



Mental Health Alliance

Briefing for the Second Reading of the Mental Health Bill in the House of Lords

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EXECUTIVE SUMMARY

The Mental Health Alliance believes that the Mental Health Bill 2006 is deeply flawed and represents a missed opportunity to introduce a radically revised Mental Health Act fit for the 21st century. In doing this the Government has ignored the recommendations of its own Expert Committee appointed in 1998 and the Joint Parliamentary Scrutiny Committee in 2004. Unless substantial new amendments are introduced we believe the Bill should be opposed.

1. The new definition of mental disorder

We do not oppose a single definition of mental disorder but it should be limited by exclusions and tighter conditions for compulsion – such as an impaired decision making criteria and therapeutic benefit test.

2. Abolition of the treatability test

The Alliance believes that the proposed 'appropriate treatment' test has no clear meaning and is too vague as a basis for using coercive powers. We believe that all compulsory treatment should have a health benefit the patient and that the purpose of mental health legislation should not be to effect the preventative detention of those who cannot benefit from treatment.

3. Supervised Community Treatment

The Alliance is not satisfied that the case has been made for the broad community treatment powers being proposed. If community powers are to be introduced - and many Alliance members oppose this - they should be for a tightly defined group and be accompanied by stronger safeguards. We believe that the 'revolving door problem' is better addressed by improving the quality and availability of aftercare and support services and the bridge between acute treatment and continuing care.

4. Nearest Relative

The 'nearest relative' has important powers in decisions as to whether a person is to be detained or discharged. The Bill makes a marginal improvement to the system by which 'nearest relatives' are identified and if necessary displaced. The Alliance believes the individual patient should be able to nominate the person who can best represent their interests, as is the case in Scotland.

5. Professional roles

The Bill widens the range of clinicians and social care professionals able to exercise statutory functions – replacing the Responsible Medical Officer with the Responsible Clinician and the Approved Social Worker with the Approved Mental Health Professional. This needs to be done with great care to ensure the professional competencies of those depriving people of their liberty are maintained. People coming to the new statutory roles need proper training, regulation and professional support.

6. Tribunals

The Bill will allow the Government to reduce the time delay before patients who have not exercised their right to an appeal to the Mental Health Review Tribunal are automatically referred. This is welcome but must be accompanied by sufficient resources to put it into effect.

7. Safeguards for people who lack capacity (Bournewood patients)

The Mental Health Alliance and the Making Decisions Alliance welcome the fact that the Government has at last come forward with proposals to address the 'Bournewood gap'. However, the current proposals will fail to provide sufficient safeguards to protect the rights of individuals who may need to be deprived of their liberty in their best interests and are complying with treatment. There should be much closer parity with the safeguards in the Mental Health Act 1983. Without such safeguards, the legislation would be clearly open to further charges of discrimination against this group of people.

Central issues for the Mental Health Alliance

There are some reforms that are central to effective and modern mental health legislation which the Alliance and other stakeholders are agreed upon. The Mental Health Alliance believes the Government should take this opportunity to modernise other aspects of the 1983 Act and we call upon the Government to put forward amendments to:

- Begin the Act with a set of **statutory principles** to guide practitioners in the exercise of their powers and duties and give confidence to service users.
- Introduce the right for patients and carers to demand and receive a **full assessment** of all their health and social care needs before a crisis point is reached.
- Provide the **right to independent advocacy** for all those sectioned under the Act, from the point they are detained.
- Enshrine the principle that treatment for those with mental illness should, as far as possible, be on the same basis as treatment for those with physical illness. **Patient autonomy** must be respected unless the patient's ability to make decisions about medical treatment is significantly impaired.
- Provide **treatment safeguards** that give patients more say in their medical treatment and further safeguards for specific treatments, particularly electroconvulsive therapy (ECT) and high doses of medication.
- **Promote the rights of BME service users** by including: the principles of non-discrimination and respect for diversity on the face of the Bill; a right to advocacy for all involuntary patients; and restrictions on the use of police cells as places of safety.
- Introduce **safeguards for children and young people** who are being detained and provided with compulsory treatment without their consent.
- Enable people with capacity to make **advance decisions and advance statements** to set out any future mental health treatment they would not like to receive and preferences for future treatment.
- **Retain the Mental Health Act Commission** which has played a critical role in improving compliance with the 1983 Act and in safeguarding and ensuring the rights and welfare of people detained in hospital under the 1983 Act.

