there to be a greater degree of openness about these issues, but related to that I wanted to ask our three witnesses at the moment, who all have constituencies, whether there are any particular kinds of mental illness that relate to, for instance, rural communities that are different from those that have, on the whole, tended to be the higher profile kinds of illness that the Bill directs itself towards, i.e. potentially dangerous kinds of disorder. For instance, is there a noticeably higher incidence of depressive illness in rural communities, and is there anything that the Bill can or should be doing to identify these regional differences, not just in provision but actually in the incidence of mental illness?

Q575 Chairman: Let us start with the farmer’s wife.
Ms Williams: I have, since 1999, attended too many funerals of my constituents who have committed suicide, too many, and this problem has been exacerbated by the huge stresses and strains placed upon rural communities following the foot and mouth outbreak. There are a number of reasons for that: in rural areas you are perhaps more isolated, it is more difficult simply to get yourself to a service, if you feel well enough to even want to get there it is more difficult to actually get there, often in many of my communities we have access to the means of committing suicide in a way that some people do not—I am thinking of guns, people have access to guns in a way they probably would not have in another area—but I think there are also issues around isolation in rural areas that potentially can make people feel it is harder to get services and to ask for help. We are also a community where everybody
knows everybody else and therefore the stigma that we have talked about perhaps in some ways is even greater in a rural area because people gossip and talk and, if you approach someone, it is only a matter of days it seems before the rest of the community knows about it. That might be a problem as well in rural areas, the stigma.

Q576 Chairman: It might be worth adding in relation to Lady McIntosh's question something about this: I think I am right in saying, am I not, that the farmers' organisations—which of which there are three in Wales—have taken initiatives to deal with rural isolation problems, including the setting up of helplines. Is that right?

Ms Williams: That is right.

Mr Thomas: (Through the interpreter): Yes, certainly, there has been an attempt by the agricultural unions and other organisations in rural areas to try and ensure that helplines are available for people, particularly those working in agriculture, because of the financial strains on the agricultural industry and this element of loneliness and isolation that Kirsty has referred to. I do think that the point she made about the nature of our rural communities and this inherent pride which exists within rural communities, they do not wish to talk about their problems. David has talked about the need for politicians to be more open; it is certainly a very great problem in close-knit rural communities. I had a very unfortunate case in my own constituency where all those elements had actually led to a murder; people were not willing to accept that a neighbour had a mental health problem, but if that could have been seen earlier then the whole situation could have been avoided.

In terms of the difference in Wales, of course the Welsh language is used in many of our rural areas—I represent a constituency in Carmarthenshire where the largest number of Welsh speakers actually live and there are similar problems in Mr Hywel Williams' constituency in Gwynedd and also in Ceredigion. I am a little fearful that given the pressure on the service in Wales to respond to this legislation, it will be extremely difficult to offer that provision through the medium of Welsh, particularly with this element of compulsion. If someone is under a compulsory order then they are in a very, very fragile situation then the whole situation could have been avoided.

Ms Williams: It might be worth adding in relation to the point you have made, David, there have been instances and, in fairness to the executive, there have been led on an England and Wales basis—that the executive is in a position where they cannot table the Code of Practice and what you wanted to say to the Committee is that the whole situation could have been avoided.

Chairman: Far be it from us to comment on your procedures. I think we may have views but we will restrain ourselves. Can I thank you all very much for giving such cogent evidence to us and taking so much trouble, and for the correspondence we have received too.

Memorandum from Powys Agency for Mental Health (DMH 181)

From a Welsh perspective we are concerned that the basic problems of the original 2002 draft bill remain, namely:

1. One problem with the Bill is that it brings together (a) provisions for peoples mental health (authority for which in Wales is devolved to the Welsh Assembly Government) and (b) the protection of the public (driven by the Home Office). There are potential conflicts in terms of implementation between a devolved matter and Home Office concerns.
2. This is a bill concerned with public safety issues rather than enshrining people's right to treatment (with sufficient resources to ensure that appropriate treatments are available). It appears to conflict directly with the intense work currently ongoing in Wales around the Mental Health NSF. We make particular reference to Standards 1 and 2.

3. This Bill plays into all the stereotypes of mental illness as dangerous when it is legislation designed to address the public safety issues raised by a very small number of disordered offenders. By the Home Office's own admission (Nigel Shackleford at the recent Road Shows) Section 3 of the 1983 Mental Health Act worked well but too many disordered offenders went to prison for lack of suitable hospital beds. It would make more sense to keep the criminal justice issues separate from mental health issues, by having separate legislation.

4. The definition of mental disorder is still too broad. The power to use compulsion with such a broad definition will inevitably cause anxiety amongst people with mental health problems and deter them from seeking treatment voluntarily at an early stage before deterioration and lack of insight set in.

5. The threat of Community Treatment Orders is not the best way forward for the therapeutic relationship. The implementation of the National Service Framework is about working in partnership. This Bill seriously undermines the building of a partnership between clinician and patient.

6. The resource implications of this Bill will inevitably result in the diversion of clinicians' time from providing treatment interventions to the bureaucracy of carrying out this legislation when there is already a serious shortage of psychiatrists and other professionals.

7. Staff recruitment and retention issues in mental health are so serious in Wales, and likely to remain so in the near future, that this issue alone could render the Bill “unworkable”... In rural Mid Wales the problem will be compounded as scarce resources are already too thinly spread.

8. In Wales, the development and provision of services are generally speaking behind those in England. Any diversion of resources will therefore have a more serious impact. The close partnership working that the Welsh Assembly Government is encouraging and in some instances leading (eg Innovations in Care Collaboratives) could be jeopardised and seriously undermined by this piece of legislation.

9. We strongly urge the committee to visit Wales to gather evidence specific to the Welsh context in both rural and urban areas.

Finally we feel that “It’s not the uses to which it is intended to be put that is the problem—it’s the misuses that it makes possible”—Consequently we feel that a further re-think is necessary.

November 2004

Witnesses: Ms Mag Richards, Development Worker, Powys Agency for Mental Health and Ms Celia Cowie, Development Worker, Powys Agency for Mental Health, examined.

Q578 Chairman: Ms Cowie and I possibly could have had some of this conversation on the lane on which we both live; however, it is very nice to see you both in Cardiff at this meeting of our Joint Committee. Would you like to introduce yourselves, first, and I would remind you before you do that the meeting is recorded. There will be a transcript available in about a week; you are able to do corrections of text but not of substance and please would you be careful to speak up so that we can all hear you. Ms Richards first.

Ms Richards: My name is Mag Richards, I am a mental health development worker, I work in Powys. We work in the voluntary sector and I have been in post for a number of years, working across Powys.

Q579 Chairman: Could you, in introducing yourselves, just give a very short description of what Powys is and the nature of the provision?

Ms Richards: It is quite difficult to get your head around Powys because it actually covers a quarter of Wales. It is affectionately known as the “empty quarter” because that is basically what it is. It is about 120 miles north to south, 20% of its population speak Welsh but it has a very small percentage of people from ethnic minority groups currently living in it. It is distinct for its extreme rurality, it has a very low population density and it has one town with a population of over 10,000, that is the largest town in Powys.

Q580 Chairman: Which is?

Ms Richards: Newtown.

Q581 Chairman: Sorry, it was not a test question, I just thought they might like to know. It is about 11,000 or is it 12,000 now?

Ms Richards: Just a little anecdote, apparently if you use public transport to travel from north Powys to south Powys it takes five days.

Q582 Chairman: Ms Cowie, did you come by public transport? Whether you did or not, please introduce yourself.
Ms Cowie: Celia Cowie, I work for Mag Richards, I am a development worker in Montgomeryshire, north Powys, working closely with users and carers and I am myself a carer.

Q583 Chairman: Does either of you wish to give an introduction, or can we continue with questions?

Ms Richards: I think it might be worth just saying really that our major concern about this Bill is that in rural areas such as Powys—and Powys is an extreme case of rurality—we have currently a very low baseline of services and we have some examples of the sorts of numbers of people we are talking about.

Q584 Chairman: The Committee would be interested in that.

Ms Richards: Just to give a couple of examples, our out-of-hours mental health service is run by one ASW to cover the whole of Powys.

Q585 How many consultant psychiatrists do you have working in Powys in terms of equivalents?

Ms Cowie: I have that detail because we had a report from the Centre for Mental Health Service delivery, Dr Les Judd, who did a report on the reconfiguration of services following the closure of Talgarth Hospital in March 2003. Powys has the lowest level of consultant posts in Wales, we currently have 2.8 whole time equivalents; our local health board has said we need 5.4 and that is before we have to deal with this new Mental Health Bill. That is for consultants, we also need staff grade posts and senior house officers. We have a huge number of vacancies and problems with recruiting staff: we have been unable to fill a post in the north—we need two consultant psychiatrists in the north—and we are on our 13th locum psychiatrist. Can you imagine the effect of that on users, who see a different locum psychiatrist every four weeks, each one changes their medication without regard to any good or bad effects from the medication, it is very demoralising and disheartening. We have one ASW on call, covering the whole of Powys, we need a further eight or nine approved social workers to come up to scratch, before we are even talking about the new Mental Health Bill. At the moment our acute unit is closed due to shortage of staff—our only acute unit in Powys.

Q586 Lord Rix: Could I ask a question which is actually not related to mental illness as such, but is about learning disability, concerning the All Wales Strategy for Mental Handicap, which came in in the Eighties. Did that kick start services in your part of the world for learning disability?

Ms Richards: I will answer that because actually I have got two sons with severe learning disabilities and live in Powys. The All Wales Strategy for people with a mental handicap has actually been a very, very successful innovation in Powys and it actually allowed us to close two large hospitals and to provide services into the community, but then there was a lot of money tied up with those hospitals and it was possible to provide the service at quite a high level. That is not the case in the mental illness field.

Q587 Lord Rix: So the hospitals were allowed to recycle the money into learning disability services were they?

Ms Richards: Yes.

Q588 Chairman: I think you are referring to Bryn Hyfryd and Llys Maldwyn.

Ms Richards: And Bron Llys, we had three.

Q589 Chairman: Is care in the community functioning well as a result of simply recycling that money?

Ms Richards: From my personal perspective as a parent, yes, excellent; my two sons get a very good service locally from that in the community.

Q590 Lord Rix: Could that not be replicated for mental health, or is it just a question of money?

Ms Richards: I think there is an issue about money, I will be perfectly honest about that. I will give you an example: when the consultation document came out about the closure of our large psychiatric hospital in Powys, one of the stated objectives at the time was to save £1 million, that is what the Trust were saying. That was a key objective of closing the hospital because it was a way of meeting their deficits. I think the sorts of monies that have been tied up in the learning disability services are not tied up—certainly they are not tied up in Powys—in the mental illness service, and my own view, as someone who has been involved in the mental health service for a long time, is that we have seen a gradual erosion and ripping away of resources through the closure of wards bit by bit over the years, and we have actually lost resources. This will not be a very popular statement but in Wales I do not think that we have had an adequate investment into mental health services—certainly in Powys we have not.

Chairman: Mrs Blackman and then Lady Eccles.

Q591 Mrs Blackman: I was actually going to ask about the funding. Are you saying that there has not been a significant increase in health funding in Wales, or are you saying that the decisions where to distribute it do not accord with your priority which is mental illness?

Ms Richards: What I think I am saying is that we have not seen money coming into the mental health service in Powys.

Ms Cowie: Especially in rural areas; we lose out because we get no money in the health inequalities because the towns and indices of poverty do not recognise that we have very deprived areas in Powys.

Q592 Mrs Blackman: That is very relevant to the inquiry, but given also that there is some money available but it is not managing to fill vacancies in the area of Powys, have you got any observations on how recruitment and retention strategies could be improved in order to fill the vacancies that would be funded if you could find the right carrot?

Ms Richards: It is very difficult for us because we work in the voluntary sector, but it is a big issue in Powys and Celia has got some figures on where the vacancies currently are. We have been looking at
how can look at slightly different ways of providing a service in rural areas, looking at different posts and different ways of dealing with the service, and I think that to us that is the major concern about this piece of legislation, because in rural areas you have to do things differently, you have to look at more creative ways of doing things, you have to look at how you can use your local resources more effectively. What we feel very strongly about is that this piece of legislation seems to bring together two things from our point of view; it brings together a health provided in the community, it was possible to find

Q594 Chairman: Is it right, just to put this into its full context, to remind the Committee that there are in-patients from Powys but they are in hospitals outside Wales, for example in Shelton Hospital in Shrewsbury and elsewhere along the border? Ms Richards: That is right.

Q595 Baroness Eccles of Moulton: The point that I was driving at, though perhaps not very clearly, was when the learning disability excellent service was provided in the community, it was possible to find people to come and work in that area.

Ms Richards: Yes, it was, but we are talking about much smaller numbers of people, because we are talking about one in a hundred, somebody who may have a learning disability, whereas what we are talking about in the mental health field is one in four of the population possibly having a mental health problem, so we are talking about completely different numbers of people.

Q596 Baroness Eccles of Moulton: The scale is not comparable.

Ms Richards: It is very different, yes.

Q597 Mr Hinchliffe: You have described a situation where you have one out-of-hours ASW for Powys, your acute unit is closed at the moment. Have these problems driven thinking about alternatives to the traditional approach where a person has a problem, because certainly I found in various parts of England in particular that they had moved away from a reliance upon admissions and compulsion, in some respects having been forced to, and it is not that long ago, when you look at the history of how we have developed our mental health services, within my working lifetime I was involved in removing women from long stay hospitals who had been there for years, before I was born, as a consequence of having a child out of wedlock, moral defectives. It seems that sometimes we are rooted in this institutional kind of framework, and I just wondered whether the problems that you have had have driven any radical thinking away from our traditional dependence—and there is probably more traditional dependence in Wales than England currently—on institutional provision.

Ms Richards: I think it has, I think we are really getting to grips with that right at this moment. We have just pulled together a three year strategy which is actually looking at how we can provide a much more accessible service that is not hospital-based, looking at the provision of safe houses, looking at home treatment schemes. The other area, which I do not think has come up this morning is the service to people with less severe mental health problems, those people who actually use services in the primary care field; and one of the things that is going to be developed in Powys is that at the moment we have a number of counsellors in GP practices but there is an initiative to actually put counsellors in all GP practices and to look at developing a preventative service in primary care which will hopefully divert people away from the secondary mental health services but at a much earlier stage than they have
been previously. It is those kinds of developments in Powys that we think are very exciting and are very much in line with the National Service Framework for Wales, that we think will be jeopardised by this legislation, because we think that those kinds of initiatives will just go out of the window and we will end up with having to divert all our staff into issues around compulsion and around meeting the requirements of the new legislation. So, yes, the answer is we have.

Q598 Mrs Browning: I was very struck by what you said at the beginning of these remarks on this issue in terms of recognising that a lot of the content of this Bill has been driven by the Home Office, and in our previous evidence sessions it has been very clear that there have been one or two very high profile national cases that have precipitated this. But I have a lot of sympathy with what you are saying; I too represent a very rural community in Devon and I think there is already a tendency to divide mental health services into what locally they describe as core and non-core. I have every sympathy with what you are saying because it is those non-core services, very often the ones that take quite low budget inputs, that actually prevent people then becoming core cases where you go into all the questions of in-patient treatment and everything else. So it seems to me pretty commonsense to look at the so-called non-core cases, but when we took evidence from the Minister earlier she was pressing us to try and influence this Bill in terms of not putting so much on the face of the Bill but leaving more to flexibility of codes of practice, but, of course, the difficulty with that is that if it is not a statutory requirement the funding does not necessarily follow, so you are caught between a rock and a hard place really. I have a lot of sympathy with what you are saying but I just wonder how you see the balance being struck there in terms of getting more recognition for the non-care services and that very important client group who really is a bill about helping the mental health needs of people through the health service and through social services, or whether it is a criminal justice bill about locking people up in order, supposedly, to protect the public. That is a big enough problem that we have got in dealing with it as it applies to England, but there is an even more confusing situation in Wales because the first of those is a devolved matter for the Assembly, the second of those is not. What added complication is that situation going to bring about, with looking after people in Wales do you think?

Ms Richards: A lot of that has been said this morning by the Minister and by the other Committee members because the National Service Framework is different in Wales, the policy initiatives and priorities are different in Wales and, to be cynical about it, if you have a Department of Health and a Home Office working from London it is much easier for them to get together and maybe put a spin on these difficulties than it is when you have health devolved to an Assembly which is probably out of that loop. Our concern about it is that the public safety driven aspect of it is going to undermine the very collaborative and quite exciting developments that are just about emerging in Wales around the National Service Framework and about the Oneness Agenda, and we think that is going to be undermined by the public safety angle of the legislation.

Q600 Tim Loughton: We had this dichotomy in the Children Bill which has just gone through Parliament and the appointment of an English/UK commissioner for children whose remit is nothing to do with the rights of children and is a very different remit to that of the existing children’s commissioner in Wales who will be able to have a more comprehensive attention and duty of care towards the welfare of children outside of the criminal justice in Wales where their rights will not be treated on an equal basis. Do you think that the result of all this will be that more people are going to be picked up in the criminal justice system rather than a proper liaison between police and social services and health as a joined-up approach to really what is best suited to that person’s individual needs for their protection before primarily we talk about their supposed dangerousness to the public at large?

Ms Richards: I do not know, but I suspect that might be a possibility, yes. I have to say that neither of us are lawyers, we do not really understand all the clauses and the machinations of the legislation, it is difficult to get your head around it—

Q601 Tim Loughton: Nor do we.

Ms Richards: But that is an anxiety. Because the definition of mental disorder is so broad within this new legislation it brings, potentially, a lot more people under its remit so potentially all sorts of things, particularly when you are looking at the Home Office driven bit around public safety where all sorts of variations, I think, could come into play. It is almost like a blank sheet of paper in some cases.

Ms Cowie: And there are real fears that the climate that will come out of it will mean that people will be afraid of compulsion and will not seek the help they
need early enough, until everything has gone wrong and until, probably, they are leading chaotic lives, not getting the support and help they need and they probably do come under the criminal justice system.

Ms Richards: Legislation? We have got about Community Treatment Orders in should Wales have its own completely separate the point I was going to make about the concern that Lady Finlay has reached a point where it is dangerous and I up the few that we can divert to the voluntary sector. Psychotherapist for adults. The state of a services and so the additional strain is going to suck psychology service and a long waiting list to see the GPs specialising, we really are very, very short of Tydfil. As you also know we have no child of county for a place of safety, we have no section 12 to come from—I think the last time was Merthyr has to travel such huge distances, we have to go out mental health social worker in theory sometimes has you have heard already) only one social worker who requires a mental health section the approved established a therapeutic relationship of trust whereby the patient is under compulsion, when they are detained in hospital. This makes it very, very difficult then to establish a therapeutic relationship of trust whereby they continue to engage with services and continue to engage with the help that they actually need; so this Bill is going to make it much harder in fact to do that work and, in a rural area, we do not have early intervention teams, we do not have home treatment teams. We have a number of users using the voluntary service who have the label “personality disorder”, women who self-harm because of a history of sexual abuse, for instance, who are extremely worried by this Bill and extremely worried that they will be under community orders.

Q602 Chairman: Connected with that can I ask you a question which I think we would like your view on because you both come from the voluntary sector; you are not here either to defend or attack Government and you can perhaps give us a bird’s eye view of the future, in a sense. Community Treatment Orders, if enacted, will bring compulsion into the community; can you comment first of all—and I think Ms Cowie may just have answered this question—on the effect that is likely to have particularly on the younger male and female quite severely disturbed and mentally ill patient? Secondly, can you comment on the effect that compulsion in the community will have on such resources as are available and which you see from your Powys Mental Health Strategy viewpoint?

Ms Cowie: We know already that 50% of young people’s first encounter with mental health services is under compulsion, when they are detained in hospital. This makes it very, very difficult then to establish a therapeutic relationship of trust whereby they continue to engage with services and continue to engage with the help that they actually need; so this Bill is going to make it much harder in fact to do that work and, in a rural area, we do not have early intervention teams, we do not have home treatment teams. We have a number of users using the voluntary service who have the label “personality disorder”, women who self-harm because of a history of sexual abuse, for instance, who are extremely worried by this Bill and extremely worried that they will be under community orders.

Ms Cowie: A lot of people have said that the Scottish model looks good, it meets a lot of the anxieties that people have raised through the consultation exercise and I think that we ought to go the way the Scottish have gone.

Q606 Chairman: Let me ask you something different; if the Bill was in the Scottish form then your answer would be different, would it?

Ms Richards: One of the things that we have recommended in our submission is that this Committee should actually be looking at the Scottish model as an alternative.

Q607 Chairman: I am just trying to clarify whether the answer to Lady Finlay’s question is yes, we would like a separate Welsh Bill because we do not like the Bill, or yes we would like a separate Welsh Bill because we do like devolution.

Ms Richards: It is a bit difficult that question; what we are saying is that devolution actually has its advantages in terms of this particular piece of legislation—

Ms Cowie: We just do not like this Bill.

Q608 Chairman: So it is both, that is fair enough. I am going to ask you this because I think your evidence has been of very great value to the Committee; is there anything you would like to add, whilst you have this opportunity, which you feel needs to be said?

Ms Cowie: If I may I would like to read you a very short piece from a GP in Machynlleth, not about this Bill but we have invited him to a local mental health planning meeting and he cannot make it. “As you know, we have a crisis in mental health. We have only one CPN with an unacceptable workload, there is no official counselling facility for any patients in this area, we have only been given lip service for the past two years to have this. Patients have had upwards of 13 locum psychiatrists in the past two years; both they and I are totally fed up. Patients with alcohol and drug problems have to wait unacceptable lengths of time to be seen because of shortage of staff; in the event that a patient sadly requires a mental health section the approved mental health social worker in theory sometimes has to come from—I think the last time was Merthyr Tydfil. As you also know we have no child psychology service and a long waiting list to see the psychotherapist for adults. The state of affairs really has reached a point where it is dangerous and I worry that we are wide open for potential litigation. I hope your meeting goes well.” That is the state of affairs currently, before we have the burden of this Bill.

Q609 Chairman: Do you want to add anything else?

Ms Richards: I was actually going to continue with the point I was going to make about the concern that we have got about Community Treatment Orders in rural areas; I think it could potentially lead to discrimination, and there are differences between an area where you have got the services and you have got the staff and people can actually get the
Joint Committee on the Draft Mental Health Bill: Evidence  Ev 395

15 December 2004  Ms Mag Richards and Ms Celia Cowie

treatment they need without having to use Community Treatment Orders and rural areas, and there is a very real concern that people in rural areas will be discriminated against.

Q610 Mr Prosser: Is it not the case that the Community Treatment Orders are a power and a facility to use or not to use, not something being imposed and directed onto you?
Ms Richards: That is true, but I think there is a lot of evidence to indicate that what really works for people is a good therapeutic relationship, with a good care plan and it is the therapeutic relationship between staff and client that really, really matters. Compulsion to take treatment in a way is almost a situation where that relationship might have broken down, so what we are trying to do is to make sure that treatment is available to people when they need it, with a good relationship, with a good care plan, with good support systems in place and, hopefully, compulsion will not be necessary.

Q611 Mr Prosser: Could not practitioners and people like you continue in that mode without drawing down these extra powers and facilities?
Ms Richards: In the voluntary sector we would not have any powers over the legislation anyway so it is not really directly relevant to our day to day work.

In the voluntary sector we work very much with people; a lot of our work is trying to work on an empowerment model, to work with service users so they can influence the way services are evolved across Powys and across Wales.

Chairman: Finally, Mr Hinchliffe.

Q612 Mr Hinchliffe: Some of the most exciting work I have seen in England is being driven by the voluntary sector and I do not know enough about the voluntary sector in Wales to know whether in mental health you feel it has evolved as far as it has within England. Is it comparable to some of the work that I have seen, quite visionary stuff in various parts of England, or do you feel in terms of provision as well that you are some way behind the levels of work being done by the voluntary sector in England?
Ms Richards: We are some way behind, not because of a lack of ideas and good practice but, again, from a lack of money we are some way behind.

Chairman: I am sure I speak for the whole Committee in saying how grateful we are to both of you for coming and giving us such a very good discursive session of evidence, it has been most helpful. I know it will take longer for you to get back to Powys than it will for us returning to London later, but have a good journey. Thank you very much.

Memorandum from the Welsh Language Board (DMH 310)

Please find below the Welsh Language Board’s response to the draft Mental Health Bill.

ABOUT THE WELSH LANGUAGE BOARD

1. The Welsh Language Board (The Board) was established as a statutory body by the Welsh Language Act 1993 to promote and facilitate the use of the Welsh language. The Act establishes the principle that in the conduct of public business in Wales, the Welsh and English languages should be treated on a basis of equality. The Board has statutory functions and powers which require public bodies to prepare Language Schemes, detailing how they will give practical effect to the aforementioned principle. Such bodies include all the Local Health Trusts in Wales, the Welsh Assembly Government, the recently created Local Health Boards, the Mental Health Act Commission, the Commission for Health Improvement and the National Institute for Clinical Excellence.

WELSH LANGUAGE PROVISION IN THE HEALTH SECTOR

2. The Board believes that there are two core themes guiding the provision of care services to the public in Wales, namely:
— that a full quality service means a bilingual service; and
— that providing such a service, respecting the principle of language equality, means that the service provider offers linguistic choice to whoever receives it.

3. The importance of providing bilingual health care is evidenced in a report by the Welsh Consumer Council\(^1\), which concluded:

“that in the case of Welsh-speaking patients, there are instances where they cannot be treated effectively except in their first language or in both their languages. This is especially true in the case of those receiving speech and language therapy, and for the following key groups: people with mental health problems; people with learning disabilities and other special needs; older people and young children.”

---

\(^1\) Welsh in the Health Service: The Scope, Nature and Adequacy of Welsh Language Provision in the National Health Service in Wales by Andrew Misell. Published by The Welsh Consumer Council (July 2000).
4. Following the publication of this report, an All Wales Language Task Group for Health was formed by Jane Hutt AM, the Minister for Health and Social Services at the National Assembly for Wales. The Task Group was formed to analyse deficiencies in providing Welsh language services in the NHS. It also co-ordinates measures to ensure improvement and comprises officials from the Assembly, the Board and health sector provider and user representatives. The Mental Health Act Commission has given a presentation to the Task Group on its work.


“The Assembly Government is determined to impress the importance of being able to deliver services in the service users’ language of choice in key service areas such as health and social care, and we are working with the service deliver organisations in these areas to help them achieve this aim.”

6. The Mental Health Act Commission, which currently has responsibility for many of the functions set out in the Bill, has a Welsh Language Scheme which sets out how it will treat the English and Welsh languages on the basis of equality. The Commission recognises that the effective use of the Welsh language in the care of detained patients in Wales is a fundamental aspect of providing quality care and treatment.

7. We are aware that this Bill proposes the abolition of the Mental Health Act Commission, with its functions being integrated into the Commission for Healthcare Audit and Inspection (CHAI). The Board will expect CHAI to continue to implement the Welsh Language Scheme which was adopted by its predecessor, CHI. This scheme will need to be updated in due course to reflect any additional powers vested in CHAI under the Mental Health Bill. We would expect the Welsh Assembly Government to consider whether it needs to bring CHAI within the scope of the Welsh Language Act, enabling the Board to notify CHAI formally that it should prepare its own language scheme.

THE MENTAL HEALTH BILL AND THE WELSH LANGUAGE ACT

8. In light of the above, the Board believes that the Bill could be improved by referring to the statutory responsibilities, in relation to the Welsh language, of bodies providing services to the public in Wales. We believe that the Bill would benefit from the insertion of a clause, or numerous clauses, which state that those bodies with a remit in Wales, including the National Assembly for Wales as the Responsible Authority, the Mental Health Tribunal for Wales and CHAI, should treat Welsh and English on a basis of equality, in accordance with the Welsh Language Act 1993. In addition to this general point, the Board would like to draw attention to those areas of the Bill which have most impact on the needs of Welsh speakers.

LANGUAGE CHOICE

9. It is vitally important that service providers offer linguistic choice in all aspects of their work. Offering language choice will be relevant to many of the procedures outlined in the Bill such as examinations, assessments and any subsequent treatment. The issue of language choice is particularly relevant given the proposed changes to providing treatment at home instead of in hospital, when appropriate. Quality of care would be improved if individuals received treatment in their preferred language.

10. The Bill aims to ensure that patients receive “appropriate treatment”. The Board believes that it should be made clear, preferably on the face of the Bill or in any appropriate secondary legislation, but certainly within guidance and codes of practice, that offering treatment or services in Welsh falls within the definition of appropriateness.

11. Guidance should also be made available on how to offer language choice, as well as how to record the choice for future contact. This would enable the individual to continue to be dealt with in his/her preferred language throughout the process, without having to ask on each occasion.

CODES OF PRACTICE (PART 1)

12. It is essential that the National Assembly for Wales, as the body responsible for preparing the Codes of Practice for Wales, ensures that linguistic issues generally, and the needs of Welsh speakers specifically, are reflected in the Codes of Practice. Issues relating to languages, and the principle of equality established by the Welsh Language Act, should be made explicit within all relevant aspects of the Code. Furthermore, the Code should establish that individuals should be able to access and receive services in either English or Welsh.

13. The Bill and Codes of Practice also need to take into consideration rural issues such as access and travel for different elements of treatment, as well as attendance at tribunals or appeals. The Board looks forward to having regular contact with the Welsh Assembly Government as the code is developed.
Mental Health Tribunal for Wales (Part 2, Chapter 9)

14. The Board believes that the Bill would be strengthened by having a clause which stipulates clearly that the Mental Health Tribunal for Wales will need to treat Welsh and English on a basis of equality, in line with the Welsh Language Act. We would also expect the Welsh Assembly Government to prepare legislation to bring the proposed tribunal within the scope of the Welsh Language Act at the earliest opportunity, thus enabling the Board to notify the Tribunal that it should prepare a Welsh Language Scheme.

15. The Board believes it important that there is an adequate Welsh language representation on the tribunal, and that the tribunals can take place in Welsh when required.

Expert Panel (Part 2, Chapter 9)

16. The Board also believes that there should be adequate Welsh language representation amongst members of the Expert Panel. The National Assembly for Wales, as the Responsible Authority, will appoint the members of the expert panel. The Board believes that there is an opportunity for the Bill to make a specific reference to having adequate Welsh language representation on the panel.

Cross-Border Provisions (Part 4)

17. The Board believes that the Bill would benefit from greater clarity regarding cross-border issues, particularly in relation to the linguistic implications of individuals who move, or are moved, from Wales to England or vice versa. The Board believes that there needs to be arrangements in place for individuals who, for whatever reason, need to receive treatment in England but who have already been dealt with through the medium of Welsh. Ensuring that appropriate arrangements are put in place would help to improve quality of care to individuals who would already be in an unfamiliar environment.

Mental Health Advocates (Part 8, Chapter 2)

18. The responsible authority, in this case the National Assembly for Wales, will need to ensure that there are sufficient Mental Health Advocates who are able to speak Welsh. The Board sees this as critical to ensuring that the new arrangements are responsive to the needs of Welsh language speakers, since the advocate will be the main contact for many people. If individuals are unable to discuss issues in their choice of language this could create confusion or tension, thereby undermining the quality of care provided.

Appeals—Mental Health Appeal Tribunal and Court of Appeal (Part 9)

19. There is currently no reference in the Bill as to how appeals in the Welsh language will be dealt with by the Mental Health Appeal Tribunal and the Court of Appeal. We believe it is important to consider at this stage how such cases might be dealt with by the appeal tribunal. Indeed, it may be appropriate to consider having a separate Appeal Tribunal for Wales. We believe the Bill would be improved by making it clear that the Tribunal would be expected to conduct its business in accordance with the Welsh Language Act.

20. If the final Bill proposes a joint England and Wales Mental Health Appeal Tribunal, then we would expect the Welsh Assembly Government to prepare legislation to bring the Mental Health Appeal Tribunal within the scope of the Welsh Language Act at the earliest opportunity.

I would like to thank you for the opportunity to provide evidence to the joint committee and would be happy to expand on any of the points covered in this written response.

November 2004
particularly poignant evidence from our last two witnesses about how very, very thin the services are spread in Powys. This really, I suppose, is a question based on priorities: when there is a shortage of public funding in general in the general budget, is it not right that these resources should be prioritised and that maybe putting further resources into the Welsh language is perhaps not as high on the list as some other needs?

**Mr Davies:** (Through the interpreter): Thank you for that question. First of all, the question suggests that the Board is asking for further resources in this area; that is not included in our evidence as such, what our evidence suggests is that the policies which are already in place should be implemented, and as is outlined in the Welsh Language Act 1993, that the Welsh and English languages should be treated on the basis of equality. Most public bodies working in mental health do have language schemes, they actually implement some aspects of those language schemes effectively and what we do want to ensure is that consistent messages are conveyed from all directions, and that includes from us as the Welsh Language Board and from the Welsh Assembly Government who have emphasised that the choice of language as part of care for an individual is vitally important in care generally and, particularly, in the sphere of mental health. This should be reinforced and there should be an opportunity for this Committee to actually reinforce this. There is something I would like to add to that: we have mentioned that this is something that we want to emphasise and obviously in working for the Welsh Language Board we would do so, but the Welsh Assembly Government have also emphasised the importance of this. What is also important is that the people themselves, those actually receiving treatment, have noted the need for that and a very important report from the Welsh Consumer Council, prepared in 2000—and there was reference to this in our written evidence—among other things notes that offering a choice of language is not a technical issue, but offering that choice of language is a matter of offering effective care for the patient. If I can quote one section from that Welsh Consumer Council report, the report notes that “in the context of mental health patients the pain and serious discomfort caused by mental health can, on occasion, be worsened if the patient is not given an opportunity to discuss his or her feelings and experiences with a mental health practitioner in his or her chosen language. Since achieving the normal balance is the purpose of mental health care then we cannot ignore the Welsh language as a factor if it should be a significant part of the life and mental processes of the patient”. So what I would suggest in responding to this point on resources—and we do appreciate that resources are always a problem—offering a choice of language is not a technical issue, it is a matter of offering effective care to individuals.

**Chairman:** Mr Williams, did you want to come in at this stage?

**Q615 Hywel Williams:** (Through the interpreter): Some people would say that what is required is a different service rather than an additional service, what I would describe as the Safeway two for the price for one strategy, if you do employ someone who speaks Welsh and English then you have two services available for that one single price. That would then normalise the use of the Welsh language; would you see that as leading to a greater demand for Welsh language service, to respond to the point made earlier that the demand at present is quite low?

**Mr Davies:** (Through the interpreter): If I could return to the point that demand is low—and that is reflected in the report quoted from in the first question—I would not first of all, see that the figures quoted were a strong statistical basis to argue that the demand is actually reducing, it is just a change from one year to the next or from two specific years. Secondly, from what I have read of the report the evidence on demand is based on individuals having to ask for provision through the medium of Welsh, not people being offered that provision from the relevant services. So it is vitally important—and we emphasised this in our evidence—that individuals should not have to request a service through the medium of Welsh, it should be part of the core activities of the services themselves.

**Q616 Mr Hinchliffe:** I was very interested in your evidence because probably 25 years ago when I was working in mental health services I had the experience of being asked to assist with the compulsory admission of a middle-aged Asian woman who allegedly had been behaving rather oddly; she could only speak a particular dialect of Urdu and there was a male consultant psychiatrist, a male GP, a male social worker, her husband and son were interpreting. Leave aside the gender issues here, forget about those for the time being, I was very disturbed at the situation we were in where we could not, other than through a member of the family who wanted to see her removed, actually communicate with this particular woman. Without going into the end result, what I would be particularly interested to hear from your perspective is, is there any evidence that you have of that kind of language problem arising currently in mental health services in Wales, particularly where you may have somebody who could be sectioned but is not able to communicate appropriately with the people who are responsible for carrying out that section?

**Mr Davies:** (Through the interpreter): I am not aware of any specific evidence and I would not expect to hear of specific cases in the Welsh Language Board, we deal with the general policy ourselves and how establishments and functions here in Wales implement those policies. However, the report by the Welsh Consumer Council on the Welsh language in the health service—and I will leave copies with you—does actually follow up the point on the problems which can arise in terms of Welsh speakers asking for mental health services that are not available. This is going back to Hywel Williams’ question, perhaps the requirement or the need seems less in terms of the Welsh language but the same is true of other ethnic minorities in Britain. Evidence suggests that people who speak Welsh and ethnic minorities generally throughout Wales use
less of mental health services. We do not know the reason for this but perhaps one of the reasons is the perception that English is the language and it is difficult to convey or express complex problems through a language which is not the individual’s first language—and there are suggestions of this in the content of this report.

Q617 Chairman: Is your health and care unit able to provide a little more flesh on the bones of the answer that has just been given in answer to Mr Hinchliffe?

Mr White: (Through the interpreter): Again, I am not aware. I am quite new to this post, so please forgive me, but I am not aware of any specific evidence, but I would endorse what was said earlier. The Ethnic Health Unit of the NHS undertook research into ethnic minorities in England and their problems, and Dr Dinesh Bhugra from the Institute of Psychiatry has compared the situation with the Welsh language and did say that Welsh speakers seem to be following that of ethnic minorities, even in areas where Welsh speakers form a native majority, that is that Welsh speakers’ expectations of services are the same. Also, to look at using services, the problems are the same as ethnic minorities experience in England of course.

Q618 Chairman: What methodology does the Welsh Language Board use to measure the deficit in mental health services in Wales arising from linguistic issues?

Mr Davies: (Through the interpreter): It is not the Board’s job to assess deficiencies or problems in this area; what the Board actually does is try and ensure that those organisations responsible for these specific areas see it as part of their remit. So what we are trying to ensure is that the organisations are providing services, but also that the organisations are reviewing these services, and the point on providing new functions for CHAI becomes vitally important.

Q619 Chairman: I do not much care who collects the information, I am concerned about the collection of the information, where does this Committee find information of a statistical and reliable kind which can tell us in statistical terms—which are sometimes useful—deficits in the provision of mental health services in Wales arising from linguistic issues. For example, how many patients would have preferred to have their initial psychiatric history, which is a key part of any treatment—taken through the medium of Welsh but were unable to do so, issues of that kind. Where do we find that information? If nowhere, why has the Welsh Language Board not used its considerable influence to ensure that that information is available somewhere among the many organisations that govern Wales in one way or the other? I think you are having some help waved at you, a timely wave from behind. Do you want to take the document, then you can give us the answer and we will look it up.

Mr Davies: (Through the interpreter): As I have already noted, what we are trying to ensure is that we work with other bodies and through other bodies. If we cannot show that functions as regards to collecting statistics are part of the responsibility of all the organisations providing services to the public, then we would not actually ensure any progress in this area. In response to your specific question we would expect that the National Health Service Unit should collect these statistics, or the providers themselves should collect these statistics. They are things that we ask them to do as part of their language schemes.

Q620 Ms Munn: What we have heard today is that there are significant problems about vacancies in various services; I do not in any way want to diminish the importance of people being able to receive a service in either their first language or their preferred language, and I do not disagree with what Hywel Williams said about buy one get one free, or two for one, if you have somebody who has the ability in both languages. Do you have a view that recruitment of people to these professions who are bilingual is not happening and could happen, and there are sufficient people who have these skills in order to be able to provide that service, or do you take any view on the fact that where you have such severe shortages you actually have to take what you can get, even if that means recruiting people who are from over the border and would be extremely unlikely to have the linguistic skills, albeit that it would not be as good a service for Welsh speakers? Mr Davies: (Through the interpreter): What we try to do is move to a situation where those bodies who are responsible for recruiting in this area get to know their own needs in this area, and there is certainly a deficiency across Wales. To respond to that, what we ask bodies to do as they prepare their action plans for their schemes, is to find out and to identify where the needs are in those special areas, be it in child care, language therapy and also in the area of mental health. I believe what is happening at present is that we have not reached a situation where we recruit specifically enough for these areas, either recruit or train people, which is another aspect we are trying to develop with the bodies who have actually agreed on their Welsh language schemes. That is one way of developing linguistic ability.

Q621 Ms Munn: I am not clear, are you saying that you think there are sufficient people out there who either have the skills or could obtain the skills pretty quickly, and they have just not been recruited into the service, or are you saying that it is a problem about the service? It is always easy for the service to say well, it would be great if the people who are recruited could speak both languages, but there are not enough of them about, or whatever, without making the effort; what I am trying to get at is whether that is the problem and nothing is being done to encourage people from areas where both languages are spoken, where Welsh is the first language, to actually come into these professions. That is what I am not clear about, and I do not know whether you are saying you do not know because people are preparing this information or whether that is actually the case.
Mr Davies: (Through the interpreter): I do not think we know in enough detail yet what the real need is. As I said, what we try to get from bodies is to get them to tell us what their needs are to implement their language schemes. It is not an easy matter of being able to identify straightaway, for us as a body to say straightaway where the need is we have to depend on the evidence and information we receive from bodies and that has not been sufficiently developed so far.

Q622 Ms Munn: But you are saying that probably the demand for services is under-reported because there is this information which says actually there is not a great demand. You are saying that; you have normal part of their training strategy or as part of the demand for services is under-reported because organisations involved in psychiatry which actually develop so far.

Mr Davies: (Through the interpreter): Yes, we do, and to respond to that point I do not think that a number of those bodies who offer these services in Wales have got to grips with this side seriously, so there are weaknesses in the clinical service offered by staff but they really have not got to grips with the question of how to respond to that deficiency, be it trying to recruit specifically for staff—and I do not think there are many cases of them actually doing that—or actually internal training. I hope that answers your question.

Lord Rix: Could I first clear up a point with Meg and Hywel? The two for the price of one concept was not invented by Safeway, it is a theatrical term—two tickets for the price of one . . .

Chairman: Tickets to the Whitehall Theatre way back in the Fifties, we know.

Lord Rix: They were known as “twofers” and theatres were known as “twofers”, that is where it all began, not with Safeway.

Chairman: There we are; thank you, Lord Rix.

Q623 Lord Rix: Obviously you are going to have to recruit professionals who are not Welsh-speaking or ethnic minority-speaking, but would it not be possible for the Welsh Language Board to have a group of advocates who are Welsh-speaking who could be seconded to the various areas of concern, as required.

Mr Davies: (Through the interpreter): That does not actually fall within our remit, our remit is much narrower than that, we would not employ such advocates to work with the health service.

Q624 Lord Rix: Would it not be possible to suggest that sufficient funding was made available so that you could run such a service?

Mr Davies: (Through the interpreter): It might be useful if I provided some of the constitutional context here, which is that the Welsh Language Board will cease to exist as a body before 2007 as our functions are being taken into the Assembly Government. That, in one sense, makes it easier to address that particular issue. These are practical issues which you have raised, and it might well be that would be the most logical way to deal with it so that different bodies work across their particular boundaries to ensure that that service is delivered.

Q625 Hywel Williams: (Through the interpreter): Can I ask whether you as a Board are aware of any organisation involved in psychiatry which actually meets the requirements of the Welsh language as a normal part of their training strategy or as part of their workforce planning strategy, so that recruiting Welsh speakers could be part of normal practice within those organisations. Is anyone in Wales doing that, or are there some organisations in Wales doing that?

Mr White: (Through the interpreter): The health service in Gwynedd is attempting to work in that way; the Gwent NHS Trust has just announced that they have had 30 applications from staff who believe that learning the language is an essential part of offering effective patient care. That has come through from the staff themselves; of course it is the organisation itself which organises the service but the staff are requesting this training. Providing Welsh-speaking staff or staff with other linguistic skills in the workplace as part of the service is about three things actually: recruiting people who speak Welsh, training people to speak Welsh and also, when required and there are not Welsh speakers available, then you need to reorganise the service.

There are a great many Welsh speakers working in the health service in Wales, very many, and it would be possible in most cases actually to reorganise services to facilitate language choice for patients. That is another point there, but there are a number of examples of that.

Q626 Hywel Williams: (Through the interpreter): If I could just follow up on that with one question, in terms of organising the workforce you will be aware of course that research has shown that those people lower down the scale in terms of power are more likely to be Welsh speakers in the health service in Wales and that people who have the greatest contact with patients are also lower down the scale. So are there organisations in Wales looking towards developing their current workforce, in order to give these people different functions, people who have language abilities and experience of contact with patients but maybe do not have the status within the organisations?

Mr White: (Through the interpreter): If I could just ask for a little clarity on that.
provide training for them and to promote their skills so that they then can actually undertake these higher grade functions and can actually work with patients?

Mr White: (Through the interpreter): This is something that has been commenced in local Government and we hope will transfer into the health service within the next year, that is to create a Linguistic Skills Strategy as part of the implementation of their language schemes, and that deals with recruitment and shift organisation when service is required, also how they are going to develop as organisations in order to provide effective service through the medium of Welsh and English for patients.

Baroness Finlay of Llandaff: I rather hope that you might feel that this is a fair representation, that the medical school here has tried very hard through its widening access policy to reach out and encourage children from Welsh-speaking areas to consider coming into all of the health disciplines, not just medicine, and it has been successful, but we cannot make people take up careers that they do not want and we cannot then make them go into branches of medicine or nursing when they have qualified that they then do not want to go into, and we cannot stop them applying for jobs in England, Scotland or elsewhere as part of their career progression. Therefore, if we go back to looking at what has been done, the lessons in Welsh for staff have been positive in that they enable staff to demonstrate empathy, but the language skills are not enough to be able to take a complex, very subtle, emotionally charged history from somebody who is very distressed because you need a very high degree of fluency for that. Therefore, when we go back to this Bill, perhaps it might be helpful in guidance in Wales to do what some of the cancer services have done, which is identify those staff who are Welsh-speaking and come to an arrangement whereby, if there is a patient who would feel more comfortable communicating about sensitive issues in Welsh, we can have a sort of rota system whereby a colleague will come over. For example, in palliative care my colleague in Bridgend would come over to see a patient for us for a sensitive communication on a one to one if that is what the patient would like. That is much more effective than using an interpreter. I do not know whether you also agree that you can have a false sense of security with an interpreter, as has already been outlined, and that actually a rotation of all the staff, identifying who is a fluent speaker—and sometimes not even directly in that specialty—

Chairman: Forgive me for interrupting, Lady Finlay, but that is quite a long question.

Q628 Baroness Finlay of Llandaff: I know it is, but I do feel that we have really tried within the university to do a huge amount, and I would hate the Committee to have the impression that there really has not been a huge effort to recruit from these areas.

Mr Davies: (Through the interpreter): I think we would be happy to agree with that point. To talk generally about how bodies have looked at their implementation of language schemes within the health and social care sector and more widely, I think it is fair to say that a lot of them have focused on the more technical aspects which is the production of documents and general information and maybe front of house contact with patients, consumers or individuals. I think what we are reaching now is the point where we need to focus more, if we are talking about the health and social care sector, on how we meet the needs of particular patients, how we identify the need and then think about practical measures of putting those into effect, working across boundaries as well.

Q629 Mr Hinchliffe: I am interested in the parallels between Yorkshire and Wales because I can think of some of my constituents who, frankly, cannot understand a word their doctors are saying because they are talking complete gibberish as far as they are concerned. There are social class perspectives here as well as linguistic perspectives, which I think we should also not lose sight of. I wanted to ask Mr White a question because he made a point a moment or two ago about the fact that within the health service in Wales there are substantial numbers of people who can speak Welsh; on the back of the discussion we heard earlier on about the approved social worker and whether the role should be broadened out to include other health professionals apart from local authority social workers, would you take a different view to the witnesses we had previously on the basis of that leading to a greater ability to communicate in Welsh to patients?

Mr White: (Through the interpreter): I would want to seek advice from medical professionals.

Q630 Mr Hinchliffe: It is a specialised area, I appreciate that, but it just struck me that the evidence you put forward of the numbers of people in the health service who can speak Welsh might be an argument, if we have a problem with communicating with Welsh speakers, to broaden out the role of the approved social worker to include some of those people.

Mr White: (Through the interpreter): That would certainly be a solution. I would, in terms of its linguistic merits, certainly welcome consideration of that but I would certainly underscore that answer by saying that professional medical and mental health professional advice would have to be sought on those sorts of implications. In addition to that answer and the previous answer, the emphasis should be very much on the patient and not on the member of staff. Obviously, the member of staff is providing a service and we would certainly welcome and congratulate examples of good practice. The vast majority of Welsh speakers and non-Welsh speakers in a lot of the services around Wales have a great awareness of the patient care importance of the linguistic element, and a study on that has just been commissioned by the Assembly; we can leave you with a copy of that. At the end of the day it boils down to the patient and, if there are no clinical implications to offering other members of staff, suitably trained but perhaps more linguistically qualified, then we would certainly welcome that.
Q631 Baroness McIntosh of Hudnall: May I make one general observation, Chairman, if I may? Certainly from my own point of view I think the discussion in the last 20 minutes has made me focus on the issue of language and communication in general, rather than simply in relation to the particular issues in Wales, and for that I am personally rather grateful. I wondered if you had any observations to make about how the Bill therefore ought to reflect the particular need for this issue to be taken into account in the provision of services. Do you think there are lessons that you can adduce from your Welsh experience that are more generally applicable and that therefore should not be limited to codes of practice that apply only in Wales? It is a rather unfair question, but I would be interested in your views.

Mr White: (Through the interpreter): I think if the lessons learned in a bilingual nation such as Wales can be applied elsewhere, whether that be in Yorkshire or whether it be in Southwark, I think we would be more than happy for people to use those lessons in terms of the linguistic elements of care for mental health patients.

Q632 Baroness McIntosh of Hudnall: Based on your own experience of how language impacts on the provision of services in Wales would you recommend the Committee to take this issue rather more seriously than just regarding it as a local issue? I am not leading you in any way at all of course. Mr Davies: (Through the interpreter): I think what I would suggest for the Committee in this area is when considering what appropriate treatment is—and that is going to be one of the aspects of the Bill, what treatment is appropriate treatment—that linguistic considerations, be it in Wales or in England, are a central part of those considerations of what we consider to be appropriate treatment. I am not sure if that has been reflected strongly enough, but there is certainly an opportunity for this Committee to emphasise this in their response to the Government. Chairman: Thank you very much. You will gather that we have focused on one question and it seemed to me the most pertinent question which required to be dealt with through oral evidence. We have your written submissions, which have been very helpful, and we are extremely grateful for your tolerance, patience and courtesy in dealing with a Committee which is only very partly Welsh. If there is anything arising from what has been said that you would like to follow up, please feel free to do so because we have not dealt with all the questions. Thank you, the meeting is concluded except to ask the Members of the Committee to do as we are told in the next few minutes because there are arrangements.
Wednesday 12 January 2005

Morning

Members present:

- Barker, B
- Carlile of Berriew, Chairman
- Carter, L
- Cumberlege, B
- Eccles of Moulton, B
- Finlay of Llandaff, B
- Mayhew of Twysden, L
- McIntosh of Hudnall, B
- Murphy, B
- Pitkeathley, B
- Rix, L
- Turnberg, L
- Mrs Liz Blackman
- Mrs Angela Browning
- Mr George Howarth
- Tim Loughton
- Laura Moffatt
- Ms Meg Munn
- Dr Doug Naysmith
- Dr Howard Stoate
- Hywel Williams

Witness: Dr Patrick Power, Lead Consultant Psychiatrist and Honorary Senior Lecturer, South London and Maudsley NHS Trust, examined.

**Q633 Chairman:** Good morning, Dr Power, and welcome to our session this morning. I think you have probably been told that you are on your own this morning.

**Dr Power:** Yes, my colleague has dropped out unfortunately.

**Q634 Chairman:** Can I just remind you, as all witnesses are reminded, that this is a public evidence session and that a transcript will be produced and will be available on the internet after about a week. You are free to make any textual corrections that you wish to do but not any corrections otherwise altering the sense of what has been said. Can I ask you to speak up, please, because although we look as though we have a superb microphone and loudspeaker system, it does not work as well as its technology would visibly suggest. Can I begin by asking you to look with us, please, at the arguments we have heard against community treatment orders. Service users and many mental health organisations as well as some professionals feel nervous about community treatment orders because they think they will become too plentiful and ubiquitous and was initially when the legislation was brought into effect. The other aspect of the order was that it was imposed on the orders Health Bill. That is certainly one reason. I am not for a necessarily long time without review. I think there are some genuine problems with the wording of the new Bill. Also, I think there are other factors. Clearly, there are concerns about change and new procedures which may have an impact on the way in which people work and there is a general concern about the State’s intrusion into personal choices, a misunderstanding about the nature and intent of CTOs and maybe a misrepresentation of some of the findings as well from studies overseas.

**Q635 Chairman:** What is your personal view on this issue?

**Dr Power:** Having gone through the experience of CTOs being introduced in Victoria in Australia, many of those concerns failed to materialise in practice when the legislation was brought into effect and the more extreme concerns essentially were unwarranted. However, there clearly are some problems with new legislation and some of the procedural aspects of it that may be overly cumbersome or may impact in a unwieldy way in the way people work or on people’s lives and that certainly needs to be taken into consideration to see how that can be minimised.

**Q636 Chairman:** Using your knowledge of Victoria, could you give us a snapshot of the most restrictive things that are done in Victoria as part of community treatment orders.

**Dr Power:** I suppose that the most restrictive aspect was initially when the community treatment orders were introduced. They were introduced for the duration of a year and then can be renewed after that. I think that is overly long. I think the changes that were made later were quite appropriate where the period was reduced to six months and where there were better review procedures put in place as well to ensure that people were not left on the orders for a necessarily long time without review. I think that was certainly one aspect. There were very few criteria set in the orders or very few components. It essentially directed people to receive treatment from a specific clinic. It did not specify, for example, the frequency at which they had to attend the clinic nor the actual nature of the components of that treatment. The other aspect of the order was that they might have to reside in a particular residence. That was rarely used. It was mainly the component that related to treatment from a particular clinic. So,
it was not, in my view, terribly restrictive compared to some other orders which are used in some other states in Australia. For example in Canberra in the ACT, they have a very much broader range of conditions to the orders which include, for example, not being able to move within certain areas of the state and that is clearly overly restrictive.

Q637 Mrs Browning: In terms of the Mental Health Services in the community, we are starting from a very, very low baseline in terms of resources and trained personnel and this is also going to involve the immediate relatives and carers of the patient. Do you have concern that, if community treatment orders were to come, albeit not immediately, there simply is not the resource and the expertise in the community to deliver what perhaps is intended by this Bill but which, in practice, could never be delivered to a satisfactory standard?

Dr Power: I agree that there would need to be a significant increase in the resources in community services to meet the requirements of these new provisions, in order that community mental health teams can effectively provide a service in the community for people within the conditions of these orders. In some well-resourced areas, I am sure they can, with home treatment teams, assertive outreach teams and mobile rehabilitation team, meet the needs of these new provisions but, in other areas where they are poorly resourced, I would be very concerned that these orders would be implemented in a very simplistic and overly restrictive way because you will not be able to add in the richer components of service provision to support these orders.

Q638 Mrs Browning: Is it not in practice going to be that the resources needed to implement these orders are going to move resources away from another group of people who quite legitimately require resources in their own right, that there is going to be a transfer of resources away from one group of people rather than additional resources coming in and it is simply going to be a ratcheting up of resources going at the top end leaving all those people who at the moment are not receiving the services they need and thus expanding the number of people who, through lack of resources, end up being, if I may use the terminology that has been used, non-core and non-core and your non-core group are going to become your core group? Is that likely?

Dr Power: Maybe I can answer with three particular points. In Australia, the states where community treatment orders were introduced actually had better community resources going alongside with those introductions. In fact, it was the more advanced and progressive states in Australia where community treatment orders came in first. When I say “advanced and progressive”, they have much more community services or the proportionation of funding for mental health was much greater for the community resources. So, that is one aspect. I do not agree with this concern about community treatment orders in a sense substituting for good community care. I do agree that there is maybe a danger of that it could substitute for impoverished community care, but I think that has not happened in practice certainly in Australia. That is my first point. The second point is that there possibly is a danger of community resources being focused purely on those people who have serious mental illness at the exclusion of people with less severe forms of mental illness and I agree that that is a concern, but that is a more general concern than relates to the whole issue of the legislation. The third point I would like to mention is that, if you introduce a form of legislation provision that is overly complicated in its administration, for example if you have an overly complicated method of initiating these orders where you have a number of complicated steps that you have to get through or you have an overly complicated system of review or an overly complicated system of supervision and revocation, then it is going to make these orders very, very unworkable administratively and consume huge amounts of clinical time with clinicians attending hearings. There are some mental health review tribunal hearings that I go to which take five hours to deliberate and that is a whole session of outpatient time that a clinician has to find time for. I worry that the administrative aspects of these new provisions need to be looked at much more closely and made as simple as possible with the least change possible to the present system.

Q639 Chairman: Just to be contextual for a moment, a number of us visited the South London and Maudsley Trust and we understand of course that the Trust serves a very large population, but I think many of us had the impression that it has a pretty wide range of facilities provided, many of which are community facilities. I do not know if there has been any discussion about this Bill in the Trust but, either on the basis of that or from your own knowledge, do you feel that that Trust could adapt reasonably speedily to a community order system if that were introduced or would it present huge problems?

Dr Power: I think they can adapt to it quite easily as long as the administrative aspects of the procedures are relatively simplistic and do not involve another layer of bureaucracy to administer. I do not think it will make a huge difference. The other aspect of community treatment orders is that they are, in a sense, old legislation dressed up in new clothes. So, that is one aspect. I do not agree with this concern about community treatment orders in a sense substituting for good community care. I do agree that there is maybe a danger of that...
Q640 Lord Turnberg: On this resource issue, from your experience in Victoria, do you know if the resources that are needed to keep a patient under a community treatment order are greater than those required to keep a patient in hospital or in an institution? My other point is about the administrative aspects. Are the administrative aspects not the same in both cases?

Dr Power: Australia versus the UK?

Q641 Lord Turnberg: No, in the community versus in hospital if they run properly?

Dr Power: Yes. The community services in Victoria, for example, compared to the hospital resources would in general be a little cheaper to provide. They do have a very rich variety of community resources including home treatment teams, crisis teams and mobile support rehabilitation teams. The majority of their mental health funding is for community resources rather than hospital resources. Hospital stays are very, very short there: on average they are 10 days in the acute ward which is dramatically shorter than in the UK which is on average may be about a month. So, to a large extent, they are able to manage acute situations relatively more effectively in the community in that sort of setting. The administrative components of it, when you look at, say for example, the administration of the review process, the Mental Health Review Tribunal, that, I agree, is virtually the same.

Q642 Lord Turnberg: Am I right in thinking that it is cheaper to have a patient at home than in an institution providing you have the people you can do it with?

Dr Power: Yes.

Q643 Mrs Blackman: One of the points that have been put to us is that the use of community treatment orders would break the trust between the patient and the approved safety worker and undermine assertive outreach. Again, with your knowledge of Australia and other places, has that been borne out in reality?

Dr Power: I can only speak anecdotally. It does run the risk of that in a small number of cases. Once the vast majority of people whose care I became involved with on community treatment orders have recovered, they can understand the rationale behind the initiation of the order. There were a small proportion of people who never agreed with the rationale for the order and bore a longstanding grudge that was impacted quite negatively on their care.

Q644 Chairman: That is not specific to community treatment orders, that relates to all forms of treatment.

Dr Power: Yes. In my experience and in the study that I did from Australia, there is a very small proportion of people for whom community treatment orders are very aversive and quite destructive resulting in them taking quite extreme steps to avoid the conditions of the order, for example moving out of state in an attempt to avoid the legislation in that particular state. But it is a very small proportion.

Q645 Ms Munn: I just want to come back to what you said earlier about the kind of things that might be specified in a community treatment order and taking also the point you made about trying not to have too much over administration. How would you think that a community treatment order could best fit with the current care programme approach because it seems to me that a number of the things which you were saying might be in a community treatment order you would want as a matter of good practice to have as part of the care plan in any case.

So, is there an argument for making sure that, if we did go the route of that, there was a close fit between those two?

Dr Power: The care plans as they are devised nowadays are very broad in their remit including a wide range of psychological and social treatments including family interventions, care issues of children and they are very much wider than the remit of what is normally part of the legislation in community treatment orders. CTOs generally tend to be quite narrow in their remit.

Q646 Ms Munn: My point was the other way round, not that the community treatment order should include everything that was in the care plan but that everything that was in the community treatment order you would expect to be in a care plan in any case or are you saying that would not be the case?

Dr Power: I think I would worry personally in my practice if the community treatment order included a wide range of interventions that the person had to agree to as part of the order because you cannot coerce people to attend psychological interventions or modes of rehabilitation or family interventions. Personally, I think that the community treatment order should be limited to medical treatments and to attending a particular clinic.

Q647 Chairman: Just in that context, I have two points. In Victoria, are there compulsory components of a care plan beyond residence, taking medicine and clinic attendance? Connected with that, have you experienced a community plan in Victoria that specified any input from the carer or family?

Dr Power: No. I have not been there now for about four or five years but, before I left, the community treatment orders had a very narrow range of specifications without any reference to anything like that. For example, it did not include carers. However, the Australian Capital Territory and I think, the Northern Territories had legislation that covered a wider range of interventions.

Q648 Baroness Cumberlege: Thank you for the presentation you gave us when we came to visit you. Listening to what you have been saying about Australia and the jettisoning of extended leave and some of the other applications that were there already and bearing in mind that we have those at
the moment and a range of things like guardianships and assertive outreach teams, do we actually need these community treatment orders?

Dr Power: That is a very good point. I would imagine that the provision of community care in terms of assertive outreach, early intervention services, crisis services and the range of other services out there will markedly reduce the need for community treatment orders. I do not think they will ever reduce it completely. Also providing much more sophisticated psychological interventions, relapse prevention, counselling, psycho-education, care and support, all those forms of interventions will assist in reducing the need for more restrictive procedures in legislation like this.

Q649 Baroness Cumberlege: So you are saying that we do need them?

Dr Power: I think that we will still need them for a small number of people but increasingly small as you provide better community services.

Chairman: That leads directly to Lord Rix’s question about the numbers.

Q650 Lord Rix: I must apologise to all concerned but I have such roaring tinnitus this morning that I am only picking up around 40% of everything that is being said and this question could have been asked by the Chairman at the outset! The definition of mental disorder in the draft Bill is so wide, it appears that many more people could be, as it were, sectioned and placed under compulsion in the community. Of course, I am particularly thinking of people with slight behavioural problems who also have learning disability.

Dr Power: I very much agree with that and I agree with the submission that was made by the King’s College group from London on this particular topic. I would suggest that community treatment orders should be restricted to people with very serious mental illness where there is clear evidence of risk of relapse associated with risk of self-harm and violence and serious neglect. I would worry if the provisions and the definitions of mental disorder were expanded beyond that to include substance use, to include dementia and to include head injury, behavioural problems and personality disorder. Some of those other disorders may be better provided for by legislation that covers, say, mental incapacity, for example dementia, brain injury and intellectual disability. Those more permanent disabilities or incapacities may be better provided for by a Mental Incapacity Act or guardianship provision.

Chairman: What you are saying is consistent with a lot of evidence that the Committee has received.

Q651 Tim Loughton: The paper that you gave us was an article published in 1999, a few years ago, and one of the points you made there is regarding the paucity of research into clinical efficacy and you cite a few minor studies particularly in the States. Has that situation changed now, five or six years on? Is there much better definitive evidence about the efficacy of these orders now or not? Your article was largely based on Australia with references to America and a little to Israel but nothing about the rest of Europe. Do you have experience of other European countries?

Dr Power: I am not aware that any other European country has provisions for community treatment orders though I might be wrong about that. Most of the states in North America have at this stage, including Canada. The states in Australia and New Zealand now have CTO legislation as well. There are a number of studies that have come out since that article in 1999. Again, most of the studies tend to be rather equivocal in their results with some benefits being shown in some areas and not in other areas, so there are still considerable doubts about the overall benefits of community treatment orders.

Q652 Tim Loughton: So, there is no definitive clinical evidence to justify these proposals on the basis that they produce much better outcomes for the health of the patients to whom they are directed.

Dr Power: There is no definitive evidence. There is some evidence of improvements for some patients on these orders. For example, the study in Australia in which I was involved did show benefits to the majority of patients on the orders. In that particular study involving 125 patients on these orders in the early 1990s in Melbourne, 60 patients i.e 48% improved on a range of factors during the time of their order compared to the time before the order. 30 patients i.e 24%: there was no change in their outcomes. For the remaining 35 patients i.e 28% there was a deterioration on at least one of the measures. Actually, five patients in this last group deteriorated on all the outcomes.

Q653 Tim Loughton: But theoretically that 60 might have been 70 if they had been subjected to residential orders rather than community treatment orders, for example.

Dr Power: That is speculation.

Q654 Tim Loughton: But it is highly possible?

Dr Power: I do not know.

Q655 Lord Mayhew of Twysden: Just on that point, you deal with it at the top of page 13 of your helpful article and I was struck by the finding in your survey that the group that experienced the best clinical outcome of your sample were significantly over 28, were in mid phase of their overall illness history and had significantly worse compliance with community treatment before the CTO. That is rather interesting because the criterion in Victoria requires that they had refused treatment beforehand or their consent was not available. I wonder if you have an opinion as to why that finding should be so.

Dr Power: I think that the group who did best on the community treatment orders were those people who had longstanding illness with clear evidence of poor adherence treatment before the onset of the order. The group who did least well were the younger group in the early phase of their illness, maybe without the full experience and impact of the illness on their lives and maybe with less respect for mental health
legislation generally. I wonder whether it was, to a
certain extent, a generational factor, that the older
group were maybe more respectful of legislation
than the younger group. The younger group were a
group often with dual disability, with substance use
problems and a range of other complicated social
problems for who maybe respect for legislation and
the law was less paramount.

Q656 Baroness Barker: You have gone a
considerable way to answering quite a number of
the questions that we have put this morning but I
suppose the ones which have yet to be fully nailed
down are these. First of all, was it simply the
availability of treatment that was the distinction
because you talked about the requirement of people
to turn up to clinic? Was that really the key factor?
Secondly, you have been helpfully narrowing down
for us the range of people for whom these orders may
be appropriate but are community treatment orders
appropriate for people with personality disorders?
Dr Power: That is outside my area of experience. I
have not worked in services which provide
specifically for people with personality disorders, so
I could not really comment on that. I would
personally have reservations about orders covering
disorders such as personality disorders because there
is considerable debate about the benefit of treatment
in this area.

Q657 Baroness Barker: In your experience in
Australia, to what extent were the feelings of carers
and family to the treatment orders a deciding factor
in whether or not they were effective?
Dr Power: Generally, the carers were very keen for
better provision of a safety net for their relatives and
were quite supportive of the orders. They were not
directly consulted or involved in the initiation of the
orders.

Q658 Baroness Barker: Was that because the orders
carried a degree of reciprocity, people would receive
treatment if they were under an order?
Dr Power: Yes.

Q659 Chairman: Should a patient have the right to
say “no” to a community treatment order in your
view?
Dr Power: Very much so. I think there should be
very important safeguards put in place to review the
orders. In Victoria, as I remember, the orders were
reviewed within four to six weeks by the Mental
Health Review Tribunal routinely and again, if they
were renewed as well six months later, then they were
reviewed by the Mental Health Review Tribunal. If the
patient disagreed with the outcome of the Mental
Health Review Tribunal, they had the opportunity
to appeal to the Administrative Appeals Tribunal
which could essentially override the decision of the
Mental Health Review Tribunal.

Q660 Chairman: Does it follow from that that you
would exclude the use of force in a community
treatment order? If I can give you a simple example:
to take medication when the patient attends a clinic.
Would you exclude the use of force as part of such
an order?
Dr Power: Yes and the clinicians in no way want to
use force in those situations.

Q661 Chairman: Because it undermines the whole
concept of voluntariness and cooperation which you
would regard as a foundation stone of someone
being part of a community treatment order?
Dr Power: Yes. The usual practice in Victoria was
that, if the conditions of the order failed after
numerous attempts at trying and pulling out all the
stops, if you like, to try and ensure that every
attempt was made to make the order work, then the
order was revoked resulting in the person being
brought back to hospital.

Q662 Baroness Cumberlege: I would like to follow
upon what the Chairman was saying. At these
Review Tribunals, were the families’ evidence taken
into consideration or the evidence of close informal
carers because the impact can be quite considerable?
Dr Power: Yes, the family views were taken into
consideration, sometimes even heard independently
of the rest of the hearing in confidence.

Baroness McIntosh of Hudnall: I apologise for
coming late into the discussion, but I am slightly
confused, which may probably be my fault. I am
beginning to lose track of what the element of
compulsion is in a community treatment order that
Australia, to what extent were the feelings of...

Q663 Baroness McIntosh of Hudnall: You replied in
a way which actually discussed how it might be
reviewed. I am beginning, as I say, to find it difficult
to understand what the element of compulsion
within a community treatment order is and what it
should be.
Dr Power: I am sorry, I misunderstood the question.
My understanding was that there should be an
element of appeal process. If the person refuses the
community treatment order from the outset, then the
clinicians involved in initiating the order is
highly unlikely to issue the order because they would
not be able to get to a point of agreement about the
conditions of the order. There needs to be some
element of agreement around the conditions of the
order before the order is initiated.

Q664 Baroness McIntosh of Hudnall: I think it would
be fair to say that that kind of community treatment
order differs very significantly from sectioning under
the Mental Health Act as it currently exists where,
as I understand it—and this is a layperson’s
understanding—there is no possibility of somebody who fulfils the conditions for being sectioned under the Mental Health Act to refuse to be sectioned.

Dr Power: It does to a degree. Community treatment orders are generally used as supervised discharge orders or conditional discharge from hospital. They are used in that way as a substitute for hospitalisation, as a condition of release from hospital, as a supervised discharge order. That is generally the way in which they tend to be used.

Q665 Chairman: Baroness McIntosh’s question, if I may say so, is a very powerful one because it asks the fundamental question, if the Bill is proposing a compulsory community order as part of sectioning, how on earth that can be voluntary? If you are going to have a voluntary system of community treatment orders, why do we need compulsion at all in that context would be the other way of looking at the same question.

Dr Power: In practice, it is not as black and white as that. The orders are only going to persuade the persuadable, if you like. There has to be an element of agreement around the conditions of the order if they are to work. If you cannot get agreement around that, then there is no point in issuing the order.

Q666 Baroness Murphy: What you are describing—and correct me if I am wrong—is the current guardianship order beefed up with more conditions and a specific treatment plan.

Dr Power: The supervised discharge order, yes.

Q667 Baroness Murphy: The current proposals in the draft for the non-resident order look then, in your view, like the current guardianship but with treatment attached; would that be correct?

Dr Power: That is correct and that is the way they are certainly in the Australian states and they are essentially extended leave provision or conditional discharge from hospital. There are very, very few orders proportionately initiated there from the community.

Q668 Baroness Murphy: There is of course within the draft a power to convey and that requires picking somebody up who is not complying and taking them to a clinic where they will get treatment. How do you view that part of the draft?

Dr Power: I think you have to have an element that covers that within the provisions so that, if the conditions of the order fall down, then you need to have some mechanism of revocation. The clinicians themselves are highly unlikely to want to resort to any coercive practices in the revocation of an order, so they will tend to rely on agencies such as maybe the police to assist with that.

Q669 Chairman: Does this mean that you are really in favour of a change to the present system or are you perfectly happy with the present system of conditional leave? What you have just been saying suggests that under a system where conditional leave is given, then if there is a breakdown, following Baroness Murphy’s point, a decision can simply be made to convey under the compulsory powers which remain.

Dr Power: The current system of section 25, supervised discharge order, unfortunately does not cover medical treatment. That is the difficulty. It covers everything else potentially but not the very important aspect of treatment and I think that is where the breakdown is. In my view, it should be the other way round.

Q670 Mr Howarth: Just to try and make the situation clearer following on from Baroness McIntosh’s question, is it helpful, in terms of compulsion, to look at the question in terms of what the choices are because it is not a choice between liberty, community treatment order and compulsory hospital treatment, it is just between two and not three, is it not? The compulsion is that either you are treated in the community or you are treated in the hospital, either way it is compulsory.

Dr Power: That is certainly the way it is in the Australian legislation. The choice is between compulsory treatment in hospital or compulsory treatment in the community depending, for example, on whether the patient will comply safely with community treatment, yes.

Q671 Lord Turnberg: It is the same question, really. What you are suggesting sounds rather like a parole system: if you disobey the rules, you are back in.

Dr Power: Yes.

Q672 Hywel Williams: I have some questions about resources and the structures that are needed to implement community treatment orders. You have already answered Mrs Browning in this respect saying that most are introduced by the community facilities that are available. In Wales, we still have some large psychiatric hospitals used as a hub and services are said to be 10 years behind those in England. Would you envisage therefore that community treatment orders could be introduced in Wales in those sorts of circumstances?

Dr Power: I cannot see why not but I think that providing for legislation around community treatment orders may encourage and enhance the development of community mental health services generally, so it may force the hand, if you like, of service providers to beef up the community agencies’ services for patients to supplement the provisions outlined in the orders.

Q673 Hywel Williams: That has been your experience in Australia at least in that they were introduced where there were already good community services rather than being a mechanism for promoting?

Dr Power: I think if the state or country is moving down the route of much more improved community mental health services, then the legislation has to follow it.
**Q674 Hywel Williams:** Can I ask you a question that arises from your paper in which you say that community treatment orders are useful in treatment adherence and when there is treatment resistance. It has been suggested to the Committee that they might be useful in rural areas where inpatient facilities are remote and I know that is categorising patients by their social circumstances rather than by their condition. What is your response to that?

*Dr Power:* One would be very concerned if community treatment orders became a substitute for good community care forcing people to attend a clinic a long way from their residence rather than providing home-based care near their place of residence.

**Q675 Lord Mayhew of Twysden:** As Lord Turnberg has elicited from you, it can be described as having the characteristics of a parole system. Might not another way of looking at it be that it is a means of enhancing the quality of life of the patient while ensuring, because he lives in his community, that he does take the medication which is essential and which at present is compulsorily administered in hospital?

*Dr Power:* I very much agree with that. From my experience in the Victoria system, I would very much agree with that view that it does enhance, it does support people remaining at home who are acutely unwell and ensures that the services are contracted to provide for them in their home and thus reduce the need for hospital treatment even if it is viewed maybe as described as a system of parole.

**Q676 Baroness Barker:** You have described some of the people that you think these orders are best used for as people who have very serious illness, people who are at risk of self-harm, neglect or at risk of violence too. Since you wrote your paper, have there been instances of community treatment orders not working and people becoming seriously ill as a result of harming themselves or others?

*Dr Power:* Have there been instances of...?

*Baroness Barker:* Where community treatment orders have failed.

**Q677 Chairman:** Can I associate that with something I wanted to ask you because there has been a lot of publicity in this country about dangers presented by people with severe mental disorder and the risk of harm being caused to entirely innocent people who happen to come into their path, the sort of more extreme publicity there has been. In Australia where community treatment orders have been used, do you know of any, let us call them, tragedies that have occurred as a result of people being the subject of community treatment orders who have committed extreme acts whilst in the community or generally has the control available been sufficient to avoid that?

*Dr Power:* I am not aware of any individual cases, no. I am aware of cases certainly from the study in Victoria in places where I have worked of cases of people on CTOs who have fared worse whilst they were on CTOs and for whom it has become a major bone of contention between them and the services and they have gone to extreme lengths to appeal against the orders.

**Q678 Chairman:** But this is a normal consequence of all medical treatment, is it not? Sometimes it works and sometimes it does not work quite so well.

*Dr Power:* Exactly.

**Q679 Chairman:** The same goes for the pills too.

*Dr Power:* It is very much a very, very small minority, in my experience anyway, but there are cases that I am aware of in hospitals where I have worked who have left the state in order to avoid the provisions.

**Q680 Chairman:** Another question that I want to ask you arises from something that you said in response to Mr Williams. You have experience of Australia which includes a very large rural community. Is it your view that rurality is not an issue which should militate in any way against using community treatment orders and, arising from that, do you feel that, in rural areas, actually having the availability of community treatment orders may enhance the general availability of an acceptable and beneficial range of mental health treatments?

*Dr Power:* One would hope so.

**Q681 Chairman:** Would you like to give a clinician’s view having worked out there in the great outdoors?

*Dr Power:* I worked in what could be considered as the outback in western Victoria about three or four hours out of Melbourne. That area was very well provided for with community services eg satellite clinics scattered throughout fairly remote rural areas and the community treatment orders were very helpful for a very small number of people in those areas. In my view, it was not much different to inner city areas where it is very, very hard to maintain contact with some people in very chaotic living environments within inner city areas, sometimes even more difficult than it is in rural areas which have much more tightly-knit communities.

**Q682 Mrs Browning:** Could I just ask you about the supervision of medication under these community treatment orders because clearly an awful lot turns on whether people are willing to take their medication as prescribed on time and, in order to supervise that in the community, where they are resistant during that or where they may lapse away from taking their medication, are you able to tell us what the view is of the staff who would be responsible for supervising this because, in the past, there has been quite a lot of concern expressed by people who feel they are having to enforce medication on their own—and I am assuming that it would only be one person who would be busy—and also the practicality of ensuring that that medication is administered on time. People’s schedules do not always mean that the person supervising can turn up within a two-hour framework of somebody having...
to take daily medication. What is your assessment of the staff out in the community and their ability to deliver medication where it is being resisted?

**Dr Power:** There are a number of practical difficulties in supervising medication in the community. It may involve carers in the process, it may require a range of other support agencies as well, say, for example, if somebody is in a supported accommodation option, that may involve the staff in that supportive accommodation providing some supervision of medication. So, there may be a range of individuals involved in the supervision of the medication. I think it is sensible in any kind of order to identify one person as being responsible for overseeing the supervision of treatment and, if the order is a treatment order specifying medical treatment, then really that should fall on the responsible treating medical officer or the RMO in the community. To involve other people really complicates the picture considerably and also complicates it administratively if it has to be revoked or if it is reviewed when it comes before review tribunals. So, I personally would favour a system which is quite simple in terms of accountability so that there is one identified person who is accountable for the supervision of medication provision, not necessarily taking the practical onus of administering it but they are responsible for overseeing it.

**Q683 Chairman:** Dr Power, thank you very much for coming to give evidence to us here today. I am sure the Committee would agree that you have added something to our deliberations, particularly with your experience of working in Australia and we are very grateful for everything you have done for the Committee during our deliberations up to now. **Dr Power:** Thank you very much for the invitation.
5. Wishing to further the spirit of consultation and consensus within which the Millan Committee had operated, the Scottish Executive established a Mental Health Legislation Reference Group to consider and comment on the recommendations of the Millan Report, particularly those which were complex or contentious. The Reference Group represented user, carer, service provider, legal and professional interests. The Scottish Executive also sponsored a number of consultative events with a range of stakeholders to enable them to comment on the Millan Report and its implications for policy and practice. In addition, the policy statement indicated that views on its contents would be welcome.

6. In parallel to the work of the Millan Committee, the MacLean Committee on Serious Violent and Sexual Offenders was established in March 1999 by the UK Government with the remit to consider experience in Scotland and elsewhere, and to make proposals for the sentencing disposals for, and the future management and treatment of, serious sexual and violent offenders who may present a continuing danger to the public. The MacLean Committee’s report included proposals relating to mentally disordered offenders. The relevant recommendations of that report were subsequently incorporated into the framework of the Mental Health Bill.

Establishment of the Act on the “Millan Principles”

7. One of the key recommendations of the Millan Committee was that the proposed Mental Health Act should contain a statement of principles. The principles which the Committee recommended (which have become known as “the Millan Principles”) are set out in annex A of this submission.

8. The Scottish Executive accepted the Millan Principles believing them to provide a sound framework within which mental health legislation and service provision in Scotland could operate and develop. The principles therefore acted as the key policy driver in the development of the Mental Health Bill, and they continue to do so today in the process of implementing the Act. Sections 1 and 2 of the Act attempt to give legal effect to these principles.

Overview of the Act’s provisions

9. The Act is without doubt a lengthy and complex document. Its over-riding aim is to put in place a framework for the care and treatment of persons who have a mental disorder but who require that care and treatment to be provided on a compulsory basis. Within that framework several key provisions and changes from the preceding legislation should be highlighted. The Act:

— provides greater clarity and precision with respect to the criteria which must be met before a person with a mental disorder can be made subject to compulsory powers under the Act;
— establishes a new forum (ie the Mental Health Tribunal for Scotland) within which decisions relating to the compulsory care and treatment of persons with mental disorder can be made, thereby transferring to the Tribunal many of the functions currently carried out by the Sheriff Court in this domain;
— expands the role of the Mental Welfare Commission and places a duty on it to monitor the Act and promote best practice;
— aims to ensure that, where appropriate and practicable, mentally disordered offenders are dealt with in a manner as similar as possible to persons with a mental disorder who are not offenders but wish some adjustments to reflect legitimate issues and justice and public safety;
— places a duty on local authority and Health Boards to secure the availability of independent advocacy services in their areas to ensure that every person with a mental disorder (that is, not merely those who are being treated on a compulsory basis) has a right of access to independent advocacy;
— confers on patients a right of appeal against detention in conditions of excessive security.

Definition of mental disorder

10. The Act refers throughout to a person with mental disorder. “Mental disorder” is defined in section 328(1) of the Act as including “any mental illness, personality disorder, or learning disability, however caused or manifested”.

11. The Act’s provisions extend not just to compulsory measures in relation to care and treatment but also to the assessment and provision of services for any person who is or has been a user of mental health services. The definition of mental disorder has been drawn widely to ensure that no-one who needs these services is excluded from them by the provisions of the Act. A person with a mental disorder as defined by the Act will only be made subject to compulsory measures if they meet the criteria for measures which are set out in the Act.

5 Further details on the MacLean Committee’s remit and final report can be accessed at: http://www.scotland.gov.uk/macleanu.
12. The Millan report recommended that the three categories of mental disorder (that is, mental illness, personality disorder and learning disability) should be defined further and that for the avoidance of all doubt exclusions should be made to the three categories. The Scottish Executive accepted this recommendation and, as a result, section 328(2) of the Act makes clear that “a person is not mentally disordered by reason only of [. . .] sexual orientation, sexual deviancy, trans-sexualism, transvestism, dependence on, or use of, alcohol or drugs, behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person, or by acting as no prudent person would act”.

13. It is not, however, intended that a person who falls within any of the categories described in section 328(2) of the Act but who also suffers from mental disorder be excluded from consideration for assistance treatment or services. Compulsory powers under the Act may be invoked in respect of those people with mental disorder who, for example, also have alcohol problems or misuse drugs. The exceptions apply so that it is clear to all that a person will not be regarded as mentally disordered by reason only of their sexual orientation, deviancy, trans-sexualism, transvestism or dependence on drugs and alcohol or by their behaviour.

Criteria to be met before compulsory powers can be used

14. Before compulsory powers under the Act can be used, certain criteria must be met. These vary according to the order being considered (eg an emergency detention certificate, a compulsory treatment order, or a compulsion order). For a compulsory treatment order (the equivalent of an order under section 18 of the Mental Health (Scotland) Act 1984 or under section 3 of the Mental Health Act 1983), these criteria are:

(a) that the patient has a mental disorder;
(b) that medical treatment which would be likely to prevent the mental disorder worsening; or alleviate any of the symptoms, or effects, of the disorder, is available for the patient;
(c) that if the patient were not provided with such medical treatment there would be a significant risk to the health, safety or welfare of the patient; or to the safety of any other person;
(d) that because of the mental disorder the patient’s ability to make decisions about the provision of such medical treatment is significantly impaired; and
(e) that the making of a compulsory treatment order is necessary.

15. Criterion (b) concerns the concept of significantly impaired decision-making ability, a concept which has similarities to that of “(in)capacity”. The Millan Committee considered at some length whether a “capacity test” should form part of the criteria to be met before compulsory powers can be invoked. The Committee rejected the use of a capacity test for a number of reasons. These are set out at pages 55 to 57 of their Report. They proposed instead that compulsory interventions could only be justified where there is evidence that a patient’s judgement is significantly impaired as a result of mental disorder.

16. The Scottish Executive, while accepting the Committee’s view that a capacity test was not appropriate, amended the Committee’s recommendation with respect to “impaired judgement” to “impaired decision-making ability” as it was felt that impaired judgement was too narrow and subjective a test which focussed on one aspect of making a decision rather than the broader decision-making processes.

17. It should be noted that with respect to a mentally disordered offender the criteria for a compulsion order are very similar as those for a compulsory treatment order. However, a mentally disordered offender does not need to have significantly impaired decision-making ability with regard to their medical treatment for a compulsion order to be made.

Offenders with mental disorders

18. The Act amends substantially the processes by which mentally disordered offenders are cared for and treated in line with many of the recommendations of the MacLean Committee, as described above. It amends the Criminal Procedure (Scotland) Act 1995 to give the courts a range of new options in how they deal with people with mental disorders.

19. It is important to note that the Act retains the effect of what is sometimes referred to as “the Ruddle Act”: that is, the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 which was passed after the successful appeal of Noel Ruddle against his detention at the State Hospital, Carstairs. (The 1999 Act will be repealed upon the Act’s coming into effect in 2005.) The Act ensures that certain high risk mentally disordered offenders may continue to be detained in hospital on grounds of public safety whether or not medical treatment is available. It should be noted, however, that this criterion is an “exit test” and not an “entry test”: in other words, under this Act a mentally disordered offender could not become detained in hospital on grounds of public safety alone.
IMPLEMENTATION OF THE ACT

20. The Scottish Executive is undertaking a considerable programme of work to ensure the effective implementation of the Act in 2005. To carry out this work, a Mental Health Act Implementation Team was established within the Scottish Executive Health Department several months in advance of the Mental Health Bill being passed. Early establishment of this team facilitated a smooth transition between the team responsible for the passing of the Bill and the team responsible for implementing the Act.

21. Throughout the implementation phase, we have been keen to foster the spirit of consensus and consultation which characterised the work of the Millan Committee and the passing of the Mental Health Bill. To that end, we have continued to convene regular meetings of the Mental Health Legislation Reference Group and its sub-groups as well as to consult widely with all relevant stakeholders through a range of consultation events and formal consultation exercises.

Establishment of the Mental Health Tribunal for Scotland

22. A key element of the implementation process has been the setting up of the Mental Health Tribunal for Scotland. This body is being established as a Tribunal Non-Departmental Public Body. A full-time President is about to be appointed along with approximately 100 each of legal, medical and general members from whom will be drawn the members for each three-person hearing panel. It is estimated that in the Tribunal’s first year of operation up to 4,000 hearings may be held.

Completing the legislative framework and drafting the Code of Practice

23. The implementation of the Act requires the completion of a substantial amount of secondary legislation as the Act provides for a large number of regulation-making powers with respect to, for example, the cross-border transfer of detained patients, the withholding of correspondence or conflicts of interest with respect to medical examination. Consultation exercises on the policy we plan to adopt with respect to these regulations are now complete, and we plan to begin laying these regulations before the Scottish Parliament over the coming months.

24. The Act also requires the Scottish Executive to prepare and lay before the Scottish Parliament a draft Code of Practice before the Act is implemented. We have developed the draft Code with extensive support from a number of health and social work practitioners seconded to the implementation team. We have also recently undertaken an extensive formal consultation exercise on the draft Code of Practice and plan to lay the finalised Code of Practice before the Scottish Parliament in early 2005 well in advance of the Act coming into effect.

Workforce implications

25. The Act has significant implications for mental health services across Scotland not least for mental health professionals. For example, it places additional duties on Mental Health Officers (the equivalent in Scotland of approved social workers in England and Wales) with respect to a more complex application procedures for long-term orders. With respect to psychiatrists, the workload implication of fulfilling the role of medical member of the Tribunal panels alone will be considerable. To meet these challenges, the Scottish Executive is supporting work currently being carried out by a range of agencies (for example, the National Mental Health Workforce Group) with respect to the re-design of mental health services in Scotland with a view to managing the workforce demands which the Act will create.

Service implications and Joint Local Implementation Plans

26. In 2003 the then Minister for Health and Community Care, Malcolm Chisholm MSP, commissioned an assessment of the state of readiness of mental health services across Scotland to meet the challenges of the new Act. The report showed that while there were some very good services in many areas overall there was much still to be done to be ensure that the new services and approaches that the Act calls for are in place in time for its implementation.6

27. In response, the Scottish Executive asked each Health Board to plan jointly with the local authorities and other partner agencies in its local area for the implementation of the Act. Each area was required to submit a Joint Local Implementation Plan covering key issues, namely: crisis response and 24 hour service availability; community services; hospital services; range of therapies; workforce redesign; organisational issues; resourcing and accountability. These plans have helped local areas to focus on service developments and on their state of readiness for the implementation of the Act while all the time facilitating the dissemination of best practice between local areas.

---

Funding

28. The Scottish Executive has committed substantial resources to ensure the successful implementation of the Act. The Financial Memorandum accompanying the Mental Health Bill, published in September 2002, announced funding to local authorities of £1.2 million in 2003–04; £12.5 million in 2004–05; and £13 million in 2005–06 in order to meet the demands of the Act. The Financial Memorandum also identified an estimated £6 million per year additional costs for NHS Scotland. The expectation is that NHS Scotland will meet these costs from within overall uplifts in their general annual allocations.

29. Since the passing of the Bill, the Scottish Executive has committed additional funds to the implementation of the Act. In 2003–04 as a result of the Partnership Agreement, funds of £750,000 were distributed to NHS Boards in Scotland for investment by the partner agencies on implementation. A further £4.5 million was issued on the same basis in 2004–05, and further allocations at levels yet to be determined will be issued in 2005–06. £2 million capital was also allocated to local authorities in 2004–05 and the same amount will issue again next year.

Training/guidance/awareness raising

30. In February 2004, the Scottish Executive commissioned a training needs assessment with respect to the wide range of professionals and other parties who may require training or guidance on the provisions and implications of the Act. The findings of this assessment have informed subsequent training and communications strategies. For example, we are working closely with the Royal College of Psychiatrists to draft bespoke training materials for psychiatrists. Similarly, we are collaborating with NES (NHS Education Scotland) to develop a wide range of training and guidance materials aimed principally at the large number of parties who, although they may play no statutory role under the Act, require a considerable degree of knowledge of the Act’s provisions and implications (for example, nursing staff or A&E staff). We have also funded the development of a wide range of training materials for mental health officers.

31. In addition to training and guidance aimed at professionals and other groups, we have been keen to raise awareness of the Act’s provisions among service users and carers to ensure that they are able to exercise their rights once the Act comes into effect. To that end, we have produced a series of Mental Health Law newsletters and guidance booklets on specific provisions of the Act such as the right to make an advance statement and to nominate a named person.7 Several more such booklets will be published over the coming months.

Conclusion

32. While recognising that many challenges lie ahead in the course of implementing this Act, we are confident that the Act is a landmark piece of legislation. It puts in place a modern and progressive framework for the care and treatment of persons with mental disorders through balancing, and protecting, their rights with the desire to ensure that they receive the effective care and treatment they need and deserve. The Act was born out of a strong spirit of co-operation and consultation with stakeholders and, wherever possible, consensus. As a result, it has been largely welcomed by stakeholders as was demonstrated by the evidence given by a wide range of stakeholders to the Scottish Parliament’s Health and Community Care Commitment during the Bill’s Parliamentary passage.8 Similarly, a recent British Medical Journal editorial described the Act as “ethically sound modern legislation with principles supported by most stakeholders”9; and the Act has attracted attention from other European countries also undertaking mental health legislative reforms. In short, we believe that this is an Act to be proud of.

33. If the Joint Committee wishes to receive any further details regarding the evidence set out in this submission, please do not hesitate to contact us.

Annex A

Millan Committee principles

1. Non-discrimination: People with mental disorder should whenever possible retain the same rights and entitlements as those with other health needs.

2. Equality: All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national or ethnic or social origin.

3. Respect for diversity: Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

7 These publications can be accessed at: http://www.scotland.gov.uk/health/mentalhealthlaw.

8 The evidence submitted to that Committee along with their final report can be accessed at: http://www.scottish.parliament.uk/business/committees/historic/health/2002.htm.

4. Reciprocity: Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.

5. Informal care: Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

6. Participation: Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Service users should be provided with all the information necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

7. Respect for carers: Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

8. Least restrictive alternative: Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.

9. Benefit: Any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.

10. Child welfare: The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

October 2004

Witnesses: Mr Colin McKay, Scottish Executive, formerly Leader of the Mental Health Bill Team, Mr Colin Faulkner, Scottish Executive, Policy Officer working on Implementation of the new Act, Ms Fiona Tyrrell, Scottish Executive, Implementation Team Leader, Mental Health Act, and Dr Madeline Osborne, Deputy Director of the Mental Welfare Commission for Scotland, examined.

Q684 Chairman: Welcome and thank you for coming. I am going to ask you to introduce yourselves in a moment. There are one or two preliminaries. Can I make a desperate plea to all witnesses and indeed all members of the Committee to speak up. The middle-aged among us are aurally interested in the Scottish experience and are witnesses and indeed all members of the Committee remember to keep your voices up. We are very interested in the Scottish experience and are studying it closely.

Q685 Chairman: But you have not done anything else! Ms Tyrrell: No! Mr McKay: Perhaps I could begin by explaining something about the principles, how they appear in the report which were, I have topscyphist a psychiatrist and Deputy Director of the Mental Welfare Commission for Scotland. I am a member of that implementation team with policy responsibility for implementing civil provisions of the Act including community treatment, cross-border provisions and liaison with the English Mental Health Bill Team.

Dr Osborne: I am Madeline Osborne; I am a psychiatrist and Deputy Director of the Mental Welfare Commission for Scotland. We have been heavily involved in the development of the Act and are also heavily involved in providing safeguards for people subject to its provisions.

Mr McKay: I am Colin McKay. I was the Secretary of the Millan Committee which was the report which led to the Scottish Mental Health Act and I was also the Manager of the Bill Team for the Mental Health Bill and also was Secretary to the MacLean Committee which dealt with serious violent and sexual offenders including offenders with personality disorder.

Mr McKay: But you have not done anything else! Ms Tyrrell: No! Mr McKay: Perhaps I could begin by explaining something about the principles, how they appear in the Act and the intended effect, and then Dr Osborne might say a little about practice and the effect they should have on practice. The Millan Committee certainly set great store by the principles that it articulated in its report which were, I have to concede, to some extent influenced by some of the principles set up by Professor Richardson in the English report and they were very influential in actually formulating the policy on the Bill, and particularly the principles around use of the least restrictive alternative, for example, was very influential in shaping the Committee’s thinking on issues like treatment in the community which you have just been discussing. The Committee very strongly recommended that they should be part of the legislation and that was very strongly supported by the mental health community, both practitioners,
service users and carers. For a number of people, in terms of getting support for the provisions in the Bill, it did provide considerable reassurance that the principles would be a safeguard and that the Bill would not be misused. I think they felt they were particularly significant because the Act is really the interface of a number of different professional disciplines and a number of different intellectual domains, as it were. It is about the crossover between law, ethics, the duties of care, the rights of the individual and having some sort of clear steer as to how you apply particularly complex individualised orders. When you try and draw together all these things, it was felt to be very, very helpful. It was certainly difficult in the process of drafting the Bill to translate what was in the Millan principles into what lawyers would accept were defined legal propositions and I think the first print of the Bill, the first version of the Bill, did not have the principles because it did take us some time to sort that through. In terms of how it works, the general duty in the Scottish Act is that practitioners, including the tribunal, doctors, social workers and so on, have to have regard to the various principles articulated at the beginning of the Act. I think the idea of having regard to some things is a fairly well understood legal concept, so I do not think there is any fundamental difficulty in having that in a piece of legislation in terms of the practical effect. I think it is particularly relevant because of the tribunal and because the tribunal will be evaluating care plans and the particular powers that are sought in an individual case and will be evaluating the extent to which the patient has been involved in that and whether or not there are any alternatives which might have been considered, either different powers being sought or no powers being sought at all. I think it will guide the tribunal in assessing those care plans and the powers sought and therefore will influence how those care plans are put together because the duty is also binding on the practitioners. The legal framework of the provisions of the Act. It is particularly significant because the Act is really the interface of a number of different professional disciplines and a number of different intellectual domains, as it were. It is about the crossover between law, ethics, the duties of care, the rights of the individual and having some sort of clear steer as to how you apply particularly complex individualised orders. When you try and draw together all these things, it was felt to be very, very helpful. It was certainly difficult in the process of drafting the Bill to translate what was in the Millan principles into what lawyers would accept were defined legal propositions and I think the first print of the Bill, the first version of the Bill, did not have the principles because it did take us some time to sort that through. In terms of how it works, the general duty in the Scottish Act is that practitioners, including the tribunal, doctors, social workers and so on, have to have regard to the various principles articulated at the beginning of the Act. I think the idea of having regard to some things is a fairly well understood legal concept, so I do not think there is any fundamental difficulty in having that in a piece of legislation in terms of the practical effect. I think it is particularly relevant because of the tribunal and because the tribunal will be evaluating care plans and the particular powers that are sought in an individual case and will be evaluating the extent to which the patient has been involved in that and whether or not there are any alternatives which might have been considered, either different powers being sought or no powers being sought at all. I think it will guide the tribunal in assessing those care plans and the powers sought and therefore will influence how those care plans are put together because the duty is also binding on the practitioners. Therefore, the intention of having the principles actually on the face of the Act in some form is that it should have a direct effect on the way that the care is thought about and organised including some things like the duty to involve carers, for example, because there are obviously well-known problems regarding issues around confidentiality and so on and I think that a number of people felt that it was helpful to have those duties articulated on the face of the Act, in order that people had a clear understanding of what matters practitioners ought to be taking into account in formulating packages of care for people. Dr Osborne might want to say a little more about how the profession and the Commission feel that will actually operate in practice.

Dr Osborne: Just to go back a little to talk about how it might change practice under the Act, there was huge enthusiasm amongst service users, carers, voluntary organisations and professional bodies associated with mental health services because we thought it would be a guide to good practice under the Act and we thought that the action of a legal framework on how things are actually done in practice requires an extra steer particularly in relation to some of the innovative aspects like community based compulsory treatment orders. Having a set of principles to guide practitioners, the tribunal and the Mental Welfare Commission in carrying out its duties was very reassuring to service users and carers. Apart from having an effect in the operation of the Act, we thought and we hoped—and there are signs that it may be happening already—that it would affect the wider culture of mental health services and that having a well-established set of principles and treating people subject to compulsory powers would inevitably seep into the way that people who are not subject to compulsory powers are treated and so, over time, there would be a shift in the culture of mental health services. As we go around the country talking to people about the implementation of the Act, there are already signs of that happening, that people are starting to think about using the principles in their everyday practice whether or not they are dealing with patients who are subject to compulsory powers.

Q687 Chairman: Have any downsides been identified from having the principles on the face of the Bill? One I could suggest as a lawyer might be the otherwise entirely laudable effect of giving a large amount of work to lawyers to challenge the legal concept, so I do not think there is any difficulty in having that in a piece of legislation in terms of the practical effect. I think it is particularly relevant because of the tribunal and because the tribunal will be evaluating care plans and the particular powers that are sought in an individual case and will be evaluating the extent to which the patient has been involved in that and whether or not there are any alternatives which might have been considered, either different powers being sought or no powers being sought at all. I think it will guide the tribunal in assessing those care plans and the powers sought and therefore will influence how those care plans are put together because the duty is also binding on the practitioners. Therefore, the intention of having the principles actually on the face of the Act in some form is that it should have a direct effect on the way that the care is thought about and organised including some things like the duty to involve carers, for example, because there are obviously well-known problems regarding issues around confidentiality and so on and I think that a number of people felt that it was helpful to have those duties articulated on the face of the Act, in order that people had a clear understanding of what matters practitioners ought to be taking into account in formulating packages of care for people. Dr Osborne might want to say a little more about how the profession and the Commission feel that will actually operate in practice.

Dr Osborne: Just to go back a little to talk about how it might change practice under the Act, there was huge enthusiasm amongst service users, carers, voluntary organisations and professional bodies associated with mental health services because we thought it would be a guide to good practice under the Act and we thought that the action of a legal framework on how things are actually done in practice requires an extra steer particularly in relation to some of the innovative aspects like community based compulsory treatment orders. Having a set of principles to guide practitioners, the tribunal and the Mental Welfare Commission in carrying out its duties was very reassuring to service users and carers. Apart from having an effect in the operation of the Act, we thought and we hoped—and there are signs that it may be happening already—that it would affect the wider culture of mental health services and that having a well-established set of principles and treating people subject to compulsory powers would inevitably seep into the way that people who are not subject to compulsory powers are treated and so, over time, there would be a shift in the culture of mental health services. As we go around the country talking to people about the implementation of the Act, there are already signs of that happening, that people are starting to think about using the principles in their everyday practice whether or not they are dealing with patients who are subject to compulsory powers.

Q688 Lord Carter: Would it not be a fundamental principle to include a duty to protect the public from harm by people who are mentally ill?

Dr Osborne: We felt that was part of the structure of the legal framework of the provisions of the Act. It almost went without saying that that was one of the principles of the Act. There are other principles that would need spelling out for some practitioners and for some bodies.

Q689 Lord Rix: Is it a serious point that it is only implicit in the Act instead of being actually stated?

Dr Osborne: It is stated that, if other grounds are there and there is a risk to the safety of other persons, then compulsory powers can be used.

Q690 Lord Rix: Both the Scottish Act and the draft Mental Health Bill contain wide definitions of mental disorder. The Committee has received a substantial number of submissions criticising the breadth of the definition in the draft Bill whereas the Scottish definition has generally been supported. I have two questions. Can you explain the key differences in the definitions and make any suggestions as to how we can improve our definition of mental disorder and could you also explain, for my personal peace of mind, why people with learning disability, however caused or manifested, are automatically categorised to be suffering from a
mental disability. Why have you expressly included learning disability within the definition of mental disorder because I see your Scottish Deputy Minister for Health said, “The definition of mental disorder has been drawn widely to ensure that no one who needs these services is excluded from them by the provisions of the Act” and I think that is very laudable but, on the other hand, I would have thought that for the majority of people with learning disability, there is absolutely no need whatsoever to say that they need the services provided by this Act. Mr McKay: If I may start again and I will deal with the two questions in turn. On the general issue of the definition, there is a different definition in the Scottish Act. I wonder whether the practical difference is as huge as might be thought. I suspect that it would be a rare person who would be mentally disordered in the English Act who is not mentally disordered in the Scottish Act or at least one who would be likely to come within the remit of the Act. There are some areas of difference I suppose but I wonder if the concern about the breadth in the definition in the English Act partly relates to how it interacts with other provisions of the Act and other, as it were, gateways into compulsion. So, it is not just about the opening gateway. Certainly, Millan felt that the initial gateway, of does the person have a mental disorder at all, should be fairly broadly drawn. The issue around compulsion is where it narrows and it should narrow in relation to the justifications for an individual compulsion in an individual case not, do you fit into some particular category. The two primary differences I suppose are that the Scottish definition has sub-categories of mental disorder and also it has specifically stated exclusions. The sub-categories in the Scottish Act are learning disability, mental illness and personality disorder. I think it was felt by the Committee and by the Executive that it was helpful to make clear that the three different, as it were, kinds of mental disorder were all encompassed by the Act, particularly because there had been some doubt under the previous legislation about the status of personality disorder within the Scottish Act. That was not specifically to greatly increase the number of people detained with personality disorder, in some respect it was actually to give people with personality disorder the benefit of the enhanced duties to provide services which actually apply to voluntary patients as well as to detained patients and that is also relevant for a learning disability inclusion. I think many of the practitioners were uneasy about that. It was difficult to think of any better way of providing services compulsorily to some people with learning disability who might need them. Our Adults with Incapacity Act does not allow compulsory treatment and we come across a small number of people with learning disability who do behave in ways that put other people at risk and, at the moment, we have no better way of treating them compulsorily. However, there was a commitment by the Executive to review the position of people with learning disability as far as legislation was concerned and we are hoping that that will be the next step.

Dr Osborne: I do not know if I have any more to say about that, but just to say a little more about the learning disability inclusion. I think many of the practitioners were uneasy about that. It was difficult to think of any better way of providing services compulsorily to some people with learning disability who might need them. Our Adults with Incapacity Act does not allow compulsory treatment and we come across a small number of people with learning disability who do behave in ways that put other people at risk and, at the moment, we have no better way of treating them compulsorily. However, there was a commitment by the Executive to review the position of people with learning disability as far as legislation was concerned and we are hoping that that will be the next step.

Lord Rix: Could I express the wish that indeed the Executive will change their minds in regard to this. I am not persuaded by the arguments. I think, to actually include learning disability, however caused or manifested, is such a wide-ranging target for people with learning disability, that it could mean anybody in that category, whereas the vast majority of people with learning disability do not have behavioural disorders and are not likely to come within the ambit of this Act. Therefore to place them right at the beginning of the Act is I think (a) very dangerous, speaking from a parental point of view or a carer’s point of view and (b) is extremely demeaning. After all, we are trying to make people with learning disability part of the community and
I think this initial wording is designed to further the exclusion of people and to take away all dignity because it is a straightforward, flatfooted irrelevance to learning disability however caused or manifested. I cannot possibly accept your argument.

**Chairman:** That is a set of arguments that has been enormously well laid out, if I may say so, before the Committee.

**Q691 Lord Carter:** Dr Osborne, you mentioned the Adults with Incapacity Act, the 2000 Act, and I am sure you are aware that there is interest on this Committee in the interplay between the Mental Incapacity Bill which we hope will become an act in the spring and the draft Mental Health Bill that we are working on. What has been the experience so far in this? I appreciate that the 2003 Act is not in force completely until 2005, but what is the experience so far of the relationship between the two acts?

**Dr Osborne:** I have to say that there is some confusion and that might clarify when the 2003 Act is implemented. The intention is fairly clear, that compulsory treatment would not be authorised by the Adults with Incapacity Act, that the Mental Health Act will have to be used for that, though other measures obviously could be authorised.

**Q692 Lord Carter:** That is a clear point. What are the other grey areas where the two acts are overlapping, interfacing or whatever the word is?

**Dr Osborne:** There is obviously an issue about compulsory treatment for physical disorder which neither Act would authorise. The Adults with Incapacity Act does authorise the use of force in certain circumstances but for as short a period as possible, so the clear intention is not that it should be used for a prolonged period of compulsory treatment for physical disorder. There are issues about how far guardianship can be used to enforce non-medical aspects of care such as residency, attendance and those sorts of aspects of care. The Act has provision for getting a compliance order from a sheriff if the person in question is resisting intervention such as living in a particular place. I am not sure that anyone has ever used that particular provision because it is rather cumbersome and takes a long time. I think there is a problem about enforcing measures which the person is not happy with or resisting.

**Q693 Mrs Browning:** I would like to return to the issue that Lord Rix raised with you. I can say that I agree with his conclusions here but I just want to go on a fix on this because I have recently, this week in fact, had a reply from the Minister about the potential of this Bill in terms of the broad definition and Asperger’s Syndrome. The Minister has replied, as you rather demonstrated to us today, that this is to enable people to access services that they would not otherwise have. I really do not understand this because, whether someone has a learning disability or a diagnosis of autism, if their behaviour means that they are a risk to other people or themselves, I do not see why, unlike any other citizen, they do not have access to services or protection or people are not protected from them like anybody else. I just do not understand why they need to be singled out as labelled with a mental health condition when, in fact, not all of them do have one. If they fall into that narrow category, fine, but surely this is a gross infringement of human rights—it has to be—to label a group of people with something they actually do not have, in order for them to access services. This is bizarre. I am glad you are reviewing it in Scotland but I just wonder how you ever came to this conclusion in the first place?

**Mr McKay:** I apologise that I did not say more about how the Millan Committee reached the conclusion that it did. I think the first point is that our understanding would be that learning disability is a mental disorder as generally defined. It is not a mental illness but it is not a mental illness act. The Millan Committee did look at the provisions in New Zealand and took evidence from a professor of mental health law in New Zealand where they did exclude learning disability from the mental health provisions down there but eventually had to come up with a separate act for people with learning disabilities. That may well be an appropriate solution but a number of the provisions are essentially the same. You could say the same about mental illness, that a number of people with mental illness will never come anywhere near being detained. The fact that you have one or other condition is not the only reason to come under the ambit of the Act. If one took a very hard line equality argument, you could say that they have the same right as everybody else to be sent to prison if they commit an offence and that is ultimately would, could happen and did happen, we understand, to some people in New Zealand. If they are not able to be compulsorily admitted to hospital, then the reality is that the alternative, if they will not accept treatment voluntarily, may be a custodial sentence. There was a view of the Millan Committee that they were not prepared to countenance a situation where that might happen and there are people already in the system who might be discharged from the system who would then lose the care that they had. The issue for both mental illness and for learning disability is the issue around impairment of judgment and that is really what the Act is about and that is one of the conditions of imposing an order in the Act, that a person’s judgment is impaired so they are not able to make a fully informed decision for themselves about accepting treatment. The Committee did agonise about this and there was a strong view from some members of the Committee that there should be separate learning disability legislation but I think what would be important is not the question of whether you have one act or two acts but what the substantive differences would be between the two parts of legislation and I think that would be an important question to address.

**Q694 Mrs Browning:** Is the bottom line not what is and what is not appropriate services for this group of people who have an autism or a learning
disability diagnosis but who also, because of their behaviour or because of either an overlying mental health problem... For example, it is very common for someone with autism to have a diagnosis of clinical depression on top of the autism; it may be an intermittent and sporadic type of diagnosis because it comes and goes, but that is no different to any other citizen regardless of their diagnosis. They are entitled to those services and I do have concern that, if you group all people with learning disability or all people with an autism diagnosis in this group in order for them to access mental health services, actually mental health services for all of that group may not be appropriate at all and, at the end of the day, it is what is the appropriate service for the individual and I think you are taking away the individual assessment of what is appropriate and grouping them altogether in a 'one size fits all' situation. Is there not a real danger that there will be inappropriate services delivered for individuals as a result of that?

Mr McKay: No, not because they are in the same bit of legislation. The issue is the kind of orders that are imposed and part of the point of the legislation is to use individualised orders which are customised to the needs of an individual person. The needs for a compulsory order for a person with a learning disability clearly could be very different from the needs of a compulsory order for a person with a mental illness and the needs of one person with a learning disability will be different from the needs of another person with a learning disability. So, the issue is that you get individualised care. The problem is not so much whether or not they have a right of access to services, the fundamental problem is whether or not they are able to or do consent to the services and whether or not it is justified to impose services on people who may not be consenting to them. That is what fundamentally the mental health legislation is about. The ultimate point is that for some people with learning disability—very few but some people—and for some people with mental illness, services need to be imposed on them to which they have not consented and that is, I think, the fundamental reason why learning disability was maintained in the legislation in Scotland.

Baroness McIntosh of Hudnall: I wanted to go back, if I may, to the issue of possible risk of harm to other people, that is people other than a person suffering from a mental illness but I do not want to do that if there is still air in the question.

Q695 Chairman: May I just ask a question before we come to that and it is a question aimed at the Implementation Team. Do you foresee any difficulties arising from different definitions of mental disorder in Scotland and in England, cross-border issues relating to transient people?

Mr Faulkner: No, I do not think so. The only difficulties we might have relate to matching up the two pieces of legislation in that legislative sense but, in the practical sense, we do not believe there will be any great substantial difficulties in, for example, transferring patients from Scotland to England.

Q696 Chairman: I just wondered about the danger of overlapping legal procedures taking place, legal challenges if a patient was, as they may be for good reasons because their carers move for example, moving from England to Scotland or vice-versa but you did not see any great difficulties arising from that?

Mr Faulkner: No. I think, as Colin said earlier, it is unlikely that a patient who is detained under the 2003 Act in Scotland would not be detainable in England under the draft Bill and vice-versa. What will be built into the system, for example, for any patient who arrives in Scotland from England—and it will work very similar in the opposite direction—would be an assessment period once they arrive in Scotland to assess whether they do still continue to meet the criteria of the Scottish Act. So, there will obviously be that assessment process that is gone through. Nonetheless, we do not expect there to be any great practical difficulties on that line.

Q697 Chairman: If a patient moves from, say, England to Scotland and, in England, they have been under the control—and I use that word—of the English and Welsh Mental Health Tribunal system, do they immediately move into the control of the Scottish Mental Health Tribunal system and does the whole procedure start again?

Mr Faulkner: I should explain that, in the 2003 Act, the cross-border provisions are left entirely to regulations. We are in the process of making those regulations at the moment and what is planned is that any patient who arrives in Scotland directly from England will be deemed initially to become subject to the equivalent order in the Scottish legislation, an order which is equivalent to the order to which they were subject to previously in England. They will deem to be automatically subject to the equivalent Scottish order. The orders are equivalent in terms of length and so on and so forth and in terms of how they are granted. They will be assessed in Scotland as to whether or not they are deemed to meet the Scottish criteria which are obviously different from the English criteria and, at that point, whether or not a review by the Mental Health Tribunal takes place is still to be decided. As I say, we are in the process of making those regulations and that is in the process of being worked out.

Q698 Chairman: Who is in the process of making those regulations, the Scottish Executive, the Department of Health or both together?

Mr Faulkner: Both together. The regulations have to be made by the Scottish Executive Health Department. We are liaising very closely with colleagues in the Department of Health to make sure that the two pieces of legislation match up. The first issue that has to be overcome is that the 2003 Act has to mesh with the current legislation and then, at a later date, the 2003 Act will have to mesh with the English Bill. So, we are trying to make sure that any regulations we make now which
match up the 2003 Act with the 1983 Act in England will be sufficient to cover the situation when the new English Act comes into effect.

Chairman: Thank you very much. We will go back to the question that Baroness McIntosh wanted to ask which returns us to the issue about duty to protect the public from harm from people who are mentally ill.

Q699 Baroness McIntosh of Hudnall: We heard evidence in an earlier session from a witness who put it to us that the main imperative driving the wish to reform mental health legislation in England was a couple of very high-profile cases in which people with mental illness had caused serious harm to other people, random other people. I wondered if you could tell us to what extent the issue of risk did form part of the deliberations of the Millan Committee and subsequently fed into the legislation. Dr Osborne said it was thought that the issue of risk and the necessity to protect was implicit in the way that the Bill is drafted, but I would certainly be interested to know whether that was as a result of deliberation or not. Could you also tell us whether there was an effect in those deliberations from either the high-profile cases that took place in England or any similar cases in Scotland that had an impact on public perception of mental illness.

Mr McKay: I think the driver for the Scottish review was not any particular high-profile case. The driver for the Scottish review was simply that their 1984 Act was relatively outdated and there were obviously a number of issues around things like whether you have treatment in the community which influenced the decision to have the review, but the review was comprehensive. Certainly, looking at the terms of reference, there was a reference to taking account of issues related to the rights of patients, their families, their carers and the public interest. So, the public interest was certainly in the mind of the Millan Committee alongside issues around the rights of patients and carers. The decision to set up the MacLean Committee which looked separately at issues around personality disorder may well have been influenced partly by some of the cases in England and there was also a case in Scotland of an offender, not necessarily somebody who had been in the mental health system but a dangerous offender who had been released from prison and had gone on to be felt to pose a threat to the community. So, some of these issues were behind the decision to undertake the review. Certainly the Millan Committee accepted that the issue of risk to other people as well as the risk to the person is one of the determinants of whether or not a person comes into compulsory care and treatment. I guess the fundamental difference is around the treatability criterion and whether or not that in itself, the existence of a mental disorder plus the risk to somebody else, is enough to detain a person under the mental health provisions without evidence that the person is actually in need of treatment and would benefit from treatment. Both the Millan and MacLean Committees looked at that and, certainly in the Scottish context, found little evidence of people who could or should be detained but were not being detained because of the treatability requirement in the current legislation and felt that it was a fundamental principle of mental health legislation that it should be directed at therapeutic benefit, although the issue of risk to others is certainly one of the factors which you weigh in the balance in determining whether or not compulsion is appropriate. The MacLean Committee felt that the issue of broader public safety and dangerousness divorced from treating people’s mental disorder is not so much an issue of diagnostic labels, it is an issue of the risk assessment and is properly part of the criminal law and they made recommendations which were subsequently enacted which were intended to strengthen the provisions in the Scottish law for high-risk offenders which would include offenders with a personality disorder and essentially introduced a new form of indeterminate sentence for offenders who were established to be high risk even though the offence they may have committed might not necessarily have justified a life sentence in other situations. So, there was a recognition there that there is an issue around dangerousness but it is not necessarily one that best fits within the mental health system. I suppose that, if we are mentioning high-profile cases, we should mention the Ruddle case which was a case which actually happened in the middle of the Millan Committee’s deliberations and that was the case of a person who was discharged from the state secure hospital in Scotland on the basis that he was no longer treatable. He had been detained and was discharged. The Executive introduced emergency legislation prior to the Millan Committee report which provided that a person who is already a restricted patient may continue to be detained, albeit not treatable, if they still presented a sufficiently high risk, so more than a particularly high threshold of risk. The Millan Committee considered whether or not to keep it and had some misgivings about it but it ended up in the new Mental Health Act. So, there is still a proviso for people who are given a restriction order and who continue to be mentally disordered but are no longer felt to be treatable and they may still be detained.

Q700 Chairman: It sounds a bit like a muddy interface between the criminal justice system and the mental health system to me. Is that an unfair observation?

Mr McKay: It is a slightly muddy interface. I think the Millan Committee felt it should only be there partly as a residual provision for people who may have gone in under the old system. They felt that, with the new system of proper risk assessment when people go into the system you should be appropriately assessed and an appropriate disposal made when you go into the system, but it was recognised that there may be some people for whom the wrong disposal was made when they went into the system. An example is people who
perhaps fundamentally had a personality disorder and should have received a prison sentence but actually received a hospital order and that turned out to be wrong and they were still deemed to be dangerous and that is the small group covered by the test. In fact, whether there is anybody in hospital for whom that test would be operative is an open question. It is certainly not something that is detaining large numbers of people. There was an ECHR challenge to it which it survived fairly successfully. That was as far, I think, as both Committees wanted to go in terms of keeping people in the mental health system on the grounds of dangerousness and they were quite strongly opposed to the idea of bringing people into the system purely on the grounds of dangerousness.

Q705 Ms Munn: One of the concerns about the issue of treatability was that people at times were defined as being not treatable because they had a personality disorder as a way of mental health services, for whatever reason, whether it was resources or whatever, not actually providing any services for them and, from my own experience, I know of people who have been defined as, well, they have a personality disorder, therefore it is not appropriate to section them, but subsequently perhaps have been sectioned and have been given a course of treatment which actually has then benefited them. How clear are you that you are actually able to define treatability? That seems to me one of the real risks of having the treatability issue within the legislation.

Dr Osborne: We are only talking about compulsory treatment here. The Scottish Act includes personality disorder as one of the sub-categories of mental disorder and puts a wide range of obligations on local authorities and health services to provide services for anyone who has a mental disorder. So, the obligation to provide services for people with personality disorder is in the Act. Where the Act would narrow the focus would be when compulsory treatment is required and it introduces more than the concept of treatability but of benefit before compulsory treatment can be applied. So, there are two things going on: one is to try and widen the access of people with personality disorder to services and place an onus on health services, for example, to provide advocacy and those sorts of services but the other is to keep the criteria for compulsory treatment fairly narrow.

Ms Munn: I suppose that brings us back to the fundamental issue which is that we were always told that personality disorders by definition are not treatable. I do not know if you are saying that the views on that within Scotland have moved on because obviously, if what you are saying is that people can receive services and treatment voluntarily, if the treatment is not going to work if you have a personality disorder... Do you see what I am getting at? It is a view about, are there certain people who can be categorised in certain ways who would therefore be deemed to be never likely to or never to benefit from a particular treatment and therefore compulsory powers would never be available to people in terms of offering them... 

Q706 Chairman: I suppose there is a question connected to this as to what is the meaning of treatable. As you know, the draft Bill contains some very wide provisions which would fall within the definition of treatment.

Mr McKay: The Scottish provision is that the criterion is that medical treatment which would be likely to prevent the mental disorder worsening or alleviate any of the symptoms or effects of the disorder be available for the patient. It is not a case that you have to, as it were, get a drug that will cure you of the disorder. I think there is sometimes a confusion in the discussion of personality disorder between the specific case of antisocial personality disorder as there may be some dispute about whether that is a mental disorder and the broader
categories of personality disorder and certainly our understanding was that there are many types of personality disorder and there are many people who have some type of personality disorder who will benefit from some treatment regime, for example people with borderline personality disorder, and that providing there is some therapeutic interventions, whether it is psychological interventions or some degree of structure, which will alleviate the effects of the disorder and allow them to live a better and happier life. Even with people who are dangerous, there are therapeutic interventions which may be thought to have some benefit. Clearly, it is not the same as a treatment which will cure you of an illness, but all of those kinds of interventions would potentially allow you to meet the treatability test in the Scottish Act.

Chairman: I would like to move on now to issues about resources.

Baroness Murphy: We know that, since the passing of the Scottish Act, the funding for implementation to the Scottish Health Boards has increased by more than a quarter of the original estimate and we gather that more is going to be made available in 2005–06 and we wondered what the reason for that is and if you could tell us what the specific areas are where increased funding has been found to be necessary and whether you were wrong in your original calculations.

Q707 Chairman: We might add to that whether there are fundamental differences between Scotland and the rest of the United Kingdom which make the experience in Scotland different in any way or can we take what has happened in Scotland as a reasonable indication of what will happen in terms of resources in England and Wales.

Ms Tyrrell: The money that was identified as being required once the Act was implemented in the financial memorandum of the Bill was the £12–13 million that went to local authorities and another £6 million for Health Boards which they were not getting but which they had to find from their own resources. The additional money which was made available came from the partnership of commitment of the new administration that came in after the Scottish elections and it was identified as being required to help improve mental health services in general and to help implement the Act, not for ongoing service provision but to help make the changes that were needed in order that we could improve the services and local areas could also manage the work that was needed to implement the Act because there were a number of things like training and some redesign of services that were needed as part of the implementation work but which will not necessarily be long-term commitments.

Q708 Baroness Murphy: Was it in terms of new personnel or further resources to professionals? Do we know where the money is being spent?

Ms Tyrrell: When we gave the money to the local areas, we gave it to the health boards but they were expected jointly with the local authority partners and other agencies to plan for the implementation of the Act and improvement of services and, in a letter, the Minister mentioned eight areas that we asked to be looked at. They were crisis response and 24 hour service because that is patchy across Scotland; community services, obviously as a result of hospital treatment in the community; hospital services, a wider range of therapies being available; redesign of the workforce because again, with treatment in the community, we felt that the workforce needed to look at different ways of working; organisational issues for the board and local authorities; and resourcing and accountability because, when Dr Grant carried out her assessment of mental health services, she found that it was actually very difficult to know what was being spent on mental health services across the country.

Q709 Chairman: Do you have staffing shortages in various parts of mental health services in Scotland? We heard a lot in Wales, for example, about severe shortages of consultant psychiatrists, a very significant percentage. Do you have that kind of problem in Scotland and, if so, is that going to delay the implementation in its full sense of the new legislation?

Ms Tyrrell: There are two issues here. The Act put extra duties on to mental health officers and we recognise from that that we would need additional mental health officers, probably about 40 across Scotland, and there will be extra duties on consultant psychiatrists as well, particularly from the new Tribunal and there already is a small shortage of psychiatrists particularly in some specialties. So, some work has been done to look at how additional resources can be found, not so much additional resources but how we can redesign the way the services work and the way that consultant psychiatrists work in order that they have more time to do the things that they need to do in relation to the Act and the Tribunal. There are projects to look at the redesign of all the mental health workforce, how they are working and whether there are ways that they can improve that and make better use of the resources they have.

Q710 Chairman: How many consultant psychiatrists are you short of in Scotland at the present time?

Dr Osborne: It is a small number.

Ms Tyrrell: I do not have the figures. I could provide them for you but it is probably about 40.

Q711 Chairman: Forty out of an establishment of...? Ms Tyrrell: Seven hundred or so.

Q712 Chairman: So, it is a relatively low percentage compared with some other parts of Great Britain.

Ms Tyrrell: Yes.

Hywel Williams: The second of the Millan principles is about non-discrimination and language is mentioned specifically. Can you tell us how that has worked out, for example in the Western Isles in terms of providing services for the medium of Gallic?
Q713 Chairman: Is the answer to that, “That was a good question! We would like to write to you and give a response”?

Ms Tyrrell: We would be happy to do that, yes.

Q714 Chairman: That was a good question, Mr Williams, and they are going to write to us and give a response!

Mr Faulkner: I suppose the one thing to say on that point is that each area produces its own joint local implementation plan and that will no doubt be one issue they will be looking at within the Western Isles local authority and within the Highland Health Board. Those issues will undoubtedly come up in that joint local implementation plan, but we will certainly provide you with evidence of it.

Q715 Chairman: Good try but I think we would like you to write to us. The Scottish Deputy Minister for Health Services and Community Care described the plans for the new Mental Health Tribunal for Scotland and asserted that a full-time president was about to be appointed along with about one hundred each of legal, medical and general members from whom the members for each three person panel would be drawn. If that is true for Scotland, then it has a remarkable and exponential significance for England and Wales. Is it true and what has happened in relation to the re-establishment in their new form with the new legislation of Tribunals in Scotland?

Ms Tyrrell: We do not have Mental Health Tribunals at all at the moment, everything is considered by the sheriffs, so we are setting up a Mental Health Tribunal Service from scratch. Over the past year, as well as setting up the administrative structure, we have been recruiting, as we say, a president and 300 members. The legal members and the medical members were interviewed at the end of last year and we now have 95 legal members who have accepted and we expect we will get to the hundred.

Q716 Chairman: All part time?

Ms Tyrrell: Yes. We expect them to do about two days a month. It may be that we will look for one or two to do a little more but generally that. We have medical members. We have made 57 offers of appointment and 41 have accepted, but we expect that will go up, so we think we are at about 57 members. We are doing another round of recruitment because 57 is not enough and we hope to get that up and again we think we will manage the loading by having some retired members who will work more than two days a month, they might work two or three days a week or something like that.

Q717 Chairman: Basically, you need to have roughly equivalent numbers of each, do you not?

Ms Tyrrell: Yes. We have just advertised for the general members and we have had 485 applications for the 100 posts, so we think we will probably be all right on that front.

Q718 Baroness Murphy: Could I follow up on that question about the current Mental Health Act Commission which in the draft Bill is to be abolished and its responsibilities taken over by the Healthcare Commission. In the Scottish Act, you beefed up the Scottish Mental Welfare Commission. Do you have any comments to make about the proposals in our draft Bill to the abolition of the Mental Health Act Commission?

Ms Tyrrell: The only thing I would say is that our Commissions were not identical to begin with. Madeline might know more on this. I think our Commission had a bigger role and I think that we felt that was worth keeping.

Dr Osborne: The Scottish Commission has a different set of duties from the Mental Health Act Commission. The only one that is similar is visiting. We have a duty to carry out inquiries and indeed, by and large, there are no public inquiries in Scotland, it is the Commission that carries out the inquiries.1 We have a variety of other reporting duties and protective duties. Under the new Act, we have a role in safeguarding the rights of people who are detained and that includes having the power of discharge although we would not want to use that because we are not set up to really give people a fair hearing in the way that tribunals are. We have the power to refer to the Tribunal and, as I say, we have the power to hold inquiries if we think that treatment is deficient or care is negligent. That seems to be quite reassuring to service users particularly in relation to community-based orders and the Commission will be making a special effort to visit people on community-based orders very early in the course of their order to see that treatment is reciprocal, that the principles are being paid attention to, that the grounds for compulsion are still in place and issues like that.

Q719 Chairman: May I ask you now a quite different question. As you know, there has been a lot of publicity, some of it wholly ill-informed, about advance directives. The 2003 Scottish Act contains provisions for some limited recognition of advance directives. How important do you think those provisions are to the ethos of the Scottish 2003 Act or is it something that has been bolted on to satisfy a particular group who have a view about advance directives?

Mr McKay: I think that the advance directives in the Scottish Act are wholly dissimilar to the advance directives which tend to be covered in the media discussion which is around life-saving treatment, refusing life-saving treatment, and those kind of issues were dealt with in the Adults with Incapacity Act. The specific issue of advance directives in the Scottish Bill is around the idea that the whole point of the Act is that you will be

1 A sheriff may hold a Fatal Accident Inquiry into the circumstances of any death. This may include the death of a person with mental disorder. These Inquiries are held in public. The Mental Welfare Commission carries out all inquiries into the treatment of mentally disordered people who may have suffered from a serious deficiency in their care or committed homicide or other serious offences. These inquiries are not held in public.
required to do things which you have not consented to but that because of the principle at the start of the Act of having regard to the patient’s current and past wishes, it is appropriate to have a mechanism by which people can make their wishes known at a period perhaps when they feel well, in order that that will influence treatment at a time when they are ill. I think it is one part of the framework which ensures that care plans are drawn up with regard to what the patient would want to happen to them when they are able to express that and that the Tribunal can take account of that and make a decision. It is not a binding thing but it is meant to be one of the tools that will influence the drafting of the care plan and the decisions that the Tribunals make. I think in that respect it is a significant part of that.

Ms Tyrrell: Advance statements and appointing a named person are the two things that service users have found really have brought the Bill alive for them and they are all very interested in being able to make these decisions up ahead of implementation.

Q720 Baroness Eccles of Moulton: Putting it at a very simple level, if you are making an advance directive about the sort of treatments you might receive when you are unwell, while you are well, you might be quite prepared to agree to accept the sort of medication which makes you feel absolutely rotten when you are ill and you are not continuing to remember how awful you feel. When you become ill the next time, you are put on put to the medication which you have not agreed to in the advance directive but which you are finding it extremely difficult to adhere to for the reasons why you did not adhere to it before you made an advance directive. Is it actually something which in theory sounds absolutely great but in practice the patient is probably not going to be any more accommodating of their medication when they are ill than they would have been if they had not agreed to the advance directive and in fact it could be even worse because they could be then put under some sort of pressure because of the advance directive that they would not have been under if it had not existed?

Mr McKay: I think it really helps to get a fuller picture of what the patient’s views are. If a patient when well says, “I know that when I am ill this will happen to me and I understand that I will be given the treatment and I accept that” or perhaps says, “There is a particular kind of treatment that I particularly object to and, when I object to it, it is not just because I am ill, it is because I have a fundamental objection to it”, then I think those things should influence the decisions that are made and I do not think you can put it any higher than that in legislation because it is a complex balancing of what the person is saying to you now and what they might have said in the past and you cannot really legislate and say that one or other should always prevail but I think it is relevant to know what a patient has said when they are well and to take account of that and, if you have gone to the trouble of a formalised advance directive which you have had signed and witnessed, that probably tells you something about how strongly they feel about it and I think it is helpful to know that.

Q721 Baroness Finlay of Llandaff: You have used the terms “advance directive” and “advance statement” and could you confirm that actually you are talking about a statement and not a directive.

Mr McKay: Yes.

Baroness Finlay of Llandaff: And that you have a proforma of criteria that you would want to see fulfilled to ensure that it is valid and that it is recorded. Does it always have to be recorded in writing or do you expect there to be witness video recordings or transcripts and also I wonder if you could give us a little bit of a feel of whether people are able to state within this that, for instance, when they become ill, they would not want to be looked after on a particular ward or, if there has been a staff member whom previously they have found particularly difficult to relate to, whether they are able to express that in such a statement.

Chairman: Before you answer that question, there is a last question from Lord Carter because Prime Minister’s Questions are more than usually attractive today.

Q722 Lord Carter: To pick up on the point Mr McKay made about if you objected to a course of treatment, if somebody said that they strongly objected to the use of ECT for example, would that mean that the doctor who felt that it was eventually in the patient’s best interests to use ECT would not be able to use it?

Mr McKay: No. The duty on the doctor or on the person giving medical treatment is to have regard to the wishes specified in the advance statement. It simply means that you have to take account of that and I guess if you were seeking to authorise ECT in the face of an advance statement, the Tribunal would want to understand why you would want to overrule the patient’s wishes and it is no higher than that. The advance statement itself does have to be in writing and has to be signed by the person and I think has to be witnessed as well, so it is a fairly formal document. That said, there is still the underlying principle of having regard to past wishes. So, if a carer, for example, says, “This person has told me in the past that they would not want this kind of treatment”, if the doctor thinks that is true, the doctor should still take account of that. I suppose a tribunal, looking at it, would perhaps give a little more weight to something that someone has gone to the trouble of having signed and witnessed as recording what the genuine wishes are at a period when they are well. It is really just how much weight you place on this statement but it is not binding.

