



The Mental Health Act 2007: the final report

Introduction

The Mental Health Act 2007 comes at the end of eight years of controversy and debate. The Mental Health Alliance was at the forefront of the campaign to change the approach the government took to this legislation and achieve a better outcome for those who have to live with its consequences.

This 'final report' examines the Act in the light of the Alliance's values and concerns: and the impact it is likely to have on the people who are affected most by the Act: service users and their families and carers.

In assessing the 2007 Act, and the impact of the Alliance campaign, we need to ask three key questions:

1. Has the 2007 Act improved the 1983 Act for service users and their families and carers?
2. Is the 2007 Act better or worse than the draft Bills of 2002 and 2004 (i.e. would we have been better off with the previous attempts at changing the law)?
3. Is the 2007 Act an improvement on the Bill when it was published in 2006 (i.e. have the amendments to the Bill made a real difference)?

In brief, we conclude:

On the first question, it is too early to gauge whether the new Act improves the 1983 Act. There are significant gains, such as the right to advocacy and some treatment safeguards, but there are also worrying developments, such as the creation of community treatment orders and the broader definition of mental disorder. Crucially, however, developments that could have yielded much better legislation, such as greater choice and rights to services, have been omitted.

On the second question; there is little doubt that the abandonment of the 2004 Bill was a major and unprecedented victory for the Alliance. While some of its worst provisions were retained in the 2006 Bill, modifications were made to some of them – such as limiting CTOs to patients detained in hospital - and these were improvements from our point of view. The 2004 draft Bill would have been a significant and unprecedented worsening of the law for service users and their carers and families.

On the question of whether the 2006 Bill has been improved as a result of the Alliance's work, the answer is 'yes'. Almost all of the benefits that will come from this legislation, such as preventing children from being admitted inappropriately to adult wards, are the result of amendments to the Bill: each had to be wrung from government through the hard work of Alliance members and their supporters. However this does not mean that the Mental Health Act 2007 is a satisfactory or adequate piece of legislation – and we are clear that new legislation fit for the 21st century remains an urgent necessity.

The creation of CTOs, new professional roles and wider powers to detain people with personality disorders have been the key drivers for this legislation since the process began in 1998. Each remain in the 2007 Act, albeit with some improvements as a result of the Parliamentary process. The removal of the treatability test and the introduction of CTOs have been government policy throughout, despite all the evidence provided by the Expert Committee, the Joint Scrutiny Committee and many others that a different approach would have been more appropriate. In this environment, it was always going to be an uphill struggle for these to be substantially amended by lobbying.

1. Improvements in the 2006 Bill

When the 2006 Bill was published, there were several gains compared with the 2004 draft Bill, achieved as a result of the policies we and others had developed and pursued. These were:

- The exclusion for drug and alcohol dependence in the 1983 Act was restored
- CTOs were limited to those who are detained in hospital on a section 3 order (for treatment) or a Part 3 order (through the courts) without restrictions
- the powers of the nearest relative (NR) were restored; although choice was much more restricted than in the 2004 Bill, which replaced the NR with a 'nominated person'.
- A better understanding of the relationship between the Mental Capacity and Mental Health Acts led to some adjustments (eg express recognition of advance directives for patients on CTOs).

However, there were also some positive proposals in the 2004 draft Bill that did not make it into the 2006 Bill. Some, such as advocacy, were later restored in Parliament. Those which were not recovered include:

- The creation of Mental Health Tribunals, with far greater powers than the existing Mental Health Review Tribunals - for example to authorise CTOs being imposed and all continuing detention beyond 28 days.
- The single assessment process for civil patients
- Enhanced powers in the criminal courts to acquire mental health reports
- The duty to consult the patient where appropriate.

2. Major changes in Parliament

Following the publication of the Bill, a great many amendments to it were passed. The most significant improvements achieved in this way for service users and their families and carers are:

1. *The right to advocacy*

Independent Mental Health Advocates will be available:

- For all patients liable to be detained, including under guardianship or a CTO
- If discussing the most serious forms of medical treatment – such as surgery
- If the patient is under 18 years of age and discussing the provision of ECT [as above]

2. *Age appropriate treatment*

- The managers of the hospital must ensure that the patient's environment in the hospital is suitable having regard to his age (subject to their needs).
- The managers shall consult a person who appears to them to have knowledge or experience of cases involving patients under 18 years old.
- Section 140 amended (duty on health authority to inform social services of arrangements) for the provision of accommodation for patients under 18.