Role and scope of the Mental Health Alliance

The Mental Health Alliance is a coalition of 77 organisations working together to secure humane and effective mental health legislation. It is the broadest coalition in the mental health world - a unique alliance of: service users; psychiatrists; social workers; nurses; psychologists; lawyers; voluntary associations; charities; religious organisations; research bodies; and carers' groups.

The members are:

Core members: Afiya Trust, British Association of Social Workers, British Psychological Society, Caritas- Social Action, College of Occupational Therapists, Ethnic Health Forum North West, Hafal, IMHAP, King's Fund, Manic Depression Fellowship, Mental Health Foundation, Mental Health Media, Mental Health Nurses Association, Mind, National Autistic Society, NUS, Rethink severe mental illness, Revolving Doors Agency, Richmond Fellowship, Royal College of Nursing, Royal College of Psychiatrists, Sainsbury Centre for Mental Health, SANE, SIRI, Together, Turning Point, UK Fed of Smaller Mental Health Agencies, UKAN, UNISON, United Response, Voices Forum, Witness, Young Minds.

Associate members: ADSS, African Caribbean Community Initiatives, Age Concern England, Alcohol Concern, AWAAZ (Manchester), AWETU, Black Majority Church Consultative Consortium, BME Mental Health Network, British Institute of Human Rights, British Medical Association, Carers UK, Church of England Mission & Public Affairs Council, Confederation of Indian Organisations, Democratic Health Network, Depression Alliance, Drugscope, East Dorset MH Carers Forum, Family Welfare Association, GMC, Haldane Society, Having a Voice, Homeless Link, HUBB Mental Health User Group, Imagine, JAMI, Justice, Law Society, LGA, Liberty, Manchester Race and Health Forum, Mencap, NHS Confederation, Race on the Agenda (ROTA), RADAR, Royal College of GPs, Sign, Social Action for Health, Social Perspective Network, Somali Mental Health Project, Southdown Housing Association, Supporting Carers Better Network, University of London Union (ULU), UK Council for Psychotherapy, West Dorset Mental Health Forum, Women in Secure Hospitals (WISH).

The Alliance was established in 1999, solely for the purpose of working for improved mental health legislation, following widespread concern about Government proposals for a new Mental Health Act. Since then the Alliance has responded to the consultations on the White Paper, the 2002 Draft Bill, the 2004 Draft Bill and developed its own policies on key areas of reform of the Mental Health Act 1983.

The degree of consensus among the different service user groups, professional bodies and carers' organisations who make up the Alliance has been remarkable and reinforced our belief that, in broad terms, we have found the way forward. Most of our policies have been endorsed by the Joint Parliamentary Scrutiny Committee Report on the Draft Mental Health Bill and are reflected in the Scottish Mental Health (Care and Treatment) Act 2003. It would be hard to imagine how legislation could work better than through such widespread consensus.

In essence our agreement over the details of the Government's amending Mental Health Bill derives from a shared belief in the values that should underpin such law. The Alliance is united in its belief that on these values, humane and effective mental health legislation is achievable.

The Purpose of Mental Health Legislation

The Government believes that the purpose of mental health law is “not about service provision, it is about bringing people under compulsion.”¹

We fundamentally disagree with this approach. Undoubtedly mental health law must include provisions which authorise detention and compulsory treatment, and safeguards to prevent their arbitrary use – but it must also ensure that every person with a mental health problem receives the range of mental health services they need, so that crises and detention are anticipated and prevented where possible. Access to mental health services remains patchy and many instances of compulsion could be avoided if patients and carers were given a legal right to access appropriate services at an early stage of their illness. This approach has been adopted in the Scottish Mental Health Act which recognises that in accordance with the principle of reciprocity there should be a duty on services to assess and meet the needs of people with mental health problems.