Q723 Chairman: I am going to have to stop you. There is a slightly creative ruling that, once you have started your answer, those who are present once you had started were deemed to still be here
throughout the answer! We are now inquorate because we have to have two members of each House present throughout our proceedings. Can I thank you very much and also for all the documentation we have received from Scotland. I think I can confidently predict that the word “Scotland” may just appear here and there in our report and we are grateful to you for coming to put some more flesh on some already well-fleshed bones and for your clarity. The meeting has finished but Lord Rix has never been put off by procedural niceties like that!
Wednesday 12 January 2005
Afternoon

Members present:

Carlile of Berriew, L. (Chairman) Mrs Angela Browning
Carter, L. Mr George Howarth
Cumberlege, B. Tim Loughton
Eccles of Moulton, B. Laura Moffatt
Finlay of Llandaff, B. Ms Meg Munn
Mayhew of Twysden, L. Dr Doug Naysmith
McIntosh of Hudnall, B. Mr Gwyn Prosser
Murphy, B. Dr Howard Stoate
Pitkeathley, B. Hywel Williams
Rix, L.
Turnberg, L.

Submission to Joint Committee on Mental Health Bill by Professor Jeremy Cooper,
Mrs Carolyn Kirby, His Honour Judge Phillip Sycamore and Mr John Wright (DMH 200)

1. There are in excess of 22,000 applications and referrals to the Mental Health Review Tribunal (MHRT) per annum across England and Wales from detained mental patients, seeking discharge from their section by a tribunal. Of these applications, over 11,000 result in effective hearings.

2. The authors of this document are Professor Jeremy Cooper (Regional Chairman, England South), Mrs Carolyn Kirby (Chairman, Wales), Mr John Wright (Regional Chairman, England North), who are the judicial officers tasked with ensuring the effective judicial operation of the Mental Health Review Tribunals in England and Wales; and His Honour Judge Phillip Sycamore, Liaison Judge for the MHRT. The Regional Chairmen have statutory responsibility for the appointment of the members of each tribunal panel, together with a number of further statutory powers and duties in relation to the judicial management of the tribunal process, set out in the Mental Health Review Tribunal Rules 1983. In addition to these statutory functions, the Regional Chairmen have a number of responsibilities concerning the recruitment, training, appraisal and discipline of tribunal members. The Liaison Judge was appointed in 2002 by the Lord Chancellor to provide leadership, direction and guidance to the Tribunal and to the Regional Chairmen in anticipation both of the Mental Health Bill, and the planned transfer of responsibility from the Department of Health to the Department of Constitutional Affairs. Although the MHRT is funded and administered by the Department of Health (and in Wales by the National Assembly), it is accountable to the judicial officers to provide effective administration of all matters related to a tribunal hearing. The Liaison Judge reports directly to the Lord Chancellor.

3. Although there are many matters contained in the draft Mental Health Bill upon which we could comment, we are limiting our contribution in this written submission to those parts of the draft Bill that deal with the proposed new Mental Health Tribunal (in particular pp 35-74).

4. The unanimous and strongly held position of all four authors of this submission is that the proposed new tribunal structure is unwieldy, unnecessary and unworkable. We believe that the paradigm shift from a reactive to a proactive tribunal has not been thought through at a level of detail necessary to vouchsafe its capacity to achieve what it is intended to achieve, which we understand to be a further strengthening of a patient’s right to have decisions about their liberty assessed with rigour and independence. This commendable goal, which we entirely support, can however be adequately and effectively safeguarded by relatively minor changes to the current legislation. The proposed new tribunal system with its monolithic straitjacket obliging every detained patient and his or her treating team to appear before a tribunal within a very short space of time following initial detention, is hugely resource intensive and disproportionate to its aims. It proposes a system that is cumbersome to the point that is probably unworkable.

5. The Mental Health Act 1983, reinforced by the Human Rights Act 1998 and extensive judicial review based case-law, already provides a number of safeguards to a detained patient’s rights, in particular a robust route to a speedy challenge to detention at regular intervals, in line with Article 5 of the European Convention on Human Rights. The fact that around 50% of the total number of detained patients in England and Wales already make use of this right to challenge their detention, and all patients who have not opted to apply to a tribunal will have their cases automatically referred to a tribunal hearing, at regular intervals (see section 68 Mental Health Act 1983), provides strong testimony to the robustness of the present system. All patients currently have access to non-means tested legal advice and representation by lawyers on the Law Society’s specialist Mental Health Lawyers Panel. The provision whereby the medical member of a tribunal, who is an experienced consultant psychiatrist, examines the patient in private before a hearing

1 All references to Regional Chairmen hereafter include the Chairman, Wales.
provides a further direct link between the detained patient and the tribunal, a link that case law has ruled to be entirely compatible with European Convention rights: S v MHRT (2002) EWHC 2522 Admin. In addition, each patient has the right to be examined by an independent expert of their choice as part of the process of preparing for a tribunal challenge to their detention, at which that expert can give written and verbal evidence. Tribunal hearings are conducted in a probing and rigorous manner, whilst also preserving the integrity and dignity of the patient. Tribunals will not hesitate to discharge a patient if they are not satisfied that the criteria for detention have been established, and do in fact discharge patients in 12% of cases. In all the above circumstances we ask the question: Why is it necessary to replace this largely effective system in such a wholesale manner, when it is already broadly achieving the goals that it is intended to achieve?

6. Our principal concerns in this respect can be summarised as follows:

— Because of the particular nature of the patient/doctor relationship the parties engaged in the new tribunal process (patient, legal representative, treating team and social workers) will be confused as to whether they are attending a judicial hearing, or an extended case conference. The hearings will be neither fully judicial, nor fully case conference. In contrast the current tribunal has a clear judicial function. The panel listens to the evidence from the hospital concerning a patient’s diagnosis, treatment and after-care plan, and in the light of this evidence decides whether a reasonable case has been made for continuing detention. Under the new system a tribunal will be asked to consider and approve something completely different, a “care and treatment plan”. This could well involve taking written and verbal evidence from up to three medical experts: the treating clinician, the Expert Panel member, and the patient’s own independent expert, all of whom may have differing views regarding the correct diagnosis, the appropriate treatment, the levels of risk and so on. We fail to understand how a panel consisting of a lawyer, a lay member and a clinical member can perform any meaningful judicial function in such a context? How are they to be expected to evaluate the competing “care and treatment” plans in a judicial sense, and what is the outcome expected from them? Are they expected to write their own “care and treatment” plan, as a synthesis of all three experts, to prefer one over another, or to reject all three plans, and adjourn for further advice?

Closely connected to these concerns is the likelihood that as a result of these proposed new procedures the tribunal will effectively become the detaining authority, as detention cannot continue without its authority. This is in complete contrast to the current position, whereby the tribunal is asked to review the lawfulness of the hospital’s decision to detain the patient. We wonder how in these circumstances a subsequent discharge application by a patient to the tribunal which authorised his or her detention in the first place, can satisfy the requirement for an independent and impartial tribunal?

— Linked to the above point is our concern that the levels of bureaucracy and paperwork required of clinicians under this new system will rapidly cripple the capacity of clinicians to carry out their clinical work. Busy practitioners already find it hard to find the time necessary to prepare adequately for tribunals, testified by the fact that in only 50% of cases do doctors manage to write the patient’s tribunal medical reports within the statutory time limits set out in the legislation. Under the proposed new system, not only will doctors continue to be writing these reports for patients who are challenging their detention, they will also be required to write a report to a tribunal for every single patient they propose to detain for more than 28 days, a formidable extra workload. This task will be further complicated by the requirement of a further report from an Expert Panel Member, which is likely to arrive late in the 28 day cycle, and may throw up a conflicting view to that of the treating doctor. Add to this workload the fact that the doctor will now have to attend a tribunal for each of his or her detained patients within 28 days of their detention, and the workload seems unreasonable and probably impossible to manage.

— The proposed tribunal system is far too mechanistic, and fails to take account of the volatile nature of mental illness justifying sectioning a patient. Around 25% of patients who currently apply to a tribunal withdraw their application prior to the application, often at the last minute, although the administrative apparatus, bookkeeping, reports etc necessary for the hearing to take place have all been assembled. This can be for a variety of reasons, but is often connected to their conclusion perhaps on medical grounds that a tribunal is not in their best interests, or perhaps they have become more ill, and do not want a hearing. It is not clear how this statistic has been factored into the new proposal, if at all, and how a patient’s wish not to have a hearing is to be taken into account.

7. What is clear is that efficient management of this new system will place massive demands upon the tribunal administration, demands that in our view the tribunal as currently administered will be quite unable to meet. Whilst this is not the forum in which to raise issues concerning the current administration of the MHRT, it is important that we place on record our evidence-based observation that (at least in England) the MHRT administration is regularly failing to deliver a reliable, professional service to tribunal users, a failure that it will require a long time to turn around. The draft Bill fails to explain how the MHRT administration that is currently systemically unable to deliver an effective tribunal service, will find the resources to deliver a tribunal that will far larger, and infinitely more complex.
8. Another major concern is the workforce requirement associated with the new tribunal. If we take the Department of Health’s own workforce figures set out in the Explanatory Notes to the Draft Bill on p 134, we estimate that they will require the recruitment, appointment, and training of c 2,375 new part-time MHRT members, a task that is literally impossible to achieve in the time scales, if at all. Where is the evidence of sufficient personnel in clinical and medical field wanting to come forward to do this work on such a grand scale? In the most recent competition to appoint new medical members, there were only c 60 applicants for 16 posts, despite extensive advertising in all the relevant professional journals. At the very least therefore we believe that a commitment to creating a cadre of full-time tribunal members will be essential to render these targets even remotely achievable. We also believe that the tribunal workforce requirements are in any event an underestimate as they fail to take sufficient account of the likely increased length of tribunal hearings; of the likely implications of the recent European Court ruling in the case of _HL v UK_, 5 October 2004 Appl. 45508/99; of the fact that there are increasing disincentives to doctors to offer their services to engage in the tribunal as Expert Panel members or clinical members; and of the fact that no reliable evidence has been produced to give us confidence that there are sufficient numbers of lawyers who would wish to avail themselves of the opportunity to join this new tribunal, as legal members.

9. Closely linked to the problem of recruiting sufficient applicants for the tribunal posts, is the problem of appointing and training new members. Currently the DCA has responsibility for the recruitment of all MHRT members using a sophisticated and highly developed process of pre-sifting, sifting, and interview against established competences. A sift panel, involving a representative of the DCA, a DCA-trained lay member, and a Regional Chairman or nominated deputy can sift through c 14 applications a day. If a panel were to sift every day, five days a week, it would therefore take about 34 weeks just to get through the 2,375 sifts required to call the minimum number of applicants. The DCA recommends however, a ratio of interviews to posts of 3:1. To achieve this ratio will require 102 continuous weeks of sifting, five days per week. Interview panels can normally interview four candidates a day. Thus, with an interview panel sitting every day, it will take _nine years_ to complete the sifting and interviews on a 3:1 ratio. This would be followed by training, with each new member required to attend a three-day induction programme before being deemed competent to sit on a tribunal. If an induction training event can hold a maximum of 100 delegates, around 24 three-day events will need to be organised to meet this requirement, in addition to the on-going training requirements for existing members. The numbers are simply unrealistic.

To the best of our knowledge none of the above sifting, interviewing and training requirements have been accurately costed into the draft budgetary assumptions for the draft Bill.

10. There are a number of other issues that concern us about the tribunal aspects of the draft Bill that can only be touched upon in such a brief submission, but include:

(a) The draft Bill proposes to reserve to secondary legislation a number of central issues that ought to be the subject of primary legislation, including for example the definition of a “clinical member,” which we have demonstrated must be central to establishing the viability of the underpinning tribunal apparatus, and the membership of the Expert Panel. In addition, the Bill’s proposed “guiding principles”, as set out in Clause 1 of the draft Bill can apparently be disapplied by the Code of Practice, which is also the subject of secondary legislation.

(b) The draft Bill’s failure to address the potential range of conflicts of interest facing Expert Panel members providing reports and evidence to tribunals is a further serious failing, in the context of the proposed tribunal. With such proposed large scale involvement of doctors on various sides of the tribunal process, the potential for conflicts to dislocate the fluent running of the system is high.

(c) We are aware that the evidence of a number of experts to the Joint Committee has indicated areas where there is potential for human rights challenges to be mounted. The tribunal will be the forum in which most of these challenges will take place, which will add considerably to its already massive proposed workload.

(d) Little account has been taken by the draft Bill’s architects of the fact that each tribunal hearing will inevitably last longer as the panels will be considering many more issues than at present, across a wider spectrum. This will have its own impact upon the capacity of the system to meet the deadlines proposed.

(e) It is impossible to envisage how the number of hearings contemplated within the scope of the draft Bill can actually be held within the time limits which the draft Bill imposes. Failure to do so will result in judicial reviews of the tribunal (an expense in themselves) with possible liability to damages awards on the same basis as those now being awarded to patients in England because of the failures of their current administration; see _R on the Application of KB et al v MHRT and the Secretary of State_ (2002) _EWHC 735 (admin)_.

11. There can be no doubt whatsoever that the administration costs of the MHT will rise very significantly over those of the current MHRT, if it is to embrace the proposed new system. This will not only be due to the vastly increased number of hearings, but also to the need to chase far more reports, organise the attendance of and reports from the Expert Panel and arrange the large number of adjourned hearings which will inevitably arise from the non-availability of key people due to excessive demands on their time.
12. In summary, as the judicial officers with ultimate responsibility for vouchsafing the quality of the tribunal that is expected to underpin the operation of the proposed draft Bill, we wish to express our grave concerns as to the feasibility of its core assumptions. We believe it is essential that we give oral evidence to the Joint Committee, in order to be able to explain why we believe that the new system will not work.

28 October 2004

Memorandum by the Council on Tribunals (DMH 305)

SUMMARY OF KEY POINTS

The Council’s key interest in the Bill lies in the appeal mechanisms and the proposal for a new two-tier tribunal system. The Council submits the following comments:

— the deficiencies in the current system, particularly in respect of the resources for and administration of the Mental Health Review Tribunal, should not be carried forward to the new system;
— concern that the guiding principles governing the operation of the new Act and its interpretation are to be contained in the Code of Practice rather than being specified in the legislation itself;
— until the Code of Practice is published it is difficult to comment on whether the principles are unambiguous, appropriate or desirable;
— concern over the broad scope of some of the conditions for compulsion and the degree of complexity that remains;
— concern over the omission of any legal criteria to guide the Tribunal in making decisions on whether a patient should be detained in hospital or treated in the community;
— concern that the Bill does not include a discretionary power to discharge certain patients in prescribed circumstances, similar to that contained in section 72 of the 1983 Act;
— the Bill will impose a significant workload on the new Tribunal which will threaten its ability to perform at an appropriate standard unless additional resources are made available;
— whilst supporting the provision of greater flexibility in the composition of the new Mental Health Tribunal, any substantive issue concerning the use of compulsory powers should always require a three-person tribunal;
— the criteria for the composition of tribunals should be sufficiently well-defined in secondary legislation and any discretion should lie with the President;
— it is unclear what power the Tribunal will have to amend care plans in the face of objections from the clinical supervisor, which could present difficulties where a Tribunal believes that a resident patient could be treated more appropriately in the community;
— concern about the nature of the decision on deferral under Clause 63(2)(b), which will require a Tribunal to predict whether the relevant conditions are likely to be met within eight weeks if the patient is not provided with post-discharge services, which could be a difficult task;
— the Council is content that some members of the MHAT may also sit as members of the MHT, subject to the caveat that no MHAT members may hear a case in which they were involved at the first tier;
— concern that the continued denial of power for the Tribunal to order leave and transfer in the case of restricted patients could lead to a breach of Article 5(4) of ECHR;
— the Regulatory Impact Assessment under-estimates the need for additional resources, in the light of the significant numbers of additional hearings that are likely to arise under the new system.

1. This memorandum is submitted in response to the Committee’s call for evidence, dated 16 September 2004, on the draft Mental Health Bill.

2. The Council on Tribunals was set up by the Tribunals and Inquiries Act 1958 and now operates under the Tribunals and Inquiries Act 1992. The Council’s main statutory function is to keep under review the constitution and working of the tribunals under its supervision and, from time to time, to report on them. These include the Mental Health Review Tribunals (MHRTs), constituted under section 65 of the Mental Health Act 1983.

3. The Council must be consulted before procedural rules are made for any tribunal under its supervision. The Council must make an Annual Report to the Lord Chancellor and the Scottish Ministers, which is laid before Parliament and the Scottish Parliament. Over the past 10 years, the Council has paid particular attention to the operation of MHRTs and the proposals for reform of the Mental Health Act, and has

4. In June 2000 the Council also published a Special Report on the operation of MHRTs (a copy of which is enclosed) to supplement its response to the Government’s consultation on Reform of the Mental Health Act 1983. The key recommendations made in the Report included:

— The new Tribunal to replace the Mental Health Review Tribunals should be headed by a national President, appointed by the Lord Chancellor;
— Every tribunal hearing should be properly supported by a tribunal clerk;
— Proper planning and management information systems should be put in place for the new Tribunal;
— There should be a robust and comprehensive training policy for all tribunal Chairmen and members;
— Good quality legally-aided representation at hearings should be more widely available to mental health patients;
— The need for a review of tribunal accommodation, with a view to securing greater consistency and an improvement in standards.

5. The Council recognises that some progress has been made since the publication of its report, for example in the appointment of a lead Liaison Judge for the MHRT and improved arrangements for training. However, the Council remains concerned that the deficiencies in the current system, particularly in respect of resources and administration, should not be carried forward to the new system.

6. In the paragraphs below, the Council comments on some of the matters to which the Committee is paying particular regard, focusing on those most pertinent to the Council’s remit.

7. The Council has some concerns that the guiding principles which will govern the operation of the new Act and guide its interpretation will be contained in the Code of Practice, rather than clearly specified within the legislation itself (apart from the general aims of the principles described in clause 1(3)). Until the Code is published, it is difficult to comment on whether the principles are unambiguous, appropriate or desirable. Some ambiguity will necessarily arise from clause 1(4) which allows the general principles to be disapplied in certain (as yet, unspecified) circumstances. Since the Code of Practice will not bind the Mental Health Tribunal, it would greatly assist the Tribunal in carrying out its judicial functions under the Act if a clear statement of the guiding principles were specified in the legislation itself.

8. The Council expressed concern that the relevant conditions for compulsion in the last version of the Bill were so broadly drawn as to make it difficult for the Tribunals, in exercising their decision making function, to discharge patients from compulsory powers. Whilst the Council notes that some aspects of the relevant conditions have been tightened up, there is still concern over the broad scope of some of the conditions and the degree of complexity that remains. In particular, the following terms remain open to very wide interpretation:

— the “nature or degree (of mental disorder) as to warrant the provision of medical treatment”—since this is no longer qualified by the need for detention in hospital, simply by the provision of medical treatment “under the supervision of an approved clinician” (clause 2(7)); and the defining characteristics of an approved clinician are left unspecified;
— “for the protection of other persons”—protection from what? No boundaries are specified, so even protection from a minor nuisance could be included;
— “that medical treatment is available . . .”—the definition of medical treatment contained in clause 2(7) is extremely broad.

9. In cases where the Tribunal makes a decision that the relevant conditions for compulsion apply, it will also have to decide whether the patient should be treated as a resident or non-resident patient (ie detained in hospital or treated in the community). The Council is concerned that the Bill contains no legal criteria to guide the Tribunal in making such a decision. The Council is also concerned at the breadth of the power contained in, for example, clause 46(7), enabling the tribunal to attach a condition to an order relating to a non-resident patient requiring the patient not to “engage in specified conduct”.
Whether there are any important omissions in the Bill

10. Section 72(2) of the Mental Health Act 1983 gives a Mental Health Review Tribunal discretion to discharge certain patients, even where it may not be satisfied that either of the mandatory conditions for discharge is met. This discretionary power is a helpful and important safeguard, which is absent from the current draft Bill. This is extremely regrettable, particularly in the light of the Council’s continuing concerns over the complexity of the relevant conditions in the draft Bill.

The extent to which the proposed institutional framework is appropriate and sufficient for the enforcement of measures contained in the Bill

11. The Council’s key interest lies in the appeal mechanisms and the proposal for a new two-tier tribunal system. The Council is keen to see the new tribunal smoothly and efficiently introduced. The Bill as currently drafted will, however, impose a significant workload on the new tribunal which will threaten its ability to perform at an appropriate standard unless additional resources are made available.

12. As regards the proposal for the composition of the new Mental Health Tribunal, the Council agreed that there was a good case for providing for greater flexibility in the composition of the tribunal, and particularly to enable a single person tribunal to deal with specific, well-defined interim or procedural categories of issue. However, the Council would expect that any substantive issue concerning the use of compulsory powers would always require a three person tribunal. Moreover, the criteria for the composition of tribunal should always be sufficiently well-defined in secondary legislation and any discretion in the composition of Tribunals should lie with the President.

13. In addition, it is apparent that the new Mental Health Tribunals will be much more involved in the approval of treatment plans than are the current MHRTs. However, it is not entirely clear what power the new Tribunal will have to amend care plans in the face of objections from the clinical supervisor, or what the position would be where agreement cannot be reached between the tribunal and the clinical supervisor. This could present particular difficulties in the case of a resident patient whom the tribunal considers could more appropriately be treated in the community.

14. The Council notes the introduction of a duty on the tribunal to make a deferral order (in clause 63) but is concerned by the nature of the decision required of the tribunal by clause 63(2)(b). In deciding to make a discharge order the tribunal will have already satisfied itself that the conditions for compulsion are no longer met, yet the duty to defer discharge requires the tribunal to predict whether the relevant conditions are likely to be met within 8 weeks if the patient is not provided with post-discharge services. This would seem an extremely difficult task.

15. So far as the new Mental Health Appeal Tribunal (MHAT) is concerned, the Council understands that some members of the MHAT panel may also sit as a member of an MHT and is content, subject to the caveat that no MHAT member may hear a case in which he or she was involved at the first tier.

The extent to which the safeguards against abuse are adequate. Whether the safeguards in respect of particularly vulnerable groups, for example, children, are sufficient. Whether there are enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery

16. See the comments in paragraph 18 below in relation to the interface with the Mental Capacity Bill and the need for adequate safeguards for compliant incapacitated patients. See also the comments in paragraphs 8, 11 and 20 concerning the tribunal’s workload and the nature of the conditions contained in clause 9. The value of the tribunal as a safeguard will be closely related to the conditions it is required to interpret and to the adequacy of the resources made available to it.

The extent to which the balance struck between what has been included on the face of the draft Bill and what goes into Regulations and the Code of Practice is right

17. See the comments in paragraphs 7 and 12 above.

The extent to which the draft Mental Health Bill is adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)

18. The Council is aware that a recent decision of the European Court of Human Rights (HL v United Kingdom, Appl No 45508/99) has thrown into some doubt the balance between the draft Mental Health Bill and the Mental Capacity Bill. In particular, it is uncertain whether the provisions of the latter contain sufficient safeguards for the detention of patients lacking capacity to consent in order to ensure compliance with ECHR Article 5. The Council is concerned that as currently drafted, neither Bill provides access to the Mental Health Tribunal for anyone to challenge detention decisions on behalf of compliant incapacitated patients, nor indeed on behalf of those non-compliant incapacitated patients who do not meet the conditions for compulsion under clause 9.
The extent to which the draft Bill is in full compliance with the Human Rights Act

19. In addition to the comments in paragraph 18 above, the Council has some concern that the continued denial of power for the tribunal to order leave and transfer in the case of restricted patients could lead to a breach of article 5(4).

What are the likely human and financial resource implications of the draft Bill. What will be the effect on the roles of the professionals? The extent to which the Government has analysed the effect of the Bill adequately, and whether sufficient resources will be available to cover any costs arising from implementation of the Bill

20. The Bill’s Regulatory Impact Assessment (RIA) indicates the need for an additional 80 legal members and 30 lay members for the new Tribunals. The Council believes this to be an under-estimation of need in the light of the significant number of additional hearings that are likely to arise under the new system, and the creation of a new appellate tier. In addition, it is not easy from the RIA to apportion the additional numbers of the clinicians to the Tribunals as opposed to those that will be needed within mental health services.

Witnesses: His Honour Judge Phillip Sycamore, Liaison Judge for Mental Health Review Tribunals, Mrs Carolyn Kirby, Regional Chairman, Mental Health Review Tribunals for Wales, Rt Hon Lord Newton of Braintree OBE, a Member of the House, Chairman of the Council on Tribunals, and Ms Penny Letts, Member of the Council on Tribunals, examined.

Q724 Chairman: Thank you very much for coming to the Select Committee. I know that for at least some of you it has been pretty inconvenient to come here today so we are very grateful to you for changing your own, and I suspect a lot of other people’s, timetables for you to be with us today. Thank you for your written submission, Judge Sycamore. We welcome the opportunity to talk to you about the tribunals aspect of the Draft Mental Health Bill. I wonder if you would like to introduce yourselves briefly, and if you would like to make a short introductory statement then perhaps one or more of you would do so.

Judge Sycamore: That is most helpful. Thank you very much for the welcome and the opportunity. To my right is Carolyn Kirby, who is the Regional Chair for the Welsh Tribunal. I am the Liaison Judge for the Mental Health Review Tribunal for England and Wales and, as you will see from our paper, that is a non-statutory position which the Lord Chancellor created in 2002. There are two Regional Chairman for England and they, in fact, are the only full-time judicial officers of the tribunal. They have been full-time since March of last year. Carolyn is not appointed on a full-time basis. Uniquely, the tribunal is in all other respects made up entirely of part-time members, just over 1,000 in all. It operates in a quite curious role in the sense that this is probably the only tribunal which by definition goes to the applicant, to the patient, because tribunals convene at the hospital where a patient is detained. As you know from the paper, the 24,000 or so applications and references each year produce 11,000 or 12,000 effective hearings; those seem to be the most recent statistics. From the paper I thought it would be helpful to highlight three or four of our particular concerns and then we can develop as you wish during the course of this evidence session. We accept entirely the underlying objective of the Bill in so far as it applies to the tribunal in that patients should have an early review and that is commendable. Our concern, as you will see from the paper, is that the proposed method of achieving that is disproportionate and we think that the existing structures under the 1983 Act could properly be adapted to achieve the earlier reviews and still stay loyal to the objectives underlying the Bill. We are concerned about the change of the tribunal’s role from one which is reactive to applications and references to one which is proactive, and a particular concern is the difficulty which would arise as the tribunal becomes the detaining authority and the issues then of independence and impartiality when it subsequently acts as a reviewing body on an application by the patient. We are also troubled by the proposed role for the tribunal in approval of care plans and whether that is an appropriate judicial role or does the tribunal hearing become more of a case conference and we ask whether that is an appropriate function for a judicial body. We know that one of the questions you wish to pose relates to the question of resource and recruitment and Carolyn Kirby will be happy to deal with that and explain how we produce the approximate numbers which are in our response. They essentially come from the department’s own explanatory notes and their own estimates that the new provisions would produce upwards of 40,000 hearings a year, something approaching four times the current numbers. Apart from that being a more than challenging task, we are concerned that views need to be formed at a very early stage, in the context of both the present tribunal and any new tribunal, as to the desirability of moving to a corps of full-time members, particularly full-time legal members, as I say, of which there is none apart from the two full-timers for England. With regard to inter-relationship with the tribunals White Paper and the planned transfer of this tribunal to the DCA, at least in so far as the English tribunal is concerned, I make no secret of the fact that I am concerned by the published timetable for the intended transfer, although we hope to improve on that. It seems to me that this is a tribunal which should properly be within the DCA rather than with the Department of Health. In saying that I make no criticism of individuals within the department who do a sterling job. If you look at the issues which this tribunal deals
with on a daily basis, the liberty of the subject and the protection of the public, it seems to us that it would be far more appropriate if it were with the sponsor department which is in the business of running courts and tribunals and then to have all the benefits of being part of the larger tribunal service which the tribunal White Paper envisages. We thought we would conclude our opening remarks by touching on the question you raise about the 28-day requirement. I have in mind a nightmare scenario which would not be so difficult to imagine occurring in a typical case. A patient is admitted to hospital in need of clinical help. The clinical supervisor is working to a 28-day timetable. That includes weekends, so in terms of working days it is a 20-day timetable. Within that time the clinical supervisor has other patients to deal with as well. He or she is going to have to prepare a report for the tribunal. The tribunal, having seen the report (and they cannot really do this until they have seen the report) are required then to appoint a member of the expert panel who has to prepare a report for the tribunal. The patient—and the majority of patients are legally represented because there is non-means tested legal aid available—will in all probability instruct solicitors. The solicitors themselves may well decide also to instruct an independent expert and I have this vision of a patient who is perhaps in need of clinical help and would like to concentrate on treatment, who may not want a tribunal at this stage, being subjected to a stream of visitors who are carrying out examinations, as they are required to, and I wonder then what the impact is going to be on the clinical welfare of the patient and on the relationship between clinician and patient. When is the clinician at that stage going to have the opportunity to get on with looking at the patient? We paint that picture not to be extreme but to demonstrate what has to be achieved in a very short timetable and the reality of a relatively small number of working days. I hope those opening remarks help to set the scene.

Q726 Lord Mayhew of Twysden: Lord Sycamore, your paper and your opening statement are of course very helpful. Can I ask you a question about your assessment of where we are at the moment? In your paper at paragraph 7 you say that the MHRT administration “is regularly failing to deliver a reliable, professional service to tribunal users, a failure that it will require a long time to turn around”. You say also that the administration is “currently systematically unable to deliver an effective tribunal service”. That is a bleak and rather dour assessment of where we are at the moment. Can you help me to see how we should read this in conjunction with what you say a little earlier in paragraph 4 when you say that the government’s commendable goal (which you have mentioned already today) of strengthening the patient’s right to have decisions about their liberty assessed with rigour and independence “can however be adequately and effectively safeguarded by relatively minor changes to the current legislation”. At first sight that seems a little difficult to square with the first rather dour picture. I wonder if you could help us about that?

Judge Sycamore: Shall I give an example of a minor change just to demonstrate what we mean?

Q727 Lord Mayhew of Twysden: Yes, or even a list.

Judge Sycamore: One of the main issues which emerges from the Bill is the timetable for the review of compulsory detention. At the moment cases come to the tribunal either by application or by reference and the 1983 Act sets out requirements for references in circumstances in which a patient has not made an application, so that, if a patient has not made an application within the specified interval then the hospital managers, or the Home Office in the case of a restricted patient, are required to make a reference to the tribunal. The 1983 Act sets out the timetable but it also goes on to say that the Secretary of State can vary that timetable by order. One of the suggestions we have is that the need for an earlier review could very well be accommodated by simply revisiting the timetable during which there must be references if there have not been applications. That is an example of the sort of change which could be made. As far as the administration problems are concerned, as I say, I have no criticism at all of the individuals concerned; they do a sterling job in difficult circumstances, but both Carolyn and I recently attended a presentation by consultants who
had been engaged by the Department of Health to identify some of the problems which are causing the administrative difficulties and Carolyn in a moment will identify the bullet points which came from that presentation. A lot of the problems arise from the location of the offices. They are London based offices. There is a poor record of staff retention. People do not tend to stay in the job very long. Their expertise does not have a great opportunity to develop over a long period. The database, which should enable staff to have easy access to information about suitable locations to ask members to attend the tribunals at suitable distances, does not work very effectively, and the telephone and fax systems are not geared to having a modern tribunal. The upshot of all of this is that very often the listing of cases is happening far too late in the day, the part-time members are being contacted very late in the day and a lot of the hearings are effective largely because of their goodwill and commitment to the tribunal’s work. An obvious consequence of that, which is undesirable in any judicial environment, is that papers arrive late or do not arrive at all and are seen by tribunal members on the day of the hearing. Those are the sorts of problems at the coal face which are capable of being resolved. I mentioned in my opening remarks that for all sorts of reasons transfer to the Department of Constitutional Affairs is desirable. One of the reasons, a practical reason, is that they are in the business of, and have had lots of experience of, running courts and tribunals, dealing with judges, dealing with part members and making sure that there is good and effective use of time. Could I ask Carolyn to pick up on the particular points?

Mrs Kirby: A distinction needs to be drawn between the judicial remit of the tribunal, which I think it is fair to say is not giving cause for concern, and the administration which underpins it, which I think is certainly giving cause for concern. I should here draw a slight distinction between the system which pertains in England and the system which pertains in Wales, not simply because I am Welsh but because we run two different systems. We run a system which is as it used to be run in England. The system in England was changed and most people agree that that is not necessarily a step in the right direction. The administrative problems as identified by the consultants who have been appointed by the Department of Health—and perhaps I should say that although we have not seen it there is a 20-page report of the shortcomings of that administration, in no particular order, prepared by those consultants which might bear examination if you were inclined to look at it, as Phillip has mentioned some of them—are that the booking system, which is used for members and is an advance booking system in which people are asked to express their availability for the coming year for the minimum number of days that they are obliged to sit, does not work for a variety of reasons. It does not have the confidence of either the members or the staff and part of the problem is that the computer database which underpins it does not keep the information accurately and therefore people are sent out to hearings either on days that they have not expressed their availability or, more particularly, some costs are wasted because people set aside days when they believe they are going to be sitting and in fact they are not given any work because the database has not identified them as being available. The IT database itself does not work for a variety of reasons. It does not have the necessary capacity and it was not built for commercial use in any event and therefore it is largely unsuitable.

Q728 Chairman: Forgive me for interrupting you. I think we have pretty well got the message about the inefficiencies of the present system and, as I have told the committee previously, I at one time for a short time experienced the difference between the Welsh system, where you still have what I will call loosely clerks, and the English system where the tribunal is left floundering on its own in an unfamiliar room in sometimes hostile territory with almost no administrative back-up at all and nobody turning up at the hearing either, which is the sort of horrendous position you are describing. The system is broke to an extent. Do you not think that the new system that is proposed gives a real opportunity to mend it?

Mrs Kirby: No.

Q729 Chairman: Why not?

Mrs Kirby: The reason we think it is not an opportunity to mend is that we have not seen any firm evidence that the real implications of the implementation of this Bill have been taken on board in terms of the resources and particularly the money that would be needed to underpin this if it were to be introduced.

Q730 Chairman: Am I to take it that none of you here has seen the 20-page consultants’ report to which you referred earlier?

Lord Newton of Braintree: I certainly have not seen it.

Q731 Chairman: Judge Sycamore?

Judge Sycamore: No.

Mrs Kirby: But we have attended an event at which the consultants took us through the points which they raise in that report. We simply have not seen the written report.

Q732 Chairman: Do you know why not?

Mrs Kirby: No.

Judge Sycamore: It is not available at this stage. The presentation was fairly recent. It was not very long before the Christmas break.

Q733 Lord Mayhew of Twysden: Arising out of that can you tell me whether your objection to the proposals for the Mental Health Tribunal are based upon the assessment that it never could succeed because it is too cumbersome, it is too complicated
or whatever, or is it on the basis that it is not going to be properly resourced and therefore is going to fail for that reason?

**Judge Sycamore:** Our objections to the proposed structure and new role for the new tribunal is that it is unnecessary and disproportionate in terms of the needs it is seeking to address. That is the first point. The second concern, as I mentioned earlier, is the blurring of the territory between the judicial role and the approval of care plans, and the third is this confusion of role, being at one stage of the process the detaining authority and at a later stage becoming the reviewing body which seem to fit uncomfortably.

**Q734 Lord Mayhew of Twysden:** In shorthand one might call these inherent objections?

**Judge Sycamore:** Yes. There are issues about recruitment and resourcing. If the tribunal were to go ahead in its proposed form, put to one side the inherent objections as it were, we would all be very concerned that something so ambitious in terms of recruitment and resource being taken on against a background where it is already difficult to recruit sufficient medical members to the tribunal and there is no certainty that there would be the necessary number of legal members and a massive commitment in terms of recruitment and the time that would take. That is something Carolyn has done some work on in terms of the numbers of days and months and beyond that it would take.

**Q735 Lord Mayhew of Twysden:** We have seen those calculations and of course they are formidable. You are going, I hope, to give us a list of the relatively minor legislative changes that are needed, to use your words. I do not at the moment see quite why itsolicitors do have ready access to legal advice in this context. In view of what we see as a quite elsewhere.

**Q736 Laura Moffatt:** There is some clarification that I require here. It is quite legitimate to raise the issue of resources when a new proposal is made such as we have before us, but I am just reading through the evidence and I am trying to get to grips with why you believe, apart from some minor changes as Lord Mayhew says, that the system is okay? You argue that 50% of detained patients have recourse to the tribunal. Then in a later paragraph on page 3 you say that 25% of those would then withdraw the application and you quite rightly cite the volatile nature of mental health and the issues around that. Are you entirely satisfied that the system as it stands is also dealing with those 50% for which you have no knowledge whatsoever about their situation at all because they have not been before you, they have not been raised at a tribunal? Are you entirely satisfied that their needs are being met?

**Judge Sycamore:** I am sure that there could be improvements to the way in which advice is provided to the individuals who choose not to make an application but the reality is that patients have ready access, for example, to legal advice, which is free legal advice. I am sure if one looked at the way the advice is provided it would be possible to ensure that the ways of offering that advice were improved. It might be that you could operate something on the lines—

**Q737 Laura Moffatt:** Is that part of your proposal? Is that what you are saying when you say minor things could be better?

**Judge Sycamore:** No. I am trying to deal with your specific question about the 50%. What we understand anecdotally is that the vast majority of patients through the hospitals and then through solicitors do have ready access to legal advice in terms of the options which are open to them. The tribunal has very recently launched a website and that provides a lot of information which was not quite so readily available to the public generally, and specifically we hope that will be of assistance to the families and friends of those who find themselves subject to the provisions of the Act. I am sure there must be ways of improving it and ensuring that every patient receives advice, but the safeguard, of course, is that if a patient does not choose to apply to the tribunal, then there is a requirement for a reference by hospital managers or, as I said earlier, in the case of a restricted patient by the Home Office. Those timetables could be revisited and shortened as appropriate. The important thing is that people have ready access to and understand what their options are.

**Ms Letts:** I wonder if I could come in here and make a point. From the point of view of the Council on Tribunals, we have looked at this issue in a slightly different way. While we share the concerns of the Regional Chairmen about the practicalities and the workability of the system and the proposals as currently drafted in the Bill, we have looked at it from the point of view of our particular interest in the needs and rights of tribunal users and patients in this context. In view of what we see as a quite...
significant reduction and changes proposed to the safeguards currently available to patients to challenge detention that are proposed in the Bill, for example, the removal of their right to apply for discharge by the hospital managers, the removal of the nearest relative’s rights of discharge, the reduction in the visiting function that is currently carried out by the Mental Health Act Commission, changes to the safeguards in relation to consent to treatment and so on, we feel that, while the Bill is reducing the safeguards available to patients to such an extent it enhances the need for the tribunal to take on this role that is proposed for it in being the independent judicial body, that confirms the need for continued compulsion after the initial 28-day period. We feel that that principle is quite an important principle and would provide an appropriate degree of safeguards for patients in the context of the reduction of these other safeguards which are available while we are sharing the concerns that the provisions as currently set out in the Bill would actually make it very difficult for the tribunal to carry out that role.

Q738 Chairman: I would like to move on now to two specific questions that we need some kind of answer to in order to help us in our deliberative process and then we will turn to the question of the role of clinicians. The Bar Council, and certainly the Hampshire Partnership NHS Trust, have expressed misgivings about the removal of the discretion under the 1983 Act in the hands of the tribunal to discharge certain patients even if the conditions for discharge have not been met. In your view what circumstances would justify the tribunal retaining that discretion even though a patient satisfies the conditions for compulsion? I will ask the other question as well; it is quite separate, so that some thought can be given to it whilst the first one is being answered. The draft Bill makes provision for the tribunal to sit in a panel consisting of a single member. We would be grateful for your views on that and in particular the kinds of issues (if any) which you regard as being suitable for a single member to determine.

Judge Sycamore: Can I comment on your second question first? We have asked the question of Department of Health officials—and when I say “we” I mean the Regional Chairmen and myself—as to the circumstances in which it is envisaged that there may be single member determinations. The most recent answer I recall, and I am sure this is right, is that it was envisaged that the majority of decisions would be made by three-member panels. We find it difficult without further information from the department to see how single member panels could operate on substantive issues. If, for example, there were to be a cadre of full-time legal members then we could see great attraction in the ability of full-time legal members to deal with case management issues and to ensure that parties focused on the key issues before the day, but beyond that, given the role of the tribunal and particularly the proposed role of the involvement in care plans, we would find it difficult to envisage circumstances in which beyond case management, which is a very important function, single member adjudications would be appropriate.

Lord Newton of Braintree: Our view would be broadly the same, Chairman. In fact, we commented on this in paragraph 12 of our evidence and said we could see a case for this where you were talking about a specific well-defined interim or procedural category of issue, but we went on to say that any substantive issue involving the use of compulsory powers, for example, we thought should remain with a three-person tribunal.

Chairman: It is really directions hearings and that is about it?

Q739 Chairman: Do you agree with that?

Mrs Kirby: I do. I think that any hearing which deals with substantive issues which is being dealt with presumably by a lawyer alone would, apart from anything else, raise human rights issues. At the moment the patient is entitled to be heard and I think the patient should be heard in those circumstances. Anyone sitting alone dealing with the issues on the papers, bearing in mind that it is about it? in independent judicial body, that confirms the need for continued compulsion after the initial 28-day period. We feel that that principle is quite an important principle and would provide an appropriate degree of safeguards for patients in the context of the reduction of these other safeguards which are available while we are sharing the concerns that the provisions as currently set out in the Bill would actually make it very difficult for the tribunal to carry out that role.

Q740 Chairman: Can you offer any thoughts on the first question?

Ms Letts: Certainly we regret the fact that the tribunal will no longer have any discretion where the conditions for compulsion appear to be met, mainly because we are concerned at the broad drafting of the conditions in the current draft Bill which makes it easy to see where patients might fulfil the criteria for the use of compulsory powers but difficult to see where those powers might no longer apply. That is certainly one of the concerns that we have about the broad drafting of the conditions for compulsion. Another is the lack of legal criteria spelt out in the legislation which enable tribunals to determine whether or not compulsory treatment is in fact justified or other types of issues such as whether the patient should be treated in hospital or in the community as a resident or non-resident patient. The drafting needs to be tightened up but in addition the tribunal should have discretion in the way in which they interpret those conditions and criteria.

Q741 Lord Rix: My question goes back to what you were saying, Penny Letts, about detention and the tribunal. Would you see the possibility of the
tribunal being the first step in closing the Bournewood gap? In other words, if an informally detained patient were granted the same rights as a detained patient, being able to come to a tribunal, to have the appointment of a named person, to be entitled to have an advocate and access to CHAI and all the rest of the safeguards which a detained patient has got, would you consider that that would be one simple way of closing the Bournewood gap? Under this Act could they not be granted the same rights as a detained person if they or their advocates were not satisfied that their best interests were being respected?

Ms Letts: That is certainly one possibility. I know that there has been a lot of discussion both in the Committee and elsewhere about where the most appropriate safeguards for both compliant and non-compliant incapacitated patients should lie, whether it should be within the Mental Capacity Bill, that is currently going through Parliament, or in the context of the Mental Health Bill. Certainly most of the statements that I have read and the evidence that has been put before you tends to favour those safeguards being placed in the Mental Capacity Bill, but in the context of decisions being made about deprivation of liberty and about detention and compulsory treatment it would seem inappropriate for there to be different bodies dealing with similar types of issues. While the Mental Health Tribunal would obviously have a body of expertise in looking at issues of this sort, it would appear to make sense for that tribunal to consider issues and safeguards in relation to incapacitated people as well rather than it going perhaps inappropriately to the Court of Protection under the Mental Capacity Bill or a new tribunal being set up. I think it would make sense for it to be in one place.

Q742 Dr Naysmith: I was interested in what Judge Sycamore had to say early on when he was arguing against the use of monitoring of care plans and so on, which seems to be envisaged in the new arrangements, that being one of the objections he was putting forward to the new legislation. I do not know a great deal about what happens in the current case but is it the case that Mental Health Review Tribunals currently never become involved in the examination of care plans and treatment and so on?

Judge Sycamore: No, it would be wrong to say that they never become involved because they do often feature as part of the evidence which the tribunal is considering, particularly if return to the community is envisaged. The tribunal will be concerned to know the detail and practicality of the package which is proposed.

Q743 Dr Naysmith: What is being proposed under the new proposals that you do not currently do?

Judge Sycamore: The difficulty we see is that you may find that a tribunal which exists primarily to exercise a judicial function in determining whether statutory criteria are fulfilled will find itself adjudicating between competing views as to what an appropriate care plan might be. There may be one view from the clinical supervisor, another view from the member of the expert panel and another view from an independent expert instructed by the patient’s solicitors. What we are saying in the paper is that we question whether that is an appropriate role for a judicial body. Is there a danger that what is intended to be a judicial hearing becomes, from the patient’s point of view, possibly a case conference, which is not the role of the tribunal.

Q744 Dr Naysmith: Remembering that while all this is happening the patient is locked up.

Judge Sycamore: Indeed, yes.

Q745 Dr Naysmith: Whose job is it then to make a decision between these competing analyses of the situation?

Judge Sycamore: That is the question we pose: is the tribunal best placed to adjudicate not a legal issue but a practical issue?

Q746 Chairman: So the difference is that under the system proposed under the Bill it becomes the responsibility of the tribunal?

Judge Sycamore: Yes.

Q747 Chairman: And what you are saying is that you are very dubious as to whether that is a proper role for a judicial body?

Judge Sycamore: Particularly at a time when it is suggested that the medical member in the current tribunal is a consultant psychiatrist. Of course, the detail of the definition of the new clinical member is absent from the face of the Bill but we are led to believe that it is not envisaged that the clinical member will necessarily be a consultant psychiatrist.

Q748 Chairman: Do we take it from that that you and Mrs Kirby are in favour of retaining a psychiatrist as a clinical member of the tribunal?

Judge Sycamore: We deal with this in the paper in paragraph 5 on page 2. The role of the clinical member in being both a member of the adjudicating panel and being required to carry out a preliminary examination has been the subject of some debate and indeed, as we point out in the paper, was the subject of a judicial review in 2002. So far the courts have taken the view that the way in which the clinical member operates in the English and Welsh system, which is a comparison with a slightly different approach, I think, in Switzerland which was mentioned in the judicial review, is such that it is an acceptable approach provided that the opinion which the medical member expresses to his or her colleagues at the outset is a provisional opinion and remains such throughout the tribunal hearing. So far the courts have said that that position is tenable and compliant with the ECHR.

Lord Newton of Braintree: Chairman, I wonder whether I could chip in because I am not quite sure whether you are all regarding the four of us as a completely seamless—
Q749 Chairman: No, I am certainly not anyway.
Lord Newton of Braintree: I just want to make it clear that, while we do share a number of the concerns the Council’s perspective, again coming at it of course very much from the user and interests of justice perspective, if you like, is that we have never really been terribly comfortable with the notion of somebody who does the examination, who gives evidence in effect, is also a part of the adjudicative panel, so that we welcome in the new Bill—

Q750 Chairman: We understand the issue. I do not think we should have a debate about what you have just said, though I can see Judge Sycamore just getting ready to have one.
Lord Newton of Braintree: I just wanted to make sure there was no misunderstanding. There is a different nuance.
Judge Sycamore: We have had the discussion.
Chairman: If you do not mind we are going to move on to something else about the role of clinicians.

Q751 Baroness Murphy: The tribunal Regional Chairs have argued that the proposed system would place an unacceptable burden on clinicians, and you alluded to that too, Judge Sycamore, in your opening remarks, because practitioners are required to write medical reports for every patient they detain for 28 days and also to attend subsequent hearings. Would you not agree with me that a clinician should surely have to justify their decision to deprive someone of their liberty to a tribunal? Is that not what the tribunal system is for?
Mrs Kirby: I think there is a distinction to be drawn. Certainly the clinician should justify detention if asked to do so, but the distinction between the current system and that which is proposed is that the clinician would be required to prepare reports and so forth in every circumstance and we see this as part of a wider issue and it brings in the issues of the reduced number of people who have the necessary qualifications to act as front-line clinicians, also potentially to be clinical members of the tribunal and also (an issue which we have not mentioned yet this afternoon) this one of the Expert Panel. There are only a certain number of people who have the necessary expertise to do all three of those functions and we have a very grave concern about the availability of all of those people to fulfil the functions which they have been given. Of course clinicians should justify their detention of patients if called upon to do so, but to require them to do so in this very cumbersome fashion in a very short timescale in every single case, whether or not the patient is applying to have his or her detention review, we think is an unnecessary burden given that the system of mental health is under some significant pressure already.

Q752 Baroness Murphy: If resources were adequate and we had consultant psychiatrists coming out of our ears—and I know that is not a very good analogy—and plenty of clinicians to do the job you would have no objection, but you do at the moment think it is the resource issue which poses a problem for the tribunal?
Mrs Kirby: It would overcome the difficulty of the number of people who would be needed to fulfil all of those functions from the clinical point of view but, of course, that would not overcome the difficulties that we would have from the tribunal’s point of view. It also does not overcome the timescale issues which Judge Sycamore referred to at the beginning, that most of these things need to be done consecutively; they cannot be done concurrently. The practical fact is that an RMO clinician detaining a patient is unlikely to start preparing a plan for that patient’s care and so forth until they have had an opportunity to consider the patient and assess them and so forth. That necessarily takes a period of time. That report would have to be produced. On the basis of that a member of the Expert Panel would have to be identified and booked and their availability determined even if there were an unlimited number of these people, which there is not.

Q753 Chairman: Is there not a critical mass issue here as well? The fact is that, although the department may say that it will fund all the new clinicians who are needed to be able to service the system, they do not just appear like that?
Mrs Kirby: No, and they cannot simply be created if they do not exist. I think you will already have heard from the Royal College of Psychiatrists about the number of psychiatry vacancies that there are currently. I am sure they will have told you yourselves that there is a significant cohort of psychiatrists who are so opposed to this legislation that they will not take part in its implementation and therefore the problem is only going to become worse, not better.
Ms Letts: The other issue in terms of the drafting of the Bill, and we were talking before about the lack of discretion for the tribunal, is that there is also a lack of discretion for the clinical supervisor, that once the clinical supervisor finds the conditions for compulsion to be met they have to use compulsory powers. There is no discretion for the clinical supervisor not to. Again, it adds to the burdens and then the need to justify the use, and they will also have to justify not using compulsory powers, so while the criteria for compulsion are so broad it adds to the burdens of the clinical supervisor as well as the tribunal.
Dr Naysmith: In your submission you argue that the Department of Health’s estimate that you will need an additional tribunal workforce of 160 whole-time equivalents, which would break down to 2,775 new part-time tribunal members. You are obviously not very keen on that idea but do you worry about the basis on which it is calculated or do you think it is realistic? Finally, do you think the best way to solve the staffing problems you are indicating would be to employ—
Q754 Chairman: Associated with that question, I think the committee might be interested in your view as to whether, if there are to be the resources provided to meet need, they would best be met by the introduction of a large number of full-time appointments rather than a very large number of part-time appointments.

Judge Sycamore: We have made the point that so far as the legal members are concerned we can see the need and attraction for full-time appointments, whether in the existing review tribunal or a new tribunal. I am not so sure that it would be so easy to attract consultant psychiatrists into full-time positions away from their NHS practice. The career structure for consultants is quite different from that for lawyers and I am not sure that the case is made out that there will be large numbers of medically qualified individuals who would seek to take the full-time appointments for the new clinical member status. As far as the numbers are concerned I am going to ask Carolyn Kirby to deal with that in a little more detail for you. The numbers initially come from the explanatory notes to the Bill in which the department set out their predictions as to the increase in numbers of tribunal hearings and the formula for conversion from part-time to whole time equivalents. That was the starting point for the contents of that paragraph.

Q755 Dr Naysmith: On the question of people being full-time rather than part-time, in the latest competition for legal members of the health tribunal system there were 233 applications for just 31 vacancies.

Judge Sycamore: This was the legal members?

Q756 Dr Naysmith: Yes.

Judge Sycamore: Not the medical members?

Q757 Dr Naysmith: That would suggest that it would be possible at least, would it not, to staff the legal requirement?

Judge Sycamore: We are persuaded on the legal member issue but whether people would be attracted to it as a full-time post is a different issue. These are individuals who have taken 20 or 30 days away from their practice at the Bar or as solicitors.

Q758 Dr Naysmith: But that is looking at the current situation. It might change if there were a different system altogether.

Lord Newton of Braintree: If I could chip in here, part of the thinking in the development of what was originally shorthanded as the unified tribunal service was to create a stronger and clearer career pattern for what are called the tribunal judiciary, and they sometimes call the others the uniformed branch. Whatever term you use they are operating in a judicial role. They often feel as if there is not a very good career structure for those who are particularly interested in tribunals, and it is true of the staff as well, and that is part of the case for the new tribunal service and it does interrelate with this discussion you are having with Phillip.

Judge Sycamore: And it would give the opportunity for legal members to sit in a variety of jurisdictions, so they would not have a permanent diet of one particular jurisdiction.

Mrs Kirby: Bearing in mind that if they sit in other jurisdictions they are not available to the Mental Health Tribunal. If they are appointed full-time we would need them full-time. The point about the numbers is that at the moment people are only required to sit a minimum of 20 days a year. At 20 days a year to have 100 full-time people you would need a lot of people for something like 20,000 sittings. That is where we arrive at the figures because that assumes that there is a full-time cohort. It is also not just an issue of simply recruiting people. There is a significant issue as to whether a full-time appointment would be attractive but if you do recruit full-time people you would have to bear in mind that of course we have no premises. We do not function from a building because that is not the way the tribunal works. All the hearings are in hospitals and all the part-time people are simply booked to go to those hospitals, so that any creation of a full-time cohort of legal members would need to be followed up by the acquisition of premises, support staff and all the costs that follow from that.

Q759 Chairman: We have a pretty clear picture in the written evidence and from what you said about those resources issues. There is one further question, which is unconnected with those issues, that we do need some evidence on. It is this. The 1983 Act empowers courts to subpoena health authorities where they fail to provide a bed. We would be grateful for your advice as to whether this power should be retained in the new legislation. Does it happen much?

Judge Sycamore: In the courts.

Judge Sycamore: I think probably the best example is in the crown court where frustration can often arise where a judge may be persuaded that it is appropriate to make a hospital order, as it is defined in the current legislation, but is constantly having to adjourn because he is told that whilst the criteria are met a bed is not available. I do not think the ultimate sanction is very often used but the threat of it can quite often produce the answer which the crown court is seeking, so I think a suggestion that a chief executive might find himself or herself in receipt of a summons if a bed is not made available, in other words to come and give an explanation, quite often is a stage in the process which is a turning point in terms of availability of a bed.

Q760 Chairman: In the courts.

Judge Sycamore: I think probably the best example is in the crown court where frustration can often arise where a judge may be persuaded that it is appropriate to make a hospital order, as it is defined in the current legislation, but is constantly having to adjourn because he is told that whilst the criteria are met a bed is not available. I do not think the ultimate sanction is very often used but the threat of it can quite often produce the answer which the crown court is seeking, so I think a suggestion that a chief executive might find himself or herself in receipt of a summons if a bed is not made available, in other words to come and give an explanation, quite often is a stage in the process which is a turning point in terms of availability of a bed.

Q761 Chairman: This is a common law power anyway, is it not?

Judge Sycamore: Yes. I am not aware of any recent evidence of an executive appearing in any crown court in answer to a summons.

Lord Newton of Braintree: I was Chairman of a mental health trust for four years from 1997 to 2001 and I am just glad it never happened to me.
Chairman: We are glad it did not as well. I am sorry it has been rather hurried, though in fact we have taken rather more time than we had allotted because you had such interesting things to say to us in writing and in your oral evidence. I simply repeat how grateful we are to you for coming. I should have said at the beginning that as this is a public evidence session a transcript will be produced and will be available on the internet after about one week. You will have the opportunity to make textual only corrections to it if you wish, so please avail yourself of that if you would like to do so. Thank you very much indeed.

Supplementary memorandum from MHRT Southern Region (DMH 444)

This note is supplemental to our initial written evidence to the Committee of 28 October 2004 and to the oral evidence given by Judge Sycamore and Mrs Kirby to the Committee on 14 January 2005.

We have studied carefully the evidence given to the Committee by other witnesses, the majority of whom have expressed concerns about possible abuses arising out of the provisions of the Bill, ranging from the breadth of the definition of mental disorder leading to initial detention, through the process of selection of patients for different types of detention to the opportunities afforded to them for seeking their discharge. Witnesses have repeatedly cited the MHRT as the central safeguarding mechanism for ensuring a thorough independent review of the detention process at every stage. These safeguards will only be meaningful if the tribunal is able to meet the workload imposed on it by the Bill. This will only happen if:

— The tribunal administration is completely overhauled and properly resourced for its increased remit.
— Sufficient people can be identified, recruited and trained to meet the increased workload before that workload becomes a reality.
— The tribunal is not prevented from carrying out the functions ascribed to it by the Bill by virtue of successful human rights challenges going to the heart of those functions.

We have seen scant evidence, from the Department of Health or elsewhere, to suggest that our concerns in these regards have been appreciated or are being addressed. It is our view, therefore, that the tribunal will not be able to fulfil the remit ascribed to it under the Bill, the safeguards envisaged in the Bill and by other witnesses will not therefore be in place and the Bill will fail the people it is designed to protect.

The reasons for our deep seated pessimism are as follows:

Tribunal Administration

A report commissioned over the past few months by the Department of Health from independent consultants SDC Consulting, has highlighted the following shortcomings in the English administration (the Welsh administration works on a different model and does not share these difficulties):

— The MHRT IT database is entirely unfit for its purpose. It is unsuitable for the function it is required to perform and does not have the necessary capacity, yet it was commissioned and installed by the DH, exclusively for this purpose.
— IT difficulties have led to a reliance on paper records which are often not correctly transposed onto the database or, if they are, then become lost (eg. records of hospitals where medical members are conflicted and thus may not be booked to sit).
— Since centralisation of the administration in London, it is housed in offices where the telephone systems are not designed for multiple use. This is causing major communication difficulties, at every level. No new system has been commissioned.
— The advance booking system for members’ availability does not have the confidence of either members or staff. This is due largely to the inadequacies of the database which does not record this information accurately, and which randomly erases other information.
— Staff training is inadequate, partly due to the rapid turnover of staff (exacerbated since centralisation in London). Around 70% of the administrative staff have been with the tribunal for less than 12 months.
— The change from case management to team structures has not worked.
— These shortcomings will not be solved simply by multiplying the current administration workforce by 400%, to reflect the anticipated increase in the tribunal workload. On the contrary, they will be magnified dramatically under the proposed new structure in the Bill. Furthermore, in light of the proposed transfer of the MHRT into the Tribunals Agency at the earliest possible date. Within the next three years, it is unlikely that the Department of Health will apply the resources necessary to resolve the current difficulties within a jurisdiction over which it will
shortly lose its sponsorship role. We consider it to be absolutely essential that the MHRT be transferred into the Tribunals Agency, at the earliest possible date, and its administration given a thorough overhaul, before any additional burdens, such as those envisaged in the Bill, are imposed upon it.

**Workforce Requirements**

Since our initial written response, the three chairmen have taken part in a DCA recruitment competition for new medical members of the MHRT, under the new procedures recently introduced. Based on that experience, our initial estimates of the time needed to sift applications and conduct interviews have had to be revised upwards significantly. We have also attempted to cost this exercise, an aspect on which we have been unable to obtain any commentary at all from the sponsors of the Bill.

Our estimates are based on the requirement to recruit and train 2,375 new members, as calculated in our previous submission. It is the policy of the DCA to apply a ratio of 3:1, therefore all these calculations could be trebled. However, there may be scope for appointment of some full time members (though no feasibility study has been done on this, and it would require the acquisition of premises, provision of support staff etc) and so we are restricting the figures to the initial estimate, to set off any savings made to the process by appointing full time members.

The current sifting procedure allows consideration of six applications per day, requiring 396 days in total. The new interview process allows three interviews per day, with one day’s reading for every two days of interviews. This will require 1,188 days in total. The minimum time requirement for the sift and interview process is therefore 6.6 years, if a panel sits every day, 48 weeks per year. This does not take into account the lead-in time for advertising and application, or the training required after appointment. The tribunal will therefore not be fully staffed to fulfil its remit for at least seven years after implementation of the Bill and in the meantime the very people whose job it will be to oversee the workings of the new tribunal will be diverted onto sift and interview boards. For such a specialised jurisdiction, it is unlikely to be acceptable for the judicial input into the process to be provided by anyone other than the three chairmen or their deputies (a total pool of no more than nine people, only two of whom are contracted full time).

The DCA have estimated their costs for the recruitment process for this number in the region of £1 million. This does not include the cost of the sift and interview panels, estimated at £1,000 per day, a further £1.584 million. We have calculated the cost of training the new members, together with training on the new remit for our existing members, based on our current experience of delivering this training, at £1.04 million. Since training and involvement on sift/interview panels are carried out by the same people, these activities need to be consecutive, not concurrent.

In summary, we calculate that the process required to bring the tribunal up to the staffing level demanded by the provisions in the Bill will take a minimum of eight years and cost a minimum of £3,624,000. The increased workload of the tribunal, however, will start from the first day of implementation, eight years before the tribunal will be ready to deal with it.

The additional costs of the new tribunal, once under way, can be broken down as follows:

- A very significant increase in the required number of administrative staff to run the system effectively.
- Premises and support staff for any full time legal members.
- 400% increase in hearing numbers, with the length of each hearing increasing by 50% (to include consideration of the care and treatment plan in addition to the discharge criteria).
- The added complexity of the need to manage the expert panel.
- The fees and travel and subsistence costs of members of the expert panel (twice over—initial examination then attendance at the hearing) on top of the current costs for each hearing.
- An increase of 400% in members’ fees and travel and subsistence due to the increased number of hearings.
- Pension and other employment costs associated with the likely creation of full time posts.

All the tribunal provisions in the Bill depend on the availability of sufficient numbers of people eligible to be appointed either as members of the tribunal or as members of the expert panel, and of the willingness of trusts and other employers to make staff available to take part in this work. We are not confident that any of these issues have been adequately addressed. The current competition for medical members has, despite very widespread advertising and personally targeted letters, produced just 65 applications. Furthermore, the evidence from the Royal College of Psychiatrists suggests that clinicians will wish to distance themselves from the implementation of this legislation, either as practitioners or as members of the MHT.

Hearings in future are likely to involve three clinicians (of whatever description), rather than the current two. This is without taking into account the patient’s right to appoint an independent medical expert. Therefore the requirements of the tribunal for medical input will increase by 50% per hearing, and there
will be 400% more hearings. This demand will coincide with increased pressure within the mental health services as the new legislation takes effect and imposes significantly heavier bureaucratic burdens upon clinical directors. The DH’s own workforce assumptions indicate a need to recruit substantially more staff as a result of the Bill. There will therefore be fewer people available to assist the tribunal than there currently are, at a time when the requirements of the tribunal for medical input will increase cumulatively by 600%.

The Expert Panel proposals create problems beyond the purely numerical. In the absence of a Code of Practice, we have not seen any indication of the eligibility criteria for membership of the panel, but since those eligible for membership are likely to be one and the same experts as will be eligible to become clinical members of the tribunal, the sequence of recruitment will be crucial. Once appointed, the panel will create a range of administrative problems which we have not seen addressed in evidence:

- An appropriate member of the Expert Panel cannot be selected until the RMO’s report is received as MHRT staff do not know the patient’s diagnosis. Even then, administrative staff are not currently qualified to match the expert to the diagnosis.
- The probability of identifying a suitable expert in every case who is available to travel to visit the patient, write a report and attend on the day of the hearing is negligible.
- Given the downgrading of the clinical status of the medical member of the tribunal, and the proposal that they will no longer make a preliminary examination of the patient, any absence of a suitable member of the expert panel will erode the patient’s human rights and will inevitably lead to applications for adjournment, and possibly judicial review.
- Video conferencing is not an option (other than possibly for a small number of Special Hospitals and Regional Secure Units) as hearings take place in several hundred locations around the country, most of which do not have a dedicated room for the purpose. It also requires a facility at both ends of the conversation.
- Coinciding the availability of every person who needs to take part in a MHT hearing is already a very complex process, likely to be rendered impossible by the additional need to consider the availability of the expert panel member.
- Administration of the panel is to be assigned to the MHT, but the experts will not be members of the tribunal. There will therefore be no apparent means of compelling them to co-operate with the tribunal process.
- The MHRT is required to pay the experts’ fees, and travel and subsistence. The fee is not specified and is likely to be dictated by the scarcity of the expertise and the travel involved. There is no evidence that this additional cost has been budgeted. The Bill also allows for payment for loss of earnings, which will differ in every case.

**Human Rights Considerations**

Our overriding concern is that once detention becomes unlawful without the imprimatur of the MHRT, the tribunal becomes in effect the detaining authority and thus loses its status as an independent body to review that detention. A successful challenge to the tribunal on that basis will render the patient safeguards contained in the Bill null and void and leave them unprotected, requiring the urgent creation of another body to take over those roles.

We have also identified the following potential erosions of human rights in comparison to the current legislation:

- Currently, a patient admitted under section 2 (a 28 day order), has the right to appeal to the MHRT during that period. If that application is unsuccessful, detention can only be extended by placing the patient under section 3 (a six month order), which triggers to right to apply to the tribunal again. Under the Bill, the patient may apply during the initial 28 day detention, but if the RMO has a care and treatment plan prepared by the time of the hearing, they may elect to amalgamate the automatic 28 day hearing into the patient’s hearing. If at that hearing the tribunal then authorises detention and the care and treatment plan, the patient becomes liable to detention for six months without a right to a further hearing. Specifically you could add a couple of sentences suggesting as an alternative that section 68 is amended to oblige hospital managers to refer cases more frequently with the suggestion of a sliding scale of responsibilities eg referral by hospital managers once every six months for young people, once every 12 months for those without capacity, and for those with specific conditions that need monitoring such as anorexia, and once every 18 months for others? Section 67 discretion could remain as a back up, to deal with the Jones point.

- The patient’s right to access to an independent expert is likely to be significantly diminished by the scarcity of available experts. That choice is already constrained by shortages in certain specialisms, and the conflict rules, to the point that the tribunal regularly grants postponements of hearings for up to six weeks to allow time to get an independent report. Under the Bill, consultants will be involved in four times as many hearings as RMO for their own patients, those who are members of the MHRT will be far busier than now and many consultants will
be members of the Expert Panel. The chances of obtaining an independent report in time for a hearing within 28 days are negligible, and the patient may not have a further chance for another six months (as above). This may well lead to Article 5 challenges.

— The increase in the number of tribunal hearings will require clinicians to spend so much more time preparing reports and care and treatment plans that patient care may suffer as a result. This may delay a patient’s recovery to the point of discharge from detention.

— The practical problems associated with the proposals for the Expert Panel, identified in the ‘workforce’ section above, are likely to result in tribunals proceeding without the assistance of a member of the Expert Panel. This, together with the probable reduction in the clinical status of the medical member of the tribunal, will significantly reduce the ability of the tribunal to test the evidence offered by the RMO.

— There is clear potential for pressure for a number of hearings to be conducted on paper only, probably by a legal member sitting alone. This is an erosion of the patient’s current right to be heard in all matters relating to his or her detention.

— The removal of both the discretion of the tribunal to discharge the patient despite evidence of mental disorder sufficient to warrant detention, and the right of discharge currently exercisable by the nearest relative reduce the patient’s chances of discharge in the face of opposition from the RMO.

**OUR PROPOSALS FOR NON-LEGISLATIVE CHANGE**

We have previously indicated to you in both our written and oral evidence that we consider that the shortcomings of the current legislation can be overcome, and the underlying aims of the draft Bill addressed, by relatively minor non-legislative changes. In summary, they are as follows:

— The referral mechanism under the 1983 Act could be amended simply by the Secretary of State using his powers under section 67 (non-restricted patients) and section 71 (restricted patients) to reduce the automatic referral period. A sliding scale of referral dates could be included in this process to reflect different types of case. In the case of patients lacking capacity, the period of automatic referral could be reduced to say six months. If the case of R on the application of MH and the Secretary of State for the Department of Health, 2004 WWCA Civ. 1690, is not overturned in the House of Lords, the government will need to seek urgent amendments to the referral provisions for such patients in any event. Other periods could be introduced for other categories of patient such as young people and those with particular diagnoses. Patients would also retain the right to apply to the tribunal, as now, with the additional safeguard that no patient would be detained longer than a shorter period than at present, without review by the tribunal. Such alterations to the referral pattern would also obviate the need for the tribunal’s remit to be extended to the care and treatment plan, as patient’s cases would in any event be reviewed more often.

— Increased clarity of the role of the medical member would avoid the need to create the Expert Panel.

— To ensure that the patient’s voice is central to any tribunal hearing, an amendment to Rule 10 could provide that all patients lacking capacity could have a legal representative appointed on their behalf. As an extension of this, consideration could be given to ensuring that all patients were legally represented. We would not, however, support a proposal to replace qualified lawyers with advocates for this or any other purpose within the tribunal.

It is our opinion that if these non-legislative changes were implemented immediately, any urgency for introduction of the Bill would be removed, allowing a period of reflection for the concerns expressed by the broad spectrum of respondents to the Committee to be considered. The immediate difficulties of the tribunal could be significantly diminished by a transfer of the MHRT into the Tribunals Agency at the earliest possible date.

Once the MHRT has bedded down within the Tribunals Agency for a period of, say, a year, it would then be possible to assess the capacity of the tribunal to expand to embrace the workload envisaged by the current draft Bill, if such an expansion were still thought desirable. In that event, a dialogue between the sponsors of new legislation and the tribunal (regrettably and significantly absent during the entire five year gestation period of the current draft Bill, despite repeated requests) would be beneficial to all concerned, but principally and above all, to the patients whose best interests this legislation should be designed to serve.

*Professor Jeremy Cooper  
Mrs. Carolyn Kirby  
His Honour Judge Phillip Sycamore  
Mr John Wright  
February 2005*
Memorandum from the Association of Directors of Social Services (ADSS) and the Local Government Association (LGA) (DMH 208)

SUMMARY

KEY POINTS

1. ADSS and LGA are concerned that the Bill is rooted in the principles of compulsion and public order. The following additional principles should be included on the face of the Bill:
   1.1 Multidisciplinary care—reinforcing the central role of the Care Programme Approach and social care.
   1.2 Socially inclusive, non-discriminatory care and treatment applied to all aspects of the Bill.
   1.3 Independence and non-medical focus for Approved Mental Health Professionals (AMHPs) who should be legally accountable to an independent body for the performance and scrutiny of their role.
   1.4 A legal right to high quality, fully funded services based on recovery and social inclusion for those under compulsory powers, which does not depend on a postcode lottery for quality and location of services.

2. The definition of mental disorder is still too broad and should contain exclusions to prevent someone with no mental health problems being detained solely for substance misuse, learning disability, behaviour problems or beliefs.

3. ADSS and LGA are concerned that resourcing issues have not been sufficiently addressed in the Bill:
   3.1 There should be a duties to provide sufficient numbers of approved doctors, AMHPs and police and ambulance assistance with conveying people under compulsory powers to hospital.
   3.2 The workforce implications included in the Bill’s Regulatory Impact Assessment are significantly underestimated for all staff groups.
   3.3 Current mental health services are under-resourced and future funding will need to be transparently allocated to community services to equip them to implement the Bill.

4. The incapacity measures previously included in the Mental Health Bill for informal patients lacking capacity to consent to treatment should be represented in the Mental Capacity Bill.

INTRODUCTION

The Association of Directors of Social Services (ADSS) represents the 187 Directors of Social Services in England, Wales and Northern Ireland. Directors of Social Services are responsible through the activities of their departments for the well-being, protection and care of vulnerable people including older people, people with disabilities, people with mental health problems and children in need and their families.

The Local Government Association (LGA) represents over 400 local authorities in England and Wales and exists to promote better local government, enabling local people to shape a distinctive and better future for their communities. It aims to put local councils at the heart of the drive for better public services, working with the Government to secure that objective.

This submission has been prepared jointly by ADSS (Mental Health Strategy Group of the Disabilities Committee) and the LGA. Our purpose in collaborating to submit a response has been to set out the common principles which our organisations believe should underpin the development of mental health policy. We represent the same service users and staff, have many common objectives and share the same views about the Draft Mental Health Bill.

PROVIDING ORAL EVIDENCE TO THE JOINT COMMITTEE

ADSS and LGA wish to take up the opportunity to present oral evidence to the Joint Parliamentary Committee at their earliest convenience.

EVIDENCE ON COMMITTEE’S THEMES:

1. Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

   1.5 ADSS and LGA are concerned that the Bill is rooted in the principles of compulsion and public order rather than provision of quality care for vulnerable people. This is neither appropriate nor desirable as it goes against the principles of social inclusion and recovery reflected in other government policies and is likely to further increase stigma and discrimination.
1.6 ADSS and LGA recommend that the following additional principles should be included on the face of the Bill:

1.6.1 **Multidisciplinary care**, which should be represented by the following changes to the Bill:

(a) Explicit links between the roles of clinical supervisor and CPA care co-ordinator.
(b) CPA care plan used for Tribunals, not a separate plan.
(c) Report by Approved Mental Health Professional (AMHP) for Tribunals following assessment period.
(d) A requirement for Tribunals to consult social care Expert Panel members.

1.6.2 **Socially inclusive care and treatment** which is non-discriminatory and respects and takes account of abilities, age, gender, sexuality, race, social, ethnic, cultural and religious background, and is in line with the principles of the Social Exclusion Report and Vision for Social Care. This principle should apply to all aspects of the Bill including use of the definition of mental disorder, detention, therapies, advocacy and risk management in the community.

1.6.3 **Independence and non-medical focus for Approved Mental Health Professionals (AMHPs)**. Given that it would be possible for all three examiners to be employed by the detaining NHS Trust, there must be robust structures for an independent body such as the local authority to have responsibility for the management of the AMHP role. AMHPs should be legally accountable to this body for the performance of their role and it should undertake approval, re-approval, supervision, provision of legal advice, training, law updates and scrutiny of AMHPs. The General Social Care Council (GSCC) should have the major role in the development of approval and training systems.

1.6.4 **Reciprocity**: a legal right to high quality, fully funded services based on recovery and social inclusion for those under compulsory powers, which does not depend on a postcode lottery for quality and location of services.

1.7 The general principles to be included in Code of Practice are appropriate and desirable but they should be included in the face of the Bill, with any necessary exemptions, as they are in the Mental Capacity Bill, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Children Act 1989.

1.8 There are a number of reasons why the general principles are unlikely to be upheld by the Bill in its current format:

1.8.1 **Patients are involved in the making of decisions**—safeguards for informal patients without capacity have been removed and this will not promote their involvement; there is a potential lack of involvement of multi-disciplinary team and patient in care planning and lack of legal standing given to advance statements on the face of the Bill.

1.8.2 **Decisions are made fairly and openly**—use of same Tribunal to make orders and hear appeals does not promote fair decisions, and see 1.4.1 above.

1.8.3 **Provision of medical treatment to patients and restrictions imposed on them during that treatment are kept to the minimum necessary to protect their health or safety of other persons**—the potential to use compulsory powers in the community lowers the threshold significantly from the current Act and see 2.1 and 2.2 below.

2. Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the Community adequate and sufficient?

4.1 The definition of mental disorder is still too broad. Under this definition it could be possible for someone with no mental health problems to be detained solely for their drug or alcohol dependency or misuse, learning disability, commission or threat of illegal or disorderly acts, promiscuity, sexual deviancy or other immoral conduct, cultural, political or religious beliefs. Exclusions should be added to the definition to prevent misuse.

4.2 The conditions:

4.2.1 The conditions are likely to lead to an increase in the use of compulsion for the reasons mentioned above and because the principle of least restriction is removed by clause 9(7) for people at substantial risk of causing serious harm to others.

4.2.2 It should be clarified whether the fourth condition (that medical treatment cannot be lawfully provided to the patient without him being subject to this part of the Bill) means that compulsory powers cannot be used if the patient consents to treatment and/or that the provisions of the Mental Capacity Bill should be considered before those of the Mental Health Bill.

4.3 Compulsory treatment in the community should only be available for patients on authorisation of the tribunal after a period of inpatient assessment. Leave of absence powers enable assessment and treatment in the community during the assessment period.

4.4 Use of community powers may lead to the following problems:
4.4.1 It may prevent people coming forward for help and damage relationships between mental health professionals, service users and carers.
4.4.2 The threat of recall to hospital could be misused to achieve compliance.
4.4.3 Community powers could be used to compensate for lack of hospital beds.
4.4.4 Aims and values of services based on voluntary attendance could be compromised.
4.4.5 Practical implications have not been fully assessed, particularly providing supervision, enforcing compliance and providing transport to clinical settings for treatment.

4.5 Additional resources will be needed to provide services for people under community powers (see 10.3) and to provide them free of charge.

3. Does the draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

3.1 ADSS and LGA consider that the Bill continues to emphasise public order over provision of care for vulnerable people. It is overly concerned with the principle of compulsory care to protect the public from risk rather than managing risk through adequate community services. The balance between state and family involvement in providing care has shifted towards the state. See section 9 below for details about human rights.

4. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient and clear? Are there any important omissions in the Bill?

4.1 ADSS and LGA have identified the following additional areas to be included in the Bill:

4.2.1 Advance statements should be given legal standing through a duty in the Bill to consult them and incorporate them as a central part of CPA care planning.
4.2.2 A duty to provide sufficient numbers of approved doctors and AMHPs.
4.2.3 A duty on the police and ambulance or other transport services to assist with conveying people under compulsory powers to hospital (there are significant problems under current legislation with securing this assistance).
4.2.4 A duty to provide places of safety which are in an appropriate environment such as a hospital, and a prohibition to use police stations for this purpose (apart from in exceptional circumstances).
4.2.5 A right to specialist advocacy not just a duty to provide it, from the beginning of the examination process rather than after compulsory powers have been applied.
4.2.6 The powers of reasonable objection and discharge previously held by the nearest relative should be given to the nominated person and for someone who has no nominated person there should be a similar provision to the current option for Social Services Departments to act as nearest relative.
4.2.7 See section 8 below for incapacity measures.

5. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft Bill?

5.1 See sections 1.2, 1.4, 9.1 and 10 for comments on professional roles, resources and the Tribunal system.

5.2 The work of the Healthcare Commission in monitoring the operation of the Bill must be underpinned by the inclusion of legal principles as listed in section 1 above. The implementation of the Mental Health National Service Framework has shown that a performance management system, however strong, cannot deliver fully functioning services on its own.

5.3 Performance indicators monitored by the Healthcare Commission should include provision of a sufficient number of AMHPs (it is essential to have guidance on this number), and promotion of social inclusion through high quality risk management and access to a range of services to meet needs such as housing, benefits, education and employment.

5.4 The power of the Healthcare Commission to visit establishments should become a duty to visit, comparable with that held currently by the Mental Health Act Commission, to ensure that services are submitted to regular inspections.

5.5 Further consideration is needed of the role of the Commission for Social Care Inspection (CSCI) in ensuring there is social care input to the mental health work of the Healthcare Commission.
6. Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

6.1 See points concerning abuse of community powers in section 2 above.

6.2 ADSS and LGA are concerned that neither the Mental Health Bill nor recent children’s legislation, including the Children Act 1989 and the forthcoming Children Act 2004, focus sufficiently on the mental health needs of children and young people so they will still be inadequately addressed. Particular concerns are as follows:

6.2.1 The improvements proposed in the Children’s National Service Framework should be reinforced through a duty in the Mental Health Bill to provide appropriate services and specialist workers.

6.2.2 The potential problems generated when a parent of a 16 or 17 year old is not the nominated person need to be addressed.

6.2.3 The proposal in the previous draft to limit parental consent to 28 days was welcomed (particularly with respect to Gillick competent children) and if it were reinstated the Tribunal involvement must be accompanied by safeguards.

6.2.4 The safeguards for those not consenting to treatment should be available to all children and young people using mental health services.

6.2.5 Children and young people should be afforded at least the same level of safeguards as adults, in particular with regard to electro-convulsive therapy.

7. Is the balance struck between what has been included on the face of the draft bill, and what goes into Regulations and the Code of Practice right?

7.1 There is too much reliance in the Bill on use of regulations and the Code of Practice. The principles and issues involving detention in hospital (clause 15(2)), interviewing of patients, care plans, advocates, advance statements, children’s services, community powers and the nominated person should be dealt with on the face of the Bill. Parliament should have the opportunity to consider these important issues: they should not be left solely for the Executive to compose.

8. Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

8.1 There do not appear to be adequate links between the two Bills. The incapacity measures previously included in the Mental Health Bill for informal patients lacking capacity to consent to treatment should be represented in the Mental Capacity Bill. There should also be a form of compulsory community care in the Capacity Bill, similar to the current Guardianship, for people who do not meet the conditions of the Mental Health Bill but lack capacity and require this legal framework. The rights and safeguards in each Bill should be brought into line and advance statements should have equal status in both Bills.

9. Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

9.1 ADSS and LGA consider that human rights would be better promoted by the Bill through the use of two distinct Tribunal systems for making orders and hearing appeals.

9.2 The Bill should meet the requirements of the recommendations of the council of Europe, in addition to human rights legislation.

9.3 There is potential for human rights contravention in the power of the clinical supervisor to order the return of a non-resident patient to hospital without further reference to the doctors and AMHP who where satisfied at examination that hospital admission was not necessary. The change from non-resident to resident status should only follow a re-examination by two doctors and the AMHP or the Tribunal.

10. What are likely to be the human and financial resource implications of the draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

10.1 ADSS and LGA consider that the workforce implications included in the Bill’s Regulatory Impact Assessment (RIA) are underestimated, which will lead to under-resourcing. In particular:

10.1.1 Approved Social Workers (ASW)—“Improving Mental Health Law” states that there are 4,500 ASWs in England and Wales and the RIA represents this as 430 whole time equivalents (WTE) currently, based on the number of hours taken for certain statutory tasks. It is not clear whether these figures are correct, nor whether they take account of the hours needed to run an ASW duty system (during which time the ASW must be available but may not be actively pursuing an assessment), or the fact that current ASW services are very stretched. ADSS and LGA have
significant concerns about the robustness of these estimates and would want to be consulted or involved in more detailed work that is required to determine the workforce requirements for social workers and AMHPs under the Bill.

10.1.2 The RIA suggests that 20% of AMHPs will be non-social workers—ADSS and LGA members’ discussions with health colleagues suggest that there is reluctance to undertake this role and probably not without significant remuneration. This situation would affect the number of social workers required to operate the new legislation. Consideration should also be given to how the AMHP role fits into “Agenda for Change”.

10.1.3 The duty to provide advocates is welcomed but the proposed number of 140 WTE specialist advocates is grossly inadequate and would not even provide one WTE per local authority area.

10.1.4 The estimate of 130 WTE additional psychiatrists seems only to be based on Tribunal and Expert Panel work and does not take account of responsibility for additional patients under compulsory powers in the community, and increased requirements for consultation and care planning. As with the AMHP role, more work needs to be done on the impact to the psychiatric workforce.

10.1.5 There is likely to be a significant need for supervision and support from mental health workers for people under compulsory powers in the community and this has not been scoped at all in the RIA.

10.1.6 No provision has been made for the resource implications of training ASWs, new AMHPs, doctors, mental health act administrators, managers and other mental health staff in the detailed operation of the new legislation, or for the substantial transitional arrangements that will be required.

10.2 The clarification about charging for aftercare services is welcomed, but the issue of what happens to people currently in receipt of aftercare under section 117 of the current Act needs careful consideration.

10.3 Resources from the Department of Health have not always been directed to the community services introduced under the National Service Framework for Mental Health. Additional funding for mental health services needs to be transparent at Strategic Health Authority and Primary Care Trust level to ensure that it reaches its intended destination. Services that need such resources include assertive outreach, crisis resolution and home treatment, early intervention, housing, crisis beds, and access to education and employment. If compulsory powers are to be used in the community, services will be in even more demand, with additional need for higher levels of supervision and support. Without further resourcing it is unlikely that mental health services will be equipped to implement this legislation; nor will they be able to achieve the right balance between public and individual safety, and the provision of quality care for vulnerable people that reduces the need for use of compulsion.

Terry Butler,
Jenny Goodall
Joint Chairs, ADSS Mental Health Strategy Group, Disabilities Committee

Councillor David Rogers OBE
Chair Community Well-Being Board LGA

October 2004

Memorandum from Kent County Council (DMH 217)

— The unanimous condemnation of the Bill by the 60+ organisations banding together as the Mental Health Alliance, masks the fact that there are some welcome elements in it. For example, it simplifies the legal description of the process through which an individual will proceed, there is a welcome (although enforced) attempt to ensure compliance with the requirements of the European Commission for Human Rights, safeguards are built in and the ASW role is essentially retained (although it is not mentioned as a safeguard), carers are given prominence, 16 and 17 year olds are to be treated as adults and the treatment of children under 16 is properly considered.

— On the other hand, the text is dense and difficult to understand and it remains essentially a Public Order measure rather than a Public Health measure.

— If the 1983 Act was a lawyers’ bean-feast, this will be a manna-fest.

— The Bill is long, convoluted and repetitive.

— Although the large section in an earlier document about Dangerous Severe Personality Disorder has been omitted and there has been some semantic readjustment to some of the ideas previously objected to—there is less overt emphasis on risk and more apparent weight placed on treatment—the effect of the measures proposed remains essentially unchanged.
— The definition of mental disorder is so broad as to be meaningless. What is given importance is the
behaviour being expressed by the person and whether that is a risk to self or others. All the
categories excluded under the present legislation are included—LD, SM (including alcohol),
paedophiles, acquired head injury, etc. (See 1.—Critique and Commentary)
— The notion of mental illness disappears, as do notions of “diagnosis” and “treatability”. (See 2.—
Critique and Commentary)
— The complex of official functions put in place to implement the requirements of the Bill will require
an influx of appropriate staff, which amounts to a human resources crisis. (See 3.—Critique and
Commentary)
— The Approved Mental Health Professional (AMHP) is the successor role to the ASW. The protests
about the need to continue the independence of the role have been listened to, to the extent that
the training and approval of the AMHPs will remain with local social services authorities (the
phrase used). However, what is at issue in regard to independence is who employs them. Will the
local social services authority reauthorise them and be responsible for their performance in the
role? (See 4.—Critique and Commentary)
— The charging regime will be similar to that in other care groups. Services which are a requirement
under a Community Treatment Order can not be charged for, but there is no equivalent to the
current s.117. (See 5.—Critique and Commentary)
— Repeated emphasis is placed on the involvement, consultation and information of informal carers.
(See 6.—Critique and Commentary, p )
— There will be a formal requirement to share information.
— The Mental Health Act Commission is to be abolished and all functions transferred to CHAI.
No role is given to CSCIE
— It will no longer be necessary for litigants to prove that professionals were acting in bad faith or
without reasonable care. The Bill changes the emphasis: the professional will have a defence of
good faith and reasonable care. While this accords with the rights all citizens, it makes litigation
easier and more likely.

CRITIQUE AND COMMENTARY

(a) Matters of general Concern.

1. What is meant by Mental Disorder?

“Mental disorder means an impairment of or a disturbance in the functioning of the mind or brain
resulting from any disability or disorder of the mind or brain.”

This broad definition has number of consequences:

(i) It removes the notion of mental illness as the reason for intervention—indeed, it raises the question
of why mental health professionals should be the primary operators of the Bill’s provisions;
(ii) It dispenses with the concept of “diagnosis” in this context;
(iii) The test becomes entirely behavioural—and this raises the question of why it should be called a
mental health act when it is in effect a public order measure;
(iv) It is so broad as to encompass any deviant behaviour—all that is required is that there is some
hypothesised connection between the behaviour and a disturbance in the functioning of mind or
brain—and this is a tautology;
(v) This allows a potentially unlimited number of people to become subject to its conditions:
paedophiles; substance misusers, including people addicted to alcohol; people with acquired brain
injury; etc.
(vi) Most importantly, this allows the capture of people with personality disorders, the outcome sought
by Central Government in casting the net so wide.

2. The “Treatability Test”

The treatability test in the current legislation means that people should only be subject to compulsory
treatment when there is a treatment available for their condition. This is held to be a safeguard against the
unjustified detention under the MH Act of people who would gain no therapeutic benefit from it.

There was widespread disquiet at the disappearance of this from the last version of the Bill and the
statement that detention could be justified by risk alone. We are now assured that “appropriate treatment”
must be available for the individual patient before formal powers can be used.
However, Medical Treatment is whatever is provided under the supervision of the Approved Clinician and includes nursing, care, psychological interventions, habilitation and rehabilitation. “Care” seems to have replaced bald “detention”. (See p 11 of the Notes.) Thus, it becomes possible to detain a dangerous person coming under the broad definition of mental disorder to provide them with the “care” that would prevent them from expressing that danger, for that reason alone.

Indeed, when it comes to treatment, the “Notes” has this to say: “Medical treatment cannot lawfully be provided to the patient without the patient being subject to Part 2 of the Bill. This condition does not apply to patients over 16 who are at substantial risk of causing serious harm to other persons. If there is substantial risk of someone causing serious harm to others, no proof is required that it was necessary to bring the person under formal powers.” (p 14)

3. Human Resource Implications

It is acknowledged by Government that the apparatus of Clinical Supervisors, AMHPs, Mental Health Tribunals, Mental Health Appeal Tribunals, nominated persons, Mental Health Independent Advocates, and the Expert Panel will require additional human resources. For example, the estimate of additional psychiatrists is 130 additional WTEs; additional social workers, 50 additional WTEs. This is based on an extremely conservative Impact Assessment, which assumes that the numbers coming under formal powers will be less that at present. Logic would dictate that a wider net will bring a larger catch. The NHS Confederation has argued that these estimates are a large underestimation.

In the case of social workers, even if the estimate is taken as accurate, the “old” age-profile and the scarcity of candidates coming forward to train as ASWs means that the system across Kent faces very real threats as a statutorily required service under present legislation. The Bill seems silent on where (or if) there is a binding statutory obligation for the AMHP arrangements.

(a) Matters of concern to KCC.

4. Approved Mental Health Professionals

Approved Mental Health Professionals (AMHPs) are to be the successors to Approved Social Workers (ASWs). It is recognised that the vast bulk of the former will be transfers of the latter into the former role.

The “Summary” of the Bill for non-professionals gives a table of changes to the Bill from the previous version. It does not mention the change to the proposed provision of AMHPs.

There is no mention anywhere of the safeguard that an independent professional embedded in the process of examination provides. This safeguard has been acknowledged in regard to the work of ASWs and it should apply equally to the unchanged role given to AMHPs. All the much-vaunted safeguards of nominated persons and advocacy are after the fact; indeed, they flow from the work of the AMHP.

The AMHP is responsible for:

— co-ordinating the preliminary examination;
— providing a non-medical view whether a person meets the conditions;
— registering patients with the responsible Hospital;
— appointing a nominated person;
— notifying patients, those with parental responsibility (under 16s) and nominated persons of decisions and the availability of advocacy.
— taking the patient to hospital; and
— taking absconders or those absent without leave to hospital.

The Clinical Supervisor must keep under review whether a patient detained in hospital could be dealt with in the community and, conversely, whether a patient being dealt with in the community needs to come into hospital. There is no reference to the AMHP contribution to this. The complete absence of any contribution required from any other professional throughout the processes of assessment and treatment, whether as a resident patient or a non-resident patient seems to describe an incomplete (not to say, inadequate) process. At the least, the feasibility of a return (or retention) in the community would seem to be a key task for the AMHP—always supposing that their “non-medical” input stretches to a knowledge of resources available in the community.

How, exactly, an AMHP becomes aware of the need to arrange an examination is not made clear. (A detail for the Code of Practice?)

The appointment and training of AMHPs will lie with “local social services authorities” and these must be satisfied that AMHPs have the required competence. The role will be open to social workers and other professions, such as mental health nurses and occupational therapists.
However, the notional “independence” of AMHPs by virtue of their training and approval is insufficient. What is key is which organisation employs them and how the influence of other professionals against which they will have to exercise their independence is kept from having influence, real or imputed, on their careers and standing. The continuing relationship with the local social services authorities is unspecified: what is the process for reauthorisation? Does the local social services authority remain responsible for the AMHP role as such?

(See also under 3., above for human resources issues.)

5. **Charging**

“Where the acceptance of a local authority care service is a ‘relevant condition’ imposed on a patient, no charge may be recovered . . . Patients cannot be charged for the provision of any service that is specified in an order as something that they must receive.” This does not “... prevent a charge being recovered for accommodation which the patient is required to reside in but which is the patient’s ordinary residence.” (Notes, p 26, paragraphs 117 and 118.)

No charge may be recovered for patients under 18 looked after by the local authority when that is a requirement. (Notes, p 26, paragraph 119.)

Unlike the contentious “section 117” provision of free aftercare treatment under the current Act, the Bill brings aftercare into line with policy on intermediate treatment in other service groups. Aftercare will be provided free for up to six weeks for patients who have been treated under formal powers for over 28 days. Beyond the six weeks, aftercare will be on a means-tested basis. (Notes, p 135, paragraph 54.)

The extent to which this may reduce costs has yet to be determined under the Impact Assessment work.

6. **Carers**

Heavy emphasis is placed on the consultation of informal carers at all decision-making junctures. Indeed, the clinical supervisor may not proceed to implement any decision until it has been conveyed to the carer (among a list of others—the patient, nominated person, advocate). This is in accord with the need to involve and support all carers and the understanding of the importance, in mental health services, of involving the carers’ input in risk assessment.

7. **Community Treatment Orders (CTOs)—conditions**

It is unclear how conditions in CTOs will be monitored and enforced. It is to be expected that social workers will play a part in this. It is mentioned that AMHPs will take people to hospital, having defaulted on these orders. (This level of detail may be a Code of Practice issue.)

8. **Duty to share information**

There will be a duty to share relevant information in making assessments and risk assessments. This will ease some of the existing ambiguities in this regard.

9. **Inspection arrangements**

The Mental Health Act Commission is to be abolished and all functions transferred to CHAI. No role is given to CSCIE.

10. **Litigation—Safeguards for Staff**

It will no longer be necessary for litigants to prove that professionals were acting in bad faith or without reasonable care. The Bill changes the emphasis: the professional will have a defence of good faith and reasonable care. While this accords with the rights all citizens, it makes litigation easier and more likely.

*September 2004*
Chairman: Before I welcome our next group of witnesses I understand there is a possibility of votes in the Commons late in the afternoon. If there is a division we will have to adjourn for 15 minutes and can I just advise those who will not be voting in the House of Commons that they are not to engage in discussion of substantive issues with the witnesses or to deliberate the Bill in front of witnesses during the adjournment. Welcome. Would you briefly introduce yourselves please and then I hope you will be content for us to move straight into questions. Who is going to start?

Cllr Robinson: I will introduce us as much as I can. My name is Maureen Robinson. I am a councillor and a member of the Local Government Association’s Community Wellbeing Board. I would like to introduce you to Ms Jenny Goodall, who is the Joint Chair of the Association of the Directors of Social Services Mental Health Strategy Group on Disabilities, Mrs Paula Hallam, who is a mental health specialist from Hampshire County Council and who has advised the ADSS and the LGA in putting together a response. Our colleagues from Kent County Council are Mr Martyn Ayre and Mr Don MacLeod. The submission that I am speaking on today has been prepared jointly by the ADSS and the LGA. Our purpose in collaborating is to submit a response that would set out the common principles which our organisations believe should underpin the development of mental health policy. We believe this should stress in particular the importance of social inclusion and of community leadership. We represent the same service users and we have common objectives and share the same views about the draft Mental Health Bill. In a few moments I will ask Ms Goodall if she will introduce the key points of our submission but I do not know if my colleagues from Kent would like to say anything.

Mr MacLeod: I represent Kent County Council, as does my colleague, Martyn Ayres. I am the Strategic Policy and Performance Manager for Mental Health for that authority and Martyn is Head of Policy. The submission is mine. However, it is based very much on deliberations with colleagues in Kent County Council, in Medway Unitary Authority and in the two mental health trusts in Kent, so it is an amalgam of opinion and it does not in any way disagree with what our colleagues in the other two organisations represented here are saying.

Ms Goodall: I am happy to say a few introductory words but it sounded as if you were ready to move into questions.

Q762 Chairman: You are right. The Association of Directors of Social Services and the Local Government Association propose adding four principles to the Bill. Even if we were of the view that principles should be included on the face of the Bill is there not a danger that adding those four principles to the face of the Bill would overload the Bill in concrete with arrangements that would be difficult to change, whereas including such principles in the Code of Practice might make the legislation more flexible to meet changing needs and clinical availability in the years to come?

Ms Goodall: Our view in recommending that they should be included on the face of the Bill was really in terms of recognising their importance and also being able to make some judgment as to what is more appropriately in the Code of Practice. Of course, at the moment we do not really know what the scope of the code of practice is going to be. There is other legislation, the Mental Capacity Bill, which you have already been discussing, which itself has adopted principles, as did the 1989 Children Act. We have examples where, if the principles are sound enough and universal enough, they would be quite appropriately encompassed in the legislation. I understand what you mean about flexibility and you would not want the list of principles to go on for ever, but I would like to pick out some key principles, particularly because one of our concerns about the Bill as it is is that it is very much geared towards public protection and public order concerns and there are some very key principles that we would to make sure underpinned every part of the new Act, and we feel that that would be better done in the legislation, in the Bill itself, rather than in the Code of Practice.

Q763 Chairman: In your submissions you propose a condition that refers to a postcode lottery. You are a group of witnesses who have a very broad view of what happens across the country, so perhaps you might be a very good group of people to reflect upon how mental health services vary across the country and whether your fourth condition might help to reduce those variations, if that is a desirable end?

Ms Goodall: Certainly, with reciprocity and the guarantee that if someone is going to be subject to compulsion they would have some rights to expect good quality care and medical services, that would reduce some of that variation. I think some of the national initiatives through the Mental Health NSF have made some difference in terms of variation in provision, because there has been some very tight monitoring of the compliance with the NSF and successful implementation of NSF. I think some of that variation is being addressed through central monitoring and driving of the NSF, but certainly needs differ. I am the Director of a deprived London Borough. Our issues are in relation to mental health, and the challenges that present to us as a local authority and trust may be different than in some other authorities. Certainly we do see that variation. I do not know if Councillor Robinson wants to add anything.

Cllr Robinson: I am a representative of a Rural Authority, and certainly some of the problems that have addressed themselves to members of the Rural community are very different to those that there would be from a London Borough, and it is in those
sorts of ways that we see a big difference between the services which are offered. In terms of quality, there is always an attempt on the part of the providers and on the part of the social services authorities to provide an equal authority, but, in terms of the difficulties that are provided, I do not think that is always possible.

Q764 Chairman: You are always going to have differences of quality, that is inevitable, but differences of provision are another matter. One can help to remove those by conditions on the face of the Bill. Is that a fair summary?
Cllr Robinson: It certainly would help, and our view is that if it is in the face of the Bill then it gives people like ourselves a chance to have our voice heard in that matter, whereas if it is covered through regulations that is not always possible.

Q765 Baroness Barker: Today, on the day when I picked up the Government’s consultation document about black and minority ethnic health services, I have been particularly worried about the issues that you have down here about non-discriminatory care and treatment being employed in all aspects of the Bill, but I wonder, if you can just say from your point of view, from your practitioner background, what is the difference in having something like that included as a principle as opposed to in a code of practice on a Bill like this, which will inevitably have to be a framework Bill. What difference will it really make?
Mr MacLeod: I think that particular aspect of trying to meet the needs of all our citizens is endemic; it is right across all the legislation that is now coming forward; it is right across all the principles that have been put forward by government. There is no reason why it should not be in this Bill as well, because that is an aspiration to which I think we are all signed up. The fact that perhaps minority ethnicities have not been well-treated in the system in the past might be picked up more sharply if it was a principle in the Bill. That is what I would say about that.

Q766 Lord Rix: The ADSS and the LGA state that compulsory treatment in the community should only be available for patients on authorisation of the tribunal after a period of inpatient assessment. Does that mean you accept, notwithstanding your reservations, that compulsory treatment in the community may be beneficial for some people?
Ms Goodall: We quite deliberately were not one of the groups that said that there should be no compulsory treatment in the community ever. I think our response was to lead some way into that, but our view is that really those opportunities for community treatment orders in the community are very limited. One can think of limited examples: for example, a patient who was not compliant with taking medication but would take medication knowing that there was the force of an order behind it. Otherwise the person was very well supported and could manage in the community, but, without the medication, would become unwell and therefore would break down again. It is possible to think of one or two very specific examples of where a treatment order in the community would be appropriate, so we have not put a blanket opposition to it, but we think it is extremely limited; and our concern is that community treatment orders could become an alternative to compulsion in hospital, because that is what somebody really needs, and compulsion in the community uses a sort of slightly cheaper alternative to that, or it could be used as a simpler way of ensuring compliance with treatment plans within the community. We have some very real reservations about it, but we see that there are some occasions for a very limited number of patients where a treatment order may be just the thing that would help somebody get along okay within the community.

Q767 Lord Rix: You also said that you are overly concerned at the principle of compulsory care to protect the public from risk rather than managing risk through adequate community services. How is risk managed in the community without compulsion and, furthermore, what additional services would you need to see in order to make community treatment orders work?
Ms Goodall: I am sorry; I did not quite catch the last part of your question.

Q768 Lord Rix: How is risk managed through community services without compulsion?
Ms Goodall: The majority of people are compliant with care plans. The aim of Mental Health Services should be to ensure compliance, to ensure people's engagement with services, and a lot of the work that the professions within Mental Health Services do is about engaging that compliance. Most people do want to comply with their care plans and cooperate, so risk management in the community is managed through the relationship between the multi-disciplinary team, the key worker and the patient. For the majority of people that is how that risk is managed. It is only in situations where somebody will not comply and then need some compulsory powers, but mostly the vast majority of people do not require that at all.
Mr MacLeod: Could I comment first and then perhaps pass on to Martin? The first thing is that the whole business of compulsion in the community seems to me to be a sledge hammer to crack a nut. As Jenny Goodall says, there will be some cases where that might be beneficial, where people are suggested enough to comply because they have been told they have to. By and large most people with mental illness do not fit into that category, and that brings a whole list of questions about who enforces that compliance, how are people got back to hospital; a whole apparatus has to be constructed, which is unclear from the Bill, in order to deal with that. In terms of risk, in reply to Lord Rix’s question, risk is absolutely at the heart of the management of severely mentally ill people; it is at the heart of the care programme approach. One of my own personal dilemmas is whether such a concentration on risk can develop or deliver good mental health services.
I think, with some reservations, probably it can, because there is so much concentration on the safety of the person and the safety of others. These would be my comments on that aspect.

**Mr Ayre:** If I may very briefly comment in response to Lord Rix’s question, I do not believe that there are any systems or processes that of themselves will guarantee risk management. Risk management, eventually and ultimately, will come down to competent professionals exercising good judgment and not a system, not a bureaucracy.

**Q769 Mr Prosser:** On the same subject, do you want to see the community treatment orders removed from the Bill or do you want to see them reformed and provided with safeguards?

**Mr MacLeod:** If we take the somewhat cautious view that we have been taking, we will suck it and see, if it comes to it, because I do not think they will have all that much of a place. We have seen provisions put into legislation which have been very poorly used, which have actually have been honoured in the breach rather than observance, if you like, and this may be one of them.

**Cllr Robinson:** My feeling is that safeguards are necessary. One of my biggest concerns about compulsory treatment orders is that they will deter people from seeking help when they need it. At the moment a lot of the service’s treatment must be placed on trust. If that trust is lost because of compulsory treatment orders, that is going to create a great deal of harm.

**Chairman:** I do not want to spend too much time on this issue because we have had a mass of evidence on it and it is broadly consistent, but I know Dr Naysmith wants to ask something.

**Q770 Dr Naysmith:** Almost all of you who have spoken in answer to the last question have been very critical of compulsory treatment in the community, and I can understand why you would be so if you think it is just going to be a cheap way of doing something else, but I know that some people who have said that they are not opposed to it have said what it does is give a better quality of life to someone who might otherwise be locked up an institution. Is that a ridiculous notion?

**Q771 Chairman:** One of you has nodded, two have approved mental health professionals, it is di

**Q772 Dr Naysmith:** That is a very cynical view. Of almost anything that is introduced, you could say the Government, or whoever is doing it, is doing it with another motive underneath?

**Mr MacLeod:** I do not think it is a motive. I think it is just a consequence. I do not think anyone has been bad or evil, it is just that is what would happen. It is very unclear to me why someone who would not be compliant would be compliant just because they were told there was some sort of sanction.

**Chairman:** If those people who are trying to come in further on this question will forgive me, we have had a huge amount of evidence on this issue and I would like to move on to something slightly more conceptual.

**Q773 Baroness Pitkeathley:** A lot of progress has been made in recent years—indeed, you have been involved in it—in breaking down what we used to call the Berlin Wall between health and social care professionals. Have we made so much progress on that that the traditional lines of professional responsibility between health and social care are now obsolete? That is the general part of the question, but I want to link two other things with that, and I would be happy to hear from any or all of you about this. Are you really thinking that the AMHPs will be approved social workers by another name, and does it, in your view, make any difference whether they would be employed by health or by the local authority?

**Ms Goodall:** I think the Berlin Walls have been broken down. You are absolutely right. One of the big success stories of the last ten years has been the establishment of multi-agency integrated mental health services. I am sure you can still find examples of barriers between professionals, but, generally, I think the professionals in mental health have really got it together in the way that they work, but I do not think that means that everybody is the same. The key to that success is that different people bring different skills and that the social workers within multi-disciplinary settings bring the skills of social workers, and they also bring with them the expertise and the services that the local authority have to provide, and we must not forget how important those are in relation to people with mental health needs: because they have to live somewhere, they have to go to work somewhere, they have to find somewhere to spend their days. In relation to approved mental health professionals, it is difficult to know, but ADSS took the view that it did realise that the world is changing and that, because people work together the professional roles are not quite as distinct as they used to be, and therefore it would not necessarily mean that only social workers would carry out the approved social worker, approved mental health professional role. What we are very clear about is that the approved mental health professional role, whoever does it, has to be independent. I think there is a difficulty if those people are employed by health, because if they are not employed by someone other than health it does run the danger that some one’s assessment process of
committing someone into hospital can be done by people that work for the same organisation, and I think that there would be a loss from the social work perspective that the ASW currently bring. It may be that in the future, particularly when we get the training right, other professional groups can also bring that independence, that different view, that different perspective, but we would have to be absolutely sure that the training was right and that all professionals undertook that sort of training and were able to bring that different perspective if the patients’ rights are to be preserved but also if we are to provide the right sort of care for people: because we do not want people to be compulsorily admitted into hospital, where it is possible we want to be able to find alternatives to that, and having different perspectives helps that.

Ms Goodall: I hope I was careful not to suggest that, and that is why we have taken a very clear line in the ADSS. We are not saying that the only people who can do that are social workers. A lot of the strength of the current ASW system is to do with the quality of the training, the rigour with which the training takes place and the assessment and the reassessment of people and what they have to do in order to keep up their role as ASWs, and any new system would have to encompass that. I personally think there is absolutely no reason why community nurses, particularly as they now are doing such different jobs, would not be able to do that. I really would not want to insult my nursing colleagues to say that they are under the thumb of doctors and therefore will do what they say—I have no reason to expect that—but there is something about providing some separate structure, whether it is nurses or social workers, so that they are not necessarily all part of the same organisation making decisions about that individual.

Mr MacLeod: I would very much like to be able to offer a perspective from Kent. We have merged our social work colleagues into the trusts, and one of the things that is consistently coming back to us is that there can be, on occasion at least, some influence brought to bear on the behaviour of our ASWs as they stand. For example, a very simple example is the delaying of the initiation of an assessment because there is not a bed available. That is not very good practice, and I think it is a thin end of a wedge. I think it is pretty essential that the ASWs, or their successors in the new Bill, be quite sure that their training is different, that they are not necessarily all part of the same organisation making decisions about that individual.

Ms Goodall: I would very much like to be able to offer a perspective from Kent. We have merged our social work colleagues into the trusts, and one of the things that is consistently coming back to us is that there can be, on occasion at least, some influence brought to bear on the behaviour of our ASWs as they stand. For example, a very simple example is the delaying of the initiation of an assessment because there is not a bed available. That is not very good practice, and I think it is a thin end of a wedge. I think it is pretty essential that the ASWs, or their successors in the new Bill, be quite sure that their training is different, that they are not necessarily all part of the same organisation making decisions about that individual.
Impact Assessment are significantly underestimated. Have you made any assessment of your own as to the magnitude of the under-estimation? Can you help us on that?

Ms Goodall: We have not as yet. We very much recognise that it is a piece of work that urgently needs to be done. We are not completely confident in the estimate that has been done as to the current numbers of approved social workers. Even just finding that out is quite a complex task within the number of local authorities that there are, but the piece of work we have been discussing with the Department of Health, doing fairly promptly, is looking at (a) the numbers, (b) the age range of current staff and (c) doing some assessment particularly around currently approved social workers.

Q778 Chairman: And the salaries?

Ms Goodall: Yes, that is a very good point.

Q779 Chairman: You have made a strong point about salaries.

Ms Goodall: The resource issues in terms of staffing that we have pointed out are not just about approved social workers. We also believe that there will be an impact, particularly if people are subject to treatment orders within the community. We are particularly talking about the very high levels of support staff, social care staff, that would need to be there to support those people within the community, and, again, that does not seem to have been calculated. We certainly need to do that.

Q780 Chairman: Could I ask you to help us, not now but possibly in writing at a further date. You, as organisations working together, have objected to the proposal to limit free aftercare to six weeks. You have made powerful points about that. It is proving difficult for us to get accurate details and data on the numbers of people who are receiving free aftercare, and, indeed, for how long, under the existing system. If you have any data, could you let us have it, please, in writing, and if you do not have exact data but you can provide something a little bit more specific than the general points, could you write to us about that: because it would be valuable to us in the preparation of our report I think.

Cllr Robinson: You would need that by when, Chairman?

Q781 Chairman: Yesterday!

Cllr Robinson: It might take a bit longer than that.

Q782 Chairman: As soon as possible—that is all I can reasonably say to you—but I think it is quite an important issue which we may well be looking at when we come to have our deliberative sessions. Our first full deliberative session is next week. If you can do something about that—you do not have to, but if you can do that—we would be hugely grateful to you.

Ms Goodall: What we would be able to come up with would be an approximate figure. Figures vary so much between boroughs, between councils.

Q778 Chairman: And the salaries?

Ms Goodall: Yes, that is a very good point.

Q779 Chairman: You have made a strong point about salaries.

Ms Goodall: The resource issues in terms of staffing that we have pointed out are not just about approved social workers. We also believe that there will be an impact, particularly if people are subject to treatment orders within the community. We are particularly talking about the very high levels of support staff, social care staff, that would need to be there to support those people within the community, and, again, that does not seem to have been calculated. We certainly need to do that.

Q780 Chairman: Could I ask you to help us, not now but possibly in writing at a further date. You, as organisations working together, have objected to the proposal to limit free aftercare to six weeks. You have made powerful points about that. It is proving difficult for us to get accurate details and data on the numbers of people who are receiving free aftercare, and, indeed, for how long, under the existing system. If you have any data, could you let us have it, please, in writing, and if you do not have exact data but you can provide something a little bit more specific than the general points, could you write to us about that: because it would be valuable to us in the preparation of our report I think.

Cllr Robinson: You would need that by when, Chairman?

Q781 Chairman: Yesterday!

Cllr Robinson: It might take a bit longer than that.

Q782 Chairman: As soon as possible—that is all I can reasonably say to you—but I think it is quite an important issue which we may well be looking at when we come to have our deliberative sessions. Our first full deliberative session is next week. If you can do something about that—you do not have to, but if you can do that—we would be hugely grateful to you.

Ms Goodall: What we would be able to come up with would be an approximate figure. Figures vary so much between boroughs, between councils.

Q783 Chairman: I know in asking that question I have stopped two members of the Committee from asking the question during the course of the afternoon, but I share their concern about that issue. I should have told you at the beginning of this session that a transcript will be produced of this session that a transcript will be produced of this public session and it will be available on the internet after about one week. You are free to make textual corrections if you would like to. Thank you very much.

Cllr Robinson: Before we go, can we make one further representation to you?

Q784 Chairman: Of course?

Cllr Robinson: The membership of the Advisory Group on the Mental Health Bill has been announced, but we have noticed there is no membership on that by an approved social worker. We believe that is a serious omission. I wonder if you could use your powers to assist us in getting someone.

Q785 Chairman: I am not sure if we will do that, but if you let us have copies of any submission you make, it will certainly be reflected as part of our evidence.

Cllr Robinson: Thank you, Chairman.

Chairman: Thank you very much indeed and for dealing with the questions with such despatch.

Memorandum from the NHS Confederation (DMH 283)

INTRODUCTION

1. The NHS Confederation welcomes the Committee’s inquiry into the Draft Mental Health Bill and welcome the opportunity to present evidence.

2. The NHS Confederation is a membership body that represents over 93% of all statutory NHS organisations across the UK. We have 100% of mental health and learning disability trusts currently in membership. Our role is to provide a voice for the management of the NHS and represent the interests of NHS organisations. We are independent of the UK Government although, of course, we work closely with the Department of Health and the devolved administrations

3. Our evidence sets out our general views on the Draft Mental Health Bill but then concentrates on the specific questions posed by the Committee
4. The NHS Confederation is an associate member of the Mental Health Alliance and supports the Alliance’s submission.

**Overall view**

5. We believe that the new Bill has many positive aspects aimed at ensuring there are clear and fair procedures for assessment and treatment; safeguards to ensure good decision-making; and support for patients. However, our members have raised a number of concerns outlined in answer to the questions outlined by the committee.

6. The Confederation is concerned that the definition of mental disorder and conditions for compulsion are too broad. It is essential that there are clear boundaries. We also recommend the reinstatement of exclusions.

7. The Bill is at times impenetrable and open to interpretation. It is essential that the Bill be accessible so that patients can understand their rights and professionals understand their responsibilities and obligations.

8. The Bill often refers to issues that will be covered in the regulations to be drafted in the future. We believe these should be consulted on fully.

9. In summary, we have serious concerns as to the extent to which the implementation consequences have been fully thought through, particularly in terms of the expanded tribunal system and capacity of the service. We believe the government has seriously underestimated both the cost and the workforce implications and do not believe the proposed tribunal system is workable.

**In Response to the Committee’s Questions**

*Question 1—Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?*

10. We support the principles of least restriction, patient involvement in decision-making and fair and transparent processes. However, the Code of Practice will state circumstances in which the application of the principles may be ignored, this is likely to create confusion for service users and staff. It would be better to have guiding principles that cover all people under compulsion, such as equality and anti-discriminatory practice.

*Question 2a—Is the definition of Mental Disorder appropriate and unambiguous?*

11. The Confederation is concerned that the definition of mental disorder is too broad. It is essential that such a broad definition has clear boundaries. We would also recommend the reinstatement of exclusions.

12. Although the current law does not prevent the treatment of someone suffering from a mental disorder that also has other behavioural issues, the removal of the current exclusion in relation to drug and alcohol dependency as well as sexual deviancy may lead to people being held under compulsory powers inappropriately. Mental health service users should not have their needs confused with those whose problems arise from drug or alcohol dependence, or who have a lifestyle that differs from society’s current norm. We recommend exemptions remain to protect people from being inappropriately incarcerated.

13. Wider criteria for compulsion may also lead to extra demand for mental health services both in the acute and community setting. It is essential that there is capacity for the NHS to deliver effective patient care.

*Question 2b—Are the conditions for the treatment and care under compulsion sufficiently stringent?*

14. The Draft Bill is likely to increase the number of people under compulsion, as the conditions for compulsion are broad, for example the condition of “protection of other persons” has no statement of seriousness or risk. The broad conditions and removal of the discretion of decision-makers to take into account other circumstances may mean people will enter into the system far too easily, but find it difficult to leave.

15. The conditions in the Draft Bill make no reference to the decision-making capacity of the person. People who are physically ill are not detained in hospital against their will because they refuse treatment that may improve their condition. However, a person with a mental illness can be detained and treated without their consent even though when the person has the capacity to understand the nature of the illness and treatment choices. Mental illness and lack of capacity are not one and the same. In the light of the clear definition in the Mental Capacity Bill we hope there will not be confusion. We recommend that one of the conditions should identify the need to show that the person has impaired decision-making capacity in relation to treatment. We support the condition in the Scottish Act which allows compulsion “because of the mental disorder the patient’s ability to make decisions about the provision of such treatment is significantly impaired”. We are aware of the debates around the difficulty of applying a concept of capacity when a person’s condition may change but these problems may be overcome by giving the clinician some discretion over discharge if person regains capacity and by setting out guidance in the Code of Practice.
Question 2c—Are the provisions for assessment and treatment in the Community adequate and sufficient?

16. We support the treatment of people in the community, but it is essential there is clear guidance on assessment and treatment, linked to a capacity test. It is also necessary that there are appropriate safeguards to ensure people under NROs are reviewed regularly and not held under compulsory powers inappropriately.

17. We would stress the importance of ensuring community mental health services are able to meet the needs of people under NROs. This may involve the development of national standards, training of staff and investment in resources.

Question 3—Does the Draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

18. As stated above the condition of “protection of other persons” is too broad and has no statement of seriousness or risk assessment.

Question 4—Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient and clear?

19. The Bill has 307 clauses, 14 schedules and the language is at times impenetrable and open to interpretation. We are concerned that this will mean professionals; patients and carers will not fully understand the Bill. It is essential the Bill be accessible to enable patients to understand the rights they have and professionals to understand their responsibilities and obligations.

20. We are concerned as to the extent to which the implementation consequences have been fully thought through, particularly in terms of the expanded tribunal system and capacity of the service. We believe the government has underestimated the cost of the proposed system and workforce implications.

Are there any important omissions in the Bill?

Aftercare

21. The current Bill places duties on both health and local social services to provide free aftercare services until they no longer in needed. The draft Bill limits the care package to a period of six weeks after discharge, aligning with current social care policy. We would welcome a debate on whether someone who is under compulsory treatment should pay for treatment they are compelled to have.

Advance statements

22. Advance refusals and advance statements setting out a patient’s wishes for their care and treatment could be a way to safeguard and promote a patient’s interests. Under current law an advance refusal to accept treatment, can be overridden if a person is under compulsory powers. We would like to raise the debate as to whether advance refusals should have the same status for compulsory and informal patients.

Question 5—Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the Draft Bill?

23. We have no specific comments on this question.

Question 6—Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient?

24. The Draft Bill states that anyone can request someone be examined for use of compulsory powers. This may lead to an increase in the number of inappropriate examinations. We would like to see clear guidance on this issue to ensure people are not inappropriately examined and that the potential impact of this increase in demand is properly understood and incorporated into workforce and financial planning.

25. Under the current Mental Health Bill the Tribunal has discretion not to use compulsory powers even when a patient meets conditions for detention. This discretion has been removed. The broadening of the criteria for compulsion, the removal of the Tribunal’s discretion and the fact that neither hospital managers or the patients nominated person will have a right of discharge may make the system easy to enter and hard to leave. We would like to see clear guidance on this issue.

26. The Bill seems focused on addressing the needs of working age adults with mental health problems and as such the needs of both children and older people have not been thoroughly considered.
27. The new Bill has many positive aspects aimed at ensuring there are clear and fair procedures for assessment and treatment; safeguards to ensure good decision making; and support for patients. However we are concerned as to the workability of the safeguards, particularly the expanded tribunal system.

*Question 6c—safeguards against misuse of aggressive procedures such as ECT and psychosurgery?*

28. The Draft Bill outlines that ECT cannot be used on a patient that has capability to make decisions. We would welcome debate around how capability could link to the Government’s current policy initiative on patient choice, if a patient has capacity to refuse ECT should a person have the right to refuse or choose other treatments?

*Question 7—Is the balance struck between what has been included on the face of the Draft Bill, and what goes into Regulations and the Code of Practices right?*

29. The Bill often refers to items that will be covered in future regulations and the Code of Practice. For example when the general principles do not apply, the powers the Mental Health Tribunal can reserve itself and circumstances when the clinical supervisor will have to go back to the Tribunal in relation to changes to the Care Plan. We believe these are significant issues and should be open to consultation.

30. Because there is much that will be part of the Code of Practice we reserve judgment until that is seen.

*Question 8—Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?*

31. We are concerned that a psychiatric patient may be subject to both the Mental Health and Mental Capacity Bill which may cause confusion for professionals and service users. We would also like to see further debate around people with fluctuating capacity.

*Question 9—Is the Draft Mental Health Bill in full compliance with the Human Rights Act?*

32. We have no specific comments on this question.

*Question 10—What are likely to be the human and financial resource implications of the Draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?*

33. The Department of Health has stated that the Bill will need an additional 830 whole time equivalent staff to cope with the increase in the total number of hearings. These staff will be needed as all patients will have their case considered by a Tribunal within 28 days of their assessment beginning to decide on the use of compulsory treatment and there will be additional examinations of patients by members of the Expert Panel to provide independent advice to the Tribunal. We also take the view that the new Bill will increase the number of people detained and so increase the number of staff needed in both acute and community settings.

34. The Department of Health estimate of 830 additional staff includes; 130 psychiatrists; 50 social workers; 200 nurses, therapists and clinical psychologists; 140 advocates; 200 support staff; and 110 legal and lay members of the tribunal. Just taking the 130 additional psychiatrists, this is 26,000 working days a year. It is essential that there are effective safeguards to protect patients and the public, but we would like discussion as to whether this is the most effective way of to provide safeguards, could the tribunal system be modernized to release staff to deliver direct patient care, and could the system be made less bureaucratic and costly.

35. There will be an expansion in the types of decisions that tribunals will consider, such as authorising care plans, authorising ECT and examining whether the relevant conditions apply. This will impact on the recruitment and training of tribunal members. The present Tribunal system is struggling to manage with appeals being cancelled and delayed. We do not believe the proposed expanded system will be workable.

36. The proposed system will lead to the establishment of a bureaucracy around tribunal management and impact on inter-trust relationships in terms of provision of independent expert advice, particularly in the context of current policies such as Payment by Results and Foundation Trusts.

37. In summary we have serious concerns as to the extent to which the implementation consequences have been fully thought through, particularly in terms of the expanded tribunal system and capacity of the service. We believe the government has seriously underestimated both the cost and the workforce implications and do not believe the proposed tribunal system is workable.
Memorandum from Tees and North East Yorkshire NHS Trust (DMH 196)

INTRODUCTION

I. This submission is provided by Tees & North East Yorkshire NHS Trust, a specialist Mental Health and Learning Disability Trust, providing regional services for Adult Forensic, Learning Disabilities Forensic, and Forensic CAMHS as well as a full range of generic services for adults, people with learning disabilities, CAMHS and older people.

II. The Trust covers a wide geographical area and has a number of in-patient facilities as well as comprehensive community service provision. The number of service users that the Trust provides care to who are subject to compulsion can fluctuate, but on average on any given day the number would be approximately 260 service users. We are pleased to have this opportunity to comment upon the provisions of the draft Mental Health Bill.

III. The Trust recognises the need to reform mental health legislation in order to ensure that the legal framework governing psychiatric compulsion is suitable to support developing services and expectations in a modern society. We are supportive of many of the concepts within the Bill such as the speedy access to a Tribunal, the necessity for formal review early on in any period of compulsion, statutory access to advocacy and that some of the Human Rights issues and requirements may be addressed. The remainder of this document will address the particular themes on which the Committee has invited evidence.

1. Is the draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

1.1 It is difficult when reading the draft Bill to determine exactly what the basic principles in which it is rooted are. Given that, it must be said that the principles are, therefore, ambiguous.

1.2 We feel that it would be useful if the Bill clearly defined the legislation in terms of its scope and purpose and we consider that within this definition should be stated, clearly and unambiguously, the principles of the Bill.

2. Is the definition of Mental Disorder appropriate and unambiguous?

2.1 The changes from the 2002 draft definition of mental disorder are welcome in that the effect of the disability or disorder is considered before the cause ie an impairment resulting from a disability rather than a disability resulting in an impairment. However, the definition of Mental Disorder as “an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain” continues to be liable to very broad interpretation. Whilst the definition endeavours to prevent any inappropriate exclusions, there is a significant potential for over inclusion.

2.2 The 2004 draft continues, as did the 2002 draft, to omit to include particular exclusions which are contained in our current legislation, namely, drug and alcohol dependence, sexual deviancy, promiscuity and immoral conduct. The 1983 Act construes these exclusions as implying that a person cannot be brought within the scope of the Act by reason of the above alone if they do not also have a defined mental disorder.

2.3 The Government explains the decision to omit these exclusions by giving the reason that the exclusions had been misunderstood and that some clinicians would not apply the Act to anyone with, for example, drug or alcohol dependence despite the person also having a coexisting defined mental disorder. This has certainly not been our experience and, from discussions with colleagues from a number of other Specialist Mental Health Trusts, it has not been an issue for them either.

2.4 It would be appropriate and correct that specific exclusions similar to those in the 1983 Act are contained in any new legislation, and that they are drafted in such a way and with the necessary clarity in order to ensure that they cannot be misunderstood, rather than omitting exclusions with very poor and undetermined justification.

Are the conditions for care and treatment under compulsion sufficiently stringent?

2.5 Given that the definition of Mental Disorder is so broad, it is imperative that the conditions for care and treatment under compulsion are sufficiently stringent in order to prevent the potential for treatment to be given in the absence of consent to those people who should not be brought within the scope of compulsion.

2.6 Some of the difficulties in determining whether the conditions are stringent enough arise from the fact that the definition of the “medical treatment” that must be “necessary” for formal powers to be used is not clearly defined. It is also clear that the meaning of the term “Approved Clinician” would have to be more specific but is currently left to the Regulations, as the approved clinician becomes the clinical supervisor who is to be in charge of the treatment and assessment of the patient. Dependent upon the clinical background of the clinical supervisor this may have a significant effect upon the treatment that may be given. The phrase...
“medical treatment for mental disorder” is inextricably linked to the term “clinical supervisor” as any treatment is given under their supervision and it is not clear who will be able to be a clinical supervisor, which may determine the range of treatments and therefore affect the conditions for compulsion.

2.7 We are pleased to see that the Bill specifies the concept of treatment as being “necessary for the protection of the patient from suicide or serious self-harm or serious self-neglect of her/his health or safety, or for the protection of others” as opposed to the current Acts concept as being “necessary for health or safety”. Even though this phrasing makes it clearer that there must be a degree of risk associated to enable the use of compulsion as opposed to compulsion being used for the general health or safety of the patient, it is still not clear what is meant by “necessary” or “serious”. This may, therefore, be left to the judgement of the assessing clinicians and there would have to be a balance between the degree of interference with the level of associated risk. This will inevitably be determined and judged differently by different people and indeed by different professional groups leading, potentially, to different thresholds to compulsion.

2.8 Given the potential for differing opinions described above, it is very disconcerting to see at Clause 16 that when it has been determined that a person meets the relevant conditions for assessment and it is necessary to determine whether that assessment should be as a resident or non resident patient, provided that the AMHP and one Registered Medical Practitioner agree, then the patient may become a resident patient. This is despite the fact that the other Registered Medical Practitioner may completely disagree and may, in fact, have greater experience and indeed may be the person who will eventually be the Clinical Supervisor responsible for the care and treatment of a person that they believe should never have been brought into hospital as a resident patient in the first place.

2.9 Within the Bill there is great emphasis placed upon the presence of risk as a determining factor when considering the use of compulsion. Whilst this is appropriate, there is the potential for it to preclude some groups of people such as the incapacitated but resistive person who only presents with moderate as opposed to serious risks. Again, determining whether risk is moderate or serious will essentially be a matter for individuals and the outcomes may vary greatly. It may be that this group of people will come within the scope of the Mental Capacity Bill, however, this is not clear and even if they do come within the scope of the Mental Capacity Bill there are insufficient safeguards in that Bill in its current draft to satisfy the Convention requirements in relation to non arbitrary detention, speedy independent review etc.

2.10 Within the relevant conditions in Clause 9, condition number 7 gives rise to some concern. It states that if a person aged over 16 poses substantial risk of causing serious harm to other persons (my emphasis) then no proof is required that it was necessary to bring the person under formal powers. Again, substantial and serious are not defined in this context which, given that no proof is required of the necessity for compulsion, may potentially not meet Convention requirements regarding arbitrary detention.

2.11 Condition 6 in Clause 9 states that “medical treatment is available which is appropriate in the patient’s case”. There is no concept in the Bill that treatment should be beneficial or that it should, as a minimum, prevent deterioration. It raises the question of whether it is appropriate to bring a person under the scope of compulsion when the treatment that is available within that framework may not even be of benefit to them.

Are the provisions for assessment and treatment in the community adequate and sufficient?

2.12 The provisions for assessment and treatment in the community are not clear enough to determine whether or not they are adequate and sufficient. Clause 15 states that the patient must fall within a description specified in regulations, which is as yet unknown, and so it cannot be determined which patients this would apply to. Improving Mental Health Law states at paragraph 3.37 that it will primarily be patients who have previously been treated in hospital (? subject to compulsion or not) but is not clear in using the word primarily that it will not apply to others who have not.

3. Does the Draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

3.1 It must always be borne in mind when considering a question such as this, that the mentally ill are also the public whom we are trying to protect from the mentally ill. Mental health problems will affect approximately 1 in 4 of us at some time in our lives, but until it happens we consider ourselves as the “public”. It is only a tiny minority of people with mental health needs who also present a risk to public or personal safety and we must be careful not to implement legislation that caters for this tiny minority and in doing so marginalises the vast majority of people with mental health needs who present very little or no risk at all.

3.2 The proposals within the Draft Bill appear to be very risk focused. This can be demonstrated in the example that it is not even required, when making someone subject to compulsion, to show that it is necessary that that person be provided with medical treatment if they are over 16 and at “substantial risk of causing serious harm to other persons” (Clause 9 condition 7). This appears to make provision for mental health legislation to be used to detain someone where it has not been shown that they require medical treatment for that mental disorder. It must surely be questionable as to whether this is protecting the Human
Rights of the mentally ill. We feel that the right balance has not been struck and that, in fact, the balance tips very markedly towards the level of risk posed as opposed to an identified need for treatment that will be beneficial in nature.

4. Are the proposals contained in the Draft Bill necessary, workable, efficient and clear?

Are there any important omissions in the Bill?

4.1 There is a consensus of opinion that the 1983 Mental Health Act requires amendment. Aspects of it have already been found to be incompatible with the European Convention on Human Rights. However, in order to address these issues of incompatibility and other issues around concern for public safety, the Government have decided to draft completely new legislation as opposed to amending existing legislation which may well have been sufficient. The drafting of new legislation is a major task in itself, not least complicated by the convoluted and complicated way in which this Bill has been drafted.

4.2 With regard to whether the Bill is workable or not, this we feel will be one of the major potential problems in relation to the practical implementation of a new Act if it remains in the form of the current Bill. The current Tribunal system is stretched to almost breaking point with numerous administrative and procedural issues and problems that have been comprehensively documented. The proposals within the draft Bill with regard to Tribunals, whilst laudable for the safeguards that they would offer to patients if they could be implemented effectively, are undoubtedly out of reach in the current climate in terms of time, space and resources (the availability of appropriate personnel as well as financial). If this major proposal, which is effectively the fulcrum on which most other proposals in the Bill will balance, were not able to be effectively implemented then the whole of the reforms will inevitably fail and leave patients in a much worse position.

4.3 The major omissions from the draft Bill are the absence of safeguards for incapacitated, compliant patients who are admitted to hospital without the use of compulsion and the exclusions that are present in the definition of mental disorder in the current Act, or some similar wording. There were clear proposals in the 2002 draft regarding compliant incapacitated patients and whilst they may have been omitted from this draft in anticipation that the Mental Capacity Bill will address them, this is clearly not the case.

5. Is the proposed institutional framework appropriate and efficient for the enforcement of measures contained in the Draft Bill?

5.1 The measures contained within the Draft Bill are intended to ensure that patients are made subject to longer-term compulsion only with the agreement of an independent body (the Mental Health Tribunal). The Tribunal effectively gate-keeps entry to longer-term compulsion. However, the Mental Health Tribunal is also the body that hears patients’ appeals against the use of compulsion. This appears to be somewhat incongruous and it could be construed that this is inappropriate.

5.2 The abolition of the Mental Health Act Commission established by the 1983 Act as an independent body with a very specific remit of safeguarding and ensuring the welfare and rights of detained patients through processes of regular visits, monitoring and advice will almost certainly affect the ability to enforce measures contained within the Draft Bill. It would equally affect the ability to enforce the measures contained in our current legislation were it to be abolished in the absence of new legislation. It is proposed that the monitoring role of the MHAC will be transferred to the Commission for Healthcare Audit and Inspection, commonly known as the Healthcare Commission. The very terms “Audit and Inspection” immediately throw a different slant on the potential monitoring role that they may fulfil and we feel that it is very important that the visiting and protective elements of the current MHAC are maintained.