The intention is that the Code will state that:

- wherever possible, a CAMHS specialist will be part of the mental health assessment;
- the trust must provide separate and appropriate facilities;
- staff to have the right training and checks;
- hospital routine that will allow the development, including education, of the child to continue

3. *Treatability test*

After much wrangling, the Bill was amended to bring in the following clause: 'Any reference in the Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.'

Although this amendment fell short of Alliance policy, which supported a narrower test, it is a major victory that a treatability test has been retained in the 1983 Act and that it has been extended to cover all patients – not just psychopathic and mentally impaired patients. More work is needed in the Code of Practice to ensure that is interpreted appropriately in practice.

4. *Renewal of detention*

The responsible clinician (the health or social care professional who manages the care of a person detained in the new Act) may not renew a detention unless a person who has been professionally concerned with the patient's medical treatment, but who belongs to a profession other than that to which the responsible clinician belongs, states in writing that he or she agrees.

This will mean that for the first time two professionals from different disciplines will be required to agree renewals of detention.

There however remains a significant Human Rights Act issue as to competencies of the detaining professional that will need to be addressed.

5. Treatment safeguards

Two major improvements have been achieved over the use of electro-convulsive therapy (ECT). No ECT can be given in the face of capacitous refusal, other than in an emergency. Emergency ECT can only be given if it is immediately necessary to save life or immediately necessary to prevent a serious deterioration in the person's condition

There were also important changes for children and young people: 16 and 17 year olds' capacitous refusal of treatment cannot be overridden by parental authority; a second opinion doctor (SOAD) is needed for ECT to be given; and there will be a referral for a Mental Health Review Tribunal (MHRT) annually for patients who do not request a hearing.

6. Code of practice

All doctors, approved clinicians, managers and hospital staff, independent hospitals and care homes, approved mental health professionals and other professionals involved in the medical treatment of patients suffering from mental disorder must have regard to the code.

This gives the Mental Health Act Code of Practice a similar statutory status to the Codes issued under other major health and social care legislation – such as the Capacity Act, Children Act, NHS and Community Care Act, etc.

7. Places of safety

The amended Act will allow patients to be transferred from one place of safety to another. This will allow patients detained by police officers on section 136 to be transferred from a police station to a therapeutic environment more quickly.

Although this stops short of Alliance policy, which wanted police stations to be used as a place of safety only as a last resort (including where it would be impracticable to use a hospital/clinical setting), it will ensure that patients spend less time in police custody.

8. Principles

The new Act will say that the Code of Practice shall include a statement of the principles which the Secretary of State thinks should inform decisions under the Act and the Secretary of State shall, in particular, ensure that each of the following matters is addressed:

- a) respect for patients' past and present wishes and feelings,
- b) minimising restrictions on liberty,
- c) involvement of patients in planning, developing and delivering care and treatment appropriate to them,
- d) avoidance of unlawful discrimination,
- e) effectiveness of treatment,
- f) views of carers and other interested parties,
- g) respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of the Equality Act 2006)
- h) patient wellbeing and safety, and
- i) public safety.

The Secretary of State shall also have regard to the desirability of ensuring:

- a) the efficient use of resources, and
- b) the equitable distribution of services.

Many Alliance members will be disappointed that, despite widespread and cross party support on this issue, principles will not be on the face of the Act. However this may turn out to be an important victory as some expert legal opinion has suggested that the amendment (along with the statutory status of the Code) will effectively make the principles legally enforceable.

9. Bournemouth

Some important improvements were made to the Bournemouth safeguards for people detained in care homes under the Mental Capacity Act:

- A third party, such as a relative or carer, can request an assessment of whether or not a person is being deprived of their liberty.
- Right to an independent Mental Capacity Act advocate (IMCA) for Bournemouth patients – if requested by the patient or their representative or where the supervisory authority believes it is necessary
- a power has also been included to reduce the maximum length of authorisation at a future time.

The lack of treatment safeguards and the requirement to pay for the period of detention and for an appeal are all, however, serious omissions.