Law also performs an educational role and its tone and language is capable of promoting positive or negative images of people with mental health problems. This is best illustrated by the Mental Capacity Act 2005 which includes statutory principles to which decision-makers must have regard, including the least restrictive alternative, the presumption of capacity and that people should not be treated as incapable merely because they make an unwise decision. In contrast the Mental Health Act 1983 contains no such principles and continues to reinforce discrimination against people with mental health problems through its failure to address the issue of capacity.

The Alliance believes that mental health legislation fit for the 21st Century must provide more than just a framework for compulsory hospitalisation and treatment – a view endorsed by the Joint Parliamentary Scrutiny Committee on the Mental Health Bill which concluded that:

“The primary purpose of mental health legislation must be to improve mental health services and safeguards for patients and to reduce the stigma of mental disorder.”²

Brief history of the process of reform

In 1998 the Government appointed an Expert Committee, chaired by Professor Geneva Richardson, to review mental health legislation (the Richardson Committee). The Richardson Committee recommended a new Act which would provide a ‘single pathway’ to compulsory treatment whether in hospital or the community and should be based on notions of autonomy and non discrimination.³

The Government’s response was to select features of the report that pleased them, and reject those that conflicted with their public safety agenda. There followed a Green Paper, a White Paper, a 2002 Draft Bill and a 2004 Draft Bill – all of which were widely condemned for the prominence given to consideration of risk and protection of the public. In 2005 a Joint Parliamentary Committee on the Mental Health Bill called for a radical overhaul of the Government’s proposals, concluding that they would force too many people into compulsion and erode their civil liberties.

In March 2006 the Government finally decided to abandon its controversial eight year attempt to achieve a new Mental Health Act and instead announced plans to introduce a shortened and streamlined Bill amending the Mental Health Act 1983.

¹ Government response to the Report of the Joint Committee on the Draft Mental Health Bill 2005, para 13.

² Report of the Joint Committee on the Draft Mental Health Bill, 2005. Summary page 5.

³ Review of the Mental Health Act 1983, November 1999

What is the amending Bill going to do?

The Bill proposes changes in seven areas:

1. A new broad definition of mental disorder and the removal of most of the conditions and behaviours which are specifically excluded from the coverage of the Act
2. The abolition of the 'treatability test' and introduction of an 'appropriate treatment test' which will apply to all the long-term powers of detention
3. A new Community Treatment Order for patients who have been discharged from compulsory treatment in hospital
4. A new right for patients to remove their 'nearest relative' through the county court system
5. The widening of the group of practitioners who can take on the role of approved social worker and responsible medical officer under the Act
6. Provisions to allow a reduction in the time limits for the automatic referral of some mental health patients to the Mental Health Review Tribunal
7. The introduction of safeguards for people in hospitals and care homes who lack capacity and need to be detained in their best interests – through an amendment to the Mental Capacity Act

What we think about the Bill

The Alliance believes that the Bill is deeply flawed. While we welcome the decision to abandon the unethical and unworkable 2004 Bill, the government proposals are in many respects the worst of both worlds. They have jettisoned the few progressive changes in the 2004 Bill and, ignoring the recommendations of the Joint Parliamentary Scrutiny Committee, retained policies which have been universally condemned by those, including members of the Alliance, who gave evidence before it. The opportunity for legislation fit for the 21st Century has been abandoned. We have lost the oversight of the treatment of patients by care plans and Tribunal approval of those plans; the role of advocates has been eliminated and the right to nominate a person to take an official role in the compulsory process has been lost.