6. Are the safeguards against abuse adequate?

Are there enough safeguards in respect of particularly vulnerable groups, for example children, sufficient?

6.1 The Draft Bill provides for longer sentences of imprisonment to be imposed on those who ill-treat or wilfully neglect patients. This must be recognised as a positive proposal given the nature of this offence.

6.2 The safeguards in relation to incapacitated but compliant patients are not sufficient as previously discussed at Para 4.3.

6.3 In respect of the safeguards put in place for children in the Draft Bill, some are welcome; however, others are somewhat concerning. A child or minor is defined as anyone under the age of 18 years and yet at clause 9(7) it can be assumed from the wording that children over the age of 16 years can be brought within the scope of compulsion and no proof is required that it was necessary to bring the person under formal powers. This is clearly a decision based upon the level of risk and the protection necessary for others and does not make the child’s welfare the paramount consideration which is in direct conflict with current enacted legislation, namely the Children Act 1989.
6.4 The safeguards proposed in relation to the treatment of children under the age of 16 years are welcome.

6.5 The safeguards that are in place for Psychosurgery are sufficient to minimise its misuse. It is also helpful to see that the High Courts can authorise this treatment for patients who cannot consent due to their incapacity but clearly stand in need of the treatment.

6.6 In relation to ECT, the safeguards go some way to prevent its misuse, however, they also paradoxically have the potential to reduce the protection available to patients. Because a capacitated patient can refuse ECT, it can only be given therefore if the patient is incapacitated or if the situation is an emergency. It is concerning that if the concept of mental incapacity is used as a legal threshold for compulsion in relation to the administration of ECT, any disagreement between a patient and the supervising clinician may, potentially, result in a finding of incapacity and thus simply have the effect of increasing the number of patients who are considered to lack capacity to consent to treatment. Also, if a capacity test were to be too stringent or rigorous it could result in incapacitated patients not receiving appropriate treatment until their condition deteriorates to such a degree that they no longer can make a capacitated refusal. It would be more likely, however, that the supervising clinician would use emergency treatment powers in order to prevent this level of deterioration. In both these situations, incapacity and emergency, the protections afforded in relation to ECT do not come into force and so, potentially, the patient is in a less protected position. Also, consideration must be given to whether it is going to be appropriate to override a capacitated patient’s refusal if that refusal could result in a risk of suicide or serious self harm to the patient or a substantial risk of serious harm to others.

6.7 The last point that we would wish to make in relation to this question is, why is it that capacitated patients may refuse ECT but may not refuse any other treatment such as medication (which may include polypharmacy and dosages above recommended limits). Surely treatments such as this must be considered to be aggressive.

7. **Is the balance struck between what has been included on the face of the Draft Bill, and what goes into Regulations and the Code of Practice right?**

7.1 We believe that in order for any legislation in relation to mental health and the use of compulsion to operate effectively, it must be clear on the face of that legislation which people can be brought within its scope and who can determine when they should be so brought. It must also make clear how formal powers will be operated and ensure that they are operated in such a way as to be compatible with Human Rights.

7.2 The Bill has been drafted in such a way as to leave many of these basic issues to Regulations and the Code of Practice. The Bill is not adequately prescriptive about fundamental issues such as the grounds for detention and yet is bordering on being overly prescriptive about such things as consultation, which, whilst essential, may have been more appropriately defined within Regulations or the Code of Practice. We feel that this is evidence that an appropriate balance between what is included in the Bill and what is left to Regulations and the Code of Practice has not been struck.

8. **Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?**

8.1 The Draft Mental Health Bill makes no reference to the Mental Capacity Bill. It appears on reading both Bills that there will potentially be significant areas of overlap. However, the one significant area, namely the treatment of incapacitated compliant patients which has been brought to the fore once again by the recent judgement of the European Court in *HL v UK*, is not adequately addressed in either Bill. This issue was addressed in the 2002 Draft Mental Health Bill but has been sadly omitted from the 2004 Bill and has not been replaced in the Mental Capacity Bill possibly, one must speculate, because the people who drafted that Bill were not expecting it to be removed from this one as it was one of the areas that was warmly welcomed and received the least criticism.

8.2 The concepts behind the Draft Mental Health Bill and the Mental Capacity Bill are very different. The first is based upon professionals determining the necessity of treatment based on a broad definition of mental disorder and taking risk issues very much into account, and the latter is based upon whether a person is able to make decisions about their own affairs (it goes much further than medical treatment issues alone). Given these two vastly differing concepts, it is impossible to say that the Bills are integrated in any way.

9. **Is the Draft Mental Health Bill in full compliance with the Human Rights Act?**

9.1 This Bill has been drafted in such a way that the Government believe it to be fully compliant with the Human Rights Act 1998. This may be so and will probably only be determined when and if challenges are made, however, there are a number of areas within the Bill that may give rise to challenges around Human Rights concerns. These include:

   — The broad scope of the definition of mental disorder.
10. What are likely to be the human and financial resource implications of the Draft Bill?

What will be the effect on the roles of professionals?

Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from the implementation of the Bill?

10.1 The human and financial resource implications are potentially massive. There are already major problems in the numbers and recruitment of Psychiatrists and Psychologists and a shortage of ASWs and Occupational Therapists. Given that, this Bill and its proposals would require that these groups of professionals, alongside nursing staff and other professionals, spend much more time away from their clinical roles in order to be present at, and prepare for, Mental Health Tribunals. This would not be such a major problem and would, in fact, be of benefit to patients if their case loads could be reduced to such levels as to ensure that they have enough time to devote to clinical duties balanced with the time that they are required to spend at and preparing for Tribunals but as we have already noted, there is a shortage of these professionals and so, in fact, their case loads are likely to increase as opposed to reduce.

10.2 Another major effect on resources would be the availability of space and accommodation. In a hospital that has a number of in-patient beds and so the potential to have a number of patients subject to compulsion as resident patients, not even counting those that may be subject to compulsion as non resident patients, Mental Health Tribunals would be sitting almost permanently and potentially more than one at a time. Space in most hospitals is at a premium, the concentration being on improving the space available to patients who are in hospital and reducing the amount of space available for offices and meeting rooms. Whilst this is on the whole appropriate, it causes some difficulty currently and having to find the extra space to house potentially two Tribunals would be almost impossible in most establishments.

10.3 As well as the impact on the clinical professionals, the implementation of the Bill would have dramatic implications for Mental Health Act Administrators. The requirements would mean that their workloads would increase dramatically necessitating an increase in their numbers with the associated cost, accommodation and training issues. It is also not clear who will provide any necessary administrative support in relation to mental health care and the Mental Capacity Bill. Could this potentially devolve to MHA Administrators due to their current expertise in this area and thus potentially significantly impact on their workload in another way?

10.4 In relation to training, the Government must ensure that the introduction of any new Mental Health Legislation, whether it is this Bill in its current form or a revised version, allows for an adequate period of training and familiarisation and the resources to enable this to happen. The sheer numbers of people that will have to be trained are enormous, ranging from MHA Administration and Management staff to the professionals who will have specific roles and duties under the Act, Advocacy Services, Solicitors, User and Carer Groups, Tribunal members down to every person who will be involved with patients subject to compulsion, either as residents or as non residents. One major question is—where will we find sufficient numbers of people with the skills, knowledge and experience to train these vast numbers and if they are in short supply, what effect will this have on any associated fees?

10.5 A significant problem at the moment with training clinical staff is that they are difficult to release from their clinical duties to attend training. We can foresee that in order to train people to a sufficient level in relation to MH Legislation will require more than a one-off training event. Rather, it will be potentially a course of training, longer or shorter depending on the staff group, but in any event they will have to be released from clinical duties. This alone could have significant cost implications to backfill their posts whilst they are away from their clinical areas and coupled with the potential costs of trainers and accommodation in which to train, the financial impact could be significant and the Government must ensure that this is taken into account.

October 2004

Memorandum from West London Mental Health NHS Trust (DMH 243)

INTRODUCTION

West London Mental Health NHS Trust was formed in 2001 through the merger of Ealing, Hammersmith and Fulham Mental Health NHS Trust and Broadmoor Hospital Authority, and latterly, through the absorption of mental health services in Hounslow. It now provides a full range
of local mental health services for children, adults and older people to three London boroughs and other specialist and forensic mental health services, including high secure services to a wider catchment area. The Trust has around 30 significant sites and approximately 1,200 beds of which 650 are secure. It employs almost 4,000 staff.

This submission collates written and verbal views invited by staff in all disciplines and all services. The majority of opinions emanate from psychiatrists, nurses, social workers and administrative staff performing statutory functions although many other professionals have commented on a single issue or in a personal capacity. It is acknowledged that there is a variety of viewpoints so where possible, strength of feeling on particular issues is reflected.

Theme One: Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

1.1 Few views were expressed on this theme as it was judged to have been fully addressed in other written submissions to the Joint Committee, notably those of the Royal College of Psychiatrists and the Institute of Mental Health Act Practitioners. Those that have commented, from all disciplines, sense that the Bill is unduly weighted by “public safety” concerns which are at least overstated. It would be more desirable that its underlying principles should include a stated commitment to de-stigmatising the vast majority of the population with mental health problems.

Theme Two: Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the Community adequate and sufficient?

2.1 There is almost unanimous agreement across all groups that the exclusions in the current Act, should be reinstated to avoid people being detained on inappropriate grounds. Equally, it seems desirable to ensure in such primary legislation, stated safeguards for the wider population, protecting them from the use of compulsion on political, religious or cultural grounds. The “breadth” of the definition may cause inappropriate referral to mental health services eg intoxicated individuals attending Accident & Emergency departments and even though in a given case it is determined that an individual does not require treatment, there is a likelihood that mental health professionals will be blamed when things go wrong thereafter.

2.2 The conditions for treatment and care under compulsion require that “medical treatment is available which is appropriate in the patient’s case . . .” It is not clear whether geographical or financial limitations will apply so that it may be fairly judged (by the assessing doctors and approved mental health professional or the Mental Health Tribunal) that this condition is not met.

2.3 A number of medical and nursing staff have suggested that the provisions for care and treatment in the community are an improvement on currently available options: aftercare under supervision, guardianship and section 17 leave. The growth of community focused services is not well-served by an Act which mainly centres on bed occupancy. However, there is little perceived need for non-resident compulsory assessment.

Theme Three: Does the Draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

3.1 Please refer to paragraph 1.1 above.

3.2 There is little, if any, perceived justification for the Mental Health Tribunal's right to reserve to itself powers of discharge, transfer and leave for some Part II patients.

3.3 In relation to restricted patients, Broadmoor Hospital’s Medical Advisory Committee is unanimously of the view that the Mental Health Tribunal should have the power to grant leave to restricted patients and approve their transfer from one hospital to another. Given that it will have the right to discharge restricted patients and authorise leave and transfer in almost all other cases, it is clearly well-placed to exercise such powers.

3.4 The same forum notes that the effect of a restriction order is very similar to the effect of a life sentence. Given that the setting of tariff dates for lifers has recently been removed from the executive to the courts in the interests of openness and the avoidance of any impression of political interference and that the Home Secretary has had to cede decisions about release of life-sentenced prisoners to the Parole Board, they would welcome a review of whether similar arrangements should apply to restricted patients.

3.5 There are allied concerns about the quality of some decisions made by the Home Office in restricted cases.

3.6 It is not entirely clear why written notice is required prior to transfer of resident patients other than in emergencies but all clinical groups are clear that this requirement runs the risk of denying a bed to a person in greater need. Perhaps an “emergency” might include the need to provide urgent treatment to another
patient. It would be appropriate to waive the required notice if a patient is initially admitted for assessment or treatment outside their local catchment area, to avoid delays in returning them to their local mental health service where this is in their best interests.

3.7 It is of wide concern that if the relevant conditions for compulsion are met, there is no discretion about its use. Equally, the Mental Health Tribunal has no discretion to discharge in the same circumstances.

3.8 The proposal that anyone should be able to request the appropriate authority to decide whether the relevant conditions appear to be met (and therefore arrange a formal assessment) is of concern. It is not clear how vexatious or repeated requests will be dealt with.

Theme Four: Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient and clear? Are there any important omissions in the Bill?

4.1 Increasingly, more staff of Consultant status who will take on the role of Clinical Supervisor are being employed on a part-time basis. Under the present scheme, it is ever more difficult to arrange attendance at Mental Health Review Tribunals. Under the proposed scheme, the frequency of Tribunals will increase. Some degree of flexibility is required to ensure this is workable.

4.2 Concerns have been expressed by several staff groups that the role of the Approved Mental Health Professional might ultimately lead to the social work role being diminished if it becomes cheaper to utilise Community Psychiatric Nurses rather than social workers.

4.3 Some feel that the independence of staff who have trained under the “medical model” will be insufficient and that their therapeutic relationship with patients may suffer. Equally, there are concerns that a lack of social care experience will reduce knowledge of available support networks.

4.4 By virtue of Clause 272(5), Clause 272(1) permits CHAI to remove original medical records from a hospital. While everyone agrees with the right to take copies, we are concerned that with modern colour coding and filing systems, there is a risk of loss of important clinical information or failure to note warnings if the original file is removed.

4.5 When a Court wishes to send a remand prisoner to hospital for assessment or treatment, there is no power, either in the current Act or the Draft Bill, by means of which disputes can be resolved. This can include disagreement between psychiatrists in medium and high secure settings about the required level of security. Where both doctors work under different Strategic Health Authorities, there is no managerial remedy. It seems sensible that the Court be empowered to formally request a resolution.

4.6 Where a Tribunal order a patient’s conditional discharge, there may be difficulties in making arrangements that meet the conditions. Local authorities can order their staff to provide a service to a patient but very often the provision of hostel places is bought in from private or charitable suppliers who insist on assessing clients and refuse to provide a service for those they consider unsuitable. Further referrals to agencies across England to provide suitable accommodation will further delay the search for a medical supervisor. We are aware of delays of more than three years in such cases.

4.7 Clauses 63 and 64 require the Tribunal to make a Deferral Order if it wishes to discharge a patient in the absence of an appropriate care plan, on the basis that he/she would be likely to meet the conditions for compulsion within 8 weeks and Clause 64(4) provides that a care plan be drawn up within that period. This is unachievable in some cases, particularly in forensic cases involving a conviction for arson.

4.8 We would welcome the ability to extend this period in appropriate cases, particularly for patients in high secure services, and for the Tribunal to have greater powers to re-consider its decision if it has not taken effect.

4.9 A number of medical staff have indicated that for many patients, relapse is likely to take several months rather than eight weeks. They would welcome discretion to make a Deferral Order in such cases.

Theme Five: Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the Draft Bill?

5.1 Only one comment was received on this theme. The proposal to remove responsibility for the Tribunal system from the Department of Health to the Department for Constitutional Affairs is welcomed. It is believed that Tribunals form a central part of their work and consequently, there should be improved systems.
Theme Six: Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

6.1 The proposal to extend safeguards to under 16s is welcome. However, our Child and Adolescent Mental Health Services have queried whether it is proposed that no child under 16 should ever need to come under Part II or III if someone with parental responsibility is empowered to consent? They take the view that particularly with older adolescents, there are situations where it is undesirable from a parent’s perspective to be party to detention. It is sometimes preferable that professionals initiate formal compulsion.

6.2 Opinion is divided on whether these safeguards should be extended to all under 16s given their acknowledged vulnerability. Some feel that this would displace an important common law right enjoyed by parents, to an external body (ie the Tribunal) while others feel it is imperative that similar rights are afforded to children who are neither resisting treatment nor capable of expressing their wishes. There is wholehearted support for automatically extending safeguards to all under 16s if they are ever admitted to a facility that is primarily for adults.

6.3 We do share concerns expressed in other submissions, that CHAI is specifically barred by Clause 260(6)(b) from investigating the management of restricted patients by the Secretary of State. Decisions about these often vulnerable patients should be made in as open a way as possible and it is in everyone’s interests that they should be subject to scrutiny. There is no objection to the continuance of annual statutory reports to the Home Secretary, copies of Tribunal reports and the right to be heard at Tribunals but decisions must be made by the Tribunal itself.

6.4 Additionally, a number of groups have expressed concern that there will no longer be a stand alone Mental Health Act Commission. The proposal that it be subsumed into the Healthcare Commission does suggest that the needs of those subject to detention will be just one of many competing priorities in an organisation whose concerns will be mainly in the acute medical arena. It is held by all staff groups that there should be a statutory right to investigate individual patient issues.

Theme Seven: Is the balance struck between what has been included on the face of the Draft Bill, and what goes into Regulations and the Code of Practice right?

7.1 We would comment on the sheer complexity of the Draft Bill for non-lawyers. Given that it will be necessary for people at all levels to be conversant with the final Bill, its Regulations and its Code of Practice, there are concerns that there will be widespread confusion once it goes “live”.

7.2 Comments at paragraph 2.1 above apply equally here.

Theme Eight: Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

8.1 Further to paragraph 7.1 above, it will be necessary for professionals throughout mental health services to have a reasonable working knowledge of both Bills and both Codes of Practice. This makes it even more likely that there will be greater reliance on expensive legal advice and a huge increase in legal actions.

8.2 Individual professionals have commented that they are unsure when one Bill would apply rather than the other. This is likely to be particularly complicated in services for older people. The recent “Bournewood” judgment (HL v the United Kingdom) from the European Court of Human Rights has created even greater confusion as it now appears that whether patients who lack capacity amount to “detained” patients, will have to be determined on an individual basis.

Theme Nine: Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

9.1 Our comments at paragraph 3.7 above relate to this theme.

9.2 The view of our speech and language therapists is that greater compliance with the Human Rights Act will be achieved by enshrining a right to have information supplied by interpreters and signers in languages other than English and Welsh. Particular consideration should be given to the needs of mentally ill patients who suffer from “language disorders” directly or indirectly by virtue of mental disorder and/or disability. This is likely to be more appropriately covered by the Code of Practice.
Theme 10: What are likely to be the human and financial resource implications of the Draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

10.1 West London Mental Health Trust has the largest resident detained population of any Trust in the United Kingdom. We are therefore acutely aware of the likely resource implications of the Draft Bill. There has not been time to quantify and analyse the future requirements of the Mental Health Tribunal locally but we are confident that in this Trust alone, four to six panels will be required to sit on almost every working day of the year to accommodate the current level of detained patients. In smaller Trusts and provider units, we anticipate huge problems in simply providing accommodation for the Tribunal.

10.2 Quite apart from the need for further investment in Mental Health Act Administration staff (again, not yet fully projected) it is also our confirmed view that the need for investment in the Tribunal system has been significantly underestimated, not least to ensure that professional time is not wasted as it so often is due to inadequate financial and human resource investment in the current Tribunal system.

10.3 Finally, there is concern through all staff groups that training requirements have equally been underestimated. We have no reason to doubt the projected costs of this but do believe that the timescale is over-ambitious. Given the need to train additional staff groups, some with little current knowledge of Mental Health Law, this is a huge task.

Simon Crawford
Chief Executive, West London Mental Health NHS Trust

October 2004

Witnesses: Mr Nigel Edwards, Director of Policy, NHS Confederation, Mr Jeremy Taylor, Chief Executive, Nottinghamshire Healthcare NHS Trust, Ms Mel Wilkinson, MHA/CPA Advisor, and Mr Nigel Maguire, Tees and Northeast Yorkshire NHS Trust, Dr Tim Bullock, Associate Medical Director, and Mr Kevin Towers, Patient Services Manager, West London Mental Health Trust, examined.

Chairman: Thank you for coming. I am sorry, we are working under some pressure of time. There could be a Division in the House of Commons, and we may come to a rather abrupt end to the meeting around about that time if we can get through most of the things we wanted to ask you.

Mr Howarth: Would it be helpful to know that some of us have had a signal to tell us we are expecting a vote between 4.30 and 5.00.

Q786 Chairman: In any event, can I welcome you, remind you that this is a public evidence session and therefore a transcript will be produced. It will be available on the internet after about one week and you will be free to make textual corrections but not corrections of substance. Can I also beg you all to speak up when answering questions, as the acoustics are not all they would appear to be at first sight, especially for those amongst us whose hearing is not what it once was. Would you like to introduce yourselves briefly and then, if you will allow us, we will move straight on to questions.

Mr Towers: My Lord Chairman, my name is Kevin Towers from West London Mental Health Trust. I work as a Patient Services Manager.

Dr Bullock: I am Tim Bullock, I am a consultant psychiatrist in West London and the Associate Medical Director of the West London Mental Health Trust.

Mr Edwards: Nigel Edwards. I am the Policy Director of the NHS confederation, which is a membership organisation for the organisations that make up the NHS.

Mr Taylor: I am Jeremy Taylor, the Chief Executive of Nottinghamshire Healthcare NHS Trust, a specialist mental health provider trust, and also a member of the Confederation’s Mental Health Policy Committee.

Mr Maguire: I am Nigel Maguire, Director of Mental Health at Tees and Northeast Yorkshire NHS Trust, which is a specialist mental health and learning disability trust.

Ms Wilkinson: I am Mel Wilkinson, I am the Mental Health Act and Care Programme Approach Advisor for Tees and Northeast Yorkshire NHS Trust.

Chairman: Thank you very much.

Q787 Baroness Eccles of Moulton: The NHS Confederation wants to add a condition for the use of compulsion based on a patient’s impaired decision-making and to give a discretion to clinicians over discharge if patients regain capacity. What would happen to a person who had the capacity to make decisions but was seriously mentally ill, was a clear a danger to himself or herself and adamantly refused treatment?

Mr Edwards: In those circumstances, we take the view that the danger to the patient or to others would override the capacity. We have had an interesting debate about what constitutes capacity in these circumstances, and would, I think, tend to take the view that circumstances where the patient is a serious danger to himself or others as a result of their illness, would override the argument that says that the capacity should not mean that they are not able to receive treatment. Is that clear?

Q788 Baroness Eccles of Moulton: That should be a clear-cut decision and not a particularly difficult one to make?
Mr Edwards: I might defer to my professional colleagues, if you would allow me, but I think we would take the view that none of these decisions are easy to take. We have great sympathy with the people who drafted this proposed legislation. It is very difficult to encapsulate this on the face of the legislation.

Q789 Chairman: Could I ask another question, which relates to the exclusions. Current exclusions of alcohol and substance abuse have largely been supported by the written evidence and, indeed, the oral evidence that we have had before this Committee. Could we have your reflections on that, bearing in mind the contrary view which has been expressed that the current exclusions for alcohol and substance abuse have been used to avoid using mental health legislation to treat alcoholics and substance abusers, even though they may have significant mental disorders? I think I may be looking at you, Dr Bullock.

Dr Bullock: The issue here is differentiating the fact of the substance misuse from the consequence of the substance misuse. I think it is entirely reasonable to use the Mental Health Act to treat the consequence of the substance or alcohol misuse if it is a identifiable mental health problem, but the fact of the substance misuse is not usefully treated by compulsion.

Q790 Lord Rix: You said “a mental health problem”. As you well know, learning disability is in the Bill, albeit obliquely. Would you consider that to be automatically a mental health problem? I think I may be looking at you, Dr Bullock.

Dr Bullock: I think that within the terms of this Bill, because it gives rise to behaviours which are often problematic for the individual and for society around them, it is usefully included in that general term, yes, but there are other contexts where it can be separated.

Lord Rix: I am not very happy with that response!

Q791 Chairman: Can I turn to the managers, if you would forgive me for using that general term, and ask you whether the existence of the exclusions or the removal of the exclusions makes any difference from the view-point of having the flexibility you need to manage cases in the most appropriate way?

Mr Maguire: I think that having an exclusion is actually helpful in terms of being clear about which people and which conditions fall within the Mental Health Bill. At the moment, as it currently stands, our understanding is that virtually anybody can fall within the remit of the Mental Health Bill. The definitions that are down there at the moment are very, very broad and are very inclusive. We have real concerns about that. We feel that having exclusions is very important, but I notice the submission from the Royal College of Psychiatrists, and I would, from a management perspective, fully support that submission that the need for us to look at the definitions, potentially the ones from Scotland, New Zealand and Australia, we believe, from a management perspective, in support of our clinical colleagues, is rather more helpful than having no exclusions. I would be extremely concerned if the Bill were to go through in its present form with the very broad definition that it has at the moment, because I have experience in mental health of 22 years and I have not come across, either in my clinical capacity or in my managerial capacity, whereby people have been excluded from mental health services who have a dual diagnosis of mental health substance misuse or alcohol problems. In fact, the converse has happened, if anything. People solely with drug and alcohol problems have come into the system inadvertently or because there have not been other resources elsewhere.

Chairman: Thank you. That is a very clear answer, if I may say so, to the question. Mr Loughton.

Q792 Tim Loughton: Could we turn to the subject of ECT, which was raised in the submission from the Tees and Northeast Yorkshire Trust, where I think you raised concerns that the draft Bill provisions on ECT could mean that patients are allowed to deteriorate to the point that they lack capacity so that ECT can be given. Is it your view that the provisions on ECT in the Bill are completely unworkable or could be made tenable subject to substantial safeguards?

Ms Wilkinson: I do not think we take the view that the provisions are unworkable. I think the provision of greater safeguards might be necessary. I think it is paradoxical the fact that the proposals in the new Bill will allow incapacitated patients to refuse ECT is what may well create some issues, in the sense that, if a person is refusing ECT, it may well be found that more people are incapacitated to enable the provision of ECT where somebody clearly stands in need however appears to be incapacitated and able to refuse that at the time. Our concern is somewhat that more people may be found incapacitated at a stage that they would not currently. The other issue is that the Bill will allow for incapacitated patients to be given ECT in the absence of their consent. Some of it is left to regulations. However, it is quite clear that the clinical supervisor can actually authorise ECT for somebody who is capable and who is capable of consenting but has not given their consent as yet. The issues and the safeguards that follow on from that, both in relation to incapacity and in relation to emergency use of ECT, are that subsection (4) states that in relation to incapacity we may specify one or more of the following: the period for which ECT can take place, how often it may be given and the total number of occasions. We do not have to specify all three, or the tribunal does not have to specify all three, it is only one or more. That leaves open to potential abuse, though I do not think clinicians would abuse in this situation, the fact that actually the safeguards are not sufficient because, if the tribunal has specified that it has to happen between this period and this period where there is no maximum number of occasions and they actually specify it as a course of ECT, even in the case of an emergency use, it is specified as a course, not an emergency application, and there is no direction
either that once emergency use is in place you have
to then refer automatically to a tribunal for further
authorisation of the use of ECT. I do not think it is
unworkable, I think potentially the safeguards that
are already there just need to be a little bit more
stringent.

Q793 Tim Loughton: Are there problems with the
system as it stands at the moment?
Ms Wilkinson: I do not think there are great
problems with the system as it stands at the moment.
If ECT is given in an emergency at the moment
under section 62 to a detained patient, for example,
that person has to be assessed before every single
application. Section 62 has to be invoked before
every single application, and the understanding is
that a second opinion will be sought as a matter of
urgency. The provisions in the draft Bill appear to be
suggesting that you can give a course of ECT, rather
than a single application, based on one
determination that this person requires ECT in an
emergency situation.

Q794 Chairman: Dr Bullock, if a patient who is
capacitous for the time being were to give an
advance statement that they never wished to have
ECT again and then they became incapacitous, if
such a statement was to be regarded as having some
authority, what would your reaction be to that
situation?
Dr Bullock: I hesitate, because it is a very difficult
issue. I am fearful that the view of clinicians is often
that it is hard for a patient in advance to truly
anticipate their state at another time. Having said
that, the status of advance directives is gaining
broader acceptance, and I would think that we may
have to accept that sort of situation in the future and
failure not to give treatment; but I think it is an
incredibly difficult issue and I, as a clinician, find the
idea of not treating people when potentially
successful treatment is available very difficult to
confront, and I am sure very many clinicians share
that view.

Q795 Chairman: What about the principle of
autonomy of the patient? We are postulating a
autonomous patient at the time when they give the
directive. They may have had an ECT in the past and
may have found it profoundly unacceptable in its
consequences. What about that? Why should one
not give primacy to the autonomously expressed
view of a patient when they are fully capacitous?
Dr Bullock: I do not take issue with that. I simply
express the view that it is difficult, when potentially
effective treatment is available, for someone who is
a clinician to accept that they are going to stand by
and watch a patient deteriorate and die. I would find
that difficult. I do not feel that I would want to make
a statement that is appropriate to undermine the
autonomy of a patient making an advance directive,
but I do not think it is easy for clinicians to do this.

Q796 Chairman: Has your Trust ever applied to the
High Court for an order to enable you to carry out
treatment where a patient has, in effect, refused the
treatment, so far as you are aware?
Dr Bullock: Certainly. Could I turn to my colleague
who works in the forensic services.

Q797 Chairman: Yes. I am sorry; I was not meaning
only to address the question at you. You just seemed
an obvious target; that is all. Anybody else who
would like to answer, please contribute.
Mr Taylor: I have been involved in such a situation
in respect of a patient suffering from eating disorder
where application was made to the court for a
compulsory intervention.

Q798 Chairman: Was that a minor?
Mr Taylor: It was not, no.

Q799 Chairman: It was a person of full age?
Mr Taylor: It was a woman of 24 years of age.

Q800 Chairman: What was the result of the court
application?
Mr Taylor: The court agreed that intervention
should take place.

Q801 Chairman: In your view is that a satisfactory
way of dealing with these extremely difficult
questions? I have heard the view expressed, certainly
informally, by judges that they find that procedure
very valuable on the whole and feel that it is one of
the areas in which they make a great contribution to
the sum of the parts of human life?
Mr Taylor: I would agree with that, and I would say,
just to add to Dr Bullock’s point, that the gravity of
the moral situation in which clinicians find
themselves is extraordinarily burdensome and can
be relieved by the intervention of judicial
authorities, and I think it is a very reasonable,
effective and appropriate action to be taken.

Q802 Chairman: So that is perhaps the other side of
the story about advance directives. Thank you. I
think that is quite a helpful piece of evidence. Care
in the community: would you like to give us your
collective view, if you have one, on care in the
community? We are postulating a smallish number
of patients who are influenced by the coercive power
of the law and are able to comply with treatment
when this is in place but do not comply when such a
direction is not in place. Without such capacity
within the Act these patients are heavy users of
inpatient services, are not treated in the least restrictive environment and do rather poorly and, with this power in place, do rather well and live in their own homes, and we have seen this by the extended use of section 17 leave in the past. So there have undoubtedly been patients who benefit from this and we would therefore support this power. However, there is a caution in than, if this provision comes to be accepted as part of a general risk-management package and therefore is put in place more indiscriminately, because the sense is, if this is not in place then a full risk-management package has not been provided, then it would lead to a greatly increased demand on the resources we have available to manage this and would be applied to individuals where it probably has very limited benefit, in as much as once out of hospital they have no sense that any people coercive power makes any difference. Therefore, it does have its utility, but I think there are potential dangers as well.

Q803 Baroness McIntosh of Hudnall: Can I follow that up with you, Dr Bullock? You said that you were able currently, using the 1983 Act, to get the treatment could be beneficial right from the start.

Dr Bullock: Absolutely certainly.

Q804 Baroness McIntosh of Hudnall: Occasionally. about the kinds of problems that people have which could be treated by these teams in the community potential, if I understood you rightly, for what is in the current draft being used too extensively or in the wrong context. Would you envisage that the group of people for whom it is valuable would in the main be people who have at some point in their past history been detained under the Mental Health Act or its successor, i.e. people who have had a period of residential detention?

Dr Bullock: I have thought about this, and in my own practice, as a general adult psychiatrist working in the group between 18 and 65, I think that would very much be the case. I could see cases dealing with the elderly where the possibility of community treatment from the off may be useful, and, therefore, my response would not be a blanket acceptance of what you have said. I think, working with older clients, there may be some times when community treatment could be beneficial right from the start.

Q805 Baroness McIntosh of Hudnall: I understand that, but you have said that you can see the potential, if I understood you rightly, for what is in the draft being used too extensively or in the wrong context. Would you envisage that the group of people for whom it is valuable would in the main be people who have at some point in their past history been detained under the Mental Health Act or its successor, i.e. people who have had a period of residential detention?

Dr Bullock: Absolutely certainly.

Q806 Baroness McIntosh of Hudnall: Would you and your colleagues think that the Bill should specify that it is that group of people to whom the community treatment order should apply?

Dr Bullock: I want to ask another question about community treatment orders. We have heard from service users a general fear that they would be applied very widely and would go on ad infinitum. In a sense, you are saying we need to be very careful about the kinds of problems that people have which would necessitate this kind of treatment. This morning we heard from somebody who had had experience in Australia who seemed to be saying that the community treatment orders seemed to be more effective if they were much more time limited, rather than being long on-going orders. Are there times when you could see that it would be of benefit to them being literally only for a short period, or are they for the sort of people who perhaps need that longer on-going support in the community which, in fact, could go on ad infinitum?

Dr Bullock: I think that across England in general we are only in the relative infancy of the implementation of a lot of the community teams: crisis resolution, home treatment teams and assertive outreach teams. One of the things Australia has done is implemented these sorts of teams rather before us. There could well be a role, particularly in shorter-term usage, in the function of these teams. These are obviously promoted by the Mental Health National Service Framework, and mandated by the Mental Health National Service Framework. I think that our practice is changing and I think that shorter term use of these orders would anticipate the development of these teams and their effective working, and I can quite easily see where shorter term usage of these might become more widespread as those teams develop and increase their practice. Their current role is to take patients who formerly would have been admitted to hospital or would have stayed in hospital and treat them in the community. There is clearly, therefore, a group who it will be possible to identify who fall into an area where they could be treated by these teams in the community.
but some level of coercion could usefully be applied, possibly for a short-term. I think that may well be
the future use of these sorts of orders.

Q808 Chairman: Mr Towers wanted to add
something in relation to the last question.
Mr Towers: May I return to a similar theme. I know
the Committee have heard a lot of evidence about
the problems with the current Mental Health Act. I
would like to add to that; I may run the risk of
mixing metaphors though. Guardianship and
aftercare under supervision have variously been
described as lacking teeth and as paper tigers. Our
feeling is that what is proposed in the new scheme
does significantly improve matters, in the sense that
you have a proper power to remove somebody from
the community back to hospital as and when
necessary, and allied to that, I think, is the fact that
the tribunal themselves are required to consider the
circumstances in which somebody may relapse or
there may be a material change in circumstances. To
actually incorporate that into the care plan, I think,
is a very helpful move. I think the “what if?” being
considered is something that is lacking at the
moment. Just to say one other thing about section 17
leave which I think was missed. It is apparent to a lot
of psychiatrists at the moment that they have the
power to, in effect, use section 17 leave as a
community treatment order, bearing in mind fairly
recent case law, and I think there is also widespread
misunderstanding that there is an equal requirement
to satisfy the requirement and there is a clear clinical
rational for providing treatment at or in a hospital
as opposed to the community. The new scheme
anticipates the greater prevalence of community-
based services and in that sense it is better that we are
all working from a simplified and standardised
practice?

Q809 Chairman: You are saying the new scheme
follows the developments that have taken place in
services?
Mr Towers: I believe so.
Mr Taylor: Chairman, can I concur with the view
that a time limited nature of these orders would be
appropriate, say 30 or 60 days, but also reflect on my
ten years experience under the Scottish legislation
where the provision is available, and, although not
often used, we found it to be manageable and
effective?
Chairman: Thank you for that. I should say that
when the bell rings we are going to bring the meeting
to a close, for practical reasons—I do not think we
have any real option—so we may run out of time
very quickly. Please forgive us if we do, but let us try
and get Lady Barker’s question in if we may.

Q810 Baroness Barker: The impact of the draft Bill
is somewhat uncertain, and particularly in respect of
the number of detentions. Do you, as an
organisation which represents the workforce in the
NHS, believe that estimations made on the basis of
no increase in the number of detentions is a
reasonable assumption? I would also like you to
comment on the Department of Health claims that
there is said to be a substantial increase in the
number of consultant psychiatrists in the NHS of
some 800 between 2003 and 2008. Do you think that
is going to happen?
Mr Taylor: I think in regard to the number of
psychiatrists it is a very ambitious target, but then
the Health Service has responded to these ambitious
targets pretty well over the last few years. I am not
doubting that we can do it, but it is going to take an
extraordinary effort, and many of those, of course,
will be female consultants on retainer schemes, and
so on. The first part of your question was about the
numbers. I think we would say it is unreasonable to
assume there will be no increase. The statistics that
I see regularly from my services show an increase in
the number of sections coming through, particularly
in our secure services where in one unit in Leicester
we have seen an increase in criminal justice system
referrals under orders go from 60% of capacity to
now 84%, which means that we are not letting in civil
sections from—

Q811 Chairman: I am sorry; capacity of what?
Mr Taylor: The capacity of the unit itself, the
number of beds in the unit occupied by CJS referrals
is now 84%. That inevitably means that there is back
pressure on the NHS system. Where we used to take
referrals from the civil section from NHS providers
coping with the difficult patients, those patients are
now being catered for, importantly, by general
hospital psychiatric services. So the forecasts are
that there will be an increase, and it is happening
now.

Q812 Chairman: That is a dramatic statistic to end
the meeting on. Can I thank you, not just for your
very clear written submissions, but for the great
clarity of your answers this afternoon. I know they
have been helpful to the whole Committee. I am
sorry we have been under some pressure of time. The
meeting is now closed.
Wednesday 19 January 2005

Members present:
Carlile of Berriew, L. (Chairman) Mr George Howarth
Carter, L. Tim Loughton
Cumberlege, B. Laura Moffatt
Eccles of Moutton, B Dr Doug Naysmith
McIntosh of Hudnall, B. Mr Gwyn Prosser
Pitkeathley, B. Dr Howard Stoate
Mrs Angela Browning Hywel Williams
Mr David Hinchliffe

Memorandum from Ms Rosie Winterton MP, Minister of State, Department of Health (DMH 396)

MENTAL HEALTH BILL—NECESSITY VS CAPACITY

1. We are aware that one of the themes of the evidence that has been given to the pre-legislative committee is that compulsory powers should be used only when a person lacks capacity to make decisions on treatment. As you know, the draft Mental Health Bill is based on necessity, not on capacity—the risk of harm that a patient poses to himself or to others is the key factor in a decision about whether or not compulsory powers need to be used. We thought it might be helpful to set out why we have taken this approach.

History of the necessity vs capacity issue

2. The 1983 Act does not require any decision on a patient’s capacity to be taken when the decision to detain for treatment is made.

3. As you know, in 1998, the Government commissioned an Expert Committee, chaired by Genevra Richardson, to advise on how mental health legislation should be shaped to reflect contemporary patterns of care within a framework which balances the need to protect the rights of individual patients and the need to ensure public safety. The report sets out the difficulties associated with a system which allowed people with capacity to refuse treatment:

— the safety of the public must be allowed to outweigh individual autonomy where the risk is sufficiently great and, if the risk is related to the presence of a mental disorder for which a health intervention of likely benefit to the individual is available, then it is appropriate such intervention should be authorised as part of health provision

— mental disorder unlike most physical health problems may occasionally have wider consequences for the individual’s family and carer, and very occasionally for unconnected members of the public affected by the individual’s behaviour, acts and omissions

— there is a disinclination to allow someone with a mental disorder, whether or not they formally retain capacity, to deteriorate beyond a certain point

— not to allow intervention to protect the patient from serious harm despite his or her capable refusal will lead in practice to the adoption of a very broad interpretation of incapacity, ie in order to allow intervention.

4. They also set out the arguments in favour of unfettered individual autonomy for people with capacity and concluded that:

“As a committee in receipt of these arguments we are aware they are powerfully held on both sides and are effectively irreconcilable. We believe they reflect a difference in fundamental philosophy which can only be resolved by according preference to one approach over the other. We have set out the alternative views as best we can and invite politicians to make the moral choice between them.”

5. In discussing the conditions for compulsion elsewhere in the report they suggested a two-pronged approach, setting out conditions for people with capacity and conditions for people without capacity. The conditions which would allow people with capacity to be brought under compulsion were:

— there is a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons if he or she remains untreated, and

— there are positive clinical measures included within the proposed care and treatment which are likely to prevent deterioration or secure improvement in the patient’s mental condition.
6. Thus, the Richardson Committee report effectively concluded that there were circumstances when necessity (in terms of the risk of harm to self and others) should trump capacity.

7. The Government’s view on this was that, by having an assessment of capacity before the assessment of necessity, the Richardson report approach would lead to different outcomes for patients with the same or similar risk attached to them. The Green Paper (Reform of the Mental Health Act 1983) noted: “[The Richardson Committee report] introduces a notion of capacity which, in practice, may not be relevant to the final decision on whether a patient should be made subject to a compulsory order. It is the degree of risk that patients with mental disorder pose, to themselves or others, that is crucial to this decision. In the presence of such risk, questions of capacity—while still relevant to the plan of care and treatment—may be largely irrelevant to the question of whether or not a compulsory order should be made.”

8. The White Paper (Reforming the Mental Health Act) maintained the position in terms of the primacy of the risk, and this has continued to be our approach in the 2002 and 2004 drafts of the Bill.

**Why we support a necessity based set of conditions**

9. As we have said, the conditions in the 1983 Act are based on the necessity of compulsion. Having carefully considered the issue, we decided to maintain this approach.

10. We would, however, like to emphasise that we fully support the general principle of individual autonomy whenever appropriate—hence the requirement in clause 1 that the general principles in the codes of practice must be designed to secure that where possible patients are involved in the making of decisions and that decisions are made fairly and openly. Throughout the Bill there are requirements to consult patients about their treatment, and this is seen as central to achieving successful outcomes and to protecting individuals’ rights.

11. We should explain that our reasoning below applies whether “capacity” is taken to mean capacity as defined in the Mental Capacity Bill or the less strict test of “significantly impaired decision-making” used in the new Scottish mental health legislation. The difference between impaired judgement or decision-making and incapacity is probably more one of degree—the Millan committee said they were “broadly similar concepts”.

12. We see the following problems with moving to a capacity based approach:

- it would be ineffective in relation to people who present a risk of harm to others, for the reasons that the Richardson report highlighted.
- there is a practical difficulty with having fundamentally different approaches for those who present a risk of harm to others and for those who present a risk of harm to themselves. Many patients when acutely ill fall into both categories, and it does not make sense to have clinicians working to different criteria in these related clinical circumstances. This difficulty is evidenced by a journal article quoted in the Mental Health Act Manual which sets out the reasons given by doctors for supporting section 2 applications under the 1983 Act:
  - 1% of applications were solely for the protection of other people
  - 32% of applications were solely in the interests of the health or safety of the patient
  - 67% of applications were for a combination of the two.
- we are concerned that, with a capacity based approach, there could be a risk of people being able to refuse treatment until they are so seriously ill that they would then be covered by the incapacity/impaired judgement criterion.
- as the Richardson report pointed out, a capacity based approach could result in professionals feeling obliged to use a very wide interpretation of impaired judgement. If anyone with a mental disorder who refuses treatment is considered to have impaired judgement, there is effectively no point in having an impaired judgement criterion. If the concept is tested in the courts, and a much narrower interpretation results through case law, there is a significant danger that professionals could be required not to treat certain people refusing treatment who they believe to be at significant risk of suicide or serious self-harm or self-neglect. Take as an example a young person with serious depression who wants to commit suicide—who appears to be fully aware of the consequences of their action and for whom it is likely that treatment would have a high likelihood of success. Would the clinician force treatment on them on the basis that they must have impaired judgement, to want to kill themselves, or could there be a danger that the person would be considered to have capacity so that nothing could be done to prevent their suicide? We do not think it right to require clinicians to stand by and watch their patients harm themselves in these circumstances, when they know that treatment itself might very well lead to patients changing their mind.
- there is a risk that a capacity based approach could disadvantage people with fluctuating capacity (eg someone fluctuating day by day). When a disorder responds to treatment, then an individual who was incapacitated might move to having capacity, and then refuse treatment, until they lost capacity again.
— a capacity-based approach could have the effect of making it impossible to provide treatment under compulsion for many people with personality disorder. It is not the Government’s intention that people with personality disorder should be excluded from treatment if they meet the conditions for compulsion. On the contrary, the Government takes the view that people with personality disorder (who may be at significant risk of self-harm, as well as a risk to others) have often been inappropriately excluded from treatment in the past. (See Personality Disorder: no longer a diagnosis of exclusion.)

— a capacity-based approach would discriminate against mentally disordered people who had offended, possibly as a result of their disorder. Most mentally disordered offenders are capable of decision making at the time they are sentenced. To make incapacity a precondition of compulsion could deprive them of the chance of diversion from a criminal justice disposal. (We recognise that it would be possible to have separate conditions for offenders but this would mean treating capacitous mentally disordered offenders differently from others with the same mental disorder who have not offended.)

**Conclusion**

13. Accordingly, we have concluded that existing mental health legislation relies on the only practicable basis for compulsion to prevent harm. Whilst a capacity-based system may suffice to protect people from unnecessary intrusion, it is ineffective to prevent the harm to themselves or others which may result from their disorder.

*November 2004*

---

**Further memorandum from the Department of Health: Resources and the Regulatory Impact Assessment (DMH 404)**

**Finance**

1. Could the department provide a breakdown of the funding highlighted in this year’s Departmental Report as ‘‘. . . new investment of over £300 million in the NHS Plan was announced to 2003–04 to ‘fast forward’ the National Service Framework’’, detailing exactly what years this funding was for, how much was finally given and whether it is to be continued?

**Response**

The NHS Plan’s extra annual investment of £300 million for mental health was allocated over a three-year period from 2001–02 to 2003–04. The breakdown of this investment is shown below:

<table>
<thead>
<tr>
<th>EXTRA ANNUAL INVESTMENT AGAINST A BASELINE OF 2000–01</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2001–02</strong></td>
</tr>
<tr>
<td><strong>£ million</strong></td>
</tr>
<tr>
<td>Revenue</td>
</tr>
<tr>
<td>CFISSA*</td>
</tr>
<tr>
<td>NHS Allocations</td>
</tr>
<tr>
<td>Capital</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

* CFISSA—Centrally funded initiatives and services and special allocations

The majority of the above revenue funding went directly into NHS baselines; a small amount was retained centrally to fund projects around high secure services.

2. Disregarding the costs of implementing the draft Bill, what is the department’s estimate of the level of extra resources needed to bring the current mental health services up to a level that the Government considers to be an acceptable standard in England and in Wales?

**Response**

In line with the Government’s policy of Shifting the Balance of Power (StBoP), responsibility for the provision of local health services, including mental health services, now rests with Primary Care Trusts (PCTs). It is for PCTs, in conjunction with Strategic Health Authorities (SHAs) to plan and develop services according to the needs of their local communities.
In the 2002 Budget announcement, the Chancellor of the Exchequer announced that as a result of the largest increase in funding of any five-year period in the history of the NHS, services for people with mental health problems have seen significant improvements in primary, secondary and community care. (Details of these improvements will be set out in the five-year review report of the National Service Framework (NSF) for Mental Health, which is due to be published shortly.)

In addition, over the three years of SR2004 (2005–06 to 2007–08) NHS spend will increase on average by 7.1% a year over and above inflation—a total increase over the period of 23% in real terms. Over three years this will take the total spent on the NHS in England from £69 billion in 2004–05 to £92 billion in 2007–08. This will benefit people with mental health problems.

3. First, does the department accept that published data may not be complete or that the data currently available is inadequate to monitor effectively the implementation of the proposed legislation?

RESPONSE

We accept that the exact spend by the NHS and social care on people with mental health problems is, and has been, difficult to estimate accurately. This is largely because information may be coded in many different ways and people themselves commonly have more than one problem or are seen in more than one specialised service, including in primary care. However, we do know that from our Autumn Assessment of mental health services that at least £262 million extra was spent on mental health to April last year.

From this year, the Department of Health (DH) will start to roll out programme budgeting across the NHS. This will help to map all future NHS expenditure, including spend in primary care, to specific mental health services.

4. Given the considerable financial impact that the draft Mental Health Bill is likely to have, what plans has the department to improve the collection and quality of data?

RESPONSE

Information technology systems used by mental health provider trusts have been evaluated as part of the national programme for information technology (NPfIT). NPfIT will procure, develop and implement modern, integrated IT infrastructure and systems for all NHS organisations in England by 2010. There are four key elements: electronic appointment booking, an integrated care records service, electronic prescribing and an underpinning IT infrastructure with sufficient connectivity and broadband capacity to support the critical national applications and local systems. The NPfIT is an essential element in delivering the NHS Plan, focusing on the key developments that will make a significant difference to improving the patient experience and the delivery of care and services.

In addition, work is being undertaken to roll out a national Mental Health Minimum Data Set (MHMDS) set to capture essential information about all those in contact with mental health services, including those detained under the Mental Health Act. The main purpose of the MHMDS project, led by the DH, is to improve data quality for all those in contact with services, and support mental health trusts (MHTs) to use the system and derive business benefit from this. MHMDS information is also an important source for 2004–05 performance indicators for specialised trusts collected by the Healthcare Commission. Good progress has been achieved in completing the analysis software and engaging with trusts. Phase One was completed in August this year; this involved delivery of training in use of the analysis tools prior to trusts being given access to use these. Fifty out of 85 trusts have trained at least one person. Initial reactions to the training and the system itself have been very positive. Delivery of the remainder of the system (Phase 2) should be complete by January 2005. The DH is aiming to complete some analyses in due course on the national dataset for 2003–04.

5. The Committee is relying on data given at HC Deb 1 Nov 2004 c139W and Department of Health, Gross and net PSS expenditure in England 1994–95 to 2002–03. Have these figures been updated? Can the department supply a more detailed breakdown showing amounts spent on, for example, assessments, patients under compulsion, “voluntary” patients and aftercare? What are the equivalent figures for Wales?

RESPONSE

The answer provided on 1 November HC Deb c139W does not relate to Personal Social Services (PSS) expenditure on people with mental health problems. It provides the most up to date information on hospital and community health services (HCHS) expenditure for people with mental health problems since 1998–99. The table attached at annex A provides a further breakdown of the HCHS data for 2002–03. A further table is attached at annex B which provides information about PSS expenditure on people with mental health problems over the last five years for which data are available.
6. On which services have the additional sums made available in the past years been spent?

Response

Our assessment shows that the additional sums of funding made available have been spent on the development of new services, such as generic and functionalised community mental health teams, including assertive outreach and crisis resolution teams, secure and high dependency provision, better access and crisis services, better access to psychological therapies, supported accommodation, and services for mentally disordered offenders.

We know that the caseload for community mental health teams increased to 303,000 in 2002 from 252,000 in 2001, an increase of 50,000, as published in the 2002 Atlas of the Mental Health Service Provision. The caseload for 2003, as published on the Durham Mental Health Service Mapping website, increased to 310,000. In addition, assertive outreach teams are now providing services for almost 13,000 people annually and it is expected that over 60,000 people will benefit from crisis resolution services in 2004–05, with an increase to around 100,000 in the following year.

The impact of these developments is now starting to be felt by service users and carers who are able to exercise more choice; be treated at home instead of hospital when appropriate; and access services more easily in an emergency.

Response from Wales on questions 5 and 6:

In terms of health, mental health services in Wales are commissioned by local health boards (LHBs) and provided by generic NHS trusts. Social care is provided through the activities of local authority social services departments. In addition to this there is a specialist commissioning body, Health Commission Wales, which commissions tertiary services such as medium secure forensic services and in-patient provision for deaf people with mental health problems, on an all Wales basis.

It is not possible to provide the level of detail that the Committee would wish to see in terms of where and how money made available for health and social care is spent in Wales as there is not a standard way in which LHBs and local authorities are required to collect financial information.

What can be shown for Wales is a breakdown of the mental health services funding (primarily adult services although some figures may contain some Child and Adolescent Mental Health Services (CAMHS) and Elderly Mentally Ill data), combining elements of readily accessible and/or published data with estimates from other funding sources. This is shown in Annex C. In addition, other funding is available centrally from the Welsh Assembly Government to support and improve service delivery—this is also summarised in Annex C.

7. How much will it cost to implement the Mental Capacity Bill and to close the “Bournewood Gap”? Where will these resources come from?

8. How much would it cost to apply the provisions in the draft Bill—for example, access to Mental Health Tribunals and the production of care plans—to people who competently or incompetently acquiesce in admission, both to those currently in hospitals and institutions and also to those who enter each year? [On seeking clarification about exactly what was required in relation to this question, we were told that Question 8 seeks information on the costs of closing the “Bournewood gap” using the Mental Health Bill, and so this is what we have focussed on in our response.]

Response

This response is to both Q7 and Q8 as they are linked.

Costs for implementing the Mental Capacity Bill in England relating to health and social care have been estimated at £11.4 million for set up costs and £18.5 million pa for running costs. The set up costs include training for health and social care professionals and revising existing guidance. Costs for necessary changes to procedures for health and social care workers are estimated at £12 million pa.

In addition, the Mental Capacity Bill introduces a new independent consultee service (a form of advocate) to assist people who are unbefriended when particularly serious decisions are taken about medical treatments or permanent moves to care are taken. The independent consultee will also be involved in an annual review of the original decision to move someone into long-term care to ensure that those arrangements are still in the person’s best interests. The Mental Capacity Bill includes a regulation making power to extend the independent consultee safeguard to other vulnerable groups or situations. We intend to consult broadly on this as we develop plans for the service further. Costs for the independent consultee service are estimated at £6.5 million.

At this stage, we cannot say how much it would cost to “close the Bournewood gap”, by which we assume the Committee means taking steps to remedy the breaches of Article 5 of the European Convention on Human Rights identified by decision of the European Court of Human Rights in the Bournewood case (HL v UK).
The priority now is to put in place appropriate safeguards for incapacitated patients who are, in fact, deprived of their liberty other than by use of the compulsory powers in the Mental Health Act. The Government has therefore, committed itself to bringing forward proposals for appropriate new safeguards as soon as possible. Before doing so, we will need to consult widely with interested parties, including representative groups, the NHS and local authorities. Formal consultation will begin in the New Year, although we are, of course, carefully considering the many ideas and proposals that we have already received.

Among the questions we would expect to see addressed in that consultation are:

- How should decisions about deprivation of liberty be taken? Who should take those decisions? What medical and other recommendations should they be based on?
- How should those decisions be recorded? For example, should there be a statutory record as there is for applications under the Mental Health Act? What should be included in any such record?
- How often should decisions be reviewed? And how should that review be carried out?
- How should carers, friends and relatives be involved in decisions?
- Should one individual be identified as having special rights and responsibilities, in the way that the nearest relative of a patient detained under the Mental Health Act does? Should one individual be appointed to represent the patient’s views? If so, how should that be done?

This is not an exhaustive list, but it gives a flavour of what we expect the consultation to cover. It is important that we design safeguards which are effective, proportionate and deliverable in practice without diverting resources unnecessarily from front-line care. However, until we have consulted and agreed on the safeguards to be provided it is not possible to provide any estimates of their costs.

As part of the work to assess the different possible approaches to providing new safeguards, an assessment of the different costs will be made.

9. Why are mental health budgets not ring-fenced as this would serve to communicate priority to PCTs and local authorities?

RESPONSE

At least 75% of funds to support delivery and development of services within the NHS are distributed to PCTs in a general allocation, weighted according to a formula that reflects population and other local needs. This principle, outlined in the policy called Shifting the Balance of Power, ensures that decisions about how resources should be spent are taken at local level by those with the greatest knowledge. In this way, local NHS commissioners have flexibility to improve services according to local priorities. To help with the planning process the DH publishes its Planning and Priorities Guidance every two years. SHAs manage the performance of PCTs in the development and implementation of Local Delivery Plans (LDPs) that show how planning priorities will be met. Some budgets are retained centrally where central planning is essential to delivery and the mental health revenue grant allocated to local authorities is partly ring-fenced.

10. How can the Department of Health influence PCTs to spend money on mental health? How does the department measure the effectiveness of the allocation of resources for mental health?

RESPONSE

a) How can the Department of Health influence PCTs to spend money on mental health?

Modernising mental health services is one of this Government’s core national priorities. The Mental Health NSF (1999) was designed to drive up quality and reduce variation in services to service users. The Framework set national standards, defined service models for services and service users, and outlined strategies to support its implementation. In addition, a number of agencies such as the National Primary and Care Trust Development Programme, the NHS Modernisation Agency and the National Institute for Mental Health in England (NIMHE) are supporting PCTs to develop their commissioning capacity in mental health.

The DH works with SHAs through their PCTs to help them focus on mental health priorities for some of which there are explicit national targets as outlined in the NHS Plan (2000).

More recently, the publication of National Standards, Local Action—Health and Social Care Standards and Planning Framework 2005–06—2007–08 was published. This guidance sets out the framework for all NHS organisations and social service authorities to use in planning over the next financial three years.
b) **How does the department measure the effectiveness of the allocation of resources for mental health?**

Since the publication of the Mental Health NSF there has been an annual assessment of mental health services, through the Local Implementation Teams (LITs) across England. The assessment contains the following elements:

- self-assessment, of the progress of local mental health services by the LIT.
- service mapping, the mapping and location of all local mental health services.
- financial mapping, a map of spend in all mental health service areas.

The results of the annual assessment are made available to LITs for their use in local planning. Additionally, the LDP Returns provide a quarterly update on some mental health activities.

11. **Why does spending vary from borough to borough in London? Has the department any plans to review the allocation formula?**

**Response**

In line with StBoP decisions on how resources are allocated are determined at a local level. This arrangement has inevitably led to a variation on the amount of funds spent on mental health services from borough to borough in London. Although the DH does not systematically investigate the relationship between spend and outcome for service users and carers, our assessment of local services through the Autumn Assessment and our consultation with SHAs on performance management issues, make it clear that the relationship between spend and outcome is not linear.

The Government expects PCTs to assess the health and social care needs of its local population and work with prospective providers, clinicians, patients and the public to plan and deliver services in light of national guidance such as the NSF for mental health and National Standards, Local Action (2004) to deliver comprehensive services to their local populations.

Currently the Mental Health Grant is issued to some local authorities as a ring fenced grant. The allocation of this grant is based on a historical formula where several grants have been merged together. From 2004-05 the Mental Health Grant is to be issued on the formula spending share (FSS) formula. This will be done over a four-year period to reduce the effect on authorities.

Another change, which will affect how funding for mental health is allocated, will be the new Payment by Results scheme. This scheme will radically change the arrangements for funding providers of care. Allocations of funds will more directly be linked to mental health service activity.

**Workforce**

*Introductory comment in response*

In noting the Committee’s questions, we thought it might be useful to put them in a wider context. First of all, there has been the sustained growth in the mental health workforce as shown in Annex D.

A number of wider issues need to be considered in relation to difficulties in recruitment to mental health services. A recent report by the Audit Commission (Audit Commission 2002) highlights that the UK labour market is currently highly competitive with unemployment at a historically low level. This means that all employers have to compete harder to attract and retain staff. Within this context, there are widespread reports of recruitment and retention problems across local public services not just mental health. There are concerns about shortfalls in the number of staff, with fewer younger people being attracted to work for the public sector in the first place and a potential demographic “time bomb” with 27% of the public sector workforce now aged 50 years or over.

The scale of the challenge is reflected in targets set by the Government across key public services. The NHS has targets for the recruitment of 35,000 more nurses, midwives and health visitors, 15,000 more consultants and general practitioners (GPs) and 30,000 more therapists and scientists by 2008. The Government has also set targets for teachers and the police (Audit Commission 2002). Mental health services therefore have to compete not just with the rest of the NHS but also with the rest of the public services.

It is also an international rather than simply a national problem, and other countries have more of a problem than England. For example, Feifel *et al* (1999) report a fall in numbers of medical students choosing to do psychiatry in the USA. There are also concerns in the USA about numbers of occupational therapists choosing to practise in mental health (Hulse *et al* 2000), and the dwindling numbers of mental health nurses in the face of increased demand (Oerman & Sperling 1999). Recruitment difficulties are reported for mental health nurses in Australia too (Happell & Rushforth (2000)), and Ireland has experienced a similar decline in numbers on pre-registration psychiatric nursing courses as in Britain (An Bord Altranais 1999).
Within the overall national picture, there are widespread geographical differences, reflecting local labour market conditions. All other things being equal, turnover is most likely to be high where there are a large number of alternative jobs available within the travel-to-work area, and to be low where a change of job involves a house move or a major alteration of travel routine. But differences from region to region also reflect local employment cultures which explain why staff, in some areas are ready to change jobs for relatively little additional reward, while elsewhere they are more inclined to stay put (Audit Commission 1997).

A range of factors that have a measurable influence on turnover have been identified by the Audit Commission (Audit Commission 1997). These include:

— non NHS pay levels for comparable jobs.
— size of private healthcare sector within the district.
— the presence in an area of more that one NHS trust within travelling distance of where employees live.
— local employment levels.
— cost and availability of housing.

On image and perception, the Audit Commission report (Audit Commission 2002) found that public sector staff think that their image in the eyes of the public would discourage potential recruits. This finding was followed up by a review of the media coverage of public sector stories to see if the evidence supported this perception. The review found that while media coverage is extensive, the picture of public sector work presented to the reading public is unremittingly bleak. All types of story across all the newspapers were reported negatively, but some were more critical than others.

THE COMMITTEE’S QUESTIONS

12. Why have increases in the mental health workforce numbers not kept pace since 1998 with general increases in NHS staff numbers, despite higher levels of investment?

RESPONSE

Whilst there remain a number of challenges around recruitment, nevertheless, there has been a substantial increase in the different types of staff working in mental health services since 1999.

There is no simple answer as to why increases in the mental health workforce numbers have not kept pace with general increases in NHS staff numbers but there are a number of factors to consider. These include:

— mental health has started from a lower baseline which makes it more of a challenge to keep pace or “get ahead of the game”.
— it may have something to do with the stigma that is still attached to work in mental ill health services as is attached to suffering from mental health problems.
— the fact that mental health services are not always seen as a good career option for some staff such as doctors—psychiatry is not as popular as other medical specialities. Some of the medical world regard it as low status and unscientific;
— the “blame” culture that psychiatrists report.

13. What plans has the department and PCTs to improve recruitment? In particular, how much is being spent and what targets have been set in England and Wales?

RESPONSE

Work on recruitment and retention has been undertaken both by the DH and the National Workforce Programme (NWP) for the NIMHE, in close collaboration with the Royal College of Psychiatrists.

On behalf of the Mental Health Care Group Workforce Team (MHCGWT), the DH has been working closely with the Royal College of Psychiatrists to develop an Action Plan to increase the recruitment and retention of consultant psychiatrists.1 The report, published in January 2004, makes a number of recommendations aimed at DH, the College, MHTs, and Academic Departments of Psychiatry. There were five recommendations for DH and the current position is set out in Annex E to this note.

1 Recommendations to increase the recruitment of and the overall numbers of consultant psychiatrists and to improve their retention: A report to the Mental Health Care Group Workforce Team and the Recruitment and Retention Sub-group of the Royal College of Psychiatrists: January 2004.
The NWP has been considering the non-medical staff working in mental health services and has commissioned the University of Central Lancashire (UCLan) to examine the general issues which impact on workforce recruitment and retention. The report, which is due to be published very soon, will include examples of best practice that emerged from a literature review. It will also set out:

- what the main barriers are to recruitment and retention;
- why staff leave mental health services;
- what positive messages should mental health services promote about working for them;
- what initiatives mental health services are undertaking to recruit and retain staff;
- what action has been particularly effective;
- the points of best practice for “excluded” groups such as those from Black and Minority Ethnic (BME) communities, refugees, women, and individuals with a disability and/or mental health difficulties;
- the key features organisations should aspire to so as to be able to undertake effective recruitment and retention.

Clearly the dissemination of such a valuable resource will be vitally important. Therefore, UCLan will be informing all PCTs, MHTs, SHAs and Workforce Development Confederations/Directorates (WDC/WDDs) about the report. It will be possible to access it via the NIMHE and UCLan web-sites and a number of hard copies will be available as well.

The next stage for the NWP is the development of a recruitment and retention strategy for mental health nursing and a meeting with the relevant stakeholders to scope out such a strategy was held on 16 December.

The NWP recognises, however, that it is simply not about recruiting more of the same types of staff—rather there is a need to develop an improved mix of staff groups. This involves looking closely at existing roles and considering New Ways of Working (see response to question 21) and creating entirely new roles so as to tap into a new labour pool. With this in mind, mental health services has been at the forefront of workforce development by creating a variety of new roles that includes Graduate Primary Care workers; “Gateway” workers; Support, Time and Recovery (STR) workers; Community Development Workers (CDW) for BME communities; Carer Support Workers (CSW); Advanced and Associate Practitioners; Psychology Associates and Dispensing Assistants. As a result, the overall size of the mental health workforce is increasing in a way that was not envisaged some five years ago prior to the publication of the NSF for Mental Health and the NHS Plan. It has also meant that we are better able to meet the individual needs of service users and their carers by having a more tailored workforce.

These major developments have been undertaken against the wider re-configuration of workforce issues with the introduction of SHAs and WDCs/WDDs who have a key role to help PCTs/MHTs develop their workforce, help with recruitment and retention as well as taking responsibility for commissioning appropriate education and training places for the growth of the future workforce.

In addition to the above, work has been undertaken by DH regarding International Recruitment and the position here is that of all client group areas, mental health has been the most successful in attracting psychiatrists to come and work in mental health. Currently, some 114 consultant psychiatrists are now in post with a larger number going through the recruitment process but yet to take up post. For nurses, 148 Indian mental health nurses have been recruited since 2002. In addition, individual PCTs and MHTs have been conducting their own successful international recruitment exercises although details are not held centrally.

More generically, the Government is implementing a range of measures to recruit more healthcare professionals, including mental health staff. These include improving pay and conditions, encouraging the NHS to become a better, more flexible and diverse employer, increasing training, investing in childcare and continuing professional development, attracting back returners and running national and international recruitment campaigns. PCTs are working with their local SHAs and MHTs to scope and deliver the workforce required to meet local needs.

The national NHS recruitment campaign in England costs about £3–£4 million each year. Attracting staff to work in mental health is an integral feature of the campaign. No figures are held centrally about the investment made locally by PCTs and MHTs.

For mental health services, there are a number of workforce targets that are set out in the National Workforce Strategy2 seen by the Committee. The present position regarding these targets is set out in Annex F to this note.

For the successful delivery of mental health services, it is not just about having sufficient staff working in the NHS. Some of the new types of worker mentioned in above, such as STR, CDW and CSR may also be employed in the social care field and the NWP has started to consider the future role of social work in mental health. Following a successful scoping event in October, a consultation paper is being prepared for distribution early next year.

---

Response from Wales

The Welsh Assembly Government has not currently introduced recruitment policies specific to staff in mental health services although work is now being undertaken in some specific areas to identify and tackle recruitment issues e.g. an action plan is currently being developed for CAMHS. In general, however, these staff are included in the generic initiatives in place nationally to support local recruitment and retention initiatives.

In terms of medical staff the Welsh Assembly has a target to increase the number of consultants working in Wales by 525 between September 2001 and September 2010. Consultant psychiatrists are included in this increase although there is no specific staffing target by specialty. Trusts submit annual workforce planning data whereby they are required to identify forecast consultant staffing requirements which are then used to inform work on floors and ceilings which determines where future investment is required in terms of Specialist Registrar (SpR) posts. This work includes requirements in terms of consultant psychiatrists.

In terms of non-medical staff, targets have also been set, i.e. 6,000 more qualified nurses and 2,000 other health professionals by 2010. As with medical staff these targets are not however broken down into specific specialties. Trusts are required as part of the workforce planning process to identify their novice requirements which are then used to inform the central education and training commissioning process. This includes staff such as mental health nurses and clinical psychologists.

In terms of recruitment some of the specific initiatives underway are identified below:

Following an All Wales consultant recruitment campaign in December/January, 70 consultant appointments were made between January and June 2004. A further similar campaign is currently underway.

Work is underway to develop a consistent approach to the provision of Work Observation schemes for medical staff in Wales. Arrangements in the past have been on an ad-hoc basis. The Work Observation Programme already in place in some areas of Wales offers a more formal mechanism for sixth form students considering a medical career. This more structured approach removes the inequality of previous schemes, enables clear guidelines for health and safety to be developed and enables patient consent and confidentiality issues to be taken on board. The programme is part of a wider initiative aimed at widening access to medical training. The School of Medicine has an excellent record in recruiting from deprived areas (with low wastage in training).

Through the national and local recruitment and retention strategies all health organisations in Wales are expected to provide a flexible and supportive working environment by challenging traditional working and training practices, involving staff in their design and development at local and national level. A Welsh Assembly Government co-ordinated group visited all trusts in Wales during 2003 in order to identify and disseminate information on good practice in human resources focusing particularly on flexible working.

Return to Practice Initiatives—the Assembly encourages health professionals whose practice has lapsed for various reasons to regain their skills and confidence through Return to Practice courses by providing free refresher training, £1,000 financial support whilst retraining and assistance with childcare support. Over 400 nurses have already undertaken a Return to Practice course since they first began in 2000, and programmes have been developed to support these returners as evidence shows this is necessary in order to retain returners and attract them in the first place.

A third NHS Open Week took place in October 2004. The purpose of the event was to promote NHS Wales and the careers within it with the main focus being 14 to 18 year olds in Wales. NHS Open Week provides a unique opportunity for the health service in Wales to work in partnership with the employment service and education establishments to promote the wide range of careers available within the health care profession.

With three large regional careers events and over forty community based events taking place during NHS Open Week, this initiative enables the Welsh Assembly Government to showcase the work of trusts and LHBs while giving an insight into the many employment opportunities the health service in Wales has to offer.

This major recruitment initiative provides the most appropriate platform on which clinical and non-clinical professions can give advice and demonstrate the skills required to deliver the health services of the future.

An All Wales vacancy website was launched on 5 March 2003 by Minister for Health and Social Services, whereby the public, both home and abroad, will be able to access all vacancies in Wales on one website.

Co-ordinated and funded by the Assembly, NHS Wales now regularly has a presence at Jobs Fairs and Careers events in Wales and the UK. This has helped raise both the profiles of NHS Wales as an employer and also of Wales as a desirable place to live and work.
The Welsh Assembly Government’s international recruitment campaigns are aimed mainly at consultants and GPs, although employers are flexible in their offers of employment, where appropriate, on negotiation with overseas applicants, eg Clinical Fellows, Staff Grade Posts.

Wales subscribes to the DH’s Global Recruitment Scheme and has access to all eligible doctors listed on the scheme.

14. It appears from the Department of Health Statistical Bulletin that certain parts of the mental health workforce has an older profile than the total HCHS workforce. Why is this, and what plans has the department and PCTs to bring the profile of mental health workers into line with the rest of the health service? Is this pattern repeated in Wales?

RESPONSE

Whilst there may be certain parts of the mental health workforce with an older age profile than the total HCHS workforce, overall the age profile of the NHS mental health workforce is comparable with that of other NHS staff. As at September 2003, 72% of the overall qualified nursing workforce and 65% of consultants were under 50, compared with 71% of nurses in psychiatry and 66% of psychiatry consultants.

However, there is no single reason why in certain parts the mental health staff have an older profile. On the one hand staff really enjoy working in mental health and therefore tend to stay working in this field but, on the other hand, as we explain elsewhere, young people tend to be more mobile, are not perhaps prepared to work unsocial hours with a shift to a 24/7 community service and have different career aspirations, eg newly qualified professional staff may be more likely to stay for shorter periods to gain post-qualifying experience. This results in an age profile that is skewed in some parts towards an older age group.

In line with the Government’s policy of StBoP, it is now for PCTs, in partnership with SHAs to plan and develop the workforce. We recognise that mental health services are better when management is devolved down to the frontline and there is less “micro-management” from the DH.

Nevertheless, the NWP of NIMHE is currently undertaking a Workforce Planning Pilot Programme (WPPP) with seven sites to help them develop workforce plans in line with the Best Practice Guidance.3 This includes looking at the age profile of their workforce along the breakdown into gender and ethnicity. The aim is not just to help these sites but to disseminate the key messages and best practice to all PCTs and MHTs.

The programme is in its early stages but, in advance of its final conclusions and recommendations, the WPPP has already issued some early pieces of supplementary guidance. The first of these is a note around the “Levels of Responsibility for Workforce Design and Development” that sets out what the various parties should consider in taking this agenda forward. Details are at Annex G.

One of the WPPP sites has, for example, already recognised the problem of an ageing workforce. But it has also recognised the challenge it faces with fewer young adults of working age, a steady reduction in children of school leaving age and, a problem for the longer term, a large drop in pre-school children.

Response from Wales

Available NHS Wales workforce data does not highlight a similar pattern in Wales. Notwithstanding this, anecdotal evidence from colleagues within service provider organisations across Wales suggests that one or two trusts anticipate a “retirement bulge” of mental health nurses in the next three to five years. It is predicted that this will affect specific service elements (in most cases Elderly Mentally Ill services). Although there is no major age profile issue relating to the consultant psychiatrist workforce, as with the nursing workforce there may be one or two trusts with specific issues in the coming years. Some medical colleagues have suggested that proposals to change pension arrangements for NHS staff could precipitate a crisis.

15. Why is there a problem retaining staff? What is the department and PCTs doing to address the issues of retention and the high levels of reliance on temporary staff? Is there a similar problem in Wales and what is being done about it?

RESPONSE

The issues around retention of staff are different at different stages. There is the retention of newly qualified staff; retention of those in what might be called the middle of their careers; and retention of those nearer to retirement. The key issue to recognise is that mental health services cannot isolate themselves from what is happening in the wider community, not just in the NHS and social care field but more generally.

Society is changing. Young people especially are brought up with a “modular” frame of mind or approach to life and simply do not accept the notion of a “job for life” or staying with one employer. The old way of doing things is fast becoming outmoded. Skills are becoming more portable across employers. In the middle stage, there will inevitably be some who decide to take a career break to look after children or elderly relatives for example. Or there may be staff who simply want a career break or sabbatical, but these may not be lost to the service entirely as they may return at some later date. For those nearing retirement, with the growth in leisure, improved incomes and increased life expectancy, a number will simply opt to go early. One way to tackle this is for trusts to consider introducing flexible retirement arrangements.

In addition, as people become more informed and have greater access to things like the Internet, there is the increasing expectations from service users and carers which, coupled with the ever growing pressure to deliver ever higher quality of services, simply means that some staff decide it is no longer for them. Staff feel overburdened and burnt out.

For the NWP, the UCLan study mentioned in response to question 13 above will be a useful resource to help PCTs and MHTs tackle retention issues. In addition, the second piece of supplementary guidance issued by WPPP sets out some tips or ideas that may be used in respect of recruitment, retention and returners. A copy is at Annex H to this note.

Apart from the UCLan report, the MHCGWT has commissioned a separate report looking at recruitment and retention from the commissioning of education and training places perspective. This is currently being finalised and will be ready for publication and dissemination shortly. However, a selection of the key messages are set out in Annex I.

With regard to the reliance on the use of temporary staff, the NWP in conjunction with the Sainsbury Centre for Mental Health and the Royal College of Psychiatrists has undertaken a study to scope the use of locums in relation to staff vacancies. It is hoped to publish the results in the near future but the emerging messages are that there is extensive use of locum psychiatrists to cover vacancies in some parts of the country which, by and large, leads to increased costs and a reduction in the quality of services. The remuneration is such that some Specialist Registrars (SPRs), on completion of training, choose to work as a locum for a period, before taking up a consultant post. Remedies to address these problems include the use of NHS professionals to improve procurement from agencies and better value for money. There are examples of MHTs in the North West, South East and London collaborating to work with NHS professionals, rather than competing with one another for staff.

Response from Wales

Turnover data for medical staff is not currently available centrally in Wales. However, workforce planning data for 2004 does identify turnover information for other staff groups. Between September 2002 and September 2003 there was 8.4% turnover of mental health nurses across all trusts in Wales. However, this sum includes nurses moving into different trusts and also into the Community. The actual turnover of mental health nurses to outside NHS Wales was 4.6%. Similarly with community mental health, there was 5.1% turnover across trusts in Wales but only 2.7% were lost to the NHS. In terms of clinical psychology turnover was 7.7% out of NHS Wales.

RIA Assumptions

16. What extra data does the department expect to become available and why is there a delay? To the extent that the department has already identified some factors, why has it chosen to ignore them?

Response

The RIA (paragraph 7) cites anecdotal evidence suggesting that innovative service developments arising from the NSF for Mental Health might reduce the number of detentions under the Mental Health Act. At present we have no formal data to corroborate this, but we have commissioned the University of Durham to undertake some research into this. We expect a report of his preliminary findings in early 2005, and we plan to revise our model in light of the outcomes of this ongoing work.

With regard to the second part of the question, because of the uncertainties of the information available (the research mentioned above should help overcome this), the model has made conservative assumptions in respect of factors that may reduce the number of people of people who may liable to treatment under mental health legislation.
17. Does the department adhere to its view that the Bill will not produce a significant increase in the number of people subject to compulsion?

RESPONSE

The draft Bill is not intended to significantly change the number of patients subject to compulsion. We have introduced five conditions which will safeguard against inappropriate use of the powers. In particular, we have tightened the threshold for compulsion in relation to the protection of the patient—compulsion must be necessary for the protection of the patient from suicide, serious self-harm or serious neglect of health or safety. The fifth condition requires that appropriate treatment must be available for that patient.

New investment and improvements in mental health services, including the introduction of initiatives under the National Service Framework for Mental Health, are aimed at reducing the number of patients who become so ill that compulsory treatment becomes necessary.

The definition of mental disorder in the draft Bill is a purposely wide one which does not rely on any specific diagnosis or label as we need to be sure that people who would benefit from compulsory treatment are not inadvertently excluded because of a narrow or too specific definition of mental disorder. Whilst this may potentially increase the number of patients brought under compulsion, taking into account the safeguards (such as authorisation by the tribunal within 28 days) and the improvements to services generally, we are satisfied that overall there will not be a significant change.

18. Has the department carried out any detailed sensitivity analyses beyond the alternative scenarios in the RIA? At what percentage increase in the number of compulsory patients does the department consider the Bill would become unworkable?

RESPONSE

No detailed sensitivity analyses beyond the alternative scenarios in the RIA have been carried out. As we say in response to question 17, there is no expectation of a significant change in the numbers of compulsory patients, and so no consideration has been given to the implications of a significant increase.

19. What updates have you made/are you making to the calculations in the RIA as new figures become available? Does the increase in doctor activity identified in 2002–03 have any implications for your estimate of workforce requirements: either in terms of numbers or timings?

RESPONSE

We have not made any new updates since the RIA. As we say above, we are planning to update our model which may of course lead to new figures for the RIA.

The increase in activity among Second Opinion Appointed Doctors (SOADs) between 2001–02 and 2002–03 would tend to reduce the additional workforce requirements arising from the Bill since these requirements are calculated by taking the number of patients and tribunal hearings, and subtracting the current activity under the 1983 Act.

Other possible drivers of change in the assumptions would include:

— the impact of service changes, such as the implementation of services under the NSF.
— the impact of any changes to the Bill.
— the impact of increases in costs—eg staffing or drugs.
— the impact of Court rulings.

We can assume that costs of the current Act will increase even though the number of patients may remain the same, because of increasing numbers of appeals to the Tribunal, and challenges under the Human Rights Act.
WORKFORCE IMPLICATIONS OF THE BILL

20. Why was the three month vacancy rate among psychiatrists at 31 March 2004 9.6% compared with a rate of 4.3% among all medical and dental staff?

RESPONSE

We have covered this in response to question 12.

21. Why has the three month vacancy rate for the psychiatry group increased from 6.7% in 1999 to 9.6% in 2004? What effect has this increase had on the service? What are the rates in Wales for the 1999–2004 period?

RESPONSE

There has been an increased demand for psychiatrists and for other staff with the increased investment in mental health services, which has resulted in an increased vacancy rate.

There has also been a major shift in the culture and pattern of service delivery, towards a person focussed and community based approach and this has presented challenges to all professional groups. Psychiatrists attended two large conferences in spring 2003 to discuss the need for change, either because they felt it was desirable or essential as their jobs, as currently defined, were undoable.

This work is supported by research undertaken by the College Research Unit of the Royal College of Psychiatrists and funded by DH that carried out an investigation into the work pressures of consultant psychiatrists and mental health social workers.

This area is being actively addressed jointly by the Royal College of Psychiatrists and NIMHE, supported by the Modernisation Agency’s Changing Workforce Programme (CWP) through a National Steering Group (NSG) on new ways of working for psychiatrists.

This has resulted in the production of an Interim Report 4 that has been produced to influence and encourage innovative and new and changing ways of practice. to encourage and support new and effective roles and to set up a process that influences change and engages professional bodies. Specifically, the Royal College guidance on job descriptions and norms is being reviewed to provide greater flexibility on how services can be effectively delivered with a variety of skill mix within the multidisciplinary team. This will provide real opportunities for other staff to extend their roles eg nurses and pharmacists around prescribing and provide creative alternatives to the use of locums. It is also anticipated that the job planning process as part of the new consultant contract will be of key importance when the process is properly embedded in trusts. The NSG guidance is being piloted in a number of sites nationally with the intention of publishing the results by way of a Final report in spring 2005.

Alongside this work on psychiatrists, the project is looking the rest of the mental health workforce to see how the principles of New Ways of Working apply and to determine what particular functions are special to any one profession or type of worker. General work carried out by the CWP, such the use of housekeepers and expanding the role of medical secretaries, are being applied in mental health settings to relieve more highly trained staff to concentrate on more complex work.

RESPONSE FROM WALES

Vacancy data in Wales has only been collected since March 2001. In March 2001 7.5% of consultant posts in the psychiatry group of specialties had been vacant for three months or more. In March 2004 the vacancy rate was 23.7%. The Annual Staff Census indicates that the number of staff in post during this time has remained consistent. As such the increase in vacancies is likely to be as a result of new posts being created. There are currently 56 SpR posts in Wales.

22. The department forecast that 800 WTE consultant psychiatrists would join the NHS between 2003 and 2008. Is this a net increase? If not, what is the expected net increase? How is the department going to achieve this target given that the number of registrars with psychiatry as a speciality fell by 1 per cent over the period 1998 to 2003? Please provide the targets for each year of the years 2003 to 2008? How many joined in 2003 and 2004? What is the target for Wales?

Response

The 800 figure is a net one.

The increase of 800 WTE is not a target, it is a projection of what we think will happen. DH does not have any targets for growth in the number of consultant psychiatrists.

In the year to September 2003 the number of consultant psychiatrists employed in the NHS increased by 250. The latest consultant figures available are from the June mini census, which showed that there were 3,483 consultants in the psychiatry group, an increase of 254 (7.9%) since September 2003.

There is a pool of doctors in the NHS in the non-consultant career grades (NCCGs) with potential to become consultants but unable to do so because of the restrictions inherent in the existing regulatory framework:

- in order to be appointed to a consultant post in the NHS, a doctor has to have his or her name included on the Specialist Register. This register lists the names of those doctors who hold the UK Certificate of Completion of Specialist Training (CCST) or, for doctors trained overseas, enter the UK already possessing qualifications considered by the Specialist Training Authority (STA) to be equivalent to a CCST. There is no provision, in law, to upgrade those not on the Specialist Register to consultant posts;
- similarly, there are doctors with skills at a level close to that of the CCST who could reach the appropriate level with “top-up” training. However, current UK legislation does not allow such training to be undertaken in the UK—doctors either need to have a CCST-equivalent qualification from overseas or need to complete a full programme of specialist training in the UK leading to the award of a CCST.

Opportunities for NCCG doctors to progress to consultant level and consequently boost the drive for greater consultant numbers will increase as a result of two initiatives:

- the establishment of the Postgraduate Medical Education and Training Board (PMETB);
- reforms proposed in the recommendations of the document Choice and Opportunity: Modernising Medical Careers for Non-Consultant Career Grade doctors.

PMETB—once the PMETB goes live in September 2005 it will be able to assess the training, qualifications and experience of doctors wherever obtained to establish if they have skills equivalent to the level of the CCST or, if not, to prescribe the training required to reach that level. In other words this will remove the legislative obstacles described above and should significantly increase opportunities for doctors “stuck” in the NCCGs.

Choice and Opportunity—this document was published for consultation in July 2003 as part of the Modernising Medical Careers initiative. It aimed to ensure that NCCG doctors were not left behind by the reforms of medical training. It set out the problems and identified the key principles for reform of the NCCGs: proper entry to, progress through and exit from a new career structure linked with opportunities for development and the chance to return to training and supported by good career advice. The Secretary of State announced on 5 May that the Government had accepted all the recommendations.

Response from Wales

As published in the Annual Staff Census data in 1998 there were 125.89 consultants in post in the psychiatry group of specialties. This had increased to 130.67 by September 2003. Wales does not have a specific staffing target for consultant Psychiatrists, although individual trusts do forecast their future consultant needs through the annual workforce planning process. Data from the 2004 Workforce planning exercise is currently being validated. There are currently 56 SpR posts in Wales in the psychiatry group of specialties.

23. Has the department reduced, or does it have plans to reduce, the time it takes before a trained psychiatrist becomes a consultant?

Response

The Department, through the Modernising Medical Careers (MMC) initiative, is taking a radical look at the way we train doctors, the speed and quality with which we do it and the end product of that process. This involves examining the opportunities for streamlining medical training and increasing flexibility in medical careers.
Specifically this means that following a two year “Foundation Programme” doctors will enter modernised training programmes for each of the different specialties including psychiatry. It is intended, where possible, these should be “run-through” programmes—ie removing the current hurdle between the SHO and SpR grades. There is scope both to remove some of the wasted time currently experienced in postgraduate medical training and to provide more focused and co-ordinated programmes that could reduce the time it takes to complete training and become eligible to apply for consultant posts.

There is much work under way in each specialty to devise the most appropriate model of training to meet the needs of the modern NHS. That is the case with psychiatry training. No decisions have be taken as yet, but there is a strong debate taking place on how to use this opportunity to deliver the best possible training for a career in psychiatry that may at the same time reduce the length of training.

24. What assessment have you made of the number of consultant psychiatrists likely to leave the speciality following the introduction of the Bill for ethical or workload reasons?

RESPONSE

We do not envisage any significant loss of consultant psychiatrists for this reason. In fact we project a steady increase in the numbers of new consultants.

25. What measures are in place to encourage recruitment of clinical mental health staff in rural areas in England and Wales?

26. How much would it cost to ensure that service users in rural areas had the same access to services provided under the draft Bill as those living in urban areas?

RESPONSE TO QUESTIONS 25 AND 26

The DH has targets for the development of new staff and services. Achievement of those targets is a local matter. The principles of flexibility and of matching plans to local circumstance are well supported by SHAs (who performance manage PCTs who in turn commission services). The SHAs, our partners in policy implementation, are able to support rural localities to plan and commission services to meet policy objectives, including the demands of the new mental health legislation.

We have recently engaged with SHAs in a process of negotiation on NHS Plan targets to support local services seeking derogation where, for example, geographical circumstances (such as rurality) make it difficult for them to conform to the targeted standard model for new teams. We have been driven in these negotiations by the importance of providing a good service to the people who need it—rather than by a slavish adherence to the model. This is consistent with the principles of StBoP and local management.

No assessment has been made about differences in access to services between rural and urban areas.

RESPONSE FROM WALES

In Wales each NHS trust has its own local recruitment and retention strategy in place that has been developed to take into account the particular needs of that individual trust. These will include demographic and geographic considerations.

Trusts workforce plans currently inform the central education and training commissioning for non medical staff. Allocations to Universities are made on a geographical basis where possible to ensure trusts’ novice requirements are met by their local education provider.

In terms of community nurses, education providers are provided with details of individual trust requirements to inform the selection of appropriate professionals to undertake this post registration training.

In terms of pre-registration training for nursing and other professions, education providers are given these details on request. However from 2005 each education provider will be given details of individual trusts requirements within their overall allocation of students. This will then support the student selection process and the allocation of student clinical placements, with the desired outcome of positive placement experiences leading to better recruitment in specific areas.

The National Service Framework for Wales for Adult Mental Health Services was published with the specific aim of setting standards for services in Wales, driving up quality and reducing unacceptable variations in health and social care provision. This sets the same standards for the whole of Wales, making no differentiation between urban and rural settings. Of the four key principles of the Adult Mental Health Strategy for Wales (the Strategy) equity is the first and this seeks to put an end to unacceptable geographical variations in the standard of care. So whilst the Strategy does not look to impose uniformity in terms of service provision, it is intended to drive up standards and provide good quality services across the board.
The Welsh Assembly Government has contracted the Audit Commission to carry out a baseline review of mental health services against these standards. They will report to the Assembly before Christmas and this will provide invaluable information about the provision of services across both rural and urban areas which will inform the programme of modernisation in terms of where the focus of activity should be.

27. What is the availability of forensic psychiatry services in England and Wales? How much would it cost to ensure that a high standard of service sufficient to meet the requirements of the draft Bill evenly across the country is put in place?

RESPONSE

Our information about current staffing and services comes primarily from the “Durham mapping project”. This is a database and routine (annual) system of inquiry into local services undertaken on our behalf by the University of Durham. It shows where teams, staff and services are located. It is designed to help local commissioners and providers to see how services are distributed in relation to their local population, and to help them be clear about where the gaps are. This database is publicly available on the internet (http://www.dur.ac.uk/service.mapping/amh/).

No assessment has been made of the cost of ensuring that all areas of the country have forensic psychiatry services which are as good as the best ones currently available.

RESPONSE FROM WALES

In Wales the commissioning of forensic services at medium secure level and above is carried out by Health Commission Wales, an executive body of the Assembly established for specialist commissioning in a number of areas of which mental health is one.

There are two NHS regional medium secure services—Ty Llewellyn in Llanfairfechan and Caswell Clinic in Bridgend. There are also two independent providers of medium security in Wales, Llanarth Court in Abergavenny and Cefn Carnau in Caerphilly. High secure facilities for Wales are provided by Ashworth Hospital for men and Rampton Hospital for women.

In Cardiff, at Whitchurch Hospital, there is a multidisciplinary forensic team providing a service for Cardiff and the Vale of Glamorgan which has access to low secure beds.

In other areas, where assessed as appropriate, the management of mentally disordered offenders is undertaken within general adult psychiatry whilst the needs for further dedicated low secure beds is currently being evaluated within each of the three NHS regions of Wales.

28. What evidence does the department have of the attractiveness to AMHPs of recruitment to Expert Panel and Mental Health Tribunals?

RESPONSE

We have drawn upon informal discussions with individual practitioners and professional staff. We are funding a survey of ASWs, to be carried out under the auspices of the Association of Directors of Social Services (ADSS), which will give a clearer picture.

29. From what sources does the department expect to recruit the 20% of AMHPs that will not be social workers? Has the department carried out an assessment of the likelihood of finding sufficient willing applicants?

RESPONSE

We should first of all point out that the anticipated 20% of AMHPs that will be nurses is not a critical figure. The important thing is to be able to recruit enough AMHPs, not the precise proportions by professional background. The growth of integrated working in community mental health teams tends to blur the demarcations between different professions where such work patterns operate, and it is from that integrated working that we would expect non-social work recruits to come. We expect some non-social workers—nurses and others—will choose to develop their careers as community mental health workers by becoming AMHPs. Clearly we will need to spell out in regulations the qualifications and training required for people to become AMHPs and determine the appropriate terms and conditions.
We have not carried out a formal assessment of the likelihood of finding sufficient willing applicants, but we will, in taking forward the legislation, be engaging with professional bodies—for example in defining the qualifications, skills and experience required of potential AMHPs.

**Mental Health Tribunals**

30. *Would the department please provide the following information in tabular form separately for England and Wales:*

   i) the number of tribunals (MHRTs and Hospital Managers’ hearings) held each year since 1983;
   ii) the number of postponed, cancelled or abortive tribunals held each year since 1983;
   iii) the WTE for each category of member of tribunals since 1983;
   iv) the average time a tribunal hearing has taken each year since 1983;
   v) the number of appeals against tribunals’ decisions since 1983; and
   vi) the vacancy rate for tribunal posts since 1983.

**Response**

We have the following information:

   i) the number of MHRT hearings since 1986 (information is not available about hospital managers’ hearings).
   ii) the number of postponed, cancelled or abortive hearings since 1986.
   iii) the WTE for each category of member of tribunals since 2001.
   iv) the average time a tribunal hearing takes—a three month pilot from July 01—Sept 01. (This information is not gathered on a regular basis.)
   v) the number of appeals against tribunals since 1986.
   vi) the vacancy rate for tribunal posts since 2001.

This is shown in the attached spreadsheet.

31. *Disregarding the costs of implementing the draft Bill, what is the department’s estimate of the level of extra resources needed to bring the current MHRT service up to an acceptable standard?*

**Response**

We are in the process of determining this. There is also a question of whether extra resources will be needed, as opposed to better use of existing resources, and to what extent investment in better systems and support would enable the tribunals to provide a better service within existing running costs.

We have already introduced changes, including the appointment of two full-time Regional Chairs, and the reduction in the number of tribunal offices from four to two in order to gain benefits from economies of scale from centralised working. We have recently recruited a new Head of the Tribunals Secretariat, who comes with highly relevant experience, having set up and run the Immigration Appellate Authority Administration in Loughborough, which has been very highly regarded.

We have also commissioned a study of the MHRT service by independent consultants. This is reviewing the current tribunal systems and processes, carrying out a simulation exercise based on the proposals in the draft Bill, and advising on the steps we need to take to improve the current service and on what the MHRT would need to do to prepare for possible implementation of the Draft Bill. The consultants will report early in the New Year.

In the light of their findings we will be taking forward work to improve efficiency and effectiveness through better processes, systems and better use of IT. This will in turn determine whether extra resources are required, and if so, what sort of resources, and over what timescale.

32. *Does the department accept the Law Society’s argument that the extended remit of Tribunals under the Bill will lead to hearings which are, on average, longer? If so, by how much?*

**Response**

It is worth noting that whilst care plans may lead to an increase in time spent, improvements in organisation, efficiency, and the better use of technology in case management and advance booking, will all drive down the total time spent, for example by reducing the numbers of adjournments and cancellations. We will be looking to use the results of the consultants’ process mapping exercise (see Q31, above) to help us to achieve these improvements. This exercise is also looking at processes under the draft Bill and we will use that work to assess the potential impact of the Bill on the duration of hearings.
33. Does the department accept that there will be a significant increase in the number of Mental Health Tribunals? By how much each year does the department expect the number to increase?

Response

Yes, we calculate that in 2003–04 there were some 23,000 Mental Health Managers’ and tribunal hearings (this figure is based on the actual number of tribunal hearings and an estimate of the number of Managers’ hearings based on a sample—because there are no formal statistical returns for this). We expect that under the Bill there will be some 42,000 tribunal hearings. We do not expect the numbers to continue to rise significantly thereafter, as we do not anticipate a significant change in the total number of compulsions. It should be noted that the increased numbers of hearings may offer some economies of scale, in that the regularity of hearings will reduce the number of “one-off” hearings at particular hospitals, and thus increase the daily rate of tribunals per member, reduce travelling times per hearing, and allow more certainty in planning members’ diaries.

34. What assessment has the department made of the extent to which existing MHRT members are likely to transfer to Mental Health Tribunals and to what extent they may choose to step down due to the increased workload or for ethical reasons?

Response

We are commissioning a study of the options for meeting the demand for extra tribunal members. That study will look at the views of those in the potential “market” for members. We have said that members who wish to transfer will be able to do so automatically. We would not seek to compel members to take on an increased workload, although it has been the case in the past that some members have greatly exceeded the notional number of sessions per year, and done so very willingly.

We do not consider that there are ethical grounds for members to be concerned. We do accept that fears and concerns have been expressed about the Bill—most particularly in this context its effect on the numbers under detention. But, as we indicated in response to Question 17 above, we believe that these concerns are not well-founded. Clearly it will be our job in the months ahead, to allay them.

35. Has the department plans to recruit full-time chairmen of Mental Health Tribunals?

Response

We are just about to commission a study (as above) which will, among other things, look at the desirability and scope for making stipendiary appointments of this sort, whether on a full- or part-time basis. We will develop our plans in the light of this study.

36. What would be the unit cost (salary, pension and support) of a full-time chairman? How much would the support services cost?

Response

This is still to be determined, but we would envisage an arrangement comparable to that for the existing MHRT Regional Chairs. We would want to assess the market and consult with the appropriate people and organisations before making a decision”.

Advocacy

37. On what basis are the department’s assumptions regarding the advocacy time required by each patient made?

Response

The assumptions were based on an assessment of the points in time when advocacy would be used. We estimated that one episode of advocacy would be used each time a person came under compulsion, one more episode in connection with each MHT hearing, and again in connection with each expert panel examination. These occasions are when key decisions about patient treatment are taken, and serve as a indication of when a patient is most likely to request the involvement of an advocate. The assumption of about two hours of advocacy time per episode was based on early thinking about what each episode of independent mental health advocacy might involve. These assumptions are being re-examined as part of a study we have commissioned from the University of Durham to prepare for the implementation of advocacy under the legislation.
Funding Implications of the Draft Bill

38. It appears that additional workforce costs under the Bill are calculated by multiplying current costs by occupation by the additional numbers of each occupation required under the Bill. But no consideration is given to the effect on wage costs of recruitment drives and attempts to improve retention. Is this assumption correct?

Response

See below

39. Does the department consider that concerted recruitment of additional mental health workforce staff and attempts to improve retention will push wages, and therefore the cost implications of the Bill, up? If not, why not? If so, by how much?

Response

We envisage that there will be only a small increase in staffing as measured against the totality of staff involved in mental health services. In response to questions 13, 22 and 23 above we have described the steps we are taking to improve recruitment and retention of professional mental health staff, and to free up professionals’ time through more efficient use of resources and new ways of working. We would expect the new staff to come from the projected increase in numbers already starting to come through the system as a result of this work.

40. Having developed scenarios of uncertainty showing the impact on workforce requirements of a 10% change in compulsions and a 25% change in average unit time, why has the department not repeated this analysis for costs? Could you supply an analysis please?

Response

We could not supply this within the timescale for responding to the Committee. We could do this by the end of January 2005, and we have commissioned this work accordingly.

41. Would the department provide a more detailed breakdown in the cost implications of the draft Bill detailing those costs relating to pay and those relating to non-pay?

Response

Non-pay costs have been calculated at 30% of pay costs for AMHPs, doctors and nurses and at 15% for advocates, MHRT office staff and Tribunal members. (The difference reflects different non-pay costs associated with the nature of their functions.)

42. Do the figures in the RIA contain any consideration of the costs associated with accommodating an expanded number of tribunal hearings? If not, please supply figures.

Response

We have assumed that tribunals will be accommodated within the meeting rooms and other accommodation already available within mental health services. We have assumed an increase in the overall number of administrative and clerical staff involved in this work, but would point out in addition that the increased number of tribunals will be offset to a significant degree by the cessation of Managers’ Hearings under the 1983 Act. Much of the additional administrative work will fall to the Tribunal Secretariat.

43. How much will the proposed changes in aftercare save?

Response

Under the Bill, people in hospital who are discharged from compulsion are eligible for free aftercare services for up to six weeks, in line with the system for free “intermediate care” services which are provided to help support people on discharge from hospital. After six weeks, people discharged from compulsory care will have access to health and local authority services in the same way as anyone else. For some local authority services there will be means testing so that people will only pay what they can afford to pay. The current arrangements do not set out a time limit for entitlement to aftercare provision.
We will shortly be commissioning some further work to estimate the aftercare costs that would arise from the proposed arrangements under the Bill, including the transitional arrangements. This work will also estimate the current costs of aftercare, so that we can estimate any savings that have been made. The analysis will also need to take into account the effect of means testing, and hence the extent of charging. We very much hope that this work will be completed before the PLS Committee reports although we will not know for certain until we have received a proposal from the contractor that we have been talking to. We will keep the Committee updated.

Jane Allberry
Mental Health Bill Manager

Annex A

2002–03 MENTAL HEALTH EXPENDITURE BREAKDOWN

<table>
<thead>
<tr>
<th>Mental Health—IP</th>
<th>Patients using a bed (including day cases)</th>
<th>Net Total (£)</th>
<th>Grossed up (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Psychiatric Specialties)</td>
<td>Net Expenditure (£)</td>
<td>PCTs</td>
<td>Trusts</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>102,376,810</td>
<td>1,176,387,039</td>
<td></td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>5,374,819</td>
<td>60,354,524</td>
<td></td>
</tr>
<tr>
<td>Forensic Psychiatry</td>
<td>–</td>
<td>402,973,578</td>
<td></td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>–</td>
<td>6,939,607</td>
<td></td>
</tr>
<tr>
<td>Old Age Psychiatry</td>
<td>66,435,766</td>
<td>591,602,865</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>174,187,395</td>
<td>2,238,257,613</td>
<td>2,412,445,008</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health—OP</th>
<th>Outpatients (including nurse clinic &amp; ward attenders)</th>
<th>Net Expenditure (£)</th>
<th>PCTs</th>
<th>Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Psychiatric Specialties)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td>21,721,588</td>
<td>340,735,119</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>14,063,029</td>
<td>114,069,198</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forensic Psychiatry</td>
<td>–</td>
<td>5,875,687</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>1,413,569</td>
<td>15,078,204</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Old Age Psychiatry</td>
<td>3,984,022</td>
<td>70,703,893</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>41,182,208</td>
<td>546,462,101</td>
<td>587,644,309</td>
<td>654,992,000</td>
</tr>
</tbody>
</table>
## Mental Health—DP

<table>
<thead>
<tr>
<th></th>
<th>Day Care Patients</th>
<th>Net Expenditure (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCTs</td>
<td>Trusts</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>413,025</td>
<td>8,673,405</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>445,221</td>
<td>9,356,574</td>
</tr>
<tr>
<td>Psychogeriatric</td>
<td>235,530</td>
<td>5,625,674</td>
</tr>
<tr>
<td>General</td>
<td>14,163,597</td>
<td>149,256,681</td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>563,131</td>
<td>17,871,500</td>
</tr>
<tr>
<td>Old Age Psychiatry (elderly mental ill)</td>
<td>9,364,322</td>
<td>92,320,225</td>
</tr>
<tr>
<td>Totals</td>
<td>25,184,826</td>
<td>343,621,000</td>
</tr>
</tbody>
</table>

## Community MI

<table>
<thead>
<tr>
<th></th>
<th>Day Care Patients</th>
<th>Net Expenditure (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCTs</td>
<td>Trusts</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>75,496,971</td>
<td>910,784,000</td>
</tr>
<tr>
<td>Grand Total</td>
<td>316,051,400</td>
<td>4,598,322,000</td>
</tr>
</tbody>
</table>

Source: DH: PFR2 and TFR2 financial returns on the analysis of the provision of healthcare functions of PCTs.

### Annex B

### GROSS EXPENDITURE ON SERVICES FOR PEOPLE WITH MENTAL ILLNESS UNDER PSS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS expenditure$^5$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total expenditure, 2002–03 prices</td>
<td>11,254</td>
<td>11,885</td>
<td>12,919</td>
<td>13,618</td>
<td>14,056</td>
<td>15,199</td>
</tr>
<tr>
<td>Expenditure on people with mental illness$^6$</td>
<td>580</td>
<td>618</td>
<td>678</td>
<td>718</td>
<td>746</td>
<td>815</td>
</tr>
<tr>
<td>percentage of total expenditure</td>
<td>5.2%</td>
<td>5.2%</td>
<td>5.3%</td>
<td>5.3%</td>
<td>5.3%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Adults$^7$</td>
<td>425</td>
<td>449</td>
<td>488</td>
<td>514</td>
<td>523</td>
<td>580</td>
</tr>
<tr>
<td>Assessment and care management$^3$</td>
<td>155</td>
<td>169</td>
<td>191</td>
<td>204</td>
<td>223</td>
<td>235</td>
</tr>
</tbody>
</table>

---

$^5$ Adjusted to 2002–03 prices using GDP deflator.

$^6$ Includes administrative and clerical overheads.

$^7$ Adults aged 16–64. Excludes expenditure on mental health provision for children which cannot be separately identified.
### Annex C

#### EXPENDITURE IN WALES

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Health Authorities £000</th>
<th>Local Authorities £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003–04</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2002–03</td>
<td>276,538</td>
<td>39,065</td>
</tr>
<tr>
<td>2001–02</td>
<td>250,807</td>
<td>32,245</td>
</tr>
<tr>
<td>2000–01</td>
<td>220,677</td>
<td>31,670</td>
</tr>
<tr>
<td>1999–00</td>
<td>204,719</td>
<td>28,728</td>
</tr>
<tr>
<td>1998–99</td>
<td>196,649</td>
<td>29,393</td>
</tr>
</tbody>
</table>

In addition other funding is available centrally from the Welsh Assembly Government to support and improve service delivery which is summarised below.

<table>
<thead>
<tr>
<th>Assembly Fund</th>
<th>2003–04 £000</th>
<th>2002–03 £000</th>
<th>2001–02 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Modernisation</td>
<td>24,266</td>
<td>19,890</td>
<td>NA</td>
</tr>
<tr>
<td>Health Commission Wales</td>
<td>33,000</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Supporting People Revenue Grant</td>
<td>8,000</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Mental Health policy</td>
<td>4,021</td>
<td>4,664</td>
<td>6,655</td>
</tr>
<tr>
<td>Social Care Policy</td>
<td>4,700</td>
<td>4,303</td>
<td>4,104</td>
</tr>
<tr>
<td>Health Inequalities</td>
<td>1,645</td>
<td>783</td>
<td>NA</td>
</tr>
<tr>
<td>Flexibilities, Special Grant Scheme</td>
<td>2,062</td>
<td>400</td>
<td>110</td>
</tr>
</tbody>
</table>

### Annex D

#### GROWTH IN THE MENTAL HEALTH WORKFORCE

<table>
<thead>
<tr>
<th>England</th>
<th>numbers (headcount) and percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1999</td>
</tr>
<tr>
<td>All psychiatry consultants</td>
<td>2,808</td>
</tr>
<tr>
<td>General Psychiatrists</td>
<td>1,569</td>
</tr>
<tr>
<td>Child and adolescent psychiatry</td>
<td>486</td>
</tr>
<tr>
<td>Forensic psychiatry</td>
<td>152</td>
</tr>
<tr>
<td>Leaning disabilities</td>
<td>181</td>
</tr>
<tr>
<td>Old age psychiatry</td>
<td>311</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>109</td>
</tr>
<tr>
<td>Non-Medical Staff Nurses (all psychiatry)</td>
<td>38,999</td>
</tr>
<tr>
<td>Clinical psychology</td>
<td>4,572</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>574</td>
</tr>
<tr>
<td>Art/music/drama therapy</td>
<td>646</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>12,663</td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
</tr>
</tbody>
</table>
England

<table>
<thead>
<tr>
<th></th>
<th>whole time equivalents and percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1999</td>
</tr>
<tr>
<td>All psychiatry consultants</td>
<td>2,524</td>
</tr>
<tr>
<td>General Psychiatrists</td>
<td>1,418</td>
</tr>
<tr>
<td>Child and adolescent psychiatry</td>
<td>422</td>
</tr>
<tr>
<td>Forensic psychiatry</td>
<td>141</td>
</tr>
<tr>
<td>Leaning disabilities</td>
<td>168</td>
</tr>
<tr>
<td>Old age psychiatry</td>
<td>290</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>85</td>
</tr>
<tr>
<td>Non-Medical Staff Nurses (all psychiatry)</td>
<td>34,974</td>
</tr>
<tr>
<td>Clinical psychology</td>
<td>3,763</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>365</td>
</tr>
<tr>
<td>Art/music/drama therapy</td>
<td>416</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>10,792</td>
</tr>
<tr>
<td>Social Worker</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Department of Health medical and dental workforce census. Department of Health non-medical workforce census

Notes:

(1) June 2004 data is taken from the medical and dental workforce mini census which collected consultants only. Non medical data is as at September 2003.

Annex E

RECOMMENDATIONS TO INCREASE RECRUITMENT OF AND THE OVERALL NUMBERS OF CONSULTANT PSYCHIATRISTS AND TO IMPROVE THEIR RETENTION

RECOMMENDATIONS FOR THE DEPARTMENT OF HEALTH

<table>
<thead>
<tr>
<th>Serial</th>
<th>Recommendation</th>
<th>Present position</th>
<th>Timing</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ensure experience of psychiatry in proposed foundation SHO year and to lobby to increase the number of SHO posts in psychiatry (National Director)</td>
<td>Deputy ND has spoken to Terri Hobbs at Modernising Medical Careers who will come back to him</td>
<td></td>
<td>Gateway number 3068 Launched at IW conference for doctors Highlighted in the December 2004 edition of the new NHS Workforce Bulletin Guidance available at <a href="http://www.dh.gov.uk">www.dh.gov.uk</a> [&quot;mentoring&quot; in the search box]</td>
</tr>
<tr>
<td>2</td>
<td>On behalf of the Doctor’s Forum, identifying current mentoring scheme and preparing guidance for services under the Improving Lives initiative. To disseminate this widely.</td>
<td>Guidance now published “Mentoring for doctors: Signposts to current practice for career grade doctors” September 2004 6 December 2004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serial</td>
<td>Recommendation</td>
<td>Present position</td>
<td>Timing</td>
<td>Remarks</td>
</tr>
<tr>
<td>--------</td>
<td>----------------</td>
<td>------------------</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>3</td>
<td>To act following the consultation of Choice and Opportunity to ease career progression for NCCGs</td>
<td>Ministers have accepted the proposals set out in the consultation exercise</td>
<td>Work taking place now to see the effect the proposals will have on pay. Detailed work yet to start on establishing the process for recognition of experience to count toward qualification to become a consultant. In addition, DH has developed the New Consultant Entry Scheme. The scheme offers NCCGs on the Specialist Register an opportunity to sample working in a consultant post for six months. On successful completion, the doctor has the option to apply for a substantive consultant post in open competition. The scheme was developed to support specialist registrars and NCCGs making the transition to consultant grade as well as to speed up the take up of consultant posts after qualifying.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Disseminate details on good practice in available support for doctors with mental health problems</td>
<td>Working Group having regular meetings—last one on 14 October</td>
<td>Looking to produce best practice report in early 2005</td>
<td>ND in lead supported by Sian Rees</td>
</tr>
<tr>
<td>5</td>
<td>To prepare and make available a further report on induction for international recruits</td>
<td>The DH International Recruitment Team have produced best practice guidance “Guidelines for NHS Employers: Induction Programmes for Consultants and GPs recruited from Abroad.</td>
<td>22 November 2004</td>
<td>Gateway number 3476 Induction, mentoring and CPD are mainly the responsibility of the employing trust with support of the WDD.</td>
</tr>
</tbody>
</table>

Notes:

Bold types represents completed action.

Deputy ND has drawn the attention of the MH Policy Committee of the NHS Confederation to these recommendations (October 2004).

16 December 2004
## Mental health services for people of working age

### NATIONAL WORKFORCE TARGETS

Set out below are the National Workforce Targets for 2003–06 for implementation as part of Local Delivery Plans. Chief Executives of PCTs; specialist MHTs; Personal Social Services Departments (PSS); and Workforce Development Confederations are responsible for meeting these targets.

**By (December) 2004**

<table>
<thead>
<tr>
<th>Teams and Places</th>
<th>Current Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>335 crisis resolution teams</td>
<td>179 in place in March 2004</td>
</tr>
<tr>
<td>50 additional Assertive Outreach (AO) teams</td>
<td>271 AO teams in place in March 2004 so this target has been met.</td>
</tr>
<tr>
<td>50 early intervention teams</td>
<td>41 in place in March 2004</td>
</tr>
<tr>
<td>140 new secure personality disorder places</td>
<td>The DSPD Unit in Rampton Hospital is in operation. The 70-bed unit in Broadmoor is expected to admit its first patient in July 2005.</td>
</tr>
</tbody>
</table>

**By (December) 2004**

<table>
<thead>
<tr>
<th>New Workers</th>
<th>Current Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,000 new graduate workers in primary care</td>
<td>Data will be available when the Durham Adult Mental Health Service Mapping is finalised in May 2005.</td>
</tr>
<tr>
<td>500 community mental health “gateway” workers</td>
<td>Data will be available when the Durham Adult Mental Health Service Mapping is finalised in May 2005.</td>
</tr>
<tr>
<td>700 more staff to support carers</td>
<td>Data will be available when the Durham Adult Mental Health Service Mapping is finalised in May 2005.</td>
</tr>
<tr>
<td>300 additional prison in-reach staff to ensure prisoners with severe mental health problems have an appropriate care plans and care co-ordinator on release</td>
<td>We will meet the NHS Plan target of 300 extra staff by March this year.</td>
</tr>
<tr>
<td>400 staff to support secure step-down</td>
<td>Information will be available in the New Year.</td>
</tr>
</tbody>
</table>

**By (December) 2006**

<table>
<thead>
<tr>
<th>New Workers and Teams</th>
<th>Current Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>300 more prison in-reach staff</td>
<td>We are confident we will meet this target as we now have an infrastructure in place for commissioning, recruiting staff and monitoring</td>
</tr>
<tr>
<td>500 Community Development Workers (CDWs) for black and minority ethnic communities 200 staff and six outreach teams for personality disorder</td>
<td>Discussions have begun with SHAs about their role in supporting the recruitment of CDWs. Four outreach teams already in place. The remainder of the teams and staff will be in place by December 2006.</td>
</tr>
<tr>
<td>3000 Support, Time and Recovery (STR) workers</td>
<td>The STR Accelerated Development Programme is scheduled to deliver 3,000 STR workers by December 2006.</td>
</tr>
</tbody>
</table>
Annex G

Workforce design and development

(MENTAL HEALTH SERVICES FOR PEOPLE OF WORKING AGE)

LEVELS OF RESPONSIBILITY

As you may know, the National Workforce Programme (NWP) of NIMHE has set up a Workforce Planning Pilot Programme to help test and support the Workforce Design and Development Best Practice Guidance published in March 2003. Outline details of the Programme are contained in the fifth NWP newsletter “Workforce”, copies of which are obtainable from john.allcock@dh.gsi.gov.uk and the Knowledge Community.

One of the developments in the Programme has been the call for a note that sets out the responsibilities for workforce design and development at the various levels in the process over and above what is contained in the Best Practice Guidance.

I attach the latest version of the note which is laid out in the form of a hierarchy and, in bullet point format, describes what the responsibilities are at each stage in the process. This needs to be read in conjunction with the Best Practice Guidance.

The note can be used by each of the stakeholders, as a form of aide memoire to remind them what needs to be done or put in place for the successful implementation and on-going support of a joint Workforce Plan across agencies.

If the process of developing a joint Workforce Plan is to succeed, there are two key things that need to be in place. They are a sense of ownership and commitment to the process by all the stakeholders and the provision of some dedicated resources to undertake and sustain the process.

I hope you find the note helpful and would welcome any feedback. These should be sent to John Allcock.

Roslyn Hope
Director
National Workforce Programme

Workforce design and development (WD&D)

(MENTAL HEALTH SERVICES FOR PEOPLE OF WORKING AGE)

LEVELS OF RESPONSIBILITY

SERVICE/FRONT LINE MANAGERS

— have a sense of ownership (at the micro level);
— have basic Human Resources competencies (eg potential career development skills and linking staffing profiles to Workforce Design and Development);
— feed intelligence upwards via line management thus feeding into the Local Delivery Plan (LDP) process;
— identify current and future hotspots— suggest potential solutions (eg reviewing skill mix);
— identify skills gaps using Ten Essential Shared Capabilities and the Knowledge and Skills Framework/National Occupational Standards.

LOCAL IMPLEMENTATION TEAMS

— have a sense of ownership (at the co-ordinating level);
— identify current and future trends and hotspots;
— co-ordinate local intelligence and potential solutions;
— feed intelligence through to the LDP process;
— co-ordinate and contribute to the development of Strategic Service and Joint Workforce Plans.

PRIMARY CARE AND MENTAL HEALTH TRUSTS

— have a sense of ownership (at Board, Chief Executive and the operational level);
— have a sense of commitment to work closely with other agencies/stakeholders;
— to provide the necessary dedicated resources to undertake workforce design and development;
— collect and analyse staff data on numbers/types/ages/gender/ethnicity to identify past and likely future trends and action required and to include new types of workers in this process;
— identify local labour markets and action required;
— identify local employment opportunities ie who are their competitors and for what type or level of employment;
— identify local housing developments (potential staff recruitment and increasing workload);
— identify local educational developments (eg a new sixth form college);
— identify emerging pressures (eg prison in-reach services, new forensic facilities etc);
— ensure consistent Recruitment, Retention and Returner’s approach across the trust eg between Working Age Adult/Older People/Child and Adolescent Mental Health Services and social services (to prevent poaching, best use of resources);
— link to future education and training requirements and skills developments;
— feed through to the LDP process;
— feed through to the development of the Local Strategic Partnerships;
— develop a clear project plan setting out the steps required to develop a . . .
— workforce plan setting out what is to be achieved; by when to include priorities; who is responsible; resources and support required mapped to local needs and national workforce/team targets; and links to other agencies/stakeholders.

LOCAL AUTHORITIES (LAs)
— have a sense of ownership of the mental health social care workforce;
— to link the social care workforce initiatives with the mental health priorities as part of the Local Strategic Partnership;
— provide access to staff data (eg numbers, types, ages, ethnicity, gender etc) on social care staff to trusts.

STRATEGIC HEALTH AUTHORITIES/WORKFORCE DEVELOPMENT CONFEDERATIONS (WDCs)
— have a sense of ownership (at the strategic or regional level);
— work with local health and social care systems to develop Strategic Service and Joint Workforce Plans and monitor these;
— identify current and future economic growth across the patch;
— to undertake a labour market survey;
— identify future supply factors at a strategic or regional level eg infrastructure changes such as new transport links (easier for people to travel into [or out!] of locality);
— identify future business environment eg large companies moving into area;
— analysis of census data to map changes between 1991 and 2001;
— collate and analyse population, demographic, morbidity and socio-economic data to include deprivation;
— help with and co-ordinate international recruitment;
— analyse entry into and attrition from education and training;
— work with local stakeholders to develop a meaningful, consistent and common set of staffing codes across agencies;
— work with education and service providers to improve relevance and quality of education and training.

NIMHE DEVELOPMENT CENTRES
— have a sense of ownership (at the Organisational Development level);
— provide facilitation to encourage local ownership and common sense of direction with all stakeholders across the statutory (NHS and LA) and non-statutory (private, voluntary and independent) commissioners and providers of services which is mental health specific [WDC work will be across all client groups, not just mental health];
— help with the introduction of new workers into the mental health workforce eg Support, Time and Recovery, Primary Care Graduate Workers, Gateway etc;
— help with the introduction of new ways of working for professional staff;
— help to identify and share good practice/documentation/process;
— facilitate problem solving across the “region”;
Workforce Planning

INTRODUCTION

1. Set out below are a number of points that local Workforce Planning Teams may wish to consider as part of their Workforce Planning process. None of this is rocket science but examples of innovative practice and tips picked up from localities. There is no sense of prioritisation or “ranking” in the examples given.

RECRUITMENT

Black and Minority Ethnic communities

2.1 Do you know how many of your staff are from Black and Minority Ethnic (BME) communities? What is their ethnic, age, gender breakdown? Are they spread equally across the trust sites? Are the majority (or all) in junior to middle ranking posts/grades? eg do you need to initiate a potential leadership or senior management programme? Are your BME staff not well represented in any one type of employment? So what can be done to encourage recruitment into these jobs? Do you know what the barriers are to recruitment? Does the individual ethnic and total breakdowns represent the make up of your local communities? What specific action have you taken to “target” the recruitment of staff from BME communities? Are there any local champions who might help you? eg church, community leaders or schools.

Local housing developments

2.2 Do you know what is planned for your local community—town—city and what does this mean for the local morbidity and need for more staff? eg one area has become aware of a huge new housing estate to be built aimed at both starter homes and homes for young families with several thousand new residents coming to live in the locality. This will almost certainly increase the morbidity of post natal depression so what will the extra pressure be on general practice? What type of extra staff will they need and by when?

Census data

2.3 Do you know what the 2001 census data is telling you for your patch compared to the 1991 data? What shifts in the population have occurred? eg in London, there has been a substantial increase in the BME community. In the Midlands, some of the large cities have had a significant reduction in population numbers.

Children

2.4 Did you know that by the age of 9 to 10, most children had already discarded a large proportion of possible employment opportunities? So what action do you propose to engage with school children regarding possible employment in NHS and social care services? (ie don’t leave all your schools recruitment until the GCSE stage—by then it will be too late for many).

Primary Care Graduate Workers (PCGWs)

2.5 How many people applied to become PCGWs? The clear message is that there was considerable over-subscription for the posts but what has happened to those who were not successful? A number of localities we have spoken to did not do anything with the unsuccessful candidates and yet these people have clearly shown an interest in working in mental health services. It seems a waste to simply turn them away. Do you still have their contact details? Why not ask them if they might want to work elsewhere in the trust and perhaps start a different career?

RETENTION

Local environment

3.1.1 When one MHT in London undertook a workforce survey, they recognised for the first time that whilst they had no specific problem recruiting staff, in one particular locality, the retention of staff was poor especially during the winter months. Basically it had nothing to do with the trust or staff not wanting to work for the NHS, rather it was an environmental problem.

3.1.2 In a nutshell, the local area around the hospital site was simply appalling which seemed worse during the dark winter months. The immediate area around the hospital exit was poorly lit; there was graffiti on the walls and rubbish was strewn about; the pavements were not maintained properly; some of the local shops and houses were either boarded up or were in a state of disrepair/decoration; the buses only ran once
an hour after 4.00pm if at all with the bus shelters vandalised. And there were even burnt out cars in the street. In addition, there seemed to be no security—one never saw a police officer for example. Female staff felt especially vulnerable and it was no wonder they decided they could not run the risk of being out in that environment either late at night or in the dark afternoons or evenings in the winter. This was the major contributor to poor staff retention but none of this was actually the direct responsibility of the NHS. What could be done?

3.1.3 The trust Chief Executive did a number of things. First, he worked with the local community, shopkeepers and staff/unions to form an Action Group. After the local community and shopkeepers cleaned up their own premises to set an example which also improved trade, together they tackled the local authority to get the immediate streets cleared of the rubbish, graffiti and cars removed; the street lighting improved and the pavements repaired. In addition, they lobbied the local bus company not only to make the buses more reliable but also to put on extra buses after 4.00pm so staff would not have to wait too long. And electronic screens were installed in the repaired bus shelters so passengers would know when the next bus was due thus removing their uncertainty. Security wise, the local police superintendent was most cooperative and agreed to make the police presence more visible, particularly at times when staff felt most unsafe. And the hospital security staff agreed to walk out of the hospital main exit at varying times and walk down to the main bus shelter, staying for a short while, simply so as to give the impression of a secure environment. (There was no suggestion they be asked to act as some form of vigilante force—it was more a matter of appearance or deterrence.)

3.1.4 This combination of measures, together with local support and goodwill where people and organisations were looking for some form of leadership, made the staff appreciate what their employer was doing on their behalf and with a better and safer environment, the loss of key staff was reduced and helped to contribute to improved retention in the trust.

Staff age breakdown

3.2 How many of your staff are in the 50-55 and 56-60 age brackets? Where are they located in the trust patch? What types of staff are they? eg are the majority in nursing. What are their intentions regarding retirement? What might tempt them to stay full time? What arrangements might you make to retain them as part-time or job-share staff? How would their existing teams cope either without them or under any part-time/job-share arrangements? What are you planning to do now for the forthcoming bulge?

Mental health officer status

3.3 Do you know how many of your staff retain Mental Health Officer status and so are able to retire early? Who are they? Are they concentrated in one part of your services? Have you asked them what their plans are? What proportion of the total staff do they represent both across the whole of your organisation or in the localities they are working in?

Local authority staff

3.3.1 It is often said that for a variety of reasons, it is very difficult to collect staff data in respect of those who work for the Personal Social Service—the local authority. It is not the aim of this note to say how this might be done, rather it suggests starting small with mapping a key group of staff. These are the Approved Social Workers (ASW) under the Mental Health (MH) Act.

3.3.2 Given their key role, it is vital that localities have a handle on their ASW numbers and their know of their intentions should the proposals under the MH Bill come into effect. This is because the current role of the ASW will no longer be the sole preserve of social workers but be undertaken by an Approved Mental Health Professional (AMHP). ie it could be a social worker but equally, it could be a nurse if they have undertaken the appropriate training. One possibility being mooted is that some ASWs are saying that should the MH Bill become law, they will no longer carry out the ASW role and simply revert to being an “ordinary” social worker. If this were to happen in sufficient numbers, the effect could be quite dramatic and plans to tackle this “worst case scenario” need to be put in place now.

3.3.3 Given this possibility, even if the local Workforce Planning Group (WPG) does not currently know details of the wider Personal Social Service—the local authority staffing data, it is important to start soon with the ASWs. Some of the questions a WPG may wish to consider asking are how many are there? What areas or teams do they serve? What is their age, gender and ethnic breakdown? What languages do they speak? What skills do they possess and what development needs do they have? How can these be met? How long have they been qualified? What has been the recent trend in terms of qualification, recruitment, retention and retirement? Where does the existing education and training take place? Is it geared up to undertake the education and training of AMHPs? Would any ASWs who have recently left be willing to return on a part-time or job-share basis? What is the current vacancy situation? Where are the vacancies and how long have they been unfilled? What do the current ASWs intend to do should the MH Bill becomes law?
Sick and absent staff

3.4.1 What is the sick and absence rate of staff in your trust? Is it too high? What is the “cost” of providing cover? Does this effect one type of staff more than any other? Is it higher in any one or more service setting or geographical locality? Does it happen more often at one time in the year? eg when particular sports events occur. What is the Trade Union view? Have you thought about introducing a system where on return to work, each member of staff is interviewed by their line manager and asked about their time away from work? The aim is to allow managers to be satisfied that the absence was genuine. This process has helped reduce staff absence in some parts of the private sector.

RETURNERS

Keep In Touch scheme

4.1 Does the trust have a KIT (Keep In Touch) policy and process whereby when staff leave, the trust keeps in touch with them? eg by checking their address at least yearly, sending them the staff newsletters or other publications, having annual “job fairs” to which they are regularly invited etc.

SUMMARY

5. This is not intended to an exhaustive list of things to consider but it does give some ideas as “a starter for ten”. A key initiative is the “Improving Working Lives” programme but that is not just about the NHS. Its’ principles and sound advice apply equally to the social care sector, both statutory and non-statutory as well as the private, independent and voluntary sectors.

NIMHE
Workforce Planning Pilot Programme
July 2004

Annex I

Choosing to Work in Mental Health: The Recruitment of Health and Social Care Professionals

AN EXTRACT

MENTAL HEALTH NURSING
— There are problems of recruiting onto mental health nursing courses at both diploma and undergraduate level. These problems are worse in some parts of England than others.
— It is not simply a question of attracting sufficient numbers of students however, as there are concerns regarding the calibre and suitability of some students that are currently being accepted onto courses

RECOMMENDATION
— Mental health nursing needs to shed its “institutional, middle-aged” image, and to be marketed as a “non-institutional, autonomous, varied and dynamic occupation”.

PSYCHIATRY
— The number of medical students entering psychiatry has always been relatively low, although there are marked variations between medical schools. Experience in the field seems to be the most critical factor in encouraging recruits to the profession.
— Charismatic teachers and high quality teaching are also important, as are certain personality traits.
— Reasons for not wanting to do psychiatry include a belief that it is unscientific and ineffective.
— There is evidence that devaluing and stigmatisation by peers may have a negative impact on recruitment.
— The Royal College of Psychiatry Working Party on Recruitment and Retention has suggested a number of strategies to address the problem of recruitment and retention in psychiatry, at a number of key points during a doctor’s career.

December 2004
### MENTAL HEALTH REVIEW TRIBUNAL
### APPLICATIONS AND HEARINGS (1986–2004)

<table>
<thead>
<tr>
<th>Year</th>
<th>Applications</th>
<th>Hearings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>5,046</td>
<td>2,972</td>
</tr>
<tr>
<td>1987</td>
<td>5,283</td>
<td>3,101</td>
</tr>
<tr>
<td>1988</td>
<td>5,836</td>
<td>3,330</td>
</tr>
<tr>
<td>1989</td>
<td>6,697</td>
<td>3,913</td>
</tr>
<tr>
<td>1990</td>
<td>7,650</td>
<td>4,570</td>
</tr>
<tr>
<td>1991</td>
<td>8,473</td>
<td>4,908</td>
</tr>
<tr>
<td>1992</td>
<td>9,475</td>
<td>5,108</td>
</tr>
<tr>
<td>1993</td>
<td>10,705</td>
<td>6,047</td>
</tr>
<tr>
<td>1994</td>
<td>12,247</td>
<td>6,763</td>
</tr>
<tr>
<td>1995</td>
<td>13,390</td>
<td>7,210</td>
</tr>
<tr>
<td>1996</td>
<td>14,913</td>
<td>7,575</td>
</tr>
<tr>
<td>1997</td>
<td>15,687</td>
<td>7,864</td>
</tr>
<tr>
<td>1998</td>
<td>18,503</td>
<td>9,057</td>
</tr>
<tr>
<td>1999</td>
<td>19,709</td>
<td>10,989</td>
</tr>
<tr>
<td>2000</td>
<td>20,421</td>
<td>11,535</td>
</tr>
<tr>
<td>2001</td>
<td>20,368</td>
<td>11,580</td>
</tr>
<tr>
<td>2002</td>
<td>20,980</td>
<td>9,999</td>
</tr>
<tr>
<td>2003</td>
<td>21,634</td>
<td>11,753</td>
</tr>
<tr>
<td>2004</td>
<td>21,647</td>
<td>12,735</td>
</tr>
</tbody>
</table>

*Note:* The projected total is calculated as follows:
Totals from January to November 2004
This total is divided by 11 to find the “average” figure for one calendar month and used for December’s figures
These two amounts added together gives the projected figure for 2004.
The number of Postponed Tribunals since 1986

MENTAL HEALTH REVIEW TRIBUNAL

<table>
<thead>
<tr>
<th>Year</th>
<th>Postponed Tribunals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>2,074</td>
</tr>
<tr>
<td>1987</td>
<td>2,182</td>
</tr>
<tr>
<td>1988</td>
<td>2,506</td>
</tr>
<tr>
<td>1989</td>
<td>2,784</td>
</tr>
<tr>
<td>1990</td>
<td>3,080</td>
</tr>
<tr>
<td>1991</td>
<td>3,565</td>
</tr>
<tr>
<td>1992</td>
<td>4,367</td>
</tr>
<tr>
<td>1993</td>
<td>4,658</td>
</tr>
<tr>
<td>1994</td>
<td>5,484</td>
</tr>
<tr>
<td>1995</td>
<td>6,180</td>
</tr>
<tr>
<td>1996</td>
<td>7,338</td>
</tr>
<tr>
<td>1997</td>
<td>7,823</td>
</tr>
<tr>
<td>1998</td>
<td>9,446</td>
</tr>
<tr>
<td>1999</td>
<td>8,720</td>
</tr>
<tr>
<td>2000</td>
<td>8,886</td>
</tr>
<tr>
<td>2001</td>
<td>8,788</td>
</tr>
<tr>
<td>2002</td>
<td>10,981</td>
</tr>
<tr>
<td>2003</td>
<td>9,881</td>
</tr>
<tr>
<td>2004</td>
<td>8,912 (projected total)</td>
</tr>
</tbody>
</table>

Postponed/Cancelled/Abortive means “Did not reach a hearing”.