10. CTOs - criteria

The Bill's provisions for CTOs were among the most strongly defended by Government ministers. However, we did achieve some improvements in this area. Two extra eligibility criteria were added to the Bill:

- It is necessary that the responsible clinician should be able to exercise the power to recall the patient to hospital;
- In determining whether the criterion is met, the responsible clinician shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).

We expect that these will help to limit the number of people subject to CTOs compared with the excessively broad entry criteria with which the Bill began, though they are not sufficient to limit CTOs to those patients who have had a prior compulsory admission and who, on discharge relapsed because of failure to take their medication (the so-called 'revolving door patients').

11. CTO conditions

Any conditions must be necessary or appropriate for one or more of the following:

- Ensuring the patient receives medical treatment
- Preventing risk of harm to the patient's health or safety
- Protecting other persons.

The interpretation of this clause remains to be seen in practice. However, it is less coercive than the 2006 Bill, and although clinicians will still be able to place ASBO type conditions on a CTO – such as where a person can live and to place limits on 'particular conduct' – they will need to be clear about the purpose of such conditions

3. Gains for the Code of Practice

During the debate in Parliament, a number of improvements were put forward by MPs and peers but did not make it into the new Act. On several of these, however, promises were made by ministers that matters would be dealt with in the Code. It is vital this does actually happen. The key issues here are:

1. The displacement of the nearest relative as unsuitable

Initially it was intended that this would only apply where the NR was abusive but the government has conceded that this is too narrow from the service user point of view. Rosie Winterton said from the Despatch Box:

“Although it is important that the courts look at each case on its merits, we intend the idea of unsuitability to cover situations in which there is no effective relationship between the patient and the nearest relative, or where the relationship has broken down irretrievably”.

2. Advance decisions

The Code will provide for advance decisions and clarify that they should be taken into account in deciding upon treatment.

3. Places of safety.

The Code will make it clearer that the use of a police station as a place of safety is not acceptable as normal practice and requires exceptional reasons for it. The current Code already provides a statement to this effect and it will be important to ensure that the wording is strengthened in the revised Code.

4. Renewal of detentions

The Code will stress the need for a recent examination of the patient before the member of the clinical team can agree with the responsible clinician to a renewal of detention.

5. Exclusions

A promise to clarify that the topics which were the subject of the exclusions (ie drug use, disorderly conduct, sexual orientation and religious, cultural and political beliefs) are not intended to be covered by the new broad definition of mental disorder.

The Code of Practice is going to be essential for the overall shape of mental health law. Apart from the issues mentioned above, the wording of the Code will also be essential on matters such as:

- principles
- the appropriate treatment test
- the nature of the history required before someone can be placed on a CTO
- recall to hospital for CTO patients,
- conditions for CTO patients,
- the clinical roles and requirements especially in the context of recalling a patient from a CTO
- the provisions for treatment for CTO patients.

4. Unsuccessful amendments

This section lists the amendments that were raised in Parliament, many of which were supported in the House of Lords, but which were either not voted on or were defeated in the Commons.

1. A broader set of **exclusions** – instead the exclusion for cultural or religious behaviour is addressed through an extra principle in the principles clause. It was claimed that this would cause “confusion” and too many legal challenges, and could not be legally drafted – despite the fact that these exclusions work well in the law of other jurisdictions (overseas and in the UK).
2. An **impaired decision making** (IDM) criterion for detention and CTOs. Ministers claimed such a condition was untested. This is inaccurate; indeed IDM is a feature of the legislation of North Carolina, which the government

relies on for support on CTOs. There were also claims that an IDM clause would lead to suicidal/homicidal patients not being sectioned – which is also not correct.