However our fundamental concern is that the Bill merely tinkers with the law when what is needed is radical revision of the Mental Health Act 1983. There is widespread consensus that the 1983 Act is out of date, based as it is largely upon its predecessor, the Mental Health Act 1959 – and yet the Government's amendments fail to address the major problems in the 1983 Act. These can be summarised as follows:

- The underlying principles used to justify compulsory treatment have not changed since 1959. In particular the basis for providing compulsion is the necessity of treatment rather than the ability of a patient to make their own choices.
- Disproportionately high numbers of people from black and minority ethnic backgrounds continue to be detained and forcibly treated under the Act.
- The Act does not provide rights to timely and appropriate care and treatment for people with mental health problems and their carers – one in four people report that they were denied access to care when their problems were developing.⁴

⁴ Rethink (2003) Just One Per Cent; the experiences of people using mental health services.

- Stigma against people with mental health problems in society has increased rather than declined⁵ and the Act reinforces discrimination against people experiencing mental ill health through its failure to address the issue of capacity.
- The Act fails to reflect changes in mental health care since 1983 – such as new treatments, multi disciplinary working and greater patient and carer involvement – and changes in the expectations and aspirations of patients, their families and professionals.
- The Act has proved to be one of the most fruitful areas of challenge under the Human Rights Act 1998.⁶ There are several legal cases outstanding and while the Government's amendments may bring the 1983 Act into line, materially, with the Human Rights Act, other aspects of the Mental Health Act are likely to need amending in the future.

It is disappointing that after so many years and extensive discussion and consultation, and particularly following the report of the Joint Parliamentary Scrutiny Committee, that the Government has decided to ignore widely held views and concerns about some key issues. Sadly we remain nowhere near achieving ethical mental health legislation as enacted in Scotland which now bases compulsion on patients' impaired decision making ability and provides patients and their carers with a right to assessment for the provision of services.

⁵ For example 40% of employers say they would not consider employing someone with mental health problems (C Manning and PD White 'Attitudes of Employers to the Mentally Ill' Psychiatric Bulletin: 19 (1995) 541-543).

⁶ Indeed the very first declaration of incompatibility under the MRA related to the Mental Health Act and led to a fast track remedial order which rewrote the discharge criteria for detained patients. There have been many other successful challenges on behalf of detained patients which have led to declarations of incompatibility or the provisions of the Act being reinterpreted to be compatible with the HRA.

Key issues in the Bill

The new definition of mental disorder (clauses 1-3)

Having a mental disorder is a necessary precondition for detaining a person under the Mental Health Act 1983 and therefore how it is defined is of central importance. The current Act uses a wide definition of mental disorder for admissions for assessment but a more a more restrictive definition for longer term treatment orders and for patients admitted via the courts and prison. The Government proposes to replace this with a single broad definition of mental disorder (“any disorder or disability of the mind”) for all detentions in hospital.

The 1983 Act also contains specific exclusions which provide that no person can be treated under the Act solely as a result of substance addiction, or because of his/her sexual orientation, immoral conduct or deviance. The Government proposes to include only a single exclusion in the amended Act on the grounds of dependence on alcohol and/or drugs.

The Alliance agrees in principle with a single broad definition of mental disorder but it must be accompanied by clear boundaries through a series of exclusions - as is the case in the 1983 Act and the law of other countries including Scotland⁷, New Zealand⁸ and Australia.⁹ 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 1983 Act. It is unhelpful and inappropriate for people who do not have an underlying mental health diagnosis to have their needs confused with those of people who do have an underlying diagnosis.

The Alliance believes that if a single and all-encompassing definition of mental disorder is to be used, then it is crucial that the conditions for compulsion are extremely strict. Only if ‘impaired decision-making by reason of mental disorder’ and a form of therapeutic benefit were included in the conditions for compulsion and the current exclusions were retained in an updated form, would the Alliance welcome the simplified definition of mental disorder.