Note: The projected total is calculated as follows:
Total postponements from January to November 2004
This total is divided by 11 to find the “average” figure for one calendar month and used for December’s postponements
These two amounts added together gives the projected figure for 2004.
Vacancy rates for MHRT Members since 2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Legal</th>
<th>Medical</th>
<th>Lay</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>22%</td>
<td>68%</td>
<td>31%</td>
</tr>
<tr>
<td>2002</td>
<td>19%</td>
<td>68%</td>
<td>40%</td>
</tr>
<tr>
<td>2003</td>
<td>7%</td>
<td>47%</td>
<td>0%</td>
</tr>
<tr>
<td>2004</td>
<td>0%</td>
<td>4%</td>
<td>0%</td>
</tr>
</tbody>
</table>

MHRT Membership vacancies since 2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Legal</th>
<th>Medical</th>
<th>Lay</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>45</td>
<td>125</td>
<td>65</td>
</tr>
<tr>
<td>2002</td>
<td>54</td>
<td>130</td>
<td>94</td>
</tr>
<tr>
<td>2003</td>
<td>27</td>
<td>110</td>
<td>0</td>
</tr>
<tr>
<td>2004</td>
<td>0</td>
<td>12</td>
<td>0</td>
</tr>
</tbody>
</table>

Membership of the Mental Health Review Tribunal

<table>
<thead>
<tr>
<th>Year</th>
<th>Legal</th>
<th>Medical</th>
<th>Lay</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>202</td>
<td>183</td>
<td>207</td>
</tr>
<tr>
<td>2002</td>
<td>288</td>
<td>190</td>
<td>237</td>
</tr>
<tr>
<td>2003</td>
<td>412</td>
<td>234</td>
<td>297</td>
</tr>
<tr>
<td>2004</td>
<td>478</td>
<td>310</td>
<td>284</td>
</tr>
</tbody>
</table>

Vacancies

<table>
<thead>
<tr>
<th>Year</th>
<th>Legal</th>
<th>Medical</th>
<th>Lay</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>45</td>
<td>125</td>
<td>65</td>
</tr>
<tr>
<td>2002</td>
<td>54</td>
<td>130</td>
<td>94</td>
</tr>
<tr>
<td>2003</td>
<td>27</td>
<td>110</td>
<td>0</td>
</tr>
<tr>
<td>2004</td>
<td>0</td>
<td>12</td>
<td>0</td>
</tr>
</tbody>
</table>
MHRT GROWTH OF MEMBERSHIP

<table>
<thead>
<tr>
<th>Year</th>
<th>Legal</th>
<th>Medical</th>
<th>Lay</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>202</td>
<td>183</td>
<td>207</td>
</tr>
<tr>
<td>2002</td>
<td>288</td>
<td>190</td>
<td>237</td>
</tr>
<tr>
<td>2003</td>
<td>412</td>
<td>234</td>
<td>297</td>
</tr>
<tr>
<td>2004</td>
<td>478</td>
<td>310</td>
<td>264</td>
</tr>
</tbody>
</table>

Growth in MHRT Membership 2001-2004

AVERAGE HEARING TIMES FOR MENTAL HEALTH REVIEW TRIBUNALS

<table>
<thead>
<tr>
<th></th>
<th>Jul-01</th>
<th>Aug-01</th>
<th>Sep-01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canon’s Park</td>
<td>1 hr 29</td>
<td>1 hr 51</td>
<td>1 hr 23</td>
</tr>
<tr>
<td>Hinchley</td>
<td>2 hr 04</td>
<td>1 hr 50</td>
<td>1 hr 58</td>
</tr>
<tr>
<td>Wood</td>
<td>1 hr 39</td>
<td>1 hr 31</td>
<td>1 hr 39</td>
</tr>
<tr>
<td>Liverpool</td>
<td>1 hr 35</td>
<td>1 hr 31</td>
<td>1 hr 15</td>
</tr>
<tr>
<td>Nottingham</td>
<td>1 hr 42</td>
<td>1 hr 41</td>
<td>1 hr 34</td>
</tr>
</tbody>
</table>

Please note that these figures are from a three month pilot and that average hearing times were not collected after this was completed.

January 2004

Further memorandum from Ms Rosie Winterson MP, Minister of State, Department of Health (DMH 405)

INTERFACE BETWEEN THE DRAFT MENTAL HEALTH BILL AND THE MENTAL CAPACITY BILL

Thank you for your joint letter of 18 November about the interface between the draft Mental Health Bill and the Mental Capacity Bill.

You asked, in particular, for an indication of our plans for responding to the decision of the European Court of Human Rights in the Bournewood case (HL v UK). But I thought it might also assist you if I were to say something about the interface between the Bills more generally.

THE INTERFACE BETWEEN THE TWO BILLS

For the most part, the interface between the two Bills is clear, not least because they serve very different purposes. The Mental Health Bill deals primarily with the relatively small number of people for whom compulsory treatment for serious mental disorder is necessary (whether or not they have capacity to consent) to protect them or others from harm. The Mental Capacity Bill, by contrast, covers very many more circumstances and very many more people. It is about empowering people to make as many decisions as they can, and clarifying the law surrounding actions and decisions which are done or taken on their behalf.
But clearly there is a group of patients who need treatment for mental disorder and who lack the capacity to consent to it, for whom the interface between the two Bills is potentially important.

Those patients will almost inevitably be touched by the provisions Mental Capacity Bill in some way, whether or not they are also touched by the Mental Health Bill. They may have appointed a donee of lasting power of attorney to take decisions on their behalf, or the Court of Protection may have appointed a deputy to do so.

If not, then it is likely that various decisions about their day to day care and treatment will be being taken by their family, friends or professional carers in their best interests in accordance with the Mental Capacity Bill.

It is only in relation to treatment for serious mental disorder that the question of the Mental Health Bill arises.

Section 131 of the current Mental Health Act 1983 specifically preserved the right to admit patients who require treatment for mental disorder to hospital, without formally detaining them. Established practice has been that incapacitated patients who need hospital treatment for mental disorder and who are compliant with treatment, are not normally detained under the Act.

The Code of Practice for the 1983 Act says

“If at the time of admission, the patient is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal . . . The decision to admit a mentally incapacitated patient informally should be made by the doctor in charge of the patient’s treatment in accordance with what is in the patient’s best interest and is justifiable on the basis of the common law doctrine of necessity.” [2.8]

This puts compliant, incapacitated patients in broadly the same position as patients who have capacity to consent to admission and who do so.

Where incapacitated patients resist admission to hospital for treatment for mental disorder and the grounds for detention under the Mental Health Act are met, then they are normally admitted formally under the Act. This puts them, in e

This differs from the approach taken in the 2002 draft of the Mental Health Bill, which attempted to establish (in clause 121) that informal treatment for serious mental disorder would never be available for incapacitated patients in certain circumstances. Where patients lacked capacity to consent to treatment, and either resisted treatment or were at substantial risk of suicide or causing serious harm to other persons, they could only be treated if they were subject to compulsion under the Mental Health Bill. Patients would have been considered to be “resisting” treatment if they had at any time indicated that they did not want to receive treatment (or a particular treatment) for mental disorder.

We did not include an equivalent to clause 121 in the new draft Mental Health Bill. In part, this was because things had moved on. We now had a Mental Capacity Bill, so the choice was no longer between compulsory treatment under mental health powers and informal treatment under the common law doctrine of necessity, but rather between compulsory treatment and informal in accordance with the much more explicit framework of mental capacity legislation.
But more importantly it is because, on reflection, we recognise that the old clause 121 always suffered from the problem of inflexibility. Even minor, occasional or isolated acts of resistance (which would not justify compulsory treatment of a patient with capacity to consent) could have prevented clinicians either considering or continuing informal treatment. That would have been true even if the patient was compliant most of the time and the clinicians and the patient’s family and friends were all agreed that informal treatment was to be preferred or the patient had previously expressed a strong preference for informal treatment.

It is to avoid such inflexibility that we want to preserve discretion for professionals to decide when compulsory treatment under the Mental Health Bill is to be preferred to treatment in a patient’s best interests under the Mental Capacity Bill. That might be, for example, where a patient’s temporary resistance to treatment is not thought to relate primarily to the treatment itself but to other factors, such as anxiety about being an unfamiliar situation.

We intend to use the Codes of Practice for the two Bills to guide decision-makers normally to use formal mental health powers where treatment needs to be given against patients' objections (and the other conditions are met.) But we do not want to create a rigid dividing line. Patients’ circumstances differ so greatly, we are wary of legislation that assumes that they can be neatly divided into those who comply and those who resist. To that extent, we doubt that the “distinct and coterminous boundary” between the two Bills to which you refer is actually what is needed.

However, we recognise that we will need to review certain aspects of the draft Mental Health Bill to make sure they properly deliver our policy intentions.

In part this is an inevitable consequence of the Bill being drafted before the Mental Capacity Bill is enacted.

For example, clause 28 of the Mental Capacity Bill provides that nothing in the Bill authorises anyone (including a donee of lasting power of attorney) to give, or consent to, treatment which is regulated by Part 4 of the current Mental Health Act 1983. This is primarily a technical provision to ensure that there are not two overlapping statutory provisions relating to the same clinical decisions. Where patients are detained under the 1983 Act, that Act itself provides the authority for them to be treated for their mental disorder in circumstances when they lack the capacity to consent. It is therefore unnecessary—and potentially confusing—for Mental Capacity Bill to make provision for the same decisions. The clause also makes clear that the procedural safeguards set out in Part 4 of the Mental Health Act 1983 take precedence.

Clearly, clause 28 will need to be updated to refer instead to the equivalent provisions about medical treatment in Part 5 of the new Mental Health Bill. And the drafting of Part 5 of the Mental Health Bill (eg in relation to electro convulsive therapy) will similarly need to be reviewed to ensure it properly reflects the provisions of the Mental Capacity Bill in relation to advance decisions to refuse treatment.

But we recognise that getting the interlace right will not just be a matter of updating references to the current Mental Health Act. We agree with various witnesses who have given evidence to the Joint Committee that we will also need to review (in particular) how the fourth condition in clause 9 of the draft Bill interacts with the Mental Capacity Bill, to be sure that it delivers the policy intention set out above and does not unintentionally alter the likelihood of incapacitated patients being (or not being) subject to formal mental health powers.

THE BOURNEWOOD JUDGMENT

The questions I have discussed above would anyway have arisen without the Bournewood judgment. But clearly it is an important new factor to be considered in the context of the interface between the two Bills.

As I have explained, it has always been our intention that compliant, incapacitated patients would not normally be subject to the formal powers of compulsion in the Mental Health Bill. Our expectation until the Bournewood judgment was that they would be treated in accordance with the Mental Capacity Bill, just as until now they have been treated on the basis of the common law doctrine of necessity.

As such, they would benefit from the better protection that the Mental Capacity Bill offers compared to the current common law. As you know, the Bill puts into statute the principle that everything must be done in the best interests of the patient; it enables people to create lasting powers of attorney; it puts advance statements to refuse treatment on a statutory basis; and it provides access to the new Court of Protection in cases of dispute. For people who are unbefriended it also creates a new safeguard in the form of the independent consultant who must be involved when certain decisions about serious medical treatment and accommodation are being made.

However, when the Mental Capacity Bill was drafted we had no reason to think that any of these compliant, incapacitated patients were deprived of their liberty within the meaning of Article 5 of the European Convention on Human Rights. While the Mental Capacity Bill includes provision about the use of restraint in patients’ best interests where certain conditions are met, these provisions were never intended to cover actions which would amount to deprivation of liberty.
It is now clear from the Bournewood judgment that in some circumstances deprivation of liberty does occur (although we see no reason to think that all incapacitated patients admitted to hospital are thereby deprived of their liberty.) That is why we have accepted that we need to put in place new procedural safeguards to protect such patients against arbitrary deprivation of liberty.

We have therefore committed ourselves to bring forward proposals for appropriate new safeguards as soon as possible. Before doing so, we will need to consult widely with interested parties, including representative groups, the NHS and local authorities.

It is important that we design procedural safeguards which are effective, proportionate and deliverable in practice without diverting resources unnecessarily from front-line care. And, of course, we will need to ensure that they are underpinned by a legal basis for the deprivation of liberty where that is appropriate. As explained above, the provisions in the Mental Capacity Bill about restraint do not provide that basis.

Formal consultation will begin in the New Year, although we are carefully considering the many ideas and proposals that we have already received.

Among the questions I would expect to see addressed in that consultation are:

— how should decisions about deprivation of liberty be taken? Who should take those decisions? What medical and other recommendations should they be based on?
— how should those decisions be recorded? For example, should there be a statutory record as there is for applications under the Mental Health Act? What should be included in any such record?
— how often should decisions be reviewed? And how should that review be carried out
— how should carers, friends and relatives be involved in decisions?
— should one individual be identified as having special rights and responsibilities, in the way that the nearest relative of a patient detained under the Mental Health Act does? Should one individual be appointed to represent the patient’s views? If so, how should that be done?

This is not an exhaustive list, but it gives a flavour of what I expect the consultation to cover.

A legislative solution seems inevitable, but at this stage we have made no decision about the appropriate vehicle. The Bournewood decision is clearly an important judgment with significant ramifications. Although we recognise the importance of finding a solution as soon as possible, these are complex issues and we should not rush to solutions. In particular, proposals need to be subject to proper consultation.

We have not ruled out the possibility of making further amendments to the Mental Capacity Bill during its passage, but it would be unwise of us at this stage to make any commitment to do so. It will, of course, always be open to us to introduce further legislation to amend the Act prior to its implementation.

In the mean-time, we have already issued interim advice for the NHS and local authorities on the Bournewood judgment. It was published on the DH website on 10 December and has been placed in the library of both Houses.

Rosie Winterton

Witnesses: Ms Rosie Winterton, a Member of the House of Commons, Minister of State, Department of Health, Paul Goggins, a Member of the House of Commons, Parliamentary Under-Secretary of State for Correctional Services and Reducing Re-Offending, Home Office, Professor Louis Appleby, Mental Health Clinical Director, and Mr Adrian Sieff, Head of the Mental Health Legislation Branch, Department of Health, and Mr Nigel Shackleford, Deputy Head of the Mental Health Unit, Home Office, examined.

Q813 Chairman: Could I welcome the two ministers and the three recidivists—if they will forgive me describing them thus, having appeared before. Could I deal with the formalities before I ask you to introduce yourselves. Could I remind you that this is a public evidence session and I am pleased to see that we have a large public gallery, including some regular attenders who are always welcome. There will be a transcript produced. It will be on the internet within about one week and available for textual correction if appropriate. Would you like to introduce yourselves, starting with you, minister.

Ms Winterton: I am Rosie Winterton, Minister of State at the Department of Health.

Mr Goggins: Paul Goggins, Parliamentary Under-Secretary at the Home Office, with responsibility for prisons, probation and, in this context, mentally disordered offenders.

Mr Shackleford: Nigel Shackleford, official, Home Office mental health representative

Professor Appleby: National Director for Mental Health.

Mr Sieff: Adrian Sieff, official from the Department of Health.

Q814 Chairman: Thank you very much. I understand that you would like to make a short introduction, Ms Winterton, so would you like to start.

Ms Winterton: Thank you, Lord Carlile. I would really like to say how pleased we are that the Committee is scrutinising the Bill. We have undertaken a lot of consultation, certainly since the draft Bill in 2002, and I think this is an extremely important part of that scrutiny process and will be
very valuable in making sure we get this Bill right. I think there has been long consensus that we do need to update our mental health legislation. I think most people are agreed on that and I think there are three main reasons for that. First, in the developments that have taken place in terms of the provision of mental health services and particularly in terms of the community-based services that we now have I think it is important that we put a new focus on the individual, particularly because of developments in human rights law. Also because there is a great need to strengthen the safeguards for patients who are treated without their consent. We believe the draft Group. We will be working with them on the Code of Practice and draft regulations. Compulsory treatment and makes sure that that information as we can from the work of the patients receive appropriate treatment (for example, have, as you say, sent the table of contents forward choice of representative, access to advocacy and the together with the recommendations that this authorise any treatment beyond 28 days), provides very key safeguards and also ensures that some very key safeguards are in place. By requiring individual written care plans for compulsory treatment and makes sure that that treatment must be available before anybody can be brought under formal powers). Compulsory treatment is necessary for the very small number of people with mental health problems who need to be treated against their wishes, normally for their protection but occasionally to protect other people. By ensuring that people who need treatment receive that treatment, we are able to ensure that the public generally is protected. Also through this Bill we believe we will be able to ensure that offenders who have serious mental disorders are diverted away from punishment into treatment. So there are many balances that need to be struck in this Bill. We believe we have found the right balance but we are also very clear that your scrutiny will help us to inform the process.

Q815 Chairman: Thank you. I understand that you do not want to do an introduction, minister. 

Mr Goggins: No.

Q816 Chairman: Thank you. As good a place to start as any is the beginning. The history of this Bill has been of some interest to the Committee. It has had the gestation period of two elephants; a conception aided by an expert committee which reported a considerable time ago. The Bill starts in clause 1(1) with a requirement to the appropriate authority to publish a Code of Practice, in clause 1(2), setting out the “general principles to which a person must have regard whenever coming to a decision under or in pursuance of this Act in respect of a patient.” Given the underpinning principle and the time there has been, the Committee has been puzzled as to why draft codes of practice were not ready when the draft Bill was published last September, so that we could see what those principles were. Are you able to assist us on why the draft codes of practice have still only reached a contents list?

Ms Winterton: I would say that it is, sort of, normal practice for work to begin on codes of practice once a bill has been drafted. What we wanted to do here and what we intend to do is to introduce the Code of Practice when the Bill is introduced to Parliament itself. I do not think that is unusual. With the Scottish Mental Health Bill the Code of Practice was produced about a year after the bill received royal assent. With the Mental Capacity Bill the Code of Practice was introduced when the bill went into committee. We did not want to pre-empt the parliamentary process by setting up an advisory group, putting together a Code of Practice that would then, in a sense, have been put together before Parliament had even seen the second draft Bill. We have now set up the Implementation Advisory Group. We will be working with them on the Code of Practice. But it is important that we put that together with the recommendations that this Committee makes so that we can ensure that the Code of Practice is fully relevant to the provisions of the Bill when we introduce it into Parliament. But we have, as you say, sent the table of contents forward and we would hope to be able to pass on as much information as we can from the work of the Implementation Advisory Group.

Q817 Chairman: It has troubled us that as a general principle we now have a procedure which involves scrutiny of draft bills which is quite different from the general run of bills to which I think you have been referring. Particularly where one has so much time in which to prepare a bill and where the Code of Practice is actually the foundation stone of the whole draft bill, where this procedure is used do you not think that it might be more informative for a Committee if a draft Code of Practice were produced and also draft regulations were made available, given that there are many important questions left to ministerial regulation? After all, you have produced a draft bill, so why on earth not a draft Code of Practice and draft regulations? It seems logical, if we are going to have a meaningful joint committee of both Houses, draft consideration and scrutiny procedure, we should be able to scrutinise the whole of the legislation that is proposed and not just a bit of it.

Ms Winterton: I do take your point. The difficulty we have had is that if we want properly to engage stakeholders in the Code of Practice—we do need to do because it is about implementation, it is about how clinicians will work, it is about what different organisations will want to see in terms of some of the principles that are adhered to—we do want to make sure we are engaging in that proper consultation. In a sense, if we publish, at the same time as Parliament sees the draft bill, a Code of Practice, then we could be accused by stakeholders and others of not consulting them properly. That is our difficulty. We are damned if we do and damned if we don’t, because we cannot say we have engaged stakeholders properly unless we do that in an open sense. If we publish something prior, at the same time as the Bill being published, then I think we could well be accused of riding roughshod over what would be considered to be a proper consultation process. I would go back to the Mental Capacity Bill and say that actually the Code of Practice there,
where that went through PLS, we did wait until it had been through that process before starting on the Code of Practice, because there certain changes were obviously made after PLS which then had an impact on the Code of Practice but it was introduced at committee stage. We are trying to do better than that and produce a Code of Practice when the Bill is introduced into Parliament.

Chairman: Having made that point, I think we can move on. I cannot speak for the Committee because we have not decided what we are going to say, but, minorities, and society’s view, in a sense, has changed. You could look, for example, at the Code of Practice, if there were instances, where some principles about how people are treated have changed. You have said in a sense there is a slightly different principle now, about, so far as possible, looking at how people can be treated in a way that is nearest to their home, nearest to their family, et cetera. There are some principles there that may change. As I say, if we could get that balance right, and look also at some of the issues around dis-application, I am not necessarily opposed to having them on the face of the bill.

Q818 Tim Loughton: Minister, general principles, which you are not proposing to put on the face of the bill. Why not? What was so objectionable about accepting substantially the principles that were put forward by the Richardson Committee?

Ms Winterton: I am not opposed in principle to having the principles on the face of the Bill but we felt that it was better to have them in the Code of Practice because it may well be that, as practice develops over time, we might want to look at whether it was necessary to alter the emphasis of some of the principles and it is easier to do that with the Code of Practice. It is important for the legislation to have those underlying principles, I agree with that. We have tried to set out the objectives in clause 1 that we believe the Bill should work from, but, as you say, we have said that the principles will be set out in the Code of Practice. If we have those principles in the Code of Practice, it allows them to retain currency, as I have said, if they needed to be changed over time. I think there have been examples of changes in that sense. If we were to have the principles on the face of the Bill, I would want them to reflect the balance between the need for patient autonomy and the principles of least restriction and so on, but balancing that with the right of society as well in terms of public protection and the need to make sure that you have that balance right in the principles. As I say, we believe that the Code of Practice can fairly reflect those principles and there are arguments for saying that it should be in the Code of Practice in order to ensure that there is a degree of flexibility within them. If they were to be on the face of the Bill, I just would want to be clear that it would be about reflecting that balance that runs throughout the Bill between those two very sensitive issues.

Q819 Tim Loughton: Minister, we are talking about principles here; we are not talking about latest trends and fashion. A principle is a principle. It is not there to reflect something: a principle is there to underpin the rights of whoever, as you say. You have said in principle you are not against it. Would you agree that actually putting the principles on the face of the Bill would carry more weight than having them in a Code of Practice, and, secondly, why is this Bill, for example, so different from the Children Act 1989—which did have overriding principles on the face of the Bill which are just as relevant today as they were when they were written 15 to 16 years ago? Why is it so different in this case?

Ms Winterton: In a sense, the issue here is about the Code of Practice being able to reflect the way that the Bill itself is applied in practice. For example, there can be discrimination against women, discrimination against people from black and ethnic minorities, and society’s view, in a sense, has changed over a long period. We would want to see within the Code of Practice, if there were instances, where some principles about how people are treated have changed. You could look, for example, at the issues of being treated in the community, where in a sense there is a slightly different principle now, about, so far as possible, looking at how people can be treated in a way that is nearest to their home, nearest to their family, et cetera. There are some principles there that may change. As I say, if we could get that balance right, and look also at some of the issues around dis-application, I am not necessarily opposed to having them on the face of the bill.

Q820 Tim Loughton: Are we making some progress? Because we have heard that in principle you are not against it but now you are saying that you may be moving towards it. Again, we are talking about principles and a lot of what you have been talking about is practice. If you take the principle of non-discrimination or take the principle of non-racial discrimination. Quite rightly, that is a principle that I would hope will not be changing in our lifetime, so when is racial discrimination applicable? Why in clause 1(4)(a) do you have the dis-application facility of “circumstances in which its application would be inappropriate or impracticable”. When is it inappropriate or impracticable not to be against racial discrimination?

Ms Winterton: I would not use that as an example where—

Q821 Tim Loughton: It is your example.

Ms Winterton:—that would be the case. I said that society’s attitude towards racial discrimination and gender discrimination had changed over time and some of the principles which you might have put on a bill, say, 30 years ago would not necessarily . . . You would move on in the way society has moved on. When we talk about dis-application, let me give you an example that I think would be helpful to the Committee. If you had a situation whereby the general principle would say the patient should have the maximum amount of information available to them. If a care worker felt that they were given information but to pass that information on to a patient might put the care worker at risk, then that would be a situation where you might say, “the general principle of giving the patient maximum information would be dis-applied at that time.” If a relative or a neighbour were in the same position and were passing information on to, again, a clinician,
and that information was not passed on to the patient because it might well put the neighbour or carer relative in a difficult position—

Q822 Tim Loughton: But no one is recommending that principle. 

Ms Winterton:—then that would be an example of when you would dis-apply the principle.

Q823 Tim Loughton: It is not an example that was in the Richardson recommendation. It is theoretical but does not actually apply.

Ms Winterton: It is an example of what I am saying.

Chairman: I think Lady Cumberlege is interested in this issue as well.

Q824 Baroness Cumberlege: Yes. I would like to follow on from what Mr Loughton was saying in terms of not only the Children Act but the Mental Capacity Bill which is before our House at the moment and that has principles. We have heard a lot from witnesses throughout this exercise, and the witnesses have told us that if they have the principles on the face of the Bill it will give confidence not only to service users but also to practitioners and tribunals in interpreting and applying the Act. We all know this is a very difficult exercise we are going through. You talked about balance and we appreciate that. We feel that having the principles on the face of the Bill would actually be a very strong indicator of what the balance was and we find it very difficult to understand your reasons for not putting them on the Bill.

Ms Winterton: I have looked at the points that have been made. Obviously we both have. I do not know whether Paul wants to come in here in regard to the issue of balance as well, but, as I have said, it is a point of saying: Do we lose some of the flexibility we might want to have in the Code of Practice? Can we get the balance right which, I think, the Bill does represent?—the balance between patients’ rights, the need for safeguards, the least restriction, patients’ right to information, et cetera. Can we on the face of the Bill in those principles get the balance right between that and the need obviously for the very small minority of people who may present a risk to others that that can be reflected? As I have said, we will obviously look at the recommendations of the Committee. I am glad that you said that you recognise that if we were to put those principles on the face of the Bill it would be absolutely right to reflect those different needs.

Q825 Chairman: We are jolly glad you will look at the report of the Committee, we were sure you would, but, in considering the question of enduring principles—and you have made a powerful point about that—of course you do have the option of having an affirmative resolution procedure which would allow for the evolution of scientific knowledge of mental health, would enable the principles to be on the face of the Bill, but allow amendments, subject to, probably, the Committee might prefer, affirmative resolutions, over the years that follow. Do either of you have any comments on that suggestion?

Ms Winterton: Certainly any changes to this Code of Practice we have said would be subject to the affirmative resolution itself, so the same, if you like, principle might apply there.

Q826 Chairman: Do you want to add anything, Mr Goggins?

Mr Goggins: I feel I am getting closer to my first contribution, Lord Carlile.

Q827 Chairman: You were offered the opportunity.

Mr Goggins: Indeed. I do not want to take up time by re-stating things that Rosie has already said. It is clear, however, that the Bill is not without principles. It has clear principles which are written through it. The question is one of whether they should appear on the face of the Bill or through the code. I would simply echo what Rosie has said to the Committee, welcoming the remarks that were made about the need to strike that balance between, on the one hand, the autonomy of the individual but also the protection from harm for the individual and, indeed, for wider society. It is making sure that however principles are expressed and whether it is on the face of the Bill or through the code that that balance is absolutely clear. Because it is a balance that is in the Bill, and if it becomes unbalanced in the statement of the principles then we have a real problem with the legislation.

Q828 Lord Carter: The draft Mental Incapacity Bill did not have the principles in the draft Bill, and of course the Government accepted the recommendation of the Joint Committee to include them and they have done so. On the example that you gave of the carer, surely the crucial thing is that the practitioner had to have regard to the principles; and the carer can clearly show they had regard to the principles, they considered them and it was not in the best interests of the patient, for all the information that we have supplied, because it might have led to violence between the patient and the carer.

Ms Winterton: Yes. Again, it is getting that balance between the two, is it not? I suppose it is giving the scope to somebody not to feel, in the particular instance that I gave, that, because they had regard to the status—which is quite strong—if there was a challenge to that, legally one has to prove that there were very good reasons for that—and, in a sense, it is the cover of dis-application in order to make it clearer for those operating in that way that there is the ability to do that in the circumstances that, one would hope, would be rare but nevertheless can be real.

Chairman: As we move on, can I just make this comment: I think one of the things the Committee has observed is that the drafting of clause 1(4) appears to be very broad and therefore we have not had perhaps as much clarity as we would have wished about the circumstances in which the principles could be dis-applied. It occurs to me that
the example you gave, Ms Winterton, of the health worker who may be worried about their safety, might be something that actually fits quite comfortably within clause 1(5) as opposed to a disapplication of principles in clause 1(4). In other words, it is a matter of practice rather than principles. I simply leave that thought as we pass on to Mrs Browning.

Q829 Mrs Browning: Thank you. Minister, could I ask you about the changes that the 2004 Bill makes to the definition of mental disorder and the consequences for the people who would be caught within the definition who are not currently identified within the 1983 Act? Could you tell me why the Government think it is right to change the definition of mental disorder to encapsulate other categories of people who are outside the existing legislation? Could you also, when you reply, tell me what you think the differences as far as definition is concerned are between the 2002 bill and this Bill?

Ms Winterton: Certainly we supported the broad definition recommended by the Richardson Expert Committee. I think Professor Richardson was happy in general with the broad definition in the draft Bill. We changed the definition after consultation on the 2002 bill because many people felt, after the consultation, that there was a danger that definition would encompass purely physical conditions. We were obviously anxious that no-one could automatically be excluded from compulsion because they had any particular physical condition, if they otherwise than that physical condition met the other five conditions within the Bill. But it certainly was not the intention that it would encompass people suffering from, say, diabetes or epilepsy without the other psychological dysfunction as well. We were trying to make clear in the changes that it was the effect of the mental disorder rather than the underlying cause that was important. That was the change that we were trying to get through the changes in the wording. We did not think that was a substantial change, but if there is still felt—and we are still looking with our lawyers at this, to make sure that what we were trying to bring about is actually brought about by the change in wording . . . . I do want to assure the Committee that we are aware that people feel there might be confusion here. Our intention, I think, was to meet the concerns that came out of this consultation but we want to be absolutely clear with legal advice that the intention is met by the change in wording.

Q830 Mrs Browning: You mentioned Professor Richardson. She was one of our first witnesses, as you will know, and in fact she was unconvinced that there had actually been a change in the definition between the 2002 and the 2004 drafts. I know the Government has said and you have just repeated it about the psychological dysfunction—and I quite accept that both of those groups could well have a genuine mental health problem overlying their condition—is surely a huge infringement of civil rights on a lot of people who would have to declare by law surely that from then on, if ever asked, “Have you ever suffered from a mental disorder?” purely by definition of their diagnosis would have to tick the “Yes” box whether they had ever seen a psychiatrist or not. I would just remind the minister, because I know she is familiar with this—we have discussed it in the context of the Mental Capacity Bill—that the Bournewood case was a classic case in point. Mr HL, whom I have met, has an autistic spectrum disorder on the more moderate to severe end of the spectrum, for whom the consequences of demonstrating challenging behaviour on one occasion resulted in him being taken into the Bournewood Hospital—and the minister is familiar with what happened then. In fact, for many people who look at what happens to autistic patients, there might well have been a much more appropriate way of dealing with that emotional outburst in behaviour, which is what it was at the time, than taking him through the mental health services. From now on, however, if this Bill becomes legislation, all of those people will be identified as mentally disordered. I wonder if the minister could let me know how she feels in terms of the civil liberties of those groups, what impact this Bill is going to have on them?

Ms Winterton: It is certainly not our intention to indicate in any way that people with learning disability necessarily have to be brought under the Mental Health Act. Nobody would be brought under the scope of this Bill unless all the conditions were met in terms of detention. We have tried, in terms of the change of wording, to clarify that that is the case. It is also true that we would not want exclusions that, in a sense, somehow created the impression that, if somebody had a learning disability but fulfilled all the other conditions, somehow they would not be able to be treated. It is for clinicians to be able to make the judgment whether an individual meets all the conditions for detention. There is absolutely no desire to single out in any way people with learning disabilities or people with autism or Asperger’s syndrome but it is a question of making sure we have wording which does not exclude people but makes it clear that it is the combination of all five conditions being met before somebody can be detained.

Q831 Chairman: Could I try to distil what I think is an essential point from Mrs Browning’s question. I am looking now at the definition of mental disorder in clause 2(3). Is it the Government’s view that a person who is suffering from an autistic spectrum disorder, without there being any statement of an exclusion or requirement of an overlaid condition to bring them within this Act, should be defined throughout their life as suffering from a mental disorder? Because if this definition stands undiluted, then any person suffering from a condition—and we will use autism as an example—anywhere in the
autism spectrum, will have to answer the question: Have you ever suffered from a mental disorder? with the answer yes. Is that what the Government believes is right or not?

**Ms Winterton:** I think we are trying here not to put that type of label on people, and to say that there can be a number of factors that would lead to . . . I think in the Scottish Act it is called mental impairment.

**Mr Sieff:** The current Scottish Act I think refers directly to learning disability. The 1983 Act referred to mental impairment.

**Ms Winterton:** So that has been changed there. Certainly we would not want to do the type of labelling that you are talking about, no.

**Chairman:** That is very helpful. Could I bring in Mr Prosser at this point.

Q832 Mr Prosser: Minister, another area of the Bill where there has been a widening of application if not definition is clause 9, with regard to the conditions under which a person can be compelled to receive treatment or care. To highlight the extent to which this has been broadened, the Law Society have told us that in theory even a smoker who has tried to give up smoking and failed—you might have heard the example—could be compelled to receive treatment under the law. Although that is an extreme example, it does highlight a change in application. The danger in it being so broad, similarly perhaps to the dangers of the definitions being so broad, is that you are putting an awful lot of onus on practitioners and health care professionals to decide whether or not to apply the legislation, and that has its own dangers. What would you like to tell us about that?

**Ms Winterton:** There has been a confusion at present in terms of whether, for example, somebody who has substance abuse problems or alcohol problems can actually be treated. We have tried to broaden the definition so that people who require the treatment are able to get it and to remove what has been confusion in the past, sometimes by what can be taking out what is, for example, substance abuse from people who want to have treatment or we feel it is necessary to have treatment under the Bill. I did see the evidence about smokers. I would say that is somewhat of an exaggeration in terms of what we are trying to achieve.

Q833 Mr Prosser: We do not want to alarm people unnecessarily.

**Ms Winterton:** No, no.

Q834 Mrs Browning: Coming back, minister, just to make the point: clearly, under your own definition of appropriate treatment, the Bournewood case showed that the treatment of that autistic man was not appropriate. What is appropriate treatment in respect of personality disorder?

**Ms Winterton:** As you may well be aware, there are a number of projects around the country looking at people with personality disorders and what treatment can be available. Very often people with personality disorder can be helped to manage, for example, aggression, or can be assisted in terms of depression that might be going alongside it. I think it is a difficult area, because, in a sense, when we talk about personality disorder people would say, “Is there what we conventionally would think of perhaps as a ‘cure’?” Obviously there is ongoing work in terms of whether that can be achieved, but I would say that there is therapeutic treatment available to people with personality disorder, not least in the management of symptoms, as I have said. I personally have met people who have said that the treatment or the care they have received has enabled them to manage symptoms and lead a better life. I do think that treatment is there. There are pilot studies going on, looking particularly at severe personality disorder, as to further treatment that is being developed.

**Mr Goggins:** Perhaps I could add, Lord Carlile, that it seems to me important in this Bill that we move from a test of treatability to a test of availability of treatment. Certainly the Government has not been slow to develop the kind of sophisticated intensive treatment facilities for people with severe personality disorder—a condition which in the past people regarded as non-treatable: frankly, it was in the “too difficult” box. We are putting together a programme which, if it cannot cure a condition such as that, can at least help to manage it. At Franklyn Prison and Whitmoor Prison, along with Broadmoor and Rampton Hospital, we are developing new intensive programmes for 240 individuals, with step-down, medium-secure facilities and community facilities that will be on-stream later this year, altogether providing 300 places for dangerous and severe personality disorder offenders for whom we think we can really make a substantial difference. It is very important that we have shifted the focus from treatability to availability of that treatment.

Q835 Baroness Eccles: Could I pursue that, please, Mr Goggins. You referred to pilots, and also we are talking about the number of people who have severe personality disorders. I suppose it is important for us to understand at this stage the proportion of people who fall into that category to whom this would apply, and whether, by using the term “availability”, this again could imply that it would be only a very small proportion of people who fall into this category who would either be able to respond to treatment or for whom the treatment would be available. It is a question of scale, I think, that I am trying to pursue.

**Mr Goggins:** From the assessment we made, we made a commitment to provide these facilities for around 300 people at any one time—and I might say with a substantial investment. The capital investment to provide these programmes is £85 million and the cost each year is between £40 million and £45 million. So this is a substantial investment in trying to help to manage people who in the past were simply regarded as simply too difficult to deal with. We are not talking about everybody who falls into the category of these various conditions requiring this level of
Chairman: We could spend the whole meeting on clause 9, the relevant conditions. Indeed, I know that the Committee would like to raise a number of issues on clause 9 that we will not have time for. Could I draw your attention particularly to clause 9(4): “That it is necessary . . . (b) for the protection of other persons, that medical treatment be provided to the patient.” The Council on Tribunals has said to us that the “authorisation of compulsion for the protection of other persons in clause 9(4)(b) specifies no boundaries as to protection from what, so even protection from minor nuisance could be included,” and, as a result, they suggested—and they are not a body given to exaggeration or wild statements—“mental health legislation could be used to create a sort of psychiatric ASBO, where the patient can be required to desist from specified conduct”. Having read that evidence, I was thinking of some work that one of my children used to do as a mediator in big blocks of flats in South London where one tenant was complaining about anti-social behaviour from another tenant in the flat above, below or next door. I can see that sort of behaviour potentially falling within clause 9(4), whereas there are much friendlier ways of dealing with this than compulsory detention under the Mental Health Act. Do you think the addition of words such as “from serious harm” might provide for greater clarity and still meet the Government’s intentions in relation to clause 9(4), the third condition?

Ms Winterton: First of all, with regard to the point about ASBOs I would say that the issue here is that the person cannot be detained unless appropriate treatment is available. To do so, and to continue detention, obviously after 28 days the Mental Health Tribunal would have to make sure that within any written care plan treatment was available. The person would have to meet all the conditions of detention and have appropriate treatment available that would be checked by the tribunal itself, so I think the idea that it could somehow be used as a controlling mechanism for sort of noisy neighbours would not really be the case.

Chairman: But why not add the words “from serious harm”? What would it diminish from your target?

Ms Winterton: Would you say again where it would go.

Chairman: Clause 9(4), paragraph (b), at the end of the paragraph “from serious harm” or words to that effect. You will note that the first part of the third condition is “that it is necessary—(a) for the protection from—(i) suicide or serious self-harm, or (ii) serious neglect by him of his health or safety . . . ” So there are repeated criteria of seriousness.

Ms Winterton: Right.

Chairman: Why not have parallel criteria of seriousness in relation to “other persons”? I think you will be aware that this particular part of the provisions has caused a considerable amount of anxiety in the form in which it stands unamended as at present.

Ms Winterton: Yes. I think throughout the Bill we are looking to the fact that clinicians will be looking themselves at the risk of harm and they will have to make an assessment as to how serious that is. So I would hope that that would be covered there.

Chairman: I think that is a yes, is it not?

Ms Winterton: I mean will take back what you are saying and look at it.

Mr Howarth: Could I step in at that point. I think we are in danger of conducting an exercise which perhaps we should be starting to conduct this afternoon. You keep using the word “we” and I am not sure that I agree with you on this. I think, first of all, we need to be a bit more careful in our choice of language as to what we are agreed on, and, secondly, we need to be a bit more clear of precisely what it is we are here to do this morning rather than this afternoon.

Chairman: I think it is certainly in order for the Committee to ask questions of this kind, of which the ministers have had notice.

Mr Howarth: Sure, I was not questioning the order of it, I was questioning the wisdom of it.

Chairman: All right. There we are. We have had an answer. I take the rebuke on the chin but I thought the answer was somewhere near to a yes, in fact. Mr Goggins?

Mr Goggins: Chairman, could I make two or three points here. First of all, it is important to recognise that these decisions are of course taken by two doctors and a mental health professional, people who are skilled in making these kinds of very difficult judgments. But two options in terms of the legislation. One is that we do not want to bring forward in this legislation a threshold of harm which is lower than that which is contained within the 1983 legislation. We certainly do not want to do that. We do—and this reflects principles—differentiate between the level of harm to self and the level of harm to others and we place a higher threshold on the level of potential harm to self than we do to others. That is quite right and that reflects a greater autonomy to the individual, but of course we have to pay very, very urgent regard to the protection of harm to other people in society. We place a higher threshold on self than on others. We certainly do not want a threshold which is lowered as a result of this legislation as compared with the 1983 Act.
Chairman: Thank you, Mr Hinchliffe.
Mr Hinchliffe: I am not sure I want to pursue specifically what you have been looking at. I want to talk about the approved mental health professional role. Are you happy for me to do that at this point?
Chairman: Please do, yes.

Q842 Mr Hinchliffe: I wanted to raise with the Department of Health witnesses the issue of the proposal to replace the approved social worker with the different definition of an approved mental health professional. I understand obviously the background to the move in that direction with far more team work in mental health and I understand the logic. I would like to know, in evaluating the impact this will have on the operation of our future mental health laws, what steps have been taken by the department to evaluate the likely impact of this change, in particular have you undertaken any analysis of the operation of the current ASW role within the sectioning procedures to look, for example, at where the operation of that role has resulted in alternatives to a compulsory admission in certain circumstances?
Ms Winterton: We certainly have an implementation group that is looking on the workforce implications of the Bill.
Mr Sieff: We have not looked at that specific question. Because I think that would be quite a significant research project.

Q843 Mr Hinchliffe: Could you speak up, Mr Sieff.
It is difficult to hear you.
Mr Sieff: I am not aware that the department has done any specific research against that question. It is certainly something to consider but it would be quite a significant piece of research. One would have to be able to develop quite a significant research protocol to identify and follow people through the system and identify which ones were diverted—I think is what you are suggesting—away from potential use of the Act. It would be quite a significant piece of costly research to undertake.

Q844 Mr Hinchliffe: My anxiety is that in making this proposal we ought to have some basis of evidence to understand that this would not undermine the protections that have existed for many years, with the ASW, and MWO prior to that, as a check on the use of compulsion where alternatives to an admission under section can be brought about. The worry I have—and this is the area where I do feel we need to raise questions—is if you have people who are working within the same team, within the same trust, albeit from different professional perspectives, involved in the sectioning procedure of one particular patient. I understand there are changes obviously in the role of the tribunal with this legislation, but does that not to some extent reduce the safeguards that are there at the present time where, certainly in my experience, the ASW can sometimes bring about alternatives to a person actually being sectioned. I would have thought that was helpful sometimes.

Chairman: Do you want to add anything, Laura? If looks could kill, you have just killed Mr Hinchliffe!

Q846 Laura Moffatt: Absolutely. It is a view that has been offered, but I do not share it of course, naturally I do not. I do not believe that nurses are in the pockets of doctors. They are independent. Nursing is a completely different profession than it used to be and it is not something that I think we need to consider as a problem.
Ms Winterton: I also understand that the Association of Directors of Social Services have felt that the new role would be effective and that there should not be those kind of conflicts. I feel fairly confident that what is being devised will be effective, but obviously that is evidence which you have had.
Chairman: Well, can we move on now to the very important and discrete issue of interface with the Mental Capacity Bill.
Q847 Lord Carter: Minister, when you wrote to us on 6th January, you said that, “It is to avoid . . . inflexibility that we want to preserve discretion for professionals to decide when compulsory treatment under the Mental Health Bill is to be preferred to treatment in a patient’s best interests under the Mental Capacity Bill”. We have had evidence from the Mental Health Commission who said, “It would be possible for a compliant incapacitated person to be treated under either Bill even though the lack of capacity might be due to a diagnosed mental illness which falls squarely within the definition of mental disorder under the Mental Health Bill”. Would this not lead to considerable confusion in practice with different professionals diagnosing a different treatment and, although the Committee understand the Government’s wish to retain flexibility, is there not real room here for confusion?

Ms Winterton: Well, I know it is an extremely complex area. We did try previously to see whether you could make a more rigorous distinction, but in fact if we are to make sure that we have, first of all, clinical discretion in terms of where an individual might be treated, I think we do need that flexibility and, secondly, with any more rigid interpretation, I think the difficulty might be that you would find people who perhaps did not have capacity, but who for perhaps a short period might resist treatment which might not necessarily be due to a general resistance, but perhaps, for example, being in unfamiliar circumstances where they might be indicating that they did not want treatment. Now, if you were to say, “Well, what we’ll do is treat all those people under the mental health legislation”, the difficulty that I think would happen is that relatives, carers or organisations might feel that because there can be stigma obviously associated with being compulsorily detained, actually that might be an inappropriate response. Therefore, whilst I accept that it can be complex, there may be different times when the different Bills apply and I think that we do have to be clear that there are decisions taken already that can be quite difficult, but clinicians do do it. We will obviously through the Code of Practice and the Code of Practice in the Mental Capacity Bill be trying to tease out or give some examples of how people might be involved in those different decisions. I do not know whether you would find it helpful for Professor Appleby to add anything at this point in terms of the two.

Professor Appleby: I think that is absolutely right. I think these are decisions which clinicians already have to make in relation to different routes of handling complex problems. One analogy is with the current mental health legislation and child protection powers where, when you are faced with someone with mental illness who also has parenting responsibilities, you do have to decide where the balance lies, what is the right route to help people in that predicament, so clinicians are used to saying, “Well, this is more appropriate to mental health legislation”, often because of the severity and the risks associated with mental disorder, or, “This is more suited to a different route which in this case is about protecting children”. I think that kind of balanced decision-making is already part of medical practice.

Lord Carter: On the subject of the use of the two Bills, the Mental Capacity Bill and perhaps the use of the new Mental Health Bill, it brings us to the Bournewood gap which has been mentioned already. It would be helpful to the Committee, I am sure, if the Minister could tell us how far the Government is on its thinking about how to close the gap and I would be interested in the Minister’s response to a suggestion I made when we debated the Second Reading of the Mental Capacity Bill. I think we all understand the problem that the Government faces regarding the type of consultation, whether it has to be done through legislation or through guidance, and of course the resource implication. Would it be possible though to place in the Mental Capacity Bill a clause which sets out the criteria for treatment in dealing with a compliant incapacitated patient and link that to an order-making power? If consultation and legal advice shows that you do not need to go down the route of legislation then you do use the order-making power. You will have the criteria in the Bill and, if you do need to go down the route of legislation, you can then use the order-making power. This would give the Government some time to consider how to deal with this.

Q848 Chairman: Before you answer the question, I think it is right to thank you for all the trouble that has been taken and the time that has been taken by you and your staff in responding to issues on this point. I think I speak for the whole Committee, at least in the absence of Mr Howarth, when I say that the Committee has found it genuinely very difficult to get our heads around the reconciliation of this issue.

Ms Winterton: I think it is a very fair point and something that we are looking at as to whether that could be done. There will be difficulties in a sense as to whether you could frame something that would be wide enough to allow the scope that we might perhaps need. We will be issuing the consultation on the Bournewood issue fairly shortly and obviously there will be a three-month consultation period during that time. We are very aware that if primary legislation is needed, and we increasingly think that it probably will be, a vehicle for it could well be the Mental Capacity Bill, but it is really a question of whether we would be in a position to be able to include enough in any amendment to enable us to make the necessary changes later, but it is something that we are looking at actively.

Q849 Chairman: Can I ask you what the Government’s view is about advance statements in the context we are discussing? I know it is a very difficult issue, but why has the Government decided not to include provisions for advance directives or advance statements in this Bill?

Ms Winterton: Well, there are two things that I would say here. The first thing is that I do believe that it is extremely important that if individuals do
the Bill already contains powers to transfer patients from prison to hospital for treatment? I would like to be rather sneaky and add in another related, though separate, question which is to do with the relationship between the conditions that have to be met for mentally ill offenders to be detained under the Act as against the conditions that need to be met for mentally ill patients who have not committed an offence. The obvious difference between the two is that the criteria that need to be met for mentally ill offenders do not include the reference to risk to other people in particular or risk to themselves. Now, I wonder if you have any comment for us when it comes to the discharge of mentally ill offenders as to whether or not they meet the criteria under clause 147 that apply which do not include reference to risk as opposed to the criteria under clause 9 which do, given that these may be, and I am talking about restricted offenders now, some of the more dangerous or risky people who might be subject to compulsion?

Paul Goggins: Perhaps I can begin and perhaps, in doing so, I could share some of the pain of members of the Committee because this is extremely complex territory and I think that those who have made submissions to you are quite right to point that out, but it is our duty of course to try and work through this. In relation to the first question of hospital directions, this of course is a power that is there at the moment and very little used. At the moment there are just 21 people in the country as a whole who are subject to a hospital direction and we do not expect under the new system that the hospital direction will supplant the mental health order. Our intention is to provide the widest possible range of disposals for the court and we expect, of course, in most cases that they will use a mental health order either to detain somebody or indeed to see them treated in the community, and that is something we very much support as a progressive move enshrined in this Bill, that more mentally disordered offenders can be dealt with in the community in the future under mental health orders. However, there may be some individual cases, some difficult cases, where the court feels that a hospital direction is the most appropriate disposal in a specific set of circumstances. Of course such a direction does have the advantage of meaning that the offender would go immediately to hospital to receive the treatment and then subsequently, when recovered, would go into prison rather than the other way round and it would give some immediacy to that treatment. Of course we continue to ensure wherever possible that people are transferred from prison where that is necessary, but it would give the court the power to ensure that that treatment began immediately, but nonetheless that the individual was transferred to prison subsequently.

Q851 Baroness McIntosh of Hudnall: Can I just be clear about that because I think this is quite important. The implication, Minister, of what you have said, if I have understood you, would be that, for instance, somebody who had been convicted of

Chairman: Can we move on now to Part 3 of the Bill and the question of offenders. Perhaps before I ask Baroness McIntosh to ask the first question on this, it might be useful if I just gave you a snapshot of some of the evidence that we have had. Some of the hundreds of people who have contacted us have found it difficult to get their heads around Part 3, complaining that it is pretty hard to follow and that this is merely a mirror image of some of the evidence we have had.

Q850 Baroness McIntosh of Hudnall: Well, the question or questions I want to ask may also evidence the fact that I struggle to understand some of what is in the Bill currently, so forgive me if it does not come over as clearly as I would like. We are talking here about the tricky business of mentally ill offenders. The first issue I want to raise with you is that the Royal College of Psychiatrists have submitted to us some anxieties about the way that hospital directions arise in the draft Bill and they have said that they are concerned that this order, the hospital direction, may supplant the mental health order and this may, they say, undo the hitherto enlightened legislation in England and Wales which took the view that mentally ill patients should not be subject to punishment when they meet the criteria for detention under the Mental Health Act. The first question I wanted to ask both Ministers, if they would be good enough to answer, is whether they support the principle that mentally ill offenders should not be subject to punishment when they meet the criteria for detention under the Mental Health Act, and if you do support that principle, why is the power to make hospital directions needed given that
an offence and suffered from a mental illness might be committed to hospital to be treated for the mental illness on the basis that, once recovered from the mental illness, he or she should then be returned to prison to serve the sentence. The implication of that would be that there was not a relationship between the mental illness and the offence because if there were a relationship between the mental illness and the offence, then it would be the Royal College of Psychiatrists’ anxiety that somebody who had committed an offence because they were ill was being punished when they should be treated.

Paul Goggins: I simply say in response to that that the world is not simply black and white and that there are some difficult decisions to make between the two. This provides the court with the opportunity of having a disposal which could reflect those rather difficult circumstances where there perhaps is a grey area and a difficult judgment to be made, but which ensures that the individual gets the treatment, because we are absolutely committed to making sure that mentally disordered offenders do get the treatment, but where the protection and indeed the punishment is provided in relation to the prison sentence as well. I do not deny that this is a tricky area. We do not expect it to supplant the mental health order. We do expect this to be scarcely used, but we want to leave it in because it may be in certain circumstances the most appropriate way to dispose of the particular case.

Q852 Chairman: Those who sit as judges, and I occasionally do myself, express a degree of frustration, Mr Goggins, at the fact that they sometimes have obviously mentally disordered offenders in front of them for whom there is no apparent psychiatric disposal available. Now, this is not a new problem and this is not a criticism of this Government at all because it has been for ever during my 30-something years practising criminal law, but do you feel that any progress is being made in resolving that situation so that more mental health disposals will be available to reduce, in some cases, up to 50% of prisoners in prisons who are suffering from mental illness?

Paul Goggins: Well, I explained before what we are doing in relation to the dangerous and severe personality disorder facilities and, along with investment from the Department of Health who of course will largely be responsible for the healthcare generally in our prisons from April of next year where most prisons will have an NHS service run by the NHS within them, we have put in place 300 additional psychiatric nurses now working in the prisons to deal with the 5,000 or so people in the prison system today who have a serious mental health problem. Of course we have to provide that route through from prison to hospital for those who need it and last year 544 people in prison were transferred across into hospital. Is there sometimes a delay in that transfer? Yes, there is. There can be at any one time around 40 people waiting, but we are determined to make sure that we continue to reduce that number and make sure that the capacity is there to deal with those who have a mental health problem. Absolutely crucial to this also is that what we do not want to see are people with a mental health problem going to prison because they have got a mental health problem. We want to be able to deal with people appropriately in the community and we are taking powers in this Bill, but increasingly of course through the Criminal Justice Act 2003 it will be possible to provide community sentences with mental health treatment conditions attached which will mean that people will not be imprisoned, but will be at home and in the community.

Q853 Chairman: Could I just ask you to deal specifically with Lady McIntosh’s question as to what is the reason for the apparent discrepancy between the criteria for discharge for mental health order and restriction order patients?

Paul Goggins: I will do my best, Chairman. Clearly there are differences and the Committee will be familiar with the fact that where there is no restriction, then once the Mental Health Tribunal indicates that the person is better, then they can return to the community, and for restricted patients the Home Secretary retains powers there. Of course one of the important things to emphasise is that where restricted patients are conditionally discharged into the community, at the moment there is continuing supervision of their condition in the community and where they deteriorate, they can be recalled into hospital and indeed at the moment around three patients a week are recalled into hospital because of their deterioration and all of those decisions are sanctioned by me and I see each and every one of them on advice from officials. Therefore, I hope that I can reassure you that this is an issue that is taken extremely seriously indeed and people are followed through in that way.

Q854 Baroness Eccles of Moulton: Ministers, this next question is a follow-on from the question that Lady McIntosh has already asked and is to do with Part 3 and offenders. It does appear that the theme of safeguards for the patient which runs very strongly through the Bill is somehow being weakened in this particular proposal. Under Part 3, courts will not be needed to be satisfied that treatment is necessary to protect patients or other people and the courts will not need to be satisfied that compulsion under the Bill is the only way to treat the patient. This is manifested in the point that Expert Panel assistance will not be deemed to be necessary, only advisable, and also that the Mental Health Tribunal will no longer have an essential input into the decision that is made for compulsion for the offender. Therefore, it would be helpful to us if you could please elaborate in more detail on the rationale behind removing the criteria of risk from the conditions for compulsion under Part 3.

Paul Goggins: I hope, Chairman, I can offer some reassurance to the Committee here because it is precisely to improve the opportunities for treatment that this condition has been removed. If we left in the condition that it was necessary for the protection...
from harm, then it could be argued that simply by removing somebody from the community and placing them in prison, you have removed that risk, but they do not get the treatment. In removing this, what we want to make sure is that the proper judgment is made as appropriate with the conditions as set out here, that people get the treatment that they need and that that treatment cannot be compromised by the fact that the risk has been removed because they are in prison and not getting the treatment that they urgently need, so this is a very positive step to make sure that actually more people get treatment rather than being simply seen as disposed of and that we are protected from them by their removal into prison where they may not get the treatment that they actually need. I hope that is of some reassurance.

**Q855 Baroness Eccles of Moulton:** But they are presumably given the opportunity to accept the treatment voluntarily before the compulsion criterion is put into operation?

**Paul Goggins:** Well, indeed we know that it is very important that people have this opportunity voluntarily to participate in treatment wherever that is appropriate and that is true throughout the Bill. However, we have to face the fact that sometimes that voluntary commitment cannot be relied upon actually to provide the protection that is required. that people may agree with the best of intentions and then not be able to sustain their commitment to the treatment, or they may be more devious than that and see that perhaps by voluntarily agreeing to treatment, they actually circumvent the judicial process, so we do have to be very clear and very careful here that, whilst we would always prefer to see people having treatment on a voluntary basis, they are simply too much of a risk in allowing that, as it were, to countermand the other conditions in the Bill.

**Q856 Baroness Eccles of Moulton:** Does that mean that if you are an offender, you will be compelled to receive the treatment regardless of whether you are capable, willing and able to receive it voluntarily?

**Paul Goggins:** Well, all of the conditions will apply as set out in the Bill to offenders and elsewhere in the Bill to non-offenders. It is not simply one condition, it is a whole series of conditions which includes whether they have a mental disorder, whether it is so serious, whether the treatment is available and so on, so all of those conditions would need to be satisfied.

**Q857 Chairman:** Are there examples of the Home Office rejecting risk assessments made by professionals and substituting its own estimates of risk in relation to discharge?

**Paul Goggins:** Clearly the judgment about discharge is made by the Mental Health Tribunal and the Home Secretary can make representations at that point, but in the end it is for the Tribunal to decide. What we then do of course, and this is partly the answer to the previous question, in partnership with those in the mental health field is to supervise and to monitor those particular individuals and where there is deterioration, where they then become once again a risk to the community, then it is of course quite appropriate that they can be recalled. As I explained, there are around three a week who are recalled and I endorse every decision.

**Chairman:** Can we move on now to what you rightly referred to as the very important issue of community treatment orders.

**Q858 Baroness Pitkeathley:** You have mentioned treatment in the community several times and you will not be surprised to know that we have received a lot of submissions that are hostile to the principle of community treatment orders, and not just hostile, but also very anxious about how these would work out. We understand that some of that is because some of it is left to regulation and we have not yet seen the regulations, but of course service users are naturally frightened that this might lead to compulsory house arrest virtually, if you see what I mean, so has the Government now formed a clearer view of the categories of people to whom community treatment orders might apply, what would be their characteristics and, if you have, how would you feel about imposing certain defined parameters on the Bill to prevent misuse of these community treatment orders?

**Ms Winterton:** Perhaps I could just start by saying why I think that community treatment orders are an important aspect of this Bill. It starts from the fact that service provision has changed considerably in recent years. We do have out in the community crisis resolution teams, early intervention teams and community mental health teams, and it is quite clear that this legislation is based as well on a principle of least restriction. There are instances where people, we believe, can be more effectively treated, even if under compulsion, in the community. That can, first of all, in fact aid recovery frankly if people are not necessarily in the rather restrictive environment of a hospital, it can help in terms of relationships with families and carers, it can reduce stigma because for some people there is stigma associated with being an inpatient, and it can allow a continuity of a person’s life insofar as it is possible to do so in what are obviously very difficult circumstances for an individual. That is the principle from which we would work here. Now, after the consultation that we undertook in the draft 2002 Bill, we did look at this very closely and I certainly accepted that there was unease about the idea that somehow people could come under compulsion in the community and would be sort of assessed in the community and that might make it easier to put many more people into detention. Therefore, what we have said in the changes that we have made is that for the majority of people, community treatment orders will be preceded by an assessment in hospital. However, there are——

**Q859 Baroness Pitkeathley:** Can I be clear—an assessment in hospital while they are an inpatient?
Ms Winterton: Yes. However, there are groups of people, perhaps what we would call “reversing door patients”, who we know will perhaps at the moment be detained in hospital because that is the only place they can be detained at the moment, so they will be detained in hospital, will go into the community, will relapse for one reason or another, whether it is not taking medication or whatever, and then will be readmitted into hospital. We know from discussions and consultation that we have had with people in those circumstances, that if there was an element of compulsion that could be carried out in the community, they would respond to that and it would be more appropriate for their care. I am also very aware, through the discussions I have had and meetings I have held, for example, of carers who have said that their relationship with their son, daughter, husband or whoever has been broken completely because there has been only the ability for somebody to be detained in hospital and that has meant that the person they are caring for has felt that their mum has kind of detached them in this way away from home and the effect that that can have on families and on individuals is enormous. They have said that, if there can be a different type of treatment available, that would be better all round, so I think we do have to reflect on what are the possibilities that we now have with current service provision. In terms of the other ways then that community treatment orders might work for the kind of reversing door patients where we would say, “Look, you are at a crisis point”, and actually we know that if we can say, “You have to turn up, take this medicine and come to the clinic or be available when the psychiatric nurse will call”, then that person does not necessarily have to be immediately assessed because they know they will have had a previous assessment within hospital, then we will be consulting on the kind of time limits that you would put on that, so that is one case. There may well be cases where I would use perhaps the analogy of somebody who comes into hospital for a short period and who has not been perhaps detained before, but is assessed for the detention, but then again there is somebody within a care plan where we are returning the person to the community because there is somebody there who will care for them and we believe that once they are in a sense stabilised, although it is still necessary for compulsory treatment in order to ensure that medication is taken, et cetera, or so that treatment can be given, it is appropriate for that person to be within the community. At the same time in terms of the idea of kind of indefinite house arrest, first of all, the Mental Health Tribunal has to look at what care is being offered and that does have to be therapeutic and available, and given that we have a principle of least restriction, it would be very difficult to think that the Tribunal would feel that detention at home for a long period would be (a) least restrictive and (b) therapeutic, so there are the safeguards there to make sure, and these are reviewed at regular intervals, as you know, that a person would have the right to apply to the Tribunal to say that they felt that the care plan, the requirements and the restrictions which were being put were inappropriate.

Q860 Baroness Pitkeathley: Does that mean that you think that the existing prevention of misuse of community treatment orders which you have just outlined are adequate, in your view, or do you think there is a case for putting specific parameters around it?

Ms Winterton: Well, I feel at the moment that the added safeguards that are in the Bill would allow challenge to community treatment orders if it was felt that they were being misused, but we would be looking obviously through the Code of Practice to make sure it was very clear that the idea of indefinite house arrest would not be considered, but I would find it astonishing that clinicians would want to put something in a care plan which involved that if there was not for one reason or another an extremely good reason for saying that it was felt that a person ought to remain in the home.

Q861 Chairman: Professor Appleby, you look as though you want to add something.

Professor Appleby: Just perhaps to emphasise what the problem is that this measure is trying to tackle. We have an unacceptable situation at the moment where people with quite severe illnesses who have had a history of frequent relapse and frequent admissions associated with high risk resulting from lack of treatment are allowed to continue that pattern because there is no power to ensure that treatment is delivered. I think that is putting patients unnecessarily at risk and it is putting clinicians and the patients’ families in a very difficult position. Therefore, this measure is there to target that group of people, the reversing door group. The main use, I suspect, will be at the time of discharge from one of those frequent admissions, so a person gets to perhaps their third admission in a year and everyone realises that another admission is inevitable unless some additional steps are taken, so a community treatment order is the next step. Now, other ways of making it clear that that is whom we are targeting this measure for, I think that is what we have to address and my understanding is that that can be done in the regulations, so there is a way of trying to say that this is primarily for the reversing door patients who are already subject to frequent periods of treatment under compulsion.

Q862 Mr Howarth: I think if would be helpful if the Ministers could confirm that the choice that will be exercised with the community treatment order is not between liberty with no restrictions and a community treatment order, but the actual choice is between a community treatment order and some form of detention.

Paul Goggins: Indeed, and particularly from the point of view of the mentally disordered offender it will mean greater liberty, not less liberty, but the
choice will be between a safe programme of treatment in the community as opposed to being in prison or being in hospital. That will be the choice and very clearly those people, and we estimate there may be 200 or 300 people who at any one time would be liable to this kind of treatment in the community, all of those people, if they were not being safely managed and treated in the community, would either be in prison or in hospital, so this is a progressive move, but it is not a move that is done without proper supervision and proper treatment. All of these people will receive that, as indeed they would have had to have satisfied all the conditions, the treatment will have to be available and it will have to be provided.

Q863 Mr Howarth: The second point is that there have been a number of very high-profile cases and two I can think of which have resulted in somebody being killed where somebody had previously been receiving treatment while under some form of detention and then they were released because there was no other avenue available to, I think in both cases, the Mental Health Tribunal, which I have in mind. What assurances can you give the Committee that that category of person will not, while under a community treatment order, be at large to have an episode and to kill somebody or perhaps a bit less than that?

Ms Winterton: I think there are two things here and I do not know whether Louis might want to add something in the sense that clinicians do make assessments about risk and obviously within the Bill that remains, that the risk factor is something that they have to take into account. Certainly we would be expecting clinicians to be very clear in terms of who could be given a community treatment order, that, as far as is humanly possible, this would clearly not be people who were at risk either to themselves or to others at the time of being treated in the community. There is also the fact that in the Mental Health Tribunal it is possible for the Tribunal to reserve to itself decisions on discharge and this might particularly be where the Tribunal had worries that perhaps somebody had been previously discharged and they had felt that it was not necessarily appropriate, so that remains within the Bill. On a slightly wider point and going back to your previous question, one of the points that struck me very forcefully during the course of consultation was that there are people who have spoken to me who had mental health problems and who in the past had been detained who have said that there are circumstances they have undergone whereby they have been told, “Take your medication, turn up here and follow this pattern of treatment. If you do not, you will be detained in hospital”, and there have been people who have said to me that the important point about this Bill is that what it actually does is give a number of people actual safeguards around that because that person in those circumstances would have the Mental Health Tribunal look at their care plan. In a sense what they have said is that there is a kind of informal sometimes way of treating people that does put that onus on them, but that what this does is in a sense give people the ability to remain in the community, but safeguards if they are not happy with the treatment.

Paul Goggins: Could I just add that the provision of the community treatment order would be very similar to the way that we operate restricted patients who have been conditionally discharged into the community and I explained before about the level of supervision there. If anybody deteriorates or refuses to co-operate or becomes a substantial risk again, they can of course then be recalled, but I hope that will be some reassurance to Mr Howarth and the rest of the Committee that whilst there are sometimes stories in the newspapers that grab the headlines, in fact the reoffending rate for restricted patients who are in the community is but 2%, so I think that is an indication that we can manage these risks effectively.

Q864 Mr Howarth: But the risks can be enormous in that 2% of cases.

Paul Goggins: They can and that is why we will of course need to operate these orders very rigorously indeed.

Hywel Williams: In the first answer, Minister, you said that bringing community treatment orders in was enabled by the fact that there are now good community services. It has also been put to this Committee that such services in Wales are very far behind the services in England, and in fact the National Service Framework in Wales might be perhaps 40 years behind its application in England. Is that your understanding as well? If so and if community treatment orders are such a good thing, do you envisage that they will be used in Wales to the same extent and also what are the implications as to the equity of access, which would be a very good thing, for people from Wales?

Q865 Chairman: I see a hospital pass coming on!

Ms Winterton: Well, obviously I think that some of those questions will be addressed to the Welsh Board and Welsh Ministers. I do not know whether Louis—

Q866 Chairman: That is the hospital pass answer!

Ms Winterton: Louis has recently analysed the services that are available in England and I do not know whether during the course of that there was any indication of the differences that there might be. I am sure that extra money is being spent in Wales on the provision of services and that they have a similar approach to us.

Q867 Chairman: We have taken evidence in Wales. Did you want to add anything, Professor Appleby?

Professor Appleby: I wanted to say that the Mental Health Act is of course no substitute for having good services and we have tried to establish services which support, with intensive community care, the people who are most vulnerable and very often most at risk. However, the Bill will give community
mental health teams an extra authority, an extra power, an extra ability to support people and treat people who are at risk. Whatever your service, it will be, I think, a beneficial addition to what you can provide.

Ms Winterton: Also I think it is important to remember that the Tribunal will have to be satisfied that services are available, so if services were not available within the community as set out in the care plan, then I think there would have to be a rethink as to how the care plan had been devised.

Tim Loughton: Can I just ask a quick theoretical risk with another is impossible.

Paul Goggins: It is an impossible answer to give because they both present different challenges and different risks. Those risks need to be assessed and they need to be provided for, but to compare one risk with another is impossible.

Can I just ask a quick theoretical risk with another is impossible.

Q869 Chairman: I think what we would say is that the question was a very good one, but the answer is too difficult to give.

Ms Winterton: Also I think it is important to remember that the Tribunal will have to be satisfied that services are available, so if services were not available within the community as set out in the care plan, then I think there would have to be a rethink as to how the care plan had been devised.

Paul Goggins: It is an impossible answer to give because they both present different challenges and different risks. Those risks need to be assessed and they need to be provided for, but to compare one risk with another is impossible.

Q870 Chairman: We are no longer quorate, I am afraid, so can I thank you for your care and attention to the questions this morning. Once again I am declining to accept treatment or a patient who has been diagnosed HIV-Positive who is intent on having consensual, unprotected sex without revealing his condition to a partner?

Q868 Chairman: I am not sure that is fair. I think I am going to protect the Ministers from that question!

Ms Winterton: Thank you very much.

Supplementary Memorandum from the Department of Health (DMH 428)

MENTAL HEALTH BILL—IMPLEMENTATION ADVISORY GROUP

The purpose of the Group is to advise officials about the development of the Bill’s regulations and Code of Practice and about other aspects of the implementation of the new mental health legislation. As the Committee has noted, it is essential that the Government makes good progress in preparing draft regulations and a draft Code of Practice to inform Parliament as it debates the Bill. I said when I gave evidence last week that we are planning to have the draft Code of Practice ready for formal introduction of the Bill. The Implementation Advisory Group will help us engage the expertise of stakeholders in doing this. I attach for your ease of reference a copy of the announcement of the establishment of the Group.

The first meeting of the Advisory Group was held on 19 January. The meeting was an opportunity to run through the Bill with members of the Group, discuss its role in advising on the regulations, code of practice and implementation and agree how the group will work. The members of the Group fully understand and accept that their initial advice will relate to the draft Bill as published in September last year and that the Bill might well change in due course as a result of decisions by Government and Parliament. Their initial advice would need to be revisited if the draft legislation changes.

I intend that, after the Government has received and responded to the recommendations of the Joint Committee, we will work to ensure that the Bill, when formally presented to Parliament, is supported by a Code of Practice that has been well thought through and has benefited from the wide-ranging experience and expertise of the Advisory Group.

I can without any hesitation assure you that the establishment of the Group does not mean that the Government has prejudged the recommendations which the Joint Committee on the Mental Health Bill may make on the Draft Bill.

Department of Health

November 2004
Supplementary Memorandum from Ms Rosie Winterton MP (DMH 429)

Thank you for your letter of 21 January.

I am of course very happy to respond to questions, which we did not have time to discuss last week. My answers are set out below. In addition, do get back to officials or to myself if you have further questions.

The Committee has received a great deal of evidence about the status and terms of the general principles which should guide the operation of any new mental health legislation. It would assist the Committee if the Government could explain what practical problems it sees if, say, the general principles set out in the Report of the Expert Committee, chaired by Prof Richardson, or the “principles for discharging certain functions” in the Mental Health (Care and Treatment) Act (Scotland) Act 2003 were on the face of a new Mental Health Act.

As you will be aware, the principles in the Mental Health (Care and Treatment) (Scotland) Act 2003 are based on principles set out in the report of the Millan committee. The principles set out in the Millan report are built upon those in the report of the Expert Committee chaired by Professor Richardson.

I explained when I gave evidence to the Committee that an advantage of defining the general principles in the Code of Practice is that they can retain a currency that would not be possible so easily on the face of the Bill. An example of why this is important can be seen from how views about the promotion of non-discrimination in the application of the law have changed over the past 20 years or so. Society’s view of discrimination has changed significantly over that time—whether in respect of women, people from minority ethnic communities or on the grounds of sexual orientation. Hence, best practice in applying such principles also changes over time, and this can be readily reflected in amended Codes of Practice.

The key issue for the Government, if we are to have principles on the face of the Bill though, is that we would need principles that balance patient rights and autonomy with a fundamental purpose of the legislation, which is to enable treatment for mental disorder to be given under compulsion to patients, in order to prevent harm to self or others. So if principles are on the face of the Bill, they must be drafted such that they allow for the powers to be used to the extent necessary to prevent harm, subject to the countervailing need to respect individual rights. There are also other balances the principles need to strike, for example between the rights of the patient and the rights of the carer.

The principles put forward by the Expert Committee would provide the basis for the individual rights based principles governing this legislation. I am confident that the three objectives set out in clause 1(3) already provide the scope to reflect a broad set of general principles in the Codes of Practice. For example, if we take the first objective of “patient involvement”, this would allow us to define general principles covering consensual care, participation, involvement of carers and others and effective communication.

I have set out to you (in my letter of 9 December 2004) the Government’s views on why we think that the legislation should be based on necessity rather than capacity. As such, we cannot accept a principle that gives primacy to patient autonomy as suggested by the Expert Committee, which was in favour of capacity based legislation. That said, we should promote principles of self determination and personal responsibility as far as possible within the requirements of compulsion, and again I think the objective of “patient involvement” would allow us to set this out.

As you will recall, the Committee was quite interested in the question of the circumstances in which general principles could or should be disappplied and I appreciate that your department has provided additional information in the very useful schedule of detailed comments which we received on 17th January. It would, however, assist the Committee if you could provide further examples of the situations in which you would need to disapply general principles.

The purpose of the principles is to guide practitioners in how they apply the law. Whether on the face of the Bill or not, they must put forward the rights of the individual, while also enabling that all decisions taken on the basis of necessity to prevent harm are taken proportionately, taking into account the harm which could result from application or disapplication of the principles. The main areas where disapplication would be necessary are as set out in the schedule of comments, that is:

— Where involvement of the patient, or provision of information to him or her would be dangerous to carers or professionals
— Where there is a need to insist on treatment that may enable long-term safe rehabilitation rather than minimal short-term containment.

1. Where the relevant conditions are satisfied a tribunal must make a compulsory treatment order. Should a tribunal be given a discretion to impose an order to allow flexibility in cases where compulsion would not be desirable or effective?

The Tribunal must always satisfy itself, by weighing the evidence, that all the conditions are met. In the same way as other decision-makers under the Bill, Tribunal members must exercise their professional judgement in deciding whether the conditions are satisfied. That is where discretion lies. As now, the Tribunal may disagree with the clinical supervisor as to whether compulsion is necessary and discharge the patient. The Tribunal will consider the evidence of the clinical supervisor’s application which must include
supporting reasons; the independent medical expert’s report which must comment on every aspect of the
application: the patient’s own views and those of other parties such as carers and social workers. The
Tribunal may, for example, find that the patient is not disordered, is not sufficiently disordered, that
compulsion is not necessary, or that the treatment available is not appropriate in all the patient’s
circumstances. Unless satisfied that compulsion is appropriate on all those counts, they must discharge the
patient from compulsion.

2. Responsibility for the Tribunals is about to pass from Department of Health to Department for
Constitutional Affairs. What incentive has the Department of Health to sort the administrative shortcomings
of Mental Health Review Tribunals which have been reported to us by, for example, the chairs of the Mental
Health Review Tribunals?

We take very seriously the current problems with the Mental Health Review Tribunals and we are
committed to tackling them.

Mental Health Tribunals have a vital role to play in protecting the rights of patients subject to compulsory
powers. The current Review Tribunals already provide an important safeguard under the Act. Under the
Bill, the role of the new Mental Health Tribunal will be greatly enhanced in safeguarding patients’ rights.
First, all use of compulsory powers beyond 28 days must be independently authorised by the new Tribunal
(or by the court for offenders). Secondly, the Tribunal will approve the care plan so it can assure itself that
appropriate treatment is available for any individual who is deprived of their liberty, or has their liberty
restricted, under mental health law.

The efficient working of the new system is fundamental to the successful implementation of the new legal
framework. We are working hard to improve the existing tribunal system to ensure that it provides a sound
basis on which to build the new system.

We have already taken action. For example, we have made strenuous efforts to tackle the shortage of
medical members, with significant success. In 2002, the vacancy rate for medical members was 68%. We have
now managed to reduce this to just 4%. The Review Tribunal now has stronger and more focused judicial
leadership following the appointment of two full-time regional chairs alongside a liaison judge.

We are also focusing on improving the efficiency, consistency and effectiveness of the administration. We
have reduced the number of locations of the secretariat, and will be moving to one site later this year,
streamlining the office organisation and administration. The Department recently commissioned external
consultants to make recommendations about improvements in efficiency in order to meet the demands of
the new Bill. We expect the final report shortly.

Having laid the foundations, we plan further improvements over the next six months to drive up efficiency
and consistency. This will include both rolling out a comprehensive training and retraining for all staff and
a significant investment in upgrading the IT system.

The Government has agreed that responsibility for the operational administration of Mental Health
Tribunals will transfer from the Department of Health to the Department for Constitutional Affairs one
year after the new Tribunal comes into effect. Officials from the two Departments are, however, currently
considering whether the transfer should be brought forward and are working closely together to ensure the
benefits of joint working are introduced as early as practically possible. For example, the new Head of the
Secretariat was a joint appointment on secondment from DCA.

After the transfer of the administration, the Department of Health will remain responsible for the policy
and the statutory responsibilities and powers of the Tribunal. Officials will continue to work together in the
future to ensure that the rights of patients are properly protected, and that the operation of the Tribunal
and its relationship with the NHS is kept under review.

3. The Bill does not include a reference to “victims” of mentally disordered offenders. Did the Government
consider giving victims of mentally disordered offenders limited rights to be kept informed about the status
of the offender eg about transfer and planned discharge dates. Given the courts and Tribunals have to make a risk
assessment of mentally disordered offenders would the Government see value in introducing a requirement that
the prosecuting authorities place victim impact statements before the court or tribunal?

Provision to keep victims informed of discharge decisions in respect of mentally disordered offenders was
made in the Domestic Violence, Crime and Victims Bill. We do indeed see merit in the Committee’s point
about victim personal statements informing the Courts’ sentencing decisions. The Court will already be
informing itself on the basis of medical reports and pre sentence reports. It may be that the latter will include
victim statements. We need to consider whether any further steps should be taken and whether it is
appropriate to introduce a requirement.
4. The successful implementation of this draft Bill seems to rest on the assumption that it will not lead to any increase in the number of people becoming subject to compulsory detention. This assumption is based on limited empirical evidence. Nearly every submission we received which comments on this point has doubted this assumption. Do you still hold to it?

As you know, there have been significant changes in the number of people who have been brought under compulsion since the implementation of the 1983 Act. This shows that there are different factors which influence rates of compulsion. Our view is that various external factors are more significant in affecting the numbers coming under compulsion than the introduction of the planned new legislation.

For example, modern patterns of practice and care lead to more care provided in the community and to shorter admissions. This may have various effects on numbers coming under compulsion, for example, it may increase the number of episodes of compulsion—shorter admissions may lead to readmissions—but may reduce episodes because crises are avoided.

Another factor over the period covered by the 1983 Act may be the prevalence of certain psychotic conditions associated with a growth in substance abuse which may have led to an increase in detention. On the other hand, patients with psychotic illness may be being detected earlier (as a result of early intervention teams), which again could avoid the crises which may result in detention.

The developments in community services are expected to continue to reduce the need for compulsion. As you know, we are making new investment and improvements in mental health services, including the introduction of initiatives under the National Service Framework for Mental Health such as Assertive Outreach Teams and Crisis Resolution Teams. Improvements in the provision and quality of services will increase the number of people whose condition is treated early enough so that they do not become so ill as to warrant the use of the Act.

The RIA cites anecdotal evidence suggesting that innovative service developments arising from the NSF for Mental Health are reducing the number of detentions under the Mental Health Act. We have no central data to corroborate this, although there are local studies and some published literature. We have recently commissioned the University of Durham to undertake some research into this. We expect a report of the preliminary findings in the spring.

Turning from the external factors to the new legislation itself, overall it is not the intention that the Bill will significantly affect the number of people who will be subject to compulsion. The aim of the Bill is to ensure that those people for whom compulsory treatment is necessary are not unintentionally excluded and denied treatment when it is needed. This may mean some change in the group of people treated. For example, we have been told, and evidence to the Committee reafirms the view, that uncertainty about the position of those misusing alcohol or drugs has meant that some have been inappropriately excluded. The approach of a single definition and conditions reduces this risk.

There are a number of safeguards to prevent inappropriate compulsion:

— There are five conditions all of which must be met before compulsion. Those conditions mean that a person cannot be brought under compulsion unless the serious nature of their mental disorder warrants; unless compulsion is necessary to protect the patient from suicide or serious self-harm or serious neglect by him of his health or safety, or the for protection of others; unless there is no lawful alternative (except for those patients aged 16 or over who are at a substantial risk of serious harm to others); and unless there is appropriate treatment available to meet the patient’s needs.

— Initially it is for three examiners each to determine that in their professional opinion all of the conditions are met. If any one of them decides that any of the conditions are not met, then compulsion cannot happen.

— During the assessment period, the clinical supervisor must satisfy himself that the conditions for compulsion are met and there is a duty to keep under review the continuing need for compulsion.

— Normally the patient has a choice of representative, who can help them represent their views.

— The patient has access to independent advocacy, who will understand the system and make sure that the patient’s views are heard.

— All use of compulsory treatment beyond 28 days will be authorised by the new independent Mental Health Tribunal.

In our view, the evidence put to the Committee underestimates the importance of these safeguards in ensuring that no patient inappropriately comes under, or stays under, compulsion.
5. In three competitions in 2003–04 for part-time medical members of Mental Health Review Tribunals, a total of 154 applications were received for 197 vacancies, and only 95 people were appointed. Given the anticipated near-doubling in hearings under the Draft Bill, from 22,800 to 41,900, how can the Government expect a sufficient number of willing medical members to come forward? Does this problem not make the revised tribunal system unworkable?

As stated in the response to Question 2 above, we have successfully reduced vacancy rates for medical members of Tribunals from 68% in 2002, to just 4% in 2004. This was the result of concerted action by Departmental Officials working with leaders of the profession. Paragraph T4 of the Judicial Appointments Annual Report both noted the historic difficulty in making medical appointments to all tribunals, and recognised the progress being made in the MH Review Tribunals, saying:

“We are optimistic that the next competition will enable all the remaining vacancies to be filled. We will explore in the coming year whether the lessons we learnt in MHRT medical recruitment can be extended to other medical appointments”.

We have calculated that the Bill will create a requirement for an extra 130 psychiatrists, measured as whole time equivalents. This is well within the anticipated growth in the overall numbers of consultants between now and 2008, which we conservatively estimate to be 800.

We therefore believe that there will be sufficient potential tribunal and expert panel members.

We recognise that the risk remains that insufficient numbers will choose to serve on Tribunals. There are many possible ways of mitigating this risk:

— Considering the use of secondments for fixed terms to provide a core of medical members;
— Working with the professional leaders to inform and encourage members of the profession to fill statutory roles;
— Examining the professional accreditation that such work would bring, and how best to incorporate it into career pathways;
— Ensuring that the consultant contract both allows and encourages consultants to carry out statutory roles;
— Looking at ways of supplementing the whole resource available—for example the use of advanced practitioners to undertake work traditionally done by consultants, and
— Ensuring that the rewards are fair.

We are already discussing with colleagues in the Royal College, the BMA and other bodies how we can ensure that we have sufficient numbers of clinicians for this and other statutory roles. Our success in reducing the number of vacancies in the current Tribunals shows that the risk, if recognised, and managed vigorously, can be overcome.

6. Why has the Government not chosen to put child welfare principles on the face of the Bill in line with the Children Acts 1989 and 2004? Given that clinicians and tribunals dealing with children have to consider all three pieces of legislation would it not make their role simpler if the same principles guided them in each Act?

I have explained to the Committee the reason for the Government’s proposal to have principles set out in the Code of Practice, rather than on the face of the Bill. Our intention is that the Code of Practice will explain the relationship between mental health and children’s legislation, setting out how the principles of the Mental Health Bill will work alongside the principles in other Acts.

7. The Children Act provides a facilitating legal environment for young people who are suffering significant harm up to 18. Why did the Government choose to only provide specific safeguards for under 16s in the draft Bill? Will this not cause confusion in the treatment of 16 and 17 year olds?

Those working with young people who have a mental health disorder have brought to our attention the problem raised by the limited legal or procedural safeguards available for young people who are being treated against their will, because their parents have consented to their treatment. The Bill addresses this problem by introducing safeguards for all young people under 18 and does so in two ways.

First, the Bill provides a new safeguard for 16 and 17 year olds who will be able legally both to consent to, and refuse, treatment for a mental disorder. Their parents will no longer be able to overrule their refusal. The effect is that where these young people meet the relevant conditions, they will be treated in the same way as adults and be entitled to the full range of legal and procedural safeguards available to adults treated under compulsion. It is important to note, however, that this change in the legal position does not affect the target in the Children’s NSF for specialist CAMHS services to be available for young people up to age 18.

Secondly, the Bill provides special safeguards for children under 16 where they are receiving treatment in hospital for a serious mental disorder, who are refusing or resisting treatment and who are being treated by virtue of parental consent. In this way the Bill provides safeguards for those children under 16 who are so seriously ill that they would satisfy the relevant conditions for compulsory treatment, were it not for parental consent providing the legal authority to treat them.

While the Bill introduces safeguards for all young people under 18 who may be treated for serious mental disorder against their own wishes, we believe that it is right that the safeguards for the two groups (the over 16s and the under 16s) are different. The nature of any boundary or threshold will inevitably appear arbitrary in some cases and may not exactly reflect the point at which all young people achieve maturity but we believe it is reasonable and right to draw the line at 16. The threshold is set at 16 to reflect the increasing autonomy of young people and to respect their ability to make their own decisions in life. Importantly this will also be compatible with the Mental Capacity Bill which provides the legal framework for decision-making in respect of young people and adults from age 16 onwards who lack capacity to make treatment decisions.

The threshold at age 16 also builds on the current legal position which already draws a distinction in this area between those under and over 16. The Family Law Reform Act 1969 (section 8) currently provides that from 16 years old, anyone with the mental capacity to do so, may consent to treatment and that consent is legal regardless of a parent’s views. However, a refusal of treatment by a 16 or 17 year old may be overridden by a parent or by the inherent jurisdiction of the court. The Bill goes a step further so that once aged 16, a young person may give both valid consent, or refusal, to treatment for mental disorder as an adult could. If a 16 or 17 year old consents, he or she can be treated informally. If a 16 or 17 year old refuses treatment, regardless of a parent’s consent, the only way that he or she could be treated would be if the relevant conditions were satisfied under the Mental Health Bill, in the same way as for an adult.

The overlap in provisions under the Children Acts for 16 and 17 year olds will ensure that where young people are vulnerable and in need, the protections of those Acts are still available.

We appreciate the complexity of some decisions about children who need admission to hospital, and treatment for mental disorder. While the choices available for those under or over 16 will be different under the Bill, the law already requires consideration of whether a 16 or 17 year old is able to consent to treatment. It is unavoidable that practitioners have to work with the powers in both mental health and children’s legislation and, as now, this may require consideration of which legal powers might be used. The Children Act and the Mental Health Bill have quite different purposes and therefore different effects and so it will be important to identify the main purpose of the proposed intervention, what outcome is desired and what needs to be achieved for the child.

Where the aim is primarily to treat the child for mental disorder, the Mental Health Bill gives appropriate powers and safeguards, provided the relevant conditions are met. Where the aim is primarily to safeguard and promote the welfare of a child in need, the Children Act 1989 powers are appropriate.

Officials are working with colleagues in DfES to ensure that the two pieces of legislation work together. For example, a Tribunal considering a case under the special safeguards may find reason for concern about the welfare of the child. There are two circumstances on which the Bill ensures that the Tribunal must consider whether it would be appropriate to inform the local social services authority of the case. One is where the Tribunal orders the discharge of the child from hospital (clause 218(8)(b) and the other is where it has refused an application by the clinical supervisor to approve a care plan for treatment (clause 211). The local authority is then under a duty to determine whether the child’s welfare is adequately safeguarded and whether it should exercise any of its functions under the Children Act 1989. A further example is in clause 237 which disapplies certain provisions of the Children Act 1989 in relation to the appointment of a nominated person by a local authority where there is a Care Order in place. This will avoid conflicting requirements about consultation with parents and others.

**DEFINITION OF MENTAL DISORDER**

I am of course very happy to provide any further information in relation to the above issues if that would be helpful. In addition, I thought it would be helpful if I were to set out in writing our thinking on the definition of mental disorder in respect of people with a learning disability or autism.

I understand the concerns of people who would like to see exclusions from the definition of mental disorder for people with learning disabilities or autism, but we consider that there are important reasons for including people with these conditions.

First, some background – as you know, learning disability and autism are covered by the definition of mental disorder in the current Mental Health Act. Mental disorder is defined in S1(2) of the current Act as meaning “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind . . . .”. To meet the conditions for admission for assessment, the patient must be suffering from the mental disorder to a degree which warrants detention of the patient in hospital and is necessary in the interests of his own health or safety or for the protection of others. The new Scottish Act also includes people with learning disabilities and autism in their definition of mental disorder.
As you know, the draft Mental Health Bill is intended to provide a mechanism to bring under compulsion the small minority of patients who need treatment for a mental disorder in order to protect them from serious harm or for the protection of others, and the treatment cannot be given any other way. The Draft Bill also provides safeguards for people to ensure that they are not inappropriately treated under compulsion. All five conditions for compulsion set out in clause 9 have to be met for someone to be treated under compulsion. The first of those conditions is that the person has a mental disorder as defined under the Bill. It is important to have a broad definition of mental disorder in order to avoid the risk that some patients may be deprived of treatment when this is necessary.

While most people with learning disabilities or autism would never meet the conditions for compulsion, as indeed the great majority of all people with mental disorders would never meet the conditions, a small minority would occasionally satisfy them. An even smaller minority do also commit serious offences and any exclusion from the definition of mental disorder would mean that a diversion from the criminal justice system would not be possible.

It has also been suggested that the legislation could provide that people with learning disabilities and autism are excluded unless they have a co-existing mental illness. Our view is that a broad definition of mental disorder is necessary, as I say above, to ensure that there is no risk of people being inappropriately excluded from treatment.

At the oral evidence session last week, it was asserted that it was wrong for people with learning disabilities and autism to be included in the definition of having a mental disorder, as this could blight their lives in many different ways, and they would have to declare in different circumstances that they had such a disorder.

I think there are two important points to make about that. First, the definition of “mental disorder” for the purposes of the Bill is just that. It does not establish some kind of national definition of “mental disorder” for all purposes. In other circumstances, a different definition might be more appropriate and it certainly does not establish a “label” to be applied to people.

Secondly, concern was expressed in Committee that people filling in forms may have to declare having a mental disorder. I do not know precisely which forms are in question, but if forms are simply asking people whether they have (or have had) a mental disorder, it seems that the forms are unlikely to be doing their intended job. I cannot think of many circumstances in which it would be a helpful question to ask, given how common mental disorders, of different degrees of seriousness, are amongst the population as a whole.

I hope that this reply is helpful.

Rosie Winterton
January 2005

Supplementary memorandum from the Department of Health (DMH 439)

MENTAL HEALTH BILL—RESPONSE TO PLS QUESTIONS

QUESTION

In December the PLS Committee asked for additional material on the resource implications of the Mental Health Bill. Question 40 asked: Having developed scenarios of uncertainty showing the impact on workforce requirements of a 10% change in compulsions and a 25% change in average unit time, why has the department not repeated this analysis for costs? Could you supply an analysis please?

ANSWER

1. The original costings as included in the PLS briefing were prepared as part of the 2004 Spending Review process and did not for the SR purpose include different scenarios.

2. The costing of scenarios relating to the number of uses of compulsion have now been examined:
   — an increase of 10% in the number of people subject to compulsion in the course of a year; and
   — a reduction of 10% in the number of people.

The results are set out in the table below—see lines 2 and 3 in the table.

3. The costing of scenarios relating to the average unit times listed below (paragraph 4) have now been examined:
   — an increase in the unit times of activities under the legislation; and
   — corresponding reductions in the unit times.

The results are set out in the table below—see lines 4 and 5 in the table.
4. The factors which have been incorporated in the assessment of the effect of an increase or reduction in unit times are as follows:

- 10% in hearings attended by clinical supervisors;
- 10% in hearings attended by expert panel;
- 33% in examination and reporting by multi-disciplinary team staff for nursing and social reports;
- 33% in examination and reporting by expert panel;
- 0.5 hours in examination and registration time by AMHPs; and
- 0.5 hours for tribunal members and 0.25 hours for other people in tribunal preparation and hearing time.

5. The results of the costings of the different scenarios are as follows:

<table>
<thead>
<tr>
<th>Mental Health Bill Scenario</th>
<th>Workforce: WTEs</th>
<th>Workforce: Costs £ Million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Forecast</td>
<td>834</td>
<td>67</td>
</tr>
<tr>
<td>Uses of Compulsion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Increase by 10%</td>
<td>1,023</td>
<td>82</td>
</tr>
<tr>
<td>Uses of Compulsion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Reduce by 10%</td>
<td>645</td>
<td>53</td>
</tr>
<tr>
<td>Unit Times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Increases</td>
<td>1,037</td>
<td>85</td>
</tr>
<tr>
<td>Unit Times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Reductions</td>
<td>632</td>
<td>50</td>
</tr>
</tbody>
</table>

Department of Health

February 2005

---

**Supplementary Memorandum from the Home Office (DMH 434)**

Further to the evidence session on 19 January I thought it might be helpful to the Committee if I set out in writing our thinking on the application of the conditions for compulsion as they apply to offenders.

The structure reflects our intention to preserve the ability in the 1983 Act to divert mentally disordered people who have offended away from punishment; where that can happen in a way that is consistent with the need to protect others from further serious harm.

I need to start with our understanding of the position of the offender in terms of his human rights and the effect of his conviction for an offence.

Most of the Draft Bill provides a structure for lawful overriding of individual liberty where the State assesses it to be necessary for the prevention of harm. Where the person has committed no offence, the need to prevent harm is the sole justification for the infringement of his liberty. The necessity condition in clause 9(4) is the reason why the State is justified in applying compulsion.

For the *non* offender you have “necessity” to justify the infringement of liberty. For the *offender* you already have that right because of the conviction of the court. So when considering compulsion for an offender, the Court is not substituting compulsion for liberty; but for punishment.

The key questions on managing convicted offenders are: Should the court commute the sentence entirely to compulsion (unrestricted mental health order)? Or should it use the finding of the court to justify a tighter regime in order to preserve public safety from further harm (restricted mental health order)? Or should the court conclude that the risk is too great and a prison sentence is needed, possibly in conjunction with the power to order treatment (Home Secretary’s power to transfer or hospital direction)?
What follows goes through that sequence in more detail

The State can justify depriving a convicted offender of liberty on the ground that a competent court has convicted him of an offence.

So our need in Part 3 is not to justify deprivation of liberty but diversion for the offender from punishment to treatment; subject to the need to manage him safely. In practice, the latter means where the structure of compulsion enables the risk of further harm to be adequately managed.

I shall break down the provisions into:

(i) unrestricted mental health orders
(ii) restricted mental health orders
(iii) prisoners
(iv) prisoners with a hospital direction,

as different considerations apply to each category.

Unrestricted mental health orders (clause 116)

These are for cases where the Court has convicted an offender and has accepted evidence that he needs treatment which can practicably be given to him. In the opinion of the Court, he does not pose a risk of serious harm to others; so his management can be devolved entirely to clinical and social work professionals.

As the Committee has noted, the third and fourth conditions (at clause 9(4) (necessity) and 9(5) (no lawful alternative) do not apply in these cases.

The Court does not need to be satisfied that treatment is necessary for the prevention of harm in order to justify making the order. It is entitled, on the basis of conviction for a criminal offence, to dispose as it thinks appropriate. That includes, where appropriate, to order treatment rather than punishment.

To require that the Court be satisfied that treatment was necessary for the prevention of harm (the third condition) would in most cases frustrate that diversion process. Diversion would not be necessary to prevent harm; because that harm could be prevented by simply containing the individual within a criminal justice disposal. Sadly, that is too often the outcome of trial of mentally disordered people now.

In cases where the offender was ready to comply with treatment, diversion would be prevented if the fourth condition applied. Treatment could be provided lawfully by another route (eg voluntary treatment in prison). So the compliant offender would be disadvantaged by comparison with the resisting offender; to whom treatment could not be provided without compulsion. So the resisting offender could be diverted.

A manipulative offender could frustrate the will of the Court by expressing resistance to treatment, enabling diversion to a mental health disposal, and immediately delivering full compliance once the risk of prison had passed so the order had to be discharged.

For those reasons, we have followed the 1983 Act in not applying a necessity or no alternative condition to the making of a mental health order for a convicted offender. Section 37(2)(b) of the 1983 Act requires only that the Court be satisfied the hospital order is the most suitable method of dealing with the offender.

The effect here is that any convicted offender (except a murderer) whom the Court does not assess as posing a risk of serious harm to others, can be diverted from punishment to treatment. Once the order is made, it is at the discretion of the clinical supervisor how long it lasts, and whether it is delivered in the community or in hospital. Should the offender still be under compulsion after six months, it is for the tribunal to decide, under all five of the conditions, whether a fresh order should be made. The Court has decided that neither punishment nor special measures for the protection of others are necessary; so any further compulsion falls to be considered as if the patient were a non offender.

Restricted mental health orders (clause 125)

The same considerations apply in respect of the necessity and no lawful alternative conditions irrespective of the Court’s assessment of whether the offender poses a risk of serious harm to others. The route to diversion from punishment is the same whether or not the Court makes a restriction order.

The difference here is the conditions applying on discharge (Clause 147(2)). A restriction order indicates that the Court has not delegated the management of risk to the clinical supervisor. It has diverted the offender from punishment and tariff and decided that he should be managed on the basis of the risk which arises from his mental disorder. It is important to understand that it is the persistence of the mental disorder which governs continuing compulsion in this case. There is no need for a necessity condition because compulsion cannot continue on grounds of risk of harm alone. A no alternative condition would frustrate the will of the Court which has specifically diverted from a prison sentence, relying on the safeguards of the restriction order to contain the risk of harm. So neither condition is present in clause 147.
**Prisoners**

In a change from the 1983 Act, we have provided that a direction by the Secretary of State transferring a prisoner to hospital for treatment does not suffice to justify the application of compulsion. A basic principle of the Bill is that compulsion will only be applied (beyond 28 days) on the order of a judicial body. For the prisoner, diversion from punishment is not an issue. The Court has already determined that punishment is appropriate; so any compulsion is an infringement of liberty in addition to the sentence of the Court. For the transferred prisoner, compulsory treatment will only apply on the order of the tribunal applying the full conditions as at clause 9.

**Prisoners with a hospital direction**

Hospital directions can only be made once the Court has decided a prison sentence is necessary. So they do not amount to diversion. They are, however, the most effective route to treatment for an offender who has been found to qualify for it. So we have not applied the necessity and no lawful alternative conditions for the same reasons they do not apply to the making of mental health orders. They would have the same inhibiting effect on access to treatment as discussed there. Hospital directions are not diversion from punishment in the same way as mental health orders. But they offer the prisoner’s best route to immediate treatment where the Court is persuaded that he qualifies for it; but is not persuaded that it is safe to divert him to management on purely health criteria.

This follows existing provision in section 45A of the 1983 Act, which requires only evidence of the presence of mental disorder and available treatment to enable the direction.

I apologise for the length and complexity of this letter. As we have established, the reasons for the distribution of the conditions are not straightforward. But I hope this assists the Committee in following our thinking and in recognising where the provision simply reflects the spirit of 1983 Act.

*Paul Goggins MP*

*January 2005*
Wednesday 26 January 2005
Morning

Members present:

Carlile of Berriew L (Chairman)  Mrs Liz Blackman
Carter, L  Mrs Angela Browning
Eccles of Moulton, B  Mr David Hinchcliffe
Finlay of Llandaff, B  Mr George Howarth
Mayhew of Twysden, L  Tim Loughton
McIntosh of Hudnall, B  Ms Meg Munn
Murphy, B  Dr Doug Naysmith
Pitkeathley, B  Mr Gwyn Prosser
Rix, L  Hywel Williams
Turnberg, L

Memorandum from Turning Point (DMH 162)

INTRODUCTION

Turning Point is the UK’s leading social care charity, founded in 1964. We provide services for people with complex needs including those affected by drug and alcohol misuse, mental health problems and people with a learning disability.

We run services in about 200 locations in England and Wales, helping 100,000 people each year. Our mental health provision spans outreach, residential, day and 24-hour crisis services, specialist forensic services and step down provision from secure settings for people with personality disorders. Our clients include people subject to the 1983 Mental Health Act.

Most of our mental health services are for people with severe and long-term mental illness, who have additional issues such as substance misuse, a learning disability, homelessness or offending behaviour. The impact of the draft Bill for such people has been comparatively overlooked and is the focus of our submission.

Turning Point is a core member of the Mental Health Alliance and we refer to their submission where relevant. Our Chief Executive, Lord Victor Adebowale is also a member of the Mental Health Taskforce and the Learning Disability Taskforce.

Ronnie Watson, Mental Health Act Co-ordinator
Caroline Hawkings, Mental Health Policy and Campaigns Officer
28 October 2004

Note:
Throughout our submission, the Mental Health Alliance is abbreviated to “the MHA” and the 1983 Mental Health Act to “the 1983 Act.”

SUMMARY

Q2a Is the definition of Mental Disorder appropriate and unambiguous?

Drug and Alcohol dependency: As drafted, some people with severe drug or alcohol dependency could be inappropriately detained. However, others with concurrent mental health and substance misuse problems who meet the criteria and require treatment, are currently being turned away. To address both these situations the exclusion clause in the 1983 Act needs modification to ensure that people who have such problems in combination with a mental disorder are not refused treatment.

Learning Disability: For the majority of people with a learning disability, the future Mental Capacity legislation will be the most appropriate. If a person has a concurrent mental disorder and compulsion is necessary, the Act is appropriate and learning disability should not be expressly excluded. However, an exclusion clause is necessary to avoid inappropriate detention of people with a learning disability per se.

Q2b The conditions for treatment and care sufficiently stringent?

No, particularly in regard to the Clinical Supervisors powers. We support a wider definition of treatment so that certain people such as those with personality disorders are not deemed untreatable. In this context, we do not believe that a stipulation that treatment should be of “therapeutic benefit” should be included. However, treatment should never be equated with containment.
Q2c Are the provisions for assessment and treatment in the community adequate and sufficient?

Turning Point supports the principle of assessment and treatment in the community for defined groups in certain circumstances, but does not believe that current provisions are adequate or sufficient. Perceived or real fears may deter many from seeking help. If non-resident orders are to be introduced, clearer criteria for their use, robust safeguards and substantial improvements to community facilities are required.

Q3. Does the draft bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

No. The debate about risk has disproportionately influenced the Bill, particularly in relation to people with personality disorders, who risk being further stigmatised. Our main concerns include the apparent lack of professional discretion to treat a person informally, poorly developed risk assessment tools and the lack of good quality treatment to avoid compulsion in the first place.

Q5. Is the draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

Clause 6 of the Mental Capacity Bill may mean that people with a mental disorder and who lack capacity could be detained under the Mental Capacity Bill, without any of the safeguards available under the Mental Health Bill. Our recommendations include: clarification of the relationship of both Bills in the Code of Practice; impaired judgement being a criterion for compulsion in the draft Mental Health Bill; parity in the safeguards for treatment in both Bills and provisions for advance statements and advance directives on the face of both Bills.

Q6 Are the safeguards against abuse adequate? Are the safeguards in respect of vulnerable groups sufficient?

We focus on people from black and minority ethnic groups for whom safeguards are not sufficient. Disproportionate use of compulsory powers is likely to continue, especially as planned improvements to services for BME groups are out of step with the timing of this Bill. We recommend an anti-discrimination statement on the face of the Bill, advocacy being available at examination stage and more recruitment of culturally and racially appropriate personnel.

Q10. What are likely to be the human and financial resource implications of the draft bill? What will be the effect on the roles of professionals?

The additional mental health professionals and time and training requirements, created by the Bill are likely to make it unworkable. Our staff are particularly concerned that the time spent monitoring whether people comply with conditions of the non-resident order may assume more importance than client focused and appropriate care.

Q2a Is the definition of Mental Disorder appropriate and unambiguous?

DRUG AND ALCOHOL DEPENDENCY

1. Turning Point works with many people who have multiple needs. We would echo the findings of the recent SEU report that approximately 30-50% of people misusing drugs have mental health problems and that figures are rising.\(^1\)

2. Some of our clients could meet the criteria under the Bill, but for them compulsion would be inappropriate. Equally, there are others who may have been turned away from mental health services in the past, who may benefit from the exclusions being removed as the Bill proposes. We deal with these two situations below.

3. As drafted, there is a danger that people who are severely drug or alcohol dependent will meet the definition of having a mental disorder and trigger the mechanisms for compulsory powers solely on the basis of these problems, especially against a backdrop of increasing “social control”, for unusual or undesirable behaviour.

4. Example: Mr C is an unemployed teenager who injects heroin and is dependent on alcohol. He often stays out on the streets all night and becomes disoriented and anxious after particularly heavy drinking episodes. He is often arrested by the police during these periods due to his behaviour and obvious distress, but has refused treatment when offered it in the past.

\(^1\) Mental Health and Social Exclusion (SEU 2004) p18.

Also, in “Waiting for Change Treatment delays and the damage to drinkers” (Turning Point 2003), half of alcohol dependent adults said they had a mental health problem.
5. However, Turning Point’s experience also suggests that many people with a serious mental disorder and substance misuse problems (“dual diagnosis”), who could meet the criteria for compulsory powers, are being poorly served in the community.

6. Currently, the 1983 Act allows for treatment of this group, but all too often, the presence of a drug or alcohol problem alongside a mental disorder is used as grounds not to treat and people are turned away from mental health services. Consequently, people are not receiving the help they urgently need, their mental health deteriorates even further and community services endeavour to help, despite being ill equipped to do so.

7. The reasons why people use illicit substances are complex. Sometimes it can be to self-medicate and treat the symptoms of mental illness and should not be interpreted as being resistant to treatment or engagement with services. We do not believe that addressing the confusion over exclusions through education and training is sufficient to remove the barriers to treatment.

8. Example: Ms A in her 30s has a diagnosis of depression and borderline personality disorder. She also has longstanding drug and alcohol difficulties and self injures on a regular basis. When admitted for inpatient treatment, she is often put on a contract stating that she will be discharged if she self-injures or uses drugs or alcohol. These are her coping strategies, so she invariably resorts to using or self harm, and so she is discharged. On occasions she isn’t admitted when expressing suicidal thoughts because she has been drinking.

RECOMMENDATION

9. Turning Point believes that it is necessary for the Bill to include some form of exclusion clause, but that the existing 1983 wording requires modification.

10. Turning Point suggests additional wording as follows: “no one may be treated under the Act as suffering from mental disorder by reason only of promiscuity, or other immoral conduct, sexual deviancy or dependence on alcohol or drugs, but this should not exclude people who have such problems in combination with a mental disorder from receiving treatment”

LEARNING DISABILITY

11. Turning Point believes that the most appropriate legislation under which the majority of people with a learning disability should receive treatment will be the Mental Capacity Bill when it becomes law.

12. We also recognise that there is a high incidence of mental illness in people who have a learning disability. When a person clearly has a mental disorder in addition to a learning disability and it is necessary to use formal powers, it is appropriate for them to come under the draft Mental Health Bill. Excluding people with a learning disability who have a concurrent mental disorder will be a barrier to them accessing the services they need.

13. Example: Mr R, a resident at a small group home, has a severe learning disability and bipolar affective disorder. He needed treatment for his mental disorder. This was his first manic episode since being a resident of the home and it was causing distress to himself, the seven other residents and the staff, who did not feel able to support him adequately. At this time, he needed help on a ratio of 3-1 which put considerable pressure on the small staff team. The local hospital refused to admit him on the grounds that they could not deal with him.

14. However, in both the 2002 and 2004 draft Bills, the definition of mental disorder is so broad that people with a learning disability could still come under formal powers even if they do not have a co-existing mental health problem. Turning Point remains concerned, especially as the Explanatory Notes explicitly state that “examples of a mental disorder include schizophrenia, depression or a learning disability”.

15. Removal of the “abnormally aggressive or seriously irresponsible conduct” criterion in the definitions of mental impairment and severe mental impairment in the 1983 Mental Health Act means that a person with a learning disability can come under formal powers, even if they do not have “seriously irresponsible or abnormally aggressive conduct” or another mental disorder.

16. The effects of this include:
   — Exacerbating existing confusion about mental illness and learning disability.

---

2 The reasons for this include:
   — no common understanding of what is meant by “dual diagnosis”
   — poor assessment tools for co-existing conditions and pre-occupation between primary and secondary conditions
   — strict criteria and high thresholds for access to services

The Dual Diagnosis Toolkit (Turning Point and Rethink 2004).

3 Research has indicated that people with learning disabilities have higher rates of mental health problems than the general population—estimated at between 10–39% by Borthwick-Duffing (1994). The Government’s White Paper, Valuing People also states that people with learning disabilities “are more likely to experience mental illness and are more prone to chronic health problems”. Valuing People also makes clear that people with learning disabilities and mental health needs should be included in the mental health NSF.

4 Paragraph 32 p11 re mental disorder.
— Increased stigmatisation and the detention of people who have a learning disability alone.
— A resultant growth in institutional care (which is counter to the intentions of the White Paper “Valuing People”).

17. Example: Mr S, who has a severe learning disability, autism and communication difficulties lives in a residential setting. He was detained under the 1983 Act because he was becoming increasingly agitated and exhibiting aggressive behaviour, by banging his head against a wall.

18. It was later discovered that Mr S had a twig in his ear which was causing him distress, which he expressed by his agitated behaviour. This scenario shows how the distress of a person with a learning disability can be automatically attributed to a mental disorder without paying sufficient attention to physical factors.

RECOMMENDATIONS

19. Turning Point does not recommend that learning disability be expressly excluded from the draft Bill.

20. An additional exclusion clause on the face of the Bill which explicitly states that a person with a learning disability, who does not have another co-existing mental disorder should be excluded from the Act, in line with legislation in New Zealand.\(^5\)

21. Furthermore, it will be essential (for the Healthcare Commission) to monitor the extent to which people with a learning disability on its own, or in conjunction with other conditions, are affected by the use of formal powers under the Act.

2(b) Are the conditions for treatment and care under compulsion sufficiently stringent?

22. We do not believe that the conditions for treatment and care under compulsion are sufficiently stringent. We fear that far more people will become inappropriately subject to formal powers and share many of the MHA’s concerns.

23. In particular, there does not appear to be any restrictions on the Clinical Supervisor’s sole discretion to modify the care plan and any treatment without consent therein once it has been approved by a Tribunal. This negates much of the protection of having care plans approved.

24. We oppose any extension of preventative detention (see Question 3).

A WIDER DEFINITION OF TREATMENT

25. Treatment under compulsion should be the last resort. However, if it is necessary, it is important that all who may need it are not excluded. Therefore, we support a wider definition and are pleased that the definition now includes “cognitive therapy, counselling or other psychological intervention.” Paragraph 2(7)(c)

26. At present, people with personality disorders who would otherwise meet the criteria for detention under the current Act are often deemed “untreatable”. When a person has a label of personality disorder, it can become an overriding factor, even in the presence of other clearly diagnosed mental disorders. A wider definition of treatment helps to mitigate the view that people with certain conditions such as personality disorders are not treatable.

27. Example: On several occasions, Mr P who has schizophrenia relapses to the point that a section may be helpful, but is refused admittance to hospital in Liverpool on the basis of his anti-social personality disorder. His “solution” is to travel to London in order to be admitted via A&E.

28. We do not believe that a stipulation within the Act that treatment should be of therapeutic benefit would be helpful. Turning Point works with many people with personality disorders and this requires greater emphasis on psychological approaches based on changing behaviour patterns. The evidence base for effective treatment for this client group is developing and is less well established in comparison to traditional interventions based on medication, but this should not be used as a barrier from people receiving support.

\(^5\) The New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992.

Part 4 General rules relating to liability to assessment or treatment
The procedures prescribed by Parts 1 and 2 of this Act shall not be invoked in respect of any person by reason only of—
(a) That person’s political, religious, or cultural beliefs; or
(b) That person’s sexual preferences; or
(c) That person’s criminal or delinquent behaviour; or
(d) Substance abuse; or
(e) Intellectual disability.
29. In certain situations, management of a condition, even when there is no prospect of “cure”, is relevant. This is used in other areas of healthcare, such as with “inoperable” cancer. We interpret management as being a form of treatment which brings benefits including stability and structure. Management should not be confused with containment. The Code of Practice should make this clear and include worked examples of good practice.

2(c) Are the provisions for assessment and treatment in the community adequate and sufficient?

30. Turning Point supports the principle of assessment and treatment in the community, providing that the groups are sufficiently defined and that appropriate treatment is available given all circumstances of the case.

31. The merits of non-resident orders (NROs) include:
   — bringing treatment closer to a patient’s home or place of residence;
   — less disruption to normal daily life; and
   — better access to family and carer support.

32. These factors may potentially achieve a better outcome for some clients and Turning Point would support their introduction in certain circumstances.

33. Example: Mrs T lives in a residential setting, with a typical cycle of being well (and compliant with medication), while on a section (25), but prone to resisting medication and then to relapse when not under section. Her husband is unable to cope and hospitalisation results. In this individual case, Mrs T herself recognises that the element of enforced structure which comes through the Mental Health Act, brings stability to her life which is beneficial.

34. However, we do not consider that the current provisions for assessment and treatment in the community are adequate or sufficient.

35. Turning Point’s concerns with the current proposals are set out in detail by the MHA and include:
   — The potential imposition of treatment on people who have capacity and may wish to refuse treatment or medication.
   — A focus on drug treatments.
   — Wide powers of the Clinical Supervisor to change the status of orders from “resident” to “non-resident”.
   — A significant undermining of the therapeutic relationship.

36. For example, disclosure of information needs to be handled sensitively particularly if by doing so, compulsion may ensue and result in children being taken into care. This delicate balance may be upset.

37. One common scenario causing concern is where a client with mental health problems continues his illicit substance misuse, which he perceives to be one of his coping mechanisms in difficult situations. However, the professional view is often that a person’s continuing substance misuse is an indication of their non-compliance with voluntary mental health treatment. The professional considers that imposing compulsion through a non-resident order is an appropriate response, but such a decision can make a client even more distressed and further alienated from community services.

38. Whilst some service users can see some benefits, the majority are fearful about how NROs will operate in practice, what conditions they will impose and how they will curtail an individual’s liberty. These fears may deter substantial numbers from seeking help and therefore presenting to services at all.

39. We concur with the MHA that if NROs are to be introduced, more robust criteria governing their application, more safeguards for their use and improved facilities in the community should be in place. We refer the Committee to the Saskatchewan criteria suggested by the MHA.

Q3. Does the draft bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

40. We acknowledge that the powers to detain people who have not offended, but who need treatment to protect them or others from the harmful effects of their disorder, already exist and that it is appropriate to use them in a very small number of cases.

41. However, Turning Point does not believe that the right balance has been achieved and that the Bill gives precedence to concerns for public and personal safety over the human rights of people with mental health problems.

42. Whilst it is important that people who need treatment under the Act can receive it, we believe that the debate about risk, particularly in relation to personality disorders, has had a disproportionate influence on this Bill. It has muddled perceptions and risks further stigmatising people with personality disorders
because too often, their disorder is automatically equated with dangerousness. There are different types and levels of personality disorders. The vast majority are not dangerous. For many, compulsion will be unnecessary and inappropriate.

43. We strongly support the detailed response made by the MHA to this question.

44. Our particular concerns include:

   The apparent lack of professional discretion to treat a person informally. This is a serious omission.

   For a person who satisfies the other criteria for compulsion and is deemed a serious risk to others, Clause 9(7) suggests that informal treatment is not an option—a person must be made subject to compulsion. Thus any patient subject to compulsion who continues to be deemed a serious risk to others cannot be discharged, even if they would accept treatment informally. It becomes difficult for a person to be discharged especially in the light of increasingly defensive professional practice.

45. Poorly developed risk assessment tools. At present assessment of risk is not adequately developed to be able to accurately predict the degree of risk among those who have not committed offences.

46. The lack of good quality treatment which is a significant factor in minimising risk in the first instance.

Q5. Is the draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

47. Turning Point is a member of the Making Decisions Alliance and broadly supports the proposals in the Mental Capacity Bill (but with concerns that adequate safeguards are introduced to ensure that the Bill does fully empower people to make their own decisions).

48. With respect to the crossover between the Mental Health Bill and the Mental Capacity Bill, Turning Point is concerned that Clause 6 of the Mental Capacity Bill, in combination with Clause 9(5) of the Mental Health Bill, may mean that people with a mental disorder already in hospital and who lack capacity, could be detained under the Mental Capacity Bill, without any of the safeguards available under the Mental Health Bill. Clarification is urgently needed as to whether the Mental Capacity Bill could be used to admit people to hospital to receive treatment for their mental disorder, where they pose a risk to themselves, even if they objected to their admission.

49. Recommendation: The Code of Practice to the Mental Capacity Bill should clarify its scope and relationship with the Mental Health Bill.

50. We are also concerned that the provisions in the Mental Capacity Bill do not close the “Bournewood Gap”. The Bill does not give sufficient protection to mental health in-patients who lack capacity and therefore cannot consent to their treatment following the decision to transfer the Part V safeguards of the Mental Health Bill 2002 to the Mental Capacity Bill. The recent ECHR Judgment on the Bournewood case highlights the need for additional safeguards. They should include:

   — Information about help available from mental health and legal advocates and the right to apply to the Court of Protection.

   — Automatic access to the Court of Protection together with legal aid.

   — The appointment of a Nominated Person, with the equivalent role to under the Mental Health Bill.

   — A right to a care plan, which is subject independent review and special authorisation for ECT and serious non-emergency treatment before approval of the treatment plan.

RECOMMENDATIONS

51. There needs to be consideration of how physical and mental health issues are dealt with by the two Bills where someone has both mental health and physical needs.

52. We believe that the Mental Capacity Bill makes the case for impaired judgement to be used as a criterion for compulsory treatment (at the moment there is no consideration of capacity by the Mental Health Bill), where the individual represents a risk only to themselves.

53. There should be parity in the safeguards for treatment in both Bills.

54. Where a treatment is provided with additional safeguards in the Mental Health Act, safeguards of the same degree should be available to someone who does not have capacity, but who is being treated under the Mental Capacity Bill. Treatments covered should include ECT, psychosurgery and treatment for more than 28 days when a care plan is not in place. Equally, the Mental Health Bill should not be able to override advance refusals of treatment. At the moment an advance decision to refuse treatment for a mental disorder may be overridden, but cannot be for a physical condition. This means someone may have control over some of their healthcare but not other aspects. This is illogical.
55. The Mental Capacity Bill and the Mental Health Bill should both include provision for advance decision making. Advance statements (which are statements of wishes) and advance directives (which are advance refusals of treatments) should both be provided for on the face of both Bills. This is important so that those providing treatment under the Mental Health Bill are aware of their duty to follow advance directives.

Q6: Are the safeguards against abuse adequate? Are the safeguards in respect of vulnerable groups ... sufficient?

56. We pay particular attention to people from black and minority ethnic groups, for whom the safeguards are not sufficient. Turning Point believes that based on figures from the 1983 Act, conditions for the use of formal powers under this Bill will have a differential impact on BME communities.

57. Recommendation: Turning Point believes an anti-discrimination statement on the face of the Bill is essential.

58. Provisions for independent advocacy are welcome but are only available when a patient is already liable to assessment and not at the examination stage when the decision whether or not a person meets the criteria to use formal powers is being taken. We believe that the examination process amounts to an assessment (as to whether the person satisfies the criteria for compulsion).

59. It is also a time when different perspectives among individuals from BME communities and professionals, many of whom are white, are likely to arise.

60. “Inside Outside: Improving Mental Health Services for BME Communities in England” states that all services should have a clear policy and practice around assessment of people from BME groups, taking into account the significance of ethnicity, culture, language and religion. It suggests as a national standard that assessments should be carried out if necessary . . . with the support of an interpreter, translator or advocate.

61. Recommendation: Advocacy should be made available at the initial examination stage.

62. Further, we have serious concerns as to whether the 140 advocates proposed under the Bill will meet demand and reflect the diversity among black and minority ethnic populations. The recruitment of culturally and racially appropriate personnel eg Advocates, Clinical Supervisors, AHMPs and members of expert panels and tribunals requires particular attention.

63. Turning Point acknowledges that since the 2002 draft Mental Health Bill, the Department of Health is undertaking a major programme of work concerning people from BME groups. This programme is essential and is a step in the right direction, but progress is likely to be slow, especially as some consider that racism within the NHS is on an institutional level. It will take a long time for attitudes and practices to change and therefore the safeguards must be more robust.

64. Improvements notwithstanding, the timing is out of step. The Department of Health states that “a full review of the NIMHE black and minority ethnic programme of work will take place in 2007 and a reassessment of the impact of mental health services on black and minority ethnic communities will be carried out in 2010.”

10. What are likely to be the human and financial resource implications of the draft bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

65. We endorse the detailed submission from the Royal College of Psychiatrists that the additional mental health professionals and time and training requirements created by the Bill is likely to make it unworkable.

66. Turning Point has extensive knowledge of frontline practice in a range of community and residential settings. Staff are concerned that the time spent monitoring whether people are complying with conditions of the non-resident order (such as taking medication or attending a day centre) may assume more importance than client focused and appropriate care.

6 A recent systematic review of research suggested that BME patients are four times more likely to be detained, whilst research undertaken for the Dept of Health suggests they may be six times more likely to be detained. Hard data collected by the MHAC show that in many areas, patients from BME groups are detained at twice the rate expected from their presence in the local population See Mental Health Act Commission, 10th Biennial Report, pages 238-9.

7 NIMHE March 2003 p27.

8 These include the National Census, commencing in 2005, being undertaken by NIMHE, the Mental Health Act Commission and the Healthcare Commission. This will be all those in contact with secondary mental health services including those under compulsion, in including questions on ethnicity, first language and faith.

Memorandum from the National Black and Minority Ethnic Mental Health Network (DMH 241)

1. **Preface**

The National Black and Minority Ethnic Mental Health Network welcome the opportunity to contribute to the pre-legislative scrutiny process to ensure that the draft Mental Health Bill 2004 is both equitable and socially inclusive.

We believe that any provision that aims to improve the creation and delivery of mental health services must be racially and culturally appropriate. Evidence that BME communities are more likely to experience inequitable and discriminatory service provision is both longstanding and compelling without having to reiterate the arguments here.

We are concerned at the loss of section 117 in the current draft of the Mental Health Bill. We believe that the absence of this essential after-care provision, and the overemphasis on the perceived risk to the public, is the wrong approach. It would be more helpful and constructive to focus on good health care for all those who are unwell.

We understand that it is a difficult balancing act—protecting patients and service users, and protecting the public. But there are also many risks facing service users and patients, particularly those from BME communities such as the loss of their family, employment, home and self-esteem.

The Bill’s emphasis on the perceived risk to the public chimes with popularly held stereotypes of “threat” and “dangerousness” applied to mental health service users, particularly those from BME communities. We are also concerned about the increased over-representation of BME communities at the more coercive end of the mental system, which is already a reality.

The reality is indeed so potent that the National Institute for Mental Health England is attempting to alleviate the burden through its Delivering Race Equality Programme in BME Mental Health, due to be published in December. This reality was also highlighted by the Inquiry Report into the death of David Bennett, which was launched in February.

Indeed, the Secretary of State for Health John Reid is expected to introduce a plan of action based on the Bennett Inquiry Report recommendations before the end of the year. Significantly, both of these Government-led initiatives acknowledge the importance of the Race Relations Amendment Act 2000.

We sincerely hope that during the pre-legislative scrutiny, the draft Mental Health Bill develops more robust and transparent links to relevant and anti-discrimination legislation in line with joined up Government, especially the Race Relations Amendment Act, The Disability Discrimination Act 1995, the Children Act 1989 and the Sex Discrimination Act 1975.

2. **The Positives**

*General principles*

**Paragraph 1: Code of Practice: General Principles and Guidance**

We like the idea of principled legislation and we welcome many of the ones noted in the draft Act. However, we feel that they could go even further by being cross-referenced with other Government initiatives and anti discrimination legislation, with some exclusion criteria. This should be done with regards to the Race Relations Amendment Act, the Disability Discrimination Act, the Children Act and the Sex Discrimination Act.

*Admission criteria*

With regards to admission criteria, although we are unhappy with the wide definition of mental disorder, we welcome:

**Paragraph 9(2): The first condition is that the patient is suffering from mental disorder**

**Paragraph 9(3): The second condition is that the mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.**

**Paragraph 9(4): The third condition is that it is necessary:**

(a) for the protection of the patient from:

(i) suicide or serious self-harm, or

(ii) serious neglect by him of his health or safety, or

(b) for the protection of other persons, that medical treatment be provided to the patient.

**Paragraph 9(5): The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this part.**
Paragraph 9(6): The fifth condition is that medical treatment is available which is appropriate in the patient’s case, taking into account the nature or degree of his mental disorder and all other circumstances of his case.

These provisions, particularly Paragraph 9(6), both reflect current practice and highlight the new concept of “appropriate” treatment which takes into account the individual patient’s particular circumstances, and rightly focuses on each patient’s needs. We do hope that culturally appropriate treatment will form part of the Bill’s definition of “appropriate”.

Treatment

We are pleased to see additions here, chiefly:

Paragraph 2(7)(c): cognitive therapy, behaviour therapy, counselling or other psychological intervention.

As BME patients are more likely to receive higher doses of medication than their white counterparts, it is useful that more non-pharmacological treatments are to be made available. Treatments must be culturally appropriate with religious and spiritual beliefs taken into account.

Mental health tribunals

Currently, with regard to the transfer of patients between areas, it is only necessary for the RMO of the sending area and receiving area to exchange forms for the patient to be transported to regions where they may be isolated from family, friends or social support networks. For BME patients, this isolation may indeed mean racial isolation, and for all patients there is very little recourse to challenge this transfer option.

Under the new conditions it is envisaged that patients will be able to appeal to a Tribunal against such transfer options. The panel will then be able to look at the care plan for the patient’s transfer, and specific circumstances such as the racial and cultural appropriateness of the transfer can be addressed.

For that reason we would like BME groups to be consulted on the make up of Tribunals.

Expert panel

Paragraph 7: There should be BME representation on the Expert Panel. And we would encourage the Department of Health to consult with BME organisations to develop a pool of potential candidates.

Advocacy

Paragraph 247: We approve of the fact that the profile of advocacy has been raised and recognised as an essential part of patients’ rights. That said, we are concerned at the small number of Advocates proposed by the Bill (140), and the fact that they are only accessible once a person is detained. We are concerned at the possible workforce implications of a projected small number of Advocates being needed to respond to what we feel will be increased demand upon the services.

3. The Problems

General principles

Paragraph 1: Code of Practice: General Principles and Guidance.

There should be a principle that reflects the Government’s commitment to joined-up thinking across departments so that the provisions in the Bill have due regard to all relevant and anti discrimination legislation as already mentioned in this document. Religious and spiritual needs, often overlooked, also have to be accommodated.

Definitions

Paragraph 2.5: “Mental disorder” means an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain; and “mentally disordered” is to be read accordingly.

We believe that the definition of “mental disorder” is far too wide and needs to come with some exclusion criteria as featured in the current Mental Health Act. Indeed, as the definition stands it can accommodate any condition such as drug or alcohol misuse and could bring people who do not suffer from a specific mental disorder under the compulsory powers of the Act. We must be mindful that such a wide definition could make the current over-representation of BME communities in the mental health system considerably worse.
Admission criteria

We are concerned at the addition of two new provisions to this draft Mental Health Bill. They are:

Paragraph 9(7): The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons.

and

Paragraph 9(8): For the purposes of this Part, a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.

These two Paragraphs primarily emphasise the risk to the public rather than the provision of a service to the patient or the patient’s risk to themselves. However, it is impossible to calculate the risk to the public, especially when looking specifically at calculating the risk of people with no prior history of mental disorder or criminal convictions, particularly for violence against other persons. The potential for risk assessments to be influenced by stereotypes of “dangerousness”, particularly where African-Caribbean men are concerned, makes this provision worrying.

There are the needs of young people to consider in this context, and Paragraph 9(7) must be linked to the Children Act and the role of Child and Adolescent Mental Health Services. The protection of young people from self-harm mustn’t be lost amid the focus on the risk to the public.

Overall, these two Paragraphs are draped in the cloak of “dangerousness” and add weight to the consensus among mental health specialists and agencies that this is a “Public Order Bill”.

Therefore, we would wish for both of these provisions to be deleted.

Treatment

We feel that the definition of treatment is too wide.

Paragraph 2(7): References to medical treatment are references to treatment for mental disorder provided under the supervision of an approved clinician; and for this purpose “treatment” include:

(a) nursing,
(b) care,
(c) cognitive therapy, behaviour therapy, counselling or other psychological intervention,
(d) habilitation (including education, and training in work, social and independent living skills), and
(e) rehabilitation (read in accordance with paragraph (d)).

While on the one hand the expansion of understanding of what constitutes treatment areas is to be welcomed, placing these wide definitions alongside widened admission criteria will make it hard to argue against detention, which surely should be the last resort. We also recommend the inclusion of alternative and complementary therapies, some of which are culturally acceptable within BME communities and are used within families as the norm, for example Indian head massage.

Mental health tribunals

We do not see the advantage of the changes to the Tribunal structure.

Paragraph 4(2): Each Tribunal is to consist of:

(a) a President, and
(b) a number of other members, appointed by the Lord Chancellor.

It would appear that in certain circumstances a Tribunal can consist of only one person. The impression is that there will be one “President” with access to a pool of consultants, which we are unhappy with because when it comes to the serious matter of liberty, it should not be the case that there will only be one person adjudicating. We are unclear as to why the present structure is changing.

There are also potential problems around time limits. Currently time limits apply to when a hearing has to be heard by. There is no mention of this in the Bill, meaning that there will be possible delays in hearings and, ultimately, justice.

Advocacy

Paragraph 247: We feel that the right to an Advocate appears far too late: when they are detained. We feel that anyone who wants an Advocate should have the right to one at any time. Good advocacy prior to detention may make compulsory detention unnecessary, which is why advocacy should be provided at the earliest possible point.
We would also like to know whether these 140 Advocates will be recruited and trained in a culturally appropriate manner as well as reflect the ethnicity of the general population and patients in the mental health system. It is important to ensure that Advocates are not used as an interpreting service and that support mechanisms are developed to facilitate them in their role. There is also the question of who will train them and how the number was calculated as we feel the figure is far too small.

**Clinical supervisor**

Paragraph 24: We have concerns that the ethnic mix of staff, particularly at this level, does not reflect that of the general population or the patients within the mental health system.

**Removal of section 117**

The removal of this section from the first draft of the Mental Health Bill is deplored. There should be an equivalent after care provision within this Bill.

4. **THE RESPONSE: CONTRIBUTING AGENCIES**

BME Mental Health Service Improvement—GLA
Christ Church, North Brixton
Croydon IAMHS, Croydon Council
Diverse Minds at Mind
Future Health and Social Care
Inyama and Co Solicitors
Mental Health Alliance
Revolving Doors Agency (Tower Hamlets Link Worker Scheme)
Songhai
The Afiya Trust
The Chinese National Healthy Living Centre
The 1990 Trust

*November 2004*

---

**Witnesses:** Lord Adebowale, a Member of the House of Lords, Chief Executive, Mr Ronnie Watson, Mental Health Coordinator, Turning Point, Dr Joanna Bennett, Workforce Development Manager, Breaking the Circles of Fear Project, Mr Chinyere Inyama, Mental Health Lawyer, and Mr Nisar Khan, mental health voluntary worker and service user, Black & Minority Ethnic Mental Health Network, examined.

**Q871 Chairman:** May I welcome you to this meeting of the Committee. Could I ask you to bear in mind that this is a public evidence session, and, as you can see, we have a substantial public gallery at these meetings. A transcript of the evidence will be produced and will be available on the internet after about one week. You will be able to make corrections of a textual nature only. We have a lot of witnesses this morning. I apologise for that, but our target is to finish this part of the evidence by about 10.30. Could I ask you for the record to introduce yourselves and then Lord Mayhew is going to ask the first question today.

**Lord Adebowale:** I am Lord Victor Adebowale. I am the Chief Executive of Turning Point provider of social care. I am also the co-chair of a national BME steering group, along with Rosie Winterton.

**Mr Watson:** Ronnie Watson, Mental Health Act Coordinator for Turning Point.

**Mr Khan:** My name is Nisar Khan. I am a service user. I am with Awaaz Manchester, which is a service-user led organisation. I am on the Mental Health Bill Implementation Group as well.

**Dr Bennett:** I am Joanna Bennett. I am Workforce Development Manager, Breaking the Circles of Fear project at Sainsbury Centre for Mental Health and I am an ex-carer.

**Mr Inyama:** Good morning. I am Chinyere Inyama. I am a mental-health lawyer. I am also a Mental Health Review Tribunal Legal Member and Assistant Deputy Coroner for Essex and Thurrock.

**Q872 Lord Mayhew of Twysden:** Good morning. I would like to ask a question about comparative rates of detention for patients who are from black or other minority ethnic communities. Your view is that under the 1983 Act they are detained at a disproportionately high rate, and I think you put it, as a result of some research, at about four times. Other research suggests six and other research suggests about two. I wonder if we could hear from you as to what reasons you perceive for disproportion, however great or little it may be?

**Mr Inyama:** I would like to answer that question, if I may. I think the first thing to be said is that the BME (black and minority ethnic) community is diverse. Some groups within that community are actually under-represented, so when we talk of over-representation we are talking of African Caribbeans, in particular young African Caribbean men, and when we talk of over-representation we are really talking about in the coercive end of the mental health system. The figures you quoted will vary
according to the issue you are looking at. For instance, last year’s report Mental Health and Social Exclusion from the Office of the Deputy Prime Minister stated that, in terms of being detained in locked wards, African Caribbean men are five times more likely to be detained in locked wards. In terms of being detained generally, they are six times more likely to be sectioned. That is the background. There is a history of misunderstanding and discrimination, we would say, when it comes to the use of compulsory powers in the mental health system. There are very complicated reasons as to why that has happened. We are more interested in stopping that happening in the future, and we are concerned about the Bill, as currently drawn, not stopping that in the future.