3. A **right to appeal** against the conditions imposed on a person on a CTO. It was claimed that the tribunal does not have the expertise or resources – and should not be able to impose care plans on clinicians; and that the patient can simply ask their clinician to review the conditions. This is likely to be the subject of a Human Rights Act (HRA) challenge.
4. A **second medical opinion** to be provided for people on CTOs in the same circumstances as for detained patients – in particular for a second opinion to be provided after the patient has been recalled to hospital rather than months in advance.. This was considered “unnecessary” by the government. It is also likely to be the subject of a HRA challenge.
5. The reduction in the waiting period for a **second medical opinion** from 3 months to 4 weeks.
6. **Advance decisions** on the face of the Act. This was said to be a matter of good practice not for statute – despite the inclusion of advance decisions and advance statements on the face of the Mental Capacity Act.
7. A **right to assessment** in the Act: again this was dismissed as not being within the purpose of mental health legislation, despite its inclusion in other jurisdictions.
8. Choice of the **nearest relative**, short of displacing them through the court process. Ministers claimed that a nominated NR would be less likely to act in the patient’s best interests and the nearest relative who has been disposed would need to challenge the choice and that would be too bureaucratic (although this doesn’t appear to be a problem for Lasting Powers of Attorney under the Capacity Act).
9. Mechanism to ensure the **transfer of prisoners** more quickly to hospital: despite evidence published in the BMJ of the need for time limits for transfer from prison to hospital.
10. **Bournewood** patients/residents care home accommodation to be free. Ministers said Bournewood patients should be liable to charges because their primary need will be for personal care and not for health care. Likely to be the subject of a HRA challenge
11. **Bournewood** –a right to a second medical opinion for serious medical treatment. This is also likely to be the subject of a HRA legal challenge.

5. Race Equality

One of the major criticisms of the Bill was its failure to tackle race inequalities in the mental health system. Despite highly effective campaigning by the Black and minority

ethnic (BME) Mental Health Network (who secured a meeting with the Secretary of State on this issue) the DH's Race Equality Impact Assessment was deeply flawed. The Commission for Racial Equality went as far as it could in criticising the DH on its REIA and we hope that the strength of that criticism will influence further developments.

The main specific gain made was a statement in the Bill on an equality principle in the Code of Practice. Other gains, such as advocacy and section 136, will also be beneficial; but the full impact of the law on BME service users and the potential to promote race equality through the Bill were not recognised by the Government.

6. The final verdict

The debate over the Mental Health Bill has been a difficult one, not least for the people who are most affected by it. During that process, it has become clear that this has been as much a conflict of values as of the legal framework needed for effective mental health treatment in England and Wales.

In the view of many Alliance activists, the Government's approach has been profoundly paternalistic and authoritarian. The need for checks on the power of clinicians has been blocked at every turn: 'every restriction on their power is a patient not treated' was a frequently made claim. Efforts to enhance patient choice were similarly resisted. The end result is that the Mental Health Act remains profoundly stigmatising. The concessions that were achieved came about only because the Lords united in their support.

Overall, the 2007 Mental Health Act will go down in history as a missed opportunity. While other countries, often with less well-developed mental health services, are fundamentally modernising their mental health laws, our already outdated law has at best been mildly improved. Nonetheless, the efforts of the thousands of people who have written to their MP, signed petitions, attended rallies and lobbies and in some cases been prepared to talk about their lives in the press and on TV and radio, have been justified by events. Without them, and without the commitment of the Alliance's 77 members to a better Bill, the outcome could have been much worse.

For some people, the 2007 Act may, eventually, bring real improvements to their quality of life. If measures to provide better hospital accommodation for children are properly resourced, the scandal of admission to adult wards can be put behind us. If advocates with sufficient skills and knowledge are made available to all who need them, then the rights of vulnerable patients will receive greater protection and the risk of abuse and neglect will be much reduced.

But there remain massive challenges for us all. Beyond the Code of Practice, the implementation of the Act will be crucial. The Act has massive training implications not just for the staff at the centre of the changes, such as the new responsible clinicians and approved mental health practitioners, but for all health and social care workers. All this will place huge demands on resources, with the significant risk that the majority of service users who are not subject to the Act get less care and support as a result.

As the 2007 Act gets put into practice, there will be significant changes to the way people with mental health problems are treated. As yet, the impact of those is unclear. For example, we can only make informed estimates about how many people will be subject to CTOs and what effect that will have on their lives. The relationship between the Mental Capacity Act and the amended Mental Health Act will also be challenging for health and social care professionals and in many respects remains unclear.

It remains our hope, however, that the 2007 Act will not last as long as the 24 years of both of its predecessors: that the need for genuinely modern legislation will lead, sooner rather than later, to a better Bill, based on the principles of human rights, equality and respect.

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Mental Health Alliance
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