It is notable that the Richardson Committee which recommended a single broad definition of mental disorder also suggested retaining the exclusions of the 1983 Act in a modified form.¹⁰ The Joint Parliamentary Scrutiny Committee also recommended specific exclusions on the grounds of substance misuse, sexual orientation, cultural beliefs or behaviours alone.¹¹

The abolition of the treatability test (clauses 4-5)

The treatability test provides that if someone is to be detained for anything other than the short term, the treatment s/he receives in hospital must be likely to alleviate or prevent a deterioration in his/her condition. At the moment, this applies to all patients detained under the 1983 Act for more than 6 months and also to patients with a mental impairment or psychopathic disorder being considered for a treatment order. The Government proposes to remove the treatability test from

⁷ Section 328 of the Scottish Mental Health (Care and Treatment) Act 2003 states that a person cannot be treated as mentally disordered only on the basis of sexual orientation; sexual deviance; transsexualism; 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; and actions that no prudent person would undertake.

⁸ The New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992 provides for exclusions on the basis of a person’s political, religious or cultural beliefs; or a person’s sexual preferences; or the person’s criminal or delinquent behaviour; or substance abuse; or intellectual disability.

⁹ In Australia the New South Wales Mental Health Act 1990 provides exclusions on the basis of political opinion or belief; religious opinion or belief; a philosophy; sexual preference or sexual orientation; political activity; or religious activity.

¹⁰ Review of the Mental Health Act 1983, November 1999, para. 5.17

¹¹ *ibid* paras. 95 - 118.

the 1983 Act and introduce a provision that any treatment will simply have to be 'appropriate' for the patient and 'available' to him/her.

The Alliance believes that the purpose of mental health legislation should not be to effect the preventative detention of people who cannot benefit from treatment. We agree that the treatability requirements of current law are not ideal – for example they initially only apply to certain categories of patients – but they do however make a clear connection that the imposition of compulsory medical treatment must be accompanied by the reciprocity of a therapeutic benefit.

The Alliance considers that the proposed 'appropriate treatment' wording has no clear meaning and is therefore not a suitable term to use in provisions governing the use of coercive powers overriding individual autonomy. It is a basic requirement of the rule of law that any interference with personal liberty must be sufficiently precise and free from arbitrariness.

We agree that there is no justification for discriminating against patients not suffering from psychopathic disorder and mental impairment by permitting their detention where there is no therapeutic benefit. The 1983 Act already requires that the treatability test applies to all patients after 6 months. The Alliance therefore recommends that the existing treatability test should be brought forward to include all patients detained on a treatment order.

Again this view is supported by the Richardson Committee which considered that a health statute should only authorize the overriding of patient autonomy if 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."¹² It is also supported by the Joint Parliamentary Scrutiny Committee which recommended the same therapeutic benefit test as used in the Scottish Mental Health Act.

Supervised Community Treatment (clauses 25-29)

The Government is proposing a new Community Treatment Order for patients who have been discharged from compulsory treatment in hospital to ensure they comply with treatment. Patients who fail to co-operate with their treatment regime can be forcibly returned to hospital and treated against their will.

The Alliance is not satisfied that the case has been made for the replacement of the current regime with such broad powers as are provided in this Bill. Research published in the Cochrane Library has recently shown that there is little evidence that compulsory community treatment is effective in any of the main outcome indices: health service use, readmission to hospital within a year, social functioning, likelihood of being arrested, mental state, quality of home, homelessness, or satisfaction with care.¹³ Only the likelihood of being a victim of crime was reduced by being subject to compulsory community treatment. The research also found that 85 people would need to be made subject to compulsory community treatment to prevent one admission to hospital and 238 to prevent one arrest. We also question the need for the introduction of costly new legislation to introduce compulsory care in the community when case law in recent years has given doctors the opportunity of treating patients in the community for extended periods of leave while they continue to be subject to the compulsory provisions of the 1983 Act.¹⁴

The Alliance is concerned that the proposals for supervised community treatment orders will merely deflect attention and resources from the real issue and the best solution to the 'revolving

¹² Review of the Mental Health Act 1983, November 1999, para. 5.95.v.

¹³ Compulsory community and involuntary outpatient treatment for people with severe mental disorders (Review): the Cochrane Library 2005, Issue 3.

¹⁴ Cases such as R (DR) v Mersey Care NHS Trust (2002) and R(CS) v MHRT [2004] mean that through the use of section 17 leave, a patient on a section may be maintained in the community indefinitely and recalled back to hospital if he/she acts inappropriately.

door' problem - the quality and availability of aftercare and support services in the community and the need to provide a more effective bridge between acute treatment and community.