Q873 Lord Mayhew of Twysden: You obviously think that the safeguards under the present legislation are insufficient. What would you like to tell us about the proposed safeguards for the present legislation?

Mr Inyama: Our main concern revolves around clause 9, the conditions for compulsion, and, in particular, clause 9(8) which allows a determination of dangerousness. We are very concerned about this because, from history, race is often seen as an index of dangerousness. In 1993, there was a major inquiry into the deaths of three black men at Broadmoor. The inquiry was actually entitled Big Black and Dangerous and highlighted the perception of some delivering health care in the mental health system about race as an index of dangerousness; then, in 2003, with the death of Rocky Bennett, the inquiry report made some similar sentiments; and even then, in May last year, with the death in similar circumstances of a young Asian man, Azrar Ayub, in Manchester. So we are concerned that race is used as an index of dangerousness, and where there is an emphasis on danger and risk in the conditions under paragraph 9(8) we believe it disproportionately affects our communities.

Q874 Lord Mayhew of Twysden: Not to put words into your mouth, are you looking for a specific prohibition against discrimination on the face of the Bill or are you looking for something more effective in your view than that would be?

Mr Inyama: Firstly, the offensive paragraph to us should be deleted. That is our view. There is already protection for the public in clause 9(4), so there is no need for this additional clause which we think disproportionately affects our communities. Over and above that, there should be—and I am sure you have heard this already, we know we are not alone in thinking this—principles in the Act which govern how the powers of the Act are emphasised. One of those principles should be equality; equality, non-discrimination, respect for diversity. These are not controversial and we are surprised they were not included in the Bill. We think they should be included in the Bill, and they should be in the body of the legislation without any method of dis-application for those principles.

Lord Mayhew of Twysden: Thank you.

Q875 Chairman: Mr Inyama, on the point you have made about clause 9(8) and its connection with clause 9(4), I do not know if you want to reply to this, as it were, on your feet, but could I try it on you. Supposing that in clause 9(4)(b) it read: “for the protection of other persons from serious harm”—in other words, the words “from serious harm” were added—and clause 9(8) were then removed, would that meet your objections?

Mr Inyama: It would certainly meet the objections in terms of lessening the emphasis on risk to the public—because, of course, the current legislation already has a similar provision in terms of protection for the public. You have asked me to speak on my feet. I will say immediately that it is not just about the serious harm, it is about the imminence of the harm and a better definition of what is “serious”, “substantial risk”, et cetera. Our concern is the over-emphasis on risk. Risk involves danger. Race is used as an index of dangerousness, even today.

Lord Adebowale: Could I add to Chinyere’s evidence. The problem is that the Government knows that people from BME groups are disproportionately affected by the current Act but in documents like Breaking the Circles of Fear we have a perception from the black community that they will be treated unfairly by the mental health system. It is not sufficient to leave the Code of Practice as the place where we address discrimination or just have principles on the face of the Bill. Some of the issues faced by BME groups are not just entirely down to implementation of services and resource issues. If the Government wants the perception to change in the BME communities and for those communities to engage, it is no good just to publish the Bill as it stands. We believe it is essential to make legislative changes which actively address those issues. The Delivering Race Equality document has just been produced in the steering group that I co-chair, and it would be a terrible shame, having done all that good work, which makes key recommendations about additional resources, about engaging the black community in mental-health challenges, if those resources are not used because the Bill does not empower the mental health system and does not actually force the mental health system to engage with those new resources. There are three specifics, if I may, that I would like to highlight. The first is about places of safety. In section 136 of the 1983 Act, the police can take a person from a public place to a place of safety for up to 72 hours for assessment to determine whether compulsory admission to hospital is needed. This is replicated in clause 229 of the draft Bill. While there are no official figures, we do know that section 136 could be used as many as 10,000 times a year. The detention of people with mental health problems in police cells has hit the headlines, and Nick Hardwick, who is the co-chair of the Police Complaints Commission, estimates that 50% of deaths in police custody have involved people with mental health problems. He puts it quite bluntly: “Whatever a police cell is, it is not a place of
Joint Committee on the Draft Mental Health Bill: Evidence

26 January 2005 Lord Adebowale, Mr Ronnie Watson, Dr Joanna Bennett, Mr Chinyere Inyama and Mr Nisar Khan

Ev 546

safety for people with mental illness”. Despite the fact that the current Code of Practice states that police cells should not generally be used in practice, they are. Mind estimates that police cells are used in about 80% of occasions when section 136 powers are invoked. This is very relevant to African and Caribbean communities, given the fact that black people are more likely, as you have already heard, to have a negative experience with the police and to be over-policed—without opening up that whole debate again, recalling the McPherson report and the death of Stephen Lawrence, et cetera. Racism aside, it acknowledges that the police, particularly custody officers, do not have adequate training, if any, about mental health issues and especially when a person is distressed and causes disturbed behaviour. To add to that, the Mental Health Act Commission has repeatedly stated in their biannual reports—as many other stakeholders have mentioned—that police stations should not be regarded as places of safety. A police station is not an appropriate place for the care of someone with a serious mental disorder. It is not appropriate for someone to be held there for up to three days whilst arrangements are made for their examination, and the Bill should state that, because we know it disproportionately affects members of BME communities. Specific number two which I think needs to be brought to your attention is the issue of care plans being drawn up by the clinical supervisor. We think it should be CPA care plans for the following reasons. The care plan should not be that of a clinical supervisor alone; we think this is contrary to best practice; ie the Care Programme approach. We think, if it is only drawn up by the clinical supervisor, there will be two care plans, which will lead to confusion—again, something that affects BME communities disproportionately. To move on to specific three, there is an issue of timing of when the final Bill is introduced before Parliament, and this again refers to the work that is being done on the BME document and the Race Impact Assessment which we know is being carried out. The objective of the Race Impact Assessment is to try to gauge the impact of the Bill on BME groups. We believe that it is essential that the mental health census that is being carried out by the Mental Health Act Commission is completed first.

Q876 Chairman: When will that be completed?
Lord Adebowale: I think the Mental Health Act Commission is due to start their audit in March. I might be wrong.

Q877 Chairman: Until?
Lord Adebowale: I think they are going to do it in a time period of about a month.

Q878 Chairman: There is no problem on the timing then.
Lord Adebowale: That is great. We certainly think that should be used as a baseline to inform the Race Impact Assessment, because it will include questions on ethnicity, first language and faith. Similarly, the Race Impact Assessment should be completed before the final draft of the Mental Health Bill and the Race Impact Assessment should be conducted by an independent body, not by the Department of Health. That is very important because the draft team at the Department of Health, in our view, do not appear to foresee any negative effect on BME communities. I think that is a real problem. As a result of this Bill, it would be inappropriate for them to phrase the questions for the Race Impact Assessment. The involvement of the black community in that Race Impact Assessment questionnaire is critical to the outcome of that Race Impact Assessment. I think most people would understand that. Those are some of the specifics we think would be helpful in addressing that question directly in the legislation.

Q879 Ms Munn: I would like to move on to talk a bit about definitions and exclusions and start off with this issue of treatability and personality disorder. You commented on that in your submission. I wonder if you could expand a bit on this around two issues. One is a concern that I have had from past experience that sometimes people are labelled with personality disorder and labelled as untreatable, for whatever reason, either because resources are not available to provide that treatment or there is reluctance to treat. Also we have had submissions from other people saying that, if people themselves are not going to benefit from some sort of treatment, then should they really come under the Mental Health Act at all in terms of the process of that. I wonder if you could comment on that from your perspective?
Mr Watson: If I could refer to the question as it was given to us on Monday, and I will take the second and third parts of that question first—it says that “mental health legislation should be concerned with mental illness and not personality disorder”. Many people with personality disorder need treatment and many of them want treatment, and that treatment is firmly the responsibility of mental health services. This is made clear in the National Institute of Mental Health in England’s document Personality Disorder: No longer a diagnosis of exclusion. To quote the stated aims on the front of that document: “To ensure that people with personality disorder who express significant distress or difficulty as a result of their disorder are seen as being part of the legitimate business of mental health services”. I think it is entirely appropriate that personality disorder is brought under the remit of mental health legislation. The next part of that question, “. . . if legislation is thought to be required to deal with non mentally-ill dangerous persons, it should be framed in terms of their dangerousness rather than on a contentious diagnosis”. Dangerousness is being confused with diagnosis here again, as this question implies. Non mentally-ill dangerous persons would not come within the remit of this legislation: they would not satisfy the first criteria that they have a mental disorder. So that is a red herring. If someone with a personality disorder commits a crime, it is
entirely appropriate that they are dealt with by the criminal justice system, and it would be up to the courts to decide whether a mental health disposal was most appropriate in their case. The vast majority of people with a personality disorder are not dangerous, and that is the group of clients with which we are concerned. People with personality disorders who would benefit from treatment are being turned away by the treatability clause in the current legislation. When a person has a label of “personality disorder”, it can become an overriding factor.

Q880 Ms Munn: In your written submission you have said, “We do not believe that a stipulation within the Act that treatment should be of therapeutic benefit would be helpful. Turning Point works with many people with personality disorders and this requires greater emphasis on psychological approaches based on changing behaviour and patterns.” It seems to me this goes to the whole issue of what we actually mean by treatment. Are psychological approaches actually treatment? And there are also questions around therapeutic benefits and you start to get a circular argument there.

Mr Watson: Yes, I was coming to that. We are pleased at the definition of treatment now includes cognitive therapy, counselling or other psychological intervention. It is vital to include alternatives to medication-based treatments, particularly for people with personality disorders, as agreed, where the treatment requires a greater emphasis on psychological approaches. We understand the concerns that have been raised about what constitutes appropriate treatment, which makes it pressing to consider the idea of therapeutic benefit, but we have some difficulty with the phrase “therapeutic benefit” itself. We feel that, when it comes to professionals interpreting the Act, therapeutic will be equated with evidence-based, particularly in tribunals, where the tribunal is required to make a decision based on the evidence in front of it. Medication-based treatments are well evidenced. The very fact that medications are licensed before they can be used means that they have to have a solid evidence base. That is not the case with effective treatments for personality disorder. They are developing. They are new and less well-established in comparison with drug treatments. They are less well studied because they are new. Many of them are much more difficult to study in evidence. Psychotherapy is an example. How do you determine efficacy with these types of treatments? Efficacy in terms of, you know, efficacy to whom? You could talk about an improvement of quality of life for the individual; you could talk about reducing the risk of harm to the individual; you could talk about reducing the risk of harm to others; you could talk about reducing re-offending. It is important that the focus is on the individual, on the patient, and what is best for them. Treatments for personality disorder are many and varied and what works for one particular individual will not work for another. What works in one treatment setting, for instance, in a therapeutic community or in a hospital setting, very often will not work in other settings. So there is great variation. It is generally recognised that there is no cure for personality disorder and therefore effective treatments tend to emphasise the management of their condition: increasing their coping skills and reducing the risk, rather than actually looking for a cure. A less well-established evidence-base should not be used as a barrier to people receiving the treatment that they need. We are just worried that restrictive interpretation of terms like “therapeutic benefit” will hamper the range of treatments that the practitioner is able to offer to people with personality disorder.

Q881 Ms Munn: Are you suggesting in fact that that should be removed or something else substituted?

Mr Watson: We support some sort of re-wording, either in terms of a benefit to the treatment or in clause 9 round the word “appropriate”. We find that a very difficult thing to do actually and we have not ourselves come up with a comprehensive statement. I think we are going to have to leave it to the lawyers. But we do have concerns about restricting the treatments that would be available.

Chairman: We will return to that point a little later on.

Q882 Mr Hinchliffe: Jumping back to Lord Mayhew’s first question, which relates to the over-representation of BME communities within the mental health system, I wonder whether you feel that there may be alternatives available in many instances to sectioning somebody from the BME community; what these alternatives might be; and whether this future legislation could play a part in ensuring that there is the development of those alternatives and that those alternatives are thought through at the time of a person possibly being sectioned.

Mr Inyama: I think the answer to that, in many ways, is race neutral, because in many instances there should be and there could be alternatives to compulsory detention. This current Bill emphasises that, even if a patient would be happy to come into hospital, they have to be sectioned if they meet the conditions. That is the first thing. In terms of BME communities, the explanatory notes to the Bill mentions advocates, “mental-health advocates”. We believe—and I am sure many others also agree—that these advocates should be available at the time of examination and part of their remit will be to explore other methods of dealing with the problem and treating a patient without resorting to compulsion. From our point of view, those advocates should also be appropriately trained—and we are going to talk about appropriateness later. I am sure—in order to give the correct advice and correct assistance to those from different communities.

Mr Khan: As a service user, I have had that experience of being sectioned. I was using cannabis and I had a history of using cannabis, and I also lived where some of us were having a lot of racist abuse. I presented myself to Samaritans on campus. I went to
the counsellor for help, but he decided to call the police, and from that chain of events . . . I was not a danger. I told them, “I am using cannabis”—you know, the paranoia sometimes is linked to the cannabis itself. So he called the police and—

Q883 Chairman: Who called the police?
Mr Khan: The counsellor. He called the police and then I panicked, ran out the window, was sort of held by more police officers, taken down the police station, where I was given an interview with a social worker and then put on a section 2, which is 28 days. The place was called Hellesdon—which is a great name for a psychiatric institution, when you are paranoid! The actual process of being admitted made me completely psychotic and I did try to kill myself a few times. Those statements, in terms of over-representation . . . you know, a WAS means a voice, a block, they just exist, they are in the system.

Q884 Chairman: You said you were interviewed with a social worker present. Was that a police interview?
Mr Khan: It was at a police station. A social worker—

Q885 Chairman: Under caution? You were cautioned and interviewed about a criminal offence, were you?
Mr Khan: I do not recall. All I recall is that there was a social worker there, and there must have been someone else as well, and from there I was admitted on a section 2. What I am saying is that I was perceived as a risk and a danger and I was not.

Lord Adebowale: Could I add to that? I think what Nisar has described is basically a cycle, a spiral basically, downwards, which is based upon a number of assumptions made by clinicians which we have already gone into about black people. The answer to your question: are there alternatives? I think has to be yes. But if you look at the work of the DRE those alternatives have to start with a rethinking of what happens in situations that have been described by Nisar, and that is about the values of the people making a clinical intervention in the first place. If you look at the work by Professor Bill Fulford on value-based medicine, the application of some of those principles in that situation may well have avoided what turned out to be a horrific life experience. There are alternatives. Could I make one more very quick comment about the high multiple doses of medication, because I think to try to get down to the specifics is quite important. One of the things that black people experience is the overuse of high multiple doses of medication, and we want to see that some of the clauses are strengthened. We want to refer the Committee to the recommendations by the Mental Health Act Commission which state that, “Doses above BNF limits should only be given with fully informed consent or to prevent serious risk to the life of the patient subject to the approval of the tribunal and for a limited time period. Drugs treatment should only be used outside their product licence in the interests of the patient’s health if there is no licensed alternative for the tribunal’s approval”—and those are minimum requirements—so there are some very specific things that can be done. I think there are also some understandings about the value-base of clinicians—and that is backed up by some of the training issues, which, again the BME brought out, on which I know Dr Bennett has been doing a lot of work. So there are some things which this Bill could reinforce. If it does not take this opportunity, then I do not think we are going to move very far forward as far as black people’s experience of the mental health system is concerned.

Q886 Chairman: Dr Bennett, do you want to add anything in that context?
Dr Bennett: I would really want to go back to the issue of substantial risk, my experiences as a carer and the inquiry recommendations and investigation into my brother’s death and the fact that within the last three years of his life he was in a secure environment, detained under the powers of the Mental Health Act, and certainly it was extremely difficult from his point of view to see an endpoint to his detention in psychiatric care. I think we do need to be cognisant really of the focus that Chinyere has mentioned of the indices of risk and the fact that race and culture influences that perception significantly. Certainly a lot of the evidence that came out in the inquiry in relationship to what happened to my brother on the night of his death suggests that, in fact, there were some misconceptions of the level of risk or degree of risk which he presented and the way in which that was dealt with in fact then led to excessive force being used in restraining him and ultimately to his death. Again, linking that to some of the other cases that Chinyere Inyama has mentioned, and also Lord Adebowale, of deaths of other people with mental health problems in police custody, certainly time and time again the evidence suggests that, in fact, there is this perception of danger, perception of risk, associated or linked with race and culture, and we need to be extremely careful about conditions for the use of the Act.

Q887 Lord Rix: It may not surprise you to know that my question to Turning Point is about learning disability. Could I, as it were, ask you the question and give you, in effect, a draft answer and see if you approve?
Lord Adebowale: That would certainly save time, Lord Rix.

Q888 Lord Rix: You say in your written evidence that the definition of mental disorder is so broad that people with a learning disability could still come under formal powers even if they do not have a coexisting mental health problem—with which I fully agree. “Turning Point remains concerned, especially as the explanatory notes explicitly state that examples of a mental disorder include schizophrenia, depression or a learning disability. Furthermore,”—you did not bother to put in the easy-read version—“mental disorder, having a mental health problem or illness, this includes
having a learning disability”. Then, in your recommendations, you say, “Turning point does not recommend that learning disability be expressly excluded from the draft Bill”—which seems to be a slight contradiction. Then you go on to say, “An additional exclusion clause on the face of the Bill which explicitly states that a person with a learning disability who does not have another co-existing mental disorder should be excluded from the Act, in line with legislation in New Zealand”. I am going to suggest this to you—and this is only a draft and, I hasten to add, I am not putting this down as the final clause. In clause 2(5): “Mental disorder means an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain; and ‘mentally disordered’ is to be read accordingly”—to which I would suggest we could add clause 2(5)(a): “Impairment of intelligence, whether or not accompanied by impairment of social functioning, shall not of itself constitute mental disorder.” I would very much appreciate your comments.

**Lord Adebowale:** First of all, let me clarify Turning Point’s position, which is pretty much what you have said really: a learning disability is not the same as a mental illness. It is as simple as that. A learning disability without mental illness should not constitute a mental disorder. That is what it boils down to. We are quite clear that people with a learning disability alone should not come within the remit of compulsory powers. The most appropriate legislation under which the majority of people with a learning disability should receive treatment would be the mental capacity legislation, when it becomes law, and people with a learning disability should only come under the Mental Health Bill if they have a concurrent mental health problem and if they are a danger to themselves or others. That is Turning Point’s position.

**Chairman:** Could I stop you, with great respect, Lord Adebowale, because I think we have agreement between you and Lord Rix on this point, so we might move on, if you will forgive me—leaving the drafting aside, if Lord Rix will forgive me.

**Lord Rix:** Yes, of course.

**Q889 Chairman:** Can we return to this question of therapeutic benefit and appropriateness, bearing in mind the word “appropriate” appears in clause 9(6). Would the groups represented here today favour a provision in clause 9 defining what is appropriate in rather narrower terms; or would you be satisfied with the Code of Practice containing guidance which is likely to have the same effect, but which might be a little bit more flexible, bearing in mind that we are not going to have another Mental Health Act for a considerable time if the form book is anything to go by?

**Dr Bennett:** The question as it is posed here, as you have reiterated, around the definition of appropriateness within the context of medical care. I would argue that we are talking here about medical treatment that is appropriate for a particular person. It is about medical care that is able to meet individuals’ needs. It is about compatibility of the medical treatment to the individual’s needs and it is about equitable treatment. It is about fairness: impartial and equal treatment. We also have to consider within this context, when we are talking about appropriate medical treatment, appropriate for whom? Appropriate from the mental health service user’s point of view or appropriate from a clinicians, point of view. I would suggest that both of those need to be taken consideration in relationship to appropriateness of treatment. The point I am trying to make here is that the emphasis in terms of appropriate treatment should be on the needs of the individual. I believe that the individual’s needs need to be seen within the context of the individual’s race and culture. That is absolutely crucial within the context of this Bill. However, I would suggest that actually there has been an overemphasis on cultural differences. In terms of over-representation of young black men, Afro-Caribbean men in this context, we are talking in fact about a black community which is generally a British black community: they are generations who have been born in this country. So this overemphasis on cultural differences, whilst it is important, I believe has been overemphasised. And I think it has been overemphasised at the expense of looking into the issue of racial discrimination and the impact that has on clinical interactions and decision-making processes. So I think it is important for us to consider culture, but cultural approaches do lead to a kind of homogenous view of a particular group and then can lead to stereotyping of individuals from those groups. I think it is important that with appropriate treatment we should consider a clause that looks at appropriateness of medical treatment within the context of the individual’s race and culture. Whilst I recognise it is important that that is probably further expanded within the Code of Practice, I think it is important that there is a clause within the Bill that actually looks at appropriateness and relates appropriateness to the individual, both their race and their culture, which then suggests that in fact clinicians need competence in both those areas, not just cultural competence, which might point to the individual dietary needs, language needs and so on, but which looks at racial discrimination and how that impacts on the decision-making processes about what is appropriate treatment for the individual.

**Q890 Baroness McIntosh of Hudnall:** Dr Bennett, I wonder if you could expand this point a little bit in relation to the available resources for both now and in the future for the implementation of any improvement or change to the provision of mental health services. You have particularly noted the necessity for people to be trained to be aware of what is appropriate in relation to individual patients, and that might include, for instance, the necessity to look at recruitment patterns and, indeed, to look at numbers, not just amongst clinicians but amongst other kinds of service provider. Do you have any observations for us about what the Bill says about
recruitment and retention for mental health professionals and, indeed, how they are organised, and what it does not say and what your own observations would tell you perhaps it needs to say? 

Dr Bennett: I think, whilst it is important to recognise that issues around so-called cultural matching and representation of BME communities within the workforce are important, I think we also need to recognise the problems associated with recruitment generally within the mental health workforce. There are huge problems at the moment in terms of recruiting, right across the range of professional groups within psychiatry. I think it is important for us to focus more on developing appropriate race equality training rather than focus so much on the idea that, somehow, if an individual is being cared for by somebody that looks like them that in fact this makes a huge amount of difference. It really is about the paradigm within which people are trained and recognising that in fact an individual’s needs are influenced by a number of factors and that those are addressed within the context of providing care. Whilst I cannot go into any detail about what the Bill actually says about recruitment and so on, I think it is important that we recognise that recruitment and representation within the workforce is important, but it is not the be all and end all of changing the experience of black people. It is about providing good race equality training so people are able to look at the individual’s needs from their perspective, their experience. The thing that a lot of black service users will say about what they need is to be treated with respect and dignity, and I do not think that necessarily translates into cultural appropriateness or being treated by somebody “who looks like me”. 

Lord Adebowale: I do not think the Bill does say a great deal about training and I would be concerned about that if it is not picked up in the guidance. Just to add to Dr Bennett’s contribution, the issue is about competence. Full Stop. Period. It is not about whether you are black, white, yellow or green; it is about competence. If you are competent you should be able to make an assessment based on an individual’s needs from their perspective, their experience. The thing that a lot of black service users will say about what they need is to be treated with respect and dignity, and I do not think that necessarily translates into cultural appropriateness or being treated by somebody “who looks like me”. 

Chairman: Ask the question and we will see.

Q891 Mr Howarth: I thought Dr Bennett went a long way to try to clear up this distinction between: Is there something within certain communities which makes the propensity for people to have mental health problems greater or is it more to do with how the professions view particular episodes? Mr Inyama made the point that it is a complex issue, and not just the statistics but the reasons behind it. Would it be possible to provide a summary of the literature on that for the Committee, so that we will better able to understand that issue?

Dr Bennett: Yes.

Chairman: I interpret the nods as a yes in answer to that very helpful question. Thank you for asking it. Could we try to deal with the issue that Mr Prosser wants to raise.

Q892 Mr Prosser: Thank you. In your written evidence you talk about the need to define clearly cases which will be suitable for care in the community, continuing assessment of care in the community. Could you tell us how you would draft the Bill to lay down the parameters to make those definitions clear? In particular, could you tell us a little more about Turning Point’s view on the treatment of people with dual diagnosis of mental illness and substance abuse, again in the context of care in the community and compulsory treatment orders.

Mr Watson: Firstly, to clarify our position on non resident orders or community treatment orders, we support the principle of assessment and treatment in the community but we would not be happy to support the Bill as it is drafted. We feel that there needs to be some quite strict criteria as to which groups would be appropriate.

Q893 Chairman: This, Mr Watson, is a common concern that has been expressed to us by many witnesses, so you can assume that the Committee is considering that issue.

Mr Howarth: We would refer the Committee to the Saskatchewan criteria which are in my submission, which say that people should have had a previous admission to hospital or repeated admission to hospital under compulsion. In terms of particular groups, we do not see any reason why people with a dual diagnosis, whether it is mental illness and alcohol misuse or substance misuse, should be specifically excluded from non resident orders. I think there will be people in all these categories and with multiple needs for whom community orders would be appropriate, but it is about each individual case. We would not exclude all dual diagnosis from non resident orders as a group. I think each case
would have to be determined individually. There are some people for whom these orders would be appropriate but we need to be very careful about how we define those groups.

Chairman: Thank you very much. We have packed a lot into three-quarters of an hour and you have been very helpful and very clear. I am sure I speak for the whole Committee in expressing our gratitude, both for your written representations and for the answers you have given this morning with such clarity. Thank you.

Supplementary memorandum from Turning Point (DMH 438)

Turning Point was pleased to give evidence to the Committee on Wednesday 26 January 2005.

This memorandum gives further information about some of the points raised.

**Question 879:** posed by Ms Munn, about treatability and personality disorder.

1. We refer the Committee to two useful papers on this subject, copies are enclosed:
   1.1 *Effective Management of Personality Disorder* by Anthony Bateman and Peter Tyrer.
   
   This paper rates the efficacy and validity of approaches across different settings. It looks at psychological treatments, drug treatments and service models.
   
   It concludes that “in general, a combination of psychological treatments reinforced by drug therapy at critical times seems to be the consensus of treatment in personality disorder”. The relationship between the service, practitioners and the individual and collaborative working is vital. This paper also shows that efficacy for one person or type of personality disorder, may not be generalisable to other individuals or types of personality disorders. The style of service delivery, the environment in which the treatment is provided and staff team can also heavily influence outcomes.
   
   1.2 *Effective Treatment Models for Personality Disordered Offenders* by Jackie Craissati, Louise Horne and Ricky Taylor.
   
   This paper complements the above review, looking at effectiveness with reference to offending behaviour. It shows that treatment of personality disorder and reduction in offending behaviour are two different factors, but both must be addressed.

2. **Question 887:** posed by Lord Rix, asking for our comments about a draft additional clause to 2 (5)—the definition of mental disorder: “Impairment of intelligence, whether or not accompanied by impairment of social functioning, shall not of itself constitute mental disorder”.

3. Turning Point believes that it is important for learning disability *per se* to be excluded from the Mental Health Bill. We would support an exclusion along the lines of Lord Rix’s proposal.

4. **Question 888:** posed by the Chairman, asking whether we would favour a provision in clause 9 (6) defining what is appropriate on the face of the Bill or if this issue should be addressed in the Code of Practice.

5. Turning Point believes that “appropriate” should be defined and that it is essential that a definition is on the face of the Bill. It is then stronger than leaving it to the Code of Practice.

6. If appropriate is defined, it would help to ensure consistent practice. This is especially important as clinicians cannot help bringing their own perceptions, values and experiences into treatment decisions.

7. A definition would also help guard against inappropriate detention and the temptation to bend “appropriate” to fit what limited resources are available (see paragraph 19 below).

8. In addition, a definition of appropriate would be useful in the event of a patient appealing to a Tribunal, again helping to ensure consistent interpretation of what is understood by appropriate.

9. As we explained in our oral evidence, it is important that a definition does not restrict the range and type of treatments available which clinicians can offer to patients subject to compulsion. However, we believe that with careful drafting, it should be possible to word a definition without being unduly prescriptive. One suggestion is to expand clause 9 (6) in the Bill as follows:

   “treatment is available which is appropriate for the patient, taking into account the nature or degree of his mental disorder, his gender, ethnicity and cultural values, and all other circumstances of his case”

10. There is also a strong case for a clause in the Bill respecting advance directives. Advance directives would allow a person to define appropriate treatment, including culturally appropriate treatment, before such time as they become ill enough to require compulsion.
11. Defining “appropriate” relates closely to our discussions about therapeutic benefit. As the Committee is aware, although Turning Point has difficulty with the word “therapeutic”, we do believe that as drafted, the fourth condition for compulsion could be too loosely interpreted and also make preventative detention easier.

12. Therefore, the fourth condition should contain a requirement to show “the benefit to the patient of the treatment”

13. Question 891: posed by Mr Prosser, about the need to define clearly the patients who would be suitable for care in the community.

14. We explained to the Committee that although Turning Point supports the principle of compulsory treatment being available for a tightly defined group of revolving door patients with sufficient resources, we do not support the proposals in the current Bill. We summarise below what we believe to be the negative effects of the orders, as drafted.

15. We are particularly concerned that non-resident orders will be over-used in relation to people from black and minority ethnic communities. Both the possibility non-resident orders, and their actual use, will reinforce negative perceptions about engaging voluntarily with mental health services. This increases the likelihood that an individual’s experience will be one of crisis and compulsion, again feeding in to negative views. Thus new circles of fear will be created which are neither in the interests of the distressed individual or the safety of the public.

16. We echo concerns of other witnesses about the potential to be used as psychiatric ASBOs—especially as one of the conditions can be that “the patient does not engage in a specified conduct” [clause 119 (7)b]. We are worried about how this clause may be interpreted and believe it should be removed. Conditions of residence and attendance at clinics and out-patients appointments may be appropriate, but this clause goes too far.

17. Evidence from abroad shows that what makes treatment in the community successful is not compulsion itself but the availability of comprehensive and co-ordinated resources in the community.

18. Coercion under the Bill is likely to increase if there is a lack of appropriate services in the community. At present there is not the infrastructure to support non-resident orders. In fact, the shortage of suitable voluntary mental health services in the community could drive clinicians to use compulsion more (for example, if it is a Saturday night and they are trying get help for a distressed person).

19. Another perspective is that the lack of discretion at examination stage means that if a person meets the criteria, they must be made subject to compulsion. A climate of defensive practice will also increase the likelihood of pressured professionals bringing a person under compulsion when other criteria are satisfied, even if they have doubts about appropriateness of available treatment options. There is a temptation to bend “appropriate” to fit what limited resources are available.

20. From either perspective, outlined in paragraphs 18 and 19, the effect is likely to be an increase in compulsion.

21. Although some of our clients welcome the theoretical possibility of being treated at home, many others have said, that in reality when they are ill or distressed, they would prefer to be treated in hospital. Clients are also worried about the additional strain that non-resident orders would inevitably place on relationships with partners, family and carers.

22. Although the use of compulsion is a possibility under the present Act, relationships of trust between practitioners and clients will be far more radically affected. This potentially affects all service users—those subject to compulsion as well as those who are not. We are concerned particularly about assertive outreach services—who are successfully engaging with “challenging” clients, some of whom may be labelled high risk, promoting their health (and public safety). If staff become associated with monitoring non-residential orders, this will deter other clients from engaging with them voluntarily.

February 2005

Supplementary memorandum from Nisar Khan (DMH 435)

A SERVICE USER’S EXPERIENCE

My name is Nisar Khan, I am 33 years old 5ft 3inches tall. My parents are from Pakistan. My father spent his life working shifts in a paper mill. My mother spent her life working shifts, she had seven children, all boys.

I am telling you my story, of what happened to me.
I was the third oldest, apparently as a child I used to steal my brother’s milk bottle and secretly drink it. I spent long periods not talking to people as I was acutely shy. I didn’t play out with my other brothers I lacked confidence and self-esteem, having an extremely critical father who would beat us physically, or destroy you with criticism that completely undermined you.

My father had it hard coming from Pakistan, having to work long shifts.

In 1988 I left Sixth Form College having passed my A-levels. I could not wait to start at University!, it was really a means of getting some freedom.

I started University in Norwich and drifted through. I started smoking “dope” (cannabis) with other friends I met.

My family were supporting me financially through university, as everyone was convinced that I would get a really well paid job. I felt under a lot of pressure to “make it good” and get a well paid job. The reality that I was spending any money my family sent me on buying drink and dope.

I spent most of the days stoned. I’d get up have a smoke (well that was my day!). Back at home in Bolton I found it increasingly difficult. My family moved to a different area where there were no Asian families and we got a lot of stress. The local boys who were white attacked my family house on several occasions. They didn’t like the fact that “Pakis/Black Bastards” (as they referred to us) were in their area.

I remember the feelings of anger when someone spat at my mother. The situation was brought to a head when 20 or so white youths surrounded the family house. We were under siege they had knives, bats, chains they tried to get in breaking the windows.

It terrified me, and really freaked me out. As far back as I could remember growing up in Bolton had been a racist experience. “Paki Bashing” was a daily occurrence and I lived in fear of being beaten up by older boys who were skin-heads, or just hated “Pakis”.

Eventually after two years at university I was “kicked out” because I had not attended enough courses. I was stuck and in a real bad situation. When I returned to Bolton my father lost his temper and kicked me out of the house. I went back to Norwich to live with a friend in the hope of finding some work.

I was smoking a lot of dope, I was freaked out from being attacked by racists. I was very scared, I was getting increasingly paranoid which was an automatic reaction to being attacked. I got more paranoid when after I smoked dope, I was addicted though some say it’s not addictive. I’m telling you that the experience and feeling is.

One night when I was smoking and drinking I started hallucinating. I remember watching an advert on TV and I thought the advert was about me. I started to feel uneasy and asked a friend if I could stay in his bedroom for comfort. I’m not gay but was very scared, I’m sure my friend was surprised at my request especially since his girlfriend was down for the weekend!

Well I felt uneasy and decided to catch a taxi to “The Samaritans” on campus. Remember reading something about the nighttime service where you could talk to someone. So I took a taxi there. I went to the room and spoke to the counsellor, whoever was on duty. I told them that I was scared and panicked, I thought that people were after me.

The next thing I remember is two policemen entering the room. I was frightened and scared. I was not threatening I didn’t have any violent tendencies. I felt betrayed and let down by the counsellor from Samaritans. To this day I am at a loss to understand why he called the police. I feel in large part it was because I was Asian, and that he saw me as more of a threat, in the same way that other minority communities particular Black males are seen as a threat.

When I saw the two policemen I climbed out of the window. I thought they were going to lock me up so I did a runner! . I remember the police officers chasing me around campus. I was terrified I thought they were going to hunt and kill me. Two more police officers joined in the hunt and I was cornered in the main university square. It was about 3.00 am and remember crying out to a passer by for help.

The policemen handcuffed me and put me in the back of the police van. I had never been in the back of a police van and was surprised at the metal cage inside. I felt like a caged animal.

I was taken to the police station and was searched and put in a cell. I was then interviewed by a social worker, well someone like that. The next thing I recall was being told that they were taking me to “Hell’s den” which was the local psychiatric hospital in Hellesden (pronounced Helles-den)

The lack of thought that went in choosing “Hells-den” as the name for a psychiatric institution for delusionally paranoid patients defies belief. It merely confirms my opinion that some psychiatrists and suppose medical authorities should carry a government health warning as “they could really screw you up!”.

Continuing with the story I was admitted to Hellesden and I recall that night as being one of the scariest of my life. On the ward I was one there were a number of patients who were heavily medicated and in distress. It was a terrifying experience I spent the night awake fearing that I would be murdered at any second. I was put in a strap and secured to a bed.

I was so terrified from being apprehended and sectioned (section 2 for 28 days) that I lost all touch with reality. I think you would too, if you had that experience, after a visit to The Samaritans.
It was like a descent into hell and my illness which they said was an “acute paranoid schizophrenic episode” was a living nightmare. I was convinced that people were trying to kill me, and I tried to kill myself on several occasions. I am sorry if that word offends people, and apologise for any hurt but I am using this word so that psychiatrists can know that it’s real people out there, that the system is letting down people and they are suffering. Psychiatrists and other medical professionals need reminding, not just the lip service and tokenism that are habitual for some. At the same time I recognise that there are committed individuals in medical professions out there striving to help people, but unfortunately I did not meet them!

My second attempt to end my life was to put my head through a window and try to cut my neck on the glass. It makes feel a bit queasy writing it down, the thought and memory make me feel sick. I have had to block the more painful parts of my experience as they are just too traumatic!

What could make a man put his head through a window and try and kill himself? It’s like something out of a horror film and I was doing it.

It didn’t get any better my family was in shock to learn that I had tried to kill myself and was under a psychiatric section. I was moved to a different hospital and my final attempt to end my life was to leap off the hospital roof. I had been given an injection of Depixol and was left unattended. I got onto the roof and then jumped about 20 minutes later. Apparently I had sat on the roof for a while and then jumped. I remembered feeling that the nightmare I was in could only end if I ended my life.

I recall trying to explain to the CPN’s and psychiatrists that I had been racially assaulted and attacked. Psychiatrists really pissed me off, the way they never looked at you, and they scribbled their notes down. When I explained to them about what had happened an how my family was attacked they put it down to a delusion. I was seen by Asian and black psychiatrist too but found that they had a lack of understanding of my experience. The Asian psychiatrist had a lack of any empathy and understanding of issues. Though they looked like me and could talk an Asian I was put on suicide watch after I tried to hang myself. I was deeply shocked and saddened to read of the death of David “Rocky” Benett in Norwich. David met his untimely death in Norwich, and he was on some of the same wards and seen by some of the same medical staff as myself.

February 2005

Supplementary memoranda from the BME Network (DMH 445)

1. EXECUTIVE SUMMARY

1.1 Dr Kwame McKenzie has produced the following academic paper. Dr McKenzie is the Senior Lecturer in Psychiatry at the Royal Free and University College Medical School.

1.2 This paper has been produced to address question 890 raised by Mr Howarth during the oral evidence sessions of the committee.

1.3 In the uncorrected evidence Mr Howarth is recorded as saying that he thought Dr Bennett went a long way to try to clear up this distinction between: Is there something within certain communities which makes the propensity for people to have mental health problems greater or is it more to do with how the professions view particular episodes? Mr Howarth went on to say that Mr Inyama made the point that it is a complex issue.

1.4 Mr Howarth asked if it would be possible for the BME Network to provide a summary of the literature on the issue so that members of the committee would be able to understand it in greater depth. The following academic paper has been produced to address this question and therefore explore whether certain communities have a propensity to have mental health problems or whether mental health services view particular episodes among the BME communities in a certain manner.

1.5 The paper explores two components of the disparity between people of Caribbean and African origin and white British patients.

— The increased risk of a diagnosis of psychosis if you are African or Caribbean origin compared to if you are white.
— The increased risk of being sectioned if you have a diagnosis of psychosis if you are African or Caribbean origin compared to if you are white.

1.6 The paper shows that the rates of schizophrenia and other psychoses are not high in the Caribbean but are significantly higher in African and Caribbean origin residents in the UK.

1.7 The increased risk of diagnosis of psychosis is attributed to a variety of interrelated factors. These include ethnic minority status, social economic factors and racism. Also of importance is the way in which symptoms are understood and dealt with by primary care and mental health services.

1.8 People of African and Caribbean origin have a complex interaction with the mental health, primary care and criminal justice system. It is this interaction, which is explored as a number of cycles, which leads to higher levels of coercion among African and Caribbean origin populations.
1.9 In chapter 7, Diverse Minds Manager, Marcel Vige explores the potential impact of non-resident orders (NROs) on BME communities. He concludes NROs will have a disproportionate impact on BME communities and have been revealed as counterproductive. The research has led the BME Network to call for NROs to be dropped from the proposed legislation.

2. ACADEMIC PAPER BY DR KWAME McKENZIE, SENIOR LECTURER IN PSYCHIATRY, ROYAL FREE AND UNIVERSITY COLLEGE MEDICAL SCHOOL

2.1 The rates of diagnosed psychosis in the African and Caribbean origin population are higher than the rates in the White British Population. This has been demonstrated by numerous studies over the last 30 years. (See Sharpley et al 2001 for review)

2.2 People with a psychosis are more likely to be detained on a section. Because of this there is an increased population risk of detention under a section of the Mental Health Act 1983.

2.3 People of African and Caribbean origin with a diagnosed psychosis are at least four times more likely to be detained under a Section of the Mental Health Act 1983 than people who are White. There are at least 23 studies which have investigated this. (See Bhui et al 2003 for review)

2.4 This leads to increased individual risk. This increased risk is not accounted for by diagnosis, age, socio-economic position, previous detention on a section of the mental health act, living alone, having a relative or partner available, the involvement of the police, though all these factors have an influence. (Bhui et al 2003)

2.5 There are therefore two components to the disparities in section rates between people of Caribbean and African origin and white British patients. The first is an increased risk of a diagnosis of psychosis if you are African or Caribbean origin compared to if you are white. The second is an increased risk of being sectioned if you have a diagnosis of psychosis if you are African or Caribbean origin compared to if you are white.

Increased risk of diagnosis of psychosis

2.6 The rates of schizophrenia and other psychoses are not raised in the Caribbean but have been reported to be elevated in people of African and Caribbean origin resident in the UK (Sharpley et al 2001). This increased rate reflects risk factors which operate in the UK.

2.7 The UK is not alone in this regard with people of Caribbean origin having high rates of diagnosed schizophrenia in the Netherlands (Sharpley et al 2001).

2.8 There are a number of risk factors which work in different ways. For instance, they may increase the rate of the development of symptoms of mental distress, may increase the progress of these to mental illness and/or increase the chance of these symptoms being diagnosed as mental illness or specific mental illnesses.

2.9 Risk factors are widespread and diverse. The increased exposure to risk factors is partly due to ethnic minority status, partly due to socio-economic factors and partly due to racism (Addendum 1).

2.10 In addition to factors increasing the risk of developing symptoms of mental distress the way these symptoms are understood and dealt with by primary care and mental health services is an important factor in increasing the rates of diagnosis of psychosis (Addendum 2).

2.11 Rates of depression and other mental illness are not raised in people of Caribbean and African origin in the UK compared to white British.

2.12 Genetic differences across African populations in the UK and between African and Caribbean origin populations argue against any common hereditary vulnerability to psychosis as an expression of distress.

2.13 Significant differences between migration histories argue against migration alone being important.

2.14 Moreover, a recent meta-analysis soon to be published in the American Journal of Psychiatry demonstrates that migration increases the risk of developing schizophrenia but migration of black people to white countries doubles the increased risk again (Cantor Grae & Selten—in press).

2.15 Given the genetic, cultural and historical differences between African populations and populations of Caribbean origin in the UK it is difficult not to come to the conclusion that their shared high rates of diagnosed psychosis reflect a difficulty that the mental health system has in dealing with people who are black.

2.16 Cross-cultural mis-interpretation of the meaning of particular idioms of distress has been considered to explain at least part of the differences in rates of illness between ethnic groups in the UK.

2.17 This is insufficient because second generation migrants are less culturally different to their clinicians than first generation but their rates are still significantly elevated.

2.18 There is a persistent problem which seems to be based on colour—that which African and Caribbean origin people and the first, second and second generations have in common—rather than culture.
2.19 Other factors are also important. Research from the Netherlands has demonstrated that, in any one year in Maastricht up to 15% of the population suffered from a psychotic symptom. Very few of these people ever needed treatment or consulted a psychiatrist. Most people have symptoms that are transient and subside with no treatment.

2.20 Whether you eventually presented to mental health services depended not only on your symptoms but on your socioeconomic status, socio-cultural factors and the ability of your social network to support you.

2.21 Socio-cultural factors included whether you lived in an area with people with similar social perspectives to you (Van Os et al) and the level of social stress.

2.22 Clearly there is some circularity because the ability of a community to support an individual will be influenced by the socioeconomic variables linked to spare time and energy, work autonomy and flexibility.

2.23 Seeing a psychiatrist predicted chronicity of symptoms. It is not clear whether this is because those who see a psychiatrist have more severe symptoms or whether use of services leads to secondary functional deficits through stigma, undermining of normal social supports or dependence.

*Increased risk of being detained on a section*

2.24 In the UK there is a complex interaction between people of African and Caribbean origin and the mental health, primary care and criminal justice system.

2.25 This can be considered as a number of self-perpetuating circles that lead to higher levels of coercion. Five examples are given below.

2.26 *Cycle 1—increased surveillance and the prison justice system*

People of African and Caribbean origin with symptoms are more likely to come into contact with the services because they are more likely to be stopped in the streets or arrested.

They are more likely to be admitted on a section 136.

People admitted on a section 136 perceive the mental health services as linked to the criminal justice services.

This leads to difficulties in developing proper clinical relationships with patients.

Poor clinical relationships predict poorer outcome and compliance with treatment plans.

Poor compliance leads to the services using more coercive techniques to improve symptomatic outcome.

2.27 *Cycle 2—differences in illness models and treatment models*

People of African and Caribbean origin who present their symptoms of distress to primary care are less likely to have their symptoms recognised.

For some of these this is appropriate because the symptoms will subside but the high rates of stress in communities means that a number will be inappropriately missed.

When GPs do recognise symptoms of mental distress in people of Caribbean and African origin, compared to British Whites, they are more likely to refer them to a psychiatrist, rather than getting their treatment from their GP.

Psychiatrists are more likely to see people of African and Caribbean origin at home and suggest admission to hospital.

These admissions are refused partly because most people do not like going to hospital, partly because in the areas where the African and Caribbean origin population live, the hospitals are of low quality and partly because acute care is perceived negatively.

Admissions of people of African and Caribbean origin are therefore more likely to be on a Section of the Mental Health Act.

Psychiatrists treat people of African and Caribbean origin different to their white peers. They are less likely to be offered psychotherapy and more likely to be offered antipsychotic treatment.

People of African and Caribbean origin who see a psychiatrist are less likely to agree with the psychiatrist’s diagnosis and treatment plan.

Because of the low satisfaction with services, unhappiness with the treatment plan and disagreement with their diagnosis, people of African and Caribbean origin are less likely to comply with the management plan that is given.

People who do not comply with their management plans are more likely to be detained on a Section of the Mental Health Act 1983.
Detention on a Section predicts future non-compliance in the community and avoidance of community care services.
Detention on a section predicts future further detention on a section.
Thus a vicious circle is set up where more and more coercive methods are needed to force compliance.

2.28 *Cycle 3—delayed treatment*

People of African and Caribbean origin with symptoms of mental distress see mental health services as places they would only go as a last resort because they do not think that the services understand them and they think they will be sectioned, admitted to hospital and treated with drugs against their will.
Those with symptoms which do not subside, do not get treatment early.
If symptoms do not subside there is an increasing likelihood of a person crisis such as self-harm or neglect.
The longer the period of untreated psychotic symptoms, the more florid the symptoms are.
If there has been a personal crisis and symptoms are more florid then professionals are more likely to decide that the individual is a risk to themselves or others.
Admission is more likely to be advised.
Given the ambivalence towards services of the African and Caribbean population, they are more likely to refuse admission.
The perceived risk will raise the possibility of the use of the section of the mental health act.
Admission using the mental health act is more likely to be undertaken with the police present.
The longer the duration of untreated psychosis the harder it is to get symptoms to resolve.
Higher doses of drugs with multiple side effects are prescribed to treat the symptoms.
Side effects, the use of medication and the presence of the police at the time of initial presentation will be associated with a poor long-term compliance.
Poor compliance will be associated with greater use of coercive powers by professionals in the future.

2.29 *Cycle 4—stereotypes*

A popular stereotype of people of African and Caribbean origin are that they are muscular and violent. Increased rates of arrest by the police perpetuate this perception. Actual offending rates are no different for African and Caribbean origin and British white groups from the same socio-economic environment.
Professionals perceive African and Caribbean patients to be more risky. They therefore use higher levels of security and higher levels of medication.
This predicts worse long term compliance, lower levels of satisfaction and more use of coercive strategies such as the use of the Mental Health Act.

2.30 *Cycle 5—pathways*

Services are set up without systematic needs assessment based at a community level.
Non-statutory sector and lay models of illness are not included in discussions about service provision.
Funding for the non-statutory sector is piecemeal and is not long term.
Alternative modes of treatment to help symptoms of distress subside in the community are not valued, funded or properly integrated in service provision.
Mental health promotion and mental illness prevention are valued by communities because they are needed to recast safety net provisions and social support networks undermined by migration and their socio-cultural and socio-economic position in the UK.
The lack of culturally sensitive primary, secondary and tertiary preventive services predicts problematic care pathways for African and Caribbean origin.
Services are increasingly concerned with risk and safety.
The problems inherent in the system through choices made on service provision interact with negative clinical experiences to constrict the possible outcomes for people of Caribbean and African origin.
Poor outcomes are considered to be associated with increased risk and, in conjunction with stereotypes and the increased involvement of the prison justice system are likely to produce more coercive pathways and higher rates of section.
It is as if the pathways to coercion and use of sections are so well trodden that people of Caribbean and African origin are fast-tracked.
2.31 These cycles are examples of the processes that occur. There are many more. They are not exclusive and people can be caught up in more than one cycle at a time. They do not happen to all service users of African and Caribbean origin but are more likely to happen to people of African and Caribbean origin. They have been documented qualitatively. (Sainsbury Centre for Mental Health 2002)

2.32 The essential feature of these cycles is that African and Caribbean origin people with symptoms of mental distress fear the services, the services fear them. The services try to decrease their fear by insisting on treatment. Patients often do not agree with the treatment leading to increased fear and this sparks increased levels of coercion.

2.33 Pathways to care are similar for African-Caribbean and White patients at first admission but after this African and Caribbean patients are more likely to be sectioned.

3. Bibliography


Sainsbury Centre for Mental Health Breaking the Circles of Fear. Sainsbury Centre for Mental Health London 2002.


Van Os J and Murray R (submitted) Neurodevelopmental and social risk factors across the spectrum of psychosis.


4. Addendum One: Factors which Increase the Risk of Developing a Psychosis Synopsis by Dr Kwami McKenzie

(Suggested reference for review (Warner 2000)).

4.1 Having a family member with a diagnosis of psychosis increases your risk of developing a psychosis. However, the risk for siblings of those African-Caribbeans born in the UK is seven times higher than the risk for those in the Caribbean. This, and the fact that the rate of psychosis is not elevated in the Caribbean point to the increased risk not being simply due to genes.

4.2 Low birth weight is linked to an increased risk of psychosis. Some research has demonstrated that people of African and Caribbean origin in the UK are less likely to have good antenatal care and more likely to have smaller babies.

4.3 One of the strongest risk factors for schizophrenia is being born in a city. People born or brought up in a city have two to three times the chance of developing schizophrenia than those who were born in rural areas. Second generation African and Caribbean origin people living in the UK are much more likely to be born and brought up in a city than other groups.

4.4 Being a migrant or being the child of a migrant is a significant risk factor for psychosis. A recent meta-analysis of migration concluded that migration per se increases the risk of developing a psychosis. However, migration of black people to countries that were white increased the risk of psychosis more than if white people moved to other countries that were white.

4.5 Cannabis use when you are young increases your risk of developing a psychosis but it is unlikely to account for the increased risk of developing a psychosis in African and Caribbean origin groups. McGuire et al (1995) found no difference in drug abuse between their white and African-Caribbean patients in South London. Selten et al 1997 found that consumption of cannabis was lower amongst Caribbean migrants to The Netherlands than amongst the white population. However, the Caribbean migrants had much higher rates of schizophrenia.

4.6 Racism (overt and institutionalised) may be a risk factor for psychosis. National studies have demonstrated an association between being a victim of racism and your risk of suffering from a psychosis. Boydell et al 2001 recently found that incidence rates of schizophrenia increased in ethnic minorities as the proportion of ethnic minorities in the locality fell, suggesting social experience (perhaps of isolation or discrimination) contributes to the development of the disorder.
4.7 Janssen et al 2001 measured subjective experience of discrimination and subsequent development of psychotic illness three years later. Experience of discrimination strongly predicted for the development of a psychotic illness (OR 2.8 CI 1.9–4.2).

4.8 Social isolation is also an important risk factor. Mallett et al (1998) demonstrated that one of the main distinguishing features of first-onset patients of Caribbean origin with psychosis in London was that they lived alone and additionally were separated from their mother at an early age.

4.9 People who are married are less likely to develop schizophrenia than people who are not even when personality before marriage is taken into account (Jablensky 1997). People of Caribbean origin in the UK are less likely to be married.

4.10 Three prospective studies have found an association between life events and onset of psychosis (Bebbington et al 1993, Ventura et al 1989, Malla et al 1990).

4.11 Several studies have found a relationship (not necessarily linear) between deprivation and incidence rates of psychosis (Croudace 2000), prevalence rates of schizophrenia (Moser 2001 BJ GP) and admission rates for schizophrenia (Boardman et al 1997, Harrison et al 1995, Koppel 1999, Boydell 2002). It is possible that the high unemployment rate amongst African-Caribbeans in London (and subsequent social isolation and stigmatisation) might have aetiological relevance Bhugra et al 1997 Bhugra et al 2000).

4.12 For most of these risk factors the social circumstances of people of Caribbean and African origin in the UK make them more likely to be exposed. Hence it could be argued that the higher rates of diagnosed psychosis simply reflects socio-economic and socio-cultural situation that people of Caribbean origin find themselves in. This would be erroneous because research has demonstrated that there are high rates of psychosis in the community that do not reach the eyes of psychiatrists and even if they do this does not lead to them being admitted on a section of the mental health act.

5. Bibliography


Janssen I, Hanssen M, Bak M et al. Evidence that ethnic group effects on psychosis risk are confounded by experience of discrimination. 2001? in press.


Marcelis M, Takei N, Van Os J. *Urbanization and Risk for Schizophrenia: does the effect operate before or around the time of illness onset?* Psychological Medicine 1999 29 p1197-1203.


6. **Addendum Two: Shortened Excerpt from Book by Professor Suman Fernando**

**Racial Bias**

Clinical evaluation

6.1 The practice of psychiatry at an individual level depends, in the final analysis, on the process of “clinical” evaluation—a concept with a wider remit than a diagnosis. This is primarily based on a patient’s history, basic personality and current “mental state”, obtained by interviewing the “patient” in a standard manner. The history is often regarded as being composed of objective facts but, in reality, it is a highly selected account of whatever information has been acquired from the “patient” and others—the crucial sorting out being done by the psychiatrist. The psychiatrist influences the content of what is obtained as “history” in two interrelated ways within the overall, variable limitations of communication. First, the type and extent of information given by the patient and others are fashioned by the perceptions of the psychiatrist about the people providing the information and vice versa; for example, a black Asian patient, aware of the negative value attached to Asian marriage customs, is unlikely to tell a white doctor or social worker much about his/her marriage. This may be interpreted usually as secretiveness or deviousness of the patient, not
as a quality of the doctor or social worker. Secondly, the picking and choosing that occurs during history-taking—the emphasis given to one item of information as opposed to another or the meaning attached to an incident—is dependent on the beliefs, value judgements, understanding and knowledge of the psychiatrist; for example, a psychiatrist, who is a part of an establishment that does not appreciate the extent of racial discrimination in employment, is likely to take down a history of persistent unemployment of a black person without qualification, ie as having the same significance for both black and white patients. Since white psychiatrists lack personal experience of predominantly black areas, such as Harlem (New York), Tower Hamlets (London) or St Paul’s (Bristol, England), they are likely to be unaware of the pressures impinging on black people who live there and so to misinterpret their lifestyles and behaviour—misinterpretations which often reinforce their racist prejudices.

6.2 The mental state examination is of utmost importance in determining the diagnosis given to a patient—probably the major determinant (Gauron and Dickinson, 1966). Here, the patient’s reports of experiences are construed as depicting an inner state of mind—“the mental state”. The validity of such a deduction is suspect (Grounds, 1987) at the best of times—ie when there is absolute rapport and full understanding between the participants at the interview—but, in a multicultural setting, and especially when barriers arising from racist preconceptions are rife, the possibility of making valid deductions from questions asked at an interview is highly questionable. The meanings attached to experiences and perceptions, the concept of illness, and the overall significance of the interview situation (during which “the mental state” is deduced) are but some of the parameters along which variation must occur when cultural differences are present between the participants of an interaction.

6.3 Deductions made from an “examination” of “the mental state” cannot be viewed as being equivalent to a medical description of the state of a bodily organ since these are described in terms that have objective validity—or at least some degree of such validity. What a doctor “finds” in a “mental state” is as much a reflection of the observer as the so-called patient. It is the result of an interaction rather than a one-sided observation.

**Issues in diagnosis**

6.4 The psychiatric diagnostic process allows the discipline of psychiatry to function in such a way that racist ideology is absorbed and applied in a scientific guise. Since objectivity is the supposed aim of a psychiatry that tries hard to be “scientific”, practitioners of the discipline do not recognise the fact that the evaluations they make are far from objective. Hence, they fail to allow for the biases that come into such assessments—biases endemic in the culture in which psychiatry has grown and in which psychiatry functions. This is an ideal setting for racism to flourish in; the way it has done so in the diagnosis of psychosis and schizophrenia in the United States and Britain is strikingly similar although the historical backgrounds of the two countries in relation to racism are somewhat different.

6.5 Early reports of a relatively high rate of black in-patients being diagnosed as “psychotic” in the United States during the latter part of the nineteenth century and first half of the twentieth (eg Babcock, 1895; Wilson and Lantz, 1957) were criticised by Pasamanick (1963) on methodological grounds; he concluded from studies in Baltimore that, while the non-white rates for “psychosis” were higher than those for whites in state hospitals, the white rates were higher in Veterans Administration hospitals and private institutions. Moreover, he calculated that, for non-institutional patients, the white rate for “psychosis” was higher than the non-white rate. Also Pasamanick observed that, between 1920 and 1955, there was a change in the style of diagnosis of black people in the United States; the diagnosis of schizophrenia increased while that of manic depression decreased. Indeed, American studies in the 1950s and 1960s (eg Jaco, 1960; Simon, 1965) reported a lower “rate” of affective illness among Blacks compared to Whites and, corresponding to this, reports published in the 1970s claimed that a higher rate of schizophrenia was being diagnosed among Blacks (compared to Whites)—for example, nearly double in the case of male admissions to State and county hospitals in 1969 (National Institute of Mental Health, 1971) and 60% higher among referrals to a private psychiatric in-patient service of a university hospital in Brooklyn (Steinberg et al, 1977). Further, when a distinction was established in diagnosis between “process schizophrenia” and “reactive schizophrenia” (the former seen as having a relatively high “genetic” component), Blacks, particularly black males, were disproportionately given the diagnosis of process schizophrenia, irrespective of socio-economic status (Allon, 1971). At the same time, American psychiatrists noted difficulties encountered by white psychiatrists in comprehending, and therefore evaluating properly, the feelings and behaviour of black people because of mutual distrust and hostility between racial groups (St Clair, 1951) leading to “diagnostic problems” (Simon, 1965).

6.6 The “overdiagnosis” of schizophrenia in the United States may not be confined to African Americans but may well apply also to Native (“Indian”) and Hispanic Americans. A hospital survey of in-patients reports a diagnosis of schizophrenia being given at a significantly higher rate to patients from “Indian reserves” compared to “non-Indian” patients in Saskatchewan (Roy et al, 1970) and a community survey reports a relatively high “prevalence rate” of all major psychoses among Eskimos in the Canadian Eastern Arctic (Sampath, 1974). Hispanic Americans seem to be underrepresented as patients attending both public and private psychiatric services (Karno, 1966) and are thought to suffer mainly from major psychiatric disorders (Adams et al, 1984). A study of outpatients of an inner city municipal hospital in New York and
diagnosed as suffering from bipolar illness (manic depression) found that previous “misdiagnosis” as “schizophrenic” was significantly greater for both Hispanics and Blacks when compared to Whites (Mukherjee et al., 1983).

6.7 Several studies of British in-patients in the 1960s and 1970s (Bagley, 1971; Cochrane, 1977) revealed that the diagnosis of schizophrenia was given more frequently to people from many immigrant groups when compared to native-born people, especially people originating in Africa, Asia and the Caribbean (Carpenter and Brockington, 1980; Dean et al., 1981)—all “black” in racial terms. A more recent survey of in-patients compulsorily detained in a hospital in Birmingham (England) shows that about two-thirds of (black) West Indian patients, as opposed to one-third of the Whites, are diagnosed as “schizophrenic” (McGovern and Cope, 1987); and studies in Nottingham (Harrison et al., 1988; Harrison et al., 1997) and London (King et al., 1994; Bhugra et al., 1997) confirm that black people are being diagnosed as “schizophrenic” or “psychotic” to a disproportionately excessive extent—twelve to thirteen times more often than expected in one study.

6.8 Researchers in New York (Simon et al., 1973) comparing diagnoses given by hospital psychiatrists and research psychiatrists using a structured interview, conclude that the excessive diagnosis of schizophrenia among black people by the former is a reflection of US hospital psychiatrists’ “diagnostic habits.” But others (eg Ademipre et al., 1982) claim that symptom profiles for “schizophrenia” differ across racial groups for cultural reasons. Another American team (Bromberg and Simon, 1968) suggests that African-Americans may present with (what they call) “protest psychosis”—essentially an expression of anger with repudiation of white people and their social structures. And a British study (Littlewood and Lipsedge, 1981) suggested that atypical syndromes among black patients may be “misdiagnosed” as schizophrenia.

6.9 Some British researchers who have found relatively high rates of schizophrenia being diagnosed among black people (Harrison et al., 1988; King et al., 1994) argue that, by using the Present State Examination (Wing et al., 1974) “misdiagnosis” is avoided. But what they and others often fail to address is the influence of race—or more specifically racism—in distorting the “objectivity” of the diagnostic process itself—a field that is poorly researched and often ignored. However, Loring and Powell (1988) did investigate this very issue in a carefully controlled study of the diagnostic approaches of 290 American psychiatrists. When the psychiatrists were asked certain questions after written case histories, using exactly similar information about clients except for details of gender and race, were circulated to them, black clients, compared to white clients, were given a diagnosis of schizophrenia more frequently by both black and white clinicians—although this was done to a lesser extent by the former; the clinicians ascribed feelings of violence, suspiciousness, and dangerousness to black clients even though the case studies (apart from racial designation) were the same as those for the white clients. It has been noted in Britain too that black people in psychiatric hospitals are being seen as “dangerous” without adequate objective reasons for doing so (Harrison et al., 1984) and that black patients are overrepresented among compulsorily detained patients in hospital (Inechen et al., 1984; McGovern and Cope, 1987; Owens et al., 1991). Loring and Powell (1988) draw the conclusion that Whites and Blacks are “seen differentially even if they exhibit the same behaviour”, and point out that “these differences will be reflected and legitimised in official statistics on psychopathology”. And so through the power of myths, self-fulfilling prophecies and genuine but inappropriate diagnoses, the racist tendency to designate black people as schizophrenic is perpetuated.

7. ADDENDUM THREE: DIVERSE MINDS CONTRIBUTION BY MARCEL VIGE, DIVERSE MINDS MANAGER

7.1 It is now widely accepted that across the board people from BME communities have a less favourable experience of the mental health system than the rest of society. As detailed in “Breaking the Circles of Fear” (Sainsbury Centre for Mental Health, 2002), professional’s fear derives from perceptions of dangerousness and violence. “Big Black and Dangerous?” Report into the death of Orville Blackwood (1993) describes how such perceptions are strongly associated with ethnicity, particularly with African-Caribbean men. These perceptions influence the therapeutic process leading to the inequalities in coercion, medication, and pathways through care which are familiar. This in turn alienates BME people from mental health services. This is illustrated by the following extract from Circles of Fear.

7.2 Black people see using mental health services as a degrading and alienating experience: the last resort. They perceive that the way services respond to them mirror some of the controlling and oppressive dimensions of other institutions in their lives, eg exclusion from schools, contact with police and the criminal justice system. There is a perception that mental health services replicate the experiences of racism and discrimination of Black people in wider society, particularly instances where individuals have experienced more controlling and restricting aspects of treatment.

7.3 Non-resident orders (NROs) will make this situation far worse. As effectively a lowering of the threshold for compulsion, NROs will extend compulsory treatment to those who fall outside the boundaries of the existing legislation. The fine judgements to establish whether someone is enough of a danger to themselves or others to receive treatment, though not enough to be brought into hospital will rely heavily on the interpretations of professionals. It is just such interpretations which are influenced by notions of threat associated with ethnicity. Cultural differences between professionals and BME communities will exacerbate the disproportionate impact of NROs on BME communities. As Consultant Psychiatrist Dr Kwame McKenzie points out, “who will have one of these community treatment orders? Clearly people who are not
ill enough to be in hospital, people who see things differently from their psychiatrist, people who have a different cultures and beliefs on treatment than their psychiatrist, people who are not satisfied with their treatment and want an alternative. Research shows us that people from minority groups in the system are more likely to fit this description. Because of this you will be more likely to be on a NRO if you are from a black and ethnic minority group."

7.4 NROs will also increase the alienation of BME communities from the mental health system, and by implication, from government institutions more generally (see earlier quote from “Breaking Circles of Fear”). The increased numbers of BME people who will be brought under compulsory treatment will exacerbate the fear and mistrust BME communities already feel towards the mental health system. For the reasons outlined here, this increased fear will be justified.

7.5 Another major problem with NROs is that they undermine the government’s attempts to eradicate ethnic inequalities within the mental health system through Strategies such as Delivering Race Equality. NROs are contrary to the spirit of such strategies. The mixed messages this sends out is itself problematic. The success of Delivering Race Equality depends on “buy in” from BME communities. This depends on the development of trust and co-operation, which given the decades of poor treatment of BME people within the mental health system, will be difficult to build. Measures such as NROs will prevent the development of such relationships, as the lived experience of BME people is of a mental health system, which whilst issuing reassuring platitudes, is subjecting them to increasing levels of coercion.

7.6 When NROs are looked at in the context of the experience of BME communities within the mental health system, and the broader efforts of government to tackle ethnic inequality, they are revealed as counterproductive. As stated by Kwame McKenzie, “The change in the service would put a harmful barrier between clinicians and the patients they are trying to set up partnerships with.” For these reasons, NROs should be dropped from the proposed legislation.

February 2005

Memorandum from the National Autistic Society (DMH 271)

INTRODUCTION

Under the current Mental Health Act 1983 autism is not defined as a mental health condition and the National Autistic Society wishes it to remain this way. However, people with autistic spectrum disorder (ASD) including Asperger syndrome are particularly vulnerable to mental health problems such as anxiety and depression, especially in late adolescence and early adult life.10

People with autism generally experience three main areas of difficulty; these are known as the triad of impairments:

— Social interaction (difficulty with social relationships, for example appearing aloof and indifferent to other people).
— Social communication (difficulty with verbal and non-verbal communication, for example not fully understanding the meaning of common gestures, facial expressions or tone of voice).
— Imagination (difficulty in the development of interpersonal play and imagination, for example having a limited range of imaginative activities, possibly copied and pursued rigidly and repetitively).

In addition to this triad, repetitive behaviour patterns and resistance to change in routine are often characteristic.

PURPOSE OF THIS SUBMISSION

The National Autistic Society is a member of the Mental Health Alliance. The purpose of this paper is to highlight the particular nature of autism and draw the committee’s attention to the impact of current practices in mental health on this group. This paper also outlines our thoughts on some proposals in the revised draft Mental Health Bill 2004 and the Mental Capacity Bill 2004.

MISDIAGNOSIS

The current lack of understanding of the nature of ASD often results in individuals with autism being misdiagnosed. This can lead to isolation and acquired mental health problems. Autism, in particular Asperger syndrome is often confused with schizophrenia and personality disorders (schizoid and schizotypal) by mental health practitioners inexperienced in autistic spectrum disorders, resulting in completely inappropriate drug treatments with the ensuing side-effects, and in some cases negative reactions.

10 (Tantam and Prestwood, 1999). Ghaziuddin et al (1998) found that 65% of their sample of patients with Asperger syndrome presented with symptoms of psychiatric disorder.
Underlying this problem is the fact that in practice, adult psychiatrists do not routinely consider a patient's developmental history, which is often the only indicator of their underlying diagnosis of an autistic spectrum disorder. By failing to ask the right questions, the condition is not identified.

For people with autistic spectrum disorder, the key to mental well-being lies in prompt and accurate diagnosis. According to a 2001 report, \(^{11}\) 46% of people with Asperger syndrome were not diagnosed until after the age of 16. Without a diagnosis, it is impossible to put in place interventions that can assist the positive development of people with autism spectrum disorders. They are unlikely to receive appropriate services and may experience feelings of frustration, depression and anger as they struggle to comprehend their impairments and live independently. In order to prevent this downward spiral, local authorities need to provide this group with practical life skills that will empower them to lead happy and productive lives, ultimately reducing the burden on the public purse.

**DIFFICULTIES ACCESSING APPROPRIATE SERVICES**

Adults with ASD often fall between Social Services’ Learning Disability Teams and Mental Health Teams. It is often the case that these teams are in dispute with one another as to which team has responsibility for an adult with ASD. There are countless cases of prolonged arguments between teams that lead to adults with an ASD missing out on support until one team finally takes charge or in some cases legal proceedings are brought against the local authority. Some local authorities are seeking to combat this by creating “Vulnerable Adults” teams, but eligibility criteria may still exclude many adults on the autistic spectrum.

**Question 2a: Is the definition of Mental Disorder appropriate and unambiguous?**

We have serious concerns about this new broad definition because we do not believe that mental health legislation is the most appropriate for people with autism. In general we believe that the mental capacity Bill, with its assumption of capacity, is the most relevant to the majority of people with autism. We urge the committee to consider the relationship between these two Bills. Under the current 1983 Mental Health Act autistic spectrum disorder is not defined as a mental health condition and we believe it should remain this way. We believe that people with autism per se without any additional mental ill health should not automatically be covered by this Bill. Whilst we acknowledge that some mental health services can be helpful to people with autism, we do not believe that people with autistic spectrum disorder should automatically be covered by this particular legislation. That is not to say that a person with autism and a genuine mental health diagnosis on top should not be treated as anyone else under the terms of mental health legislation.

The National Autistic Society urges the committee to consider the non-psychotic nature of autism and look at the particular needs of people affected by this condition before making recommendations relating to the definition in the Bill. The National Autistic Society would be happy to provide further advice on this matter and would welcome the opportunity to give oral evidence to explore this issue further.

**LINK WITH THE MENTAL CAPACITY BILL**

The National Autistic Society is an active member of the Making Decisions Alliance and the Mental Capacity Bill is currently being considered by Parliament. The National Autistic Society believes that clauses 34–39 of the Mental Capacity Bill which propose an “independent consultee service” under the Capacity Bill should be removed and replaced with independent advocates.

**BACKGROUND ON THE BOURNWOOD CASE**

Mr L had autism and severe learning disabilities and was admitted to Bournewood hospital following an outburst at a day centre that he regularly attended. The doctor in charge of the case decided that there was no need to detain Mr L in hospital under the Mental Health Act as Mr L was compliant and did not resist or attempt to run away. The patient was unable to consent to admission but was not actively refusing to go or remain in hospital. Mr L’s carers opposed this course of action and then took action against Bournewood NHS Trust claiming that he was unlawfully detained.

Following the judgment of the House of Lords it was established that those who do not have the capacity to consent to admission to hospital for mental disorder but do not actively object can be admitted informally under section 131 of the Mental Health Act 1983. Thereafter they can be treated in their best interests under the doctrine of necessity. Mr L’s carers took the case to the European Court of Human Rights which ruled on 5 October 2004 that his treatment in a hospital amounted to detention and that this detention was unlawful.

In practice, the Bournewood case demonstrated that carers have no right to challenge the decisions of doctors when an informally detained patient is in hospital. Neither the person with autism and learning disabilities nor his carers had any legal right to challenge the decision because he had not been detained under the 1983 Mental Health Act.

---

The Bournewood gap leaves people and their carers without any of the safeguards available to detained patients such as access to hospital managers’ hearings and Mental Health Review Tribunals, a care plan or review of that care plan or controls on treatment such as second opinions. This was described by Lord Steyn as an indefensible gap in our mental health law”.

This is an area of law commonly referred to as the “Bournewood” gap. It is of deep concern that this individual was placed under continuous supervision and control in a ward for a period of five months and was not free to leave. Clearly, Mr L was deprived of his liberty. Health professionals assumed full control of his treatment solely on the basis of a clinical assessment, completed as and when they considered fit. There was no requirement to fix the purpose of admission or limits in terms of time, treatment or care attached to that admission.

**The Bournewood Case in Relation to the Mental Capacity Bill**

It has been stated by some that the Mental Capacity Bill would safeguard against future cases like Bournewood. However, the National Autistic Society does not share this view. We are concerned that neither the Mental Capacity Bill nor the draft Mental Health Bill addresses the concerns recently highlighted by the European Court. The Mental Capacity Bill provides none of the safeguards that were included in Part V of the initial draft Mental Health Bill 2004. This includes appeal rights against detention and second opinion on treatment options, a right to a care plan and a review of that care plan, a right to a nominated person to act as that person’s representative and an advocate to be available if that person wishes. These safeguards are necessary to protect those who do not require formal detention but who are regularly admitted into NHS settings.

The Committee recently (Wednesday 20 October) took evidence from Professor Genevra Richardson who stated that one of the ways to close the Bournewood gap would be to improve the safeguards in the Mental Capacity Bill. She said "I am worried that the relationship between these two terribly important Bills has not been properly worked out.” We share this concern and call on the scrutiny committee to consider this matter and highlight these concerns with the Government.

*October 2004*

**Witnesses:** Mr Richard Mills, Director of Research and Dr Juli Crocombe, Consultant Psychiatrist of Care Principles, National Autistic Society, examined.

Q894 Chairman: May I welcome you both. I will ask you to identify yourselves formally for the record in a moment. Could I ask you to note that this is a public evidence session. A transcript will be produced. It will be available on the internet after about one week. You will be able to alter the text but not the sense, if you see what I mean. We are working to a fairly tight schedule, I am afraid, so we have about half an hour for this session. You can assume that we have read your written evidence and you will be aware that there has been a great deal of discussion during the course of the Committee, not least because of the presence of Mrs Browning, about issues concerning autism. I should say we are very grateful to Mrs Browning for that. Would you like to introduce yourselves, and then if you will permit us we will go straight into questions.

Dr Crocombe: I am Dr Juli Crocombe. I am a consultant psychiatrist for people with a learning disability and I work in a secure unit for people who have offended or have a challenging behaviour with a learning disability, so I work with people with autism in that context. I am also involved in giving opinions in other secure units, principally diagnosing autistic spectrum disorders and then giving advice on treatment and appropriateness of detention for those people. I am also involved in research work with the National Autistic Society.

Q895 Chairman: Heavens! Thank you. Mr Mills.

Mr Mills: Yes. I am Richard Mills. I am the Director of Research for the National Autistic Society and I am also the honorary secretary of the Autism Intervention Research Trust, now called Research Autism.

Chairman: Thank you very much.

Q896 Baroness Eccles of Moulton: My question is based on a definition of autism, which at this stage of our discussion would be very helpful to the Committee so that we can understand more clearly how the plans in the new Bill would be more sweeping than existing legislation. If you could kindly define autism for us that would be very helpful.

Mr Mills: This is always a tricky one. Autism, or the term the autistic spectrum, as it has now become known, is that. It is a spectrum of developmental conditions which arise out of early brain development. We know that the condition seems to affect more men than women. A few years ago, it was thought that only people with severe intellectual impairment were affected by autism; it is now known that the majority of people with autism are in fact normal or above average intellectual capacity. It does affect all levels of intellectual functioning. There are probably up to half a million people in the UK with some form of autism, although most of
those will never go anywhere near services. The core characteristics of autism, described by our colleague Dr Lorna Wing as the “triad of impairments”, affect social functioning, imagination and communication. Those are rather glib terms at one level but perhaps I could explain the core characteristics. The diagnosis of autism is concerned not just with the presence of abnormal or unusual behaviours but also the absence of normal or usual behaviours. For example, the abnormal or unusual behaviours that you might see in autism would include an overwhelming fascination with objects or with facts, an insistence on sameness or routine, and a rigidity of behaviour or a repetitiveness of behaviour and mannerisms. The absence of normal or usual behaviour that you would expect to see in a normally developing child would be the lack of attachment, say, to mother or to significant others, this inability which most people with autism have in attributing thoughts to other people, so that makes it very difficult for them to predict what other people are going to do. This impaired “social instinct” as it is called, this intuitiveness that goes with being able to pick up a whole range of social cues from the environment, all contributes to make autism a very complex set of difficulties—it is a fascinating area to work in but it is a very complex set of difficulties—for the people who are affected. Having said that, people with autism do have often unusual skills in particular areas of interest and make great contributions in the world of computers, for example. Our colleague at Cambridge, Professor Simon Baron-Cohen said there is also a triad of abilities to go with the triad of impairments, but, of course, if you go through life not knowing what life is going to throw at you, this can cause very high levels of anxiety to occur, so people with autism are prone to anxiety, and people with autism or a higher ability form of autism known as Asperger’s syndrome can often be prone to anxiety and depression. We see a number of individuals, who, as a result of their social circumstances and their inability to make effective relationships with other people, become very lonely and that loneliness can again lead to other mental problems and depression and they can in some cases be exploited by others.

Mr Mills: Yes. Dr Crocombe and I are currently involved in a piece of research which is a follow-up study of an earlier study that I did with Dr Lorna Wing looking at the prevalence of autistic disorders in the special hospitals. We found that there was an over-representation but not significantly over, and yet many of the consultant forensic psychiatrists whom we met as part of this study are of the impression that there are significant numbers of people who are inappropriately placed within the criminal justice system, not necessarily for committing serious offences but seemingly because the system does not know how to respond to them. There are no studies, as far as I am aware, of the prevalence of autism in the prison population. It is a study that we would dearly love to do, along with the study of people with Asperger’s syndrome who have come to the attention of mental health services.

Q898 Mrs Blackman: You are saying that there is plentiful evidence to show that people with ASD are often misdiagnosed.

Mr Mills: Yes.

Q899 Mrs Blackman: I am not putting words into your mouth about that. The Government is currently saying there are sufficient safeguards, if we look at the definition of mental disorder and what clause 9 in the Bill has to say, to ensure that people with ASD are not wrongly taken down a pathway to compulsory treatment. Would you agree with that?

Mr Mills: No, but my colleague will answer that.

Dr Crocombe: No, we would not agree with that. In our opinion, the definition of mental disorder—as currently defined is too broad, and could be applied to the majority of people with an autistic spectrum disorder. An additional concern is that the second condition is also too broad when the definitions of medical treatment are taken into consideration, and, taken to extremes, under the powers of the draft Bill it is conceivable that a person could be detained for no other reason than that they have an autistic spectrum disorder and that this is of a nature or degree as to require, for example, training in work. Finally, the third condition as currently stated in the draft Bill gives scope for an over-cautious interpretation of the requirements necessary for the protection of the patient from serious neglect by him of his health or safety.

Q900 Mrs Blackman: What should be done to safeguard somebody with ASD being inappropriately treated? Would you like to see something in the Code of Practice or a specific exclusion on the face of the Bill?

Dr Crocombe: We would have a number of suggestions. Firstly, we would recommend that the definition of mental disorder within the Bill be revised, we would believe to include reinstatement of the requirement that the mental disorder is also associated with behaviour that gives cause for serious concern. You will be aware that in the 1983 Act there was a requirement in the example of people with severe mental impairment that this be associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. At the time of the introduction of that Act, it was noted that the inclusion of that requirement was to acknowledge the need to distinguish the small minority of people who need to be detained from the majority who do not, and we believe that for people with autistic spectrum disorder it is important that this distinction continues to be made. We do, however,
acknowledge that the exact wording in the 1983 Act did leave quite a lot of scope for interpretation of what was meant by abnormally aggressive or seriously responsible.

Q901 Chairman: Forgive me for interrupting, could you help us as to which of the words in clause 9(4)(a) you object to. You have: suicide; serious self-harm; serious neglect by him of his health; serious neglect by him of his safety. Which are the objectionable parts of that, so we are absolutely clear what you are saying?

Dr Crocombe: It is: serious neglect by him of his health or safety. With regard to that particular part we would recommend that there would be some clear guidance, possibly within the Code of Practice, for that respect, to assist practitioners in making sound judgments when considering what degree of neglect of health or safety warrants detention and treatment, and this would be to protect against over-paternalism which has been recognised—

Chairman: I am glad I asked the question because I understand your answer more clearly now.

Q902 Mrs Browning: You, in your evidence, consider the mental capacity Bill, with its assumption of capacity, is the most relevant bill for the majority of people with autism. Do you consider a capacity-based Mental Health Act would be workable in practice?

Dr Crocombe: I think—and I share the opinion of a lot of other psychiatrists—that it is very unfortunate that the capacity requirement within the Mental Health Act has not been included. The other issue at the moment, with the two Bills, is which legislation has primacy. We would advocate, with the two current Bills, that the capacity Bill should be the prime Bill for persons with autistic spectrum disorder, and if they did not have capacity they could receive care and treatment under that legislation, but there would also be a requirement for that Bill to have additional safeguards built in for the treatment of mental disorder. Because the Bill as it currently stands does not address issues about safeguards for admission and treatment and there is no sort of review process for potentially prolonged periods of detention and treatment. If that Bill was prime, then that would mean that the Mental Health Bill would only apply to a person with autistic spectrum disorder who has capacity, but would then refuse care or treatment, and would only meet criteria, in our opinion, as amended by the points we have made today.

Q904 Lord Carter: You have mentioned already the interface between the Mental Capacity Bill and the draft Bill, and you know that the Government have stated that incapacitated patients who are compliant with treatment for mental disorder will not normally be subject to compulsory treatment under the Mental Health Bill. Does that ease your concern about the relationship between the two Bills and what concerns remain for people with autism?

Dr Crocombe: The concern is that, if incapacitated compliant patients are not subject to the Mental Health Bill, if they are subject to the Mental Capacity Bill, it explains my earlier point that there are no safeguards in the Mental Capacity Bill. It does not provide any sort of prescribed process for assessment and admission and subsequent detention, there is no review of people receiving treatment for mental disorder, and I know that one of the major concerns of people with autistic spectrum disorder is whether or not they are receiving the right treatment, in particular medication. If you go back to basics, if they are inappropriately diagnosed they often receive
inappropriate medication and if there was no format for reviewing that, then there is potential for a lot of mistakes to be made—unintentionally, but they will be made.

Q905 Lord Carter: Does this relate to the Bournewood gap? You know that we are considering that and it has been argued that the Mental Capacity Bill is the Bill in which the Government should attempt to deal with the Bournewood gap.

Dr Crocombe: Yes.

Q906 Lord Carter: In your written evidence you mention the safeguards that were included in Part V of the initial draft Mental Health Bill 2004. I wondered if you meant the first draft Bill in 2002.

Mr Mills: Forgive us, we did not draft this.

Q907 Lord Carter: That is what we suspected. In fact we discussed the Bournewood gap in committee in the Lords on the Mental Capacity Bill only yesterday, and I actually had an amendment down on the Bournewood gap. When I mentioned the safeguard in the initial draft Mental Health Bill in 2002 the reply was, “That applied to then and not now” and I was not at all clear what that meant. Are you saying that if those safeguards could be transposed in some way into the Mental Capacity Bill, that would close the Bournewood gap?

Dr Crocombe: It would certainly go a long way to helping it, but I think the question would be how firm you would want those safeguards to be. Certainly, it would go a long way to closing the Bournewood gap, because as the Mental Capacity Bill stands at the moment it does not address the Bournewood gap.

Q908 Chairman: Can I just put to you what I think may be concerning members of the Committee? We have wrestled, for 15 meetings, in every meeting, with the interface between mental capacity and mental disorder, and there is a danger that we will produce an answer which could be headlined “That is a difficult question”. You are practical people who work in this field, you are experts in this field, can you try and help the Committee to identify a couple of concrete answers which would help us to stop simply wrestling, get up off the floor, separate ourselves from the issues we are wrestling with and try and produce some headline responses? I must say that as chair of this Committee I have been finding this terribly difficult, and the more I read the harder it gets. (Pause—laughter). Well, that was a difficult question. Please.

Dr Crocombe: Personally, my opinion—and I do not think I am alone in this—is that capacity is the fundamental issue, and if you are going to deprive someone of their liberty and force detention and treatment on them, whether or not they are capable is a primary concern, and if they are capable then, you really have to have very stringent criteria as to what would make you able to take away their liberty and force treatment on them. My concern is that too much emphasis has been moved over into the Mental Health Bill and the issues of capacity and individuals’ rights and freedoms have been lost. I do not think that just applies to people with autistic spectrum disorders, I work also with people with a learning disability as the bulk of my work and I think quite often the issue of a person’s own ability to have some say over their life basically is just missed

Q909 Lord Carter: It has been suggested by the Government that they need a long time to consult, which I can understand, and there is also the mention of resource implications. Do you think it is the difficulty of drafting the safeguards and the criteria or the resource implications which are the main problem for the Government?

Mr Mills: On resources I think we see an awful lot of waste of resources because people are not being given the appropriate help at the right time. It is co-ordination of resources, and the difficulties we see are difficulties between social services departments and health authorities in accepting responsibility for a care plan. I think if we could bring that together—

Q910 Lord Carter: The suggestion has been made that there could be up to 50,000 people who would be caught by Bournewood. If you were the minister would you be concerned about the resource implications?

Mr Mills: I am not sure there would be additional resource implications.

Q911 Lord Carter: it is the marginal costs that matter, is it, the extra costs?

Mr Mills: Yes. It is news to me there would be 50,000 but I do not think there would be considerable additional costs in that, it is where those costs would fall which would be the issue.

Q912 Chairman: You are saying that one needs to get the costs into the right compartment so that the services are best directed, without there necessarily being additional costs.

Mr Mills: If I think of individuals who have been affected by this, I think the expression “joined-up” is one that does not spring to mind, and you have different departments which are competing with each other to shed responsibility very often.

Chairman: Lady McIntosh.

Q913 Baroness McIntosh of Hudnall: The question I want to ask you may appear either dreadfully naive or just rather confused, but one of the issues that troubles me about autistic spectrum disorders as distinct from learning disability is that I am not clear about the issue of treatability as it relates to it, and when you talked about people who have disorders arising from an autism problem, sometimes manifesting other disorders that would fall within what we understand to be mental illness—depression, anxiety and so forth—I wanted to ask were such people to be caught as it were within the mental health system as a result of their
anxiety and depression, and to be diagnosed within that as suffering from autistic spectrum disorder, is there any treatment for that which would then become available to them as a result of their having been caught through their mental illness in the mental health system? I just do not know whether you as clinicians regard autistic spectrum disorders as in any way treatable in the conventional sense and therefore whether there would be any benefit to somebody in being perhaps detained.

Mr Mills: It refers back to my colleague’s earlier comments about the ability of not just doctors but other professionals to assess and diagnose the condition. Very often we are brought in to look at individual cases where the original diagnosis was either absent, in terms of an autistic spectrum disorder—it was not picked up—or it was wrong. These things happen, but it does happen rather a lot and you need to distinguish between those symptoms and those conditions which flow from the core problems of autism and those which are separate but are co-occurring or co-morbid conditions such as depression or schizophrenia, which any one of us can develop. The treatments are very different; if you treat the underlying causes of depression in an autistic disorder then you might do something about re-ordering, restructuring that person’s environment, making life more predictable. If someone has had a sudden dislocation from their regular routine then you might look at dealing with that, rather than putting them onto various forms of medication, although you might do both. The treatment outcomes are very different and depend absolutely on skilful diagnosis.

Baroness McIntosh of Hudnall: May I just press that a little bit? My understanding—which is limited, as you will have gathered—of autism is that there is at least some evidence that some forms of autistic spectrum disorder are in fact treatable, that people can have their condition improved through interventions of one kind or another which, within this Bill, could be defined as treatment. Do they fall within the categories of thing that are defined as treatment within the Bill and, if so, is there any reason for looking at people who suffer from autistic spectrum disorders as being in a way differently placed in relation to the Bill from, for instance, people with learning disabilities which may be as a result of, say, physical injury or genetic conditions and which really genuinely cannot be treated? Their symptoms can be ameliorated but they cannot be treated or altered.

Q914 Chairman: Let me be slightly more specific with the question, if Lady McIntosh will forgive me. Is there medical treatment available to some patients or clients within the spectrum, irrespective of any additional mental disorder, which is, to use the words of the Bill, “capable of available treatment appropriate to the patient’s care”?

Dr Crocombe: This refers back to one of the concerns I mentioned earlier on. The Bill lists a number of treatments; I think it is about looking at what is regarded as a treatment and actually our points reflect some heard earlier in the debate. I think it is an issue of proportionality, whether you think it is appropriate to detain someone in order to give them skills in working or training in working, and it is about what level of treatment is of sufficient benefit and importance for an individual as to warrant deprivation of their liberty. There is not a treatment to cure autism; there are methods of improving a person’s ability to function and their quality of life, but again whether you would want to get into detaining someone in a hospital, for potentially a very long time, to put in those training programmes, whether you think that that would be an appropriate use of the Mental Health Bill. If they develop a secondary illness in the same way that someone with a learning disability or without a learning disability does, and they need a specific treatment that does warrant detention for a hopefully more well-defined period of time, that is a separate issue, but the core condition of autism there is no treatment that could be put in in that context.

Chairman: Thank you. Lady Eccles.

Q915 Baroness Eccles of Moulton: I just wondered whether there was a possibility that the incidence of misdiagnosis will lessen with increasing knowledge of what constitutes the spectrum, and I was particularly thinking of the definition of Asperger's which I believe is quite a recent definition, and whether in your opinion this will mean that as the knowledge increases misdiagnosis will become rarer?

Mr Mills: The term “Asperger’s Syndrome” was introduced in 1981 by Dr Lorna Wing and I think it is only in the last six or seven years that it has found its way into medical practice in any significant form, but I think you are right, we are seeing an improvement in awareness of autism by clinicians at all levels. Some of the difficulties do arise in that, as I said, autism is no longer considered rare; it is not rare but it is not that common either, so many of the people who are seeing individuals with autism, they do not see that many of them, and so the more complex cases tend to be much more difficult to diagnose and to prescribe appropriate treatment for. That is one of the difficulties; it is an enduring labour of the National Autistic Society to try to raise the awareness of autism and Asperger’s Syndrome with the general public and with the medical community, but based on my recent experience and I know on Dr Crocombe’s experience there is a long way to go. Things have improved, but there is an awful long way to go before we can be confident that everyone is receiving the right kind of help.

Chairman: Lord Rix often gets the last word.

Q916 Lord Rix: It is a very quick question. Just to go back to the Bournewood gap again, would it help close the Bournewood gap, if people who were detained, as it were against their will, were given access to all the same rights as people who are
detained under section, in other words given the right to a tribunal and so on. Would this help close the Bournewood gap in this particular Bill?

Mr Mills: Yes, it would.

Lord Rix: Thank you so much.

Chairman: Thank you, you have helped us greatly with what are root conceptual issues that we have been wrestling with in dealing with that Bill, and we are very grateful to you for the clarity of your answers. Thank you so much.

Memorandum from Alzheimer’s Society (DMH 242)

INTRODUCTION

The Alzheimer’s Society is the UK’s leading care and research charity for people with dementia, their families and carers.

Dementia affects over 750,000 people in the UK alone. The Alzheimer’s Society has over 25,000 members and works through a network of over 250 branches and support groups. It provides information and support for people with any form of dementia and their carers through its publications, helpines, website and local network. It advises professionals, runs quality care services and campaigns for improved health and social care and greater public understanding of dementia. The Society funds an innovative programme of biomedical and social research in the areas of cause, cure and care.

The Society has concerns about the proposed Mental Health Bill that relate to the lack of safeguards for people with dementia who are informally detained. We do not believe the provisions of the Mental Capacity Bill are sufficient to close the gaps left by the Mental Health Bill.

Are people with dementia affected by the Bill?

There are thousands of people with dementia detained informally in care homes and in hospital. In many cases people with dementia are detained informally because they do not have the capacity to give consent, but do not resist treatment or detention so are not sectioned under the Mental Health Act.

There are also a number of people with dementia are detained against their will without being sectioned. These include people who are in locked wards and care homes.

There are also a small but significant number of people with dementia who lack capacity and are detained compulsorily. The review of research relating to the Mental Health Act (1983) found that of people over 65 who are sectioned, up to 48% had a diagnosis of dementia.

All groups require adequate safeguards that protect them from abuse and bad practice.

Lack of Safeguards for Those Detained Informally

The Mental Health Bill does not provide safeguards for people with dementia detained informally. As the Bill stands they have no right to assessment or a care plan, and no right to ask for a review of treatment or to challenge detention. This lack of protection was highlighted by the recent ruling on the Bournewood case which concluded that the informal detention of HL was a breach of his human rights.

People with dementia are particularly vulnerable to abuse. This could include physical, psychological, financial or sexual abuse and neglect. In addition, the care provided to people with dementia is frequently of a poor standard, often due to the lack of staff trained in caring for people with dementia. The Society estimates that, even though three quarters of people in care homes have some form of dementia, only 10% of care home staff are trained in working with people with dementia. The inadequate care experienced by people with dementia highlights the importance of adequate safeguards and the right to contest poor care practices.

Of particular concern to the Alzheimer’s Society is the frequent overprescription of neuroleptic drugs experienced by people with dementia. These drugs are often used to deal with behavioural symptoms of dementia, rather than attempting to investigate and understand the cause of the behaviour. They are often prescribed over long periods of time with no review of their use. If the Bill provided the same kinds of safeguards to people detained informally as for those who are sectioned, people with dementia would be entitled to have their treatment reviewed. This would help to guard against unacceptable practices such as overuse of neuroleptics.

The safeguards contained in the Draft Mental Health Bill 2002 for people detained informally were helpful, but whether a person was protected by them depended on setting rather than the needs of the individual. The safeguards did not apply to people with dementia detained informally within a residential home. While it may appear that residents in nursing homes are more likely to have high needs and require protection from safeguards, high proportions of older people living in residential homes also have dementia and therefore require the protection of these types of safeguards.
The Society believes that all people with dementia should have the right to a care plan and a review of that care plan within a specified period of time. We know that while this is available to some people, there are many whose care is not properly planned or reviewed and so does not meet their needs. However, those people with dementia who are detained informally within a care home, and have not appointed an LPA, are a particularly vulnerable group who are often subject to abuse and neglect. For this reason their rights need to be protected by the same kinds of safeguards available to those who have been compulsorily detained.

**The Mental Capacity Bill**

The Alzheimer’s Society does not share the Government’s confidence that the Mental Capacity Bill will provide adequate protection for people with dementia detained informally. While we welcome many aspects of the Mental Capacity Bill, its provisions do not match the safeguards provided by the Draft Mental Health Bill 2002. As the Mental Capacity Bill stands, it will not allow patients detained informally the right to a tribunal, statutory care plan or access to an advocate as the Draft Mental Health Bill 2002 would have. The independent consultees included in the Mental Capacity Bill are likely to have a much more limited role than an advocate and will only be available in a very limited number of circumstances. These deficiencies make it more likely that people with dementia are left in care homes or hospital without properly planned and reviewed treatment and care and with no right to appeal against poor care or abusive treatment.

However, we believe it is necessary to have a mental capacity framework, provided by the Mental Capacity Bill, in place before the Mental Health Bill is implemented. The Mental Capacity Bill’s general principles which include assuming that a person has capacity, a requirement to act in the person without capacity’s best interests and attempting to maximise decision making, provide the basis upon which the Mental Health Bill can operate in terms of people who may not have capacity.

The Alzheimer’s Society believes the government needs to consider the gap in the protection of vulnerable groups created by the inadequacies of the two bills and work to remove the disparity in the safeguards provided to people detained formally and informally.

We would welcome clarification on whether decisions made by the nominated person, as set out in the Mental Health Bill, will override decisions contained within an advance directive, as set out by the Mental Capacity Bill, should an individual be compulsorily detained. This needs to be made clear if the legislation is to work effectively.

**Aftercare**

The Society disagrees with the reduction of free, integrated health and social care services for people who have been discharged from compulsory hospital treatment to just six weeks. This period of time will be inadequate for many people with dementia leaving hospital following compulsory treatment. These individuals are likely to have a high level of need and will require intensive support from health and social services. This support is a health need and should not therefore be means tested and should be available for as long as is required by the individual.

*October 2004*

**Witnesses:** Mr Clive Evers, Director of Information and Education and Professor Clive Ballard, Director of Research, Alzheimer’s Society, examined.

**Q917 Chairman:** Welcome. I will ask you to introduce yourselves in a moment; can I ask you to note that this is a public evidence session and a transcript will be produced and be available within a week, to which you will be able to make alterations of text but not of meaning. Can I also remind you to speak up into the microphones as the system is imperfect. Can I start by asking you to introduce yourselves, and then if you will allow us we will go straight into questions because this is a fairly short session, as I think you know.

**Mr Evers:** My name is Clive Evers, I am the Director of Information and Education at the Alzheimer’s Society.

**Professor Ballard:** I am Clive Ballard, I am Director of Research at the Alzheimer’s Society and also a Professor of Age-Related Diseases at King’s College London and Honorary Consultant in Old Age Psychiatry.

**Q918 Chairman:** Can you just tell us what the Alzheimer’s Society is in a few words, please?

**Mr Evers:** The Alzheimer’s Society is the leading care and research charity for all forms of dementia, we cover England, Wales and Northern Ireland, we are a membership organisation, we provide information support and helplines, printed information; we run direct care services, home care services, day care services and we undertake campaigning and significant amounts of research as well.

**Chairman:** Thank you very much. Lady Pitkeathley.

**Q919 Baroness Pitkeathley:** As you know, there is a broader definition of mental disorder introduced into the Bill and I want to ask you how you think that will affect people with dementia. In your evidence you say that nearly half the people who are detained over the age of 65 have some form of dementia. Would you, for example, expect that figure to increase or decrease under the provisions of this new Bill?
Professor Ballard: I would actually expect it to make very little difference. Although the definition is slightly broader and might potentially encompass more people, when applying the other criteria I think the additional people that would be encompassed would be unlikely to meet the other criteria, so I suspect that overall it will make very little difference.

Q920 Baroness Pitkeathley: How about the safeguards that are in the Bill, do you think they are adequate to prevent people such as those you represent being treated under compulsion except when it is absolutely necessary? If not, how many more safeguards and what kind of safeguards would you like to see introduced?

Professor Ballard: I think our main concern, as with the previous people giving evidence, is about the people who fall into the Bournewood gap, but we welcome a lot of the safeguards that have been introduced, the access to advocates, the clearer care planning. I think those we would see as very positive things, but we would be concerned that people who are informally detained would not have the opportunity to have the same safeguards.

Mr Evers: There were significant safeguards in the 2002 draft that we believe could be usefully added, safeguards like a person with dementia could have a nominated person who is consulted before medical treatment is commenced, who is kept up to date; if the nominated person tells the clinical supervisor that the person would not have consented to a treatment unless in an emergency, then the doctor must stop the treatment. There were issues around the timing as well, and a care plan would have been written within 28 days and included in notes. There are a number of other provisions like that in the 2002 draft that we think could be usefully added.

Q921 Baroness Pitkeathley: Is that nominated person likely to be someone who has had a previous relationship with the person with dementia, their carer or other professional with whom they have had contact?

Mr Evers: They are likely to be a close relative or a friend, and in that sense we would regard them as, in general, having the best interests of that person at heart and also knowing what their wishes and their preferences would have been.

Q922 Baroness Pitkeathley: Do you think there are any circumstances in which the issue of the safety of the general public should override the best interests of a person incapacitated with, in this case, dementia?

Professor Ballard: I think there are occasional circumstances where there might be quite a large risk to other people. A specific example might be if somebody is living at home and is incapable of turning off the gas and lighting it appropriately and therefore could put a lot of other people at risk. So I think there might be some limited situations which usually can be dealt with in an informal way by an experienced clinician, but which could potentially lead to a higher level of risk and might override the individual's best interests.

Q923 Baroness Pitkeathley: Just to expand on that a bit, are those other kinds of safeguards, the kind of services that could be put in, dependent on there being adequate services available and therefore adequate resources to provide the kind of services to ensure the person does not leave the gas on?

Professor Ballard: I think that providing good quality, safe services for people with dementia is the fundamental cornerstone really, and I think often emergency situations arise because those services are not available or because they cannot be introduced in an appropriate way. Certainly, therefore, I think that the number of people requiring provisions under the Act would be a lot less if the quality of the services is improved.

Q924 Chairman: Your example does not really bear close examination, does it, because it is much cheaper to rip out the gas and put in an electric cooker than to detain someone in a secure hospital for a month?

Professor Ballard: That is why I said that in usual circumstances it could be managed in other ways, but often if somebody with dementia, for example, is suspicious, will not let people into the house, there might be occasional circumstances where it is difficult for people to gain access to actually implement what are fairly straightforward things. So that is an occasional situation and it is the type of example which, in the vast majority of circumstances, would be dealt with by other means, but not always.

Q925 Chairman: Can you try and give us some figures on this; in your own practice or the practice of those whom you supervise, how many cases would you expect in a year?

Professor Ballard: I have been a consultant old age psychiatrist since 1995 and I can only think of one example where this has actually happened, so it is a rare situation and I do not think it is something I want to over-estimate. There is the occasional example where the interests of the community around that person override that person's best interest.

Chairman: Thank you, Lady Finlay.

Baroness Finlay of Llandaff: Thank you, chairman. In your evidence you argue that people with dementia who are detained informally should have a right to tribunal, statutory care plan and advocacy. Do you think these rights should be extended to all psychiatric patients who are detained informally because they do not resist treatment and, if not, why do you think patients with dementia should have a unique right to such safeguards?

Q926 Chairman: You might couple with that giving us some kind of idea whether there is a large number of elderly patients who fall within the Bournewood gap.

Mr Evers: To our knowledge there is not a large number of elderly patients with dementia that fall into that gap, but there are some, certainly. We
Mr Evers: a range of different psychiatric conditions that occur in the elderly as opposed to the young, do you think there is a right to treatment in specialist geriatric psychiatry units and should the elderly be treated in separate units to some of the other psychiatric patients?

Professor Ballard: I think the key phrase that you used is special psychiatric units. We believe that all people, whatever their form of dementia, whatever their age, whether they are below 65 or over 65, should have specialist care and assessment. There is a range of different dementias that affect younger people, a wider range of rarer dementias—for example, frontal lobe dementia. In older people it is mainly Alzheimer’s disease and vascular dementia that we see, but specialist assessment, care and treatment should be available to all.

Q927 Baroness Finlay of Llandaff: So they should be there for everybody.

Mr Evers: Yes, they should be there for everybody.

Q928 Baroness Finlay of Llandaff: If we just look at the different profile of psychiatric conditions that occur in the elderly as opposed to the young, do you think there is a right to treatment in specialist geriatric psychiatry units and should the elderly be treated in separate units to some of the other psychiatric patients?

Professor Ballard: I think the key phrase that you used is special psychiatric units. We believe that all people, whatever their form of dementia, whatever their age, whether they are below 65 or over 65, should have specialist care and assessment. There is a range of different dementias that affect younger people, a wider range of rarer dementias—for example, frontal lobe dementia. In older people it is mainly Alzheimer’s disease and vascular dementia that we see, but specialist assessment, care and treatment should be available to all.

Q929 Baroness Finlay of Llandaff: Do you consider that the lasting power of attorney for welfare decisions which is outlined in the Mental Capacity Bill will provide adequate safeguards for the way that decisions are made and whether the concept of just a nominated person that you have outlined would be an adequate replacement for the nearest relative?

Mr Evers: The nominated person is a reasonable alternative to the nearest relative, but we see a whole range of different provisions and approaches, so the independent advocate is important as well as other facilities like a tribunal; it is a range of different safeguards that will be appropriate.

Q930 Baroness Finlay of Llandaff: Do you think whoever that person is should be provided with information about the patient if the patient objects, or could that be seen to be infringing the patient’s human rights?

Mr Evers: I think that is a possibility. I think there is a strong possibility that infringement would occur in those circumstances.

Baroness Finlay of Llandaff: Thank you.

Q931 Chairman: On the issue of patient confidentiality could you just develop how you resolve what can sometimes, I am sure, be difficult issues between retaining the confidentiality which the patient may be asking for, possibly not completely rationally, and breaking the confidentiality which is in question by informing carers of relevant matters which the patient does not wish the carer to be told?

Professor Ballard: I think this is one of the very important roles for advocacy in people with dementia, when there are a whole variety of major decisions, but this might be an example of a decision where an advocate might be able to talk to the person, talk to the professionals involved and help that person make a balanced decision about what is in their best interest.

Chairman: Thank you. Lady Murphy.

Baroness Murphy: Could I pick up, first of all, on the Bournewood gap issue before going on to my question? Would you not agree with me that the vast majority of informally detained patients with Alzheimer’s are, in fact, in registered care homes and nursing homes and not formally in hospitals—the ones who are de facto informally detained behind combination locks and so on? I think there are about half a million of those, in fact, of which perhaps half at some stage might resist care and treatment and might be receiving medications, for example neuroleptic medication?

Chairman: Lord Rix cannot hear you, Lady Murphy.

Q932 Baroness Murphy: I am sorry, I will shout up then. I am referring to this large number of people with dementia that we know are in registered care homes and nursing homes, many of them receiving neuroleptic medication without any checks and balances. I understood from your submission that actually you would see those as falling into the Bournewood gap, and were asking for some kinds of safeguards for those patients, is that correct?

Professor Ballard: I would certainly support that particular view. There are a large number of these people, most of them cannot make fully informed decisions about the treatments they are receiving, or in fact often the place of residence that they are residing in. Personally, therefore, I would see those people as falling into the Bournewood gap.

Q933 Baroness Murphy: Would you see the Mental Capacity Bill or the Mental Health Bill as the most appropriate place to try to tackle the safeguard issue for them?

Professor Ballard: I think our view would be that it is probably best dealt with in the Mental Capacity Bill, however our very large concern is that it does not fall in between the two bills and not be addressed by either.

Q934 Lord Carter: In your evidence you have already stated the idea of picking up the safeguard part of the 2002 draft Mental Health Bill and perhaps transposing that into the Mental Capacity Bill. You probably heard that I put the same question to the previous witnesses; do you think this is the way to do it, that in fact if we were able to transpose that into the Mental Capacity Bill now that would be sufficient to close the Bournewood gap?

Mr Evers: I think it would go a significant way towards doing that, but I think we would need to look at all the individual proposals from that 2002 draft to see if they met the safeguards that we would like to see in place.
Q935 **Lord Carter:** There is of course a resource implication of all of this, and I am sure you heard the figure that there could be 50,000 people who would be caught in this way. Are the resource implication the significant problem that the Government seem to think they are?

**Mr Evers:** The figure of 50,000 is a new figure to me and I would be interested to learn the evidence for that. I think the main issue for the Alzheimer’s Society, just alluding to the previous question, certainly there is a significant number of people in residential care homes who might be affected by this proposed legislation. The issue for us though is about quality of care rather than the detention issues. We need to make a real gear shift in the way that people with dementia in residential care, and also in the community, are treated and cared for, and with significant numbers of people not having care plans in residential care at the moment, we would like to see approaches to improve that. If rights are included in this legislation to ensure that people have access to care plans, that they are regularly reviewed, then care will be improved and there will be less likelihood for anybody to have to apply for compulsory treatment in care.

**Chairman:** Yes, certainly. Dr Naysmith.

Q936 **Dr Naysmith:** You are absolutely right, this is the most important aspect. It is not so much the freedom, it is the fact that there are far too many people who are not receiving adequate treatment, who are receiving bad treatment. Why do you think this happens? I know you just suggested that care plans could be provided for everyone, but it is much more deep-seated than that. Why do you think it is that there are so many people who are not being counted as patients and do not get an adequate service at the moment?

**Professor Ballard:** Within residential and nursing homes I would agree absolutely that it is a very deep-seated problem. I think there is a lack of clear responsibility, for which health professionals are responsible for the care of these individuals, the structure of staffing within these organisations provides no real means of people developing skills and monitoring the quality of the service that is provided. There is a huge staff turnover; for example, in a recent study in London over three months there was a 600% turnover of care staff.

Q937 **Chairman:** In how many months?

**Professor Ballard:** Over three months.

Q938 **Chairman:** 600%?

**Professor Ballard:** Yes. So within these kinds of environments where you have a poor quality of employment for the individual workers, no commitment to training or providing good training, it is very difficult to see without a major reform how there can be very, very substantial improvements. However, I do feel that as these people are informally detained and have not got their full capacity, there is an opportunity with legislation to at least make sure that they have the opportunity to proper care plans, proper review of medication and at least minimise some of the very harmful effects that they are being exposed to at the moment.

Q939 **Dr Naysmith:** The two forget-me-not reports that you were associated with quite a lot, do think anything has improved really since then?

**Mr Evers:** I would say that there have been improvements. We are certainly seeing earlier diagnosis happening, we are seeing people contacting the Alzheimer’s Society helpline earlier and more frequently, but I think that the initial impetus that both those reports built up was being lost slightly, and we need a much stronger focus on the contribution that primary care can make to identifying and referring on to old age psychiatry people who may have a dementia, and it is out of old age psychiatry, with multi-disciplinary support, that the most effective care and treatment can be provided.

Q940 **Dr Naysmith:** Most of the care and treatment in nursing homes insofar as medical practitioners are concerned is through general practitioner services, is it not?

**Mr Evers:** It is.

Q941 **Chairman:** Is that a concern?

**Mr Evers:** It is a concern to us because although, as the forget-me-not reports and other research the Alzheimer’s Society has supported have indicated, some GPs have a better understanding of dementia, they have a long way to go to translate that knowledge into effective care and support.

**Dr Naysmith:** If we were to recommend something along the lines of the care plans being more widely written, that would be a useful thing. I know it is slightly tangential ...

Q942 **Chairman:** No, it is a helpful question, Dr Naysmith.

**Mr Evers:** It would, yes.

**Chairman:** Lady Murphy.

Q943 **Baroness Murphy:** Could I come back now to aftercare? In your submissions you criticise the reduction in the draft Mental Health Bill from the 1983 Act section 117 of the provision of free integrated health and social care, aftercare, to a period of six weeks. I wanted to ask you what your experience was at the moment of using section 117 aftercare to provide the appropriate services that patients with dementia need. Does it work at the moment?

**Professor Ballard:** I think it does work in my own clinical experience. We have actually looked to try and find numbers and it is very difficult to find specific numbers nationally for people with dementia; we are able to find numbers for older people generally but not broken down by diagnosis, so it is limited to anecdotal experience really. I think it is a relatively small number of individuals, but I think the current system does work well and provide those individuals with some safeguards.
Q944 Baroness Murphy: That continues to provide free aftercare at the moment, does it not?

Professor Ballard: Yes it does.

Q945 Baroness Murphy: Often residential care, for example.

Professor Ballard: Yes.

Q946 Baroness Murphy: Are you saying, therefore, that you would like to see continuing free aftercare provided for as long as necessary, or would you want to put a time period on it?

Professor Ballard: Our members certainly feel very strongly about issues of paying for certain key aspects of care and residential nursing care, it has been a very big agenda item for members of the Society. It is a particularly difficult issue when you are imposing residential or nursing care on somebody as what you think is the only safe option, but then insisting that that individual pays for the care. I think it does create an ethical dilemma and also, a practical dilemma if you have to try and make the resources available to pay for that.

Q947 Chairman: Is the change proposed in the Bill a significant change in your view, that is the difference between the six week obligation and the clear, open-ended obligation provided under section 117 of the 1983 Act?

Professor Ballard: I think it is a very major shift, because people might well be covered by aftercare plans for quite a long period of time.

Chairman: Lord Mayhew.

Q948 Lord Mayhew of Twysden: Can there be any justification for fixing an overall period of time? Can there be any explanation for doing that other than an economic one, a desire to save money, and if you get it wrong in the case of an individual does that not suggest a greater likelihood of that person going back into residential care because the aftercare cannot be protracted to the extent that that individual requires?

Professor Ballard: It is difficult to see advantages other than economic of the time limitation, and I also would agree that it is true that if that jeopardises the long-term success of the care in the longer run that might increase the cost through hospital readmission.

Chairman: Ms Munn.

Q949 Ms Munn: I have been very puzzled about this whole issue the whole way through. We have had some initial comments from the Department on some of the issues, but what I am not clear about on this whole range is because they have also responded that if anybody could not afford to pay for it, there would not be a question of them not receiving treatment, which of course gets you into interesting areas. But I am not clear again whether this is around the traditional problem there has always been between social care services which could be charged for, and those provided by the health services where there are much more strict limits—although obviously they do charge for such things as prescriptions et cetera—or whether in fact what is actually being suggested is that, say, for example, there is a charge for day services, it is at six weeks that that can come in or not. I do not know whether you have had the opportunity to look at that, as to whether that is the area we are actually talking about?

Mr Evers: We have not had an opportunity to look at that in detail, but certainly our members continue to raise concerns with us about access to essentially free NHS care as it is needed. A range of different help will therefore be needed, it may well be respite care, it may well be continuing care, but those concerns on charges are there and, essentially, although the social/healthcare gap has closed slightly, there are still instances of it causing difficulties and people seeking devices like section 117 to try to secure what they see as NHS support which they believe should be there.

Q950 Chairman: Acting as devil’s advocate for a moment, if I come out of hospital following a physical illness I am not entitled to on-going, permanent, unlimited aftercare free. Why should the situation be different for people who have been suffering from a mental condition; suppose people had been suffering from a physical condition?

Mr Evers: Because if you are discharged from hospital having suffered a physical condition, it is assumed that you are recovered. If somebody has a mental illness like Alzheimer’s disease or another type of dementia, those conditions are not reversible. There are treatments to help but they do not stop or reverse the condition.

Q951 Ms Munn: I do think we need to try and get some clarity on this issue because, as I say, it is this very difficult area between social care services and health services and what is a free health service and what you can legitimately charge for in social care. Also, because in health services and social care we are seeing pooling of budgets, we are seeing people working within one trust, that does get more complex, but picking up the Chairman’s point, if you look at somebody, say, who comes out of hospital with a physical condition and they are discharged, they may say, particularly talking about elderly people, that they need to go to a day centre because they are not physically able to get their meal or whatever but they would be charged whatever the cost of that service were—if they were at home they would be charged for meals-on-wheels, or those kinds of situations. I do think that is the difficulty of this area, it is complex and we do need to get much more clarity about what is being talked about.

Professor Ballard: Clearly there are an awful lot of grey areas at the moment over the definitions between social care and medical care, and certainly we would welcome some clarity and our members would welcome some clarity. Clearly, that issue is much broader than just that within this particular legislation, although clarity generally will help this legislation as well, I think. For me, in addition to the other issues that Clive raised, the other thing that is actually different is that in a situation where you are imposing a particular care plan on somebody that they might not want to have imposed on them.
because you think that is the safe way or in their best interests within the definition of the Act, that is slightly different to somebody with a physical illness who is choosing to opt for particular types of aftercare.

Ms Munn: I suppose, again, it comes back to which things are going to be charged for, does it not?

Q952 Chairman: Do you think the six week provision, if enacted, might lead to clinicians regarding a community treatment order as a neat way to get round the costs issue and therefore might lead to more community treatment orders than would otherwise be the case?

Professor Ballard: I think that is true and most clinicians would say that in somebody with a complex mental health problem six weeks is actually a fairly short period of time to see whether a particular treatment plan will actually be effective or not.

Chairman: Lady Eccles.

Q953 Baroness Eccles of Moulton: Has any research been done into people who are at present receiving continuing services because there is not a six week cut-off period, how many people roughly would that affect and do we know what a difference it would make to existing users?

Professor Ballard: As we have said, it has been very difficult to obtain figures specifically for people with dementia. We might be able to get specific access to those figures, but at the moment the only figures available are for older people generally so I can only really talk to my own clinical experience; during the time I had a catchment area service for older people we would be probably be talking of a few people a year in one catchment area of about 10,000 older people. So I do not think it is huge numbers.

Chairman: Thank you very much indeed; especially in the last part of the meeting you have helped us to put a little more detail on a teasing question which did not have much substance before. Your evidence and your written material have been of great assistance to the Committee.
Wednesday 26 January 2004
Afternoon

Members present:

Barker, B. Mrs Liz Blackman
Carlile of Berriew, L. (Chairman) Mr David Hinchliffe
Carter, L. Tim Loughton
Eccles of Moulton, B. Laura Moffatt
Finlay of Llandaff, B. Ms Meg Munn
Mayhew of Twysden, L. Dr Doug Naysmith
McIntosh of Hudnall, B. Dr Howard Stoate
Murphy, B.
Pitkeathley, B.
Rix, L.
Turnberg, L.

Memorandum from the British Association of Social Workers (DMH 60)

1. The British Association of Social Workers (BASW) is the major professional body representing social workers in the United Kingdom. The Association is a core member of the Mental Health Alliance and it supports the Alliance’s general stance on the Bill. Although BASW’s members are concerned about many aspects of the Bill, this evidence focuses primarily on the role of the Approved Mental Health Professional (AMHP) which it is proposed will replace the role of the Approved Social Worker (ASW) in the present Act, and we have therefore attempted to follow the standard format for evidence. BASW was the only national body to put forward to the government detailed evidence and proposals to the government on the AMHP role, which are contained in the Appendices, and we would welcome the opportunity to give verbal evidence on this issue in particular. The Association’s Forensic Special Interest Group will be making a separate submission in relation to Part 3 of the Bill.

2. There are currently around 4,500 ASWs, and they make virtually all the applications for compulsory admission to hospital under the civil procedures and are therefore the main “gatekeepers,” ensuring that the legal requirements are met and that a proper balance is struck between the interests of the patient and other parties. They are in practice the primary interpreters of the “conditions for compulsion” at the point of a patient’s first entry into the mental health service, and they therefore have a particular interest in this aspect of the Bill. Since they view the situation from a social care perspective, they provide a counterbalance to any tendency to over-medicalise what are often multi-dimensional problems. They have to be experienced social workers with an additional specialist qualification, and, uniquely in local government law, they act in a personal capacity when making decisions under the Act, and can therefore be sued as individuals. A list of the ASW’s duties is attached as Appendix 1.

3. This evidence deals with the following issues:
   — The government’s general approach to the civil procedures for admission ( paras 4–7).
   — The “conditions for compulsion” ( paras 8–11).
   — Incompatibility with other elements of the government’s mental health strategy ( paras 12–13).
   — The AMHP role ( paras 14–16).
   — BASW’s proposals in relation to the AMHP role ( paras 17–20).
   — Workforce implications ( paras 21–22).

The Government’s General Approach to the Civil Procedures for Admission

4. The Association has been concerned throughout about the way in which the whole process of review of the legislation has been managed by the government, which contrasts sharply with its experience of the last major review from 1977–82. There has been an excessive preoccupation with a small and very untypical group of patients, the so-called DSPDs, and much time and energy has been expended on infighting between the Department of Health and the Home Office about this group, to the detriment of other priorities. It has been clear to us that the Bill Team has lacked members with practical experience of operating the civil procedures for initial admission (as opposed to the criminal procedures administered by the Home Office) and that it has not had access to appropriately-competent external advice, a deficit compounded by the arm’s-length approach adopted to professional bodies such as BASW whose members have vast experience of operating this part of the present Act.
5. As a result, far too little attention has been paid to the civil procedures for admission and to the interests of the vast majority of people who are likely to be subject to them, and even after seven years the latest draft still contains measures which are ill-thought-out or incomplete. There is, for instance, a ludicrous error in Clauses 22 and 23 which would have the effect that, having examined a patient at home and having completed all the paperwork for a compulsory admission, the AMHP would first have to travel to the hospital to register the patient, then return to transport him or her to the hospital, since the power to transport is conferred only by registration. Under the present Act, the power is conferred as soon as the ASW completes his or her application.

6. Only slightly less serious is Clause 17. In transposing the present emergency procedure (Section 4) into the new format, the officials appear to have lost sight of the fact that under the present Section 4, both the ASW and the one doctor involved have to agree that the situation is an emergency and cannot wait for the arrival of a second doctor (usually the psychiatrist). Although only the doctor has to certify this on the documents, the ASW is entitled not to make an application at that point if he or she considers it is not justified “in all the circumstances.” This procedure has caused difficulty ever since 1959, and it is almost invariably the ASW who takes the lead in concluding that a situation is not an emergency and that admission should not proceed. In the Bill, however, the AMHP would have no choice but to admit immediately if the doctor, who might well have no knowledge of or long-term interest in the patient, or any experience in psychiatry, decided that it was an emergency. Such errors give a clear message to ASWs that those drafting the Bill had little understanding of the present civil procedures, and are bound to undermine what little confidence they have in the legislative process as a whole.

7. A further example is Clause 228, which would extend the present powers of the police and would allow them to remove people from their own homes by forcible entry without a warrant, “on information from an AMHP.” There are practical difficulties with the present Section 136, which allows police only to remove to a place of safety people found in places “to which the public have access,” but what is now proposed has major human rights implications which have not been debated. This clause has some similarities to Section 20 of the 1890 Lunacy Act, which was grossly misused, to the extent that it became the main route for compulsory admission, and as a result, Parliament in 1959 laid down much stricter criteria for forcible entry and removal, which are contained in the present Section 135 (1) and which require a warrant and the presence of both an ASW and a doctor. The risk of malpractice is just as great as it was prior to 1959, and BASW also takes the view that an AMHP would be far too vulnerable to legal action if he or she used such a power, and would advise its members not to do so.

**The “Conditions for Compulsion”**

8. BASW shares the view of the other Alliance members that the “conditions for compulsion” are still too broad. It is just not possible to devise a single set of conditions which will leave the door open for the DSPD group without opening it far too wide for other groups, and the correct course is to have two separate processes as is now the case in Scotland. Although Ministers have talked disparagingly about “myths” surrounding the conditions, experienced ASWs can see straight away that if they were to apply these new criteria to the people they assess at present, they would be forced to impose compulsion on far greater numbers of people, many of whom would then remain subject to compulsion for very long periods because it would be difficult to satisfy the grounds for discharge. The main factor is the absence of the discretion provided in the present Act not to take action even where the minimum conditions are satisfied. Again, it is very apparent that those drafting the conditions were operating from a theoretical standpoint and were not familiar with the situations actually encountered by professionals on the ground. A paper analysing the conditions in detail from an ASW perspective is attached as Appendix 2.

9. In addition, the absence of reasonable discretion may have the effect of forcing the examiners to act in contravention of their professional codes of ethics, which generally prohibit them from taking action which they do not believe to be in their patient/client’s best interests. BASW’s position as a professional body is that it will advise its members not to become involved in operating legislation which might force them to contravene the BASW or GSCC Codes.

10. A particular concern, which is addressed in the attached paper, is the very large number of people suffering from self-neglect or causing public nuisance as a result of alcohol or drug misuse or lower-level personality disorders (ie not “DSPD”). Mental health services are under constant pressure, especially from the police, the courts and local authorities, to admit people in these groups, and in practice they do admit a great many of them, so it cannot be said that there is no “appropriate treatment available,” but those who retain the capacity to make their own decisions and to understand the likely consequences of their actions are not generally seen to be detainable at present, and they are unlikely in any case to benefit from treatment unless they are consenting to it.

11. The conditions in the draft Bill, however, would give the examiners little option but to impose compulsion. The critical factor is the removal of the discretion which is encapsulated in the present requirement laid on the ASW to consider “all the circumstances.” This is the means by which the ASW and doctors at present can (and frequently do) take into account the patient’s capacity, but this possibility would be excluded by the Bill. Hospitals cannot cope with an increase in admissions, and the danger is that the examiners would then be forced to resort to “non-resident” assessment in the community even where this
was not practicable. Whilst BASW supports non-resident treatment in a limited range of cases and subject to strict conditions, we have seen no credible case for non-resident assessment, and we think that it should be removed entirely from the Bill, not least because of the high risk of misuse.

**Incompatibility with other elements of the Government’s Mental Health Strategy**

12. The conditions for compulsion are one of many areas in which a Bill which is claimed to enhance rights and protections actually does the opposite. It is also completely at odds with the other major strands of the government’s mental health strategy, and in particular with the multi-disciplinary principle and the “New Ways of Working” proposals to limit the expectations on psychiatrists, and with the Care Programme Approach (CPA) which is now the basic administrative framework for services to people with serious mental illness. All powers are given to the clinical supervisor, who in practice will almost always be a psychiatrist, and there would be situations in the management of “non-resident” orders, where other professionals acting as community supervisors might be ordered by the clinical supervisor to act contrary to their own better judgement. This is not an acceptable position for social workers to be in, and could put them in breach of their professional codes, and BASW would be forced to advise its members not to take on this role.

13. In addition, the requirement which has existed since 1959 for a Tribunal to receive a report from a social worker has disappeared, and the Bill also appears to require a care planning process directed by the clinical supervisor which would be quite separate from the CPA process driven by the care co-ordinator. Our hope and expectation at the outset had been that the government would take the opportunity to bring the CPA process, which is currently based solely on guidance, into the legal framework, and it is difficult to avoid the conclusion that those drafting the Bill were either unfamiliar with the CPA or made a deliberate decision to ignore it.

**The AMHP Role**

14. It is difficult, due to lack of information, for us to make any judgement about the government’s overall intentions in respect of the AMHP role, which still appears to be something of an afterthought despite its central importance in these procedures. For instance, the Bill provides for the training and approval of AMHPs to be lodged with the local authorities, (which BASW supports) but it is then silent as to which body will be responsible for ensuring sufficient numbers, and for managing them and holding them accountable after approval. We are bound to assume that most of this will be set out in Regulations, but we have not yet had even a hint as to what they may contain. It is also likely that the detailed prescription of professional and agency roles will be left to the Code of Practice, and until we have seen these documents it is impossible for us to form a view about the overall effect of the Bill.

15. In particular, it is difficult for us to judge the extent to which the AMHP will be independent of the medical examiners and of the NHS Trust which will implement the compulsory powers. The present civil procedures are founded on the principle that the ASW, as an officer of the local authority, is completely independent of the doctors and of the receiving hospital and is acting in a quasi-judicial capacity. This principle is no less important in the new legislation, and its retention was strongly supported by the bodies responding to the 2002 consultation. The government tried to claim that, because compulsion after 28 days would be authorised by a Tribunal, the involvement at the entry point of an independent quasi-judicial official would no longer be necessary to achieve Human Rights Act compliance, but it is only possible to argue this because the ECHR says so little about the rights of people with mental disorders, having been written in the early 1950s when the Lunacy Act was still in force. The government was, in effect, advocating a much lower level of safeguard against an unwarranted 28-day loss of liberty than is provided by the criminal law.

16. The independence of the ASWs has, however, already been seriously eroded by their secondment to joint mental health services and in some places by actual transfer to the NHS Trust as their primary employer. In the absence of any contrary indication, we must presume that AMHPs will be Trust employees, accountable for their statutory role to the Trust, and in addition it is envisaged that many of them will be from health professions (mostly nursing.) The government has, however, given no indication as to how it intends to guarantee their independence other than by exhortations in the Code of Practice that they should behave in such a way, which will be virtually worthless as a defence against institutional pressures to conform to the employer’s wishes.

**BASW’s proposals in relation to the AMHP role**

17. BASW’s main body of evidence in December 2001 (Appendix 3) concluded that, although the ASW role, which was originally proposed by the Association in 1977, had been a success, it was rapidly becoming unworkable in present-day conditions, leading to a steady fall in ASW numbers, and that it should not be carried over unchanged into the new legislation. The two draft Bills have, however, done precisely that, although we do not believe that this is because the government positively disagrees with us but because it has simply not given any attention to the issue. In 2001 and subsequently we have put forward a number of proposals which we believe would resolve these problems, but we have yet to see any clear indication that they are being taken seriously.
18. In particular, we have recommended that the present ASW role should be divided, with the quasi-judicial element being separated from the co-ordination and transporting function, in order to reduce the workload on one individual and to lessen role conflicts. We have also recommended that, since finding a “second doctor” has been an endemic problem since 1959 and it wastes vast amounts of ASW time to little or no benefit for the patient, it should be possible to substitute a suitably-qualified mental health professional such as an experienced community mental health nurse. It is quite ludicrous for the “second doctor” requirement to be perpetuated at the same time as, due to the new GP contract, some PCTs are withdrawing out-of-hours GP services, which will make it even more difficult for ASWs to find one at short notice.

19. We have also brought to the Department of Health’s attention the fact that police assistance in transporting resisting patients, which is absolutely essential given that most ASWs work single-handed, is now extremely difficult to obtain in many areas, and that this is adding to the stresses, frustrations and dangers of the job and is exacerbating the loss of staff. The difficulty arises, at least in part, because police assistance has always been given on a purely goodwill basis, and many forces have recently received legal advice that it may conflict with the Human Rights Act. This may be a matter which can be resolved by administrative action by the Home Office, but if not, it will be necessary to incorporate a duty into the new Act.

20. The burden on ASWs has also increased in recent years due to an avalanche of caselaw, which has had the effect both of increasing their legal vulnerability and of making the law much more complex and difficult to administer. In this respect, the Bill as it stands would make things a great deal worse. Even though a large chunk has been removed to the Capacity Bill, it is now more than twice as long as the present Act and just 23 clauses short of the 1890 Lunacy Act, which has been described as a “monument to Victorian legalism.” It contains a vast amount of obscure, redundant or repetitive verbiage which is quite inappropriate in a statute which has to be operated on a day-to-day basis by non-lawyers, and often under great time pressure, and which would offer enormous scope both for honest mistakes and for opportunistic legal challenges.

WORKFORCE IMPLICATIONS

21. Finally, we have submitted a substantial body of evidence on the workforce implications of the Bill, including a paper in December 2003 which is attached as Appendix 4; this concludes that the Bill is not practicable in its present form, and this evidence has not been rebutted. The government’s assumption about the number of present ASWs who will transfer to AMHP posts is grossly optimistic and flies in the face of recent research evidence, which shows that numbers are still falling rapidly and are likely to continue to do so; and a similar optimism has pervaded its assumptions about the staffing requirements of the new Tribunal system. In respect of AMHPs at least, we believe that our proposals will go a very long way towards bridging the numbers gap, but this will require a willingness to make substantial policy changes, including some changes to the face of the Bill. However, the only response we have had so far is that everything can be resolved by “workforce planning,” as if in the next three years the Department of Health can conjure more experienced social workers (and psychiatrists, and nurses) out of a hat.

22. The workforce shortfall will now be made very much worse by the judgement of the European Court of Human Rights in the “Bournewood” case, which is likely to result in thousands of additional assessments of patients who are currently admitted informally as “non-resisting.” The additional demands on psychiatrists are unlikely to be very great, since they will be treating these patients anyway, but they will mostly not be known to ASWs and this will therefore represent a very large influx of new referrals. Under the Bill, these patients would be entitled to Tribunals after 28 days, and it is essential that the government recalculates its workforce assumptions and does not presume that the extra numbers can simply be absorbed.

Ian Johnston
Director, BASW

Roger Hargreaves
Chair, Mental Health Special Interest Group

APPENDICES

1. Roles and responsibilities of ASWs.
2. Analysis of conditions for compulsion.

October 2004
Memorandum from the Royal College of Nursing of the United Kingdom (DHM 301)

EXECUTIVE SUMMARY

— The RCN welcomes the opportunity to respond to the Joint Committee on the second draft of the Mental Health Bill. The RCN acknowledges that the Government has accommodated many of the concerns raised by the RCN on earlier drafts of the Bill and welcomes the progress which has been made. However, there do remain areas of particular concern to the many mental health nurses within the RCN.

— The RCN has concerns about treatment under compulsion. Compulsory treatment should always be used as a last resort. An emphasis on compulsory treatment is likely to increase, rather than decrease, any risk to the public, as fear of indeterminate detention is likely to discourage people with mental health problems from seeking help. Mental health nurses believe that being involved in any detention of patients which is not therapeutic as opposed to “clinically appropriate” will compromise their role.

— Mental health nurses have concerns about community treatment orders. A patient who requires compulsory treatment is inevitably seriously unwell. Where a patient is so unwell as to require compulsory treatment, that patient almost always needs inpatient care. This is evidently the case where the only form of treatment amenable to enforcement is chemical. It is unlikely that community resources will be sufficient to provide adequate care for such patients without placing a further burden on community staff and carers. It is unacceptable that compulsory treatment in the community is used to ease pressure on in-patient beds.

— Whilst we welcome the inclusion of measures such as advocacy and mental health tribunals, we feel that advocacy should be available at the point of consideration of detention, rather than commencement of detention.

— The RCN has serious concerns about the implication of the draft Bill on the nursing workforce. Some of the proposals in the Bill will add a new dimension to the nursing role which may well be counter productive and could damage the nurse-patient relationship.

— It should be emphasised that problems in community care are a result of lack of resources rather than the lack of legal powers of compulsion.

1. Introduction

1.1 With a membership of over 370,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector, and in educational settings. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1.3 The RCN is a member of the Mental Health Alliance, a group of over 50 voluntary, professional and representative organisations. The RCN shares the Alliance’s concern regarding many of the proposals within the draft Bill.

SPECIFIC ISSUES FOR COMMENT

2. Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

2.1 The RCN considers that the failure to embed the draft Bill within a set of explicit and enumerated principles as utilised in the Scottish Mental Health Act is a serious omission. The most salient of these being that, “service users should be provided with any necessary care, treatment and support in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account, where appropriate, of the safety of others.” Such a set of principles can translate into values based practice and education for service providers. It would also provide a bench mark for an ethical audit of care and treatment. The RCN believes that the set of principles outlined by the Mental Health Alliance provide the best foundation on which to base the Bill.
3. Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the Community adequate and sufficient?

3.1 The RCN considers that the present definition of disorder has afforded a greater degree of clarity. Expansion on the conditions for treatment and care under compulsion have allowed for greater clarification. However, under the terms of the draft Bill the issue of “clinically appropriate” treatment does not require a demonstration that such treatment would also be of therapeutic benefit to the client. The RCN considers that expanding on this in the draft Bill would benefit both nursing staff and clients.

3.2 The issue of treatment under compulsion in non-residential settings continues to be a considerable concern for mental health nurses. The issues surrounding non-compliance with medication are complex and the proposed solution in the Bill is both simplistic and coercive. In other countries the criteria surrounding community treatment orders are so specific as to limit their use to a very specific client group. As indicated in the written evidence submitted by the Mental Health Alliance, it is rare in other countries such as Australia and New Zealand for a community order not to be preceded by a period of assessment and treatment in hospital. The RCN endorses the recommendations of the Alliance that a set of criteria similar to those used in the Canadian province of Saskatchewan be introduced into law.

3.3 As the RCN made clear in its response to the consultation on the draft Mental Health Bill in 2002, many mental health patients are cared for successfully in the community. However, if a patient is so unwell as to require legal compulsion that patient almost always also requires in-patient care. We acknowledge that there are some exceptional cases where this is not the case, but would emphasise that these are very rare. A patient who requires legal compulsion is, inevitably, seriously unwell. Existing community resources will rarely permit adequate care of such patients and the burden on family and other carers is likely to be very great. The RCN therefore has serious concerns about assessment and treatment in the community. In the absence of additional safeguards we believe that these proposals might lead to:

— compulsory treatment taking place in the community, due to lack of hospital beds, when the patient ought to receive hospital care; and
— compulsory medication being used as a substitute for adequate mental health care.

3.4 The RCN suggest the following safeguards:

— compulsory treatment should take place in hospital unless the best interests of the patient specifically require that it should take place in the community;
— before making a decision involving compulsory community care, the tribunal must make enquiries and ensure that sufficient resources will be available for the care of the patient in the community;
— The tribunal must be assured that the patient will have access to mental health care, according to need, 24 hours a day;
— if a situation arises where a patient in the community needs to receive treatment against resistance, this should lead to immediate transfer of the patient to in-patient care until further notice; and
— The Mental Health Act Commission (or an equivalent body) should monitor community care to ensure that these standards are maintained.

4. Does the draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

4.1 The balance between individual rights and the public safety is a difficult and fine judgement. We consider that as nurses we have a duty to not only the client but also a responsibility to those with whom they interact. However, we feel that there is a risk here of perpetuating certain misunderstandings regarding the propensity of mentally ill individuals to violence. This may lead to inappropriate detentions and again create an aversive perception of services that deters the most vulnerable members of our society from seeking help. The RCN welcomes the opportunity to discuss the guidance that the new Code of Conduct will afford to practitioners in areas such as these.

5. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient, and clear? Are there any important omissions in the Bill?

5.1 The RCN continues to have grave reservations regarding the proposed non-residential treatment orders. These focus mainly around our view that coercion could have a negative and corrosive effect upon our relationship as mental health nurses with our clients. Good and effective engagement with service users is underpinned by a relationship built on trust not coercion. Furthermore, this process could potentially alienate individuals with whom we are most keen to engage with. “Revolving door” clients are people who may be mistrustful of the services provided and as mental health nurses we have more creative means of engagement and maximising client outcomes than coercion. As a result the RCN would welcome further clarification regarding the criteria for the use of non residential treatment orders.
5.2 The RCN also believes that the needs of carers, who may in some instances be young people, should be considered and assessed if someone is so unwell as to require compulsory treatment in a non-residential setting.

5.3 As mentioned previously (in 2.1), a major omission has been the opportunity to explicitly clarify as in the Scottish Act the clear underpinning principles that guide not only the Act’s structure but which would clearly guide its use.

5.4 The RCN believes that a clear consideration of the issue of advanced directives would reinforce compliance with human rights legislation. We support the Mental Health Alliance view that advance directives are an important mechanism for safeguarding and promoting a patient’s interest and health. The RCN supports the Mental Health Alliance recommendation that a duty to consult the advance directives should be contained within the Bill.

6. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft Bill?

6.1 The RCN underlines the Mental Health Alliance’s support for the Bill’s proposals for advocates and for the mental health tribunal, both of which are welcome measures. In earlier stages of consultation the RCN has called for the inclusion of advance statements as a useful tool for patients and clinicians. We therefore welcome their inclusion in the draft Bill. However, we recommend the involvement of advocacy at the point of consideration of detention rather than the commencement.

7. Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

7.1 The RCN believes strongly that the emphasis on individual “case” consideration and the use of expert opinion in situations of irreversible treatment are important safeguards.

7.2 The draft Bill places emphasis upon parental consent to safeguard children who have serious mental disorders. It is crucial that there are independent advocacy arrangements in place to ensure that the best interests of children and young people are always central to decision-making. The draft Bill also underlines the need for legal intervention (either through tribunal or court) prior to the use of electroconvulsive therapy for children and young people. The RCN strongly supports this measure as a means to safeguard the welfare of children and young people. The RCN also emphasises the need to ensure that children and young people are not cared for on adult wards and that age-appropriate accommodation is provided unless there are compelling reasons not to do so.

8. Is the balance struck between what has been included on the face of the draft Bill, and what goes into Regulations and the Code of Practices right?

8.1 The development of the Code of Practice is an essential piece of work and is where much guidance is sought by nurses in the implementation of legislation. The RCN looks forward to contributing to the detail of regulations and codes of practice from a practitioner point of view.

9. Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

9.1 There could have been clearer integration particularly in the issue of Advanced Directives. This is an aspect of practice that will undoubtedly impact on the delivery of services and needs careful exploration. This may indeed occur within the Code of Practice but would be a welcome addition to the Bill.

10. Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

10.1 Whilst guidance supplied by the Department of Health provides examples of compliance, it is questionable that the detention of an individual on the basis of their likelihood to undertake future behaviour (which is notoriously difficult to forsee) is consistent with the Human Rights Act.

11. What are likely to be the human and financial resource implications of the draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

11.1 This is an area of specific concern to the RCN. The proposed workforce requirements of an extra 200 nurses to implement this Bill are considered to be inadequate. The effect of certain aspects of the Bill will undoubtedly impact upon the work of nurses, in particular the non-residential treatment orders. This may well create an added dimension to the nurse-patient relationship that will prove counter-productive. It
is envisaged that clients may well withhold information regarding their health and treatment for fear of a compulsory return to hospital. This may adversely affect client outcomes as interventions may commence later rather than sooner (contrary to the aspirations of the Bill).

11.2 The RCN believes that implementation of the national service frameworks for mental health in England and Wales and the availability of plentiful and attractive mental health services would ensure better care for service users, support for carers and lead to a reduction in the need for compulsion. Clients possibly fail to engage with services simply because they do not meet their perceived needs.

11.3 Furthermore it should be noted that where there are problems in community care, these are not the result of a lack of legal powers of compulsion. They are the result, notably, of lack of resources and we would urge that greater resources should be provided, and the dissemination of more creative ways of working should be disseminated.

Royal College of Nursing

October 2004

Memorandum from UNISON (DMH 328)

UNISON HEALTH SUBMISSION TO THE DRAFT MENTAL HEALTH BILL 2004

1. Introduction

1.1 UNISON is the largest trade union in the UK, with 1.3 million members. We have 450,000 members working within the health service and across the whole range of Mental Health Care provision. We have been instrumental in helping to develop health policy and we are pleased that the Government have listened to the concerns expressed in our earlier evidence on this issue.

1.2 We have sought to work in partnership with a number of other organisations in sharing views and concerns relating to the current proposals. UNISON has had information on the Bill available on our website, we have worked with a number of senior mental health nursing practitioners and mental health social worker within UNISON to formulate this response. We will continue our consultative work, throughout the political process to ensure that all of our member’s views can be fully taken into account in developing a comprehensive response across our full membership. It would be our intention to submit further evidence and information during this time, as there has not been sufficient time over this period to ensure that our initial submission comprehensively reflects the views of our whole organisation and across our multidisciplinary membership. It is our intention to submit further evidence on the role of approved social workers, and the civil rights of individuals.

1.3 In the main this submission currently reflects the views of our nursing membership, we would wish to consult more extensively within our health and social care services to ensure that the Mental Health Bill becomes an effective bill capable of delivering comprehensive care across the health and social care spectrum, in addition that it maintains attains the principal of patient centred care and where appropriate offers patient choice.

1.4 Mental Health organisations have over the last 24 months come under the most public scrutiny from the media and subsequently public. We are concerned that some of the sensational media has in some ways helped to stereotype the perception of Mental Health Service users being violent when in effect this is far from the truth. We have concerns that the effect of this may deter some individuals from seeking assistance when needed; the result of this could be the presentation of a more critical episode than was necessary.

1.5 As a member of the Mental Health Alliance, we support many of the recommendations outlined in the joint submission.

2. The Government’s Strategy for Mental Health

2.1 We recognise and value the additional funding, which is being given to Mental Health Services, in addition we are supportive of new initiatives such as assertive outreach services, home treatment and early intervention teams. However, we are concerned that the targets expected by NHS organisations in achieving these objectives, have on occasions been at the expense of other aspects of the day-to-day service. Whilst we recognise the need to achieve change, we firmly believe that this should not be at the expense of other aspects of service provision we will only achieve Mental Health Services fit for the 21st Century when change is an organic process. The new initiatives will help to achieve this, however all aspects of Mental Health currently need to be a priority.
3. How has reform of the legislation been developed?

3.1 We want to recognise the partnership approach that Government has taken to develop this package, we acknowledge that the road has been long and our journey still continues, however, patient involvement is fundamental to achieving new legislation—as it has to work for them. We will continue to work with all parties and stakeholders to ensure that UNISON’s views and values of services with Mental Health are taken forward in this process.

4. The size of the problem

4.1 Mental Health problems are more common than asthma. Up to one in six people suffer from them over the course of their lifetime, while 630,000 people have severe mental health problems at any one time from schizophrenia to deep depression. Beyond this, mental health has a far wider impact on families: there are over 1.5 million carers supporting people with mental health problems. People do not experience mental health problems in isolation; in particular severe mental illness is frequently linked to poverty, discrimination and other complex needs. Within this group are also health workers, who also suffer from depression, which often goes unrecognised.

5. Is the definition of Mental Disorder appropriate and unambiguous?

5.1 We believe that there needs to be a broad definition of mental disorder and therefore welcome this approach, however, we are concerned that the act may have a negative impact on individuals with learning disabilities and believe that an option may be to consider clear boundaries and possible exclusions. We would welcome the opportunity to look at other examples, which may help to protect this often vulnerable group.

5.2 We support the MHA recommendation of on the definition of mental disorder 1C and 2.

6. Are the Conditions for the Treatment and Care under Compulsion Sufficiently Stringent?

6.1 Whilst we welcome many aspects of the new bill, we would ask that the Government give further consideration to some aspects of the Scottish Bill. Whilst we support the need for English legislation, we have some concerns that a lack of continuity in its approach may not be in the public’s interest.

7. Are the provisions for the assessment and treatment in the community adequate and sufficient?

7.1 We believe that there is merit in further work being undertaken looking at this aspect of care. It is a new concept and its important that it has the full support of service users. It is our view that for some patients this may be the best option, especially for those with children for whom separation could have a detrimental effect on their condition and relationship. However, we would wish to give further consideration to this aspect, we do not believe that there has been sufficient time to currently do this and would welcome the opportunity to discuss this further with Government and Policy advisors.

8. Does the draft bill achieve the right balance between protecting the personal and human rights of the mentally ill v’s public and personal safety?

8.1 Clearly public protection is vital and we would support many aspects contained within the Bill. However, there is a difficult balance to be stuck to ensure that the introduction of such a clause does not inadvertently continue the negative stereotype those with a mental health illness.

8.2 We would again welcome the opportunity to discuss this further, we believe that the Bill goes a long way to achieving this goal but needs some safeguards to also protect those with mental health illness.

8.3 There is no doubt that for high risk offenders the judicial system may be the most appropriate, however, for others it will not, this coupled with issues within the prison system regarding care of mental health patients means that the Bill needs to effectively achieve this balance, currently we are concerned that it may not.

9. Approved Mental Health Professional

9.1 We will submit further evidence regarding this role, we welcome the further amendments, which have taken into account earlier concerns expressed by UNISON. However, we recognise the importance of the continued role that approved social workers will play. Some of our nursing members expressed concern that such a role could lead to a conflict of interests and effect detrimentally their therapeutic relationship. Whilst others recognised that this offered advance practise for many nurses within Mental Health settings. We believe that this accurately reflects many of the fears of Mental Health nurses, we would again welcome the opportunity to have further discussions with Government regarding this aspect of the bill.
10. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft bill?

10.1 UNISON broadly welcomes many aspects of the bill, we do also, however, support the Mental Health Alliance’s recommendation on the composition of tribunals.

10.2 We also welcome the provision for advocates, the ability to appoint a nominated person, the single assessment process for civil patients, the ability to appoint a nominated person, the improvements to treatment safeguards for patients undergoing ECT, the special provisions for children and young people, the enhanced powers in the criminal courts to acquire mental health reports and the duty to consult the patient where appropriate.

11. Are the safeguards in respect of particularly vulnerable groups, for example children sufficient?

11.1 We genuinely welcome the revisions to the Draft Bill, in addition welcome the publication of the children’s national service framework and every child matters. Currently we believe that there is insufficient environments to care for children will a mental illness in 2002–03, 213 under 18’s were placed on an adult mental health ward. We believe that urgent work needs to be done to tackle the specific needs of children with mental health illness, in addition the support that children who are caring for parents will a mental illness need. We would ask that Government prioritise this work and try to implement their vision for children as soon as possible.

12. Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

12.1 We feel that the safeguards surrounding psychosurgery are sufficiently covered in the act.

12.2 Our concerns surrounding ECT are sufficiently covered by the recommendations outlined by the MHA. We support the need to obtain informed consent from service users with capacity, we firmly believe that this builds on the change that the Government have sought to improve on consent following the public outcry of the inquiries in to Bristol and Alderhey.

12.3 We also strongly support the emergency criteria outlined in the MHA for ECT that it should be restricted to preserving life—where an individual does not have the capacity to consent.

12.4 We also support the involvement of the advocate where this aspect of treatment is being considered.

13. Is the balance struck between what has been included on the face of the draft bill and what goes into regulations and the code of practices right?

13.1 We would recommend that there is a need to review the code of practice that it needs to be able to be organic and respond to changing needs, however we believe that where this is necessary it should be subject to a consultative process.

14. In relation to questions 8 and 9 asked by the Scrutiny Committee we would wish to submit further evidence during the parliamentary process.

November 2004

Further memorandum from UNISON (DMH 415)

INTRODUCTION

This document is an addendum to UNISON’s submission to the Joint Committee on the Draft Mental Health Bill. This piece of evidence has been delayed as UNISON wanted to consult with members who are expert in the field of mental health social work. We are now pleased to be in a position to submit this paper which covers the role of the approved social worker (ASW) within the ambit of mental health. We would like to offer our apologies that this evidence could not be included in the original submission. However, we do hope that the Committee will find our conclusions to be of value.

THE ROLE OF APPROVED MENTAL HEALTH PROFESSIONALS (AMHP)

Under current legislation two doctors, one of whom must be a consultant psychiatrist, and an approved social worker (ASW) must agree that a patient should be compulsorily detained.

This procedure has worked well in the past, allowing decision making to arise from agreement between a high level medical perspective as well as an independent, social-work orientated perspective.
UNISON is concerned that the Draft Bill seeks to dilute this provision. Section 2.12 of the consultation document states: “Two doctors and an approved mental health professional will consider whether a person meets the conditions for initial use of compulsory powers.”

The basic definitions of the Bill confirm “a person is an approved mental health professional if he falls within a description specified by the appropriate Minister in regulations”. UNISON is concerned about the implications of widening this definition. At present the basic training for ASWs consists of a specialist postgraduate training course—including both academic and practical work. This is completed before the formal process of appointment to work as an ASW can be considered by any local authority. There is no indication in the consultation document of the sort of non-medical training which an approved mental health professional would be expected to have.

UNISON’s position is that ASWs work within a framework which avoids institutional pressures and which allows the ASW to retain an independent status for decision making. Without this element, the exercise of compulsory powers would be a wholly medical decision and would lack the checks and balance of the non-medical perspective, brought by the approved social worker. The input of personnel who are distinct from the admitting care team, and who embody a social context perspective, is key.

Therefore UNISON believes that there should be no change to the current arrangements, requiring agreement from an ASW, unless the new AMHP role can be demonstrated to embody the key features of the ASW role. UNISON is not yet convinced that the Draft Bill strikes the right balance in the provisions which set out the requirements for the AMHP role. In UNISON’s view the key features of the role currently undertaken by the ASW are:

— the non-medical approach to mental illness which they bring to the assessment process and;
— the organisational independence which they enjoy.

In deciding whether the mental condition of the patient requires compulsory admission, it essential to ensure a balanced judgement about the medical and social factors which contribute to the patient’s situation. To provide this, the ASW undergoes training which ensures that they have a wide understanding of the range of social factors which underlie mental illness.

It is not yet clear that this training and background will be required of those taking on the AMHP role. There is a concern amongst current ASWs that, if the AMHP is from a nursing background, they may—because of the training route they take to qualification—tend to take a similar view of the situation to the medical professionals involved, thereby depriving the patient of the balancing role currently played by the ASW. We acknowledge that nursing training is evolving fast but only clear requirements (mirroring the current ASW training) would be acceptable for the AMHP role.

Our members are also concerned that, if the AMHP is part of the same organisation as the psychiatrist who is the first signatory of the admission order, it may be more difficult for them to express a dissenting opinion. There are occasions, albeit rare, on which the ASW feels obliged to disagree with the doctor(s) about whether compulsory admission is necessary. In the current situation, the fact that the ASW is employed not within the NHS but within the local authority (and with a responsibility to the Home Office) provides a crucial measure of independence. We can see no recognition of this factor in the arrangements suggested for the AMHP in the new Draft Bill and, without some measure of organisational autonomy for the AMHP, we would again have to argue that the civil rights of the patient, under the proposed changes, cannot be fully protected.

**CONCLUSION**

In summary, UNISON acknowledges that reform of the Act is necessary. However, there are key issues around the compulsory hospitalisation of individuals which, if implemented, could weaken the current procedures. UNISON also has concerns that some of the changes could adversely affect the civil liberties of patients by extending powers of compulsion and extending the definition of “mental disorder”.

UNISON hopes that this consultation process will result in firm assurances that the key features of the ASW role will be preserved and that there will be trained and qualified staff able to provide an independent assessment prior to the use of compulsion. We urge the Government to consider this issue very carefully. Failure to do so could bring the issue of compulsion fully into the medical sphere, removing the important social care dimension from the decision making process.

*January 2005*
Chairman: Welcome to the Committee. I will ask you in a moment if you would introduce yourselves. Can I just remind you that this is a public session of the Committee and that therefore a transcript will be produced. The transcript will be available on the internet after about one week and it will be open to you to make any corrections to the text but not to the sense. Can I also ask all witnesses to speak up please and straight into the microphones, if you can, otherwise we will not all hear you, which would not be welcome. Can I remind you please—there are quite a number of you here and we have got large evidence sessions this afternoon—that time is of the essence. We will try and get through the questions in this session by 3.30, possibly slightly earlier as we have to adjourn until 4 o’clock for procedural reasons. Would you like to introduce yourselves and then, if you will allow us, we will move straight into questions.

Ms Lewis: My name is Hazelanne Lewis. I am a member of BASW. I train approved social workers from seven local authorities and still practise as an approved social worker. I am a lay member of the Mental Health Review Tribunal and until recently for nine years I was a Lead Commissioner with the Mental Health Act Commission.

Mr Hargreaves: I am Roger Hargreaves. I am the Chair of the Mental Health Special Interest Group of the British Association of Social Workers. I was the Vice Chair at the time of the last review of the legislation in the late 1970s. I was a practising mental welfare officer under the 1959 Act and then approved social worker under the present Act for the greater part of the period 1971 to 1999. Since then I have been self-employed, amongst other things doing independent reports for Mental Health Review Tribunals and I have also been a member of five independent NHS inquiries into serious incidents.

Mr Hulatt: My name is Ian Hulatt. I am the Mental Health Adviser to the Royal College of Nursing.

Ms Adams: Gail Adams, Head of Nursing, Unison.

Mr Davies: Owen Davies. I am a national officer in the local government section of Unison and I represent our members who work in social services departments.

Chairman: Thank you all very much. Baroness Pitkeathley?

Q954 Baroness Pitkeathley: My question is for our colleagues from BASW, please. In your evidence you point out that there is an absence of a discretion in the Bill not to take action even where the minimum conditions are satisfied. Surely, if somebody meets the conditions in clause 9 they are going to be seriously mentally ill and therefore in need of treatment, so I am not quite sure what is the purpose of providing a discretion.

Mr Hargreaves: The conditions of clause 9 are so broad that they would in fact encompass thousands of people who are definitely not seriously mentally ill in the way that we generally understand that term. In Appendix 2 of our evidence we give as an example two very large groups of people who are constantly coming to the attention of mental health services but who are very rarely detained under the present Act, although they are often admitted informally into hospital and who would very clearly meet all the conditions in clause 9 of the Bill. The present Act would also allow many of those people to be detained, although not all of them because some of them would be explicitly excluded by the exclusions. At least they would be detained for the first 28 days until the conditions become tighter under the present Act. However, that does not happen automatically at present because the doctors and the approved social worker have discretion. They are not forced to detain somebody simply because the minimum conditions in the Act are satisfied. The Bill, however, takes away virtually all of that discretion. It is basically a simple tick box exercise. If all the boxes in clause 9 are ticked then compulsion must be imposed and this means that the doctors and the AMHP cannot take into account any factors which have not been explicitly envisaged in clause 9. In particular, they cannot take capacity into account. There has been a lot of talk about the need for a capacity test in this Bill. I think it has been overlooked that the present Act does allow capacity to be taken into account because that is one of the areas where the doctors and the ASW can exercise discretion. In practice, that is one of the most common reasons for not detaining somebody when the minimum conditions are satisfied. The Bill therefore removes the capacity test which is inherent in the present Act even though it is not explicitly stated.

Q955 Baroness Pitkeathley: It is your view that no discretion would remain to the professional even though they would have to decide whether the person was seriously ill or not? There is not sufficient discretion?

Mr Hargreaves: The discretion is only contained within each individual condition. There is no overarching discretion to not take action even though all the conditions are satisfied. There is some discretion, particularly in this latest draft, within each condition but there is not an overarching discretion as there is at present, so it very much narrows the range of discretion and it would result in very large numbers of people being made subject to compulsion who we would never consider making subject to compulsion at present.

Q956 Chairman: Are you absolutely certain what the Bill says is that there is no discretion? Surely, clause 9 merely sets out the relevant conditions before a section can be made? It does not require, does it, that
every person who complies with the conditions in clause 9 should be made subject to compulsory treatment?

Mr Hargreaves: It states that, if those conditions are met, the AMHP examiner must then register that person as either a resident or a non-resident patient. It does not say “may register”. If it said “may register” then that would restore the discretion but it does not allow for a situation where all the conditions are satisfied but the three examiners can nevertheless agree not to register.

Q957 Dr Naysmith: Following up that point, as I understand it, psychiatrists were worried about exactly the same point that you have just made, that it would be a tick box exercise and you would have no discretion. They have been assured and reassured and they gave evidence to that effect before the Committee that they will be able to exercise clinical judgment, which is an aspect of discretion, and they seem not to believe what you believe.

Mr Hargreaves: I have to say that is not my understanding of their position.

Q958 Chairman: Forgive me for interrupting. We want to be sure that we are talking about the same Bill. Could you look at clause 14. Clause 14 provides for “the appropriate authority, if requested to do so by any person, to determine whether all the relevant conditions appear to be met in a patient’s case”. Let us just get to the fundamental point because we may have to clarify this. You are saying that your understanding of the Bill is that, if a person satisfies the relevant conditions, there is a requirement that they be sectioned. I am not sure that the Bill says that at all?

Mr Hargreaves: It is clause 16 (3) that is the crucial one.

Q959 Chairman: Sub-sections 16(4) and 16(5) apply “if, on examining the patient, all of the examiners determine that all of the relevant conditions are met in the patient’s case”. So there has to be an examination?

Mr Hargreaves: They have to determine that all of the conditions are met.

Q960 Chairman: Being the unanimous determination of all the examiners?

Mr Hargreaves: Yes, correct.

Q961 Chairman: Is that not quite a substantial gateway?

Mr Hargreaves: Not given that the conditions are themselves so wide. It is the width of the conditions which creates a large part of the problem. The conditions would apply, as I have set out in appendix two of our evidence. If you apply them to the people that social workers and doctors see every day, these conditions would apply to tens of thousands of people who are not made subject to the Act at present. It is the width of the conditions coupled with the lack of discretion to narrow the effect of those conditions which together widen the effect of the Bill.

Q962 Chairman: So can you just remind the Committee of the main narrowings of the conditions which you would require.

Mr Hargreaves: There are two possible ways of doing this. One is to define the conditions more precisely. The other is to define the conditions very widely but allow discretion. The present Act follows the latter course. The present Act, certainly for the first 28 days, has very broad conditions indeed, in some ways broader than the clause 9 conditions. In some ways the clause 9 conditions tighten up the conditions of the present Act. So we start at the moment with a very broad funnel which is narrowed down in practice by the use of discretion. What is missing in this formulation is that narrowing down because the discretion can only be exercised to a limited extent within each condition and not globally. In particular, it cannot be used to take into account factors that are not envisaged in the conditions, capacity being one of them, the views of relatives and carers being another. There is very extensive provision in the Bill for consultation with relatives and carers, but if all the conditions are satisfied and the carers nevertheless say “we would like to carry on caring”, that discretion to allow that to happen does not exist because there is no provision for that to be taken into account. At the moment that is one of the main reasons why ASWs do not proceed with an admission. ASWs only admit about two-thirds of the people who are referred to them for possible admission. One of the common reasons is that they are satisfied that existing care arrangements can continue, that the person’s needs can continue to be met, and that the carers are willing to carry on. That is not provided for here.

Chairman: You have helped us to clarify an important point. Can I advise the Committee that I have had advice that, if the examiners are unanimous that the conditions are met, then clauses 16(4) and 16(5) provide that the patient is then automatically liable to assessment as a resident or non-resident patient pursuant to clause 16(4). We might have a note about that please. Baroness Murphy?

Q963 Baroness Murphy: I would like to ask all three of our organisations about the job of the approved mental health professional as set out in the Draft Bill. Is it workable and will it be attractive to your members to become one of these new creatures?

Ms Lewis: I would say it is unlikely to be workable and certainly speaking for ASWs it is not seen as very attractive. Why is it not workable? There are three areas to consider: one is independence; the other is the workforce; and the third is the practicality of implementing the Bill. When I am talking about independence I am not saying the AMHP cannot be independent if they are not a social worker, although many of our social work members do say that. I am saying that the structure when all the AMHPs are employed by the same authority that will be the detaining authority will put pressures on the AMHPs. At the moment the local authority will appoint and train the AMHPs but they have not been given responsibility for
monitoring performance and checking that AMHPs are retaining their independence. The second area of independence is the Act allows for a doctor who does not work with the clinical supervisor or a member of the team to be independent, but it does not allow for an independent AMHP, so if you have a CMHT where you have an AMHP and a clinical supervisor, where the two have had a case conference and decided that a user needs to be admitted, two people who have already made up their minds more or less will be going to assess someone with a third person who may in rural areas quite often be a GP who will accept advice from the experts. I do think that there needs to be some provision for the AMHP to be independent from the clinical supervisor or vice versa when you are coming to the assessment. In terms of practicalities, the job as I read it (several times now) is larger than the current ASW’s job and there is no requirement for the other agencies who are always involved in Mental Health Act assessments to be obliged to co-operate. For example, currently many assessments require police co-operation. Section 135 has been lifted more or less word-for-word into clause 228 but there is nothing that obliges the police to come out when someone has a section 135 warrant. There are situations now when the police are unable to respond for three weeks. There are other areas in the country where even in cases of emergencies police will only come out on one specified day a week. Unless there is something that requires support by the other agencies the AMHP’s job is going to remain very difficult. Section 140, which is emergency admission under cases of urgent necessity, has not been kept in the draft Bill. This means that when you carry out an assessment and you feel a bed is urgently needed, you have no chance of phoning the hospital unit and saying, “I need to bring this person in. It is urgent necessity, section 140. You can guest the person on the ward until you can find a suitable bed”. Already we have ASWs waiting nine hours with distressed, distraught people for a phone call to say there is a bed somewhere and then waiting for ambulances. In some areas of the country people are waiting 13 days. There is nothing in the draft that obliges the provision of a bed. Then the third point is practicalities. As I read it, once the assessment has been completed and it is decided that someone meets the conditions for the clause laid out, the AMHP has to leave the person, go to the hospital, register the patient, go back in the hopes that the person will let them in or is still there and possibly get a new 135 warrant because one will be barred by then before they can take the person to hospital. This may have been an oversight in the drafting but the wording does need to be changed.

Q965 Mr Hinchliffe: I am interested to tease out the extent to which the ASW currently does challenge the proposed admission. Mr Hargreaves suggested about two-thirds of cases referred to ASWs are admitted so one-third are not admitted. I would be interested to know first of all where you got that figure from because I asked the Department of Health about the role of the ASWs and they did not have any information at all about the extent to which the ASW may be able to point to alternative means of disposal as opposed to a section.

Mr Hargreaves: Our evidence in 2001 quotes the research that was available at that time so I could refer you to that.

Q966 Mr Hinchliffe: Do you know what research it was?

Mr Hargreaves: Without looking it up I cannot remember exactly now. Basically I trawled what research there was at that time. I think that is a fairly reliable figure at that time.

Mr Hinchliffe: At the risk of upsetting a fellow Unison member sat round this table who is a nurse I got in trouble last week for suggesting that there are certainly professionals who may be more willing to go along with a doctor’s opinion on a section possibly than an ASW would. That was my experience when I was a mental welfare officer many years ago that those who had a nursing background were more often willing to challenge the opinion of the doctor. That might be profoundly unfair to many of my colleagues and friends who are nurses but I wonder what your thoughts are, from different professional backgrounds as to these distinctions between the professional backgrounds of the individuals who will be the approved professional under the proposals in the Bill, how that might be different from the role of the ASW currently.

Q967 Chairman: Before Mr Hinchliffe gets his ear bashing from Ms Moffatt, Mr Davies, do you want to answer the question?

Mr Davies: Can I say that, if one looks at the current situation, I think there is certainly a fear among the ASW members, that I represent, that might be the case. I think the crux here ought to be the training that is to be provided for the AMHPs because neither Unison or BASW is saying only social workers can do this but what we are saying I think is there will need to be training of a sort which will give colleagues from other professions (not just nursing because occupational therapists, as I understand it, are also a potential source of these workers) confidence to be able to do their job. Again, if you pose it as standing up to the psychiatrist that may be the wrong way of looking at it because our view is that it is the civil rights of the patient that are the crucial issue here because the patient deserves to have the additional perspective of someone with social work model or a non-medical
model. As long as that is available through the training of the AMHP we do not see it as a fundamental barrier. There is a danger and a tendency in the people I represent for that worry to be there, but we jointly believe that if the training is correct and the structural solutions are correct (and I would like to agree with what my colleague on the far right said about organisational independence) if those can be done then there is no fundamental reason why nurses and occupational therapists and others should not do this job very well.

Q968 Chairman: Mr Hulatt, do you want to add anything?  
Mr Hulatt: Linking that to the previous question of would members of the Royal College of Nursing want to engage in this role, it would nice to be able to give you an emphatic yes or no but I am afraid I cannot because there is a division of opinion on this. I think there are those nurses who would not wish to take on this role, supporting my colleague’s views, because they have seen the rigours of the current role for social workers who undertake it and they may be reticent to engage in it. There are others who would see this as an appropriate extension and development of their nursing role and would be comfortable in that way. The issue of independence and historical and traditional views of, dare one say, subservience—

Q969 Chairman: I think you are safe on this one, Laura Moffatt is on the Committee! So there is a need to address workforce issues very urgently.

Mr Hulatt: I think that nursing has moved a long way and I think part of that movement has been a confident development of a body of knowledge, specific skills, and confidence in those skills, and I would like to assert that that can be independently stated in this role. I think it will be something that will require, as you say, very specific training, education and I would suggest as well—and we have not mentioned this yet—a training programme that involves service users as well to challenge values that people may well have.

Q970 Tim Loughton: On the problems with the shortage of ASWs at the moment, is it not the case that over the last 10 years the number of ASWs to the head of population has more than halved, with the exception of Northern Ireland where I gather there are three times as many ASWs as in England per 100,000 of the population. It would be quite interesting to know why that is. That cannot be explained by the ASWs in a social services department being in some of the new set of intervention outreach teams because there has been a net outflow. Are you not worried therefore that these ASWs are going to be replaced by the new form of mental health social worker and, indeed, could the outflows get worse if the fears you are raising is that it is not going to be attractive to ASW, in which case where on earth do we go from here?

Mr Hargreaves: The latest research by Professor Peter Huxley does confirm that the numbers have halved and I think more to the point, they are continuing to decline and that confirms an anecdotal view. It is not universal. There are some places where the numbers are holding up but in other places there is a very serious problem. There is a very serious problem with an ageing workforce. At least a third are over 50 and you can work out the implications of that, so, yes, we are very seriously concerned about the numbers and about whether the present services can actually last until the new Act comes into force. That then raises a question as to whether there will be sufficient ASWs able and willing to transfer over to operate the new Act, bearing in mind that people are in their 50s and in many cases 60s and a lot of them are going to choose to retire. This always happens with new legislation, they will choose to retire at the point of transition. We think there is a very serious numbers problem. We cannot quantify it exactly. We know that, after a great deal of pressure from us, work is now being done to try and quantify it but we really cannot say more than that at this stage. There may be a very serious problem. That is one reason why BASW is proposing not to continue the present ASW role effectively unchanged into the new legislation but to approach it in a rather different way which would accommodate the decline in numbers and make the transition much easier to achieve. If things carry on as at present, we could need literally thousands of new AMHPs who would mostly have to be health professionals and, even if potentially they are available and willing to volunteer, that is still a massive training problem given that the present system is geared to just 300 or 400 candidates a year. So there is a need to address workforce issues very urgently.

Q971 Tim Loughton: Is there not also a problem because the new social work degree qualification has only minimal coverage of mental health within it?  
Mr Hargreaves: I think you could say the same about the old qualification. It is something that people have to pick up later. The practical problem is that, although the new degree has increased the number of candidates and there has been a very welcome increase in the number of people in training because they have to get through the degree, then they have to do at least two years before they can start training as ASWs, we are talking about 2009–10 at least before that new cohort begins to filter through. Even then there will be big competition from child protection services. It is not as if this is the only area of social work that is short of people.

Q972 Ms Munn: Moving on to talk about community treatment orders, I am first going to refer to some of the evidence given by the Royal College of Nursing but I think other witnesses can respond to the general point. The evidence sent to us by the Royal College of Nursing was against community treatment orders, particularly on the grounds that, if patients need that kind support and if they are that unwell, they should really be in a hospital setting. Throughout the course of the evidence we have had in this Committee we have heard differing views on this. We have heard that
view. We have heard views from service users who feel that it is inappropriate. We have also heard from people who feel it is an appropriate response particularly to what is called— I think unhelpfully— "revolving door" patients, so people who find themselves going back into hospital because their treatment regime in the community has broken down. We have also heard from people who work with perhaps some of the most severe and difficult cases saying it does provide a real option for getting people back out into the community and supporting them in the community with appropriate safeguards. Really what I put to the Royal College of Nursing is can you not see if the community treatment orders were drawn up in a particular way it would allow people to be within the community who, if your recommendations were accepted, would have to be in hospital?

**Mr Hulatt:** Yes, I accept your reservations about the term “revolving door”. I think it is a pejorative term and an unhelpful one. Before we get to the question of whether with certain safeguards a CTO would be agreeable, I would want to make the point that I think that contemporary nursing practice and other disciplines have more to offer and more imaginative ways of assisting individuals than returning them to hospital and close supervision in the way that this is implied. There are ways of working with individuals, carers and families to have a positive impact on what we might call relapse requiring readmission. As a first point there is implicit within here some sort of belief that, if people are properly monitored, they properly consume the drugs for which they are prescribed, they are likely not to be revolving. There is good evidence to show that people who are very compliant with medication still relapse and still become unwell. I do not think it is quite as simple as is implied here. I will defer to my other colleagues on this, but I know there are models of community treatment orders that are argued to be successfully used with a small specific group of clients, but I think the reservation that is strongly expressed by members of the RCN is that this element of supervision and possible coercion could be unhelpful.

**Q973 Ms Munn:** It has also been put to us that patients in hospital currently go on home leave and essentially during that period that could be deemed to be a community treatment order rather than being seen as home leave and that might be a more honest way of doing it and get round this issue where people go on home leave not necessarily because that is in their best interests but because of pressure on resources and on beds.

**Mr Hulatt:** I think you are making the point. It is home leave not necessarily for the client’s benefit but for the service’s. That sounds inappropriate.

**Q974 Ms Munn:** There are also some people who go on home leave as part of a programme for returning to the community. That could also be deemed to be a form of community treatment. I suppose what I am trying to get at is are you against some kind of compulsion and treatment in the community per se or is it the specific format within which it is phrased in the draft Bill?

**Mr Hulatt:** I think it was the lack of clarity about it that was unhelpful. I think that our concerns are that clients may well disengage from services and disengage from working with nurses and others because of the fear of return to hospital. I think that community treatment orders, perhaps with very explicit and tight criteria, may well be acceptable to service users and those service providers, but I did not see that clarity and my members did not see that clarity here.

**Q975 Mrs Blackman:** Can I move the questioning on a little bit to Roger Hargreaves. Your Association made the point very starkly that you would support community or non-resident treatment in a limited sense but certainly not non-resident assessment. Could you just expand on that a little bit? Why is the assessment so risky, in your opinion?

**Mr Hargreaves:** Basically for two reasons. First of all, if somebody is ill enough and disturbed enough and is at risk to themselves and others enough to justify the use of compulsion as set out in the conditions, then it is hard to envisage a situation where they should not be in hospital, at least initially. If somebody can be left where they are, then the question is do they meet the threshold.

**Q976 Chairman:** You may be able to get them out of hospital very quickly if the community treatment option is available?

**Mr Hargreaves:** As a treatment option as opposed to assessment. That is the difference and that is the nub of the question whether we should be assessing people without admitting them to hospital in the first place.

**Q977 Mrs Blackman:** But it has been put to us that there are certain categories of people, for example homeless people, who if they were having their assessment in a hospital setting that would actually mask the chaotic nature of their experience, their lives.

**Mr Hargreaves:** If their life is chaotic you cannot assess them in the community. In order to be able to assess somebody they have to have stable accommodation, you have to be able to access, you have to be able to be certain that you can maintain contact with them, you have to be certain that you can keep them safe whilst you are doing the assessment. There would be very, very few circumstances where we could envisage that that would be possible. We could not relate to the case examples that were put in the White Paper stage. They did not relate to the experience of approved social workers at all. The other issue that looms very large now, as you have heard already, is the fact that in some places people who are acutely ill and need to be in hospital immediately are waiting two or three weeks for a bed. The temptation to use non-resident assessment as an alternative because you cannot get a bed would be extremely high. BASW’s view all
along has been we should not ever consider non-resident assessment until there are enough beds to make that not a possibility. What would happen in practice is that examiners because of the lack of discretion, because of the way in which the conditions drive you in a certain direction would have to place people on non-resident assessment even though they thought that that was ill-advised and possibly dangerous.

Q978 Chairman: Does Unison want to put a different view forward?
Ms Adams: In terms of the community treatment orders there are some reservations out there about service provision, about the practicalities which link with some of the workforce information, and that is primarily where the concern is coming from. There are implications for homeless people and how the assessment can be conducted and in that context that is where the reservation is based. It is primarily on the workforce; it is not necessarily on the principle, although there are occasions where they would not be appropriate. In some ways talking to colleagues earlier it is quite ironic because prior to the supervised practice discharge procedure their initial view was that they wanted compulsory treatment orders. There is no principle opposition but there is service level concern about the practicalities of that and the further dilution that may impact on service provision.
Chairman: Thank you. Ms Moffatt?

Q979 Laura Moffatt: That brings me very nicely on to the next lot of questions. I would really like to hear from all of you about should community treatment orders become part of the proposed Bill. I understand reservations on all sides but should that be part of the Bill? I wonder if you could honestly tell the Committee what resources you believe should be in place for them to work. That is difficult particularly if you are not madly keen on them because there is a temptation to over-egg the pudding. I would be really keen to ask you what is needed. Also we have been taking evidence in Wales where people have told us that the Welsh system is about 10 years behind us therefore they were going to be in a very different position, particularly Powys where they have only got one approved social worker for a huge area and the practicalities of being able to support community treatment orders. Could you help us with that, and I do not mind who starts.
Mr Hulatt: I think it may well be the issue, as Gail has alluded to, of resources. There are community psychiatric nurses working with unsafe caseloads in that sense.

Q980 Laura Moffatt: Now?
Mr Hulatt: Yes, people with very large case loads of very vulnerable people who are not necessarily living in caring and supportive environments or neighbourhoods or families. The community psychiatric nurse may well be the only contact that client has. I think it would be an issue of concern with the community treatment orders in as much as clients under those may well be obliged to have high levels of supervision and high levels of supervision need the appropriate numbers of staff to provide it. I think it really is in some senses as simple as that—the resources and the systems to support nurses and others in making such a system work.

Q981 Laura Moffatt: The RCN, as I understand it, have made an assessment of how many extra staff they believe they should have.
Mr Hulatt: Our evidence on the workforce was whilst we did not provide a number we felt the notion of 200 extra was woefully inadequate, for reasons I can discuss but I do not think they are relevant to this question.

Q982 Mr Hinchliffe: Do you have some notional idea of what a safe case load is? You made a point a moment ago about a large number have unsafe case loads. Does your organisation have a guide level on an unsafe case load? Surely every case is different so how do you come to terms with what is a safe and unsafe case level?
Mr Hulatt: I think the term “unsafe” perhaps was unhelpful, perhaps I should say almost unworkable.

Q983 Chairman: As in one out of hours ASW on duty in Powys at any one time?
Mr Hulatt: That is certainly a challenge for that person over a 120-mile long county but it is the CPNs in urban areas I know who have case loads of 90, and I think that is, frankly, absurd with very vulnerable individuals on that case load.

Q984 Chairman: One of our Welsh members is not here but I know he would want me to ask you this question and we have also been to Wales. Can I ask you all specifically if there is any evidence of which you are aware of the Welsh Assembly addressing adequately the employee shortages in Wales? Do you know of any such evidence? Have you dealt directly with the National Assembly for Wales on these issues?
Ms Adams: None that I see. Certainly if it would be helpful to the Committee we could check with colleagues who deal on a daily basis with the Welsh Assembly to see if they have examples if that would be helpful. We have heads of health for Wales and officers who work directly with the Welsh Assembly.

Q985 Chairman: That would be helpful.
Ms Adams: By all means we can do that.
Mr Hulatt: I can certainly do that.
Chairman: Baroness McIntosh?

Q986 Baroness McIntosh of Hudnall: I would like to give our witnesses a chance to say what they want to say.
Mr Davies: I want to make a point about the health and safety issue which is relevant to this matter. It is my understanding—anecdotally and I cannot give hard evidence—that a lot of members I represent as ASWs go into situations single handed which I as a trade union official would advise them not to. They put themselves in very risky situations. My understanding is that the health and safety policies
of the National Health Service are much more rigorous than is the case in some local authorities and it might well be that AMHPs working under NHS rules, as they invariably will be, will not be able to go in single handed and that in itself will have a major impact on the number of AMHPs who it would be necessary to have in the system.

**Mr Hargreaves:** We think that the current ASW practice falls far, far outside current health and safety standards in most parts of the country. It is not sustainable. It simply carries on because that is custom and practice and always has been. I think if it was examined from a modern health and safety perspective then it would be found to be seriously wanting. I agree entirely that the numbers do not permit safe working at present.

**Q987 Chairman:** Examinations often take place after a tragedy, unfortunately.

**Ms Lewis:** They do indeed.

**Mr Hargreaves:** Most known clients have a care co-ordinator and I know there is no draft Code of Practice but it would be helpful if it was stipulated that the care co-ordinator was expected to attend all the Mental Health Act assessments and that would cover the lone working, within hours at least. However, that would mean that those people would be taken out of their normal work time. Mental Health Act assessments go on for a very long time and that will have knock-on implications for staffing for all the disciplines if you have a doubling up.

**Q988 Chairman:** Given that community orders would involve inevitably general practitioners because they are the community clinicians for their patients, what level of confidence do you have that general practitioners would be prepared to be involved with community orders to the requisite level in the daytime given that they no longer largely practise outside office hours anyway?

**Ms Lewis:** I will pick that up and say there are some general practitioners who might be willing but on the whole—

**Q989 Chairman:** That sounded pessimistic!

**Ms Lewis:** For the community treatment orders I do not know that general practitioners would be prepared to be the prime clinician. They would expect the clinical supervisor or the current RMO to take responsibility for treatment and I think, from my experience and the experience in seven boroughs of local authorities, that on the whole general practitioners do not want to be involved in the active treatment of their clients under a Mental Health Act. They are very interested in their physical health and maintaining a supportive relationship with them.

**Ms Adams:** May I add some information to the work force which I think was the original question. In mental health services it is incredibly difficult. I am not a mental health nurse by background so all of the evidence I have gathered is from talking to different practitioners across the spectrum. There is a huge shortfall in the work force in mental health services which impact across the range and there have been a large number of initiatives brought in by government which have been wholly welcomed—the crisis services are fantastic but the reality is it is being staffed by the very experienced CPNs who possibly could be the approved mental health worker. In order for us to get a feel for the total picture around the workforce we need to look at the numbers and we need to look at it in the context of training for that type of role, whether it is going to generic including approved social workers and other occupations, and also where their location is going to be based, the geographical boundaries of their area. It is incredibly difficult to formulate statistical information which would help the Committee without that detailed information. There is evidence of vacancy short falls in CPNs, in occupational therapists and in a range of specialties but there is an opportunity within mental health services for them to grow their own. We recently had a health care assistant conference and 35% of the audience were health care assistants and 34% of them wanted to access professional training. So it strikes me that there is an opportunity through other mechanisms that the NHS has already established for growing your own for those roles to develop. In terms of the capacity within the Bill for individuals to hit the ground running now with a new role it is incredibly difficult to predict based on the information that we have available.

**Q990 Baroness Eccles of Moulton:** The next question falls very much within what has already been discussed. We have already talked about the fact that the RCN in their evidence have suggested that the number proposed by the Department of Health is not adequate but in your evidence you go on to say that the problems in community care are not the result of the lack of legal powers of compulsion but they are lack of resources, and the lack of resources is a general view shared by everybody, whether supporting CPOs in order to administer them or in order to provide more creative ways of working, as you have already said. We have heard during our visit and taking of oral evidence that the assertive outreach teams and the crisis prevention teams go a very long way to provide the same sort of persuasion and support that a CTO would need to provide. Therefore, could I put it to you that, if the increase in resources could be achieved—and it would obviously take time because of the training of CPNs and the availability of people who would be prepared to go into that role—that the need for CTOs could virtually disappear?

**Mr Hulatt:** I suppose a short answer would be yes. At the risk of being considered idealistic I think, yes, with good resources. As you say, assertive outreach teams have made an impact on the client group that would be subject to CTOs where assertive outreach teams exist. That is exactly the point—where they exist.

**Q991 Baroness Eccles of Moulton:** Are we not now in a rather circular situation of saying it would not
be possible to administer CPOs effectively without an increase in resources but if we had that increase in resources CTOs would begin to cease to be necessary.

Mr Hulatt: It may well appear so.

Baroness Eccles of Moulton: We are in a kind of Catch-22 situation.

Q992 Chairman: Can I remind you that a recent study of 26 assertive outreach schemes in London demonstrated no reduction in compulsion at all. That is research published in 2004. How would you comment on that in the context of the question that has just been asked?

Mr Hulatt: It did not result in a reduction—?

Q993 Chairman: In compulsion.

Mr Hulatt: Did it prevent an increase?

Q994 Chairman: I do not know the answer to that. It is a good answer.

Mr Hulatt: It is the one I rest with.

Q995 Chairman: You would view not reducing compulsion as a satisfactory outcome, would you?

Mr Hulatt: No, I would not say that.

Q996 Chairman: It was a good answer. Touche’.

Mr Hargreaves: Can I come back briefly. I was not aware of that particular piece of research but one of the things that concerns me is the Government has been claiming that everything will fit together in two or three years’ time because the new services that are coming on board will reduce the use of compulsory powers and it will all work out. I have been in this business an extremely long time and nearly 30 years ago I was the team leader of the very first community mental health team in the country. We assumed that we would reduce the number of admissions to our unit and so we did for the first year or so. After that the effect ceased and the number started going up. A 60% increase in the use of the Act coincided with the greatest increase in the development of community services from the late 1980s to the late 1990s. We simply do not know what the connections are and it is very dangerous to draw optimistic conclusions about the effect of new services on the level of need for beds or the need for compulsory powers.

Chairman: With that timely warning, I think we will bring this session to an end but we are very grateful to you for the completeness and conciseness of your answers and also for the written material you have provided us with. I can assure you that all your evidence will be taken fully into account by the Committee. Thank you very much indeed to you all.

Supplementary memorandum from the British Association of Social Workers (DMH 433)

During our verbal evidence to the Committee on 26 January we were asked by David Hinchcliffe MP about research into the effectiveness of Approved Social Workers (ASWs) in diverting unnecessary compulsory admissions. A similar question had been put by Mr Hinchcliffe on 19 January to Adrian Sieff, Head of the Mental Health Legislation Branch at the Department of Health.

In our original proposals in October 2001 (Appendix 3 to DMH 60 in the written evidence to the Committee) we referred firstly to the Social Services Inspectorate (SSI) report “Detained”, published in February 2001 which was based on an inspection of ASW services in 10 local authorities. This found that 35% of patients assessed by ASWs for possible compulsory admission were not subsequently detained in hospital. Secondly, we quoted a paper, “Reforming the Mental Health Act—an ASW Perspective” by Patricia Walton in the Journal of Social Welfare and Family Law, November 2000: this reported a survey in the North-West which found that 18% of patients who had been referred to an ASW for assessment, and where two doctors had already recommended compulsory admission, were dealt with in an alternative way.

These two findings are almost certainly compatible, since the SSI survey encompasses a broader group of patients many of whom would not at that point have been medically assessed at all, or at least not by two doctors. Care does, however, need to be taken in interpreting these figures, on two grounds. First of all, many patients diverted from compulsory admission will nevertheless be admitted informally; and secondly, where an ASW declines to apply compulsion following an assessment, the alternative course of action may well be to monitor the situation closely and to reassess, in which case the patient may be made subject to compulsion at the subsequent assessment, this being especially the case where the patient is already in hospital informally.

It would, therefore, not be accurate to conclude, for instance, that, following assessment from an ASW, 18% of patients who had been judged by two doctors as needing hospital in-patient treatment did not actually receive it. Nor can it be assumed that in 18% of cases there was disagreement between the doctors and the ASW, since in a great many of them there would have been inter-professional discussion and agreement about an alternative course of action. Nevertheless, these figures do indicate that ASWs have a significant effect on the level of use of compulsory powers, very largely by exercising discretion in circumstances where the minimum statutory conditions for compulsion would be satisfied.

We are not aware of any more recent published data. Mr Sieff was asked about the possibility of commissioning a study; however, we think it would now be impossible, due to the severe bed shortages in most areas, for any researcher to reach valid conclusions. Whilst the lack of beds ought not in theory to
affect an ASW’s assessment as to what would be the *ideal* course of action, in practice it is bound to have at least a subconscious effect on his or her judgement, and it will certainly have a major effect on actual outcomes (which is what was being measured in the studies above) since if there is no bed nor an immediate prospect of one, or if a bed will be made available only in the most extreme circumstances, the ASW will be forced to pursue alternatives to admission even if these are against his or her better professional judgement.

A fairly steady upward trend in compulsory admissions from the late 1980s peaked in 1999 and there has been a slight reduction in numbers since, but this is almost certainly due to the shortage of beds placing a ceiling on admissions rather than to any change in the underlying trend. By the same token, we think that great care needs to be taken in evaluating claims that the new crisis resolution/home treatment teams are proving to be effective in reducing admissions, since where there is a severe shortage of beds they are clearly working under an artificial constraint. ASWs have a professional duty to carers and to the general public as well as to the “identified patient,” and they are concerned in some places that these teams’ objective of diverting patients away from hospital is being achieved only at the cost of placing unacceptable burdens on carers and neighbours.

We think that the bed shortage must now be seen at least as a medium-term problem which will not be resolved during the currency of the present Act, and that consideration therefore needs to be given as to how the admission process set out in the Draft Bill would operate in this situation. At present, ASWs often find themselves in a very exposed position, legally and professionally, when they have applied for admission (and have thereby assumed personal responsibility for the safety of the patient and others) but are unable to get a bed, often for several days, and the scheme as set out in the Bill is so lacking in clarity that it is possible that the same could apply to the AMHP, especially if they continue to be employed in their statutory role by the local authority. What is required is an explicit provision which ensures that, once the three examiners have made a determination that in-patient assessment is needed, responsibility for finding a bed, and for ensuring the safety of the patient and others in the meantime, passes immediately to the service-providing Trust and is not left on the shoulders of any one individual.

Roger Hargreaves
Chair, BASW MHSIG
January 2005

Memorandum from the British Psychological Society (DMH 19)

GENERAL COMMENTS

The British Psychological Society is the learned and professional body, incorporated by Royal Charter, for psychologists in the United Kingdom. The Society has a total membership of over 40,000 and is a registered charity.

The key Charter object of the Society is “to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge”.

The Society is authorised under its Royal Charter to maintain the Register of Chartered Psychologists. It has a code of conduct and investigatory and disciplinary systems in place to consider complaints of professional misconduct relating to its members. The Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology. It also has in place quality assurance programmes for accrediting both undergraduate and postgraduate university degree courses.

The Mental Health Act 1983 is clearly in need of amendment. European Legislation, changes in the structure of the National Health Service, changes in the roles of mental health professionals, evolving professional opinions regarding mental health care and improvements in therapeutic practice and theoretical understanding all necessitate changes in legislation underpinning mental health care.

The British Psychological Society welcomes, therefore, the draft Bill. We also note the real changes made in the present draft Bill in response to consultation, and welcome the consequent improvements. The British Psychological Society considers that progress has been made, but we also strongly believe that the changes do not go far enough in reconciling the needs and rights of service users in a Mental Health Bill for the 21st century. The British Psychological Society, therefore, retains concerns over many details of the present draft Bill, including key issues regarding the definition of “mental disorder” and the conditions for compulsory treatment. These are detailed below.
RESPONSES TO POINTS FOR CONSULTATION

1. Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

The “principles” referred to in Clause 1 of the Draft Bill are welcome. They are appropriate and desirable. They are not, however, complete or unambiguous. The British Psychological Society recommends that the principles are listed on the face of the Bill (as with the Mental Capacity Bill, and in contrast to being included in a Code of Practice) and strengthened—from an aspirational statement for “regard” to certain issues to a requirement for all parties acting under the aegis of the legislation to adhere to these principles. The British Psychological Society also recommends, for reasons that will be made clear in further comments below, that a further principle is included: that a person’s own choices about treatment (or lack of treatment) for mental disorder should be honoured unless, because of a mental disorder, the person’s ability to make decisions about the provision of health care is significantly impaired. We strongly believe that such a principled amendment would improve the Bill. It would ensure that the Bill is fully compatible with the Human Rights Act, the Mental Capacity Bill and consonant with recent judicial rulings in respect to capacity and medical treatment. We also believe that such an amendment would make the Bill’s provisions more (rather than less) workable. Such an amendment could both reflect and also help to clarify the main reason for the necessity for a Mental Health Bill—because mental disorder can result in impaired judgement, it is not always possible merely to leave treatment choices to the individual. Finally, we believe that the Bill should also be based on the principle of reciprocity— that any treatments permitted by the legislation should be of genuine net therapeutic benefit to the individual.

2. Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the Community adequate and sufficient?

The British Psychological Society appreciates the benefits outlined in the Richardson Report of a broad definition of mental disorder coupled with supplementary criteria for compulsion. We welcome the revision to the definition of “mental disorder” in the present draft Bill, and in particular the implied reference to impairment of psychological functioning. We believe this is an improvement upon the (currently applicable) 1983 Mental Health Act. Nevertheless, we believe that this definition remains too broad in its scope. The definition of “mental disorder” and its appropriateness cannot be separated from the proposed conditions for compulsion. It is necessary, therefore, that strict conditions also apply.

The British Psychological Society very strongly recommends that the conditions for compulsion are amended further to reflect the principle that persons whose capacity to make decisions about their health care is unimpaired should retain their right to decide their own treatment. We recommend, therefore, that a further condition be added—“that because of the mental disorder the patient’s ability to make decisions about the provision of such medical treatment is significantly impaired”. This wording appears in the Mental Health (Care and Treatment) (Scotland) Act 2003.

We believe that this amendment is vital for two reasons. First, while we welcome the Government’s intention to reduce the number of people subject to compulsion, and note that the definitions and conditions in the present draft Bill are stricter than those in the 1983 Mental Health Act, we remain concerned at their breadth. With the removal of the exclusions (see below), the removal of the “treatability loophole”, and the potential for compulsion in the community, there still remains great potential for greatly increased compulsion. This danger may be potentiated if, as many believe, there is a developing culture of “defensive practice” where (for instance) practitioners may feel obliged to treat a person under compulsion rather than run the risk of being blamed for any future adverse incidents. Strict conditions must guard against this eventuality. Secondly, we believe it is the impairment of judgement that provides the ethical, professional and legal basis for compulsion. We will expand on this point below, when discussing the Human Rights Act.

We very strongly welcome the fact that the Bill is based on a care plan (as opposed to the 1983 Act, which provides for admission and then treatment in a very general sense). We recognise that this fact, coupled with the specific provisions of the draft Bill, allow for compulsory treatment in the community. However, we also share the great concerns expressed by colleagues in respect to this issue; that without robust controls this provision could lead to excessive use of compulsory powers. We believe that this excess could also fall disproportionately on people from Black and ethnic minorities and other socially excluded groups such as people in inner-city and socially deprived areas. On the other hand, we also recognise that the present draft Bill reflects substantial changes in this issue. The British Psychological Society also notes that the possibility for care plans to be implemented under compulsion in the community may offer a better “least restrictive alternative” than the present Act, which permits only admission. We also note that such powers of compulsion in the community are only lawful if the person involved continues to meet the conditions for compulsion.

The British Psychological Society notes, however, that care plans are most likely to be effective if they are based on true collaboration between the patient and the care team. We also note that appropriate alternative services must exist “on the ground” for the concept of a least restrictive alternative to be a genuine one.
We therefore recommend that, in addition to the necessary amendment to the conditions outlined above, further amendments be made to limit the possibility of compulsion in the community to people who more closely fit the “revolving door” profile for which the provisions are drafted. These amendments might follow the approach taken in the Canadian Province of Saskatchewan. This limits compulsion in the community to people who meet certain specific clinical history profiles. It should be noted that such a clinical history criterion would not only address the “revolving door” issue, but would also ensure that such community powers could not be used in the case of people perceived to be dangerous (but who are not classic “revolving door” patients). This model is compatible with the views of the British Psychological Society in respect to public safety outlined below.

The British Psychological Society also has concerns regarding the wording of the fifth condition—“the fifth condition is that medical treatment is available which is appropriate in the patient’s case, taking into account the nature or degree of his mental disorder and all other circumstances in his case”. We understand this to be a welcome recognition of the need for reciprocity—ensuring that the proposed care plan is of therapeutic benefit. We consider, however, this clause to be clumsy and difficult to understand. As such, it may have the opposite effect to that intended. That is, the complex and ambiguous wording may leave clinicians believing that any and all treatments are appropriate, rather than ensuring that they take care to plan only treatments of therapeutic benefit. We have concerns that a “bare minimum” service will be the only one on offer, meaning that patients treated under compulsion will be provided with services that may permit lawful compulsion, but are of an objectively unacceptable standard.

Finally, the British Psychological Society strongly regrets the decision not to retain the provisions that people whose mental disorder is solely characterised by the drug or alcohol use or by sexual deviance should be excluded from the provisions of the Bill. We believe that allowing the mental health legislation to be used in such cases, in the absence of other consequences or concomitants of mental disorder, may permit disproportionate and inappropriate compulsion. Moreover, we note that both in terms of the provisions of the Human Rights Act, and in terms of existing UK legislation, powers to deal with alcohol and drug abuse and to deal with sexual crimes already exist. If it were felt that additional powers are required, either for the protection or care of individuals, or to protect society, there are routes other than the distortion of the mental health legislation by which these ends could be met.

3. Does the draft bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

The British Psychological Society remains concerned that the draft Bill places undue emphasis on a misguided attempt to assuage perceived (but largely illusory) public fears and thereby threatens to undermine the human rights of people with mental health problems. We recognise the need for Mental Health legislation to protect the public from the very small number of people whose mental disorder renders them dangerous. However, in our opinion, such protection can be maintained with provisions similar to those proposed, with the important inclusion of the “Scottish clause” (“that because of the mental disorder the patient’s ability to make decisions about the provision of such medical treatment is significantly impaired”) referred to above.

This, we believe, is feasible and justified because (a) dangerous individuals are very rare, (b) it is, in practice, statistically impracticable validly to identify such people before they have committed offences if they are not experiencing mental disorders of a nature or kind as to render their decision-making capacity impaired, (c) there exist present and planned provisions under criminal justice legislation that serve the same purpose under judicial rather than medical process, (d) such provisions are presently under-utilised and (e) we believe attempts to protect society from such perceived threats in such a manner are incompatible with the Human Rights Act. In particular, in this context, we note the provisions of the Powers of Criminal Courts Act (1973), which permit a Court to impose Community Rehabilitation Orders including specified conditions of treatment under the supervision of a chartered psychologist, but which are relatively seldom used.

We also note with concern a major assumption that pervades the Bill, one that has potentially grave implications. The Bill could be read as an enabling provision—permitting doctors to care for people in the way they, the doctors, think best. The conditions do not allow the competent patient to choose to reject the doctor’s advice, and they permit the development of a care plan in worryingly broad terms. The British Psychological Society does not believe that all judgements by all doctors are necessarily correct or benevolent. We similarly, of course, believe that not all judgements by all psychologists are necessarily correct or benevolent. We recognise that decisions must be made on behalf of people who cannot make valid decisions for themselves, but the Bill should not presume that any powers devolved to professionals would necessarily be of benefit to patients.
4. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient, and clear? Are there any important omissions in the Bill?

The British Psychological Society recognises that the Mental Health Bill itself is necessary. The British Psychological Society very strongly welcomes the central premise of the Bill—the implementation of care plans under compulsion. We believe that this properly reflects the nature of modern mental health care.

We also note that whether the Bill’s provisions are workable depends, in great part, on workforce considerations.

The present draft Bill contains new and welcome safeguards (such as rights to advocacy and the substantially increased provisions for Tribunals) that depend on proper staffing and training. The draft Bill also states that compulsion is lawful only if there is appropriate treatment available. In the short term, this may lead to great pressure on clinicians—caught between the evident needs of the patient, an unavailability of resources, legal, societal or familial pressure for action, the rights of the individual and the unlawfulness of inappropriate treatment. It may be necessary to review the provisions in the draft Bill that apply if compulsory treatment is indicated, but no appropriate care is available. There are also potential large financial and resource implications. We believe that the Scrutiny Committee should consider in some detail the plans for implementing the provisions of the Bill.

One important omission from the Bill is the provision for patients to make binding statements of preference in respect to future treatment. Such statements of informed choice by sound-minded persons are clinically important and are part of the provisions of the Mental Capacity Bill. The British Psychological Society believes that there should (a) be an obligation on clinicians to draw up statements outlining the patients desires in relation to future treatment and (b) a duty on clinicians implementing the Bill to adhere to them, or to derogate from them only under specified circumstances which should be clearly recorded. This may best be incorporated in respect to the duty to develop a “clinically appropriate” care plan incorporating “all relevant factors”. These relevant factors should also include other care plans developed during consensual care. Although the Care Programme Approach care plans are not legally binding, they should be relevant in order to ensure good continuity of care.

5. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft bill?

On balance, the British Psychological Society believes that the abolition of the Mental Health Act Commission, and for the transfer of responsibilities to CHAI, the Healthcare Commission, is appropriate. On balance, we believe that the proposed responsibilities, and the power of CHAI and the other authorities, are appropriate. We welcome the increased functions, powers and remit of CHAI compared to those of the present Mental Health Act Commission.

6. Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

Although the British Psychological Society welcomes the greater focus on safeguarding the well-being of children in the present draft, and the amendments made to the provisions for the compulsory treatment of prisoners, we believe that much greater safeguards are necessary throughout. In particular, we believe that the Bill should include a clear statement of the principles upon which care plans should be based—for the proposed treatments to be of proven efficacy, to be based on currently accepted professional practice guidelines (eg the British National Formulary in respect to drug regimes and guidelines from the National Institute for Clinical Excellence) and for the therapeutic benefits to outweigh the likely cost to the individual.

The British Psychological Society strongly believes that a major safeguard against abuse, generally, would be the adoption of an “impaired judgement” condition as exists in Scotland and as outlined above (point 2 above). More particularly, we view the provisions against the misuse of what we think are correctly termed “aggressive procedures” such as ECT and psychosurgery as weak. The British Psychological Society believes that it is inappropriate, unethical and indeed illegal (in terms of the Human Rights Act) to provide for the compulsory treatment of people who are able to make valid decisions about their health care. In physical care, such decisions are not legal, and we believe the principle of non-discrimination means that such decisions should not be taken in the case of people with mental disorders.

This position becomes even more relevant where the proposed treatment has the potential to harm or damage the individual’s brain. The draft Bill states that people who retain capacity should not normally be given treatments such as ECT and psychosurgery. But such treatments may still be given to capable persons “in emergencies”. The British Psychological Society questions the notion of ECT being an immediately lifesaving treatment, when compared with 24-hour one-to-one intensive care for instance. The British Psychological Society believes that none of the provisions of the draft Bill should apply to people who are not significantly impaired in their ability to make decisions about their health care. It follows that, for the aggressive procedures, the safeguards should be even stronger. We believe that ECT, psychosurgery and
other such procedures should be prohibited for persons not able to give informed consent. Given the nature of these procedures, the British Psychological Society also recommends that such treatments should be subject to the ratification of a Tribunal even if the patients are able to give informed consent.

As mentioned below, the British Psychological Society believes that there should be greater clarity regarding the nature of the care plan. In particular, we believe that the Bill should specify that clinicians are not permitted to draw up care plans that deviate from accepted professional standards—i.e., that adhere for instance to BNF guidelines for prescribing and the relevant professional codes of professional behaviour.

We note that the Bill contains no offence related to inappropriately using these provisions in respect to a person who does not meet the relevant conditions, nor of negligently investigating the relevant circumstances in this regard. We recommend that consideration be given to this issue.

7. Is the balance struck between what has been included on the face of the draft bill, and what goes into Regulations and the Code of Practices right?

Although the British Psychological Society recognises that not all matters should be in the text of the Bill, we believe that the present draft omits important matters. Because the emphasis on a care plan is central to the Bill, and is welcome, the British Psychological Society believes that the Bill should clarify the essential nature, scope and content of this care plan more closely. The Bill, in essence, will render the care plan legally enforceable. The British Psychological Society recognises the fact that the present provisions for a care plan are more rigorously specified than the current 1983 Mental Health Act. Nevertheless, we recommend that the Bill be amended further to clarify the procedures that the Clinical Supervisor must follow when drawing up a care plan, which professionals must be consulted and be involved, what therapeutic elements must be considered etc. We also believe that the Bill should require clinicians to provide written reasons for their actions (including their decisions not to do certain things).

We believe that there are some important details of the process that are not yet clarified. In particular we believe that greater clarity over the procedural duties of the Clinical Supervisor in developing a care plan is required. We note that it is possible for a Tribunal to impose changes to a care plan after this has been prepared. We believe that this offers protection to patients. Nevertheless, we are concerned that it may leave Clinical Supervisors in the position of implementing care plans that they believe are inappropriate. In such circumstances, we recommend that the Bill (rather than the Code of Practice) should specify that Clinical Supervisors could refuse to oversee care plans that they consider inappropriate and that the Bill therefore should contain provisions for the appointment of alternative Clinical Supervisors.

8. Is the Draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?

The present draft Mental Health Bill is not adequately integrated with the Mental Capacity Bill. The legal aspects are relatively clear—the Mental Capacity Bill excludes provisions for treatment otherwise covered by the Mental Health Bill.

The British Psychological Society, however, believes that—in contrast to the clear view of Government—both Bills should address the needs of people whose ability to make decisions for themselves is impaired by mental disorder. Thus the Mental Capacity Bill effectively allows for proxy decision-making in respect to decisions other than mental health care if the person cannot make decisions for themselves. We believe that the Mental Health Bill should allow for appropriate clinicians to provide compulsory treatment if the person’s mental disorder renders them impaired in their ability to make valid decisions for themselves.

At present, the Mental Capacity Bill appears ethical, lawful and necessary; the Mental Health Bill uses criteria that leave the two Bills asymmetrical in their scope. This means that the Mental Health Bill is discriminatory—people with physical health problems are legally protected in their decision-making autonomy (even if their decisions in this respect are bizarre or life-threatening), people not subject to the Mental Capacity Bill are similarly “masters of their own fate”. The British Psychological Society does not believe that people whose decision-making ability is indeed impaired by mental disorder should be left to suffer from the consequences of potentially irrational decisions. We do believe that people who retain the ability to make un-impaired decisions but who happen to have a mental disorder (that is, one in four of the population) should have the same rights to decide on the nature of their treatment as do people with physical illnesses.

We do not believe that the Mental Health Bill should use the same definition of “incapacity” as the Mental Capacity Bill. This is because we recognise that people with mental disorder can frequently make very clear and unambiguous decisions. We therefore seek to distinguish an inability to make decisions from the impairment in decision-making ensuing from mental disorder. But we do contend that a condition such as that applicable in Scotland is necessary for England and Wales. Because, in the case of mental disorder, such impairment in decision-making is likely to be transient (reflecting the natural course of mental disorders), continual reassessment is necessary.
We note also, in this context, the issue of people with learning disabilities who may also require psychiatric care. We note that, because learning disability is a “mental disorder” in the terms of the Bill, people with such learning disabilities already and always meet this first condition. This means that there is potential for abuse in terms of becoming inappropriately subject to the provisions of the Bill. The obvious vulnerability of some people in this group in other respects should give cause for additional concern. The British Psychological Society does not believe that the Bill should exempt people with learning disabilities from its provisions (for this would either exclude people from the care they needed or involve inappropriate care with fewer safeguards under the provisions of the Mental Capacity Bill). But we do believe that the Bill should recognise the special needs of people who meet the criteria for both Bills. The British Psychological Society recommends that the Bill should include a provision to invite a Special Visitor (in the terms of the Mental Capacity Bill) to overview the applicability of the conditions and the appropriateness of the care plan in the case of people who have or are suspected to have a learning disability or who do or may be deemed to lack capacity in the terms of the Mental Capacity Bill. Again, it is worth noting that this exemplifies the distinction between our recommended “impaired judgement” condition for the Mental Health Bill and the inability to make decisions referred to in the Mental Capacity Bill. Nevertheless, we believe this arrangement reflects the reality of the situation, is compatible with the concept of “unsound mind” (see below) and will ensure proper compatibility between the two Bills.

9. Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

The present draft Mental Health Bill is not in full compliance with the Human Rights Act.

Article 5 of the Human Rights Act states that “No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law”. The “following cases” include “persons of unsound mind”. While the British Psychological Society unreservedly welcomes both the principles behind and the provisions of the Human Rights Act, we believe that psychological science has a great deal to offer in respect to the interpretation of the term “unsound mind”. We note that research and consequent understanding in this have advanced significantly in recent years.

The British Psychological Society recognises that the legal advice given to Government—and indeed the Scrutiny Committee—may be that “of unsound mind” can legitimately be equated with meeting the conditions outlined in the Bill, and specifically with meeting the definition of “mental disorder”. Indeed, we recognise that other European Governments have so interpreted the phrase. Nevertheless, our submission, as the UK learned body representing those scientists who study the functioning of the human mind, is that one can only be considered “of unsound mind”, in this context, if a person’s mental disorder is of a “nature or kind” to make the person significantly impaired in their ability to make valid decisions for themselves.

We note that many of the commonly-cited judgements in the European Court of Human Rights date from some 30 years ago, and are based on contemporaneous interpretations of Convention Rights drafted in the 1940s. We also note that, in practice, the opportunity to change mental health legislation comes once in a generation. The British Psychological Society therefore believes it is important to ensure that the present draft Mental Health Bill reflects modern scientific knowledge of mental disorders, and the implications of this understanding in Human Rights terms.

10. What are likely to be the human and financial resource implications of the draft bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

We note the large human and financial resource implications of the draft Bill. We recommend that the Scrutiny Committee seek careful clarification that these issues will be properly addressed.

The Bill will have very major impacts on the roles of many professionals. We welcome the emphasis on care planning, and anticipate that the inclusion of care planning in the Bill will lead to greater emphasis on this aspect of care in the wider mental health service. We also note the fact that the Bill alters the statutory duties of a number of professions. In particular we note proposals to reform the role of the “Responsible Medical Officer”. The British Psychological Society welcomes the fact that Chartered Psychologists might take Clinical Supervisor responsibilities. We note, however, that this is a very significant change in the responsibilities of psychologists. The British Psychological Society recommends that the Government support both in principle and in financial terms the training that will be required in enabling psychologists to undertake such extended roles and responsibilities.

The British Psychological Society recommends that the Scrutiny Committee consider ways in which the Bill, the Code of Practice and the plans for implementation of the legislation address the competencies required of Clinical Supervisors. The possibility that psychologists may become Clinical Supervisors has led to significant debate within the profession. Many psychologists welcome the proposal, but others wish to play no role in compulsion and are concerned about the impact of these changes on their therapeutic relationships. Others feel that these proposals, in the context of the present draft provisions, threaten the basic values underpinning their practice. Many psychologists do not wish, personally, to exercise these powers, but recognise that there are potential benefits to these proposals so long as proper professional
safeguards are in place. Many senior and experienced psychologists see themselves as having the high-level skills in assessment and treatment that would equip them suitably for the Clinical Supervisor role, especially when the principal mode of treatment will be a psychological intervention.

Psychologists eligible to be clinical supervisors should be Chartered Psychologists (or psychologists eligible for chartered status) with appropriate competencies, experience and seniority. The British Psychological Society recommends that there be a requirement for additional training to contextualise and extend existing competencies. Appropriate competencies for such individuals should include (but not be limited to): psychopathology, mental health law, mental health services, forensic service, risk assessment, care planning, clinical governance, supervision and management, psychological formulations and psychopharmacology. To reflect the concerns of many in our profession outlined above, the threshold for registration or approval should be set high.

The British Psychological Society recommends that the Scrutiny Committee consider ways in which the Bill, the Code of Practice and the plans for implementation of the legislation address the nature of training necessary in this regard. We would welcome detailed plans for such training, and recommend that such training be generic—that all Clinical Supervisors, whether psychologists, psychiatrists or members of other professions, should be subject to the same requirements for training and levels of competency.

We note that, both in the choice of most appropriate Clinical Supervisor and in the selection of an Expert Member of a Tribunal, there is ambiguity. We would recommend that the Bill better clarifies this issue. This may best be achieved through an additional element in Section 24 of the draft stating that the managers, when appointing a Clinical Supervisor, should have regard to all relevant circumstances, including the nature of the mental disorder, the likely nature of the care plan to be developed, and the professional training and competencies of the clinician, before appointing the Clinical Supervisor. It is also important to note that, particularly for psychologists, adoption of the Clinical Supervisor role may lead to conflicts between the imposition of coercion and the therapeutic role.

Further memorandum from the British Psychological Society : Division of Clinical Psychology (DMH 402)

PSYCHOLOGISTS IN THE ROLE OF CLINICAL SUPERVISOR

My colleagues and I have had the opportunity to read a letter to yourself from the Royal College of Psychiatrists on this matter.

Although I am aware that the British Psychological Society is to give oral evidence to the Joint Committee in the New Year, I feel there are some points I should raise before then.

First, I am of course glad that the Royal College of Psychiatrists supports the views of the Committee that senior and experienced psychologists have extensive experience and authority. It is important to stress, however, that this authority is indeed not limited to forensic in-patients. Indeed I would suggest that the opposite is true, that the skills and expertise of psychologists is more often seen in out-patient mental health care.

The British Psychological Society would, of course, agree that Trusts would need to exercise great care in determining that health care professionals who may act as clinical supervisors in relation to individual or particular groups of patients patients have the necessary training and skills to ensure that vulnerable people receive the best possible service.

The British Psychological Society reiterates its point that there should be equivalent training for all professionals in relation to clinical supervisor responsibilities. While it may be the case that the clinical care of people involved in mental health care may render it essential for a member of the care team to have medical expertise, we do not believe that this is true for the role of Clinical Supervisor. The draft Bill carefully outlines the role of Clinical Supervisor, and we believe that people should be appropriately trained for this role. We do not believe that the Bill allows for two classes of Clinical Supervisor—“medical clinical supervisor” and “others”—and we do not believe that it would be appropriate to have two classes of training. We also believe that such a move would be constitutionally wrong. The Bill, as drafted, would institute a single new role of Clinical Supervisor. It would be constitutionally wrong for this to be undermined with a practical implementation of a system that would instantiate two different types of Clinical Supervisor.

It is perhaps true to say that “a range of medical illnesses play an important part both in relation to the causes and consequences of psychiatric disorders”, but the British Psychological Society notes that physical health care in mental health settings has routinely attracted strong criticism and also that we are aware of a vanishingly small number of patients for whom the resolution of their mental health crisis is achieved by standard medical care. Instead we note the point that the vast bulk of innovative clinical and theoretical research in recent years has highlighted the importance of psychological causes of and interventions for mental ill health.
Moreover, even if one were to accept this point, it does not follow that a recognition of any medical or organic causal route implies necessary consequent “clinical primacy” of medically trained professionals. The example of learning disabilities is informative: in such conditions the causal mechanism is frequently organic—even genetic—and yet medical treatments almost invariably play less of a role than social, educational, occupational and psychological interventions. People who receive mental health care under compulsion have complex problems, rarely requiring the involvement of a single professional group. Indeed, the British Psychological Society notes that the current draft Bill does not imply that the Clinical Supervisor role be limited to psychologists and medical practitioners. We would emphasise the broader principle that any professional with appropriate competencies, successfully undergoing a single route of training, could fulfil the role of Clinical Supervisor.

We do not suggest that any other professional group be excluded, merely that psychologists should not be excluded from fully serving in such a role. It is also worth noting that an acceptance of this principle—that members of many professions play a co-equal role in mental health care and that clinical, professional and administrative leadership may legitimately be the aspiration of members of all these professions—is a corner-stone of the “New Ways of Working” discussions which have been strongly endorsed not only by the joint Ministers of State Paul Goggins MP and Rosie Winterton MP, but also by the Royal College of Psychiatrists themselves.

In summary, then, the British Psychological Society simply believes that psychologists are well placed to be clinical supervisors, that this competence extends across the broad expanse of mental health care, that this competence places on an equivalent plane to consultant psychiatrists and, finally, that this should be reflected in a single process of training.

We, therefore, believe that our role will not be limited to non-psychotic patients usually in longer-term forensic settings. To be blunt—we look forward to psychologists working as clinical supervisors with all patients of the mental health services—including, but not limited to, patients with psychotic disorders, mood disorders and personality disorders, people with learning disabilities, dementia or brain injury; and being cared for in secure and in non-forensic or non-secure settings as well as in the community.

I hope I have expressed my concerns clearly. Please let me know if further clarification is required.

Peter Kinderman
Professor of Clinical Psychology
Chair: British Psychological Society Division of Clinical Psychology

January 2005

Witnesses: Dr David Harper, Senior Lecturer in Clinical Psychology, University of East London, Professor Peter Kinderman, Professor of Clinical Psychology, University of Liverpool, Ms Sue Ledwith, Consultant Clinical Psychologist and Clinical Lead, North Yorkshire Forensic Psychiatry Service, and Dr Graham E Powell, President Elect, British Psychological Society.

Q997 Chairman: Welcome to our witnesses from the British Psychological Society. Can I remind you that this is a public evidence session and as a result there will be a transcript kept of everything that is said. It will be published on the internet within about a week and you will have the opportunity to make any corrections to the text although not to the sense of it, if you wish to do so. Can I ask you all please to keep your voices up when you answer questions. I am afraid for procedural reasons connected with some extremely important votes in the House of Commons (and would the Members of the Lords please desist from laughing every time that is said!) we are going to have to curtail this session at about five or 10 past four, if you will forgive us but, of course, we do have your written submissions together with your further written submissions with much thanks. Would you like to introduce yourselves and then we will continue with the questioning.

Professor Kinderman: My name is Peter Kinderman. I am Professor of Clinical Psychology at the University of Liverpool and Consultant Clinical Psychologist with Merseycare NHS Trust. I am the current Chair of the British Psychological Society’s Division of Clinical Psychology and I head the British Psychological Society’s Working Group on mental health legislation. I have also had the pleasure of giving evidence to Lord Carter’s Committee on the Mental Capacity Bill.

Ms Ledwith: I am Sue Ledwith. I am a Consultant Clinical Psychologist and Clinical Lead for North Yorkshire Forensic Psychiatry Services. I have also worked as a Mental Health Act Commissioner for the past five years but I have recently discontinued that. I have worked with people who have been liable to be detained for the past 20 years, so I am appearing from a clinical point of view on some of the issues.

Dr Powell: I am Dr Graham Powell and I am President Elect of the British Psychological Society and as such I have a duty to ensure the appropriate training and support of our members to take on new roles. I am a Clinical and Neuro Psychologist with a special academic interest in the reliability and validity of assessments. I work clinically with brain-damaged individuals who have disability of mind and therefore problems in the area of capacity.

Dr Harper: I am David Harper. I work on the training course in clinical psychology at the University of East London. I am a member of the British Psychological Society Mental Health Bill
Working Party, and I have got a particular interest in alternative approaches to psychological problems particularly from a social perspective.

Q998 Chairman: I will take what to cricket fans is known at the moment as the “Flintoff” role and start with as fast a ball as I can bowl at you. In your supplementary memorandum you challenged the view of the Royal College of Psychiatrists that for the vast majority of severely mentally ill patients in general adult and old age services it is essential for the clinical supervisor to have a medical training. Why do you not accept the psychiatrists’ approach and for what categories of mentally ill patients and for how many patients do you think psychologists would be able to act as clinical supervisors?

Professor Kinderman: I am going to take the issue of how many as a second point. For what categories our general answer is for all categories. We believe that not only the competences but the clinical actions of psychologists cover the breadth of mental health problems, and certainly all of the so-called categories of people that fall under the Mental Health Act but also people outside the Mental Health Act as well. We consider our competencies to be very broad. It is the case in practice that clinical psychologists and other psychologists work with a very large number of people who fall in this category so it is not right to suggest that psychologists only work with a certain select, small number of patients. There is a second point which is that, although it may very well be the case that very many people receiving treatment under the auspices of the Mental Health Act require the services of a medical practitioner as part of their team, that is not the role of the clinical supervisor. The role of the clinical supervisor is to do those assessments that are specified by the Bill and draw up as part of the multi-disciplinary team the care plan. We believe, in essence, that is what psychologists do for a vast array of patients and we think it is right and proper that that should be reflected in the competences of the Bill. In terms of numbers it is true that the role of the clinical supervisor would be a new one for psychologists. It would be a challenging one for psychologists. In our written evidence we suggested that the competences are indeed met by psychologists but we suggested for various obvious reasons that the standards should be set high and therefore at least in the first instance relatively small numbers of psychologists should become clinical supervisors. We have received figures from the Department of Health that they were running on workforce planning estimates of around 5% of the instances of clinical supervisor being a psychologist, and we do not think that is unreasonable.

Q999 Chairman: Given that clinical psychologists do not have the power to prescribe drugs—which I think is right, is it not?

Professor Kinderman: Yes. For instance, a colleague of mine works at a place called Five Boroughs Trust where he has evolved a system whereby he does, in fact, draw up care plans for patients who are detained under the Mental Health Act. These are effectively signed off by psychiatrist colleagues. They become legally responsible for what is done but have very limited input into it. The relationship, I stress, works very well. The professionals involved are aware of their responsibilities but the care planning is done by the psychologist, and the law is out of kilter with our competencies.

Q1000 Chairman: —Do you see that as any kind of disadvantage in carrying out the role of clinical supervisor?

Professor Kinderman: No. I would see that as a disadvantage in the role of carrying out the prescription of drugs but that is not the role of the clinical supervisor. What I, in fact, do when I am the in de facto co-ordinator of care for the patients for whom I am co-ordinator of care—and those are of course by definition people not detained under the Mental Health Act—then I make my clinical decisions about what I think is necessary and appropriate and I liaise with psychiatrists in terms of the prescription of medication. Psychiatrists and psychologists work very well together in the different parts of the care plan that the two professions are responsible for. I do presume to call on psychiatrists when I believe it is right for them to make the assessment as to whether prescription and medication is appropriate; I think it is right for us to work together on that instance. If I were working as a clinical supervisor then I suspect for a very large number, if not all, of the patients for whom I was responsible, I would not only request but desire and demand the input of a psychiatrist and that would involve the assessment as to whether prescription is necessary, but that is not the role of a clinical supervisor. The role of the clinical supervisor is not to make prescriptions but to plan care and to assess whether the patient meets the criteria, and I think I have those competencies.

Q1001 Chairman: From what you have said it sounds as though, in non compulsory cases, clinical psychologists are in many cases carrying out that role in any event. Is that right?

Q1002 Professor Kinderman: Yes. For instance, a colleague of mine works at a place called Five Boroughs Trust where he has evolved a system whereby he does, in fact, draw up care plans for patients who are detained under the Mental Health Act. These are effectively signed off by psychiatrist colleagues. They become legally responsible for what is done but have very limited input into it. The relationship, I stress, works very well. The professionals involved are aware of their responsibilities but the care planning is done by the psychologist, and the law is out of kilter with our competencies.
individual to choose their own autonomous future and their right to receive good treatment and their rights versus the rights of wider society, so there are issues of principle inherent in the Bill. What we are discussing when we are discussing the wording of the text of the Bill is about how those principles are rolled out in practice so for that reason we think that adherence to the principles is important, and there are principles about the care of people with mental health problems that are not necessarily reflected in the conditions, for instance, the principle that whatever you do should be in the best interests of the patient, and there is a danger that the practicalities of the arrangements of the Bill might in some instances allow the principles to be lost.

Fire alarm sounds

Chairman: I think we will have to finish at this point. I am very sorry.

---

Supplementary memorandum from the British Psychological Society (DMH 431)

Thank you for the opportunity for the BPS to address in writing the outstanding issues from our interrupted oral evidence session on Wednesday 26 January 2005.

We will, as you suggested, address ourselves succinctly to the four questions posed to us.

6. In your supplementary memorandum you have challenged the view of the Royal College of Psychiatrists “that for the vast majority of severely mental ill patients in general adult and old age services it is essential for the clinical supervisor to have a medical training”. Why do you not accept the psychiatrists’ approach? For what categories of mentally ill patients and for how many patients would psychologists be able to act as clinical supervisors?

In our supplementary memorandum to the Committee of 7 January 2005, the BPS made it clear that we regard ourselves as competent to fulfil the role of Clinical Supervisor in respect to the total population of patients subject to the provisions of the Mental Health Bill. We also believe, as we made clear in our initial written submission to the Committee, that we are competent to discharge the roles of “examiners” under clause 14(4) of the draft Bill.

We suggest, therefore, that the Committee, when reporting to the Department of Health, recommends that the provisions of Clause 3 remain in respect to definition of an approved clinician, that the provisions of Clause 24 remain in respect to the Clinical Supervisor role, and that Clause 14(4) be amended to empower approved clinicians to undertake the initial examination (permitting psychologists and other appropriately competent clinicians to carry out these two roles).

We also strongly recommend that there should be a single route of training for all people taking on these roles. The purpose of the training is to prepare people for a single role. And we can foresee many difficulties if there were distinct groups of Clinical Supervisors, each having exited different training routes, purporting to be performing a single statutory role.

Our training (all Clinical Psychologists have a three or four year 1st degree in psychology accredited by the BPS, followed by normally at least two years relevant work experience and finally a three-year then a Doctoral clinical qualification again accredited by BPS; Consultant Clinical Psychologists have at least an additional six years post-qualifying clinical experience) gives us broad competencies in the assessment, formulation and treatment of complex mental health problems. Our assessment and formulation, based on a bio-psychosocial model of mental health, will always include an ongoing assessment of whether, in each case, it is necessary to involve other professions such as medical practitioners.

We do not regard ourselves as competent to deliver all necessary interventions—we coordinate such interventions through our formulation and care plan. This means that we do not prescribe medication. In the context of multi-disciplinary working, however, clinical psychologists and other appropriately qualified professionals are competent to know when we require the expertise of another discipline, such as psychiatry.

Patients potentially subject to the provisions of the Bill will require the assessment of a complex range of needs, and for these needs to be addressed through a coherent and comprehensive care plan, delivered by a multi-disciplinary team. This, as we stated in our supplementary memorandum of 7 January 2005, is entirely consistent with the “New Ways of Working” programme in the Department of Health. This is particularly pertinent in the case of people potentially subject to the provisions of the Bill, whose difficulties are inevitably complex. This requires appropriate competencies, not membership of a particular professional group.

The roles of the examiner and Clinical Supervisor also involve an initial and ongoing assessment as to whether the patient meets the criteria of the Bill. Our competencies more than adequately equip us to make these assessments. Again, the roles in question are ones requiring appropriate competencies, not membership of a particular professional group.
for how many patients would psychologists be able to act as clinical supervisors?

The Clinical Supervisor and initial examiner roles would be new and challenging ones for clinical psychologists. As we stated in our initial written submission to the committee, we believe that the threshold for acceptance onto the relevant training course should be high. This would reflect the novelty of the role, the newness of the Act and the concerns of many in our profession that a high threshold of competence is required. It is likely, therefore, that, initially, relatively few and very highly competent and experienced individuals will adopt this role.

We have been involved in discussions with the Department of Health in respect to preliminary workforce planning, and a figure has been mooted that no more than 5% of the clinical supervisors are expected to be clinical psychologists within the first five years of the new Act’s operation. We believe this figure is wise.

7. The British Psychological Society has called for a requirement for all parties acting under the aegis of the legislation to adhere to principles which would be set out on the face of the Bill. Is the Society calling for a mandatory requirement to enforce principles?

As we stated in our written submission, we agree with our colleagues in the Mental Health Alliance that a comprehensive set of principles are listed on the face of the Bill (as with the Mental Capacity Bill, and in contrast to being included in a Code of Practice). We stated that there should be a requirement for all parties acting under the aegis of the legislation to adhere to these principles.

We are not lawyers, and are unsure how lawyers interpret the phrase “a mandatory requirement to enforce principles”. We do, however, believe that the principles should be on the face of the Bill and that people should be under an obligation to adhere to them.

Legislation such as the Mental Health Bill is peculiarly dependent upon principles by which professionals, such as psychologists, should judge their decisions. Principles underpinning the Bill should be over-arching and relatively unchanging—reflective of basic human rights—and they should therefore be on the face of the Bill. We believe that the Code of Practice should be drafted in the light of these principles, not vice versa.

8. The British Psychological Society strongly recommends that the conditions for compulsion are amended further to reflect the principle that persons whose capacity to make decisions about their health care is unimpaired should retain their right to decide their own treatment. How do you respond to the argument that capacity based mental health legislation is unworkable since it permits persons who may have serious mental illness to refuse treatment?

The British Psychological Society very strongly repeats its call for the Committee to recommend that the Bill be revised to include a further condition—“that because of the mental disorder the patient’s ability to make decisions about the provision of such medical treatment is significantly impaired”. This wording appears in the Mental Health (Care and Treatment) (Scotland) Act 2003.

We have not recommended that the Mental Health Bill include a “capacity test” such as that employed in the Mental Capacity Bill, and this distinction is important.

The Mental Capacity Bill explicitly concerns the care of people who are unable to make decisions for themselves and provides for a “capacity test”. People lawfully subject to its provisions cannot make decisions about a particular issue and it is appropriate for others therefore to make these decisions on their behalf. “Capacity”, in this context, therefore refers to an inability to make decisions. We believe that the Mental Health Bill should address the needs of people who are, in contrast, capable of making decisions but whose mental disorder means that, at that time, their ability to make decisions is significantly impaired. “Impaired”, in this context, means that the mental disorder has harmfully influenced the decision-making process rather than prevented the decision being made.

This is an important distinction. Mental disorders do not generally prevent people from making decisions, but they can harmfully influence and thereby impair the decision-making process. Such influence is, moreover, usually not permanent, and should therefore be continually monitored.

This means that, if such an “impaired decision-making” criterion were included in the Bill (as our colleagues in the Mental Health Alliance and the Royal College of Psychiatrists have also recommended), people could “pass a capacity test” as outlined in the Mental Capacity Bill but still lawfully be subject to the provisions of the Mental Health Bill if it were the case that their ability to make a decision (to refuse treatment) has been significantly impaired—has been harmfully and significantly influenced—by the mental disorder.

There are many reasons for this call. We endorse the principle that people who are able to make valid decisions about their future should be empowered to exercise this autonomy. We note the parallel with Scotland—and while England and Wales must make their own laws, there is no reason why they cannot learn from the Scots. We note the parallel with laws concerning physical health care; where people not significantly impaired in their decision-making have an absolute right to refuse treatment. Finally, we note that the Human Rights Act legitimises such compulsion only in the case of “persons of unsound mind”. As psychologists, it is axiomatic that being “of unsound mind” equates to being significantly impaired in decision-making—in this case being harmfully and significantly influenced by the mental disorder.
We do not think that this clause would make the Bill unworkable. People would be subject to the provisions of the Bill, even if they passed a “capacity test” (evidently made decisions) if it could be shown that mental disorder was nevertheless significantly and harmfully influencing the decision-making process at that time.

An example may be useful: A person may be offered an antipsychotic medication to help control the symptoms of schizophrenia, for example delusions. It may be thought that, without the treatment, the person could be at risk of significant harm. The patient might, however, decide that the adverse consequences of the treatment (the side-effects) were, for them, worse than the symptoms themselves (they might decide that they did not wish to run the risk of functional impotence). Indeed, research indicates that for patients as a whole, the benefits of such treatments are only marginally able to offset the negative consequences of such treatments (and of course, therefore, for many patients the balance of judgements is unfavourable).

If the patient were making a rational decision to refuse treatment (their decision-making process was not significantly impaired, was not harmfully and significantly influenced, by the mental disorder) we would respect this decision, even if we thought it was unwise. The patient may, however, be making a decision to refuse treatment that was significantly impaired by the mental disorder. They may, for example, delusionally believe that they were being deliberately poisoned. In such a case the mental disorder would be significantly and harmfully influencing the decision-making process. The person would be judged to be capable of making a decision, but nevertheless be significantly impaired in their ability to make a decision about the provision of care. We would then agree that compulsion was lawful if the other conditions of the Bill were met.

We believe that the vast majority of patients currently detained under the Mental Health Act (1983) who have serious mental illnesses would quite clearly be demonstrably and significantly impaired in their decision making because of their mental disorder. We believe that psychologists and psychiatrists already make these judgements frequently in their clinical practice. Therefore, we do not believe that such a criterion would be unworkable in practice.

We recognise that this approach would mean that a very small number of people believed to be at risk of self-harm or suicide would be permitted to refuse treatment because it were judged that this risky decision was based on decision-making that was not significantly impaired. But we believe that (a) there will be very few such cases and (b) there will be very many cases where a person will thus avoid grossly inappropriate violations of their autonomy.

We moreover believe that there are viable solutions open to Government to address the risks posed by people judged not to be significantly impaired in their decision-making. Some people will be judged as not significantly impaired in their decision-making by mental disorder but will be believed to pose a risk to others. In these cases, the criminal justice system should be used for people who have offended, and solutions such as Anti-Social Behaviour Orders and civil procedures such as injunctions should be used for people who have not yet offended. We accept that these provisions may themselves require some legislative change, but believe strongly that this is more appropriate than to distort mental health legislation.

As healthcare professionals, we are naturally distressed when we hear of those very few patients who threaten or commit suicide and who appear unimpaired in their decision-making. We do not believe that these people should merely be “allowed to kill themselves”. We believe that these issues can best be addressed through the provision of appropriate consensual services. We think that all necessary services should be available, offered and assertively provided. Indeed, it is important to stress that the Mental Health Act does not prevent suicide. If it were implemented perfectly, it could not prevent all suicide. Unfortunately, the best quality available treatment frequently does not prevent suicide. If it were implemented perfectly, it could not prevent all suicide. Unfortunately, the best quality available treatment frequently does not prevent suicide. We should not bias the Mental Health Act inappropriately away from the principle of autonomy, in a vain attempt to do the impossible.

9. The Government has removed the exclusions in the current definition of mental disorder characterised solely on the basis of drug or alcohol use or sexual deviance on the basis that clinicians are reluctant to diagnose mental disorder if one of the excluded factors was also present. In your experience, is the Government’s decision to remove these exclusions justified? (And, in respect to learning disability, what possible abuses might arise if such an exclusion were not made for people with a learning disability?)

We agree with our colleagues in the Mental Health Alliance that people who meet the definition of mental disorder SOLELY on the basis of the basis of drug or alcohol use, sexual deviance or learning disability should be excluded from the provisions of the Bill. We do not think that people with these conditions, including learning disability, should be excluded from the provisions of the Bill per se. We believe that people should be subject to the provisions of the Bill if they meet the conditions of the Bill (including our recommended new condition) whether or not they have these conditions. We do think they should be excluded if the ONLY criterion is the presence these conditions, including learning disability.

We recognise that, if the Bill is interpreted correctly, the specified criteria (in Clause 9) should provide protection against inappropriate compulsion—especially if our additional criterion is accepted. But we do think that exclusions are important to avoid abuse. There is a phenomenon called “diagnostic overshadowing” where the presence of a particular diagnosis—in this case particularly learning disability—overshadows other judgements, such as whether the person is at risk or needs treatment, or indeed meets the provisions of the Bill.
We believe the exclusions would serve to prevent such diagnostic overshadowing. If it were clear that a person could not be subject to the provisions of the Bill SOLELY on the basis of these conditions, it would mean that the examiner must, by law, look beyond the diagnosis; protecting the individual by ensuring that the criteria truly are assessed.

Peter Kinderman  
Professor of Clinical Psychology
Wednesday 2 February 2005

Morning

Members present:

Barker, B.  Mrs Angela Browning
Carlile of Berriew, L. (Chairman)  Mr George Howarth
Carter, L.  Tim Loughton
Cumberlege, B.  Laura Moffatt
Eccles of Moulton, B.  Ms Meg Munn
Mayhew of Twysden, L.  Dr Doug Naysmith
McIntosh of Hudnall, B.  Mr Gwyn Prosser
Murphy, B.  Dr Howard Stoate
Pitkeathley, B
Rix, L.
Turnberg, L.

Memorandum from Carers UK (DMH 193)

I. Summary

(i) Carers UK is the leading UK-wide organisation of carers, run by carers, for carers. We warmly welcome the role of the joint committee scrutinising the Bill and the opportunity to submit evidence.

(ii) Carers UK has restricted its evidence to a few key points relating to carers, which are not already covered by the Mental Health Alliance. We have not, for example, compared the existing rights of the Nearest Relative to those of the Nominated Person as we did not wish to avoid duplication of evidence.

(iii) The main points of our evidence are as follows:

— The definition of carers is more workable.
— The new provision that seeks a carer’s consent that they wish to be known as the carer is particularly welcome.
— There are issues of clarity in the Explanatory Notes with regard to carers that need to be addressed.
— The duties to consult carers at key stages are very necessary.
— The Code of Practice needs to ensure that all relevant information is considered when carers are consulted, not just the patient’s wishes and feelings about treatment.
— The human rights of all main parties, patient and carer(s), need to be balanced, i.e. the human rights of the patient should not be to the detriment of the carer and vice versa. This should be addressed in the Code of Practice needs to address this.
— The Code of Practice needs to address information sharing with carers.
— The Code of Practice needs to address prejudice held by some professionals against carers in relation to suitability and eligibility to be the nominated person.
— The Code of Practice needs to cross-refer to key pieces of relevant and related legislation containing carers’ rights i.e Carers (Equal Opportunities) Act 2004 and the Community Care (Delayed Discharges etc) Act 2003.

1. About Carers UK

1.1 Carers UK is an organisation of carers, run by carers, for carers. It represents the views and interests of the UK’s six million carers who provide support, unpaid, to family members, partners or friends because of frailty, chronic illness or disability.

1.2 Carers UK works with policy makers and practitioners to raise awareness of carers and to find solutions that prevent social exclusion and negative effects of caring. We also run an information and advice service which responds to around 20,000 enquiries from carers and professionals. Through our extended network, we are in touch with over 300,000 carers.

1.3 Carers UK also has offices in Wales, Scotland and Northern Ireland, each with their own advisory board of carers.
2. **Overall View of the New Draft Bill.**

2.1 Carers UK warmly welcomes the opportunity to submit evidence to the Committee. We have been involved at every major stage of consultation on the draft legislation, have submitted evidence at various stages and have discussed potential problems and solutions with the Department of Health, where appropriate.

2.2 Carers UK’s evidence has been largely confined to the pertinent issues affecting carers that have not been covered elsewhere in evidence submitted by the Mental Health Alliance. This is because we did not wish to duplicate evidence already submitted.

2.3 In relation to the last draft of the Mental Health Bill, we note that the Department of Health has taken on board a range of earlier points made by us, which is welcome. The slightly different drafting raises some new issues, too, which we touch upon.

3. **Are the Proposals Contained in the Draft Mental Health Bill Necessary, Workable, Efficient and Clear? Are There Any Important Omissions in the Bill?**

    **Definition of carers**

3.1 In relation to the last Bill, Carers UK made a number of suggestions which we believed would improve the workability of the Bill.

3.2 We raised the issue that the definition of a carer in the last Bill did not include those who might not be currently caring, but would be so in the future—and this might be problematic in the workability and interpretation of the Bill if it became law. The current definition is now consistent with that used in the Carers and Disabled Children Act 2000, as we suggested and, in our view, more workable.

3.3 The all-important definition of a carer in Clause 301(1) also has differences to the Carers and Disabled Children Act 2000. These clarify that a carer can also be someone who provided support before the person with mental illness was detained in hospital. This should thoroughly dispel any potential misunderstanding about who is, was or is about to become, a carer. In our view, this should improve the workability of the Bill and make it clearer.

3.4 There is an area of confusion, but this is raised by wording of the Explanatory Notes, and not by the Bill itself. The misleading paragraph appears under paragraph 56. This suggests that there is one exception to the carer being consulted and that is where, “consultation with the carer takes place before a patient’s nominated person is appointed in accordance with Chapter 1 of Part 8 of the Bill. In these circumstances, paid carers, ie those providing care by virtue of a contract of employment or as a volunteer for a voluntary organisation, are also consulted”. Carers UK would be concerned if the Bill used this “paid carer” definition as we would have argued that this would have introduced confusion between the definition of a carer.

3.5 However, the Bill itself is, in fact, far more open, well drafted and more workable under Clause 236(1)(b) than the definition used in the Explanatory Notes. Subsection (1)(a) suggests that the carer will be consulted first, or under subsection (1)(b) if the patient has no carer, such other person who knows the patient (if any) as the appointer considers it appropriate to consult. This definition is suitably broad to encompass a close friend, but who did not provide substantial care; an advocate, a volunteer, a paid member of staff, etc.

3.6 To avoid confusion about the Bill, Carers UK would suggest a slight amendment to the wording of paragraph 56 in the Explanatory Notes to better reflect the interpretation of the Bill.

3.7 Carers UK also views the Bill’s requirements of professionals, to consult carers, as very necessary. Each of these stages—assessment, treatment, discharge and care plan—is crucial for carers and the person for whom they care. At each stage carers will have vital information to contribute to helping professionals make decisions about appropriate care and treatment of carers.

3.8 We also consider it vital that carers are singled out for consultation rights, in case they are not the same as the nominated person. Otherwise, carers can be excluded from crucial stages of the consultation process and yet they are the ones who provide the care and support after the professionals go home. Not only does this make the Bill more workable, but we also consider it to be more compliant with the Human Rights Act.

3.9 Carers UK also welcomes the new drafting of the requirements to consult with carers under Clause 12 in Part 2. We raised our concern in the consultation on the last draft Bill, about the narrow scope of consultation with carers. The last draft Bill suggested that the carer should only be consulted about the patient’s wishes and feelings about treatment. Carers UK felt that this would miss a great deal of important contextual detail that might ensure better treatment for the person with mental illness.

3.10 Clause 12, Part 2 has been redrafted in a more workable way. First it suggests that consultation about the patient’s wishes and feelings about treatment is a minimum consultation. Second it ensures that the carer is consulted under subsection (6)(b) about what effect the medical treatment or matter is likely to have on both him and patient. This provision is warmly welcomed by Carers UK. It is a way for
professionals to collect all relevant information to ensure the best treatment possible for people with mental illness. It should also ensure that the professional takes account of the broad scope of the human rights of all concerned.

3.11 We would recommend, however, that the Code of Practice and other guidance accompanying the Bill, make it clear that an open approach to consultation needs to be taken. This could make the crucial difference to meaningful consultation with the carer. For example, if the treatment involves the carer supporting the person with mental illness at a particular time in the day, because they want and need that support it might affect their ability to work. This could leave the carer with a difficult choice—having to fall back on state benefits for income and supporting the person you care for and about, or to continue working, keep paying the bills but not support the person for whom they care. If the consultation with carers, as set out in the Bill, takes account of important issues like this, the treatment could be made at a time convenient to both patient and carer so that the family’s welfare is respected.

3.12 We also welcome the fact that the carer has to be notified if the conditions have not been met and the patient is about to be discharged. This was a vital part missing in the last draft Bill and we warmly welcome its inclusion. Discharge from hospital is probably the single most difficult time for all carers, when extra arrangements need to be made, there is often little time for any concerns to be raised, carer’s assessments to be done and the right sort of and amount of support given to the patient and family. For carers, this makes this part of the draft Bill workable. We also consider this to be compliant with the Human Rights Act 1998.

4. IS THE BALANCE STRUCK BETWEEN WHAT HAS BEEN INCLUDED ON THE FACE OF THE DRAFT BILL AND WHAT GOES INTO REGULATIONS AND THE CODE OF PRACTICE, RIGHT?

4.1 In discussing the last draft of the Bill, Carers UK was concerned about the way that some mental health professionals and other professionals wrongly exclude carers of people with mental illness from coming under the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000. Both define a carer, as this draft Bill does, as someone who is providing or about to provide regular and substantial care. Some practitioners have defined this in physical terms and have excluded any care that might be episodic—such as is often the case with mental illness.

4.2 In our response to the consultation on the draft Bill, we suggested that the definition would be more workable if the Bill clarified that “regular and substantial” could also include care of an episodic nature and which was not based on physical tasks. The Government has made the suggestion that there should be clear clarification of this in guidance. Since the introduction of Standard 6 of the National Service Framework for Mental Health has started to change attitudes, we consider that this would be the right balance. However, it will still be important to cross refer to this in the Code of Practice since prejudice still exists.

4.3 The Bill does not mention a carer’s own right to assessment or informing them of their right to an assessment. With the introduction of the Carers (Equal Opportunities) Act 2004 in April 2005, which directs local authorities to inform carers of their rights, we understand that this would be an unnecessary duplication of legislation. However, we believe that it is vital to cross refer the Code of Practice to this new piece of legislation and other legislation.

4.4 One major problem with mental health legislation is that it is often seen as being separate from other carers’ legislation and practice is not integrated. Other landmark legislation, namely the Community Care (Delayed Discharges etc) Act 2003, does not apply to discharge from a hospital where the patient has been detained under the Mental Health Act 1983. Yet the principles contained in the Community Care Act are vital for carers. They state that carers who have had an assessment in the last 12 months should be automatically reassessed. It also places a duty on local authorities to consider which services might be necessary, having carried out a carer’s assessment, to ensure that the patient is safe and ready for discharge. We would like to see where the Government sees the principles of the Community Care Act 2003 and the Carers (Equal Opportunities) Act 2004 fitting in with this legislation. However, we consider the Code of Practice to be the best vehicle for this.

Appointment of the Nominated Person

4.5 Carers UK welcomes the new provision under Clause 236 subsection (6), which ensures that the carer is consulted about the choice of the patient’s nominated person. In some respects we believe that this will make the Bill more workable and understandable. Our previous submissions raised the concern that the carer might have important views or information to contribute that might affect the appointment of the nominated person. We feel that this new drafting now addresses this point.

4.6 We consider it vital that there is strong direction in both regulations and guidance, as to who the “most suitable eligible person” might be. With so much stigma attached to people who care for a person with mental illness—as being part of the problem not the solution—there is the danger that carers will automatically be excluded as being “suitable” by the appointer of the nominated person. This will be of huge importance to carers who will fear exclusion, which is borne out of prejudice from a number of professionals.
4.7 Unfortunately, the way that this Bill has now been drafted, there is a decreased chance that the carer is the nominated person. This is because the last draft of the Bill included a default. If the person with mental illness was not able to appoint a nominated person, there would be a default mechanism to the carer and then to a list of individuals.

4.8 Our concern is that, if the carer is not the nominated person, there could be key instances when they are not given vital information. One example is not having copy of the care plan. If this matter is not resolved on the face of the Bill, which Carers UK believes it should, then it is vital that the Code of Practice refers to other guidance which suggests that it is good practice to ensure that copies of vital documents are shared with the carer.

5. **Is the Draft Mental Health Bill in Full Compliance with the Human Rights Act 1998?**

5.1 Carers UK cannot comment in relation to full compliance, however, there are a few areas we have considered in relation to the Human Rights Act 1998.

5.2 First, we consider the new definition of carers under Clause 301(1) to be fully compliant with the Human Rights Act. The Clause suggests that the carer has indicated that they wish to be considered for the purposes of this Act as the carer of the patient. In surveys undertaken by Carers UK, the majority of carers are often not given the choice about whether or not to become a carer or taking on the potentially vast responsibilities and stresses that often come with the role. Carers UK considers that this lack of choice has impacted, on occasions, on a carer’s right to family life. Not only does this drafting give carers a choice, but it also ensures that the professionals do not waste time with a person that they have inappropriately assumed is, or would be, the carer.

5.3 Another issue regarding carers’ human rights has been addressed in this second draft of this Bill. The first Bill placed a duty on carers to respond if they were consulted about the wishes and feelings of the patient in relation to treatment. Carers UK felt that placing this duty on carers would be inappropriate and detrimental to their rights. Carers can be blamed by the person they care for, for their admission to hospital for treatment. This can ruin relationships and trust for years. Secondly, if a carer gives information about someone and this is entered onto their personal file, that person with mental illness has a right to view any personal data held on them. This has, on occasions, caused problems for carers where sensitive details have been shared in what carers thought were confidential circumstances. The fact that the draft Bill has now removed this duty to give this information, the carer at least has choice about whether they wish to provide the information, which is welcome.

5.4 There is an issue raised in the Bill regarding the carer’s human rights which is not dealt with in the Bill. In responding to queries from carers through our information and advice service about the operation of existing mental health legislation, we are aware that the human rights of individuals—person with mental illness and carer—may be at odds with one another. Carers UK recognises that this can be difficult to balance at times. However, the Human Rights Act is also clear that, in pursuing the rights of one individual, it should not be to the detriment of another.

5.5 To give a fairly typical example from the enquiries that we receive, a patient was about to be discharged from hospital. He was an adult son, lived with both his parents and his younger siblings who were under 16. The mother was informed that he was about to be discharged from hospital and she asked for information about his care plan and treatment as she was concerned about the safety and welfare of the family as well as her ability to support her son in the way that he needed to be supported. Prior to his treatment, he had reacted badly to medication and had become violent and aggressive towards all members of the family. She was unwilling to let him come home until she had this important information. The practitioner said that the son had refused permission to share this information and she was told that refusing to have him home was illegal. Clearly all have rights—the son to privacy of information, the mother and carer, the right to a family life. Pursuing his rights could infringe the rights of the family and vice versa. We recognise that this difficult question is probably not possible to solve on the face of the Bill. It is also important to recognise that not all people with mental illness and carers are in conflict. However, we believe that there need to be clear and strong statements in the Code of Practice and guidance which explore the issue of the carer’s own human rights to ensure that the interests of one party do not impinge on those of another.

5.6 In particular, we would suggest that the Code of Practice actively pursues the sharing of information as a priority and directs professionals to seek consent in a positive way and when the person with mental illness is well.

*November 2004*
Memorandum from North Derbyshire Forum for Mental Health Carers (DMH 259)

1. INTRODUCTION

This submission is made on behalf of the North Derbyshire Forum for Mental Health Carers. The Forum is a properly constituted body that meets monthly. Between them, members have lengthy experience of caring for people with mental health problems; many either share or, in the past, have shared, their homes with a relative needing care but caring does not end with a move to a separate dwelling. These carers help and support someone with mental illness on a daily basis. They know what it is to care 24 hours a day, seven days a week for someone they know and love well. They have learned to work with professionals and cope with crises. They are well-informed about diagnoses, prognoses, systems, services and treatments and invite a succession of speakers from the statutory and voluntary services to keep them up-to-date. They may also participate in a self-help group. The Forum circulates a regular newsletter to 60+ carers of people with mental health problems. The Forum is fully recognised by the Derbyshire Mental Health Trust. Members represent carers' interests on NIMHE (East Midlands) and various Forums and management committees of the Trust.

2. SUMMARY OF CONCERNS

Whilst an updating of the 1983 Mental Health Act is generally to be welcomed, the current draft is a missed opportunity to enshrine the improvements in mental health care that have been developed, albeit slowly and painfully in recent years. Given that suicide rates amongst people with mental illnesses are above average, whilst homicide rates are significantly below, our position is that the balance in favour of providing appropriate support and care for people in distress is being heavily outweighed by the occasionally necessary requirement for detention and compulsory treatment. Our concerns are:

— the current Bill has no focus on entitlement, only on compulsion;
— the definition of “mental disorder” is too wide and ambiguous;
— the powers of the Mental Health Tribunal have been extended to the detriment of patients rights to appropriate treatment;
— there are no details about how the Care Programme Approach will be implemented;
— in leaving details to the Code of Practice, the Bill allows future developments to avoid any effective parliamentary scrutiny;
— there is nothing about integrating the Mental Health Bill with the Mental Capacity Bill;
— reducing aftercare to six weeks ignores the need for long-term appropriate services for patients with severe and enduring mental health problems; and
— treatment safeguards in the original draft have been dropped without consultation, thereby reneging on promises the government made to safeguard the interests of informal patients following the Bournewood case.

3. ENTITLEMENTS TO SERVICES

The Bill fails to address any question of entitlement to service provision. One in four people seek help for mental health problems at some time in their lives. Yet the Bill focuses only on compulsory treatment both in hospital and in the community. Whilst compulsory treatment is sometimes essential, it is inevitably a traumatic process known to exacerbate existing symptoms. It is generally agreed that, wherever and whenever possible, compliance with treatments, including hospitalisation is best achieved within relationships of trust, on a voluntary basis. The Bill ignores the current shortage of both hospital beds and community-based services for those seeking informal help for themselves. Unrealistically, it supposes that people in crisis who will not consent to treatment, may yet comply with the kind of conditions that may be imposed by a “clinical supervisor”, in order that compulsory assessment may be carried out in the community (26 (3)–(8)). Most re-hospitalisation occurs because of failure to take medication, yet the current system means people with mental illness have to remember to re-order medication from their GP before it runs out. There is no recognition of the importance of community-based services for ensuring medication compliance in trust relationships, only an unwarranted concentration on compulsory treatments.

Case study

James had been stable for more than 10 years. He lived in his own flat and coped well. He had attended, successfully, a number of training and work-experience courses. He failed to re-order his medication from the GP in time (it is difficult for people with mental illness to plan ahead) and his behaviour deteriorated until he was finally hospitalised compulsorily under the 1983 Mental Health Act. He has now been in hospital for more than six months, simply to ensure he takes his medication until he is stable enough to cope again. He resents his confinement and the boredom, and his relationship with his parents has deteriorated badly. Had his medication re-ordering been monitored, this would probably not have happened.
4. **Definition**

The definition of “mental disorder” is far too ambiguous and wide-ranging; indeed, the definition could well include anyone, not least someone with a learning impairment. The use of this definition in association with the Bill’s focus on compulsion, is likely to result in an unnecessary, costly and counter-productive extension of compulsory treatment. The provisions associated with this definition in the Bill will deter people from seeking help at an early stage and will work generally to the detriment of patients’ proper entitlement to appropriate informal care in either hospital or the community.

5. **Mental Health Review Tribunals**

The powers of the Mental Health Review Tribunal have been extended to such an extent that the detained patient’s rights have been reduced to an appeal to an anonymous body. This body will have no personal knowledge of the patient’s history and its concerns will be primarily the legality of the process, rather than the appropriate care and treatment of a known individual. The substitution of the “clinical supervisor”, for consultant psychiatrist, potentially lowers the threshold of expertise the patient has a right to expect. The scheme to provide, “Mental Health Advocates”, does little more than help to inform patients of how limited their rights are. The rights of the nearest relative effectively to oppose compulsory treatment, previously a safeguard against inappropriate detention, have also been withdrawn. Under the proposals in the Bill, distressed patients and their formal and informal carers would be faced with a bureaucratic nightmare, when they should be focusing on compliance with clinically appropriate support and care.

---

**Case study**

Bored and frustrated after seven months of informal hospitalisation, John refused his medication on the ward. A few weeks later, at the end of one day’s leave at home, he begged another day. His mother phoned the hospital and the leave was granted. However, on next day, when he still refused to return, it was decided to take him back under Section 2 of the 1983 Mental Health Act. After a further 28 days, languishing on the ward (without further treatment), staff wanted to use Section 3 of the 1993 Mental Health Act, in order to treat him compulsorily. At a meeting with his parents, staff could offer no ideas about what they planned to do. His parents decided to oppose the Section and take him home. He lived at home two months before deciding voluntarily to take his medication again.

---

6. **Care Programme Approach**

There are no details about how the Care Programme Approach (CPA) is intended to work, either for compulsory or informal patients. The good work currently developing with the use of the CPA in the community has been overlooked as a potential evidence-base for good practice. Indeed, the interests and entitlements and welfare of informal patients currently (but still only minimally) supported by the CPA, have been completely ignored. For example, homely, welcoming, crisis houses where sufferers can go, voluntarily, in a crisis are desperately needed, both to avoid the trauma of compulsory hospitalisation and to take the strain off elderly carers.

---

**Case study**

Paul has been diagnosed with schizophrenia for 20 years. For the last 11 years he has been stable in the community, living in his own flat only yards from his elderly parents. His improvement dates from the use of Clozapine, prescribed by a psychiatrist from another trust (recommended to his mother). Paul’s parents, although both in their 70s and with their own health problems (particularly his father), have continued to support him with daily living with no help from the statutory services. When he showed signs of relapse a few months ago and moved back with his parents, his mother contacted the local Community Mental Health Team. The newly minted “Crisis Team” arranged to talk to him in his own flat and completely ignored his parents. He moved back to his parents and continued to deteriorate. His mother managed to get an appointment with his psychiatrist who prescribed additional medication. Paul stayed with his parents for the next eight weeks, where his mother cared for him until he was well enough to return to independent living. Without his mother, he would have been back in hospital.

7. **Code of Practice**

In spite of its length, detailed practices under the Bill are left to a “Code of Practice”, to be drawn up by the “appropriate authority”. In effect, the Bill provides a legal framework that allows detailed provisions and costs (no doubt influenced by future Government Directives and Guidance), to come into effect under this unspecified “code”, without further parliamentary scrutiny.
8. Integration with Mental Capacity Bill

Questions need to be raised about how the Mental Health Bill will be integrated with the Mental Capacity Bill currently before Parliament. There is particular concern about the right to care and treatment on offer to people with learning impairments.

9. Aftercare

It is unclear how patients with severe and enduring problems will access appropriate community care in the longer term (which may be life), under the proposal to reduce the period of free aftercare to six weeks. Provision for care during the recovery period, including appropriate accommodation and support, as currently specified under Section 117 of the 1983 Mental Health Act, has been dropped.

10. Treatment Safeguard

The treatment safeguards included in the first draft of the Bill have been dropped without consultation, ignoring the safeguards the Government promised to bring in following the Bournewood case. Our concern here is particularly with patients who lack capacity to consent to treatment and we urge that further consultations are required.

11. Conclusions

As it stands, the Draft Mental Health Bill represents a retrograde step in the support and treatment of people seeking help for mental distress. There appears to be a low evidence-base for its provisions, some at least of which appear unworkable. The language suggests practices are analogous with practices for detaining dangerous criminals. The Bill perpetuates false stereotypes, stigmatising mental disorder rather than proposing entitlement to appropriate care for people in distress.

October 2004

Witnesses: Ms Imelda Redmond, Chief Executive, and Mr Mark Robertson, Public Affairs Manager, Carers UK; Dr Gwen Wallace, Chair, and Mrs Linda Lansdell, Committee Member, North Derbyshire Forum for Mental Health Carers, examined.

Q1004 Chairman: Can I welcome you to this session of the Committee. Could you note please that this is a public evidence session and a transcript will be produced and will be available on the internet after about one week and you will be free to make alterations of a textual nature, but not in substance. Perhaps you would like to introduce yourselves and then, if you will permit us, we will move straight into questions.

Ms Redmond: The definition in this draft Bill is much clearer and much more workable and relates back to previous legislation. Our only comment is that in the explanatory notes, paragraph 56, it still refers to "paid care workers" in the context of carers and suffers from schizophrenia for 23 years. I am a carer and a member of the North Derbyshire Forum for Mental Health Carers. It meets monthly and we have over 90 members. For many years I have also been a member of Making Space, a registered charity in the north of England, which helps people with a wide range of mental health problems, especially schizophrenia, and I have attended many conferences and groups.

Mrs Lansdell: My Lord Chairman, I am Linda Lansdell. I have two close members of my family who have suffered from a mental illness. One has suffered from schizophrenia for 23 years. I am a carer and a member of the North Derbyshire Forum for Mental Health Carers. It meets monthly and we have over 90 members. For many years I have also been a member of Making Space, a registered charity in the north of England, which helps people with a wide range of mental health problems, especially schizophrenia, and I have attended many conferences and groups.

Dr Wallace: We would agree with that. In terms of the second part of the question, when should information be withheld, we do know that there are times when service users and carers are at loggerheads because of the illness, so it is very difficult to ask a service user then whether you should ask a carer if they can be told what is happening. We would like, therefore, to have something as we have got in the Incapacity Bill where carers and service users can, and I think we are actually doing this in Derbyshire, in their care plans nominate the person they would want to be told when they were ill so that that is sorted during a period when they are not in a crisis.

Q1005 Chairman: Could I start by asking if you are satisfied that the definition of "carer" in the draft Bill is sufficiently clear and workable? Also we note that Carers UK has welcomed that carers have to be notified if the relevant conditions have not been met and if the patient is about to be discharged. What circumstances do you envisage in which that information might be withheld from a carer?

Ms Redmond: The definition in this draft Bill is much clearer and much more workable and relates back to previous legislation. Our only comment is that in the explanatory notes, paragraph 56, it still refers to “paid care workers” in the context of carers and from our point of view it is really important that those two categories of people are separated out in all explanatory notes, in codes of practice and in all guidance because that is part of the confusion that comes from professionals when they do not quite understand the role of carers.

Dr Wallace: We would agree with that. In terms of the second part of the question, when should information be withheld, we do know that there are times when service users and carers are at loggerheads because of the illness, so it is very difficult to ask a service user then whether you should ask a carer if they can be told what is happening. We would like, therefore, to have something as we have got in the Incapacity Bill where carers and service users can, and I think we are actually doing this in Derbyshire, in their care plans nominate the person they would want to be told when they were ill so that that is sorted during a period when they are not in a crisis.
Q1006 Chairman: So that they then change their minds because of their illness?  
Dr Wallace: That is right.

Q1007 Chairman: And how does one determine whether they have changed their minds because of their illness or because they just do not want that carer to be told?  
Dr Wallace: I think that is very difficult. I think you would have to have something fairly clear in the care plan and most of the things that professionals have to do when someone is mentally ill require quite fine judgment. Obviously there might be a fine judgment required at that point, but we would think that, if the service user has said in a time when they were feeling all right, if you like, on their care plan that should they fall ill, they would nominate this person in terms of the nominated person, that person should be seen, provided that the care plan is kept up to date, every six months or something. It is unlikely that something serious will have changed in that relationship that has not been provoked by the illness.

Q1008 Chairman: I think that the provision of support from a carer, a nominated person, an advocate and a lawyer runs the risk of overwhelming the patient and causing a muddle of advice.  
Ms Redmond: I think that part of it is about clarity of the roles. It makes perfect sense for somebody who is very willing to do a lot of the care for perhaps a son with a mental health problem to have them live with them and to help them with their daily living, but not wish to be the nominated person. They might want another member of the family to do that. I think the thing for professionals is to see that there is a team that includes both the service user, the carer, the nominated person and advocate. I do not think it has to be confusing; it is about calling on different expertise.

Q1009 Chairman: Do you think there is anything more the Bill could do to remove the stigma, if that is the right word, on carers, particularly unpaid carers, people like you, Mrs Lansdell, who have cared out of love and affection not as a profession for 20-odd years, or is there more the Bill could do to recognise more the role played by carers, particularly family carers?  
Mrs Lansdell: I do think that they are usually forgotten. I do not know how to remove the stigma. There is stigma with mental illness all the way through, is there not.

Q1010 Mr Prosser: Yesterday I was talking to a group of carers and care support people in Dover and east Kent and one of the points they raised quite strongly was that they did not feel that their role was recognised sufficiently in this Bill.  
Dr Wallace: That is true.

Q1011 Mr Prosser: They felt very strongly about that. In fact we had the Minister down to listen to them directly. Also specific to this section we are considering today, there was also a feeling that the carer who was also the close relation was the person who almost became “the enemy” of the patient or the user when that user went into crisis. This means, because of some of the measures in this new Bill, that they might then be excluded even at that stage. Is there any way that the Bill can be modified to protect that circumstance?  
Dr Wallace: Only by advance directive, I think. The other problem is that service users are also very, very frightened of anonymous people who come from outside. I care for someone who refuses to go to a tribunal even when there is a statutory one and insists that I do it instead, so as for the idea, and we have had this from other carers, that somehow you can bring in advocates or even crisis teams, we are having problems with crisis teams at the moment because they are covering a wide area, they do not know the situation and they are not known to the service user, so as well as all those problems with the carers, there are problems with everybody else as well. We cannot just say that, because they are hating the carer, they will leap into the arms of the advocate. It is a problem.

Q1012 Baroness Pitkeathley: I declare an interest, Lord Chairman, as the former Chief Executive of Carers UK, but I would like to ask the current Chief Executive of Carers UK about what was in their evidence about meaningful consultation with the carer. How do you define “meaningful consultation” and how can this Bill make sure that the carers get meaningful consultation?  
Ms Redmond: The current Bill, as it is drafted, leaves the situation about consulting carers in the hands of the service user. What we know is that when a service user is well, they might have a different opinion about their close relatives than when they are ill, so there are a number of ways I think we could have meaningful consultation with carers. One is that, if there is a carer involved, then you have to see them as partners in the delivery of that care. They are not an add-on, but they are absolutely part of the team. They have also to be seen as a person in their own right because even if the service user has said that they do not want the carer consulted, if actually then at point of discharge you are expecting the person to stop working to look after their son or daughter who has been discharged back into the house, then actually you have to see the balance of their own rights and their human rights as separate from the service user. In the Bill currently as it stands, if a service user says they do not want consultation with the carer, then is that it and that, to me, actually would seem that it denies the carer’s human rights. If the service user is very clear that they do not want their details and their treatment plan to be consulted on, there is also the issue about the impact it has on the carer, so just consult on that, but make sure that you do, so, for example, at the point of discharge, what sort of intervention would come into the house at a later stage, those sorts of things. I think the main thing is that, if the professionals do not understand the role that family members play in the support of service users, then they are actually missing a big
part of the jigsaw and they have to second-guess what somebody was like in leading up to their particular episode of ill-health.

Q1013 Baroness Pitkeathley: You talk about the human rights of the carer, but some would say that giving information to the carer against the wishes of the user would be a denial of the user’s rights, so how do we wrestle with that?
Ms Redmond: I think there are two things. I think advance statements are absolutely key to quality mental health services and when the person is not so ill, better discussions can take place that involve the carer. If the person is adamant that they do not want the carer involved, then what you do is separate out the issues that specifically will impact on that carer and consult with the carer on those issues. It is absolutely reasonable for somebody to say, “I cannot be there when this person is discharged next Thursday because I work full-time”. A carer I was talking to just last week went for a planning meeting at the hospital and the hospital said, “You can take your husband home now. He could do with a day at home”. She said, “No, I’m going back to work”, and they said, “But you are here now”. She said, “But I’ve only got half a day off work”, and they said, “Well, you can take him home”. She phoned in work and said, “Can I have the day off?”, and she got carer’s leave. Then they rang her and said, “Would you mind now keeping him?”, and she said, “I’m afraid I can’t. I really have to go to work, but he can come back in a taxi”, to which they said, “No, he can’t go out unescorted”. That was the first point she had been told that. In that situation, he was not saying, “Don’t tell my wife anything”. Had he have been, she still has an absolute right to her own consultation about, “Are you prepared at this point to give up some work or to stop working and to remain in the house in order to support this person?”
Q1014 Lord Mayhew of Twysden: And that persists today?
Mrs Lansdell: I think it does in some quarters.
Q1015 Lord Mayhew of Twysden: I have a point about the stigma attached to those who care for mentally ill people. I was horrified to read in the carers’ evidence at paragraph 4.6 that there is so much stigma attached to people who care for a person with a mental illness as being part of the problem and not the solution. Now, is this a sort of professional amour propre because I would have thought everybody connected with this system realised that it would be in the soup if it were not for the thousands and thousands of carers who take so much of the load?
Mrs Lansdell: One is used to the blame for the illness years ago. They used to think that they caused it and because there was a crisis and a person was ill and someone would go in, they would think the family was in turmoil, but it was not normally like that; it was because the person was ill. This stigma was partly to do with the fact that the parents and carers were blamed for causing the illness, I think.
Q1016 Lord Mayhew of Twysden: Can the Bill help or not?
Mrs Lansdell: I do not think so.
Dr Wallace: My guess is that it will make things worse, but there you are. We have a number of examples of this and I will give you just two. One is that we have a self-help group for carers which is not directly connected to our particular forum where north Derbyshire is quite rural and people will not meet in a carer’s group in their own village. They will meet in another village where they are not known, but not in their own village. That is one example. Another example is that we have a new independent hospital in the area and we are having quite a lot of trouble with a GP surgery, and I do not want to slander anyone at this point, but where they—
Q1018 Chairman: It is all right, you get parliamentary privilege here!
Dr Wallace:—where they do not particularly want the residents on their books. I could say what has been said, but that is a problem.
Q1019 Chairman: I should declare an interest here as someone who has had a severely mentally ill teenage daughter at one time. Do you think there is any
family that does not feel a sense of guilt when a member of that family becomes mentally ill and is that not part of the problem with the stigma?