We welcome that the Government has finally accepted that any community treatment order imposed would have to be preceded by an inpatient treatment order. However, this is a minor improvement since, under the 1983 Act as amended by the Bill, a patient could be discharged on a compulsory treatment order within 24 hours of being in hospital. The Alliance believes that if this measure is to be introduced at all it must only be for a small and closely defined group of people who could be classified as "revolving door" patients. The eligibility criteria for the imposition of a Community Treatment Order go much wider than this and have the potential to capture many more people than this group. Supervised community treatment also has the worrying potential of becoming a 'lobster pot' which is easy to get into but very difficult for a patient to ever get discharged from - there are no maximum time limits for treatment under these orders and they can be renewed using the same broad grounds as those applied to determine whether to place a patient on the Community Treatment Order.¹⁵

We are also extremely concerned by the broad scope of the restrictions that may be imposed on patients on Community Treatment Orders, which would allow all sorts of restrictions on a patient's lifestyle, associations and activities to be enforceable under the threat of compulsory hospitalisation – such as specifying that a person cannot go out to the pub. This raises the possibility of the inappropriate use of Community Treatment Orders as a form of psychiatric ASBO.

The Nearest Relative (clauses 21-24)

Under the 1983 Act, the 'nearest relative' is one of the major safeguards for the patient's rights. The person who is identified as the nearest relative has extensive powers in relation to the decision to impose compulsion – including the right to be consulted about any decision to detain, the right to block compulsory admission for treatment and the right to direct the patient's discharge.

The issue of who is identified as the nearest relative is one of the most complex in the 1983 Act and one of the commonest area where mistakes are made. The nearest relative is normally identified by reference to a list of 'relatives' in the 1983 Act, ranked in order of priority, and the 'nearest relative' is the person nearest to the top of the list. The nearest relative will not necessarily be the person identified by the patient as their next of kin, and indeed the patient has little control over who will be seen in law as the nearest relative. The nearest relative may be someone the patient dislikes and does not want involved in their life, let alone decisions about hospitalisation – and the patient has no power to apply for the displacement of an unsuitable nearest relative. This inflexibility has been upheld, in different decisions, as incompatible with Article 8 of the Human Rights Act 1998.¹⁶

The Bill proposes that patients should be allowed to apply to the county court for a displacement of their nearest relative in certain circumstances.

We are disappointed that the Government has abandoned plans to replace the nearest relative with a 'nominated person'. This provided that where a patient has capacity to make this decision, they should have the right to choose their nominated person. The nominated person is more likely to be someone in whom the patient has trust and confidence, and someone who will safeguard the best interests of the patient. This would also provide greater legal clarity about who is the patient's representative and would avoid the need for intrusive questioning during the sectioning process – such as 'who is your eldest parent' or 'were your parents married when you were born'. It would also avoid unnecessary legal costs of requiring the patient to go to court to displace a nearest relative they disagree with. Where there is no nominated person, we believe that the patient's carer should assume the role of default nominated person.

¹⁵ This concern was originally raised by Professor Genevra Richardson in her evidence to the Joint Committee on the Draft Mental health Bill (Q11)

¹⁶ For example, *JT v United Kingdom* [2000] 1 FLR 909

A similar system already operates under the Scottish Mental Health Act which provides for the patient to appoint a 'named person' who is given specific rights and powers in relation to the patient.

We are also concerned that patients would have to go through the County Court system – which has proved to be incomprehensible, costly and inaccessible for vulnerable people.¹⁷

Professional Roles (clauses 8-20)

The Bill proposes to widen the range of clinicians and social care professionals able to exercise statutory functions - replacing the Responsible Medical Officer (RMO) with a Responsible Clinician and the Approved Social Worker with the Approved Mental Health Practitioner (AMHP).

The Alliance believes that this needs to be done with great care. People coming new to statutory roles need proper training, regulation and professional support and they should not be put in place until a capable workforce is identified and prepared. We believe that the role of the AMHP should be independent, given its essential role during the assessment period. Without proper safeguards of the AMHP's neutrality, the procedure for assessment would run the risk of contravening human rights law.

We also believe there are a number of implications to the system as whole if non psychiatrists take on the role of Responsible Clinician and these need clarification. For example:

- One of the duties of an RMO is to keep under review whether or not the detained patient continues to meet the conditions for detention, and if the conditions are no longer met, to discharge the person from detention. It is unclear how a Responsible Clinician, who is not a qualified doctor and cannot sign the medical recommendations, can discharge this responsibility.
- One of the current RMO responsibilities is to decide whether or not to recommend a further period of detention when the section comes to an end. This renewal is based on this single medical recommendation. It is unclear whether a non-medical Responsible Clinician will be able to renew or whether an outside doctor will need to be brought in.
- The Government has indicated that where a doctor is required to prescribe medication or ECT then that doctor will need to be an approved clinician. This means that some patients will have two approved clinicians one of whom will be the Responsible Clinician. In practice, how this would be managed needs clarification particularly in instances where disagreements occur between the two Responsible Clinicians.

Tribunals (clauses 30-31)

Currently, patients who have not exercised their right to appeal against their detention to the Mental Health Review Tribunal within six months of their detention must be referred to the tribunal by the hospital managers. After that patients must be referred to the tribunal every three years. The Government are proposing to include a power in the 1983 Act to reduce this period when resources allow. The Bill also extends the automatic referral process to patients who continue to be detained for assessment while the County Court determines who their nearest relative should be.

The Alliance welcomes the Government's intention to reduce the time in which hospital managers must refer a case to the Tribunal. We call on the Government to make sufficient resources available to the Mental Health Review Tribunal to implement this proposal and reduce the period

¹⁷ The Disability Rights Commission evidence to the Joint Committee on the Draft Disability Bill 2004 showed that the court system presented significant barriers to disabled people – (para 370).

as soon as possible. In particular this enabling power should be used to cut the referral time for children and young people detained under the Act who currently must be referred every year following their initial referral.

Safeguards for people who lack mental capacity (Bournewood patients) (clauses 38-39)

The Government is proposing a new legal framework that will be inserted into the Mental Capacity Act 2005 to allow people who lack capacity to have their liberty taken away, if it is considered to be in their 'best interests'. The changes are a response to the 'Bournewood judgement'¹⁸, which concerned an autistic man who lacked decision making capacity and was detained in hospital under the common law (with no legal safeguards). In accordance with established clinical practice the Mental Health Act was not used because the person was not actively objecting to detention. In 2004 the European Court of Human Rights held that the common law was not enough for these patients: it was too vague and had too few safeguards to comply with the Convention. Whilst we agree that the Government needs to legislate to introduce new safeguards covering this group, we are concerned that the current proposals are inadequate.

The new proposals will allow people who lack mental capacity to be detained in a hospital or a care home. The detention orders will be for up to a year and the detained person will have a right to appeal to the Court of Protection.

The Mental Health Alliance welcomes the Government's decision to introduce safeguards for people who lack the capacity to give informed consent to decisions made over their care. However, we have a number of concerns about the detail of the proposals and would like to see the safeguards strengthened to give more protection to these vulnerable people. The Making Decisions Alliance (a consortium of 40 charities set up to campaign for new legislation on mental capacity and to support the implementation of the Mental Capacity Act) shares our views on these proposals, and is producing its own briefing which provides further details on how these provisions could be improved.

People detained under the Mental Capacity Act will have fewer safeguards than people detained under the Mental Health Act. For example:

- They will not have the right to free aftercare services
- There is no right to a second medical opinion for any medical treatment provided while the person is detained
- Relatives will not be able to discharge a patient
- A detention order for up to one year is double the length of detention orders under the Mental Health Act

Also, the Court of Protection is not a suitable body to hear appeals because it lacks expertise in authorising detentions and does not have sufficient resources to deal with the increase in workload. We believe the appropriate body is the Mental Health Review Tribunal. We are also concerned that Bournewood patients will not receive non means/merits tested legal aid - which is available to Mental Health Act patients.