Mrs Lansdell: I think it helps if you get educated and you know that the people are wrong and you just ignore it.

Chairman: You find that there are a lot of other people in the same boat, do you not?

Q1020 Baroness McIntosh of Hudnall: I wanted to pull out a little point, well, it is quite a big point, but it is buried in the Carers UK evidence, about the case history that you give us at 5.5 where you say that the carer who was not allowed to have the details of the care plan was told that it was illegal for her—I think it was her—not to take her adult son back into her home. Now, there are two points I wanted to raise. First of all, I would guess that that statement, if made, would be in fact untrue and, therefore, arising from that, is it common for carers to be, as it were, put under that kind of pressure when they are faced with a difficult situation of that kind that this carer clearly was facing?

Ms Redmond: Our experience is that it is fairly common, that the pressure on beds within hospitals is so great and that the urge to move people back home is so great that there is pressure put on families to deal with situations that they find impossible to cope with. Another one of our members was telling me about the fact that with two young children, her husband having a mental health problem and a marriage which is breaking down, she did not feel she could cope with it all, and the pressure on his hospital discharge was that he would come home because it was his home even though she felt that she could not cope with everything that was going on. I am afraid it is fairly common.

Q1021 Baroness McIntosh of Hudnall: Given that there is a difference between pressure and outright untruths, I think it would be fair to say, is there anything that you could recommend to us which it might be appropriate to put, say, into codes of practice or elsewhere which would help mental health professionals perhaps to understand that some kinds of pressure are not appropriate?

Ms Redmond: This is why I said right at the beginning that the definition of “carer” really matters. Getting that confused with care workers confuses professionals about what responsibility some people should take. Both within the legislation, but also within good practice guidance, talking about proper, thorough consultation with families, seeing them as partners in the delivery of care I think would make a big difference rather than not seeing them at all, but suddenly expecting them to implement the care.

Q1022 Dr Naysmith: Dr Wallace said that she thought that the Bill might make things worse for carers in terms of stigma for carers. What aspects would make it worse?

Dr Wallace: Well, I suppose my worry about the Bill is the way it is tied so closely with the criminal justice system, particularly with compulsory treatment orders where carers may find themselves under some obligation to work with a team, to make sure that somebody does not leave the house or takes their medication or does not go out to the pub or whatever kind of restrictions are imposed. The carer is going to feel (a) that they have to help maintain those orders, and (b) maybe they have to inform on the person they are caring for, so I just feel it is going to put carers into a very, very difficult position. I do think there is a big, rather heavy tie-up here with the criminal justice system, reminiscent of ASBOs and things like that which is entirely inappropriate.

Q1023 Mrs Browning: I understand why you make that point, but following on from that, if there are genuinely more resources to support the carer in that situation, do you think then that a community treatment order would be more acceptable to carers or is it purely the legal responsibility they would be taking on?

Mrs Lansdell: Compulsion in the home is disruptive and it can interfere with people’s lives, especially those with younger children and elderly people, and it is very tiring. People just think that if they are put in with a crisis team, the families can manage and they do not give it much thought, but that is a downside of teams because they just come for half an hour, but you are caring for that person for 24 hours, and what if someone wants to wander off? I do not think it is workable, compulsory treatment at home, only in a very few cases. I think it would be very difficult for the families and carers and for the service user and I think it might increase the stigma against the whole family.

Q1024 Ms Munn: I want to move on to the issue around blocking compulsory treatment. Obviously the draft Bill, as you are aware, removes the right of the nearest relative to block compulsory treatment or initiate the release of certain patients. Now, obviously we do not know whether the carer will be the nominated person and I know this is a complex issue, but perhaps, firstly, we could deal with the issue of the nominated person. Would it be your wish to see the nominated person have that right to challenge compulsory treatment?

Mrs Lansdell: Well, the many carers we have discussed it with say that they do not want to lose the safeguards we have at present under the 1983 Act for the following reasons: they know that it is a very serious step to take which can have a long and lasting effect upon the person’s life; it will cover a wider group of people because of the term “mental distress”; and it takes all the power away from both the patient and carer which could have detrimental effects on both people. It also should not be forgotten that carers have to care for someone 24 hours a day, so they should be consulted from the start.

Q1025 Ms Redmond: Can I ask Carers UK for your views?

Ms Redmond: Our view on it is that assuming that the safeguards are there, that is going to be an appropriate person and they are there, the
nominated person should have the right to challenge compulsory treatment. If the nominated person is not the carer, the carer should also be properly consulted and seen as part of that team.

Q1026 Chairman: Is it a right that has been used effectively by carers in the past? I think we have seen a number of examples where it has certainly been used.

Mrs Lansdell: I have got a good example of compulsion destroying the career of a young lady. She successfully completed two years at university, studying architecture, when she became ill and was eventually diagnosed with bipolar affective disorder. When she refused to take medication due to the awful side-effects she was experiencing, she was threatened with section 3 of the 1983 Mental Health Act. Her parents were helped and given useful advice by a social worker who advised that, if this went on, she would not be allowed to teach, work for the Civil Service or travel to certain countries and it would have other serious future effects. This was carefully explained to her along with the need for her to take the medication. She co-operated and is now a useful member of society, earning a living teaching, and has not since had another relapse. She would have been devastated if she had been physically forced to take the medication which was proposed, but the point of that is that under the new Bill, the access to a social worker or another person is denied for 28 days. The parents stepped in and would not agree to sign section 3 of the Act. Do you see what I mean? It can affect people very deeply and this person has not got much confidence because of all this. She realises that this could happen and she would not divulge that she felt like she did probably and go for help to professionals.

Q1027 Ms Munn: I certainly understand exactly the point you are making about the serious consequences of it. Is it your view that most nominated persons will be the carer? Do you think that is what is likely to happen?
Dr Wallace: My guess is they will.
Ms Redmond: I just do not know. I can think of plenty of families where the carer will be perhaps the elderly parent and they might well nominate a sibling to do the negotiating through the hospital system. I can think of a very good example of somebody who is living with their parents, but it might well be their partner who becomes the nominated person, but it might well be different.

Q1028 Ms Munn: We have a complicated situation where the nearest relative, the nominated person, the carer, could all be three different people. Given that, what would you like to see? Do you think the current position in terms of being able to block compulsory treatment is the right situation or would you like to see that updated given that the nominated person, carer and nearest relative could all be different people?
Mr Robertson: I think that is going back to why we think the definition of “carer” is so crucial to the Bill. If it is properly framed, we are identifying individuals who have quite a serious investment in that and to deny them any access to challenge because someone has chosen another nominated person is a difficult conflict which the Bill is not going to be able to address entirely, but you are leaving yourselves with an issue where you are identifying someone who has such an investment in this care plan, yet has no right of access to challenge the outcome.

Q1029 Ms Munn: So in a sense it is a nominated nearest relative?
Dr Wallace: Absolutely.

Q1030 Baroness Eccles of Moulton: I was just wondering, in all of your experiences, how often it is that there is somebody who is recurrently mentally ill and is cared for at home and where it is not actually possible to identify a carer who would fulfil the requirements that are obviously most desirable, and what happens then?
Dr Wallace: This is a very, very difficult area because carers have not been identified in the past and to some extent the work we are doing with the forums in Derbyshire is an attempt to identify carers. We do know service users clearly, but if a service user is asked, “Do you have a carer?”, they will usually say no. If they are asked, “Does somebody do your washing?”, they say, “Yes, my mum”, so it is a difficult area.
Ms Redmond: There will be plenty of people without carers. Not all people with severe mental health problems will have carers. What we are talking about is those that do. The ones who do not will be living independently or in supported housing and they might or might not have contact with their family still, but the ones that we are representing are the ones who do live, or have very close relationships, with their families.
Chairman: I think this may give us a natural connection with the question that Lady Cumberlege is going to raise.

Q1031 Baroness Cumberlege: I would like to move on now to the question of aftercare. In the evidence that was given by the North Derbyshire Forum, you are saying there that the Government has not replicated in this draft Bill section 117 of the Mental Health Act of 1983, the current one, and that provides free aftercare as long as a person needs it. It has been put to us, this Committee, that ending that position in terms of being able to block compulsory treatment. If the nominated person is leaving yourselves with an issue where you are identifying someone who has such an investment in this care plan, yet has no right of access to challenge the outcome.
argument where you are asking for something different for people who have a mental illness than for those who have a physical illness?

Dr Wallace: We are talking here about something that is little understood, that is chronic, that is not amenable to treatment, although symptoms may be reduced by medication, and total cures may be apparent for many years, but then you can get a recurrence, so we are actually talking about something which is very, very different from a hip replacement or a physical illness where somebody is better.

We are talking about a chronic illness. Admittedly, some physical illnesses are chronic and presumably they have rather different aftercare systems from a hip replacement, but we are representing a whole range of illnesses. We have talked a bit about schizophrenia and bipolar here, but we also have carers caring for people with Alzheimer’s where there is a steady decline where they will have someone home for a short while and then back in hospital, and they need permanent care. They need permanent care at home and the carer needs permanent help with the person they are caring for and they are often elderly spouses or partners, so the idea that you can walk off after six weeks is just appalling. We think that has to be a clinical decision made in consultation with the carers.

Mrs Lansdell: I do not know why it was made at all. Whether it was to save money, I do not know.

Q1032 Baroness Cumberlege: So you would clearly like that to be reinstated in the draft Bill?

Mrs Lansdell: They have got to be looked after, the people who are severely ill. They cannot manage without some help.

Chairman: I think it might be helpful, because of the viewpoint you present, if we were to spend the next quarter of an hour or so talking about community treatment orders.

Q1033 Dr Stoate: This is something which particularly concerns me because I am actually still doing some practice and, as a general practitioner, of course I come into contact with a large number of users of mental health services and people with chronic mental health problems, so I understand very much what you are saying about the problems. You have already touched earlier on your concerns about community treatment orders and I recognise those concerns. In your evidence, you cite the case of “James” who has been detained in hospital for more than six months under the Mental Health Act simply to ensure he takes his medication and until he is stable enough to cope again. Is that not an example of somebody where hospital compulsory treatment surely seems over the top?

Dr Wallace: Well, hospitals are not very suitable. We are not that keen on hospitals, I have to say, and we would much rather have halfway houses where people can go for, if you like, asylum, in the real sense of the word, and also retain some skills and some autonomy. We are not entirely happy with the hospital situation in that sense, but we are equally unhappy with community treatment orders partly because of the burden that places on the carer, and I could come back to that later, but mainly because there is a kind of underlying belief in this Bill that somehow you can identify who might not take their medication. Now, in this particular case with James, his parents were alerting the community mental health team for about six weeks before he was finally sectioned. They were visiting and they were asking him if he was taking his medication and he was assuring them that he was, but the parents were convinced he was not. Now, there was no way of checking because, and I do not know if you have a system, our GPs do not have a trigger to tell them when somebody is not reordering their medication.

Q1034 Dr Stoate: We do actually. Most modern GP systems actually have an order trail on prescriptions and it is actually quite easy to detect whether someone is not collecting their prescription. It is not the same thing as checking that they are taking their prescription, but at least you can tell if they are collecting them.

Dr Wallace: We do not have it in Derbyshire. We have been told that, although they can tell if someone is overdosing and has ordered too much, they cannot tell if they have not reordered their prescription, so we are trying to get a system in place whereby the community team can be alerted if the prescription has not been ordered and picked up because people with mental illness have a lot of problems, realising that they have got to order some more tablets three days before they run out.

Q1035 Dr Stoate: I understand your concerns, the difficulties and the practical problems, but you cannot have it both ways. We have heard earlier today that you are very concerned about the pressure on beds and yet we have got here a chap who is taking up a bed for six months. Now, I understand fully that there will be problems, but would it not be better to have a system where, if possible, if someone is on a mental health section and it was felt that they could manage in the community because for all the right reasons they were able to comply, they had the back-up, they had the support, everything was working, that surely should be an option? Now, if it breaks down and three or four weeks later the carer cannot cope, the person is not taking their medication, there are problems in the community, they can always be taken back into hospital again, but currently we do not have the option to say to somebody, “Thou shalt take your medication in the community or have hospital treatment”. What I am saying is: why can we not have a situation where, if someone is on a section, if they will take their medication in the community, great, leave them in the community, but if they cannot or will not or the situation does not work, take them into hospital. There needs to be that flexibility. Surely that must be available as an option.

Dr Wallace: The first thing in this case was that he was too ill by the time—
Q1036 **Dr Stoate**: I am not talking about an individual case.  
**Dr Wallace**: Okay, I can understand the general principle. Here we have section 17 at the moment, so if somebody is sectioned and allowed out, they could be allowed out on leave with this proviso that they took their medication, so we already have that option without a compulsory treatment order. The very tone of compulsory treatment orders and the scope that they can cover is very alarming to us. The idea that somebody can be forced to take medication in the community is reminiscent of, you know, depot injections in the kitchen kind of stuff.

Q1037 **Chairman**: Can we try and look at it from James' viewpoint now because that might be useful. James is in a hospital and he has been in the hospital for two months and he is, to use a word which I think you used earlier, bored and he is becoming deskillled. He is offered the option of going home on a section subject to compulsory treatment and during that time he can either get himself reskilled or possibly go back part-time or full-time to his proper job and so on and spend time with his family. What is James' attitude to that going to be, in your view, and what if James' attitude is, "Yes, of course I would rather go home and even if I am forced by the state to take my medicine, that is my option, that is my wish"?

**Mrs Lansdell**: They need to feel safe and secure. I asked my son actually now he is well whether he individual case. **Dr Wallace**: Okay, I can understand the general principles going into hospital and he said, "Well, it's the illness. I don't like being ill. I don't mind where or being in hospital". As people get old, it is very difficult and this Act would make life very difficult for a lot of carers who are quite elderly.

Q1039 **Chairman**: This is all based on the assumption of course that everybody who is made the subject of a community treatment order has been an inpatient at all. Are you effectively saying that somebody should have been ill enough to have needed hospital admission before they should be subject to any compulsory powers?

**Mrs Lansdell**: I thought they had to have been in hospital before they could have this.

Q1040 **Lord Turnberg**: The question really is: are there any circumstances in which this provision would be helpful?  
**Dr Wallace**: It is helpful in the sense, and I have experience of this, of being able, as under section 25 at the moment, to make somebody live in a particular place, and they can be brought back if they disappear, so I think that can work, particularly if the place they are told to live in is, say, a residential home or a supported flat or something like that. That exists at the moment under section 25 where you can specify where somebody lives in the community and you can get them back.

Q1041 **Lord Mayhew of Twysden**: I am impressed, I am sure we all are, by what you said about the they ... say is it did not work. I do not understand quite why you need compulsory treatment orders when you can use section 17.

Q1042 **Lord Mayhew of Twysden**: As I have understood you, you have been saying that you do not need the community treatment order because they can be released on leave.

**Dr Wallace**: Yes.

Q1043 **Lord Mayhew of Twysden**: But a carer under that option will, nonetheless, have the same.  
**Dr Wallace**: Yes, but they can be recalled from leave.

Q1044 **Lord Mayhew of Twysden**: But would I be right in thinking that the question of how they go will be put first to the carer?  
**Dr Wallace**: No. Leave is often granted without the carers even knowing. We have had people turn up on the doorstep and told that they had to say to their carers, “They’ve let me out on leave”.

**Dr Wallace**: It is if the person is not well enough. If they have been sectioned and given compulsory treatment initially presumably in hospital, they can then be let out on section 17 leave for a few days and go back and so on and so forth, which happened in this case, but the leave was ultimately cancelled because when this person was going out on leave, he was getting drunk, spending all his money and causing trouble at home because he was going home for meals and this kind of thing. The carer's responsibility is very important in this and his parents were actually begging the hospital to keep him in. Now, I understand the boredom and I understand this issue that they might be able to carry on with their lives in the community, but if they are ill enough to be under a compulsory treatment order, then I would say they are ill enough to be in hospital.
Q1045 Lord Mayhew of Twysden: I am sorry; I did not make myself clear. Imagine somebody is out on leave. Naturally, the clinicians will want to know how they are going.

Dr Wallace: Yes.

Q1046 Lord Mayhew of Twysden: It is an obvious question to ask. I should have thought, of the carer.

Dr Wallace: That is right.

Q1047 Lord Mayhew of Twysden: So under either system you have got that factor?

Dr Wallace: Yes. We are not against that, as such. It is the idea that you could impose a compulsory treatment order which almost gives carte blanche to a possible anonymous team or a team that seems to have fewer safeguards, given that the psychiatrist does not have to be involved, and we are a bit alarmed sometimes about the way the current crisis teams are working, so we are a bit concerned about how those compulsory treatment orders might be used and we do think they could cause a lot of problems. We can do what we need to do at the moment.

Q1048 Chairman: Ms Redmond, do you want to add anything?

Ms Redmond: I have to say that I think this is a terribly complicated area and there is not a simple answer. I have spoken to a number of different people about their opinions, a number of different carers about what they would like, and I think the most important thing that people say consistently is that, where possible, advance statements on this sort of issue will make all the difference because then if somebody has said, "If I get to this state, then I want you to make me do this because I will not be making sound judgments", then that feels very different. I have to say there have been some people who have said to me that at least if there was compulsory treatment, they would have the right to say, "Help!". I think that does come from quite an emotional position where people are watching their, particularly, sons or daughters deteriorate, not knowing how to step in, so although the idea of compulsion repels everybody, the idea of having an absolute backbone that helps and intervenes to save people’s lives is the other balance and getting that balance is critical. The word “compulsion” I think really frightens people, but the intention of keeping people safe I think would be supported.

Baroness Eccles of Moulton: I just wanted to pursue a point of clarification. Some time ago Dr Wallace was likening compulsory treatment orders to depot injections in the kitchen by force, just to stress it at its strongest. Is it not the case, Chairman, that compulsion would be used in order for the person to be readmitted, but the actual administering of medication would not take place in the home and the patient would have to be back in hospital? I just think it is quite important to understand the difference between compulsion and force, that the medication would not be applied by force in the home, but the patient would be compelled to return to hospital. Is that a correct definition?

Dr Naysmith: Or a clinic in the community, not necessarily a psychiatric hospital.

Chairman: We have had some evidence about the potential for clinics in the community to be the place where medication was given and clear opposition, I think, to it being done in the home.

Q1049 Baroness Eccles of Moulton: I think we perhaps need to have it clear that the medication would not be administered in the home.

Dr Wallace: You are either talking about depot injections, but you are also talking about the service user having to go to the clinic when they are in a pretty bad state themselves, or the alternative to that is to send a couple of police to go and take this person to the clinic to have the medication and maybe twice a day if they are on tablets, night and morning. There is plenty of medication that works well that is not available in depot injections and it would be unfortunate if people had to shift to depot injections simply because they were now under a compulsory treatment order.

Dr Naysmith: Just to clarify this, you said if they were in a terrible state, but it is not envisaged that everyone who would have to go to the clinic to receive their regular treatment would be in a terrible state when they did that. This is really important.

Chairman: I think it is a very good question, but I think we have a fairly broad picture of evidence on this now.

Q1050 Tim Loughton: You mentioned halfway houses as your preferred alternative to community treatment orders. Can you elaborate why and what form they would actually take, and let us work within the system as it is at the moment where there are not enough people to be looking after people who are in some form of community care. My experience has been that, if you put seven people with mental health problems together in independent living in flats, if they are not properly looked after, it can be pretty chaotic. How do you envisage that working and why do you think that is a better option? Is it because you are placing a step between the carer at home and the person being cared for one step removed or what? What is really the attraction of it?

Mrs Lansdell: I did not mean that kind of house anyway. They keep talking in our area of having smaller places nearer to where people live rather than going to the big general hospital where there would be staff to support people who are not quite as ill and do not need to be in hospital.

Q1051 Tim Loughton: So what is the difference between a big hospital and this?

Mrs Lansdell: I am not sure what the proper name is for these places, but it has been talked about for a long time. Instead of the crisis team just coming out for half an hour to see someone each day, they could be based maybe there, so they do have 24-hour crisis help.
Q1052 Chairman: Dr Wallace used the term “asylum” I think in its proper sense earlier. Is this a reflection of what you said, Dr Wallace?

Dr Wallace: Yes, we have talked about this. We have had examples and it is a pity I cannot recall them offhand because I had not thought of this one, but I think Denmark, and I may have got the wrong country, has this kind of facility where people can be looked after 24 hours a day. They have some autonomy and it is more like sheltered housing than a hospital where they perhaps have a bedsit and a small kitchen, that sort of thing, but there is somebody there, staff there, 24 hours a day while they are in crisis and until they are ready to go back to their own flats and look after themselves.

Q1053 Chairman: Lord Rix, who has a way with words, as you know, has just muttered “respite care” as a sort of description of this.

Dr Wallace: Yes, but respite care covers a huge range of things.

Q1054 Baroness Barker: All of the discussion we have had this morning pertains to situations where people have been receiving treatment. I would like to ask you, perhaps not now and you might like to write to us about it, about situations in which a carer knows that somebody is ill, but the person who is ill either refuses to present for treatment or goes to a number of different places in order to cover up the extent of their illness. Do you think that anything in this Bill would enable carers to assist people who are ill to get access to treatment in the first place or not?

Ms Redmond: My first thought on that, and I do not know whether it is in the Bill or in guidance, but you cannot force somebody to go and get treatment and that is right, but to be able to raise concerns with the right professionals in the right way at the right time and be heard, that is a culture shift. You can put it in legislation, but if people, and I do not know whether it is a very recent example, but if people are going to the GP and saying, “My husband is actually terribly depressed”, and then the GP just saying, “I can’t have this conversation”, but actually to have a different conversation with that person saying, “Well, have you tried this and have you tried that and have you talked to them in this way and have you suggested this” would be more helpful, but that is about culture and approach rather than legislation.

Q1055 Dr Stoate: I think you have been extremely clear with your evidence, but I have a very final point. Are there any circumstances at all where you can see the use of community treatment orders being of any benefit?

Mrs Lansdell: For a very small number of people maybe, but I think it needs stronger guidelines and they are not stringent enough, the way they are used.

Dr Wallace: You would have to put boundaries around what they meant and under what circumstances they would apply. As I said, possibly Denmark, and I may have got the wrong compulsion and the fear of compulsion is a disincentive in terms of this Bill. There may be other machinery.

Ms Redmond: My first thought on that, and I do not know whether it is in the Bill or in guidance, but you cannot force somebody to go and get treatment and that is right, but to be able to raise concerns with the right professionals in the right way at the right time and be heard, that is a culture shift. You can put it in legislation, but if people, and I do not know whether it is a very recent example, but if people are going to the GP and saying, “My husband is actually terribly depressed”, and then the GP just saying, “I can’t have this conversation”, but actually to have a different conversation with that person saying, “Well, have you tried this and have you tried that and have you talked to them in this way and have you suggested this” would be more helpful, but that is about culture and approach rather than legislation.

Chairman: I suppose part of the answer to Lady Barker’s question would be that this Bill is about compulsion and the fear of compulsion is a disincentive in terms of this Bill. There may be other machinery.

Mrs Lansdell: Can I just say that there is such a big shortage of psychiatrists that we do not know how the draft Bill will be worked because I believe that not many people are training for the profession, as you know.

Chairman: Can I thank you on behalf of the Committee for coming today. I can assure you that your evidence will be highly valued, as have your written representations been valued. Many thanks. Derbyshire is very lucky to have a group like yourselves, if I may say so!

Supplementary memorandum from North Derbyshire Forum for Mental Health Carers (DMH 442)

1. INTRODUCTION

This additional material arises out of the witness event with the Scrutiny Committee 2 February 2005 and should be read in conjunction with the original Submission and the transcripts of the event.

2. SUMMARY OF CONCERNS:

Our remaining concerns are:

— Q1005 the issue of meaningful consultation with carers;
— Q1007 service-user care and the National Service Framework;
— Q1008 the role played by informal carers when compulsion is at issue;
— Q1022 the worsening of the stigma under the current proposals;
— Q1031 the focus on imposed “Treatment” at the expense of planned “Care”;
— Q1045 Section 17 as against CTOs;
— Q1049 administration of compulsory medication;
— Q1054 getting treatment for someone who needs it but lacks insight;
— The five conditions for treatment.
— A possible alternative.

3. Meaningful Consultation

If consultation with carers is to be meaningful, then carers must have some powers to influence and, where appropriate, change decisions particularly about compulsory treatment.

4. Service-User Care and the NSF

The standards set for care and treatment in the National Service Framework provide clear and appropriate guidelines for providing carers with information about the service-user’s illness. In partnership with the Derbyshire NHS Mental Health Trust, we are working to implement all the standards in the NSF. It would be a disaster of some magnitude should the proposed Mental Health legislation work in any way whatsoever, to undermine the evidence-based standards of practice advocated in the NSF. If this Bill is passed it has been estimated that more than 130 extra psychiatrists and 770 other staff will be required to implement its provisions effectively. The greatly increased load on professionals will inevitably detract from the progress now being made in implementing the CPA and lead to yet more costly restructuring and further delays in service improvements.

5. The Role Played by Informal Carers when Compulsion is at Issue

The current system of allowing the “nearest relative” the power to oppose compulsory treatments should be retained as a safeguard. The “nearest relative” who either is or is likely to be in close contact with the carer who cares 24 hours a day, knows the service-user better than anyone and provides the kind of continuity of service-user care that is too often lacking from professionals. The “nearest relative” is not necessarily a fixed role but one that can be adopted by agreement between those who care. An alternative designation might be appropriate and we would draw to the committee’s attention the use of the role of “Appointee” by the Benefits’ system. With reference to the problems that might arise in the absence of a suitable “nearest relative”, we should like to make the point that, a number of organisations (eg Making Space, Rethink) offer training for carers. Such training may well help to solve a lot of potential problems. The lack of an evidence-base on which to make any judgement on this issue, as on others, is unfortunate.

We would also wish to retain the option of the service-user having the services of a solicitor to advise them. This is the present position and it is not currently a problem. Service-users may or may not take up this option as they wish. The services of the advocate should also be an option for the service-user, not a requirement.

6. The Worsening of Stigma under the Present Proposals

Whilst a small minority of people with mental illnesses may commit criminal acts, it is unnecessary and inappropriate to locate reform of the 1983 Mental Health Act in a Bill almost exclusively focused on compulsory treatments and Criminal Justice. There is a misconception of how dangerous people with mental health problems are, and service-users and carers have to cope with this misunderstanding in the media and the general public. The homicide rate for the mentally ill is lower than the average in the general population, and is dropping annually. The mentally ill are more likely to harm themselves than others. The police have little understanding or insight into mental illness and more could be done about this in their training. If the Bill goes forward in its present form, it will reinforce in media and public minds, the belief that people with mental illnesses are a public danger.

7. The Focus on Imposed Treatment at the Expense of Planned Care

We would urge the committee to reconsider the Bill in the light of the standards set in the NSF for the use and development of the Care Programme Approach. Any reform of or revisions to existing legislation should support and not undermine all the good work currently in progress.
8. SECTION 17 AS AGAINST CTOs

Having listened to the witness tape recording of the Assertive Outreach representatives, we note that, although in favour of CTOs, they see them as applying to a very tiny minority who consistently refuse medication. They also argue that they would want to administer tablets in the homes of these people and not escort them (or have them escorted) to clinics for depot injections. In hospital people are safe, their treatment and medication can be professionally monitored and any adverse reactions may be treated quickly. It is also vital that the psychiatrist receives feedback from the nursing staff so that any adjustments to medication can be made. Our view that the use of supervised leave from hospital under Section 17 is an infinitely preferable alternative to CTOs has been reinforced, rather than challenged by the case made by the AO representatives.

9. COMPULSORY MEDICATION IN THE COMMUNITY

We cannot envisage a situation where someone who is relatively well becomes the subject of a CTO, simply because they are not taking medication. A relatively well person hardly meets the five conditions required for compulsory treatment. Equally, we cannot envisage someone who is not taking medication because they are ill, going to a clinic on their own and/or voluntarily. These are mind-altering drugs that can have severe side effects. Without going into another case study, we know of a service-user who attempted suicide in order to avoid an appointment for a depot injection that was having serious side effects.

10. GETTING TREATMENT FOR SOMEONE WHO LACKS INSIGHT

CTOs can never be the answer to providing effective community care, although we acknowledge the difficulties experienced by carers when a service-user, for whatever reason, is not accessing appropriate medication. One way the Bill might help might be by enhancing the rights of the carer/"nearest relative" to call on a GP or other health professional for help for someone, for professional intervention, without the consent of that person, before that person becomes a danger to themselves or others. This would still leave the issues around treatment as matters for persuasion rather than compulsion, but opening up options for intervention currently not available would be an advance on the current system. Even more pertinently, there is already a great shortage of psychiatrists throughout the UK. In one area in Derbyshire we have had long spells without a permanent psychiatrist and the local general hospital is short of three psychiatrists. One psychiatrist has told us he is doing the work of five, and there is an eight to twelve week waiting time for consultations. A service-user, after a recent relapse, was told he would have to wait two months between consultations. The problem is not about imposing CTOs on the non-compliant, but about having the appropriate resources to intervene with care and persuasion in a relationship of trust, as and when necessary.

11. THE FIVE CONDITIONS

We wish to draw the Committee’s attention to the subjective judgements involved in determining all five of the conditions used to define mental disorder. We doubt whether any two psychiatrists (let alone anyone else) would agree on a set of objective criteria for determining each of the conditions. Yet the entire bill is predicated on the idea that these conditions constitute a diagnosis.

12. AN ALTERNATIVE?

We are not alone in our negative responses to the provisions of this draft bill. Given that the current 1983 Mental Health Act is superior in many ways to the new draft, we would support the view that making some essential amendments to the current Act could be a way forward. This would allow a breathing space for a new Bill to be drafted on an evidence-base with particular reference to the NSF and the CPA.

February 2005

Memorandum from Action for Advocacy (DMH 46)

1. INTRODUCTION

Action for Advocacy (A4A) is the central point of information on advocacy for advocacy providers, the wider voluntary and community sectors and members of the public needing advocacy support. We have built a reputation as one of the UK’s leading authorities on the development of effective advocacy services for vulnerable and disempowered people and aim to “advocate for advocacy” at a strategic level as well as provide the advocacy sector with essential support and information services.
We co-chair “The Advocacy Alliance”, a coalition between national charities and the advocacy and user involvement sectors, campaigning for improved access to advocacy and provide administrative support to AMHA, the new Association for Mental Health Advocates which aims to provide a national voice for mental health advocates.

We welcome the opportunity to respond to Government’s proposals to introduce independent advocacy for people subject to compulsory treatment under the new Mental Health Act. We estimate there are around 1,000 advocacy organisations across the country interested in and potentially affected by these proposals.

1.2 Summary

Action for Advocacy welcomes the Government’s proposal to introduce independent advocacy for people subject to compulsory treatment. However, we believe the new mental health legislation should recognise and promote the importance of independent advocacy for all people who use mental health services.

In this regard we would draw the Committee’s attention to the Mental Health (Care and Treatment) (Scotland) Act 2003 which puts a duty on authorities to ensure that independent advocacy is available to all people with a “mental disorder” and that they have an opportunity to use it.

We believe independent advocacy is a vital service to safeguard the rights of people subject to the new legislation. Advocacy features in a number of legislative proposals, such as the Mental Capacity Bill, and we would like to see more joined up thinking in relation to the legislative development and provision of advocacy services across the board. We believe a statutory requirement should be introduced and placed on local and health authorities to produce local advocacy plans which will outline a plan for the development and funding of advocacy services to meet the needs of all mental health service users and other groups of people that can benefit from advocacy.

We would also like to see an increase in funding for advocacy and the allocation of the responsibility of advocacy to a single Government department or body. Their role would be to develop a strategic approach to the provision of advocacy and promote and monitor the implementation of local advocacy plans and regulate the quality of services.

2. Responses to Government Proposals

2.1 Functions

We urge the Government to reconsider both the point at which patients should be entitled to access advocacy services and the range of people with this entitlement. A4A believes that by limiting access to advocacy for people who are subject to compulsory treatment, ignores the potential benefits of advocacy for all people encountering mental health problems. Advocates can help by limiting the escalation of financial, housing, personal, and medication problems. Advocacy enhances communications between patients and professionals and can reduce distress experienced by those encountering mental health problems. Early ongoing support from advocates may reduce the use of clinical services and the need for hospital admission and involvement with other services.

We believe, in any meeting or negotiation with clinical or social care staff, a patient should have the right to be supported/represented by an independent mental health advocate of his or her choice.

2.2 Access to records

In general we support the Governments desire to accelerate access to mental health records, as scrutiny by the individual of their records can help to ensure that appropriate and effective treatments are put into place.

However, we believe this would be better achieved by fast-tracking the right of access to records for patients themselves, with the assistance of advocates as appropriate. Where a person lacks capacity, the nominated person should be given the right of access.

2.3 Point of access/qualifying patients

The Bill proposes that patients should only become entitled to information about their right to access advocacy services after the initial examination has taken place and only once a formal decision is made that a patient is liable for an assessment under part 2. A4A believes that the Bill should instead provide the right to access specialist mental health advocacy at a reasonable point within the 120 hour limit of the examination process.
2.4 **Nominated person**

The provision of advocacy to both patients and their nominated persons may cause conflicts of interest. This section should be redrafted to minimise such conflicts occurring, and ensuring the advocates role is not compromised.

The proposed number of advocates will not allow for separate advocates for both parties.

2.5 **Right to meet**

We support the proposal to enshrine the right of patients to meet with their authorised advocate. However we are concerned that the right to meet in private, proposed in the 2002 Bill, has been removed.

2.6 **Regulation**

We support the model of advocacy proposed by Durham University that IMHA Advocacy should be embedded in existing community Advocacy Services and should be run according to professional voluntary sector standards.

A code of practice and training standards for IMHA Advocacy should be developed in consultation with people who use mental health services and advocacy schemes.

2.7 **Independence**

A4A supports the Government’s commitment to the independence of advocacy from services responsible for care and treatment. In addition A4A believes that advocacy has a key role to play as an agent for change and supporting continuous improvement in mental health services generally.

Independence is key because it is vital that the ability of advocacy organisations and advocates to carry out their roles is not compromised in any way.

Ideally, independent advocacy should be provided by an organisation whose sole role is advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy. This would be in line with our own “Advocacy Charter” (Action for Advocacy 2002) which has been adopted by over 300 advocacy organisations in the UK.

The Bill should reflect the need for IMHA Advocacy to be independent and the Government should ensure that Advocacy Services are supported to work towards independence.

2.8 **Costs**

It is unclear on what basis the government’s figure of £5,000,000 has been arrived at. We believe that this figure is likely to be a substantial underestimate.

This needs to be looked at in relation to the funds (believed to be 6.5 million) made available to implement the “independent consultee” proposals in the Capacity Bill. We suggest that the committee obtain information from the DOH on how these figures were arrived at.

2.9 **Workforce implications**

Given that there are some 50,000 uses of the Mental Health Act each year the figure of 140 advocates with a duty to provide information and representation appears somewhat conservative.

We urge the Department to release information on how this figure was arrived at.

2.10 **Criminal Justice System**

A4A believes that the Bill should provide people with the right of access to specialist mental health advocacy when the affected person arrives at the place of safety specified in this clause, whether it is a psychiatric hospital or police station.

2.11 **Access to advocacy under S.116 Mental Health Orders**

The provisions of the Act as currently written do not give opportunity for patient/advocacy input into the creation of any care plan, necessitated by a mental health order.

The Government proposes that the making of a mental health order by the court is conditional upon the preparation and submission of a “care plan” by an approved clinician—clause 115(1). However as clause 248(f) states that a patient will only become a “qualifying patient” for the purposes of clause 247, when a mental health order is “in force”, anyone for whom a mental health order is proposed will not have access to advocacy.
Elsewhere in the Act, clause 31(a), it is stated that in preparing a care plan for the patient, the clinical supervisor must consult the patient about the medical treatment to be specified in the plan unless it is inappropriate or impracticable.

While schedule 5 states that provisions of part 2 do not apply to part 3 unless specified in part 3, the proposal to consult people being subject to treatment under statutory powers appears to create a “spirit” for the act in keeping with provisions of the Care Programme Approach.

It is recommended that section 248 be extended to those people for whom a “care plan” under section 115 (1) is being drawn up, therefore before a mental health order is made.

2.12 Capacity and link with Capacity Bill

The role of an advocate is to empower people to make decisions for themselves which they are capable of making with support. Where a person lacks capacity, the role would be to help the person to participate in the decision making process, to help them to speak up for themselves and to make sure that their views are heard. A basic principle of advocacy is that the advocate does not make any judgements, or express any opinions, of their own. They may help to ensure that the person is aware of relevant issues they may not have considered. They may speak on behalf of the person to ensure their views are heard and taken account of, but will not make any decisions or judgements on the person’s behalf.

It should be remembered that because people’s capacity may change over time an advocate’s role in working with that person will also change accordingly.

In order to make the right of access to independent advocacy meaningful, advocates should be able to:

- Attend, where practicable, any consultation, interview or meeting about the person’s treatment or support;
- Have access to the person at any reasonable time;
- Correspond or communicate in any other way with the person on any matter relating to their role as an advocate; and
- Receive such information as would assist them to perform their role.

Where a person lacks capacity and cannot consent to information being shared on their behalf, health and social care staff should make available to the advocate such information as is necessary for them to operate effectively. As a minimum, it would be expected that advocates are informed when:

- A person is admitted to hospital;
- There is a review of care or treatment;
- Any form of compulsion is considered;
- Special treatments are considered; and
- Plans for discharge or transfer are being made.

Giving this information to advocates is permissible under the Data Protection Act 1998, which contains a specific exemption from restrictions on disclosure where the reason for disclosure is to protect a person’s vital interests.

A4A believes that the proposals to develop “Independent Consultees” under the Capacity Bill should be abandoned and replaced with Independent Advocates directly linked with IMHA Advocates.

2.13 Advance directives

Clearly, advance directives may be useful for people to indicate whether they would wish to have an advocate or not. This would enable professionals to make a referral, if appropriate, where the person lacks capacity to request or consent to an advocate at a later date. Advocates may assist people to write and maintain an advance directive. However, it would not be appropriate for an advocate to be witness to an advance statement as this would involve making judgements about the capacity of the person making the statement.

People should have the right to advocacy support when developing and implementing advance directives.

2.14 Correspondence

A4A agrees that IMHA Advocates should be included in the list of official communicants in Schedule 11 as this will safeguard the patients right to correspond with his or her representative without interference by hospital or other authorities.
2.15 **Tribunals**

An independent advocate may assist a person to make an application to the mental health tribunal under the Act but may not make an application on their behalf. If the person is not able or does not want to attend the tribunal in person, then their advocate may present their views on their behalf, in line with normal advocacy functions. However the role of an independent advocate at tribunal must not replace legal representation. An advocate may support a person in communicating with their legal representative.

An independent advocate should not be asked to give evidence (other than that which they are assisting the person to communicate to the tribunal) in order to respect the confidential conversations a person would expect to have with their advocate. An advocate’s role in supporting a person is incompatible with the role of a witness.

2.16 **Contact A4A**

Action for Advocacy has many examples of good practice in the provision and development of advocacy across the country and is working with hundreds of organisations to ensure effective advocacy is available to people who need it. We would be pleased to work more closely with the government to clarify the role advocacy services have to play in relation to users of mental health services.

*October 2004*

**Memorandum from Association for Mental Health Advocates (DMH 267)**

1. **Introduction**

AMHA is the new Association for Mental Health Advocates. AMHA’s vision is for a world where the voices of people who use mental health services are heard loud and clear by mental health and other services. AMHA’s mission is to empower mental health advocates to work effectively with people who use mental health services to get their voices heard in the way they wish to be heard. AMHA aims to promote diversity and quality in mental health advocacy and to provide a national voice for mental health advocates. AMHA was formed in February 2004 and currently has 150 members from England, Wales and Northern Ireland. Fifty per cent of AMHA members have direct experience of using mental health services.

AMHA estimates that there are in the region of 2,000 people working as Mental Health Advocates in the UK. AMHA’s members will be responsible for delivering IMHAA and AMHA is expecting to play a central role in the implementation process. AMHA members were consulted on this submission and came together to debate the proposals at a national seminar in October.

1.2 **Summary**

AMHA supports the principles behind the Government’s proposal to introduce independent advocacy for people subject to compulsory treatment. However, the provisions fall short of providing the individual with a legally enforceable right to an advocate. AMHA considers an enforceable right is essential because access to advocacy at all stages has a crucial role to play in safeguarding the rights of people subject to the new regime.

In relation to the use of compulsory powers AMHA believes that an individual right to independent advocacy is vital for people who are:

- liable to compulsory treatment;
- at the point of “examination” for assessment;
- assessment;
- during periods of compulsory treatment; and
- under aftercare arrangements.

However, AMHA believes that a right to advocacy should be introduced for people who use mental health services across the board. In this regard we would draw the Committee’s attention to the Mental Health (Care and Treatment) (Scotland) Act 2003 which puts a duty on authorities to ensure that independent advocacy is available to all people with a “mental disorder” and that they have an opportunity to use it. Whilst this does not meet the standard for an individually enforceable right, it is, in our opinion, preferable to the proposals presently under consideration for England and Wales.
2. RESPONSES TO GOVERNMENT PROPOSALS

2.1 Functions

AMHA believes that advocacy is effective in terms of reducing distress and in reducing the use of clinical services. Our experience shows that early and on-going support from advocates reduces the need for admission to hospital and involvement with other agencies such as the courts and homelessness services.

Advocates can help by limiting the escalation of financial, housing, personal, and medication problems. Advocacy also enhances communications between patients and medical and social care practitioners. This is why we strongly urge the government to reconsider both the point at which patients should be entitled to access advocacy services (2.3 below) and the range of people with this entitlement. We agree that “The advocate can play an important role in using their expertise to communicate with professionals on behalf of the patient and helping the patient to exercise their rights.” And that advocates will “support patients in understanding their rights under the Bill and exercising those rights, which will include challenging treatment under formal powers where the patient believes that they have wrongly been brought under compulsion.”

We support the outline of the functions of AMHA Advocates outlined in clause 247(3)(a)(i-v). We would stress that the key to the role of the IMHA Advocate is contained in the phrases “help in obtaining information about and understanding” (247(3)(a)) and “Help (by way of representation or otherwise) in exercising those rights” (247(3)(b)).

We support the central role of providing assistance to qualifying patients in obtaining information but this function needs to be fully described in accompanying guidance— it is vital that the relevant authorities duty to provide information is not avoided through a mistaken emphasis on these provisions. It is also vital that IMHA Advocacy support is not defined solely as representative as the key principle of advocacy is that it promotes self advocacy ie it provides support to the qualifying patient to get their voice heard, in the way that they wish to be heard.

The specific functions of IMHA Advocates should be decided as part of the DH’s proposed stakeholder group and detailed guidance developed in the code of practice.

2.2 Access to records

In general we support the Governments desire to accelerate access to mental health records (clause 247(4)(b) and 247(5)) as scrutiny by the individual of their records can help to ensure that appropriate and effective treatments are put into place.

However, we believe that this would be better achieved by fast-tracking the right of access to records for patients themselves, with the assistance of advocates if they so wish. This access should include social work and nursing records as well as clinical notes.

Giving direct access to advocates, even having “regard for the wishes and feelings of the patient” is open to abuse and works against the principle of self-advocacy and autonomy.

Where a person lacks the capacity to decide whether or not they wish themselves or their authorised advocate to have access to their records the nominated person should be given the right of access. However, it may be appropriate, in some circumstances, for there to be a duty on the hospital authorities to ensure that key information is communicated to the advocate, for instance in situations listed in 2.4 and 2.12 below.

We recommend that the proposal to provide IMHA Advocates with access to records without the patient’s informed consent should be scrapped and, for people whose decision-making in this regard is impaired, that the Nominated Person be given this right.

2.3 Point of access/qualifying patients

The Bill proposes that patients should only become entitled to information about their right to access advocacy services after the initial examination has taken place and only once a formal decision that a patient is liable for an assessment under part 2. The examination process can take place in a variety of different settings: a place of safety ie a hospital or police station, or at the patient’s residence. The examination can take place over a period of 120 hours. We have considered the response expressed in the Guidance document. Whilst the response acknowledges that the information about advocacy services not being made available during the examination stage was the main criticism of the advocacy sections of the first draft, it does not then address the problem. It may be that there has been some confusion about the precise nature of the criticism so we are here attempting to clarify exactly what we want to see in the new legislation. For the avoidance of doubt, we are not suggesting that the IMHAAs should arrive alongside the professionals who will carry out the examination. We fully understand and support those who say that for advocates to be involved in the process in this manner would confuse their role with the “detaining process” itself. We are not asking for this.
We are asking for people undergoing the examination process to be given the information, and the opportunity to contact a mental health advocate if they choose to. We understand in extreme emergencies it may not be possible to impart this information in a meaningful way and that occasionally some patients may not be well enough to make use of the information and/or take the opportunity to contact the advocacy service. However, this is also true of some patients when a decision has been taken to undertake the assessment stage. Notwithstanding the condition of the patient, AMHPs are still under a duty to explain the help available from IMHAAAs at this point.

Without information about IMHAA being given during the examination the patient will be completely isolated in the hands of the examiners. At this time the nominated person will not have been appointed. Hence for five days a patient can be detained, examined and compulsorily administered treatment if the professionals consider it urgent to do so, with no safeguard in place. No right to access advocacy services and no involvement by the nominated person.

The initial care plan must be drawn up over the first five days of detention for assessment. This will allow treatment to be administered without the patient’s consent. Delaying giving information about advocacy will inevitably delay meaningful input into this critically important document if the examination results in admission for assessment.

We cannot see how information about IMHAA being given at the earliest reasonable opportunity will confuse the detaining/compulsory role, or in any way impede the examination. Providing the opportunity to make contact with advocacy services at this stage will safeguard the patient’s rights, assist communication with clinical and care staff at the earliest opportunity, give advocacy services time to ensure patients are seen by advocates sooner rather than later, and may reassure patients at a most distressing time for them. It will also mean advocates can assist in ascertaining who the patient most wants to act as nominated person, and in put into the initial care plan from the outset.

AMHA believes that the Bill should provide the right to access specialist mental health advocacy at a reasonable point within the 120 hour limit of the examination process. In any meeting or negotiation with clinical or social care staff, a patient should have the right to be supported and (at the patient’s request) represented by an independent mental health advocate of his or her choice, in the following circumstances:

— when s/he is receiving in-patient treatment for mental disorder, and
— when s/he is receiving care and treatment in the community, whether informally or subject to a care and treatment order or a supervision order.

2.4 Information about advocacy

Other times when people should be informed about advocacy include:

— on admission to hospital;
— whenever special treatments are considered (including electro convulsive therapy (ECT), psychosurgery and the implantation of hormones to reduce sex drive);
— on review of care or treatment;
— at discharge or transfer from hospital or release from compulsion;
— any other significant decision is being made;
— when a person is in seclusion; and
— when the patient has strong objections to a proposed course of action.

Information about independent advocacy organisations must be communicated to people in a way which they can understand and that takes account of any special communication needs they have. This will mean having in mind the needs of people with a visual or auditory impairment, and/or people for whom English is not a first language. In addition, all communication should be written in clear and easily understood language. While it is essential to leave the person with a permanent record of advocacy information, just handing over a leaflet will not be sufficient. Information about advocacy should be displayed in public areas and on wards as well as in a wide range of accessible formats.

2.5 Nominated person

The provision of advocacy to both patients and their nominated persons may cause conflicts of interest. The proposed number of advocates will not allow for separate advocates for each. Conflicts may arise where the patient is broadly happy for the nominated person to pursue their role, but where there is a key point of disagreement the advocate is supposed to continue unless advised by the appointer. The proposals don’t reflect the primacy of the wishes/needs of the qualifying patient. Ultimately, the point of IMHAA is to act as a patient safeguard. It is not primarily intended to provide support to other safeguarding roles. This should be more accurately reflected in the legislation so that in the event of conflict between the patient and the nominated person, the patient is not left feeling coerced into putting up with a nominated person they
are unhappy with for fear of losing their advocacy support. Unless the patient is clear that in the event of conflict it is the patient’s entitlement to advocacy which will remain intact, the safeguarding effect of both nominated persons and IMHAAs will be reduced.

2.6 Right to meet

We support the proposal to enshrine the right of patients to meet with their authorised advocate. However, we are concerned that the right to meet in private, proposed in the 2002 Bill, has been removed. We would draw the committee’s attention to the clauses of the new Bill dealing with the rights of Healthcare Commissioners, in particular Clause 270(3)(a) which enshrines a right to visit, interview or examine in private and and 270(3)(b) which requires that commissioners be afforded “such facilities and assistance ... as are necessary to enable him to exercise his powers”.

We recommend that the right to meet in private is reinstated.

2.7 Regulation

We support the Governments proposals to arrange for the regulation of IMHA Advocates as clearly anyone undertaking statutory duties must be properly trained and accredited.

There should be a new agency tasked with overseeing quality measures, ensuring effective scrutiny and overseeing standards setting in mental health advocacy and this should be independent but governed by statute and accountable to government. This is already happening in Scotland in the form of the Advocacy Safeguards Agency. Any such new agency must ensure that people who use services and advocacy workers themselves are involved in developing standards. It is especially important that people with experience of using mental health services are included as a central part of the new organisation.

AMHA supports the model of advocacy service proposed by Durham University that IMHA Advocacy should be embedded in existing Mental Health Advocacy Services and should be run according to professional voluntary sector standards.

We do not believe that responsibility for the giving of advice to the appropriate authority on standards for the appointment, training and monitoring of advocates should be given to the Healthcare Commission.

A code of practice and training standards for IMHA Advocacy should be developed in consultation with people who use mental health services and advocacy workers.

We propose the formation of a dedicated Advocacy Standards Agency.

2.8 Independence

AMHA supports the government’s commitment to the independence of advocacy from services responsible for care and treatment. In addition AMHA believes that independent advocacy has a key role to play as an agent for change and in supporting continuous improvement in mental health services generally. Many advocacy organisations are already independent but some are not.

Independence is key because it is vital that the ability of advocacy organisations and advocates to carry out their roles is not compromised in any way. For example, if an advocate was also a care provider and someone wanted to raise issues about their care, it is clear that the advocate’s ability to support that person would be severely compromised. Independence is concerned with the minimisation and management of real or potential conflicts of interest.

Ideally, independent advocacy should be provided by an organisation whose sole role is advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy.

The bill should reflect more strongly the need for IMHA Advocacy to be independent and the Government should ensure that advocacy services are supported to work towards independence.

2.9 Costs

It is unclear on what basis the government’s figure of £5,000,000 has been arrived at. This needs to be looked at in relation to the funds (believed to be £6.5 million) made available to implement the “independent consultee” proposals in the Capacity Bill. Using the government’s projection of 140 for the number of Whole Time Equivalent (WTE) Advocates needed produces a sum of £35,174 per WTE advocate per annum.

We believe that this figure is likely to be a substantial underestimate.
2.10 Workforce implications

Given that there are some 50,000 uses of the Mental Health Act each year the figure of 140 advocates with a duty to provide information and representation appears somewhat conservative.

We urge the Department of Health to release information on how this figure was arrived at and to ensure that further detailed work on this is undertaken in partnership with advocacy providers and other stakeholders.

2.11 Criminal Justice System

Under the Bill the police will continue to have the power, currently provided under section 136 of the 1983 Act, to remove a person from a public place who appears to be suffering from a mental disorder and in need of immediate care and control, to a place of safety for assessment. The power will as now last for up to 72 hours. A person can also be removed to a place of safety where a magistrate has issued a warrant under Clause 400 authorising entry to premises, if need be by force. The place of safety can be a hospital or police station.

AMHA believe that the Bill should provide the right of access to specialist mental health advocacy when the person arrives at the place of safety, whether it is a psychiatric hospital or police station.

2.11.1 Access to advocacy under section 116 Mental Health Orders

The provisions of the act as currently written do not give any opportunity for patient/advocacy input into the creation of the care plan necessitated by a mental health order.

The government proposes that the making of a mental health order by the court is conditional upon the preparation and submission to the court of a “care plan” by an approved clinician—clause 115(1). However, as clause 248(f) states that a patient will only become a “qualifying patient” for the purposes of clause 247, when a mental health order is “in force”, anyone for whom a mental health order is proposed will not have access to advocacy.

Elsewhere in the act, clause 31(a), it is stated that in preparing a care plan for the patient, the clinical supervisor must consult the patient about the medical treatment to be specified in the plan unless it is inappropriate or impracticable.

While schedule 5 states that provisions of part 2 do not apply to part 3 unless specified in part 3, the proposal to consult people subject to treatment under statutory powers appears to create a “spirit” for the act in keeping with provisions of the Care Programme Approach.

It is recommended that 248 be extended to those people for whom a “care plan” under 115(1) is being drawn up, therefore giving access to an advocate to assist in the preparation of the care plan.

2.12 Capacity and link with Capacity Bill

The role of an advocate is to empower people to make decisions for themselves that they are capable of making with support. Where a person lacks capacity, the role would be to help the person to participate in the decision making process to the fullest extent possible, to help them to speak up for themselves and to make sure that their views are heard. A basic principle of advocacy is that the advocate does not make any judgements, or express any opinions, of their own. They may help to ensure that the person is aware of relevant issues they may not have considered. They may speak on behalf of the person to ensure the person’s views are heard and taken account of, but the advocate will not make any decisions or judgements on the person’s behalf.

Advocates work with individuals to support them to have a say in their lives and to make as many decisions as possible. Where this is not possible, advocates represent the individuals’ views and wishes and make sure they are involved as far as possible in the decision-making process. This includes working with individuals to establish what their preferences are, even when these cannot be communicated in conventional ways. The role of an advocate in such circumstances is to safeguard the basic human rights of the person for whom they advocate and ensure that their treatment meets agreed standards of good practice.

It should be remembered that because people’s capacity may change over time an advocate’s role in working with that person will also change accordingly.

In order to make the right of access to independent advocacy meaningful, advocates should be able to:

— Attend, where practicable, any consultation, interview or meeting about the person’s treatment or support.
— Have access to the person at any reasonable time.
— Correspond or communicate in any other way with the person on any matter relating to their role as an advocate.
— Receive such information as would assist them to perform their role.

Where a person has incapacity and cannot consent to information being shared on their behalf, health and social care staff should make available to the independent advocate such information as is necessary for them to do their job as an advocate effectively. This is necessary for the advocate to be able to undertake their safeguarding role. As a minimum, it would be expected that advocates are informed when:
— A person is admitted to hospital.
— There is a review of care or treatment.
— Any form of compulsion is considered.
— Special treatments are considered.
— Plans for discharge or transfer are being made.

Giving this information to advocates is permissible under the Data Protection Act 1998, which contains a specific exemption from restrictions on disclosure where the reason for disclosure is to protect a person’s vital interests.

AMHA believes that the proposals to develop “Independent Consultees” under the Capacity Bill should be abandoned and replaced with Independent Advocates directly linked with IMHA Advocates.

We recommend that the committee require the DH to provide an account of the links between the Bills advocacy proposals and proposals in the Capacity Bill to introduce “Independent Consultees”.

2.13 Advance directives

Clearly, advance directives may be useful for people to indicate whether they would wish to have an advocate or not. This would enable hospital managers and others to make a referral, if appropriate, where the person lacks capacity to request or consent to an advocate at a later date. Independent advocates may assist people to write an advance directive and keep it up to date. However, it would not be appropriate for an advocate to be a witness to an advance statement as this would involve making a judgement about the capacity of the person making the statement.

People should have the right to advocacy support when developing and implementing advance directives. Where someone lacks capacity IMHA Advocates should be consulted to determine the existence of any advance directive.

2.14 Correspondence

AMHA agrees that IMHA Advocates should be included in the list of official communicants in Schedule 11 as this will safeguard the patients right to correspond with his or her representative without interference by hospital or other authorities.

2.15 Tribunals

An independent advocate may assist a person to make an application to the mental health tribunal under the Act but may not make an application on their behalf. If the person is not able or does not want to attend the tribunal in person, then their independent advocate may present their views on their behalf, in line with normal advocacy functions. However, the role of an independent advocate at tribunal must not replace legal representation. An advocate may support a person in communicating with their legal representative.

An independent advocate should not be asked to give evidence (other than that which they are assisting the person to communicate to the tribunal) in order to respect the confidential conversations a person would expect to have with their independent advocate. An advocate’s role in supporting a person is incompatible with the role of a witness.
3. **General Issues**

3.1 **User involvement**

User involvement should be central to all advocacy practice and is essential for the healthy functioning of an advocacy service. AMHA believes that advocacy services must ensure that there are routes to meaningful involvement at all levels of the organisation.

> The Government should include guidance on user involvement in the MHA Code of Practice and should strengthen support for capacity building for advocacy services.

3.2 **Informal advocacy**

People should have the right to choose an untrained advocate/friend in place of or in addition to a specialist advocate if they wish. It is of vital importance that “informal” advocacy, such as that provided by local support and self-help groups, friends and family is not excluded in favour of professional advocacy.

People using mental health services must have the right to bring along a supporter of their choosing to ward rounds, CPAs and other meetings.

3.3 **Model of advocacy service—Implementation**

AMHA supports the Government’s apparent intention to ensure that IMHAA Advocacy is provided by properly trained advocates. Advocacy under the Act needs to be delivered by people with appropriate levels of skills and a thorough knowledge of the Mental Health Act. In addition advocates need to be properly supported and supervised and this requires that advocacy services are properly financed and that salaries reflect both market rates and the necessary skills.

3.4 **Comparison with Mental Health (Care and Treatment) (Scotland) Act 2003**

Section 259 of the Act puts a duty on local authorities, in collaboration with Health Boards, to ensure that independent advocacy is available to people with a “mental disorder” and that they have an opportunity to use it. The right to independent advocacy applies to anyone with a mental disorder. The term “mental disorder” is defined in section 328 of the Act and includes any:

- Mental Illness.
- Personality disorder.
- Learning disability.

People with dementia are covered by the Act. The right to advocacy applies to people of all ages, including children, young people and people over 65. In summary, the right to access independent advocacy applies to any person who has a “mental disorder” (as defined above):

- Regardless of age, disability, ethnic origin, culture, faith, religion, sexuality, social background or personal circumstances.
- Whether or not they are subject to compulsion.
- Whether or not they are ordinarily resident in Scotland.

The advocacy sections of the Act are due to be implemented from April 2005.

4. **Issues for Discriminated Against Communities**

Discriminated against communities, including Black and Minority Ethnic people, Lesbian Gay and Bisexual people, women, people with learning disabilities, older people and children and adolescents are subject to multiple and well researched barriers to effective mental health care. Advocacy is a key component in combating these discriminations.

4.1 **Black and Minority Ethnic communities**

Advocacy services and their ability to meet the needs of black and minority users of mental health service is an area of concern. The inequalities black and ethnic minority communities face within the mental health system with respect to patterns of admission to mental hospital (over representation in acute/secure provision); diagnosis (misdiagnosis); treatment (more controlling, drug based and less talking treatments); accommodation and after-care services (poor referrals; low take-up of services; lack of information about services) are widely known.

Research shows these inequalities exist as a result of a combination of institutional and individual discrimination, poor planning, inadequate training of professionals and inadequate allocation of resources by funders. It is clear that an individual’s race plays a significant role in the service they receive.
Minority ethnic groups generally experience poorer quality contact with the health service than the white population. Caribbean people are more likely than white people to be compulsorily treated and this occurs more often through the police.1

Barriers to mainstream health and social care services include a complex array of poorly organised and delivered services, inadequate communication services for non-English speaking groups, direct staff insensitivity to users cultural and religious needs and institutionalised barriers that perpetuate discriminatory behaviour and poor practices.2

Advocacy services which can help members of black and ethnic minority communities say what they want, obtain their rights, represent their interests and gain the services they need, would significantly improve ethnic minorities’ general experience of the mental health system.

It is crucial to ensure that advocacy services working with ethnic minority communities can meet their needs. This means more than simply having a translator on hand. Recent research3 among over 200 black and minority ethnic service users has highlighted that for effective advocacy for black and minority ethnic communities, advocates must be able to relay linguistic, cultural, religious and social messages about clients to professionals and where necessary challenge discrimination and racism. In order to do this staff competencies need to develop beyond simple cultural awareness. Competencies need to be sector specific, deal with issues of racism, the complexities of culture, an understanding of the context in which the user is approaching the service, combined with an ability to communicate with service users.

In order to ensure that advocacy services are sensitive to the needs of their client base, organisations delivering the services must be diverse in the range of people they employ. To develop a diverse organisation means more than attracting a higher proportion of black and minority ethnic people into the organisation as staff and volunteers. Culture will only change if there are more BME people as directors, senior managers and trustees together with greater accountability for delivering a sensitive and appropriate service at all levels of the organisation to communities and funders. Attention must therefore be paid to recruitment, retention and progression of black and minority ethnic people at all levels of the organisation.4

Training on cultural awareness, equality and valuing diversity should be a fundamental part of any advocacy service training programme. It should be such that advocates, no matter what their colour, are able to identify the cultural, religious, social and linguistic needs of their service users.

BME communities should be involved in developing local advocacy infrastructures, including BME specific mental health advocacy forums.

Where needed, advocacy services should provide bilingual workers. Contracted interpreters should be knowledgeable about mental health, advocacy and cultural matters.

Funding arrangements must ensure equitable distribution of resources according to local needs and ways of developing advocacy services in partnership with local communities should be explored.

4.2 Children and adolescents

Statistics on child admissions to psychiatric wards are not accurately or effectively collated, and it is impossible to access figures for children detained under sections of the Mental Health Act, or for children who are in private mental health facilities.

At present, there are 81 adolescent in-patient units in England and Wales (approximately 972 beds). In addition to these every year there are about 500–600 inappropriate admissions to adult wards, and 150–250 admissions to paediatric wards. These figures do not include independent sector inpatient care. Figures show roughly 7,000 children per year passing through NHS mental health in-patient care.

Though the vast majority of children in psychiatric in-patient care are informal patients, a significant minority are formally detained in these settings, primarily under the civil or criminal provisions of the Mental Health Act 1983. There is no lower age limit for Mental Health Act detention, and the Act itself has no detailed specific provision for children (it is all in the Code of Practice). The provisions in the MHA which are designed to support patient’s rights are inaccessible to children.

A minority of children are detained under section 25 of the Children’s Act, which allows detention in secure accommodation, with treatment under common law. This is more legally contentious, though arguably much better for the children involved, as the Children Act has both a child-centred ethos and safeguards for children that the Mental Health Act lacks. The common law doctrine of necessity for treatment has advantages and disadvantages—it means treatments have to be more clearly justified but militates against preventative treatments.

---

4 One year on and counting (after the Stephen Lawrence inquiry)London Borough Grants March 2000.
In adult mental health, people are accustomed to talking about the “de-facto” detained—it is arguable that all children, certainly all under 16s are de-facto detained. Under 16s can be, and almost always are, admitted by their parents or guardians without consent. For children, the distinction between formal and informal detention is therefore misleading.

Children under 16 are assessed for competency in relation to treatment decisions (the so-called Gillick test, which considers whether or not the child has sufficient understanding to comprehend the nature and implications of the proposed treatment). A “Gillick Competent” child can give valid consent to treatment, but cannot refuse consent. No child under 16 has an enforceable right to refuse consent to treatment.

All children in contact with mental health services should have access to specialist mental health advocacy services which are designed to work with children and young people.

Children will have a right of access to a nominated person and/or to a specialist advocate. These changes are welcome, but will not be effectively enforced without providing children with comprehensive specialist advocacy services. The safeguards in the 1983 Act and the proposed safeguards in the new Act are adult-centred—they are not accessible to children. For example, the absence of information in child-friendly language and the absence of specialist advocacy provision make it a nonsense to suggest that a child could exercise their rights through the new processes in the MHA that are designed as safeguards for patients.

Specialist advocacy services are needed because: children are subject to a far more complex and restrictive legal process; children who experience mental distress are subject to a different and more complex set of socially excluding factors; children are excluded from all of the processes and forums that allow other mental health service users to make choices about their treatment and exercise and promote their rights; children require substantial translation work, including all of the information/legislation; working with children and young people in an empowering way requires a very specific and highly developed set of skills.

4.3 Lesbian, gay, bisexual and transgender communities

Despite the fact that homosexual orientation and behaviour has been absent from the DSM classification of mental disorders for almost 30 years, homophobic attitudes and assumptions still prevail in mental health service delivery. People who experience serious mental illness are frequently stigmatised and excluded from their communities. The DoH funded report “Diagnosis Homophobic”\(^5\) found:

- difficulties in accessing services;
- discriminatory attitudes from staff;
- abuse from other patients;
- that patients had both the experience and the fear of being pathologised negatively on the basis of sexuality;
- that patients fear the consequences of disclosing their sexuality but also fear that concealing sexuality leads to being misunderstood and may result in inappropriate treatment;
- misunderstanding of the implications of the Mental Health Act; and
- that research demonstrates that frequently lesbians and gay men avoid contact with statutory mental health services and do not get the help they need.

Perkins (1995) suggests that most mental health assessment interviews assume heterosexuality by only asking about marital status. The conclusions of research show that lesbian or gay mental health service users need to access a lesbian and gay advocate with whom they can build a trusting relationship.

Comprehensive mental health advocacy services should include specific services for lesbians and gay men. The proposal to replace “Nearest Relative” with “Nominated person” is a welcome step. Under the 1983 Mental Health Act, section 1(3) makes clear that a person may not be considered to be suffering from mental disorder solely by reason of “sexual deviancy”. The proposal not to include section 1(3) in the new Act reduces the existing protection and makes it even more important that advocates properly support this section of the community. It is crucial that advocacy services for LGBT communities are linked in to the communities themselves.

4.4 People with Learning Disabilities

People with learning disabilities who also have a mental health problem often suffer double discrimination. Prevalence rates for schizophrenia in people with learning disabilities are approximately three times greater than for the general population, with higher prevalence rates for South Asian adults with learning disabilities compared to White adults with learning disabilities. Reported prevalence rates for anxiety and depression amongst people with learning disabilities vary widely, but are generally reported to be at least as prevalent as the general population, and higher amongst people with Down’s Syndrome.

People with learning disabilities are at risk of receiving no mental health service, due to a lack of communication between mainstream psychiatry services and learning disability psychiatry.

\(^5\) McFarlane, L 1998. PACE.
A very high proportion of people with learning disabilities are receiving prescribed psychotropic medication, most commonly anti-psychotic medication (40%-44% long-stay hospitals; 19%-32% community based residential homes; 9%-10% family homes) Anti-psychotics are most commonly prescribed for challenging behaviours rather than schizophrenia, despite evidence of harmful side-effects.6

Valuing People emphasises that “As with other health needs, people with learning disabilities should be enabled to access general psychiatric services, even with specialist support.”7 However “at present, most people with mental health problems who have learning disabilities receive the majority of their mental health support from specialist learning disability services.”

People with a learning disability who are subject to the Mental Health Act 1983, in practice are less likely to be given adequate information about their rights, less likely to be supported to seek legal representation and are more likely to be treated under a section three for longer periods of time. It is therefore essential that appropriate independent advocacy is provided for this group of people.

There is an urgent need to collate the research available on the advocacy needs of people with learning difficulties. Despite the Government’s commitment to advocacy for people with learning disabilities (in the Valuing People and Green Light for Mental Health papers) there is a lack of consistency in the availability of advocacy for people with learning difficulties. AMHA urges the Government to implement adequate and effective advocacy which could include self advocacy for people with mental health problems who have a learning disability.

It would be appropriate for IMHA advocates to be placed within both mental health and learning disability advocacy services. Advocacy services would need to work together to develop a consistent, high quality service and to ensure that people with learning difficulties are accessing specialist advocacy that meets their needs.

4.5 Older People

Older People are often discriminated against and experience many barriers when accessing Mental Health Services. About 5% of the population over 65 has dementia and, at any one time, about 10-15% of the population aged over 65 will have depression.”8

Independent Advocacy should be available to Older People in order to provide support in their decision making in relation to health care. Older People often “are the least likely to complain or even ask for advice and information”9 regarding their admission, diagnosis or treatment, particularly in a Mental Health in-patient setting.

The Department of Health NSF Older People states that “Older People should be involved in making their own decisions, where this is possible and is what they wish, about the options available to them . . . It is also for the older person to determine the level of personal risk they are prepared to take when making decisions about their own health and circumstances” the NSF for Older People also states that “In order to make decisions about their care people need . . . independent advocacy services.”10

Failure to address older people’s needs can lead to isolation and feelings of lack of control, which in turn can lead to mental ill health. According to the Older People’s Advocacy Alliance (OPAAL) UK, significant life events affecting people in later years include:

— the consequences of retirement, which often brings about a reduction of income and social networks;
— the consequences of a decline in physical and mental health, sensory impairment and the need for support services;
— the consequences of a change in housing arrangements; and
— the consequences of ageism.

Dementia North in their report “Hear What I Say” identify “growing numbers of people with early dementia who expect to have a strong voice in the decisions that affect their lives.” The same report recognises that “in the field of older people’s mental health, service guidance has highlighted the importance of encouraging empowerment and of maximising the independence and autonomy of people with dementia. Many Older People with Mental Health problems have difficulty representing their own interests . . . they may need help making key decisions, which will affect their lives . . . or in managing a complaint against treatment they have experienced.”11

---

6 Key Highlights of Research Evidence of the Health of people with Learning Disabilities. Valuing People Support Team.
Access to information is often a key element of advocacy and this can be an issue for older people who have a visual or hearing impairment. A report published by Joseph Rowntree Foundation recommends that “Older People should be provided with information about advocacy services—their availability and ease of access”\(^\text{12}\).

Independent Mental Health Advocates will need to be aware and be trained in issues relating to Older People and have access to older peoples advocacy services, where available.

Nationally, there is a lack of comprehensive advocacy services for older people, OPAAL UK have called for a strategic nationwide system, supported by government legislation, to provide independent advocacy services for older people in hospital” \(^\text{OPAAL 2000.}\) Age Concern England has identified that “there is currently no systematic framework to ensure that all Older People have access to advocates to support decision making . . . the draft Mental Health Bill will only provide for some of the Older People who require it”.\(^\text{13}\)

4.6 AUTISM AND ADVOCACY

People with an autistic spectrum disorder (ASD) are particularly vulnerable to mental health problems such as anxiety and depression, especially in late adolescence and early adult life (Tantam & Prestwood, 1999).\(^\text{14}\) Ghaziuddin \(^\text{et al}\) (1998) found that 65% of their sample of patients with Asperger syndrome presented with symptoms of psychiatric disorder. However, as mentioned by Howlin \(^\text{16}\) (1997), “the inability of people with autism to communicate feelings of disturbance, anxiety or distress can also mean that it is often very difficult to diagnose depressive or anxiety states, particularly for clinicians who have little knowledge or understanding of developmental disorders”.

Similarly, because of their impairment in non-verbal expression, they may not appear to be depressed (Tantam, 1991).\(^\text{17}\) This can mean that it is not until the illness is well developed that it is recognised, with possible consequences such as total withdrawal; increased obsessional behaviour; refusal to leave the home, go to work or college etc; and threatened, attempted or actual suicide. Aggression, paranoia or alcoholism may also occur.

In treating mental illness in the patient with autism or Asperger syndrome, it is important that the psychiatrist or other health professional has knowledge of the individual with autism being assessed. As Howlin (1997) says, “it is crucial that the physician involved is fully informed about the individual’s usual style of communication, both verbal and non-verbal”. It is therefore essential that appropriate independent advocacy is provided for this group of people.

All people with an ASD have impairments in social interaction, social communication and imagination. They therefore need support to express their aspirations, interpret and process information regarding their rights and to request relevant services.

The National Autistic Society report Autism: Rights in Reality (2003)\(^\text{18}\) found that only 11% of adults had access to an independent advocate. People with an ASD are falling through the gaps between mental health and learning disability advocacy providers because of the strict funding criteria that many local authorities place on advocacy providers.\(^\text{19}\)

Advocacy support is needed with:

— Transition into adulthood and adult services.
— Access to housing.
— Access to employment.
— Assistance with social integration and life planning.
— Access to health services.

Adults with experience of independent advocacy testified to its value, but more advocacy organisations need to be equipped with the skills to work effectively with people with an ASD. This would be made easier with greater financial support from National Government for advocacy provision to ensure that people with an autistic spectrum disorder have access to independent advocacy that is suitable for their needs. A

---


\(^{13}\) Age Concern Policy Position Paper on Capacity and Consent.


statutory requirement should be placed on local authorities to produce a local advocacy plan, which will outline how provision will be developed in the area, how different groups will be served and how funding dedicated to advocacy will be spent.

October 2004

Memorandum from Cymar (DMH 45)

Cymar is the Welsh Association of Mental Health Patients Councils and Advocacy Schemes. It is a network of all the activity we have been able to identify across Wales. We have recently completed some research into the current state of Advocacy in Wales with the specific intention of informing the Welsh Assembly so they might understand the work necessary to prepare Wales for the implementation of a new Mental Health Bill that makes reference to the provision of advocacy for people with mental health problems. This is the section that refers to the bill:—

The Draft Mental Health Bill (full)

There was a great deal of concern from participants that they may not be able to meet the requirements of a specialist advocate. Some of this concern was because the term specialist advocate is not clearly defined in the Draft Bill.

If the Bill is accepted then there will be a need for a large increase in the numbers of advocates. That being the case, there was also concern and searching questions asked about where all the advocates themselves, needed to provide a legally binding service as described by the act, will come from?

“We've just gone through the first process or recruiting a paid advocate and it became extremely clear that there are very few people out there who have ever done the job before, so you are not going to recruit people by and large, who have had much experience, you know, and Sheila has not done advocacy but she had the right set of attributes, thinking and skills, that meant that she could learn very easily, plus her CAB work had given her some idea of the issues from CAB”

There was a consensus of opinion that funding needs to come from a central source. If advocates spend a lot of time fund raising, this detracts from them providing a service to their clients.

If all detained patients have a right to advocacy, as proposed by the Draft Bill, the main concern for existing advocates would be the increased workload. This will stretch advocates who are already under pressure even further. There was also some concern that with increased powers of detention, might come more human rights issues.

“Outside of the Mental Health Act, . . . if you got a compound, disorders, you don’t need mental health problems, they tackle you straight away, can’t they and you haven’t got rights then, human rights.”

Advocates felt that not only would there be an increase due to a legal obligation to provide a service for detained patients, but that the law will also lead to more people being detained. If more people are detained then this will lead to overcrowding which will in it’s turn lead to more conflict that needs the service of an advocate to resolve.

“It would generate more work but it would also take away from the other work that we’re doing . . . It would also do the same for the other professionals, . . . more people would end up under the Mental Health Act, particularly with community treatment, probably people that are now under Section 117, a lot of them would probably be actually under the Mental Health Act. . . . Most of the services then are going to be tied up with them, there aren’t going to be enough services for them, any services, not just advocacy.”

There is also a fear that more issues will arise with people being forcibly medicated in the community. This again place more demands on advocacy services that are already stretched or in many areas of Wales, non-existent. This applies to the entire services not just advocacy!

“The criteria seems to be lowered for detention which means that we’ll have more sectioned patients in hospitals to work with, and I . . . those of us who just work with inpatients, will find that our role expands into the community, as more people are forcibly medicated in their own homes seek help.”

Many mentioned the lack of resources that are made available and this situation will worsen as demand increases. Not just money but also such things as suitable space in which to provide a quality service is also an issue. There was mention of the new need for a 24 x 7 (24 hour 7 day a week) service and the fact that advocates would need to be on call with communication aids like pagers.

“If the Bill goes through, they’ll all come forward and want a great mass of advocates and there won’t be enough advocates to go round”

“But it would make it full-time, as well I think, the job, because there's going to be evening, weekend commitments and all the rest of it, and I work as a part-timer at the moment, so it would have quite a big impact on me. Probably there are some advocates who wouldn’t want to accept those sorts of conditions really, so, yeah, it would fundamentally affect the nature of the job to it really.”
Another major issue for people is that their identity as an independent advocacy service may be lost. People fear they may be perceived as yet another part of the system. This will become a legal obligation and that may lead to real difficulty with the advocate client relationship, in terms of trust.

The concern about legal liability is illustrated by this quote:

“You know really that you had a legal obligation to provide this service because people had a legal right to expect it really, so presumably if you fell down in providing that service or you gave people wrong advice, then you would personally legally liable, I guess, so there’s quite a few little worrying aspects to early.

CONCLUSION

In conclusion then most of the Participants feel that the current draft of the New Mental Health Act will have very far-reaching effects on mental health advocacy. It will possibly induce change, which the current service is very ill prepared for, and many feel it will be almost impossible to cope with.

MENTAL HEALTH BILL (SUMMARY)

Concerns about the Mental Health Bill and its implications for advocacy

All of the participants felt that there were currently inadequate resources in terms of funding and staff to provide an advocacy service as set out in the Bill, and that it would be difficult to find sufficient funding for this to happen.

The Bill does not define what “specialist” advocates are. Some people felt they were specialist advocates, most didn’t. Participants felt that training would be needed for most current advocates to enable them to meet the requirements of “specialist” advocates.

There was concern that the Bill would lead to a huge increase in workload; firstly because the Bill would lead to more people being subject to legislation, and secondly, because once people are detained their problems are magnified through being less able to get things done themselves.

There was also concern that because of the legal requirement for advocacy for detained patients, the service would have to focus on this and the rest of the service would suffer.

Participants also expressed concern that if law requires advocates, they will become part of the system and as such clients will not trust them.

October 2004

Memorandum from the UK Advocacy Network (UKAN) (DMH 227)

1. INTRODUCTION

1.1 The UK Advocacy Network (UKAN) is the national federation of mental health advocacy projects, patients’ councils and user forums. UKAN was formed in 1993 and currently has 227 member groups. UKAN has played a key role in defining and promoting good practice in mental health advocacy through the provision of information and training and the development of mental health advocacy standards.

2. INDEPENDENT MENTAL HEALTH ACT ADVOCACY

2.1 UKAN welcomes the proposed introduction of Independent Mental Health Act Advocacy but we strongly feel that the limited role of Independent Mental Health Act Advocates will fail to meet the needs of people who use mental health services.

2.2 The right to an advocate should be available to everyone in contact with specialist mental health services, including services provided by the voluntary sector, as all mental health service users are potentially subject to compulsion.

2.3 In terms of Independent Mental Health Act Advocacy as envisaged in the Bill, UKAN believes that people who are liable to compulsion should have a right to advocacy support at the point of examination, during the period of assessment, during the development of the care plan and in matters relating to discharge and aftercare.

2.4 One of the indispensable fundamental principles of advocacy is that an advocate only acts on behalf of a service user as the service user wishes. In no circumstances should advocates be given access to a patient’s records without the consent of the patient.

2.5 UKAN believes that patients should be able to meet their advocates in private.
2.6 A Stakeholder Group consisting of service users, advocates and existing advocacy service providers should address issues relating to the training and accreditation of Independent Mental Health Advocates.

2.7 The introduction of Independent Mental Health Act Advocacy should not preclude a patient from choosing to receive advocacy support from someone other than an Independent Mental Health Act Advocate.

2.8 UKAN remains concerned that the Government’s support for an inherently limited form of mental health advocacy could have a detrimental effect on agencies providing advocacy support to people who are not subject to compulsion. It needs to be stressed that Independent Mental Health Act Advocacy is one form of advocacy, not superior to any other form.

3. FORMAL POWERS IN THE COMMUNITY

3.1 UKAN agrees that treatment should be provided in the least restrictive setting possible. We would argue that the extension of formal powers to treat people in the community runs counter to this principle and is likely to lead to an increase in the number of people subject to compulsion.

4. KEY CHANGES SINCE 2002 PROPOSALS

Compulsion in prison

4.1 UKAN welcomes the decision not to pursue the policy of compulsion in prison.

ECT

4.2 UKAN welcomes the provision in the Bill enabling patients over 16 with capacity to refuse ECT although we remain concerned that this provision might be circumvented by defining a patient as an “emergency case”. UKAN believes that ECT should not be administered to children under 16 in any circumstances.

Carers

4.3 UKAN maintains that mental health professionals should not consult carers without the express permission of the patient. The interests of patients and carers should not be assumed to be compatible. Where the interests of patients and carers are incompatible, the interests of the patient should be of paramount concern.

October 2004

Witnesses: Mr Rick Henderson, Director, and Ms Karen Mellanby, Policy and Communications Manager, Action for Advocacy; Ms Hilary Dyter, Director, Leeds Mental Health Advocacy Group, and member, Association for Mental Health Advocates Steering Committee; Mr Jonathan Coe, Chair, Association for Mental Health Advocates Steering Committee, Chief Executive, Prevention of Professional Abuse Network (POPAN), and Chair, Mental Health Alliance Advocacy Special Interests Group; Mr Peter Munn, Secretary, Cymar, and Chair, United Kingdom Advocacy Network, and Ms Beverly Mills, Member, Management Committee, United Kingdom Advocacy Network, examined.

Q1056 Chairman: Good morning and welcome to our witnesses from Action for Advocacy, the Association for Mental Health Advocates, the United Kingdom Advocacy Network and Cymar. I am going to ask you if you would introduce yourselves fairly rapidly so that we can go into a somewhat time-limited question session in an attempt to get through most of the issues.

Mr Henderson: I am Rick Henderson and I am the Director of Action for Advocacy which is a resource and support agency for advocacy groups primarily in England.

Ms Mellanby: My name is Karen Mellanby and I am the Policy and Communications Manager at Action for Advocacy.

Ms Dyter: I am Hilary Dyter and I am on the Steering Committee for the Association for Mental Health Advocates and I am also a manager of the Leeds Mental Health Advocacy Group.

Mr Coe: I am Jonathan Coe and I am the Chair of the Association of Mental Health Advocates and the Chief Executive of POPAN, which is the Prevention of Professional Abuse Network, appearing before you for the second time.

Mr Munn: I am Peter Munn and I am diagnosed with a bipolar disorder. I am Chair of the United Kingdom Advocacy Network and the Secretary of Cymar.

Ms Mills: I am Bev Mills. I am a member of the Board of Trustees for UKAN. I am also a Deputy Director for Easier Empowerment for Mental Health Matters, a Board adviser to the Sainsbury Centre for Mental Health and former co-Chair of the European Network of Ex-Users and Survivors of Psychiatry.
Chairman: Can I just remind you that this is a public evidence session. There will be a transcript produced and it will be available on the Internet after about a week. You are free to examine it and make any textual corrections, but not corrections of substance.

Q1057 Lord Carter: Which skills and attributes do you consider essential to fulfilling the role of an independent mental health advocate? Is it really necessary to provide a job specification for specialist advocates on the face of the Bill?

Mr Coe: In answer to the second part of that question, no we do not think there is a need for a full job description to be on the face of the Bill. We are not aware of any precedent for that. It is extremely important that there is a set of clear functions for the Mental Health Act advocate on the face of the Bill. In terms of the skills and attributes, a piece of work was carried out over the last 18 months in London looking at the court competencies for advocacy workers. I would like to take that as the basis for my response. Top of the list was the need for clarity on professional boundaries as an advocate worker. The ability to identify and defend the rights of people detained under the Mental Health Act is clearly significant. The ability to promote self-advocacy as the main purpose of advocacy is of fundamental importance. The individual qualities of the worker must be focused on the ability to promote the voice of the service user and not the voice of the advocate, This is a cross-cutting issue in advocacy. It is absolutely about supporting people to get their voices heard in the way that they wish to be heard by mental health services. It is not about having another professional voice in the mix of professional voices. Listening skills and the ability to support people are vitally important. The ability for workers to review and reflect on their own practice is a prerequisite for any kind of work in this field. The ability to negotiate effectively with a wide range of people and the ability to work within an anti-discriminatory framework are vitally important. I want to make a distinction between mental health advocacy and any other kind of advocacy. Advocacy is much closer in concept to the role of a solicitor than it is to, for instance, the role of a community psychiatric nurse or a psychiatrist.

Ms Mills: It is very important that an advocate has person-centred skills and an ability to have warmth and empathy. It is very important that they are able to put their own agenda to one side, even if they do not agree with what the service user is saying, so that they can support the service user to be able to speak up for themselves.

Mr Munn: I hope from our written evidence that people have had a chance to look at the research which we did over a two year period about advocacy in Wales. I have a copy of that with me if people would like it. A quote from that regarding independence states that independence has to be emphasised because I do not think you can do advocacy if you are not independent. One of the most important things is that it needs to be an independent service. As far as skills and attributes are concerned, people who have been doing advocacy for some time have the best ideas about what skills and attributes are required so one should ask those organisations who have been doing it for a number of years. Good listening skills are obvious. Ability to empower the client to speak for themselves whenever possible; a real understanding of mental health difficulties, preferably personal or life experience; an ability to represent their client at all levels, especially with senior medical staff and tribunal members; ability to maintain confidentiality and speak for the client even when they believe it is not in the client’s best interest; an ability to search information, access services to help empower the individual and enable them to regain control of their lives. True independence can only be obtained if the advocate is not controlled in any way by other agencies, apart from their client—ie, the person who is experiencing the mental health difficulty. The advocate must be able to speak freely on their client’s behalf. It is not essential to provide a job description for a specialist advocate if this rule of independence is observed as the advocate will seek all the help, legal advice and otherwise, to deal with the problems. However, if current advocates are to take on the legal requirement to provide advocacy, the resources will have to be made available to allow existing advocates and new ones the time and training to do this work. Many current advocacy services do not have the stability to provide a guaranteed service; nor are there sufficient schemes or employees to cover all areas of Wales or, I believe, England.

Q1058 Lord Rix: Several of us sitting round this table were engaged in the Committee stage of the Mental Capacity Bill last night. One of the things that we were debating was independent advocacy. Do you consider the mental health advocates that you are proposing here to be a separate issue from the independent advocacy—or the consultee as it was called until yesterday—in the Mental Capacity Bill? Do you see this as a separate issue specifically for mental health?

Mr Coe: Building on the evidence we gave to you some weeks ago, we wanted to draw a very close line between the two proposals. We followed the debate last night and contributions from Members present were extremely useful. The debate about what an independent consultee is we are extremely pleased to see moving in the right direction. A commitment from Lady Ashton last night to introduce new amendments to make the change in terms of the name is a great move. There are overlaps in terms of advocacy for people who are deemed to lack capacity and the work that is outlined in this Bill for the Mental Health Act advocacy. I would reiterate the point I made when I was last before you, which is that these new
developments have to be integrated. They need to be embedded within existing advocacy provision. Lady Ashton accepted last night that the idea of creating an entirely new service was one which was simply not tenable. We know that there are a large number of highly skilled, well run advocacy services out there that are well positioned to deliver both independent mental capacity advocacy as well as Mental Health Act advocacy. We can see that these developments are coming together and moving in the right direction. Not everybody deemed to lack capacity who qualifies for an independent capacity advocate will fall into the bracket of mental health services but that is a question of looking at the broad range of advocacy provision that there is now and ensuring that the right skills and knowledge bases are there within the services that are going to be delivering both. The key issue is getting training right across the board for both groups and just who is going to deliver that training and how standards are going to be set is something I hope we can get into more this morning.

Ms Dyter: I manage a mental health advocacy scheme and I supervise eight different types of advocate. We are already providing a service that would be provided by this advocate and also by the advocate you were discussing last night. I was in the Strangers’ Gallery so I heard that debate. I welcome both these because it would mean for us that there is more advocacy. We have a waiting list at the moment. It means we do not have enough resources and I know that we are better off than a lot of other parts of the area in England, Wales and Northern Ireland.

Q1059 Mrs Browning: Under existing legislation and in the practice that you have of advocacy, in those more complex cases where people are detained sometimes for a long time or people are being considered for detention, given the scope of this new piece of legislation in the Bill we are looking at for detention, how frequently in the work of the advocate do you require, in the interests of the patient, to bring in independent, expert witnesses? How easy are they to access at the moment?

Mr Coe: This question about independent experts and the situations in which they would be called in would be when there is an appeal against detention. In those cases, the legal solicitors’ firms representing have an option to bring in their own experts to make assessments and reports to the tribunal if they are thought to be useful to the application. In terms of access to independent forms of expertise in the day to day work of advocacy, it would be extremely unusual for the resources to be available in order for those forms of expertise to be brought in. If you are talking about bringing in expert witnesses in the court or tribunal setting, you are talking about several hundreds of pounds of expenditure for that work.

Q1060 Chairman: Representation orders cover that, provided it is asked for by the solicitor. Ms Mills: That is right. They are not covered by the usual contracts issued by PCTs and local authorities to deliver advocacy services.

Mr Coe: If we are trying to deliver a mental health service more from a user perspective, essentially, the idea would be to ask the patient if they wish or require some special input, if that is at all possible. I appreciate in some cases it may not be but there is going to be a very small number of cases of people who severely lack capacity to enable them to have an opinion about who might help them.

Ms Mills: With mental health, it depends on whether the Mental Health Act will supersede the Mental Capacity Bill. People with mental health problems have shifting capacity. It is not a constant state. Someone might lack capacity at one point in one particular area of their life but it is quite possible that someone can be unwell and lack capacity in one area of their life and not another. That is a very important point. Advance directives are very important when it comes to capacity.

Q1061 Chairman: We have been wrestling with the problem you have highlighted throughout these evidence sessions.

Mr Munn: It is also one of the major skills of an advocate to identify when and how they can get the information from a person who may appear to be quite confused. If you listen to the person properly and have a real understanding of them, you can get their views.

Q1062 Mr Howarth: Mr Munn earlier mentioned the concept of the best interests of the patient. What is the role of an advocate when a course of action that somebody wishes to take is clearly not in their best interests and could even lead to them harming or endangering themselves or others?

Mr Munn: There are boundaries which the advocate cannot work outside. When engaging with a client, the advocate generally goes through those boundaries. If there were ideas of putting children at risk, for example, the advocate would most likely say they could not step outside that and other people would have to be informed. There are confidentiality boundaries as well. Generally speaking, you can get the best information from the patient and they should be leading their recovery. The advocate’s role is to enable the patient to speak for themselves. Where they cannot speak for themselves, they speak for them. Where they cannot speak for them, giving their own views, it has to be a view that they have gained from working closely with the patient.

Q1063 Mr Howarth: If in the course of talking to the patient an advocate clearly gets the impression that, if they are allowed to do what they want to do they might not damage a child but they might, for example, harass another adult to the point where that adult’s life is turned into a misery,
would you think it reasonable in those circumstances for the advocate to still put that point of view?

Ms Mills: That is a difficult scenario to answer.

Q1064 Mr Howarth: But it happens.

Ms Mills: Yes. The role of an independent advocate is to speak up on behalf of that person. That would be set out in a contract between the advocate and the service user about what is and is not negotiable. That would be an instance of something not being negotiable, perhaps that person having to signpost other agencies or make other people aware and, in that position, saying quite clearly to the service user, “I am not able to advocate for you in this situation. I am going to have to refer this to someone else”—for example, if someone is going to self-harm. It would be irresponsible of an advocate not to share that with the medical staff. That is about having clear contracts as between an advocate and a service user. The vital point in all of this is that an advocate is there to speak up for and help a service user to speak up for themselves. It is about the advocate and the service user creating a contract with one another about those boundaries.

Mr Munn: For me, even if the mental health patient would appear to be harassing another adult, both people have rights. If the person is feeling harassed, they have the right to step away from all of that. There are other laws and other things that can protect people if that is occurring and one might use those but essentially the advocate has to speak for the client. It is no good the advocate saying what they think is best for that person. That is not what they are about.

Ms Mellanby: There are obvious, complicated issues around that. A lot of advocacy organisations would have clear protocols and be very clear with all the key stakeholders when there are issues of potential serious harm in the action they take. I would like to stress that for many people that go into hospital the experience is confusing and bewildering. Most of the people they come into contact with, the nurses, psychiatrists and social workers, have a very clear duty to assess, diagnose and make decisions. The strength in the role of the advocate is very much them being perhaps the only person that is able to provide support without having that extra responsibility to make a judgment. There are other people who have that assessing and diagnosing responsibility.

Mr Munn: Can I make reference to the UK Advocacy Standards which clearly lay out a lot of standards for advocates and would help advocates to form boundaries and contracts with their clients?

Q1065 Lord Carter: You explain the skills and attributes of advocates very well and their relationship to the patient. The Association for Mental Health Advocates consider that any independent advocacy has a key role to play as an agent for change and is supporting continuous improvement in mental health services generally. Can you explain what you mean by that and what evidence you have to support that view?

Mr Coe: In general terms, having an external presence within statutory services acts to help to focus the minds of clinicians and service managers. Local advocacy services are much better positioned than, for instance, national inspection agencies to monitor and feed back issues of concern to service users. I want to stress that advocacy services working on the ground are having hundreds of issues brought to them every day by a whole range of people who use services. There is all this information that comes in. Many advocacy organisations take the view that, if you simply deal with one issue at a time you may well be dealing with the same issue with the same person or other people the next day, the next year and the next decade; whereas if you can establish patterns, if you can pull together the multiplicity of individual reports and use that in a targeted way, working closely with people who use services, you can act to get services changed where they need to be changed. I wanted to give you one example of that.

When I was working for an advocacy project in central London, we were working in a hospital where the basic communications with patients from staff was severely lacking. Their ward conditions were very bad. People were routinely not informed about what would happen to them in terms of their care and treatment. Many people reported to us that they were not given information about their rights under the Mental Health Act. This is a central London hospital where the rate of use of the Mental Health Act in admission terms hovered between 90 and 100%, so it is a very high use of the Mental Health Act. We were repeatedly picking up issues about basic courtesies, basic communications from people on the wards. Nurses would routinely walk into people’s bedrooms, for instance, without knocking, without saying that they were coming in. We would observe this happening ourselves on a regular basis.

Q1066 Chairman: This raises a question I would like to aim at Mr Henderson. Some of the problems that you have just been describing may have diversity issues involved in them, different customs, the way in which one treats the privacy of people from different ethnic backgrounds and so on. Are you satisfied from the viewpoint of Action for Advocacy that the cultural and ethnic make-up of advocacy organisations reflects the diversity of the people they assist? Also, are you satisfied that in terms of dealing with older patients the diversity of the advocates who are available reflects the increasingly old age profile of the country? Are there the older advocates available who understand the needs of older patients?

Mr Henderson: Within the very limited resources that are available to advocacy schemes currently, most of those schemes would do their level best to ensure that they reflect the diversity of their own local communities. It is especially true in urban
Q1067 Lord Carter: You explain the situation extremely well in terms of improving service management but under the Bill a patient will potentially have the support of a carer, a nominated person, an advocate and a lawyer. How do you see all those roles relating to each other?

Mr Munn: I would first of all like to remove the advocate from that group of professionals because I do not believe that the advocate should be professionalised. It should be a privileged engagement and partnership with the service user.

Q1068 Lord Carter: You see the service user and the advocate here and the others over there? Is that right?

Mr Munn: Absolutely, at least to a large degree. The advocate, where possible, can get a relationship with the other professionals but must not be seen to be colluding with them; otherwise the service user would not trust them and engage in that. Could I go back to the problem of diversity?

Q1069 Chairman: If you are going to do that can I ask you to deal with the specific issue on the question whether there are sufficient Welsh speaking advocates available in the view of Cymar?

Mr Munn: The answer is no. There also is not the diversity of advocates. One needs to raise the issue about people's choice and whether they might be able to have a male or a female advocate who speaks a different language etc. It is not there. The Government will have to invest in the infrastructure of advocacy and there are organisations like The Advocacy Federation, like Cymar, UKAN and so on that are there, forming an infrastructure. That needs to be supported to enable the development of advocacy per se. An advocate can help empower people to enable them to move toward recovery instead of a lifetime of engaging with mental health services. They can find some worth and become useful members of society instead of a burden. I recovered sufficiently to hopefully be able to speak reasonably well to you today and to run my own business and to step away from 10 years of the benefit system. If people can be helped to recovery, advocacy will pay for itself as fewer people become dependent on the state. That is the value of putting in the resources that we are talking about.

Q1070 Lord Rix: Those of you present last night will have heard a father of a learning disabled daughter say that many parents resented the intrusion of people offering advocacy. Do you find the same applies to parents in the mental health field?

Ms Dyter: It is more common for people with children with learning difficulties. I think he was coming from the position that an advocate would
come in and say something different or do something different from the parents; but an advocate would only do and say what the son or the daughter would want. Quite often, it is a situation we all recognise. It is about your sons and daughters growing up. They do not always see eye to eye and neither should they. An advocate can come in at that point and make a difference. It is not so common in the mental health world in quite the same way because of the capacity. People can be kept as children maybe much longer than they need be. In mental health, nobody is born mentally ill. The problem develops later on so that is a fundamental difference.

Q1071 Baroness McIntosh of Hudnall: I wanted to ask about an issue that comes up in your evidence which relates to the context within which you do the job. The Association has recommended the scrapping of a proposal in the Bill to give advocates access to patients’ records without those patients’ consent. I think I can envisage what your answer to this question might be but I would be very grateful if you could tell the Committee why you find this proposal as difficult as you clearly do and whether or not having access to patients’ records on occasion might help an advocate to do his or her job better. Ms Dyter: Being an advocate is not quite like anything else. We cannot do anything that the individual does not want us to do. We cannot say anything; we cannot put forward any views. If a service provider tells us something that is not very nice about that individual that we are advocating for, we are not allowed to keep that information to ourselves. We are to all intents and purposes like a loud hailer. When I am trying to explain advocacy to somebody coming across it for the first time who might want an advocate, I say we are a mixture of your best friend and a loud hailer. Our expertise is in knowing the way through things and negotiating; who is a good person to talk to; maybe go to that person because they will listen and another person will not. We are laying out options. They can sack us at any time. It would be like going behind their backs. Looking at deeply personal information without their permission? You simply cannot do it.

Q1072 Baroness McIntosh of Hudnall: As a matter of personal judgment, I understand entirely what you are saying. Just to be devil’s advocate for a moment, if you were in a situation in which you were trying to do what you have variously described to us as the job of an advocate, which is to elicit from your client the information that you then need to speak on that client’s behalf, it is sometimes easier, is it not—it may not always be appropriate—to get the information you need if you are in possession of information which will help you to frame your questions? I can see why you find this difficult but can you see no circumstances in which it might help you?

Ms Dyter: We quite often access patients’ records but we do it in support of patients requesting to see their records.

Q1073 Chairman: Can we take a straw poll on this issue? Do any of our six witnesses believe that there are any circumstances in which advocates should have access to the patient’s medical records without the consent of the patient? Ms Mills: No.

Mr Munn: No.

Q1074 Chairman: Do any of you think there are circumstances in which you should have access to the patient’s medical records with the consent of the patient but without the patient seeing them, which may be a quite different set of circumstances? Mr Coe: There are some circumstances where that happens. We would support that happening, for instance, where the person using services wants to see what is written about them at a particular time or about a particular circumstance but reading it directly themselves would be quite a distressing experience. There may be all sorts of information there that they do not want to know at all. At the direct request of an advocacy client, I personally have sat and read through their records on their behalf, taken notes and reported back to them, so yes is the answer to that question.

Ms Mills: There are five or six files like that on me at the moment. If you were to read through them, you would see various psychiatrists’ opinions of me. You would not necessarily get a picture of who I am. It would not be a very holistic picture. The whole point about advocacy is getting to know the person and not judging them. An awful lot of prejudices would be made about me if you were to look at my medical records.

Mr Munn: We could accept that but it does not matter because if that happens and the patients have some concerns they have the right to see their own records these days anyway.

Q1075 Chairman: Is that a right which in your judgment is effective, the right to see their own records?

Mr Munn: At the moment, the process is quite difficult. One has to apply and go through the right process to get hold of the records, but it is possible and an advocate would probably help a patient to do that.

Ms Mills: Also, we do not have complete freedom of information. I have heard of people accessing their records and where things have been considered to be damaging to their mental health have been blacked out, so there is some concern over that.

Q1076 Chairman: Do you have a view as a group—you may have disparate views—as to whether there should be an advocacy standards agency as has been established in Scotland?
Mr Coe: It is AMHA’s clear view that an advocacy standards agency is the best way forward. We feel that advocacy by its nature and philosophy is very close to the needs of service users. By having a dedicated agency, service users and advocates would be able to have more of an influence in how services are monitored. We would see a standards agency, given that advocacy is still something that is very much in development, as able to be more flexible and adaptable to changing needs and circumstances. What we would like to see is that standards agency reflecting our proposal about embedded advocacy and new proposals being embedded within local services reflecting that requirement and for the standards agency to take account of standards and codes of practice across the board in all kinds of advocacy, not just in capacity advocacy or Mental Health Act advocacy, but to take responsibility across the board. That is going to be much more effective than, for instance, moving out these responsibilities to an inspection agency like the Healthcare Commission which, although it has slightly refocused over the last couple of years, is still perceived as being a remote agency that is harder to influence and access. If we look at the alternatives, what we are talking about here is effective accountability and regulation. There is only a very limited number of options here. The Government and nobody would accept that this accountability and regulation should be entirely determined by advocacy services. That is simply not tenable when you are talking about statutory roles. It is either going to be large inspections agencies or a new agency. I understand from Scotland that the Advocacy Safeguards Agency, as it is called there, which is established to have this kind of role, has done a lot of good work but it is frustrated because it has not been given the teeth to enforce its inspection and monitoring role. It can go in and do an evaluation of the service but it cannot force through change. These are problems that we are all well aware of in terms of the inspection and accountability of health and social care services generally but I think we have an opportunity here to get it right for what is still very much a developing service.

Q1077 Chairman: Can I do another straw poll? Do any of our witnesses oppose the setting up of an advocacy standards agency, bearing in mind that it is yet another quango being inserted into an already complicated health care system?
Mr Henderson: Our hesitation in recommending this at this stage is that it is too soon in relation to the Scottish initiative to be able to say whether it has had any real impact on standards on the ground. What we need to do is consider the standards that are involved in running any publicly funded body, but also the issues around the quality of the experience of the users. It probably is too soon to be able to say whether or not the Scottish Advocacy Safeguards Agency has achieved that. The other thing to recognise is that there are many, many areas in the country where, off their own bat, advocacy organisations have got together and set their own standards. In places like Leeds, Gloucestershire and Essex, you will find best practice in this area. At this point we would simply be recommending that the advocacy organisations work in partnership with government departments to look at the various options and to weigh up the pros and cons.

Q1078 Chairman: Why is not self-regulation, as suggested by Mr Henderson, as good as setting up a quango?
Mr Munn: I think it is. I am opposed to the requirement and for the standards agency to take up quango. Having only received the questions on Monday, it is difficult to have got the views of UKAN but I can speak for them and Cymar. We would oppose that because what we really need is to strengthen the infrastructure, with perhaps the Advocacy Federation or something similar, with people of experience of advocacy, not from an imposed theme from government. We are at this point opposed to that. I am a Healthcare Commission reviewer and I believe what the Healthcare Commission would do would be to pick up problems in advocacy within local health boards, as they are in Wales, primary care trusts. They could then reflect that back to the Advocacy Federation or a body that could look at that if that were necessary. Also, individual schemes already do their own monitoring and that is often done by user involvement groups. There is a very good one in Wales, Pontydd, that has done a number of advocacy evaluations.

Q1079 Lord Mayhew of Twysden: There are about 50,000 uses each year made of the Act. The Department reckons that the Bill will require 140 whole time equivalent advocates. You generally thought that was, putting it politely, rather conservative. Some other witnesses have not been quite so polite. Are you aware of the basis upon which the Department has calculated the need imposed by the Bill? If you are, do you think it stands up to real examination?
Mr Coe: We have tried to elicit a direct response on that from the Department and have so far been unsuccessful.

Q1080 Lord Mayhew of Twysden: Can I help you because they have told us that one episode of advocacy would be used each time a person came under compulsion; one more episode in connection with each mental health tribunal hearing and again in connection with each expert panel examination, with each episode lasting two hours. It is fair to say they are not reconsidering that but we do not the outcome.
Mr Coe: Not everybody is subject to compulsory treatment and chooses to use an advocate. However, if they did, on the 140 figure, that would make 140 advocates responsible for about 357 uses
of the Mental Health Act each, so that is still quite considerable. On the basis of the figures that you have given there, we were discussing our response to this question and that seems to us to be a huge under-estimate of the level of advocacy input that is often required. The level is variable from person to person. Some people need a one-off meeting but some people request and need advocacy input through many different occasions through the course of their stay under section. If you look at the functions outlined in the draft Bill, it is clearly about helping people to obtain information about their rights and to provide help by way of representation or otherwise. We think that is a useful phrase. That may involve supporting somebody to prepare to go to a ward round. That might happen weekly over a course of, say, six months admission, to participating in care programme approach meetings, to do all the tribunal preparation work and so on. Those figures are severe under-estimates.

Q1081 Lord Mayhew of Twysden: Have you collectively or individually a figure which you consider more realistic?  
Mr Coe: No. We consciously do not want to provide figures off the back of an envelope. We have not done in depth research on this. We are aware that the work that has begun under contract to the Department, carried out at Durham University, is going to look at this issue. We are expecting to contribute to that. We do not have the resources here to do the complex research that needs to be done.

Q1082 Lord Mayhew of Twysden: Are you all aware of the conclusions that Cymar derived from the research they have carried out? We have seen the research. Have you all seen it?  
Mr Coe: I have seen the research, yes.

Q1083 Lord Mayhew of Twysden: Taking account of different circumstances, do you want to distance yourselves from any general conclusions that they form, particularly about increased workload, or does it ring true to you?  
Mr Coe: I know Cymar’s views on increased workload. There is the whole question about whether the proposals in the Bill are going to increase the use of the Mental Health Act in general terms and increase the number of sections. I know that is a disputed topic. If you take the Government’s view that it will not increase, clearly there is not going to be an increase in the episodes of advocacy. However, in terms of the workforce, we think there are enough advocacy providers out there to be able to get advocacy workers trained up to provide this very specific role in general terms. However, specifically, we think in Wales that there are only between 25 and 30 paid advocacy workers there so we think there is a significant capacity issue.

Q1084 Chairman: Are you satisfied that, given the increasing numbers required, training standards can be maintained in a difficult world in which more and more advocacy is required?  
Mr Coe: Given the right resources and given an agreed national training programme and an agreed code of practice, absolutely. We have every chance of making that work.

Ms Mills: In order to provide quality provision, there is absolutely no way that 140 people are going to be able to cover diverse needs, rural areas and older people. That is vital. We want a quality service from an advocate.

Chairman: We are going to have to bring the meeting to a close because there is important business in the House of Commons this morning. Can I thank all six of our witnesses. I know you would all have liked to say more but please be reassured that we have read your written evidence as well. Can I thank you for coming and for being such enthusiastic providers of information which has been of value to us.

Supplementary memorandum from CYMAR and UKAN (DMH 436)

Dear Lord Carlile of Berriew and Members of the Scrutiny Committee,

We would like to thank you for giving us the opportunity to submit evidence today! There were however a few points we did not have the opportunity to discuss. We hope you will allow us to submit these further comments at this juncture;

1. Compulsory Treatment/Community Treatment Orders

In principle we are against compulsory treatment. However, Community Treatment Orders if discussed with the service user in partnership with other agencies, one could see circumstances where the service user may agree to take medication in the community for an agreed length of time. This would need to be negotiated through the Care Programme Approach/Care Management and take into account self management and alternative forms of treatment that may be deemed to be more appropriate, eg talking treatments. It is important to remember that medication does not work for all individuals and that other forms of treatment can be effective. We would like to point out that many service users self-manage
medication, negotiated with their consultant psychiatrist, and do not believe that constant long term medication is beneficial for their overall health, well being and ability to be fully functioning citizens. Research clearly demonstrates that self medication is proven way of enabling recovery.

2. DURHAM REPORT

Neither UKAN nor CYMAR were consulted by Di Barnes for the Durham Report. We strongly believe that the omission of Service User-Led Advocacy was a serious omission, especially as UKAN has been leading on advocacy from service users’ perspectives for over a decade. UKAN and CYMAR have been successful in pioneering and highlighting advocacy, however educationalist and people seeking a career in advocacy are deemed to be the experts—what about the “Expert Patient”? We are “Experts by Experience”.

3. INDEPENDENT ADVOCACY

Specialist Mental Health Act Advocacy needs to be an integral part of the overall advocacy a Service. A successful Advocacy relationship can play a vital role in recovery! Specialist Mental Health Advocacy, in order to be a service of quality meeting diverse needs requires also a quantity of time, far greater, we believe, than is currently being indicated by the Department of Health.

Thanking you in anticipation.

2 February 2005
Memorandum from the National Forum for Assertive Outreach (DMH 406)

Submission to the Joint Parliamentary Scrutinising Committee of the Draft Mental Health Bill 2004

THE PROPOSAL FOR COMMUNITY TREATMENT ORDERS (NON-RESIDENT ORDERS)

I am the Chair of the National Assertive Outreach Forum. This submission has been prepared and endorsed by the elected committee of the NFAO. Our Assertive Outreach Forum members are fully aware that if Community Treatment Orders (CTO’s) are agreed in the new Mental Health Act (MHA) we are the service that will be responsible for many of them. Assertive Outreach patients almost by definition have a major psychotic illness, many are ambivalent or avoidant of taking consistent medication and are subject to repeated, disruptive and distressing relapses often necessitating compulsory admissions. Lack of awareness of mental illness is a persistent feature for many patients.

There are now over 240 Assertive Outreach (AO) teams in the UK and they were established specifically to serve psychotic patients with a history of difficulty in engaging with traditional services. 126 of these teams are registered with our organisation and vote for officers like myself and regional representatives. Many more teams attend our practitioner events. The organisation serves as a practitioner based body organising regular and regional events to facilitate good practice. Our members and AO teams are predominantly made up of mental health nurses, occupational therapists, psychologists, social workers and doctors.

We have discussed this issue at regional and national meetings and we have had Rachel Munton, Director of Mental Health Nursing with the Department of Health, speak to our 2003 National Conference of over 200 AO practitioners on the Draft Bill. It was clear from this speech that the thrust of the Bill, and CTO’s, is to modernise legislation recognising that the majority of acute care now takes place in the community.

Although we have not taken a formal poll of the memberships views on CTO’s it is clear that opinion is divided about their potential value and the ethical effects on practice. Opinion of Assertive Outreach practitioners is however guided by our close exposure to the harsh realities of the lives of people with severe mental illness and by our experience of working with Aftercare Under Supervision (Section 25a MHA 1983) with treatment avoidant patients. As practitioners we are conscious of the pragmatic application more than the principled debate that has taken up much of the scrutiny committee’s deliberations. We cannot avoid however the tension between pragmatism and principle. In principle we would like in all cases to follow a long-term, collaborative approach to recovery, engaging people in health and social care by choice with respect to autonomy except in the absence of capacity. In practice for some individuals this becomes problematic for the reasons below.

Working alongside someone you have got to know well and like, and having to wait, once they have discontinued medication, while they deteriorate slowly to the point of warranting compulsory readmission becomes increasingly difficult. Especially as this so often follows a predictable course, destroying relationships, losing accommodation, running personal risks, alienating family and unravelling all the preceding year’s rehabilitative gains.

We also work alongside carers and many carers and the general public fail to see how the MHA cannot be more proactive where they observe disturbance and distress in a relative or neighbour whom they know is well known to services. It is not uncommon for the public to contact their elected MP, and for health and social services to in turn explain that the law requires a threshold to be met before compulsory treatment can be initiated.
Initially we were sceptical that Section 25a would not make any difference. The current Section 25a aftercare under supervision legislation is a cumbersome bureaucratic process and took a lot of getting used to. From my long association with the Wandsworth AO team, and the experience of several other members of the NFAO, we believe that it has worked well for a number of our patients. It is used to try and ensure improved medication compliance and to gain regular access to people’s homes. We have been struck by the fact that many patients (despite denying that they are ill at all) recognise the force of law and agree to abide by it—allowing us regular access. We are absolutely scrupulous about explaining that the Section does not permit us to force medication, but binds us together in a mutual obligation to work together with a frankly articulated statement and care plan of the rationale based on objective risks and losses. This is a pledge to the patients that we take these risks, and their care, extremely seriously. Despite the drawbacks Section 25a has enabled us to ensure regular medication and social stabilisation in many patients who had repeatedly completed the cycle or relapse and catastrophe, in many cases an escalating cycle.

It is probably worth outlining the drawbacks of section 25a. Firstly it doesn’t work for everyone—far from it. It is an issue of “persuading the persuadable”. If we have to recall a patient more than once or twice we inevitably end up abandoning the Section 25a. Section 25a gives the power to take and convey a patient back to hospital if the contract is defaulted upon.

Section 25a is not widely understood or recognised by the Police and in the majority of recalls a Police presence is requested to prevent an assault upon staff. This has not been forthcoming and older powers more familiar to the Police are then required, specifically section 135 MHA (warrant to search for and remove a patient) and section 3 MHA (compulsory admission for treatment) creating further delay. The new Bill would benefit from placing a clear duty on the Police and Ambulance services to assist with conveying a patient to hospital under the CTO where recall to hospital was necessary.

Section 25a’s essential drawback is that it is not easily enforceable, and that defaulting on an agreed package of care warrants recall to hospital but that treatment or detention cannot then follow without resorting to older in patient treatment orders. This strikes many working in this field as neither one thing nor the other. Indeed many teams will prefer to use section 17 leave of absence from hospital to treat people in the community who have been in hospital on a section 3 before Section 25a is tried as it provides more practical recall and treatment should conditions of leave fail.

Treating people in their home environment is generally preferred to institutional care by patients, even where treatment is backed up by a degree of coercion. The submission from the Royal College of Psychiatrists states that “community treatment orders should be available for patients only on authorisation of the Tribunal after a period of in-patient assessment”. Presumably this is to ensure people meet the in-patient committal criteria. The Saskatchewan model outlined in the Royal College of Psychiatrists submission suggests, amongst other safeguards, a history of 60 or more days as an involuntary in-patient or on more than three separate occasions as a threshold, and that failure to receive community treatment would be likely to cause harm or substantial mental deterioration. The Saskatchewan criteria would be familiar to most AO practitioners as the rationale for referring patients to Assertive Outreach Teams.

The Saskatchewan criteria also requires the patient to be unable to understand or make an informed decision on the need for treatment, care or supervision. This is a sensible and workable principle with the caveat that review of a CTO by a Tribunal will need to appreciate that by the time a Tribunal is called many patients will have sufficiently recovered to present us having understanding. This in practice does not mean that the CTO should be immediately removed. Section 25 takes months—not weeks—to be worthwhile. The benefits arise from prolonged stability in the community and the re-evaluation of personal objectives this allows. It is probably between six to 12 months that we see the differences. However the Wandsworth AO team have had one patient on repeated Section 25 for three years.

There is also international experience of “diversionary” CTO’s in which a person meets the in-patient committal criteria but is diverted to community treatment, and “preventative” CTO’s where a person can be treated in the community prior to meeting in-patient criteria with known histories of involuntary admissions and risk-related relapse patterns as above. There is a case in our experience for including these provisions in the new legislation with sensible safeguards for civil liberties.

We have not found Section 25 to be a significant problem for the therapeutic relationship. The patients who eventually become subject to this sort of compulsion are long familiar with services and have no illusions about the realities of compulsion. Denying the unequal power relationship in mental health is transparent to them, as they already know that the services have such powers. We welcome the clarity that is brought by the necessary consideration of risks and benefits openly discussed with the patient.

In my experience of the Wandsworth AO team serving an inner city population of 250,000 with 100 patients we have rarely had more than six patients on a Section 25 at any time. The AO Forum members, are aware of the complex ethical issues that are posed by CTOs and we don’t have absolute or simple answers to these. However our experience of the nearest thing to a CTO has convinced many of us that there is a place for judicious use of compulsory community treatment in our patient population. Current arrangements are partial and problematic benefiting only those who preserve the ability to respect a legal order since it is largely unenforceable. A CTO will be more honest, allow prolonged treatment in non restrictive environments and will we believe be used by practitioners in the spirit in which it is intended, and not as a
method of control or as a short cut alternative to long-term constructive and collaborative engagement. Finally CTO’s will not be effective in improving patient treatment outcomes without us continuing to see the development of comprehensive, accessible and effective community mental health services.

I hope these observations into some of the practicalities of working with limited compulsion in the community will be of some value to the committee in its deliberations.

Mike Firn
Chair, National Forum for Assertive Outreach

Witnesses: Mr Mike Firn, Chairperson, Mr Michael Hicks, Northern and Yorkshire, and Ms Judith Fairweather, London, National Forum for Assertive Outreach, examined.

Q1085 Chairman: Welcome to what is, in fact, the last evidence session of the Committee’s hearings. Before you introduce yourselves, may I remind you formally that this is a public session of the Committee, that what you say will be recorded and transcribed, that there will be a transcript available on the internet in about one week which you are free to make suggestions for changes of but only in terms of making sense of the text, not in relation to the substance. Could I ask you if you would very briefly introduce yourselves and then we will go straight into questions, if we may. We are grateful to you for attending.

Mr Firn: My name is Mike Firn. I am the Chair of the National Forum for Assertive Outreach and I manage three assertive outreach teams in South-West London for an NHS Trust.

Ms Fairweather: My name is Judith Fairweather; I am the London Regional Lead for the National Forum for Assertive Outreach. I am also the team manager in South-West London, St George’s, for an assertive outreach team.

Mr Hicks: I am Michael Hicks. I am the Northern and Yorkshire representative for the National Forum for Assertive Outreach, and I also work for Selby and York Primary Care Trust in assertive outreach as a community nurse.

Chairman: Can I ask all witnesses to speak up, please, because the acoustics are not always terribly effective. Lady Pitkeathley.

Q1086 Baroness Pitkeathley: Can I begin by asking you to describe very briefly what is assertive outreach and how does it differ from more traditional arrangements in managing the treatment of mental illness?

Mr Firn: Assertive outreach is a targeted approach to people with severe and enduring mental illness. Essentially the difference from standard community mental health follow-up is that it is a multi-disciplinary team whereby each worker would only have a small number of patients (12 to 15 patients) and they will be required to provide very comprehensive health and social care for that small group of patients. There is a criteria for referral, so it is a tertiary referral, to the specialist assertive outreach team based on typically people with psychotic illness of long standing, revolving door patients with very complex needs, often with chaotic lifestyles, co-morbid problems around substance abuse or physical illness essentially.

Baroness Pitkeathley: In your submission you have set out the advantages and disadvantages of section 25A of the 1983 Act providing aftercare and supervision. What changes need to be made to the existing system to turn them into an effective community treatment system?

Q1087 Chairman: Could everyone speak up, please, including Committee members for the benefit of the older males, including me, on this Committee! Mr Firn: Certainly. Our essential concern about section 25A is that there is an ambiguity around section 25A in that it provides for supervision follow-up of people who are discharged from hospital who meet certain criteria, and the supervision is intended to be for the purposes of delivering health and social care treatments, although it does not allow for the enforcement itself of those, particularly health treatments, and often a major part of treatment is maintenance anti-psychotic medication. We feel that the lack of clarity is unhelpful. Only being able to supervise people means that you are often still in a position whereby you are observing somebody following a predictable pattern of deterioration, which has implications for their health and well-being, and the safety sometimes of other people, but ultimately, in order to provide treatment, you are forced to fall back on older powers, such as section 3 of the Mental Health Act, and that causes a delay which can cause concerns for health and safety.

Q1088 Baroness Pitkeathley: Is it also right to assume that this takes a long time, this treatment: months rather than weeks?

Mr Hicks: I supervise patients under section 25 in the community. My experience of it is that it works well for people who agree to it and it does not work very well at all for people who do not agree with it, so we end up with the conflict and the ambiguity that my colleague referred to in his answer previously.

Q1089 Baroness Pitkeathley: Is it also right to assume that this treatment is of a long-standing nature: months rather than weeks?
Mr Hicks: By nature of the client group that we work with, they are all long-standing needs, they have established serious mental illness over years and will have it long-standing into the future. Yes, it is a long-standing treatment.

Q1094 Ms Munn: I respect what you have said about psychological benefit of it, I am just saying that, if that were a principle that was either in the Bill or in the Code of Practice, you are getting into a really difficult situation?

Mr Firm: I think there would need to be safeguards. The safeguards would need to be that somebody has a history of repeated compulsory admissions recently, that they have a severe and enduring mental illness, that they have an impairment of their ability to appreciate the need for maintenance medication. I am not quite sure if I understand the—

Q1095 Ms Munn: I am just saying there is a dilemma which you are describing, and I absolutely understand what you are saying. If somebody says “It would be helpful to me to have a clear plan and to know that I have got to follow this and, therefore, I am happy to be”, as it is on under the powers of section 25 at the moment, or transposing it to a new situation of a Community Treatment Order, whereas I am saying we might actually want to see in the Bill something which says use the least restrictive, or the least invasive, or whatever the word is, and that would cut across that; because if somebody is agreeing to it by definition you would not need an order?

Mr Hicks: I do not think we disagree with that.

Ms Fairweather: I think I understand a bit about what you are saying. Why do you need it if somebody is agreeing to the treatment?

Q1096 Ms Munn: Yes.

Ms Fairweather: Initially some people will not agree to it and section 25 is put in place to engage with that person in another way. You probably will not need a section 25, but then they agree to the engagement but they will not necessarily agree to the treatment.

Q1097 Lord Mayhew of Twysden: Going back to the “persuading the persuadable” line, we are talking about treatment-avoidant patients, are we not?

Mr Firm: Yes.

Q1098 Lord Mayhew of Twysden: I understand the point I think you are making, but I want to ask whether you would think it the case that there are some treatment-avoidant patients who are more likely to be treatment avoidant and dig their heels in if they are under detention than if they are out in the community under a provision which enables them to be recalled if they do not take their treatment, their medication. Do you see what I mean? I have not put that very clearly, I am afraid. Are you more likely, do you suppose, to be in the persuadable class if you are living at home though you know you can be compelled to go back into hospital if you do not take your medicine?

Mr Firm: I think essentially we need to recognise that the majority, even of acute care, can take place in the home environment, and we are moving away from care which is centered around a hospital setting. If we are trying to think ahead to legislation which potentially could last for a generation, I think this is an opportunity to clear up the ambiguity of section
25A and to put in place lasting legislation that will be effective for the treatment of the unpersuadable. As assertive outreach practitioners, we go to great lengths through having very intensive well-resourced teams with small case-loads, visiting people every day, if necessary, and offering them medication for maintenance every day, if necessary, taking care to minimise the side-effects, which are a real issue for patients on anti-psychotic medication, providing for social care, taking people out recreationally, helping people with money, benefits, in order to foster a positive relationship. There are a very small number of patients for whom you exhaust all possibilities over several years and section 25A does not provide an effective solution, and ultimately only a Community Treatment Order or, what I suspect will be less desirable, admitting people into hospital often in rather unpleasant circumstances—There are occasions when 20 policeman turn up outside people’s houses and a social worker and a doctor because these are people that the police have looked up on the computer and they say, “Goodness me, look at all this previous”, and they turn up en masse; and it is very distressing for relatives and not least for the patients themselves. I think it is trying to be creative as well as pragmatic to say we do need for a small group of patients to have a community treatment option which is enforceable, and currently section 25A is barely enforceable. That is our central concern.

Q1099 Dr Naysmith: We have had a lot of evidence in this Committee critical of Community Treatment Orders—and you have probably heard that—from service users and many mental health organisations and from some professionals as well. They strongly oppose the use of compulsion in the community in almost any circumstances; some of them say “any circumstances”. One of the arguments that has been put to us is that Community Treatment Orders will undermine assertive outreach, and, of course, that is related to what we have just been talking about, but, if someone was to say to you this will be bad for the kind of professional service that you now offer, what would you reply to that?

Mr Hicks: Following on from what Mike has just said, in my practice I would be thinking about a very small minority of my client group for which all the process that Mike has just outlined has taken place over a number of years, which would prove to me that assertive outreach as an approach has not helped that person, has not worked for that person, that it has in fact failed that person. I would not feel that my assertive outreach practice is undermined by resorting to what I would call a very last resort having gone through two/three years knowing a client very, very well and having demonstrated that this intense assertive outreach approach has not worked for that person. I can see why people might say that, because of the nature of trying to foster the relationship and a very close working relationship with the client, but if you are demonstrating to yourself and the client that it has not worked, I can see the argument going the other way as well. I take the point, but I would disagree because it is such a minimal amount of my work that I envisage this being used more into the future.

Q1100 Chairman: Do you think that, if you were pressed you would be able to write a protocol or a list of criteria which would sufficiently limit the group of patients who would be the subject of Community Treatment Orders so as to clearly avoid the risk, as some have put it, of these orders becoming ASBOs for the mentally ill?

Mr Hicks: Yes. We have spoken about this as being absolutely critical to this legislation that there is almost a mandatory flow-chart that somebody must go through from A to B to C to D before you then start looking at them.

Q1101 Chairman: But you think it can be achieved?

Mr Hicks: I think so. I think there are fairly easily recognisable criteria that you would have to look at over time, over circumstances, over involvement, over different types of care, trials of different types of care, and so on and so forth. Yes, I think that is achievable.

Q1102 Dr Naysmith: How would you define that sort of patient, and would there be wide agreement amongst professionals, or would it start another big argument about who should and who should not?

Mr Firn: You would need to be very clear that you had an effective treatment for that person. I have mentioned that maintenance medication is a large part of some packages of care for people with very serious psychotic illness.

Q1103 Chairman: You mean depot injections?

Mr Firn: Not necessarily depot injections, and, in fact, it is possible that—depot injections are used often where there are concerns about compliance with medication and depot injections are currently older medications which have more side-effects. Assertive outreach attempts to give people newer medication, often in oral form, sometimes by daily supervision, and that is effective maintenance medication. We are very keen as an organisation that CTOS would not be used as a short-cut to this very long-term process. The other thing that I would like the panel to appreciate is that these patients who would be subject to a CTO would be a small number and would be very well-known patients with very well-known histories and the deterioration can be predicted from an earlier point to which currently we are able to intervene.

Q1104 Dr Naysmith: We have also heard evidence to argue that people will be admitted to hospital for a relatively short period of assessment, and then, if they fit certain criteria—the sort of thing that you have been talking about—most of them will be allowed back into the community under either voluntary or compulsory treatment orders. What proportion do you think of the ones who would be admitted like that would be able to return early back home or back to the community under this legislation?
Mr Firn: I think we already have within the NHS plan and the modernisation of mental health teams which do allow for people to be discharged at an earlier stage from hospital. The problem is there is a very small group of people who immediately upon leaving hospital will say, “I am not taking my medication”, and that has happened several times already.

Q1105 Dr Naysmith: Can you assess that while they are in hospital, or is it impossible to do it?
Mr Firn: My view is that assertive outreach teams know their patients very well and you already know that and you do not need a period of assessment in hospital to determine that.

Q1106 Dr Naysmith: For patients you know well?
Mr Firn: The patients are very well known, and to some extent, which is why we have mentioned tentatively in the submission the idea of a diversionary CTO or a preventative CTO which does have some international precedents, because the assessment period in hospital would not necessarily tell you anything that you did not already know by long association with this patient, their family and their community.

Q1107 Baroness Eccles of Moulton: You have quite largely answered my two questions by your emphasis on the need for CTOs to be restricted to extremely few patients which obviously produces quite difficult legislative problems, but the questions I was going to ask you and I will continue to do so. Firstly, you have painted a very comprehensive picture of the sort of support that assertive outreach teams provide, also covering some of the social aspects of the clients’ existence. This morning we heard from the carers, and obviously there are many sides to the environment in which anybody undergoing a CTO would exist; and so really it is a question of the extent to which that sort of very, very high quality environment is practical in most cases. The other point that you made was the horror of a large number of policemen, having looked up the record on the screen, appearing on somebody’s doorstep. As I understand it, if a CTO has to be enforced because there is continuing resistance to treatment—the persuadable aspect of it is not present—then, as a last resort, exactly the same procedure might have to be followed, that the police might have to be party to the individual being removed to hospital for forcible treatment?
Mr Firn: That is quite likely, but it would give them provision to recall somebody prior to them meeting the necessary in-patient criteria—what sort of immediate risk they present to self and/or to others—because it would usually be based on default of the conditions of the Community Treatment Order, one of which would often be compliance with maintenance medication. If you have seen somebody stop their medication several times and deteriorate and that followed a well trodden path, then you would be able to recall them at that point which, in our experience, recalling people earlier, leads to a less traumatic, a less hostile and less police officers, if any police officers, rather than at the point at which somebody has lost complete touch with reality, their emotions and is acutely paranoid and therefore thinking that people are coming to kill them.

Q1108 Baroness Eccles of Moulton: Do you collectively believe it is possible for the quality environment to be available to somebody under a CTO in all respects, both assertive outreach and carer?
Mr Firn: I think the aspirations are there in the NHS plan and the targets of the NHS plan have been partially achieved and are being implemented rigorously. One of the things that we did consider, in terms of effective treatment in the community and linking in with the reciprocity principle, was that somebody on a CTO, it could be written into the legislation that they have a minimum level of input, which might be weekly contact with their supervisor or with their treatment team or a nominated person or fortnightly as an absolute minimum, and I think that would go some way to ensure that people are not put on a CTO and do not receive good quality care.

Baroness McIntosh of Hudnall: I just wanted to pick up on something that you have already, in a way, notified us to, which is that you do think that the patients to whom CTOs would be appropriately applied are limited in number and that there are narrow circumstances that would have to be present in order for that to be appropriate. Can I just ask you to give us a bit more of an idea about what the parameters should be. For instance—here are some options—do you think there should be a maximum time limit on the period that somebody can spend under compulsion in the community? Should anybody be able to veto the application of the Community Treatment Order? Should there be limits on the conditions that can be applied to somebody under a Community Treatment Order? For instance, is it appropriate that they should be subject to curfew, that there should be some other restriction on their liberty or that they should be asked to abstain from using alcohol or drugs? I will not go on with a long list.

Q1109 Chairman: Could I add one, Lady McIntosh? Do you envision a CTO requiring specific inputs from carers? Do they have role in such care? That picks up a concern that was expressed this morning.
Mr Firn: We discussed this as a group, and it is very clear that CTOs should not be used to determine people’s lifestyle, that people are able to choose a lifestyle however unorthodox. It should be limited to
people with very serious, predominantly psychotic, illness if not exclusive psychotic illness, which would be schizophrenia and bi-polar illness with psychotic features, where there is, for some people with more serious illnesses, a failure to appreciate the need for treatment and care. I think the Saskatchewan criteria which appeared in the Royal College of Psychiatrists’ submission and our submission of a recent history of at least three compulsory admissions and obviously people who present very serious concerns particularly around risk to self and risk to others. In terms of alcohol and lifestyle, absolutely not even on the horizon, not even part of the equation, and not an ASBO. We had a discussion about ASBOs. None of our 250 patients in South-West London are on an ASBO, although Michael has experience of one patient in York who is on an ASBO, but that is a different process. It is not initiated or managed by the Mental Health Team.

Mr Hicks: Neither was it to do with his mental health problems. It is to do with social problems of persistent begging, which is unrelated to his mental health illness.

Mr Firm: In terms of time limits, we feel there is a need for a tribunal, obviously, whether automatic or not, but it may be prudent to consider an automatic tribunal. A time limit: these are not treatments and sort of health packages that have immediate results, and six months would be an adequate review period, and there would presumably be the ability to renew it either at the instruction of a tribunal or otherwise, but I certainly want to distance ourselves from any notion, first of all, of conditions around curfew, conditions around drugs and alcohol.

Mr Hicks: And also distance ourselves from any notion that people would be forcibly treated in their own living-room.

Chairman: I can see Lady Cumberlege is itching to intervene in your answer, so I am going to let her.

Q1110 Baroness Cumberlege: It was really to expand a bit on that, because these are very sick, disruptive people who can wreck families, and I want to repeat your question really, my Lord Chairman, in terms of should unpaid carers have a right of veto?

Mr Firm: I think, as with all Mental Health Act legislation, the carers are consulted where there are carers. We have to say in our experience of assertive outreach teams, we are often dealing with isolated marginalised people who do not have carers. Where carers are involved, as with a section 3 application or other Mental Health Act applications, the next of kin or the nominated person in the new Act would have right of veto, and, if that right of veto is felt to be invalid, then, as currently, you have the option of going before a court to have that person removed as the nominated person. I think that would be a valuable safeguard to include.

Q1111 Chairman: Can I ask you a question that goes back just a tad on what was said earlier? Supposing that a choice is a stark one between being an in-patient in, in some parts of the country, really not very acceptable hospital facilities and being the subject of a Community Treatment Order in which there is a condition, because it is a problem, that the patient, for example, will not visit the pub and will not beg, what is wrong with that if the effect of it is going to be that that patient is going to be out of hospital, possibly able to go to work and living a much more generally functional life?

Mr Firm: I have an instinctive problem with it, but I am trying to put it into coherent words. It feels wrong morally.

Baroness Cumberlege: Can I reframe it slightly, because I think it is the same question. You did say that issues of use of drugs and alcohol and other what you describe as lifestyle issues should not be included. There are circumstances where somebody who is suffering from a mental illness and is also using drugs and alcohol may presumably—I ask the question, I do not assert this—be exacerbating their problem and/or undermining the effect of their medication by continuing to use alcohol or drugs. I make no moral choice about whether people should or should not do that. That is not the issue. The issue is whether the impact of the treatment order can be effective if other issues are left untouched. So I ask you again, can you imagine circumstances in which it might be necessary, as it were to prevent people from going to the pub, in the interests of delivering the community treatment?

Chairman: Before you answer, did you want to come in on the same point, Dr Stoate?

Q1112 Dr Stoate: Yes. As a practising GP I can think of classic examples. You may see something as morally repugnant to put somebody on a Community Treatment Order, and yet I have had patients in the past with bi-polar affective disorder who have been perfectly well at home, they then, for all sorts of reasons, decide that their medication is no longer necessary, and we all know what the consequences are—they gradually get more and more irrational, I suppose, for want of a better word, their families get extreme levels of distress, their children get extreme levels of distress, the husbands, if it is a woman, are beside themselves with “What can I do about this?” As a GP my hands are tied, because I cannot ask for a section on this patient until they get to the point where they are a danger to themselves or to others, which can be very far down the line; whereas I know, as a GP, that, if that person were forced to take their medication, they would be back to normal again before having to have the distress of a disrupted family, a compulsory admission, a month in hospital.

Mr Firm: We are agreeing with you on that.

Chairman: Before you answer, because I know it is the same point, Mr Loughton.

Tim Loughton: It is very relevant. Yesterday I happened to be visiting a mental health establishment for veterans in Shropshire, not held subject to section in that particular case, although people who may have been sectioned previously, and they operate a policy specifically on going to the pub, interestingly, and they grade their patients in three different levels: (1) are allowed to out the pub, (2) may go out to the pub under some sort of supervision, and (3) absolutely nowhere near the
pub; and if any of them break it they are not allowed to stay there any more. There is a practical application on a lower level of detention because they know that, if they do go to the pub and go completely rampant, the tribunal will completely wreck their whole treatment procedures. They operate it very successfully. What is the problem with that?

Q1113 Chairman: I feel the Bournewood pint coming on! Would you like to answer the general picture posed by those questions and then we have one other question? We really must finish then.

Mr Firn: I certainly agree with the scenario about the manic depressive patient who is following a predictable relapse and the need for some early intervention and, under certain circumstances, possibly could be under a Community Treatment Order. I also agree that the use of drugs and alcohol does undermine the effects of medication, and there is good evidence for that. However, I think, broadly speaking within the profession, the limiting of people's freedom of movement, access to lifestyle choices is a step too far.

Q1114 Chairman: That is on instinctive grounds.

Mr Firn: That would be social control.

Q1115 Chairman: But on instinctive grounds?

Mr Firn: That is on instinctive grounds.

Chairman: Lady Murphy, you have been very quiet, so get a quick one in.

Baroness Murphy: I wonder if what Mr Firn means out-patient clinic setting or to a hospital setting; and to say perhaps is that the treatment order is to enable the treating team to get hold of the symptomatology of psychosis, and you are then working with the person who has suffered these symptoms to enable him or her to be as crazy as rest of us in going to the pub, in going out when they feel like it in the evening and choosing where they want to live, but that you hope that by reducing the symptoms and enabling the person's personality to emerge you will be able to enable them to do that and not to confuse it then.

Q1116 Chairman: You are about to quit you are winning with a "Yes", are you not, Mr Hicks?

Mr Hicks: I was just going to say, that goes back to the flow-chart, and if that can be seen in the treatment plan as being beneficial to other lifestyles by treating the symptoms in the first place, that fits into the A, B, C flow-chart in my head.

Mr Firn: It is about providing a structure for the delivery of therapeutic interventions, which may in turn have an impact on behaviour, but if the behaviour is to some extent independent of the mental illness, such as often is the case with the use of drugs or alcohol or other persuasions, then generally we would be uncomfortable with stepping outside of a remit of therapeutic activity.

Chairman: Thank you. That has been a very interesting aspect of the questioning. Can we have finally, one brief moment about resources, please, Lady Barker?

Q1117 Baroness Barker: Yes, resources and structure. Earlier on the Committee heard about the experience of Community Treatment Orders in Australia. In the Australian system people are required to attend a clinic and to receive their medication there. All I wanted to ask you was—and you used the word “reciprocity” earlier on—whether reciprocity is a crucial element of Community Treatment Orders, ie people have to have access to the services that they are being compelled to use? Secondly, I want to ask you about the effect of work load. We have heard from assertive outreach teams working in your area that they can achieve much of what a compulsory treatment order seeks to do, but one of their biggest limitations is having the personnel to do that. Could you comment about that?

Mr Firn: I think assertive outreach teams have usually a maximum of 12 patients to each full-time worker, so the argument about resources would wash not very favourably with some of our community mental health team colleagues and other people working in the field with much larger case loads of people. I think the resources argument is, to a certain extent, how long is a piece of string, but certainly assertive outreach teams, home treatment teams are another part of the NHS plan which provide for acute care outside of a hospital setting. I think we need to be clear from an assertive outreach point of view that we would be using Community Treatment Orders to visit people in their own homes by and large, rather than asking them to come to an out-patient clinic setting or to a hospital setting; and that is the way that you actually deliver more effective health and social treatment, because, if you do not see the inside of somebody’s home, often you miss part of the equation about what their difficulties are about surviving in the community, whether their benefits are coming through or whether they have food in the cupboard and those sorts of things, which are the basic sort of survival skills which some people struggle to maintain.

Q1118 Baroness Barker: May I ask you one follow up question, which is this. In different parts of the country we have heard that there are staff shortages in particular disciplines. We have also heard about the shortage of psychiatrists. Do you think there is a problem in implementing this system, for example, in rural areas?

Mr Firn: I think we are talking about a very small number of patients. From our trust, which serves a population of a million people, there are 35 patients currently on supervised discharge orders. Twelve of those people are from our assertive outreach teams of which we have got three. So that is four patients in an assertive outreach team, which would average about 90 patients. I know from Michael Hicks’ figures that for his team, there would be one patient probably in his team who currently would be suitable for a Community Treatment
Order. I think the resource concerns are of that order for the treating teams, and obviously, depending on the tribunal arrangements, there will be resource implications for the wider services around ensuring that due process and safeguards were in place.

Q1119 Chairman: We are going to have to stop there, but can I thank you for coming to visit us in our own home, and I hope you have some understanding of the problems we face in this environment. You have been most helpful with your evidence. We are very grateful. Thank you.

Memorandum from Dr Peter Bartlett (DMH 418)

CANADIAN PERSPECTIVES ON ENGLISH MENTAL HEALTH REFORM

Thank you for inviting me to provide a Canadian perspective on mental health reform in England and Wales. By way of introduction, it is appropriate to remind you that Canada has a federal system of government, and civil mental health law, about which I will focus my remarks, is a matter of provincial jurisdiction. That means there are 13 mental health legislative regimes in Canada: one for each of our 10 provinces, and one for each of our three territories. Of necessity, I will not talk about all of them. There are some themes that do seem to be consistent throughout the jurisdictions. I will focus on Ontario and Saskatchewan, which offer somewhat different legislative approaches to these common themes.

LEGISLATIVE CLARITY

What is perhaps most startling initially to a Canadian observer is the lack of drafting clarity in the bill currently before you. I would invite you to read the Saskatchewan act as a comparator. It can be read in about an hour, and on the key points its meaning is clear. Such clarity is the norm for Canadian mental health statutes, and as far as I am aware, for such legislation in American and other foreign jurisdictions as well. My sense of the reason for this is an unspoken consensus that those charged with implementing the legislation, who will after all be liable to criminal and civil censure if they make errors, must understand what they are meant to be implementing. I am not convinced that this test is passed for the current bill.

A significant difference may be the tradition of a Code of Practice in this country, which does not exist in Canada. I am much more hesitant than English commentators on such Codes. Either such a code will mirror the terms of the statute in clearer language (in which case, why not use that language in the statute?) or they will not (in which case they run the risk of contradicting the statute, or at the very least increasing uncertainty). The Canadian view would be that standards that are of concern ought to be in the statute, clearly expressed.

"DANGEROUSNESS"

As a threshold for intervention in civil mental health law, dangerousness would not strike a Canadian as odd. It is a relevant factor in all Canadian mental health legislation, although not necessarily to the exclusion of other criteria. Our legislative language tends however to be significantly clearer than that employed in the bill before your Committee. The precision of the following language from the Ontario statute will serve as a point of comparison to the relatively woolly language of the bill:

15(1) Where a physician examines a person and has reasonable cause to believe that the person,
(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
(c) has shown or is showing a lack of competence to care for himself or herself
and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
(d) serious bodily harm to the person;
(e) serious bodily harm to another person; or
(f) serious physical impairment of the person
the physician may make application in the prescribed form for a psychiatric assessment of the person.

This provides the physician charged with administering the Act a much clearer set of criteria as to whether the threshold of dangerousness is met than that provided by the English bill.
CAPACITY AND COMPULSION

There has of course been considerable debate in England and Wales as to what role, if any, capacity ought to have in mental health compulsory powers. In Canada, capacity has become much more important in the last few decades. This is reflected in two markedly different approaches, exemplified by Ontario and Saskatchewan.

The Saskatchewan approach is to introduce a concept akin to capacity into the confinement criteria themselves. There, in order to be civilly confined, it must be shown not only that the individual is suffering from a mental disorder requiring treatment or care in a psychiatric facility, and that absent detention he or she will cause harm to self or others or deteriorate mentally or physically, but also that the following clause is satisfied:

24(2)(a)(ii) as a result of the mental disorder the person is unable to fully understand and make an informed decision regarding his need for treatment or care and supervision. [C.S.S. c. M-13.1]

Ability to make treatment decisions therefore controls the civil admission process. While the Saskatchewan legislation does allow for treatment of civilly detained patients without their consent, note that the above clause means that if the patient has capacity to consent, they are unlikely to meet the threshold for civil confinement.

The approach in Ontario, by comparison, is to sever the link between compulsory admission and treatment. Apart from a relatively narrow exception noted below, compulsory admission to Ontario psychiatric facilities is based on the dangerousness criterion noted above. Involuntary admission does not, however, provide a power to treat the individual. Here, Ontario has adopted a non-discriminatory approach. People with capacity may refuse psychiatric and other treatment, whatever their inpatient or outpatient status. People without capacity are treated on the basis of consent provided by a designated substitute, whatever their inpatient or outpatient status, whether for psychiatric or somatic treatment. This non-discriminatory approach was extremely controversial when it was introduced in 1986. It now seems to be accepted as a broadly desirable part of Ontario law.

The exception to the severance of the link between treatment and admission concerns, once again, patients lacking treatment capacity. In 2000 it was enacted that where an individual was suffering from a disorder for which he or she had been successfully treated in a psychiatric facility in the past, then if the individual is incapable of consenting to treatment and is at risk of physical or mental deterioration, the individual could be involuntarily admitted to a psychiatric facility. Note that the individual would still only be treated on the consent of the approved substitute. It is however an exception to the general Ontario approach, as treatment factors are relevant to compulsory civil admission.

In the event that the individual lacks capacity, the Ontario approach allows treatment to be performed following consent by a substitute, according to defined criteria of best interests analogous to those found in the current Capacity Bill before the UK Parliament. The substitute is, in order of preference, an individual designated by the Court to perform the role, an individual so designated by the patient, an individual so designated by the Consent and Capacity Review Board (analogous to MHRT here), or the first named individual on a statutorily prescribed list. These provisions form part of Ontario’s incapacity legislation, not its Mental Health Act.

COMMUNITY TREATMENT ORDERS

Both Ontario and Saskatchewan have recently introduced out-patient treatment orders. While the approaches differ somewhat, it is express in both cases that they are designed for so-called “revolving door” patients. For the initial CTO, both statutes set minimum thresholds of previous confinement as a condition of the implementation of a CTO. In Saskatchewan, the individual must have been previously admitted at least three times in the preceding two years, for a cumulative 60 days. In Ontario, it is two admissions for a cumulative 30 days in the previous three years. The CTO will thus never be a first intervention in these provinces. Both have additional threshold criteria, broadly reflecting the concerns of their compulsory admission criteria.

Perhaps significantly, both require treatment to be available under the order. Ontario’s law is clearer on this: by necessary implication, persons failing to provide the services they agree to provide under the CTO may be liable to the patient for that failure. Consistent with the Ontario approach to treatment generally, the CTO must be agreed by the patient, if the patient has capacity to consent to the treatment, or otherwise by the patient’s substitute, and the patient or substitute can terminate the order on three days’ notice. This consent rule in part flows from the fact that a CTO is generally unnecessary to treat a patient lacking capacity: Ontario law already covers that. Perhaps more significant, it provides a space where aftercare can be negotiated by the relevant parties in a way which binds them all. As such, it is arguably about the inclusion of the patient or carer in the provision of care, and not the imposition of terms by the healthcare provider.
REVIEW BOARDS AND PROCESS

The system of review tribunals in Canada broadly mirrors that in England and Wales. There are some significant differences, however.

While hearings held absent the application of the patient are a rarity, the patient may request hearings much more frequently than in England and Wales. For involuntary confinement, as here, a patient can go to the review tribunal once for each certificate of confinement. Unlike England and Wales, the certificates last a relatively short time. In Saskatchewan, they last for 21 days, although after three such certificates, a court order may be sought for a longer period. In Ontario, the certificates grow in length with each renewal: the first lasts for two weeks, the second for a month, the third for two months, and the fourth and subsequent for three months.

There is much to be said for this approach, as hearings can be significant for different reasons at different times. If the patient requests a hearing immediately upon admission, the importance may be whether the criteria are met as a matter of diagnosis or degree, but it may also be that a fundamental error has been made, in the extreme such as that the wrong person has been admitted. No doubt all in the system attempt to avoid errors, but they occur frequently enough that it is important that patients have the opportunity to challenge immediately. At that initial hearing, any medication will not have taken effect. It is not unreasonable for a patient to have a subsequent hearing relatively soon after the medication effects are manifest.

Depending on the province, review tribunals may also consider a wide variety of other disputes. In Ontario, they may be called on to adjudicate a wide variety of issues relating to capacity, to adjudicate the appropriateness of informal admission of a Bournewood-type patient, and to appoint a substitute for purposes of decision-making when an individual lacks capacity. These duties are consistent with the non-discriminatory approach adopted in Ontario, and they clearly overlap with the duties currently under development through the Capacity Act.

The cost of the review board structure is an obvious area of curiosity, but it does not seem exorbitant. The Ontario Consent and Capacity Review Board received 3,091 applications in 1998–99, resulting in 1,785 hearings. The cost of this to the taxpayer was just over CDN 2 million, or about £900,000. In this period, roughly 15,000 people (excluding criminal confinements) were involuntarily admitted to psychiatric facilities in the province. The higher number of confinements in England would militate towards an increase in this figure, but the higher population density would counteract this to some degree, as the range of decisions governed by the tribunal would be smaller, and transportation costs to get board members to hearings would be reduced.

The other area of surprise to a Canadian is the current delay in the process. Ontario is the most express of Canadian jurisdictions in this regard: hearings must be held within seven days of an application unless all parties agree to a postponement; a decision must be rendered within one day of the hearing; and reasons, if requested by any party, must be provided within a further two days. In this context, the current delays in review tribunal scheduling in England are little short of astonishing to a Canadian.

January 2005

Memorandum from Professor Graham Thornicroft (DMH 420)

1.1 This memorandum is intended to support the evidence I shall give to the Committee in person on 2 February 2005. I have been invited to comment upon the Draft Mental Health Bill in relation to wider international mental health policy trends. My submission will therefore mainly address Themes 1: “Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?”

1.2 In terms of my qualifications, I am Professor of Community Psychiatry at the Institute of Psychiatry, King’s College London, and Director of Research and Development of the South London and Maudsley NHS Trust. I have worked over the last 20 years as a psychiatrist in South London. I have written 17 books and over 150 scientific papers in the field of mental health services. I have advised and taught on mental health services and policy in over 30 countries, as well acting as a consultant to the World Health Organisation. I chaired the External Reference Group for the National Service Framework for Mental Health in England.

1.3 In terms of the key international mental health policy trends, most economically developed nations are now in the final stages of a transition from mental health services based in large institutions to a balance of community-based services and acute in-patient units. Full details are given elsewhere.

1.4 For brevity, this paper summarises the key national and international policies relevant to the Draft Mental Health Bill, tabulates a comparison of their recommendations in terms of guiding principles, offers a commentary on the degree of fit between the Bill and these policies, and appends the main relevant policies discussed. I shall seek to avoid repetition of points made in previous submissions to the Committee.
2. Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

3.1 A series of national and international statements of relevant principles is available to assist the committee in considering this question. Nationally, the most relevant may be considered the:
- Guiding values and principles of the National Service Framework for Mental Health, 1999 (Appendix A);
- Social Exclusion Unit Report Mental Health and Social Exclusion published by the Office of the Deputy Prime Minister, 2004 (Appendix B).

2.2 Internationally the most relevant policy statements are:
- World Health Organisation, World Health Report on Mental Health, 2001 (Appendix C);
- United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, 1991 (Appendix D);

2.3 The Draft Mental Health Bill does not explicitly give a full account of its guiding principles, so we must interpolate how far its measures, if implemented, would be consistent with the principles set out in Appendices A–E. This is done in Table 1, which sets out the principles relevant to the Bill in relation to key national and international mental health policies.
Table 1
PRINCIPLES RELEVANT TO THE DRAFT MENTAL HEALTH BILL (2004)
IN RELATION TO KEY NATIONAL AND INTERNATIONAL MENTAL HEALTH POLICIES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Therapeutic benefit to the individual patient.</td>
<td>Effective care.</td>
<td>Importance of providing maximum benefit to patient.</td>
<td>Reciprocity between detention and right to treatment.</td>
<td>Right to the best available mental health care. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs . . . in the best interest of the patient.</td>
<td>Efficient treatment. Providing the best therapy available consistent with accepted scientific knowledge. Treatment must always be in the best interest of the patient.</td>
<td>No therapeutic benefit principle stated. Treatment definition (including eg habilitation, training and education may not consistent with international definitions of treatment.</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>---------</td>
<td>---------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>---------</td>
<td>---------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>4. Non discrimination.</td>
<td>Non discriminatory.</td>
<td>Fair access regardless of ethnicity, gender, age or sexuality.</td>
<td>Have regard to encouragement of equal opportunities.</td>
<td>Non discrimination.</td>
<td>These Principles shall be applied without discrimination of any kind.</td>
<td>Equality and non discrimination.</td>
<td>Fair and equal treatment of the mentally ill. Discrimination by psychiatrists on the basis of ethnicity or culture, whether directly or by aiding others, is unethical.</td>
</tr>
<tr>
<td>5. Access.</td>
<td>Accessible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Principle addressed in part in the Non-Resident Order (Community Treatment Order, CTO). International evidence base for CTOs is weak</td>
</tr>
<tr>
<td>6. Safety.</td>
<td>Promote safety.</td>
<td></td>
<td></td>
<td></td>
<td>Physical integrity of service user.</td>
<td></td>
<td>Safety through the emphasis on risk assessment, and risk management is a prominent implicit principle in the DMHB</td>
</tr>
<tr>
<td>7. Autonomy and empowerment.</td>
<td>Independence.</td>
<td>Maintain employment.</td>
<td>Service user autonomy.</td>
<td>Treatment . . . directed towards preserving and enhancing personal autonomy.</td>
<td>Patient empowerment, autonomy.</td>
<td>Provide the patient with relevant information so as to empower.</td>
<td>This principle not explicit or implicit</td>
</tr>
<tr>
<td>-----------</td>
<td>---------</td>
<td>----------------</td>
<td>---------------------------</td>
<td>--------------------------</td>
<td>---------</td>
<td>----------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>8. Family involvement.</td>
<td>Social and family participation.</td>
<td>Have regard to needs and circumstances of patient’s carer.</td>
<td>Consensual care.</td>
<td>Partnership with families, involvement of local community.</td>
<td>Psychiatrist should consult with the family.</td>
<td>Relates to the role of the Nominated Person, when a carer, whose roles and responsibilities are not yet stated in detail</td>
<td></td>
</tr>
<tr>
<td>9. Dignity.</td>
<td></td>
<td></td>
<td>Respect for diversity.</td>
<td>Treated with humanity and respect for the inherent dignity of the human person.</td>
<td>Preserve dignity.</td>
<td>This principle is neither explicit nor implicit.</td>
<td></td>
</tr>
<tr>
<td>10. Least restrictive form of care.</td>
<td></td>
<td>Have regard to minimum restriction of the freedom of the patient necessary.</td>
<td>Informal care when possible, least restrictive alternative.</td>
<td>Every patient shall have the right to be treated in the least restrictive environment.</td>
<td>Therapeutic interventions that are least restrictive to the freedom of the patient.</td>
<td>Code of practice must secure that interference with, and restrictions of patient must be kept to minimum necessary to protect their health or safety or other persons. Principle is not given in explicit detail</td>
<td></td>
</tr>
<tr>
<td>11. Advocacy.</td>
<td></td>
<td>Have regard to views of patient’s named person, carer, guardian, welfare attorney.</td>
<td></td>
<td></td>
<td></td>
<td>Explicit function via Independent Mental Health Act Advocates</td>
<td></td>
</tr>
<tr>
<td>12. Capacity.</td>
<td></td>
<td></td>
<td>Base provisions on principle of capacity.</td>
<td>The person whose capacity is at issue shall be entitled to be represented by a counsel.</td>
<td></td>
<td>This principle is neither explicit nor implicit.</td>
<td></td>
</tr>
</tbody>
</table>
3. **COMMENTARY**

3.1 Table 1 makes clear that most of the principles seen as fundamental to good practice in mental health (in the relevant national and international policies) are neither explicit nor implicit within the current Bill.

3.2 In my opinion this is a very serious omission, and such fundamental principles should be explicitly stated and be consistent with all parts of the new Act, not deferred to the Code of Conduct.

3.3 In particular the principle of *therapeutic benefit to each individual patient* detained should be fundamental as a ground for detention in a health facility.

3.4 The wide ranging *definition of mental disorder* in the Bill potentially significantly broadens the range of individuals who might in future be detained under such arrangements and this appears to conflict with the principle of *least restrictive treatment*, where powers of detention may in future apply to categories of people with mental illness, learning disability, or substance misuse to whom current law does not apply. Explicit exceptions are necessary for these any other appropriate groups from these legal provisions.

3.5 The *definition of treatment* gives: (a) nursing care, (b) cognitive therapy, behaviour therapy, counselling or other psychological intervention, (c) habilitation (including education, and training in work, social and independent living skills), and rehabilitation (read in accordance with paragraph (d)) is first of all unclear. “Habilitation” is a term never used in routine mental health practice and appears to mean “qualify for office, especially as a teacher in a German university.” (Concise Oxford English Dictionary).

3.6 The definition of mental disorder proposed also unreasonably and excessively extends *what is understood as treatment by mental health practitioners*, and appears to include in its span all those who may require education or training of any type. It does not refer primarily to evidence-based interventions for patients diagnosed as having a disorder, made according to internationally agreed diagnostic and classification systems.

3.7 The proposals for the *Non-Resident Order* do not currently fulfil the principle of effective interventions as the international research on these arrangements does not show strong evidence for their effectiveness.

3.8 In so far as the implicit principle of *safety* is given salience in the Bill (in relation to risk assessment and risk management), for the whole range of mental disorders, this is likely to reinforce common and stigmatising stereotypes that associate mental illness and violence. This conflicts with the principles of participation, autonomy and empowerment, and dignity. It is also in direct conflict with the policies contained in the Government’s recent policy paper by the Social Exclusion Unit (Mental Health and Social Exclusion. London: Office of the Deputy Prime Minister; 2004).

3.9 The sole principles which appears to be satisfied by the Bill at present are: the requirement for advocacy, and, to some extent, the introduction of the Mental Health Tribunal so that decisions to continue detention are made by authorized legal and not by clinical/professional authorities.

3.10 At the same time it is clear that the current Mental Health Act is used relatively more often for African and Caribbean patients than for people from other ethnic groups, and no reference is made to any principles in the Bill which may reduce or stop such forms of discrimination.

*January 2004*

**APPENDIX A**

**GUIDING VALUES AND PRINCIPLES OF THE NATIONAL SERVICE FRAMEWORK FOR MENTAL HEALTH (1999)**

People with mental health problems can expect that services will:

A.1 involve service users and their carers in planning and delivery of care;
A.2 deliver high quality treatment and care which is known to be effective and acceptable;
A.3 be well suited to those who use them and non-discriminatory;
A.4 be accessible so that help can be obtained when and where it is needed;
A.5 promote their safety and that of their carers, staff and the wider public;
A.6 offer choices which promote independence;
A.7 be well co-ordinated between all staff and agencies;
A.8 deliver continuity of care for as long as this is needed;
A.9 empower and support their staff;
A.10 be properly accountable to the public, service users and carers.
APPENDIX B

SOCIAL EXCLUSION UNIT REPORT MENTAL HEALTH AND SOCIAL EXCLUSION

The principles to guide its action plan are stated as:
“Our vision is of a future where people with mental health problems have the same opportunities to work and participate in the community as any other citizen. This will mean:

B.1 communities accepting that people with mental health problems are equal;
B.2 people receiving the support they need before they reach crisis point,
B.3 people having genuine choices and a real say about what they do and the support they receive in order to fulfil their potential;
B.4 people keeping their jobs longer and returning to employment faster, with real opportunities for career progression;
B.5 recognition of the fundamental importance of people’s relationships, family and caring responsibilities, a decent home, and participation in social and leisure activities; and
B.6 health and social care services working in close partnership with employment and community services, with fair access regardless of ethnicity, gender, age or sexuality.”

APPENDIX C

WORLD HEALTH ORGANISATION. WORLD HEALTH REPORT ON MENTAL HEALTH.
W.H.O., GENEVA (2001)

C.1 PRINCIPLES OF CARE
Community-based care means that the large majority of patients requiring mental health care should have the possibility of being treated at community level. Mental health care should not only be local and accessible, but should also be able to address the multiple needs of individuals. It should ultimately aim at empowerment and use efficient treatment techniques, which enable people with mental disorders to enhance their self-help skills, incorporating the informal family social environment as well as formal support mechanisms. Community-based care (unlike hospital-based care) is able to identify resources and create healthy alliances that would otherwise remain hidden and inactivated. Good care, however and wherever it is applied, flows from basic guiding principles, some of which are particularly relevant to mental health care. These are: diagnosis; early intervention; rational use of treatment techniques; continuity of care; wide range of services; consumer involvement; partnership with families; involvement of the local community; and integration into primary health care.

C.2 COMMUNITY CARE
Community care is about the empowerment of people with mental and behavioural disorders. In practice, community care implies the development of a wide range of services within local settings. Care in the community, as an approach, means:
— services which are close to home, including general hospital care for acute admissions, and long-term residential facilities in the community;
— interventions related to disabilities as well as symptoms;
— treatment and care specific to the diagnosis and needs of each individual;
— a wide range of services which address the needs of people with mental and behavioural disorders;
— services which are coordinated between mental health professionals and community agencies;
— ambulatory rather than static services, including those which can offer home treatment;
— partnership with carers and meeting their needs.

C.3 RESPECTING HUMAN RIGHTS
Mental health policies and programmes should promote the following rights: equality and non-discrimination; the right to privacy; individual autonomy; physical integrity; the right to information and participation; and freedom of religion, assembly and movement. Human rights instruments also demand that any planning or development of mental health policies or programmes should involve vulnerable groups (such as indigenous and tribal populations; national, ethnic, religious and linguistic minorities; migrant workers; refugees and stateless persons; children and adolescents; and elderly people) in the planning and development of mental health policies and programmes.
Beyond the legally binding International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, which are applicable to the human rights of those suffering from mental and behavioural disorders, the most significant and serious international effort to protect the rights of the mentally ill is the United Nations General Assembly Resolution 46/119 on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, adopted in 1991 (UN 1991). Although not legally binding, the resolution brings together a set of basic rights which the international community regards as inviolable either in the community or when mentally ill persons receive treatment from the health care system. There are 25 principles which fall into two general categories: civil rights and procedures, and access to and quality of care. Principles include statements of the fundamental freedoms and basic rights of mentally ill persons, criteria for the determination of mental illness, protection of confidentiality, standards of care and treatment including involuntary admission and consent to treatment, rights of mentally ill persons in mental health facilities, provision of resources for mental health facilities, provision of review mechanisms, providing for protection of the rights of mentally ill offenders, and procedural safeguards to protect the rights of mentally ill persons.

The United Nations Convention on the Rights of the Child (1989) provides guidance for policy development specifically relevant to children and adolescents. It covers protection from all forms of physical and mental abuse; non-discrimination; the right to life, survival and development; the best interests of the child; and respect for the views of the child. There are also a number of regional instruments to protect the rights of the mentally ill, including the European Convention for Protection of Human Rights and Fundamental Freedoms, backed by the European Court of Human Rights; Recommendation 1235 (1994) on Psychiatry and Human Rights adopted by the Parliamentary Assembly of the Council of Europe; the American Convention on Human Rights, 1978; and the Declaration of Caracas adopted by the Regional Conference on Restructuring Psychiatric care in Latin America in 1990.

C.4 MENTAL HEALTH LEGISLATION

Mental health legislation should codify and consolidate the fundamental principles, values, goals, and objectives of mental health policy. Such legislation is essential to guarantee that the dignity of patients is preserved and that their fundamental human rights are protected.

APPENDIX D

UNITED NATIONS PRINCIPLES FOR THE PROTECTION OF PERSONS WITH MENTAL ILLNESS AND THE IMPROVEMENT OF MENTAL HEALTH CARE


D.1 APPLICABILITY

These Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

D.2 DEFINITIONS

In these Principles:

“Counsel” means a legal or other qualified representative;

“Independent authority” means a competent and independent authority prescribed by domestic law;

“Mental health care” includes analysis and diagnosis of a person’s mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;

“Mental health facility” means any establishment, or any unit of an establishment, which as its primary function provides mental health care;

“Mental health practitioner” means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;

“Patient” means a person receiving mental health care and includes all persons who are admitted to a mental health facility;

“Personal representative” means a person charged by law with the duty of representing a patient’s interests in any specified respect or of exercising specified rights on the patient’s behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;

“The review body” means the body established in accordance with Principle 17 to review the involuntary admission or retention of a patient in a mental health facility.
D.3 General Limitation Clause

The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

D.4 Statement of Principles

D.4.1 Principle 1. Fundamental freedoms and basic rights

D.4.1.1 All persons have the right to the best available mental health care, which shall be part of the health and social care system.

D.4.1.2 All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.

D.4.1.3 All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.

D.4.1.4 There shall be no discrimination on the grounds of mental illness. “Discrimination” means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of these Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.

D.4.1.5 Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

D.4.1.6 Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

D.4.1.7 Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person’s condition, to ensure the protection of his or her interest.

D.4.2 Principle 2. Protection of minors

Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

D.4.3 Principle 3. Life in the community

Every person with a mental illness shall have the right to live and work, as far as possible, in the community.

D.4.4 Principle 4. Determination of mental illness

D.4.4.1 A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.

D.4.4.2 A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.
D.4.4.3 Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person’s community, shall never be a determining factor in diagnosing mental illness.

D.4.4.4 A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.

D.4.4.5 No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

D.4.5 Principle 5. Medical examination

No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorised by domestic law.

D.4.6 Principle 6. Confidentiality

The right of confidentiality of information concerning all persons to whom these Principles apply shall be respected.

D.4.7 Principle 7. Role of community and culture

D.4.7.11 Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.

D.4.7.2 Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.

D.4.7.3 Every patient shall have the right to treatment suited to his or her cultural background.

D.4.8 Principle 8. Standards of care

D.4.8.1 Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.

D.4.8.2 Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

D.4.9 Principle 9. Treatment

D.4.9.1 Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others.

D.4.9.2 The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.

D.4.9.3 Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

D.4.9.4 The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

D.4.10 Principle 10. Medication

D.4.10.1 Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of Principle 11, mental health practitioners shall only administer medication of known or demonstrated efficacy.

D.4.10.2 All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient’s records.
D.4.11 Principle 11. Consent to treatment

D.4.11.1 No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 below.

D.4.11.2 Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

(a) The diagnostic assessment;
(b) The purpose, method, Likely duration and expected benefit of the proposed treatment;
(c) Alternative modes of treatment, including those less intrusive; and
(d) Possible pain or discomfort, risks and side-effects of the proposed treatment.

D.4.11.3 A patient may request the presence of a person or persons of the patient’s choosing during the procedure for granting consent.

D.4.11.4 A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 below. The consequences of refusing or stopping treatment must be explained to the patient.

D.4.11.5 A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.

D.4.11.6 Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient’s informed consent if the following conditions are satisfied:

(a) The patient is, at the relevant time, held as an involuntary patient;
(b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient’s own safety or the safety of others, the patient unreasonably withholds such consent; and
(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient’s health needs.

D.4.11.7 Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 below, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 above, consents on the patient’s behalf.

D.4.11.8 Except as provided in paragraphs 12, 13, 14 and 15 below, treatment may also be given to any patient without the patient’s informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

D.4.11.9 Where any treatment is authorized without the patient’s informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

D.4.11.10 All treatment shall be immediately recorded in the patient’s medical records, with an indication of whether involuntary or voluntary.

D.4.11.11 Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient’s medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

D.4.11.12 Sterilization shall never be carried out as a treatment for mental illness.

D.4.11.13 A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

D.4.11.14 Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.
D.4.11.15 Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.

D.4.11.16 In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.


D.4.12.1 A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.

D.4.12.2 If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient’s interests and willing to do so.

D.4.12.3 A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.

D.4.13 Principle 1. Rights and conditions in mental health facilities

D.4.13.1 Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:

(a) Recognition everywhere as a person before the law;
(b) Privacy;
(c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television; and
(d) Freedom of religion or belief.

D.4.13.2 The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:

(a) Facilities for recreational and leisure activities;
(b) Facilities for education;
(c) Facilities to purchase or receive items for daily living, recreation and communication; and
(d) Facilities, and encouragement to use such facilities, for a patient’s engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.

D.4.13.3 In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.

D.4.13.4 The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.


D.4.14.1 A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:

(a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;
(b) Diagnostic and therapeutic equipment for the patient;
(c) Appropriate professional care; and
(d) Adequate, regular and comprehensive treatment, including supplies of medication.

D.4.14.2 Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with these Principles.

D.4.15 **Principle 15. Admission principles**

D.4.15.1 Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.

D.4.15.2 Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.

D.4.15.3 Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in Principle 16, apply, and he or she shall be informed of that right.

D.4.16 **Principle 16. Involuntary admission**

D.4.16.1 A person may (a) be admitted involuntarily to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that person has a mental illness and considers:

(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

(b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

D.4.16.2 Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient’s personal representative, if any, and, unless the patient objects, to the patient’s family.

D.4.16.3 A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

D.4.17 **Principle 17. Review body**

D.4.17.1 The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.

D.4.17.2 The review body’s initial review, as required by paragraph 2 of Principle 16, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.

D.4.17.3 The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.

D.4.17.4 An involuntary patient may apply to the review body for release or voluntary status, at reasonable intervals as specified by domestic law.

D.4.17.5 At each review, the review body shall consider whether the criteria for involuntary admission set out in paragraph 1 of Principle 16 are still satisfied, and, if not, the patient shall be discharged as an involuntary patient.

D.4.17.6 If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.

D.4.17.7 A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.
D.4.18 Principle 18. Procedural safeguards

D.4.18.1 The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

D.4.18.2 The patient shall also be entitled to the assistance, if necessary, of the services of an interpreter. Where such services are necessary and the patient does not secure them, they shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

D.4.18.3 The patient and the patient's counsel may request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible.

D.4.18.4 Copies of the patient's records and any reports and documents to be submitted shall be given to the patient and to the patient's counsel, except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others. As domestic law may provide, any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any part of a document is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and shall be subject to judicial review.

D.4.18.5 The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.

D.4.18.6 If the patient or the patient's personal representative or counsel requests that a particular person be present at a hearing, that person shall be admitted unless it is determined that the person's presence could cause serious harm to the patient's health or put at risk the safety of others.

D.4.18.7 Any decision whether the hearing or any part of it shall be in public or in private and may be publicly reported shall give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

D.4.18.8 The decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel. In deciding whether the decision shall be published in whole or in part, full consideration shall be given to the patient's own wishes, to the need to respect his or her privacy and that of other persons, to the public interest in the open administration of justice and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

D.4.19 Principle 19. Access to information

D.4.19.1 A patient (which term in this Principle includes a former patient) shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.

D.4.19.2 Any written comments by the patient or the patient's personal representative or counsel shall, on request, be inserted in the patient's file.

D.4.20 Principle 20. Criminal offenders

D.4.20.1 This Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.

D.4.20.2 All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of Principle 1.

D.4.20.3 Domestic law may authorise a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.

D.4.20.4 Treatment of persons determined to have a mental illness shall in all circumstances be consistent with Principle 11.

Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.

D.4.22 Principle 22. Monitoring and remedies

States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

D.4.23 Principle 23. Implementation

D.4.23.1 States should implement these Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.

D.4.23.2 States shall make these Principles widely known by appropriate and active means.

D.4.24 Principle 24. Scope of principles relating to mental health facilities

These Principles apply to all persons who are admitted to a mental health facility.

D.4.25 Principle 25. Saving of existing rights

There shall be no restriction upon or derogation from any existing rights of patients, including rights recognised in applicable international or domestic law, on the pretext that these Principles do not recognise such rights or that they recognise them to a lesser extent.

APPENDIX E

WORLD PSYCHIATRIC ASSOCIATION, DECLARATION OF MADRID (1996)

E.1 Medicine is both a healing art and a science. The dynamics of this combination are best reflected in psychiatry, the branch of medicine that specializes in the care and protection of those who are ill and infirm because of a mental disorder or impairment. Although there may be cultural, social, and national differences, the need for ethical conduct and continual review of ethical standards is universal.

E.2 As practitioners of medicine, psychiatrists must be aware of the ethical implications of being a physician and of the specific ethical demands of the specialty of psychiatry. As members of society, psychiatrists must advocate for fair and equal treatment of the mentally ill, for social justice and equity for all.

E.3 Ethical behaviour is based on the psychiatrists individual sense of responsibility towards the patient and their judgement in determining what is correct and appropriate conduct. External standards and influences such as professional codes of conduct, the study of ethics, or the rule of law by themselves will not guarantee the ethical practice of medicine.

E.4 Psychiatrists should at all times, keep in mind the boundaries of the psychiatrist-patient relationship, and be guided primarily by the respect for patients and concern for their welfare and integrity.

E.5 It is in this spirit that the World Psychiatric Association approved by the General Assembly, on August 25, 1996, the following ethical standards that should govern the conduct of psychiatrists worldwide.

E.6.1 Psychiatry is a medical discipline concerned with the provision of the best treatment for mental disorders; with the rehabilitation of individuals suffering from mental illness and with the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the equitable allocation of health resources.

E.6.2 It is the duty of psychiatrist to keep abreast of scientific developments of the specialty and to convey updated knowledge to others. Psychiatrists trained in research should seek to advance the scientific frontiers of psychiatry.

E.6.3 The patient should be accepted as a partner by right in therapeutic process. The therapist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. It is the duty of psychiatrists to provide the patient with relevant information so as to empower the patient to come to a rational decision according to his or her personal values and preferences.
E.6.4 When the patient is incapacitated and/or unable to exercise proper judgement because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal right of the patient. No treatment should be provided against the patient’s will, unless withhold treatment would endanger the life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient.

E.6.5 When psychiatrists are requested to assess a person, it is their duty first to inform and advice the person being assessed about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment. This is particularly important when the psychiatrists are involved in third party situations.

E.6.6 Information obtained in the therapeutic relationship should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or financial or academic benefits. Breach of confidentiality may only be appropriate when serious physical or mental harm to the patient or to the third person could ensue if confidentiality were maintained; in these circumstances, psychiatrists should whenever possible, first advise the patient about the action to be taken.

E.6.7 Research that is not conducted in accordance with the canons of science is unethical. Research activities should be approved by an appropriately constituted ethical committee. Psychiatrists should follow national and international rules for the conduct of research. Only individuals properly trained for research should undertake or direct it. Because psychiatric patients are particularly vulnerable research subjects, extra caution should be taken to safeguard their autonomy as well as their mental and physical integrity. Ethical standards should also be applied in the selection of population groups, in all types of research including epidemiological and sociological studies and in collaborative research involving other disciplines or several investigating centres.

E.7 Guidelines Concerning Specific Situations

The World Psychiatric Association Ethics Committee recognizes the need to develop a number of specific guidelines on a number of specific situations. Five such specific guidelines are stated below. In the future, the committee will address other critical issues such as the ethics of psychotherapy, new therapeutic alliances, relationship with the pharmaceutical industry, sex change and the ethics of managed care.

E.7.1 Euthanasia. A physician’s duty, first and foremost, is the promotion of health, the reduction of suffering, and the protection of life. The psychiatrist, among whose patients are some who are severely incapacitated and incompetent to reach an informed decision, should be particularly careful of actions that could lead to the death of those who cannot protect themselves because of their disability. The psychiatrist should be aware that the views of a patient may be distorted by mental illness such as depression. In such situations, the psychiatrist’s role is to treat the illness.

E.7.2 Torture. Psychiatrists shall not take part in any process of mental or physical torture even when authorities attempt to force their involvement in such acts.

E.7.3 Death Penalty. Under no circumstances should psychiatrists participate in legally authorised executions nor participate in assessments of competency to be executed.

E.7.4 Selection of Sex. Under no circumstances should a psychiatrist participate in decisions to terminate pregnancy for the purpose of sex selection.

E.7.5 Organ Transplantation. The role of the psychiatrist is to clarify the issues surrounding organ donations and to advise on religious, cultural, social and family factors to ensure that informed and proper decisions be made by all concerned. The psychiatrists should not act as a proxy decision maker for patients nor use psychotherapeutic skills to influence the decision of a patient in these matters. Psychiatrists should seek to protect their patients and help them exercise self-determination to the fullest extent possible in situation of organ transplantation.

E.7.6 Psychiatrists Addressing the Media. The media have a key role in shaping the perceptions and attitudes of the community. In all contacts with the media psychiatrists shall ensure that people with mental illness are presented in a manner which preserves their dignity and privacy, and which reduces stigma and discrimination against them. An important role of psychiatrists is to advocate for those people who suffer from mental disorders. As the public perception of psychiatrists and psychiatry reflects on patients, psychiatrists shall ensure that in their contacts with the media they represent the profession of psychiatry with dignity. Psychiatrists shall not make pronouncements to the media about presumed psychopathology on any individuals. In presenting research findings to the media, psychiatrists shall ensure the scientific integrity of the information given and be mindful of the potential impact of their statements on the public perception of mental illness and on the welfare of people with mental disorders.

E.7.7 Psychiatrists and Discrimination on Ethnic or Cultural Grounds. Discrimination by psychiatrists on the basis of ethnicity or culture, whether directly or by aiding others, is unethical. Psychiatrists shall never be involved or endorse, directly or indirectly, any activity related to ethnic cleansing.
E.7.8 Psychiatrists and Genetic Research and Counseling. Research on the genetic basis of mental disorders is rapidly increasing and more people suffering from mental illness are participating in such research. Psychiatrists involved in genetic research or counseling shall be mindful of the fact that the implication of genetic information are not limited to the individual from whom it was obtained, and that its disclosure can have negative and disruptive effects on the families and communities of the individuals concerned. Psychiatrists shall therefore ensure that: people and families who participate in genetic research do so with a fully informed consent; any genetic information in their possession is adequately protected against unauthorized access, misinterpretation or misuse, care is taken in communication with patients and families to make clear that current genetic knowledge is incomplete and may be altered by future findings.

Psychiatrists shall only refer people to facilities for diagnostic genetic testing if that facility has: demonstrated satisfactory quality assurance procedures for such testing; adequate and easily accessible resources for genetic counseling.

Genetic counseling with regard to family planning or abortion shall be respectful of the patients' value system, while providing sufficient medical and psychiatric information to aid patients make decisions they consider best for them.

Reference List


Witnesses: Dr Peter Bartlett, Senior Lecturer in Law at the University of Nottingham, and Professor Graham Thornicroft, Professor of Community Psychiatry at the Institute of Psychiatry, King’s College London, and Director of Research and Development at the South London and Maudsley NHS Trust, examined.

Q1120 Chairman: Welcome to you both. We have been looking forward to hearing from you for some time. I noticed you were sitting at the back, so you will have heard a little bit of an introduction into the international dimension from our previous witnesses. Would you just introduce yourselves briefly and then I think Lord Carter will start the questions.

Dr Bartlett: My name is Peter Bartlett. I am currently a Senior Lecturer in Law at the University of Nottingham and from 1 September I will be the Nottinghamshire NHS Trust Professor in Mental Health Law at the University of Nottingham.

Professor Thornicroft: My name is Graham Thornicroft. I am a Professor of Community Psychiatry at the Institute of Psychiatry at King’s College London, and I am also Director of Research and Development at the South London and Maudsley NHS Trust and a consultant psychiatrist working in south London.

Chairman: Thank you very much. May I formally remind you that this is a public session. It is being recorded and there will be a transcript which you will have the opportunity to amend for textual reasons only. You are both very welcome.

Q1121 Lord Carter: Professor Thornicroft, in your extremely helpful memorandum you take the view that it is a “very serious omission that the fundamental principles are not explicitly stated and are not on the face of the draft Bill”. I think we would all agree that practitioners will be using the Codes of Practice, not the Mental Health Act itself. Why, therefore, should it matter whether the principles are in the Act or not as long as they are actually in the Codes of Practice?

Professor Thornicroft: In my opinion, the mental health policy in this case mental health law should be based squarely upon the available evidence, that is, the evidence base and the relevant ethical base. It seems to me that the ethical base should be transparent and clearly spelt out in the body of the main Act itself. I would like to tell you briefly why I think that. It is clear that the law will affect practitioners and those subject to the provisions for generations, so it is very important we get this right. We hope it will set the framework for a consensually based set of regulations and we are likely to establish a widespread consensus if the ethical base is quite clear throughout the main body of the main Act itself. I think setting out a clear statement of principles is more likely to assist those in the future who will need to interpret the legal aspects of the provisions where they may not be completely clear in their practical implementation. I think it is helpful to see the extent to which the contents of the law are consistent with other policies within this country, for example, the National Health Service Framework and the arrangements of the Social Exclusion Unit, as I have set out in Table 1 of my evidence. It is also important to see the extent to which the content of the law is consistent with other international regulations and policies which I have also set out in my memorandum and summarised within Table 1. In particular, I think it is important to see the extent to which we comply with other various international treaties and obligations. I think it is important for the field of practitioners to have a clear statement of principles so that we are going to emphasise the extent to which all practice in mental health, both the legal and the non-legal aspects, should avoid abuses of human rights, and I think the more clearly that is spelt out in every aspect of our policy and law, the better that is for the field. I think it sets a framework for independent inspection standards to be set in due course which will be consistent with the meaning as well as the body, so the spirit and the detail of the Act. You can see within Table 1 that I have included within my evidence that of the 12 principles that seemed to come out of my own overview of the international policies which are most pertinent as well as the national policies, it seems to me that the current provisions within the Bill satisfy three of them, that four of these key principles are not clearly addressed and that five of the key principles seem to conflict with the content of the Bill.

Chairman: We found the table very helpful indeed.

Q1122 Lord Carter: If there were to be principles on the face of the Bill, should one of the general principles be a duty to protect the public from harm by people who are mentally ill, and on whom should this duty fall?

Professor Thornicroft: You can see from one of the principles I set out in the table that there is the issue of safety. It is clear that there is a complex balance to be struck by mental health practitioners between direct care and therapeutic benefit to those receiving care, sometimes compulsory care, and the wider duty to society for whom mental health practitioners are acting as a type of legitimised agent and that is a very fine balance to strike. I would agree that safety is an important element. I think to summarise, on the principles question I would refer the Committee to the Millan principles which are set out in the Scottish arrangements. I think they are a very nice statement about principles that are very helpful indeed. Oddly enough, although the principles may seem to be abstract and rather obtuse, in fact they are summaries of an overarching statement of purpose and they are actually very useful tools. The statement of the Millan principles goes on to say why they are important for that Act and not set aside as a subsequent and potentially movable feast as a code of practice. What they say is that the Act will give effect to the principles. Therefore, the details of the Act are based upon those foundation principles. Secondly, they are the basis of executive policy on mental health law and, thirdly, they provide a picture of how mental health law should work.
Q1123 Chairman: Professor Bartlett, do you want to add anything to that from your viewpoint as a lawyer?

Dr Bartlett: I support broadly what has been said. I think the only thing I would wish to add concerns the Code of Practice. To a Canadian, the notion that we would rely on the Code of Practice for practitioners is simply very odd. Based on a number of codes of practice I have seen, I am actually quite concerned that they do not quite necessarily mirror the actual substance of the main Bill. If I were a practitioner and I followed the Code of Practice and then found myself sued because the Code did not match the Bill, I would feel somewhat aggrieved and I think I would be right to feel somewhat aggrieved. I do not view these as alternatives. I do think that it is appropriate to insist on a Bill that has reasonable clarity and which a reasonable doctor should be able to understand. That is the standard which would be taken as normal in Canada and also the United States.

Q1124 Chairman: You will appreciate that it is a feature of regulation to use codes of practice and there is a draft Code being circulated on the Mental Incapacity Bill and on many other Bills now it is common practice.

Dr Bartlett: I do appreciate that. I can certainly see an argument where under the Act one has a variety of possible options and a code of practice may be helpful. Let me take as an obvious example the discussion in the Richardson Report about removal to a place of safety, where they were saying we do not much like police stations as places of safety but sometimes we may have to. When we are looking at a variety of options, all of which are legal, it seems to me a code of practice may make some sense. We should not be relying on a code of practice as being what doctors follow. The classical argument is a person with a watch knows what time, but a person with two watches is never sure!

Q1125 Baroness Murphy: I would like to turn to the issue of stigma. Many of those who have submitted evidence to this Committee have regretted that stigma still attaches to those with mental illness in this country. I wonder if you could both tell us from your knowledge of international services whether the position in regard to stigma is worse in this country than elsewhere? Can mental health legislation have a role in shaping public attitudes to stigma? Perhaps Dr Bartlett might expand on that from what I know is his great historical knowledge in that area as well.

Dr Bartlett: I had not thought of it from an historical perspective so much. I am not convinced that stigma is particularly different here than in North America. I am not sure that I have seen any very good studies of it, but it feels the same. I am also doing some work in Central Europe at the moment and, frankly, I think we enjoy a much lower level of stigma than mental disorder does in much of Central Europe. In terms of the second part of your question, law is part of a much greater range of social arrangements. It would be naive and absurd to pretend that simply by introducing a more progressive or less stigmatizing Mental Health Act we were going to solve the problem of stigma. Certainly in other fields we can see evidence that changing the law does have an effect on public attitudes. Perhaps I might use an example and it is in another field but it is a particularly clear example. I have watched in my lifetime sexual orientation being introduced in non-discrimination legislation in Canada and we have had to introduce it 11 times before the 11 different jurisdictions. Before it is introduced, people are broadly opposed by about 60:40. After it is introduced, you see those numbers reversing remarkably quickly. There are all sorts of hesitations one could follow through about that, for example, what people say in posters does not necessarily represent how they behave and all sorts of things like that, but I do think law does make a difference.

Professor Thornicroft: I am writing a book on stigma at the moment, so I am literally surrounded by the evidence on this. There is very little evidence indeed that compares the degree of stigma between countries in any satisfactory way, so we need to look for indirect measures. One example would be employment rates. If we look at Western European countries, which are reasonable comparators, a recent study found that in Holland, Denmark, Spain and Italy about a quarter of people with schizophrenia were employed either full-time or part-time or in training; the figures in England were 6%. That shows a significantly lesser degree of social participation and social inclusion, in this case by some people with psychosis, compared with relatively comparative Western European countries. It is clear that the nature of stigma does vary cross-culturally. For example, in the Indian subcontinent questions about marriage or blood come into the equation and in the Far East questions of shame and blame are also much more prominent. Broadly speaking, if we think about the trend of stigmatisation over the last 10 to 15 years in this country, we can see two conflicting patterns. One is that attitudes towards depression and usually less disabling conditions have become slightly more favourable over that time and there have been campaigns, for example, by the Royal College of Psychiatrists and GPs, which have had some limited impact, and we now see increasingly celebrities, including politicians, speak openly about having had mental illnesses themselves. The other conflicting trend is for attitudes toward psychotic conditions to become less favourable over the last three or four years. The Department of Health conducts regular surveys of the population and did it every year from 1993 to 1997 and it has conducted these every three years since 1997. The most recent report, which can be made available to the Committee, was in 2003 and it shows that attitudes towards the mentally ill were stable throughout the 1990s but have become significantly worse in the period between 2000 and 2003, for example, in relation to if the mentally ill are a burden on society, if mentally ill people deserve our sympathy, if they should receive the best possible care, if we should be more tolerant or not, and if they should be the
subject of ridicule. There is a real paradox here because among this general population sample 49% said that someone close to them had had a mental illness, but in fact a greater proportion, about 60%, said they thought mental illness occurs only to about 10 per cent of the population or less, so there is a very strange distancing and proximity paradox or dilemma that goes on with respect to stigma. In terms of policy, I think it sets an overall framework or an atmosphere, for example, where a law might connect the ideas of mental illness with the idea of dangerousness and I think such a law may act negatively to reinforce and to make worse stereotypical representations of mental illness.

Q1126 Baroness Barker: Dr Bartlett, your paper highlighted for us different approaches taken in Canada. Saskatchewan has introduced capacity into the confinement criteria and in Ontario compulsory admission to psychiatric facilities is based on a dangerousness criterion. How does Saskatchewan deal with a person who has the capacity to make a decision, is seriously mentally ill, is a clear danger to him or herself but adamantly refuses treatment?

Dr Bartlett: I have to be honest, I am an Ontario lawyer, but I have not practised in Saskatchewan, so I have to be slightly careful about answering that question. Certainly my understanding under the Act would be that you wait until the person does something which allows some other form of intervention. There are interesting questions about what “capacity” means, but if we believe what they tell us in the statute, if the person has capacity and refuses treatment, then that is it, they do not go in, you find some other way.

Q1127 Baroness Barker: What about if the person does not have capacity?

Dr Bartlett: If the person does not have capacity then you are over that hurdle. Assuming the other criteria in the Act are met, which include things like a risk criterion, then you involuntarily admit them.

Q1128 Lord Rix: Are people with a learning disability, intellectual disability or autism without allied mental health problems treated under mental health or other legislation in the provinces of Canada? Does the stigma which we have been talking about through mental health problems apply just as much to people with a learning disability in other parts of the world, certainly in Canada, as it does in this country?

Dr Bartlett: Let me address the stigma point first. I take Professor Thornicroft’s point that this is not well studied. I have not seen any good studies that I would wish to cite to you. I do not have a feeling that it is particularly different to the situation we face here. In terms of intellectual disabilities, in the event that coercion needed to be applied, then again if the person had capacity you would be looking to the Mental Health Act in Ontario. In the situation where the individual does not have capacity we do not have separate legislation involving capacity, so there would be a closer connection to here and it would be relatively unusual that you would see somebody with an intellectual disability being brought under the Mental Health Act in Ontario, but it is not impossible.

Q1129 Tim Loughton: Professor Bartlett, in your submission, under the subject of dangerousness, you refer to the Ontario legislation and the rather better “precision” of the language rather than the relatively woolly language of the Bill. One thing that struck me is the inclusion of the word “likely” under the assessment criteria, which is certainly something that is lacking under clause 9 in our Bill. One thing that I have taken up before is, just because you have somebody who, on the face of it, is physically giving the appearance of being dangerous or has the physical capacity to pose a physical threat to somebody does not mean that they are any more likely than somebody who is a 10-stone weakling to inflict damage on another person. Do you think that is a fair assessment? Do you think the inclusion of a likelihood condition into clause 9 would help to solve the wooliness of the language that exists in the Bill as it stands?

Dr Bartlett: I think that would be of assistance. I share your concern that physical shape is not a determinant of this. I think that if what we are looking at is cleaning up the wooliness of the language, the first portion of those Ontario criteria, which requires the person to have “done something”—and there is litigation in Ontario about what this clause means which gets into the differences between acts and omissions—that is something fairly concrete, it is a shopping list for the doctor to look at. They are told fairly clearly what that hurdle is in terms of a threat or having done something or the inability to care provision. That does seem to me much clearer than what is in the current Act.

Q1130 Tim Loughton: So effectively what we are looking at is a middle way between a hypothetical capability and an actual act having been committed? It is a likelihood of an assessment that somebody is capable and showing a likelihood of committing that particular act which would lead to dangerousness, is it?

Dr Bartlett: And you have some sort of concrete reason to back that up. If we are thinking, for example, of harm to others, it has got to be either they have done something or they have threatened to. There is a focusing point there.

Q1131 Lord Carter: I am sure you are aware that in this country there is concern at times, often whipped up by the media, of a situation whereby mentally ill patients are released from hospital and kill. There are 13 different regimes in Canada for mental health law, as I understand it. Are there any figures at all which link any differences in the provinces in that aspect?

Dr Bartlett: Not that I am aware of.

Q1132 Lord Carter: I presume murder is a federal offence, is it?
Dr Bartlett: That is correct. I have not seen any attempt to link murders by people with psychiatric disorders to individual provincial psychiatric regimes. You are right, it would not be difficult. I will put it on file for an attention paper.

Q1133 Chairman: In your general experience, both of you as experienced and distinguished experts in this field, do you believe that there is any evidence at all that the regime for control of mentally ill people, short of an obviously unacceptable regime, has any effect in terms of enabling clinicians to predict the sort of incident that Lord Carter has referred to?

Professor Thornicroft: If we look at the time trend in this country over the last 40 years, we see that the total number of homicides has gone up from about 150 to about 600 per year, of which those committed by people who are probably mentally ill at the time has been more or less constant, about 50 to 60 per year. Over that time period we have seen astonishing change from an institutionally based system to a largely community-based system. It would be hard to imagine a greater transition in the pattern of care than the one that we have been through during the last half decade and yet that has had no palpable effect overall upon the number of homicides committed by mentally ill people. I think that is pretty strong evidence. Unfortunately mental health professionals are remarkably poor at being able to predict specifically who will commit a violent act in the future, and one of the best reviews was conducted by a Professor Buchanan and Dr Leese who gave an overview of the literature with respect to personality disorder. The question was how many people would need to be locked up to prevent one severe act from taking place and the answer was seven, which meant that the provision based upon, for example, dangerous and severe criteria would, therefore, lead to six innocent people who would not have committed that act being locked up for no particular reason.

Q1134 Chairman: Can we now move on to an important issue on which we feel you, as witnesses, may be able to help us and that is about community treatment orders. We have a number of questions related to community treatment orders of which you have been given notice, but perhaps I can ask you to give us your general comment about whether community treatment orders, in your opinion, should be part of the new law in this country and, if so, whether you think it is possible to set out criteria which would ensure that community treatment orders were used in an appropriate way. Who is going to go first?

Dr Bartlett: Let me answer from a Canadian perspective since I think it is probably a different perspective for you. In both Ontario and Saskatchewan we do have community treatment orders but both of them have capacity requirements built into them. One of the fascinating things about moving here and, therefore, looking at Canada from a certain distance is I am seeing that slightly differently than I did when I was at home. There is perhaps a very different image of community treatment orders that the Committee might wish to consider. In Canada I think it is in practice more about creating an environment where a deal can be struck between the patient and carer and, if the patient lacks capacity, between the patient’s family member or what you would call a nominated person and a psychiatric professional. As the individual must still be competent to consent to treatment, and that is something that we care very much about in Canada, arguably what it is about is strong-arming better services out of the health care system to create some kind of an agreed plan that both the doctor and patient are content with. That is quite a different image than what I have seen discussed about CTOs here. Regarding the images I have seen here, I very strongly believe, consistent with the Canadian approach, that it is not justifiable to force medication on someone who has capacity and is refusing the medication. I appreciate the problems that causes for families and for practitioners, I appreciate the practical problems, but in the end that is the foundation of what it is to be a person; it is to make it that kind of extraordinarily personal decision. So I would say that, if we are going to do it, it would have to be for people lacking capacity only. I do find myself wondering, if we are looking at it for people who lack capacity, what precisely inclusion under the Mental Health Act would add to what is happening under the Incapacity Bill.

Q1135 Chairman: Professor Thornicroft?

Professor Thornicroft: I want to start with the evidence. There is not strong evidence that community treatment orders or their equivalent are effective. Most of the published work comes from Canada or Australia and there are few European studies. They tend to show conflicting results and they have different objectives, but they do not show consistently that these are effective with respect to any of the particular desired targets, such as increased medication compliance or reduced hospitalisation. One of the most detailed reports came from the RAND Corporation published in 2001 and reviewed arrangements in nine of the United States, where now 38 of the states do have outpatient treatment orders or similar arrangements, and they concluded, “There is no evidence to suggest that simply amending the statutory language is likely to produce the required results”. I think we also need to look at the wider context within European regions. For example, four of the previous 15 EU States do have outpatient commitment orders. Britain is virtually alone in having an increasing rate of compulsion within its mental health system over the last 10 years and, although most countries see stable patterns of the use of coercion in these ways, we have seen increasing rates of section 135, which is the compulsory entry to premises, of three times over the last decade, of section 136, which are the place of safety detention orders, of five times, and use of section 3 by 1.4 times over that period. For some reason England is an exception in terms of the trends of compulsory treatment just within the European region, Western Europe in this case. Perhaps I may
move on to the ethical aspects. As I mentioned earlier in that summary table, I think the community treatment orders do cross-cut, in fact they violate many of the principles which are established internationally as well as relevant national mental health policy, as set out in the relevant documents. I think this is a very difficult balance of judgment. I think the one practical way to increase patient compliance, meaning agreement with a recommended plan of treatment, is to offer choice. For example, in my own practice in south London we now have home treatment teams, we have crisis houses for women and we have acute inpatient treatments. I can ask a woman who is in a crisis, “Would you prefer to go into hospital, to be treated at home or to go to a crisis house?”, and this means that we use compulsion less than we would have done five years ago. We now have new arrangements in the form of a crisis card and there is accumulating evidence that these do reduce compulsory admission rates to hospital. I think there is an offset or a balance here: on the one hand, it seems likely that CTOs, if properly and narrowly applied, would probably apply to less than 1% of 1% of the population, approximately the same numbers as were applied for supervision registers and supervised discharge orders; on the other hand, we need to understand the wider framework and that is this. Of all inpatients, there is evidence that one third of the voluntary inpatients believe themselves to be compulsorily detained and two thirds are not sure whether they are compulsorily detained or voluntary. So we have got forms of pressure and coercion that go well beyond the narrow legal restraints of the powers that are set by our Government. Therefore, I think, on the one hand, this may provide a limited benefit to a small number of patients, but, on the other hand, I think we need to listen carefully to what service user groups are saying, which is that this will not just stop current patients from wanting to continue with treatment, but it will then reinforce a connection in the public mind between violence and mental illness. We know that of all people with mental illness in England about one quarter are getting effective treatment and that the proportion is far less in many other countries. I suspect that, if we were to frame this too widely, then we would see more people self-stigmatising and not presenting to services because they do not want to be labelled as a mentally ill person because that is connected with violence and we will see fewer people having treatment and that will serve no one for the best in the long term.

Q1136 Baroness Eccles: I have a question of clarification for Dr Bartlett and one of opinion for Professor Thornicroft. Dr Bartlett, you made it quite clear that you thought that nobody should be compelled to take treatment in the community unless they have capacity. Presumably the requirement for enforced treatment as an inpatient does not require capacity?

Dr Bartlett: In Ontario the treatment decision is completely separate from the admission decision. If you have capacity then you can make treatment decisions about yourself, whether that is for somatic or psychiatric treatment, whether you are an inpatient or an outpatient, whether you are an informal patient or an involuntary patient. In the end that is what I support. I think it is appropriate to emphasise that the concern that this would lead to a warehousing of patients simply has not materialised. In fact, what seems to have happened—and I hasten to add that this is anecdotal, I do not have formal studies on this—is that it creates a more complex playing field where negotiation can happen with a psychiatrist. The patient probably wants to get out, the patient almost certainly understands that they have got some difficulties because, remember, they do have capacity and some kind of an arrangement gets met. The doctor may not think it is ideal treatment, but the doctor is prepared to go along with it, and the patient may not be exactly delighted, but the patient is prepared to go along with it. I desperately want to be able to say that that leads to better compliance in the long term, and I think it should, but I have to be frank and say that I have not seen a study.

Q1137 Baroness Eccles: So it is not something you could really write a law about?

Dr Bartlett: We can certainly write a law that says if you are in a psychiatric facility and you have capacity you can make treatment decisions. Ontario has done that.

Q1138 Chairman: The Ontario situation sounds like a bit of a semantic paradise or nightmare, according to your viewpoint, if one has to define in every case the meaning of capacity. What is capacity in the case of a formally detained patient there?

Dr Bartlett: There is a formal definition of capacity and I would be happy to provide it to the Committee.

Q1139 Chairman: Is it uncontroversial?

Dr Bartlett: I think it is reasonably uncontroversial. Certainly when the system was introduced in 1986 it was extremely controversial, the doctors did not like it at all. I was rather delighted to see one of the leading doctors from Ontario claiming a year or two ago that it had all been the doctors’ idea. It was not, but it is an indication of how far we have come to this becoming simply an accepted part of the world.

Q1140 Chairman: Let me just try something very simplistic on you because it is the sort of argument politicians like us understand. Let us say you have a “revolving door” patient who has been in and out of compulsion in psychiatric hospitals in south London or in Nottingham. On this occasion they are offered the opportunity to spend three months or more in the hospital but to go home, possibly back to their job and live with their family as long as they agree to certain criteria and that is called, as a term of art, a community treatment order. What on earth is wrong with that as an option to be used in that restricted group of “revolving door” patients? It sounds to me...
awfully like something you are doing by different means, Professor Thornicroft, in south-west London.

Professor Thornicroft: I have worked as a psychiatrist for about 20 years now and I have worked in Camberwell, which is one of the more socially deprived areas, and I now work in Croydon, which is a mixed area. From my work in Camberwell, I can think of one or two people at any one time from a caseload of about 400 for whom such a provision might be helpful and in Croydon at the moment I can think of nought or one person in such a category. That may be of some use, but if they completely refuse to go along with it you are left where you started anyway, that is, having to enforce and take them to hospital, and if they are bluffing effectively you are where you are already now with the supervised discharge order, which is that you have a legal provision which you hope will have some leverage or persuasion over the individual concerned. My concern on the other side is what this does to the whole enterprise of mental health services and the degree of trust invested in the service by patients, but also the extent to which practitioners will feel they can practise in good will given those legal circumstances. I have heard recently some practitioners say that they may wish, should the new provisions come in as they are written at present, not to let their section 12 be renewed. That would mean that they wish to carry on practising as psychiatrists but not have the power to detain patients under those circumstances. There is this debate going on. We have a form of understood contract between the psychiatric professions particularly and the wider society and patient groups and this would substantially change the centre of gravity of that understood contract.

Q1141 Chairman: That kind of argument about whether they are going to accept section 12 contracts or not, it is all very well to threaten us all with it, but at the end of the day if the law is changed, they are going to obey the law, are they not?

Professor Thornicroft: They will certainly obey the law, but some psychiatrists may not be comfortable practising under those circumstances.

Q1142 Lord Mayhew of Twysden: Professor Thornicroft, I am sure it is my fault, but I lost you in the course of your last contribution when you said, as I understand it, that a CTO would serve to increase stigma in the public eye for mentally suffering people. I think the stigma was the propensity to violence. I am afraid I lost you at that point. I did not quite follow the reasoning. Can you help?

Professor Thornicroft: There is little evidence about the extent to which popular opinions of mental illness and the views of people with mental illness about their own conditions are related to the law in any country, so this is a matter of opinion. My view is that a law based upon one central tenet, among others, which is the connection between mental illness and violence, further serves to strengthen that view in the wider population and that will serve to deter people from coming forward when they have symptoms of mental illness for assessment and treatment and also may serve to further exclude mentally ill people from within the mainstream of our society.

Q1143 Dr Naysmith: Professor Thornicroft, in your opinion, do we need a new Mental Health Act to replace the 1983 Act?

Professor Thornicroft: In my personal opinion, the current Act works reasonably well on most counts and the provisions before us would set us back a generation.

Q1144 Lord Rix: There have been quite strong representations from your Royal College that we should adapt the 1983 Act, that we should put in the necessary amendments to cover the Bournewood Gap and things of that nature. Would you consider that to be a desirable outcome?

Professor Thornicroft: Yes.

Dr Bartlett: May I respond to that?

Q1145 Lord Rix: Yes, of course.

Dr Bartlett: The first thing to say is that I do think that the 1983 Act is well out of date. It is appropriate to remind you, for example, that under the 1983 Act there is nothing legally wrong with treating a patient who is involuntarily for the first three months without even telling them why you are treating them. No one would defend that now, it really is out of date. Here, if I may, I will give the historical answer that Lady Murphy was asking for. One of the things which has also happened is that, as a matter of history, with the 1983 Act you can still see the roots of the 1808 County Asylums Act. Chunks of it have never been properly redrafted. As a lawyer, when you stick bits of it together they simply make no sense. I do think it is time for a new Act. I do think it is time for a properly drafted Act.

Q1146 Dr Naysmith: But it is not this one—is that what you are saying?

Dr Bartlett: But it is not this one.

Chairman: On those two extremely challenging opinions I think we will have to draw this session to a close. Can I thank you both for coming and certainly stimulating our thoughts and the discussion. Thank you very much.
Memorandum from the British Medical Association (DMH 248)

INTRODUCTION

The British Medical Association (BMA) is a voluntary, professional association that represents all doctors from all branches of medicine across the UK. About 80% of practising doctors are members, as are nearly 14,000 medical students and over 3,000 members overseas.

The British Medical Association has recognised for many years the need to bring mental health legislation in line with changes in psychiatric practice and the growing recognition of the rights of the mentally ill. We very much welcomed the recommendations of the 1999 Report of the Expert Committee: Review of the Mental Health Act 1983—the “Richardson Report”. In common with many other professional groups, the BMA was disappointed by the failure of the 2002 draft Bill to fully engage with the Richardson Report’s recommendations. The BMA was also disappointed that the English draft Bill did not follow the principled example set by the draft Scottish Bill, now the Mental Health (Care and Treatment) (Scotland) Act 2003.

The British Medical Association has a wide-ranging membership with a variety of views. Many of the issues raised by the draft Bill are not covered by formal BMA policy. In those areas where we have been unable to give a single response we have set out as succinctly as possible the range of views among the profession. Much of the day to day operating detail of the Bill will presumably be contained in the Code of Practice, and we look forward to taking part in the consultation process.

THE 2004 DRAFT BILL

The BMA recognises that the current draft Bill differs in many important respects from the 2002 draft. We welcome the introduction of the obligation to consult patients about their treatment. We also welcome the changes to the Community Treatment Orders which ensure that any first episode of compulsory treatment must be provided in a hospital setting. We also welcome the increased protections for children and young people. Having said this, the BMA believes that the primary purpose of mental health legislation is to enable the provision of medical treatment to mentally disordered people in a way that provides a benefit to the patient and is consistent with professional ethics. The BMA believes that in certain important respects, the draft Bill falls short of this goal.

The draft Bill is an exceedingly complex piece of legislation and in several points the drafting of the Bill makes it extremely difficult to understand. This complexity means that, inevitably, a great deal of the Bill’s functioning will depend upon clarification provided by the Code of Practice. We have found it difficult to comment on the impact of a legislation that will depend so much on an accompanying document that has not been drafted. A draft Code of Practice must be made available as a matter of urgency. Furthermore, doctors are concerned that the manner in which the Bill is drafted means that only specialist mental health lawyers will be able to fully understand it. The BMA believes this to be a regressive step.

The BMA is also extremely concerned about the impact of the draft Bill on services, particularly in relation to personnel. Although the BMA welcomes the enhanced role of the Mental Health Tribunal, we have grave worries about the extent to which its enhanced needs for expertise can be met within current staffing levels, particularly given the extent of shortages in psychiatry. If the Mental Health Tribunal is to be the main procedural safeguard in the Bill, it is vital that it is properly staffed and resourced.

The BMA also notes with concern that the United Kingdom is the only member of the 45-strong Council of Europe that has reserved the right not to comply with the Council’s Recommendation on Human Rights and Psychiatry. The BMA understands that the reason for non-compliance is that several Clauses of the draft Bill are in conflict with the Recommendation. The implications of this for the Bill’s compliance with human rights give rise to serious concerns about the impact of the legislation on the rights of mentally disordered individuals.

The Scrutiny Committee has requested that written responses are limited to 1,500 words. Although we have tried to be as concise as possible, we have been unable to provide a response to this very complex piece of legislation within that limit. Our response follows the questions set out in the call for evidence. We also raise at the end a number of additional issues not directly covered by the questions.

1. Is the draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

The draft Bill is confusing in this respect. Clause 1(2) states that the Code of Practice must set out general principles. It also states that practitioners must “have regard” to the general principles, not that these principles are binding. Clause 1(3) sets out what those general principles must be designed to secure. Clause 1(4) states, however, that those principles can be dis-applied where their application would be “inappropriate or impracticable”. It follows therefore that the Bill is not rooted in a set of unambiguous principles.
The BMA believes that the inclusion of a robust set of principles rooted in ethics and the reality of psychiatric practise would be helpful in guiding practitioners providing care and treatment under the Bill. There is now a clear precedent for the incorporation of principles on the face of legislation. The Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults With Incapacity (Scotland) Act 2000 and the current English Mental Capacity Bill all incorporate principles on the face of the legislation.

The BMA recommends the following principles. These echo those drawn up in the Richardson Report.

— Compulsory treatment powers should only be used where the patient’s mental condition is thought to be treatable; people who may be dangerous but are not suffering from a treatable medical condition should be managed differently.

— Patient autonomy should be promoted to the greatest practicable degree.

— Wherever possible, treatment should be provided without recourse to compulsion.

— Care and treatment should be provided in the least restrictive and least invasive manner compatible with the delivery of safe and effective care.

— As far as possible, choices in care and treatment should reflect the preferences of the service user.

— Service users should be involved, to the extent of their capacity in all aspects of their care and treatment.

— Where society imposes an obligation on an individual to receive care or treatment there should be a reciprocal duty on society to provide appropriate services.

— Service users should receive care and treatment in a manner that accords respect for their individual backgrounds and that properly takes into consideration their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

— Informal carers should receive respect for their role and experience and have their views and needs taken into account.

— Service users are entitled to the benefit of the effective sharing of information, consistent with the obligations of confidentiality and law.

— Service users should be provided with all the information necessary to enable them to participate fully in decision-making.

2. Is the definition of mental disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the community adequate and sufficient?

Definition of Mental Disorder

In earlier consultation responses, the BMA argued in favour of retaining separate categories of mental disorder. The current draft Bill gives a single definition of mental disorder, defined as “an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain.” This is the definition used in the Mental Capacity Bill. Clearly such a definition casts the net extremely wide. In accordance with the recommendations from the Council of Europe, the BMA believes that the definition of mental disorder should be linked to internationally accepted guidelines such as ICD or DSM.

If such a single and all-encompassing definition is to be used, it is crucial that the conditions for compulsion are extremely strict. The BMA notes that, unlike the Scottish legislation, the 1983 Act, and many other common law jurisdictions, the current draft Bill contains no exclusion criteria. The absence of exclusions relating to individuals with a single diagnosis of learning difficulties or dependence on drugs and alcohol is particularly worrying. The BMA is also concerned that the combination of a single wide definition of mental disorder, the absence of any exclusion criteria and the introduction of compulsory treatment in the community will lead to a very large increase in the use of compulsion.

Duty to arrange Examination

The section relating to the determination of whether all the relevant criteria for compulsion are met is confusing. It may be very difficult to determine whether all the criteria are met before an examination is carried out. It would be more appropriate to state that there should be reasonable grounds to believe that all the criteria are met before arrangements are made for a patient to be examined.

Conditions for Treatment and Care under Compulsion

The BMA has some reservations in relation to the conditions for compulsion. It is difficult to understand the fifth condition, namely that “medical treatment is available to the patient which is appropriate in the patient’s case, taking into account the nature or degree of his mental disorders and all other circumstances of his case”. This condition makes no mention of therapeutic benefit. In the 1983 Act, the so-called
“treatability” criterion dictates that, in the case of psychopathic disorder or mental impairment, treatment must be available that “is likely to alleviate or prevent a deterioration of his condition.” The ethics that govern medical practice dictate that interventions must be directed at providing a net benefit to the patient. Although opinion in the profession is varied, the BMA believes that a considerable body of psychiatrists and other mental health practitioners would be opposed to medical interventions whose sole aim is custodial. The fifth condition also appears to state that if a person is a risk to others, he or she cannot be treated without using compulsory powers, even if he or she is willing to consent. This contradicts the principle of least-restrictive treatment and is a retrogressive step.

Medical treatment is given an extremely wide definition in the Bill, and includes nursing, care, various kinds of therapy and psychological intervention, habilitation (including education, training in work, social and independent living skills). As mentioned above, the broad definition of mental disorder and a liberal interpretation of treatment again raise the possibility of a considerable extension in the use of compulsory powers. This would be particularly inappropriate in the case of people with learning disability. The BMA believes that, as a matter of principle, informal treatment should be used wherever possible, and is concerned that the Bill as it stands undermines this principle.

Community Treatment Orders

The BMA fully supports the principle of providing for compulsory treatment in the community. It accords with the principles of respect for patient autonomy and the use of the least-restrictive alternative. The BMA has some serious concerns, however, about their use in practice. The extension of psychiatric care in the community has not been without controversy. While the principles behind it have been excellent, it has often been significantly under-resourced. The provision of high quality care in the community, whether formal or informal is resource intensive, and the BMA is concerned that the use of community treatment orders (CTOs) will not be properly funded. While the BMA welcomes the assurance that any first episode of compulsory treatment must be provided in a hospital setting, the Bill gives the patient’s clinical supervisor the power to change the patient’s status from resident to non-resident at a very early stage. There is a clear danger that hospital admission for first-time assessment could become an empty formality. It is essential that CTOs are used to improve the flexibility of care, not merely to furnish an inexpensive means of compulsion.

Mental health service user groups and the Royal College of Psychiatrists have put forward the “Saskatchewan” principles as a possible model for the use of CTOs. Under these principles, a person must have spent, in the previous two years, either 60 days as an involuntary in-patient in a psychiatric hospital or been an involuntary in-patient in a psychiatric facility on three or more separate occasions. The services must also be available in the community and the patient must lack the capacity to make a decision on his own behalf. The BMA would recommend that the suitability of this approach be explored.

3. Does the draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on the one hand, and concerns for public and personal safety on the other?

There are two aspects to this question: first, should people who have capacity be treated against their wishes where they present a serious risk either to themselves or to others; and second, is mental health legislation an appropriate vehicle for controlling the behaviour of those who present a serious risk to others but whose mental disorder cannot be treated? The BMA recognises that these are among the most difficult and controversial areas of the legislation. Opinion among the profession, among BMA members, and among service users differs. These are not issues on which the BMA has yet developed policy, and discussion is ongoing.

With respect to the first question, the BMA has in the past recommended a pragmatic approach, arguing that it is acceptable to override a competent refusal in a health provision on grounds of public safety in certain circumstances. Public safety must be able to outweigh individual autonomy where the risk is sufficiently great, and, if the risk is related to the presence of a mental disorder for which a health intervention of likely benefit to the individual is available, then it is appropriate that such an intervention should be authorised as part of a health provision, irrespective of whether the patient retains the capacity to consent to treatment.

The BMA recognises however that there is a considerable body of opinion that believes, on the basis of non-discrimination, that a mental health act should authorise treatment in the absence of consent only for those who lack capacity. According to this view, the refusal to accept treatment from a person with capacity must be respected in the context of mental ill health just as it is in the context of physical ill health, whatever the consequences for the individual.

Although the BMA is still considering its position, we would recommend that the Committee consider the Mental Health (Care and Treatment) Scotland Act 2003. One of the conditions for compulsion under this Act is that “because of the mental disorder the patient’s ability to make decisions about the provision of such medical treatment is significantly impaired.” This balances a principled respect for autonomy with the recognition that the assessment of capacity may be more difficult in the presence of a mental disorder.
Autonomy and self-harm

The issues become more difficult still in relation to self-harm. Again opinions differ. There are many health professionals who would find great difficulty in accepting a capacity-based approach where it leads to vulnerable people with mental disorders subjecting themselves to significant harm. This welfare-based approach also recognises that the impact of untreated mental illness both on the patient and those close to the patient can be extreme. They argue that, in practice, such a measure might result in the development of a very broad interpretation of incapacity, and that carefully controlled powers should therefore be retained in the legislation to provide for compulsory treatment to be given to capacitous patients who self-harm.

There is, however, a considerable body of opinion that believes, on the basis of non-discrimination and a respect for autonomy, that a self-harming person’s competent refusal of medical treatment for mental disorder must be respected, regardless of the consequences.

This is not an area in which the BMA has established policy, and discussion is ongoing. Once again the BMA would refer the Committee to the functioning of the Scottish legislation.

Personality Disorders

Another significant area of controversy relates to the inclusion of those with personality disorder in the legislation. Again opinion differs. There is disagreement within the psychiatric profession as to whether personality disorders are mental illnesses. Some see mental illness as a deviation from the individual’s normal functioning, with personality disorder as a description of functioning that is normal for the patient, however at odds with prevailing social norms it might be. Other see illness as deviation from “species-typical” functioning and therefore find room for personality disorder. These issues are outside the BMA’s expertise, and we would refer the Committee to the Royal College of Psychiatrists for further information.

The BMA believes that compulsion under mental health legislation should only be permitted where there is a reasonable belief that the condition for which compulsion is being evoked will respond to treatment. It would be unethical to use a health provision for purposes of social control or public order alone. If an individual with a personality disorder is thought to be untreatable but poses a risk to others, alternative methods of dealing with that risk should be sought.

4. Are the proposals contained in the draft mental health bill necessary, workable, efficient and clear? Are there any important omissions in the Bill?

As mentioned earlier, the BMA is extremely concerned about the draft Bill’s lack of clarity. The Bill’s proposals are long and complex and are couched in a language that makes them extremely difficult to understand. The Government is publicly committed to simplifying the legal system and ensuring open government. The opacity of this piece of legislation contradicts this commitment.

The BMA believes that any mental health legislation is likely to be more effective in achieving its goals where it receives broad support from those professionals who are charged with implementing it. The Bill’s twin goals are to provide for therapeutic intervention in relation to the mentally disordered, and to ensure public protection from the very small group of mentally disordered individuals who pose a threat to others. The main difficulty with the Bill is the confusion of these two goals. The powers required to protect the public from dangerous individuals conflict with the powers required for therapeutic interventions to assist individuals suffering from mental disorders. This fundamental confusion of purpose is at the heart of Bill’s difficulties. It follows therefore that the BMA has reservations about whether the Bill is workable.

Important Omissions

Right to an assessment of mental health needs

The BMA supports the principle of reciprocity in relation to compulsory powers. That is to say that where society imposes an obligation on an individual to comply with a programme of treatment, it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion. Allied to this principle is the issue of a right to assessment. The BMA believes that both service users and, subject to certain controls, their carers, should have a right to have the mental health needs of a mentally disordered patient assessed.

Bournewood patients

The BMA notes that provision for compliant incapacitated patients was moved from the draft Mental Health Bill to the draft Mental Capacity Bill at a late stage in the drafting of both Bills. While the BMA supports the principle that informal treatment should be provided wherever possible, this potentially large group of patients will be without the rigorous safeguards provided under formal powers. At the time of writing, the Strasbourg judgment on Bournewood had just been given and the BMA has not yet fully digested its implications, but has reservations about whether the safeguards in the Mental Capacity Bill meet the
standards required by the ECHR judgement. The development of appropriate safeguards for compliant incapacitated individuals is a crucial issue for the way the draft Bill interfaces with the draft Mental Capacity Bill.

5. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft Bill?

This question has been addressed elsewhere in the evidence.

6. Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

Safeguards and the Protection of the Particularly Vulnerable

One of the difficulties in approaching the process issues in the Bill is their complexity and opacity. There are, however, some positive changes. The Mental Health Tribunal, the enhanced provisions for advocacy, and the changes in relation to children and forensic provisions seem likely to enhance patient rights. The Government has also listened to criticisms in relation to the apparent absence of the patient’s perspective in the earlier draft, and the need to consult the patient is now acknowledged.

In relation to children and young people in particular, there are now safeguards for children who are being treated under parental consent which are very welcome. A number of issues are outstanding:

— Nothing is mentioned in the Bill about the family and educational needs of children.
— There are no provisions for assessing the needs of the children of mentally ill parents.
— There is no respect for the competence of children.

Although the Bill mentions increased advocacy, it nowhere states that patients will be entitled to legal representation and access to legal aid. An absence of legal representation will clearly disadvantage those subject to compulsory powers.

Specific Treatments

Electro-convulsive therapy (ECT)

The provisions under the draft Bill allow for the patient’s Clinical Supervisor to prescribe ECT. This might entail non-medically qualified personnel authorising ECT. Under the draft Bill, ECT can be given to a patient who has capacity:

— with the consent of a patient who has capacity, or
— with the authority of the Clinical Supervisor in an emergency.

The BMA believes that ECT should only be prescribed by properly trained and qualified professionals. The BMA is opposed to the provision of ECT against the informed wishes of a patient who has capacity to make a decision about the treatment. The Bill makes no mention of advance directives in relation to ECT or other specified treatments. Treatment plans drawn up with patients while they have capacity could cover this option.

Neurosurgery for mental disorder (NMD)

In relation to NMD, the current position is that only patients who have capacity to consent can receive this treatment. A second opinion supporting the treatment is also required, and this must be given by a three-person team, two of whom must certify capacity and the third, a psychiatrist, must confirm the necessity of treatment. The current draft Bill also enables the High Court to authorise the treatment where an individual lacks the capacity to make the decision himself. The BMA notes that the Royal College of Psychiatrists is opposed to extending this treatment to patients who lack capacity.

Medication

Currently, compulsory medication for mental disorder is prescribed under the authority of the Responsible Medical Officer and it can be given without consent for up to three months. Under the draft Bill’s proposals, the clinical supervisor can only authorise medication for the duration of the assessment order—28 days. After this time, authority for compulsion will pass to the Mental Health Tribunal. The BMA believes that these changes are positive ones and are likely to lead to increased protection for patients.
Other controlled treatments

Concerns have been raised in the past over the use of polypharmacy, and the administration of doses above those recommended in the British National Formulary (BNF). Guidance on their use should be given in the Code of Practice.

7. Is the balance struck between what has been included on the face of the draft Bill, and what goes into regulations and the code of practice right?

As already mentioned above, the BMA believes that basic principles governing the exercise of the powers provided by the Bill should be placed on the face of the Bill.

8. Is the draft Mental Health Bill adequately integrated with the Mental Capacity bill (as introduced in the House of Commons on 17 July 2004)?

The BMA has been extremely supportive of the Mental Capacity Bill and has worked closely with the Department for Constitutional Affairs on certain aspects of it. It is likely that the majority of patients who are treated under mental health legislation will also come under the jurisdiction of the Capacity legislation. It is only mental health legislation, however, that provides powers to compulsorily treat patients who retain the capacity to make the decision themselves. The Capacity Bill aims to promote patient autonomy, putting Lasting Powers of Attorney and advanced refusals of treatment on a statutory footing. In contrast, the draft Mental Health Bill permits a restriction of autonomy, irrespective of the patient’s capacity, where he or she is suffering from a mental disorder and presents a significant risk either to himself or to others. One of the difficulties for mental health practitioners will be doubt about the appropriate legislation to use in each circumstance. Clear guidance will be necessary.

In relation to the relevant conditions for compulsion, Clause 9(5) of the draft Mental Health Bill states that “The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.” We take this to mean that the Mental Health Bill cannot be used if treatment can legally be provided in another, presumably less-restrictive, way. Clause 6 of the Mental Capacity Bill, which sets limitations to acts undertaken in connection with care and treatment, permits the use of restraint or force in relation to an incapacitated person where it is “necessary to do the act in order to prevent harm to P” and that it is a “proportionate response” in the patient’s best interests. An unintended consequence of these two Clauses could be that the Capacity legislation has to be used in place of the mental health legislation to provide treatment for mental disorders where a patient lacks the capacity to consent to it. This means both that a burden is placed on the Capacity legislation that it was not designed to meet, and that the safeguards available under mental health legislation will not be available for incapacitated patients.

As mentioned earlier, the BMA is concerned that neither piece of legislation can properly deal with the needs of the large group of compliant incapacitated patients identified in the Bournewood case. Following the Strasbourg judgment it is likely that the Mental Health Bill is the only mechanism that will provide appropriate safeguards. The implications of this need to be fully explored.

9. Is the draft Mental Health Bill in full compliance with the Human Rights Act?

While the BMA does not have specific expertise in this field, we welcome the enhanced role of the Mental Health Tribunal which we believe will offer greater protection to patients and improve the Bill’s compliance with the Human Rights Act. As mentioned earlier, however, the fact that the United Kingdom is the only member of the 45-strong Council of Europe that has reserved the right not to comply with the Council’s Recommendation on Human Rights and Psychiatry suggests that there might be problems in this area. The BMA understands that the reason for non-compliance is that the Clauses of the draft Bill discussed below are in conflict with the Recommendation:

— The Council of Europe proposes using “mental disorder as defined in accordance with international medically accepted standards”, and refers to ICD10 Chapter 5 Mental and Behavioural Disorders. This keeps the definition restricted—for example, epilepsy would probably only be included if it caused organic psychosis. In relation to drugs and alcohol not complicated by other mental disorders, the Council of Europe recommendation does not exclude use in these circumstances but refers in its explanatory memorandum to this only occurring under specialists in drugs and alcohol treatment.

— The recommendation specifies with regard to criteria for involuntary placement that “the placement includes a therapeutic purpose” and in the explanatory memorandum that it cannot be solely for custodial purposes. Treatment in the new Act is defined as including “care” which makes it much wider than the equivalent concepts in the recommendation.

— The recommendation specifies the involvement of a “competent body” which is independent in its decision making from those “proposing the measure”. The approved mental health practitioners (section 3) may not be seen as sufficiently independent to exercise this function in the period prior to consideration by MHRT.
— Psychosurgery without consent is not sanctioned.

The BMA believes that the Bill should be reconsidered with a view to bringing it into line with the Council of Europe recommendations.

10. What are likely to be the human and financial resource implications of the draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?

This is not something about which the BMA has clear evidence. We note however that the Royal College of Psychiatrists estimates that 12% of consultant psychiatry posts in England and Wales are currently vacant. One of the underlying reasons is the difficulty in recruiting young doctors into the specialty combined with a serious fall-out rate during training. The Royal College also inform us that all possible initiatives for increasing the number of consultant psychiatrists are being pursued. We have already mentioned that if the Bill is enacted in its current form, we fear that there are a significant number of professionals who will regard aspects of the Bill as running counter to their professional ethics. Some psychiatrists may therefore leave the specialty, and it may also act as a further disincentive to recruitment.

The Committee will be aware of the current difficulties in relation to Mental Health Review Tribunals, with as many as 95% of reports being delayed. The BMA understands that the Department of Health is also incurring costs as a result of legal action in relation to unacceptable delays in holding Tribunals. The BMA understands that the current delays are primarily due to the shortage of psychiatrists. Many psychiatrists serving on the Mental Health Review Tribunal (and as Second Opinion Appointed Doctors) are retired from full-time practice. Given the new General Medical Council requirements in relation to revalidation, the availability in the future of retired doctors is likely to be markedly diminished. The removal of the need for psychiatrists from Tribunals under the draft Bill is unlikely to ease the workforce problem because of the need for the presence of a psychiatrist, from the Expert Panel, at each Tribunal.

The Mental Health Tribunals for England and Wales are to be at the centre of the new legislation, and will play a crucial role in safeguarding patients and ensuring that the legislation is compatible with the Human Rights Act. These new Tribunals will be expected to adjudicate on a very wide range of issues, and enjoy extensive powers under the Bill. These powers include the ability to specify that certain decisions can only be made by the Tribunal, particularly in relation to discharging certain patients; the power to authorise ECT for children and incapacitated adults, as well as the power to discharge a nominated person.

In the BMA’s judgement, the success of the Bill will depend upon the effectiveness of these Tribunals. If, as a result of practical difficulties in relation to the availability of expertise, the Tribunals are ineffective, the Bill’s safeguards will be compromised.

The Department of Health have stated that an extra 130 psychiatrists will be needed. The BMA has reservations about this figure, and would like to see more information about how this estimate was reached. The draft Bill will place a variety of extra demands on consultant psychiatrist, including:

— more Tribunals and appeals (each patient to have at least one Tribunal after 28 days in addition to any appeals);
— increased numbers of patients subject to the Act, all patients to have formal care plans and expert panel doctors required after 28 days (rather than three months as currently); and
— need for medical review of approved care plans as patients’ mental states changed.

Given the existing staff shortages in psychiatry, the BMA is concerned about the Government’s ability to meet the new demands that the Bill will place on psychiatric expertise. It would be regrettable if such medical provision could only be acquired at the expense of patient care, particularly to those patients at earlier, less severe stages of illness or not requiring compulsion.

Areas not Directly Covered by the Committee’s Questions

Offences under the Act

The BMA has concerns regarding the proposals in relation to protection for acts done in pursuance of the Act. We are particularly concerned about Clause 298. Under the 1983 Act, an action could not succeed unless the complainant could prove that professionals were acting in bad faith or without reasonable care. In the draft Bill, the onus is shifted onto the person complained against to prove that they acted in good faith and with reasonable care. The BMA recognises that a balance needs to be struck between the rights of patients to a fair trial, and the need for health professionals to be protected from spurious litigation. This is not an easy balance to strike. Nevertheless, the BMA would like to point out the distress caused to health professionals by complaints procedures, and the potential cost in terms of staff time and morale, in addition to the legal costs incurred. If it is compatible with the Human Rights Act, the situation under the 1983 Act should be retained.
Criminal justice provisions

The new draft Bill seems to provide increased flexibility throughout a defendant’s progress through the criminal justice system, and this is welcome. The court does, however, in certain circumstances, reserve the right to authorise care plans for offenders. It is difficult to see how a court would have the requisite level of expertise to be able to make an informed decision.

The criminal justice provisions of the Bill, together with other changes, such as the increased use of Mental Health Tribunals will increase pressure on mental health professionals. It is vital that a thorough assessment of the impact of the new legislation on available resources is made before the Bill is enacted.

A loss of discretion

Under the 1983 Act, an individual could accept treatment voluntarily where the conditions for compulsion were otherwise met. The BMA understands that under the draft legislation, if the conditions for compulsion are met, the powers of the Act have to be used, irrespective of the patient’s willingness to consent. Furthermore, under the 1983 Act, a Tribunal had the discretion to waive the use of compulsion in individual cases. Under the draft Bill, these discretionary powers have been lost. Once again, the impact of the draft Bill is towards an increase in the use of compulsory powers and a contradiction of some basic ethical principles.

Monitoring

Unlike the 1983 Act, there appears to be no requirement to register hospitals or mental nursing homes as able to accept resident patients. “Hospitals” are very broadly defined to include all general hospitals and any premises to which medical treatment under the Act is provided. This makes monitoring the conditions in these establishments by the Healthcare Commission impossible. It is also contrary to the Council of Europe’s recommendations.

October 2004

Memorandum from the Royal College of General Practitioners (DMH 222)

The College welcomes the opportunity to comment on the Draft Mental Health Bill.

The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the “voice” of GPs on issues concerned with education; training; research; and clinical standards. Founded in 1952, the RCGP has over 21,500 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

We focus our comments on the questions and themes set out in the Joint Committee’s call for evidence published on 16 September 2004.

1. Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

1.1 The principles underlying any piece of legislation that deprives people of their liberty must be clear and binding. Placing them in a Code of Practice that can be over-ridden in emergencies is not, in our view, a sufficient safeguard.

1.2 The Government has rightly stated that values lie at the heart of good mental health practice (Woodbridge and Fulford, 2004). The values underpinning the draft Bill are in many ways contradictory. The Explanatory Notes, for example, state that it should reflect “modern patterns of care and treatment for severe mental illness”. Yet the Bill focuses strongly on the medical, rather than social, dimensions of treatment despite the many advances in the latter in recent years.

1.3 The Government also states that it sees the draft Bill as strengthening safeguards for patients—yet in many aspects the safeguards are weaker than those which currently apply, such as the power of professionals over the appointment of a nominated person and the failure to include advocates at the examination stage.
2. Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the Community adequate and sufficient?

The Definition of Mental Disorder

2.1 The draft Bill’s definition of mental disorder is much broader than the 1983 Act, which made specific reference to the nature and type of the disorder and which had clear exclusions of drug and/or alcohol misuse, promiscuity, sexual deviance and immoral conduct where they exist on their own.

2.2 This may lead to mental health legislation being used on people who do not have a mental illness. This could turn many people away from using drug and alcohol services, for fear of compulsory treatment. Using the mental health system to treat such people will also block entry to it for people with severe and enduring mental health problems.

2.3 Specific exclusions should be made within the definition of mental disorder. These need not exclude people who have co-existing mental health and other problems, regardless of the person’s “primary diagnosis”.

The Conditions for Compulsory Treatment

2.4 The criteria for compulsory treatment in the draft Bill are worryingly open to interpretation. While clause 4, for example, ensures that patients must be treated without resort to compulsory powers where it is possible to do so, clause 7 modifies and, in some cases, removes the basic principle of treating people outside compulsory powers. It places no burden of proof on professionals that compulsion is necessary. Any people who fall into this category will have to fight an uphill battle to demonstrate that their level of dangerousness to others has reduced.

2.5 Section 9 (8) modifies these criteria further, stating that a potential “substantial risk” is to be treated as a part of the determination of whether all of the above criteria have been met. The notion of substantial risk is difficult to establish. Many studies have shown that risk assessment is frequently an imprecise science (Morgan 2000). Practitioners tend to over-estimate risks and are often risk averse in their approach. The term “substantial risk” could lead to a culture of excessive caution. The nature of the risk, its severity, likelihood and consequences should be more clearly specified.

2.6 The issue of function is also not addressed. Most people who experience mental health problems function normally in their communities. Though they are symptomatic, they continue to live without support from the mental health system. Since it is known that using the mental health system can lead to social exclusion, marginalisation and stigmatisation (SEU 2004), use of such a system should only be enforced if an individual is disordered and not functioning well within their social system. We recommend that the issue of function be specifically addressed within the conditions.

2.7 The stipulation that treatment should be appropriate and available is not enough of a safeguard. We endorse the Mental Health Alliance policy that there should be a test of therapeutic benefit for treatment imposed under the Act. We suggest that treatment be defined as “clinical and/or social interventions that are likely to be of therapeutic benefit to the individual concerned”.

Non-resident Orders

2.8 A system similar to that used in Saskatchewan, Canada, should be considered for non-resident orders in England and Wales.

2.9 Non-resident orders (NROs) should only be applied where there is clear evidence that they would reduce the need for repeated compulsory admissions to hospital. There are two key principles: that people are treated in the least restrictive setting possible; and that the use of NROs should on balance benefit the life of the individual by preventing the regular use of more restrictive treatment settings.

2.10 Both principles are in the end for the judgement of clinical and professional social care staff. These judgements should be made more secure through the approval of a qualified social care professional to the course of action proposed and through a binding Code of Practice.

2.11 One of the conditions for a non-resident order is that the treatment is available. It should also be accessible, for example in terms of time, location and language. There should be an obligation on the service provider to ensure that the person can attend (e.g. funding a taxi, offering it at a time so that they can continue to work).

Race Equality

2.12 The current Mental Health Act is not implemented equally among ethnic groups. African and Caribbean people face a disproportionate risk of being placed under compulsory powers and of receiving coercive treatment within them. This discrimination can be explained only in terms of the stereotyping of Black people in our society (SCMH 2002).
2.13 Although action is being taken on this issue, racism will remain a real threat in mental health services for the foreseeable future. It is vital that a new Act includes a specific provision for race equality and for monitoring its use among different ethnic and religious groups. It should also specify that any care or treatment under the Act is provided in a culturally sensitive manner and environment. Without these specific safeguards, Black people are likely to continue to stay away from services.

3. Does the draft bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?

3.1 There is concern that the draft Bill does not balance these two concerns. There is a significant risk that the proposals in the Bill, and the message it sends out more widely, will strongly contradict what the Government is trying to achieve in tackling the stigma of mental illness and promoting inclusion among those who experience it. The draft Bill is incompatible, for example, with plans to help more people with mental health problems to get into work, education and training.

3.2 Advances in the treatment of personality disorders, and new sentencing powers, already make it possible to treat people who have committed violent crimes under existing law. There is a risk that the draft Bill would bring many more people with personality disorders into the ambit of compulsion with no evidence that it would either benefit them or protect others.

4. Are the proposals contained in the Draft Mental Health Bill necessary, workable, efficient, and clear? Are there any important omissions in the Bill?

A Right to Assessment

4.1 The absence of a right to be assessed for mental health needs is a major omission from the draft Bill. Homicide inquiries frequently discover that tragedies have followed a patient’s (or their carer’s) requests for help being ignored.

4.2 While waiting times across most of the NHS continue to fall, in mental health delays in getting access to psychological therapies remain prohibitively high. The new Mental Health Act is an historic opportunity to tackle this inequity. A legal obligation on services to assess people’s needs and to provide the treatments they require as quickly as possible would also be an important means of helping services to become more patient-centred.

Advance Statements

4.3 There is no provision in the Bill for advance statements: a missed opportunity to be rued in years to come. Advance statements allow practitioners and service users to make plans in advance for future relapses. They also reflect the growing value of patient choice in health care. Establishing reference to or consultation with these plans would help to create a sense of control for service users at a time when they have little or no control over their lives.

4.4 Advance statements are now being implemented in Scotland under their new Mental Health Act. Their experience of putting advance statements into practice will be invaluable for England and Wales and should not be dismissed at this stage.

Aftercare Arrangements

4.5 The proposals for aftercare in the current draft represent a major loss of service. The suggestion that services need only be provided for a six week period reflects a lack of understanding of the process and delivery of an adequate care plan. Where someone has been subject to formal powers for many months it is important that services facilitate a programme of support for them to return to a satisfactory quality of life. This often takes time.

4.6 If a person has to be placed on a waiting list for aftercare, anything provided after six weeks would need to be paid for. This could lead to people dropping out of services. We suggest that aftercare be provided for as long as is necessary—subject to the review of the care plan by the multi-disciplinary team.

5. Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft bill?

Access to Advocacy

5.1 The welcome creation of a new role of the Independent Mental Health Act Advocate is an important step forward. We are disappointed, however, that access to advocacy is not proposed until after the examination stage. This leaves some of the most vulnerable patients without access to a most important source of support—the first few days are critical. Additionally, those who are “ill” or have a “mental disorder” cannot be advocates yet often could be the most appropriate advocates.
5.2 It is also vital that sufficient resources are made available for this service. Providing a decent level of support to the 25,000 people who are treated compulsorily each year requires a significant number of highly skilled people. It is vital that the new service is not “poached” from existing voluntary sector provision of advocacy to some of the most marginalised groups of people in the mental health system.

Care Planning

5.3 The draft Bill gives little guidance about what constitutes a care plan. Mental health services currently use a Care Programme Approach (CPA) to plan a person’s care. Implemented properly, the CPA has many benefits, not least the involvement of the person and their carers in the process, and the breadth of issues it covers.

5.4 It is important that people treated under the new Act are offered full CPA care plans. Without them, we risk creating a two-tier system as well as causing confusion for staff and service users alike—especially for those who move between voluntary and compulsory care.

9. Is the Draft Mental Health Bill in full compliance with the Human Rights Act?

9.1 There is a risk that some aspects of non-resident orders could clash with the Human Rights Act. In particular, the requirement people must live in a certain place, without providing financial assistance to do so, and the proposed powers for the police to take people from their homes (in some cases without a warrant).

10. What are likely to be the human and financial resource implications of the draft bill? What will be the effect on the roles of professionals?

Staffing Concerns

10.1 There is concern about the staffing implications. Overall, the powers in the draft Bill make it highly likely that more people than currently would be brought under compulsory powers. The necessary safeguards and procedures also increase the amount of work each case of compulsion will entail; while the creation of non-resident as well as hospital care for those under compulsion will make the system much more complex to manage. These factors combined will have an enormous effect on staff time as well as changing radically the way some teams work.

10.2 There remain major gaps in the understanding of the impact of the proposals in the draft Bill on mental health workers. Three of these are noted below. They must all be fully explored before any legislation is allowed to pass through Parliament.

Approved Mental Health Professionals (AMHPs)

10.3 The creation of AMHPs could be problematic in the short term. The existing shortage of ASWs will be exacerbated by the need to train them in the new role and the likely wastage from that process of those nearing retirement. That will place the greatest pressure on nursing staff, for whom the transition to AMHP status will require considerable training, and whose former roles will need to be filled.

10.4 Longer term, the loss of the ASW could also have a major impact on services. As a professional grouping with a clear identity, ASWs act as a peer group, providing support to one another in making decisions and maintaining a different perspective to that of the health professionals. This is an important safeguard for patients and indeed the wider public. The new AMHPs will come from different professions and have varying lines of accountability (not all need be social services staff).

Effects on Community Teams

10.5 The creation of non-resident orders will have a dramatic impact on community mental health teams. The brunt of enforcing NROs could fall on assertive outreach teams, who work with the people other services find it hardest to engage.

10.6 These teams, recently established across the country, work on the basis of encouraging people to comply with care plans voluntarily. Much of the value of assertive outreach, indeed, is in building the confidence of clients and helping them get back to an ordinary life. Imposing compulsion in these circumstances could damage those relationships and undermine the basis on which services are currently provided.
Non-dangerous Offenders

10.7 The Draft Bill suggests a new model of dealing with non-dangerous defendants and offenders in the courts. This proposes that persons can be remanded in hospital (as under the 1983 Act) or in the community. This has the benefit of offering a less restrictive alternative for some people. There is a risk, however, that community teams will lack the skills to support people remanded in the community, or that doing this will divert resources from other groups of service users.

Specific Impact on Primary Care

The above comments relate specifically to the Bill as published. However, there are a number of concerns that relate to the potential implementation of the Bill which should be addressed in the Code of Practice. In particular there are issues of safety and communication between community teams and primary health care teams when providing care for people on non resident orders.

Dr Maureen Baker CBE DM FRCGP
Honorary Secretary of Council

REFERENCES

Sainsbury Centre for Mental Health 2002, Breaking the Circles of Fear London: SCMH.
Social Exclusion Unit 2004, Mental Health and Social Exclusion London: ODTM.

29 October 2004

Witnesses: Dr Michael Wilks, Chair, Ethics Committee, Dr JS Bamrah, Chair, Psychiatric Sub-Committee, and Dr Robin Arnold, Psychiatric Sub-Committee, British Medical Association; Professor Andre Tylee and Dr Alan Cohen, Royal College of General Practitioners, examined.

Q1147 Chairman: May I welcome you from the years before taking up that position. I chair the primary care programme of the National Institute for Mental Health in England.

Dr Cohen: I am Alan Cohen. I have been a GP nearly 25 years and I am approved under section 12 of the current Mental Health Act.

Q1148 Lord Rix: I am sure the Committee will be very relieved that this is the last evidence session and we were very relieved that this is the last evidence session. In your experience, is the Government’s decision to remove these exclusions justified? What other conditions should be excluded from the definition of mental disorder? Do you consider that learning disability, intellectual impairment without allied mental illness should also be added to that list of exclusions?

Dr Arnold: The underlying problem is with the broad definitions, in particular the broad definition of mental disorder. I heard mental illness being referred to quite a lot earlier and in some of the questioning that I read of the Minister the Committee was referring to mental illness, and in his launch on the Today Programme of the Draft Mental Health Bill Professor Louis Appleby referred to the sole purpose as being mental illness. Mental illness is not mentioned in the Act. People
assume that mental disorder is a synonym for mental illness and it is not, the nature of mental illness is very different. Mental illnesses are arbitrated by doctors and doctors work out how to deal with it on a pragmatic basis. Sexual deviance is a rather uncomfortable phrase because it was only in the Sixties that they stopped treating homosexuality with the electric shock treatment. One of the new tinkering with the Bill that has been introduced instead of a treatability clause was that a treatment would be available and at that time the electric shock was available. Would it therefore be used? Would we be making a mistake now with regard to sexual preference? Obviously it gets very difficult to say with paedophilia. The problem with paedophilia is not the predilection for children, it is the fact that children are abused. If people did it quietly in their own rooms and there was no abuse going on it would not be a problem. I do not want to go down as being a supporter of paedophilia, I just want to highlight the problems. There are many other sexual preferences which are more complex. We now pretty much universally accept that homosexuality is a sexual preference and people’s right and choice. Undoubtedly I think this is caught within the very broad definitions and I think pretty well all psychiatrists would not consider mental deviation to be a mental illness of itself. With regard to drug and alcohol use, this is complex, but this is what I referred to as mental illness being a pragmatic issue.

Louis Appleby in what he said on the Today Programme acknowledged that personality disorder is not a mental illness, and at a conference in October of 2003 between our faculty and the general adult faculty, with 300 delegates, we had a debate on whether personality is a mental illness and that was defeated at the beginning of the debate by 86% and at the end by 92%.1

Q1149 Chairman: What was the question again?

Dr Arnold: Is personality disorder a severe mental illness? They did say severe mental illness so they may have thought it was a minor mental illness but I do not think so. I do not think learning disability is a mental illness. Our original evidence to Genevra Richardson, which I led, said that personality disorder, mental illness and capacity or incapacity should be separate and should be dealt with separately. At the time we knew the Capacity Act was around but it had gone into a limbo for a while and we did not know what was going to happen with it. The Capacity Act is now there with some adjustments to take account of Bournewood and so on. I think that a pure learning disability can be dealt with. If someone becomes mentally ill who has a learning disability then that should be dealt with as a mental illness. I think that the problem is the broad definition. I think that a pure learning disability should be excluded from these processes but it should only be excluded by narrowing it down to mental illness. That will give the Government a problem because they want to incorporate a severe personality disorder. To some extent that is being dealt with through the justice legislation and other areas, but by pooling it with mental illness you get all of these problems which affects other groups, including those with a learning disability and those with dementia as well.

Q1150 Chairman: Can we be clear as to what your view is as to what should be done in the criminal justice aspect of all of this because the Mental Health Act 1983 and this Bill are designed to deal to a very great extent with the criminal justice system and with people suffering from various forms of mental conditions who come before the criminal justice system. What would you do which is not in this Bill?

Dr Arnold: We do not have a problem with mental illness which leads to criminal behaviour because there the person should be treated. There is a problem where people indulge in criminal behaviour and have a mental illness either concurrently or later when they get into prison. They certainly need treatment, but there is a problem at the moment, and it would certainly continue in this Act, in that then their criminal behaviour gets excused and it gets treated as though it was mental illness. That brings people with mental illness into disrepute. It also means that later on when they are released the mental illness is not dealt with. I do not know how you can deal with all dangerousness. What people want is that anybody who might be a danger in the future is prevented from being a danger, whether it be mental illness or personality. That is impossible to deliver because we cannot predict dangerousness in that way. So I think even the criminal justice system cannot deal with it. I think what you have to do is wait until someone has committed an offence of one kind or another and then assess the risk and deal with that through the justice system. If they commit the offence because of mental disorder and they lack capacity and so on then, as with the present Act, that should be dealt with through the Mental Health Bill, but that is the problem of confusing personality with mental illness, they are diametric opposites. Mental illness was developed as a social institution to differentiate it from your normal personality and what you do out of that.

Q1151 Chairman: Forgive me for asking yet another question but my mind is becoming befuddled perhaps because of the number of evidence sessions we have had. If it is clear to a psychiatrist and social workers that a patient is reaching a high degree of dangerousness which may be quite directed, for

---

1 Note by Dr Wilks: In reply to a question about possible exclusions for groups of patients. Dr Robin Arnold made reference to individuals with paedophilic tendencies. The BMA is extremely concerned that these statements might be taken out of context. We would like to emphasise that the comments expressed Dr Arnold's personal views and were not those of the BMA. Dr Arnold has also assured us that he was in no way condoning paedophilia, merely stating that it was not appropriate for mental health legislation to treat individuals with anti-social tendencies where their impulses were controlled and they therefore presented no risk of harm to others. Although the use of paedophilia is a particularly bad example, he stated that the protection of children from abuse was the prime issue in paedophilia and this is provided by criminal justice and social services. Psychiatrists could not prevent this so sexual deviance should be excluded from the Mental Health Act.
example, at their mother or their siblings and it is known that there is a risk that that dangerousness could lead to something that would objectively be described as a criminal act, how are we going to deal with that issue under your prescription?

**Dr Arnold:** Let me take two extremes. If there was someone with a schizophrenic illness at home with their mother and they were developing a whole series of delusions and hallucinations and the voices were commanding them to knife their mother, then you would get them in for treatment, you would get them away from the mother and you deal with the dangerousness.

Q1152 Chairman: So you section them?

**Dr Arnold:** Yes. If, however, someone is on their way to commit an armed robbery then they are clearly meeting the question that you gave me, but that should not be an issue for psychiatrists and social workers and others. There are grey areas in between, but the implication of the Act is the person on their way to commit an armed robbery is our problem and we should prevent it and that is the whole issue around the Stone case. Some time ago I asked our parliamentary office—I do not know whether I should be saying this but I will set out the criteria—whether, if Stone were found innocent at the Old Bailey at appeal and deemed not to have committed the murders that he committed and walked down the steps of the Old Bailey a free man, he should be detained by two psychiatrists and a mental health worker under this Act indefinitely. That is what is facing you in a sense because Jack Straw made it quite clear that he felt that he should have happened retrospectively over that issue when he spoke about it and that is the problem facing us. I was told that the issue was too subtle to risk asking the question, but that is what you are asking psychiatrists to do, to predict who is going to be violent and to prevent them doing it. I have no problem with people who have mental illness.

Q1153 Chairman: The Stone case is no longer **sub judice** and it is a very good example to take because we have seen so much detail of it publicly. Dr Wilks, in hindsight is there anything that ethically could have been done by the medical profession or by the criminal justice system that could have led to the prevention of (leaving the detail out) a case like Stone? Does this Bill provide any benefit for dealing with a case like Stone or not?

**Dr Wilks:** I doubt that it does because it is not really an ethical answer to your question, it is more of a psychiatrically based answer and the question of predictability and the extent to which predictability of possible future harm might be a reliable indicator for removing someone’s liberty from them. There seems to be a pretty general consensus within the psychiatric community that about the only basis on which you can predict if someone is dangerous is that they have been dangerous and the fact that those people will probably be suffering from a mental illness or mental disorder or a mental condition which may not be treatable. What we are seeing here is a piece of mental health legislation in which the diagnosis is difficult to make, there may be no treatment and the only option, because there is no treatment, is detention. It seems to us that while it is difficult to devise a framework for the detention of people in other areas, it would have to be under some sort of criminalised based legislation, it should not be within the scope of mental health legislation to make those kind of liberty depriving decisions and with the help of doctors on the basis of a condition which is poor predictability to violence and may not be treatable. That does not seem to be the right vehicle in mental health legislation to do that kind of job.

Q1154 Dr Naysmith: I do not disagree with much of what Dr Wilks has just said, but is it not true that Stone was known to mental health services and had indeed sought help not very long before he committed the act that we are talking about? Are you saying that there was nothing that could be done?

**Dr Arnold:** I do not know. I have not examined the notes or anything so I am going by what I have heard through the press. My understanding is that he was still receiving help from a community psychiatric nurse. As was reported in the press, he had been admitted for a period of treatment but they had found him not treatable. The only other solution would have been to have kept him indefinitely because presumably sooner or later he would have done something similar. There is absolutely no evidence that you can treat personality against someone’s will. You can treat some mental illnesses with antipsychotic in injectable form and with ECT and so on for depression against someone’s will, but there is no evidence at all that you can treat these problems. He was still receiving help.

Q1155 Dr Naysmith: We probably should not probe this too closely since few of us know the details. There is a suggestion that he had sought help fairly recently before he committed the act and had been turned away and told there was nothing they could do for him.

**Dr Arnold:** What I had understood was that a CPN was still seeing him and was still trying to help him.

**Chairman:** Let us move on and try and tease out whether you have a different view of Community Treatment Orders from the previous witnesses.

Q1156 Baroness McIntosh of Hudnall: You have told us that you do have a different view. I have some difficulty in understanding the value of Community Treatment Orders as they are currently envisaged. We heard some very interesting evidence from the witnesses who immediately preceded you, which you may have heard. They were keen to tell us that if they were to be useful, which indeed they thought they might be, it would be for a very, very small group of people. Could you tell us what you feel about Community Treatment Orders as the Bill represents them? I am asking you about that because what I felt about the last lot of evidence was that we were hearing about Community Treatment Orders as the people who gave us the evidence would like them to
be but not as they are currently drafted in the Bill. It appears to me that you have some support for the Community Treatment Orders as they are drafted. Could you tell us why?

**Dr Bamrah:** The BMA supports the principle of patient choice and it is really in the context of patient choice that treatment in hospital and in residence given certain conditions could be considered. We heard the last bit of Professor Thornicroft's evidence. The jury is still out on Community Treatment Orders. I think the Supervision Register is less used. The Institute of Psychiatry did a survey on Supervised Discharge Orders a few years ago and found that by and large psychiatrists favoured Supervised Discharge Orders, which are the precursor to the Community Treatment Orders. Given certain criteria, whether it is the Saskatchewan principles or other principles, I understand that these Community Treatment Orders are in use in New Zealand, Australia, Canada and in some states of America and it looks like there are a small number of patients who would benefit from them and they are the "revolving door" patients, ie patients who are currently mentally ill and who could be treated at home. I can see that, if you have a 29-year-old manic mum who has three children at home, it may not be appropriate for her, but, if you have a 24-year-old schizophrenic with the right support at home, let us say he/she lives with their parents, it may well be the right kind of treatment for them providing they have the enhanced community facilities, not just assertive outreach teams but 24/7 care for them.

**Q1158 Baroness Eccles of Moulton:** Could I try and achieve a bit of clarity here? Dr Arnold made a very clear distinction between mental illness and mental disorder. Dr Bamrah is talking about mental disorder. I just want to know whether that is what he means or whether he is actually talking about mental illness.

**Dr Bamrah:** Mental disorder is a very broad term as the Bill is framed. Psychiatrists are not experts in dealing with all kinds of mental disorders. I guess I am referring to the kind of mental illness that we are experts in diagnosing and treating, which is very broadly the psychoses and the neuroses.

**Q1157 Baroness McIntosh of Hudnall:** The difficulty is that we have had a lot of evidence which suggests that as drafted the potential that Community Treatment Orders have to be used in a very wide range of different circumstances is quite significant and each witness who has come before us who has something good to say about Community Treatment Orders has tended to do as you have just done, which is to say that they would be good as long as they were limited, as long as this did not happen, that did not happen and it was only targeted in a very particular way. Could you tell us what you think the Bill should actually say about Community Treatment Orders? Do you think it should say what it says now and then the application of it should be left to guidance and Codes of Practice, or should the Bill itself be much more carefully written to restrict the application?

**Dr Bamrah:** It certainly should be restricted. The whole problem boils down to the definition of mental disorder which I do not need to go into because I think a lot of people before us will have spoken about mental disorders. It is such a broad term that you cannot have recurrent offenders who do have a mental illness being treated at home even on a Community Treatment Order. So you are looking at a small group of patients who are devoid of insight being non-compliant with their medication, who become ill quite frequently, with a reasonable but bearable risk of disturbed behaviour, being treated at home.

**Q1159 Chairman:** Given certain criteria, whether it is the primary care providers here because, if we are going to have CTOs, it seems to me that primary care providers could find themselves in the eye of the storm. I hope the general practitioners' representatives here will forgive me for putting it as directly as this, but there is a patchy pattern of response by general practitioners, many of whom are over-stressed around the country, in their response to many extracurricular activities or things that do not fall within their absolute every day pattern of work. Do you think that the introduction of Community Treatment Orders would place an increased burden on general practitioners? If so, is that a burden you think GPs are competent to undertake and would they accept it?

**Dr Cohen:** I think there are a number of issues. First of all, there are large numbers of people with a severe and enduring mental illness which are managed entirely in primary care already and are not in contact with secondary care services, the figures vary from 30% to 50% in different areas, so it is something that GPs do already. The act of sectioning a patient most GPs find an uncomfortable experience. The opportunity offered by a Community Treatment Order or a Non-Residence Order is an opportunity to maintain a relationship with a patient and it may be quite long lasting. I can think of several patients who I have known for a long time where it would have changed the relationship considerably had a Community Treatment Order been in place. As to whether GPs are able to do it and should be doing it, it is part of their work already and were it to become something special it would be deskilling both the professionals and not in the best interests of the patient either.

**Q1160 Chairman:** Given that GPs in Powys where I live and, I have no doubt, in other parts of the country do not provide services through their practices between 5pm and 7am now and given that florid episodes of mental illness do not always occur in working hours, are you satisfied that under the present primary care system the general primary care is able to cooperate out-of-hours with such crises because, unfortunately for those of us who have experienced mental illness in our families, it is a 24-hour operation?
Dr Cohen: I think the changes in the nGMS contract from April 2004 and the change in the out-of-hours services and the use of co-ops means that many co-ops are now employing a section 12 approved doctor as part of their on call rota. The opportunities for treatment and information are more available now than previously. Certainly in north-west London where I work the co-op has a section 12 approved doctor on call.

Q1161 Chairman: What about where there are no co-ops? There are a lot of areas like mine where there is no co-op and it is a commercial company doing the out-of-hours service.

Dr Cohen: It would be written into their contracts that they should provide it and be part of the level service agreement and terms and conditions. You are able to get around it.

Professor Tylee: I completely support that. It is perfectly possible for deputting agencies that are contracted to make provision and have trained doctors to be able to help and similarly with the NHS Direct which is now available as the first port of call for most people when they need some help, there has been increasing training at that level so that the people that are the first contact on the phone and who are often nurses are well placed and increasingly trained to be able to know how to advise somebody.

Dr Cohen: There are concerns about the Community Treatment Orders. The relationship with the GP, which we see as central, does not seem to be reflected in any of the clauses within the Act about who needs to be informed that a patient is being either assessed or being compulsorily admitted. The Act says very clearly it should be the carer, it should be the appropriate parent or whatever, but it does not mention the GP anywhere in the Bill. I think that is something that we would like to see reviewed if possible. There is a central role for the GP in providing continuing care and this role is not being reflected either in the Community Treatment Orders or in the assessment and compulsory admission.

Q1162 Chairman: Do you feel that the number of compulsory orders which are required might be reduced if more GPs followed the successful practice to which you have referred of having primary mental health provision in general practices for example, as happens in some practices, through employing psychotherapists, psychologists and the like at a primary level? Has that been successful?

Dr Cohen: It is a welcome change, although you will not see that change being reflected in many parts of the country where GPs take up special interests. Bearing in mind the changing role of GPs now and we heard about the research that was done on the workload that GPs have with people with a mental illness and it is quite considerable and it was the area that they felt least equipped to deal with, do you think with the trend now and with GPs with a special interest we could see a changing role in the professions in terms of GPs taking on more of this work instead of psychiatrists? The psychiatrists are shaking their heads!

Dr Bamrah: It is a welcome change, although you will not see that change being reflected in many parts of the country where GPs take up special interests. It would be a welcome change if more GPs took an interest in particular areas of psychiatry. Much of their performance targets are non-psychiatric in a sense, so I cannot see them rushing and queuing up to become specialists in psychiatry. I think you will know already that it takes a minimum of 11 years to train as a psychiatrist in this country and often many of us will embark on other careers in research or in other hospital medicine before we become psychiatrists. So that is a long, long time to turn a ship. I have got some statistics for you which might be of interest to you. There are about 30,000
consultants in the UK and 10% of them are consultant psychiatrists, which is 3,200. There are over 400 vacancies in consultant psychiatrists’ posts. The DoH has come up with a figure of 130 (recently revised to 200) full-time equivalent consultants required to implement the new Bill when it becomes an Act. That is a gross over-estimate. They also estimate that there will be a net increase of 160 consultants every year from 2003 to 2008. That is also a gross under-estimate because it does not take into account part-timers and many of them, both male and female, are part-timers in psychiatry, and about 40% of consultant psychiatrists are female. Also, it does not take into account things like maternity leave, sick leave and long sick leave and that sort of thing. We also retire early. We are amongst the few privileged people in that we can retire at the age of 55. After 2006 there will be a number of retirements in consultant psychiatrists’ posts. I hate to say this, but the number of NHS psychiatrists will be far fewer than the Department of Health predicts, the number of tribunals will be more and there will be more sections. I heard a liaison judge at the Scrutiny Committee saying that the number of tribunals will increase from 12,000 to 40,000 and the number of sections will increase. It is a good thing that sections will be shorter, but it will require more manpower from psychiatrists and that will include GPs as well.

Dr Arnold: Certainly since the GP contract came in we have seen even GPs who are interested in psychiatry doing somewhat less and saying that this is a specialist area, it has to be commissioned and that may be solved once the commissioning process gets under way. The patients we are talking about who should be under the Mental Health Act are the people with the most complex problems and they should not go to people who have the least training in psychiatry, which is GPs. For all their benefits, this is not an area they are specialists in. They are people who should have specialist services, not only psychiatrists but nurses and OTs and other people. So the GPs I would see as working in an area which did not impinge on Community Treatment Orders under the Mental Health Act because that should only be applied to the people who are really have severe and complex needs and need the most specialist care.

Dr Cohen: It would be entirely appropriate for GPs with special interests to train in mental health. The opportunity that offers is to free up psychiatrists who would otherwise be doing other things. Although I agree entirely that it is not appropriate to have a GP with a special interest dealing with the sort of patients who might need sectioning because they are complex, they are very difficult and you need lots and lots of training to do that, but it does not mean that GPs with a special interest do not have a role doing other things that psychiatrists would be doing instead. It is about skilling up GPs with a special interest or clinical assistants, whatever you want to call them, so that it allows psychiatrists to spend more time with a smaller number of very severe, very difficult to manage patients as part of the mental health team. The answer is that I do think GPs with a special interest have a role. We are trying to develop a training course at the Royal College of GPs with the RCN to create 700 new practitioners with a special interest because there is the demand from people with common and enduring mental illness and who have a whole range of problems that psychiatrists would otherwise be dealing with. There is an opportunity when you look at the whole system not to manage more sections because that is not appropriate but to manage a different group of patients and to free up the time of psychiatrists.

Q1165 Chairman: Gentlemen, your oral evidence has provided a rousing coda to what has been a very long symphony of evidence. I think this is our eighteenth meeting and in seventeen of them we have taken evidence. May I thank you very much for your written submissions and for your oral evidence.

Dr Wilks: Thank you for giving us the time. I think we have actually dealt with about three-quarters of what you gave us notice of. One area that we have not looked at is the issue of principles. I think there is a fairly long answer to that based on basic, ethical and human rights evidence that we would like to give you some evidence on but we will do that in writing.

Q1166 Chairman: The reason why I omitted that question, it was my decision from the chair, was because we have had a lot of evidence about it. We would be very grateful for your evidence, but it seemed to me that oral evidence on the other matters we have discussed was going to be of more oral value.

Dr Wilks: I quite understand.

Chairman: Thank you very much.

Supplementary memorandum from the British Medical Association (DMH 446)

At the close of the oral evidence session on the 2 February the Committee requested that the British Medical Association submit a written account of its concerns relating to the ethical and human rights dimensions of the draft Bill. The BMA has a significant albeit non-statutory role to play in promoting the highest standards of ethical practice in medicine. It is important therefore that the Bill does not impose responsibilities on doctors that conflict with their professional obligations. There are a number of ways in which the BMA believes that the Bill will present difficulties in this respect, and we welcome this opportunity to expand on these.
ETHICAL ISSUES

Mental health legislation is charged with striking a difficult balance between a number of competing values. On the one hand it has to weigh the need to safeguard individual rights and personal freedoms against the public interest in being protected from the risk of serious harm presented by a small number of mentally disordered individuals. On the other it has to balance the need to protect personal freedom with the requirement to intervene to safeguard the welfare of vulnerable individuals with mental disorder. The BMA believes that the Bill does not strike an appropriate balance in relation to the following issues:

— By giving a very wide meaning to “treatment”, the Bill effectively removes the “treatability criterion from the 1983 Act. The Bill therefore permits the detention of individuals, such as those with learning difficulties or personality disorders, for whom medical treatment is not indicated. The BMA believes that under a mental health instrument, the justification for the very serious restriction of civil liberties it permits is the reciprocal provision of treatment that is reasonably believed to provide therapeutic benefit. In the absence of this justification, the Bill must be regarded as unethical. In spite of the Government’s assurances, there is considerable concern that doctors will be called upon to become involved in preventive civil detention for people who are seen to pose a risk to others, who have not been convicted of a serious offence and who cannot be treated in any meaningful way. Such a role would fundamentally conflict with doctors’ professional obligations.

— One of the more contentious areas of the Bill is its power to override the express wishes of a competent adult in relation to treatment for mental disorder. While it is likely that the majority of patients whose condition is serious enough to warrant treatment under the Bill will have lost capacity in relation to decisions about their mental disorder, a considerable number will not. Legally and ethically doctors are obliged to respect the wishes of those who have the capacity to make decisions in relation to physical disorder. The ability to override a competent adult’s refusal of treatment for a mental disorder therefore appears discriminatory. The justification for this discrimination has been questioned but this is not an issue on which the BMA has a clear view. There are also inconsistencies in relation to consent for treatments for mental disorder; for example patients are given the right to consent to or refuse ECT, whereas consent is not required and refusal is not possible for long term administration of psychiatric medication (Part 5, Clauses 177–201).

— The Bill removes the ability for patients to consent to medical treatment where they present a risk of serious harm to others. The loss of this freedom conflicts with the principle of least-restriction that the BMA believes should govern the use of compulsory powers.

— The BMA is concerned that the Tribunal will be able to authorise continued compulsory “treatment” of a patient who is subject to civil compulsion, irrespective of a decision by the clinical supervisor that the patient should be discharged. This would present doctors with a real dilemma as they have a professional obligation not to provide treatment and care which they consider to be clinically inappropriate or not in the interests of the patient.

HUMAN RIGHTS COMPATIBILITY

The framework of compulsion for assessment and treatment affects a number of rights including Article 5, the right to liberty, Article 3, the prohibition against inhuman or degrading treatment, Article 8 the right to respect for private and family life, and Article 14, the prohibition of discrimination. AS outlined in more detail in our written evidence, the United Kingdom is the only member of the 45-strong council of Europe that has reserved the right not to comply with the Council’s Recommendation on Human Rights and Psychiatry. This raises the possibility that the Bill may end up being declared incompatible with Convention rights. The written submission from the Law Reform Committee of the Bar Council states that “the Bill signally fails to set the standards by which civilized nations should treat this vulnerable and stigmatised group.” The chief areas of potential rights incompatibility are:

— The criteria for the imposition of detention and compulsory treatment are too vague, the threshold for such imposition is too low and the safeguards against arbitrariness too weak to comply with the provisions of Articles 5 and 8.

— The absence of any reciprocal right to treatment of a minimum standard and in appropriate conditions and to suitable aftercare is incompatible with international rights standards and may violate Articles 5 and 8 or 14.

— Treatment may be imposed on competent, dissenting patients in circumstances that may violate Articles 3, 8 or 14.

— The absence of any power in the Tribunal to order a patient to be transferred to another hospital or to be given leave of absence in the face of objections from the patient’s doctor or (in restricted cases) the Home secretary, effectively neutralises its function where transfer to lower conditions of security or leave of absence are a necessary precondition to discharge; this may violate Articles 5(4) and 8.
— Inadequate protection is given to the residual rights of detained patients in relation to issues such as seclusion, searching, visiting, access to personal possessions or computers etc, potentially in breach of Articles 3 and 8.

It follows therefore that it is likely that the Bill as currently drafted will be vulnerable to challenge under human rights law.

Michael Wilks  
Chairman  
BMA Medical Ethics Committee