We are also concerned that the only people entitled to request an assessment of whether or not a person is being deprived of liberty are the managers of the hospital or care home which is responsible for the deprivation of liberty in the first place. Relatives or friends will have no right to 'blow the whistle' if they feel someone is being wrongly deprived of their liberty

Both the Mental Health Alliance and the Making Decisions Alliance believe that there should be much closer parity with the safeguards in the Mental Health Act. The law needs to be fair, so that whether you are detained under the Mental Health Act or the Mental Capacity Act, you are provided with effective and robust safeguards. Without such safeguards, the legislation would be clearly open to further charges of discrimination against this group of people.

¹⁸ HL v United Kingdom [2004]

A Missed Opportunity

Our fundamental concern is that the Bill merely patches up an outdated piece of legislation, when a radical revision of the Mental Health Act 1983 is urgently required. The reform of mental health law is a once in a lifetime opportunity and must reflect the needs and expectations we have of 21st century healthcare. The Mental Health Alliance believes that the Government still has an opportunity to draft legislation so that it is workable and enjoys the support of patients and their families, professionals and the public. Our detailed policy proposals for change in mental health law to provide for ethical mental health legislation include the following:

Statutory Principles

The Alliance believes that mental health legislation should contain a set of general principles on its face and that, as in the Scottish Mental Health Act, the Act should stipulate that practitioners 'must have regard to' them. We recognise that there are inherent tensions the aims of mental health legislation to safeguard patient autonomy, least restriction and public safety, but like the Joint Parliamentary Scrutiny Committee, we support the view that the very existence of different and potentially conflicting objectives provides all the more reason for principles to be set out on its face. In England and Wales, both the Children Act 1989 and more recently the Mental Capacity Act 2005 set out principles within the legislation itself. There is widespread agreement that these provisions would give confidence to service users and be a valuable guide to practitioners and tribunals in applying and interpreting the Act.

Right to Assessment

People with mental health problems and their families regularly ask for help and fail to get it when they need it most.¹⁹ Evidence shows that patients who are able to access appropriate services at an early stage of their illness will be less likely to be admitted to hospital under compulsion, have an increased chance of recovery and a reduced risk of relapse.²⁰ The Alliance believes that there should be a statutory right to a comprehensive, holistic assessment of health and social care needs, with a further right to receive services to meet those assessed needs. The Joint Parliamentary Scrutiny Committee accepted this recommendation, and an identical right has been enshrined in the Scottish Mental Health Act.

Right to Advocacy

The Alliance strongly opposes the decision by the Government not to include a right to advocacy in its plans to reform the Mental Health Act 1983. The Government has promised to increase access to advocacy through other means but we believe that this is insufficient commitment. We agree with the Joint Parliamentary Scrutiny Committee, that mental health legislation should include an individual right to independent advocacy for people at all stages of the process of assessment and treatment under the Mental Health Act. For a frightened and mentally distressed person who distrusts authority and who may have no one to support him or her, an advocate can make a real difference, particularly at the initial stage when a person unknown to services first presents for admission or is detained in a place of safety.

¹⁹ One in four people reported being denied access to the help they sought from mental health services when their problems were developing according to a 2003 Rethink survey - Just One Per Cent; the experiences of people using mental health services.

²⁰ For example: Heinimaa and Larsen, T. (2002) Psychosis: Conceptual and ethical aspects of early diagnosis and intervention. *Current Opinion in Psychiatry*, **15**, 533-41.

Impaired decision making

The 1983 Act treats people with mental illness differently from those with physical illness and in the view of the Alliance this is discriminatory. A person diagnosed as mentally ill can be detained under the Mental Health Act 1983 and treated against their will irrespective of their capacity to make their own decisions. People who are physically ill and have capacity are not detained in hospital against their will because they refuse to take the treatment that should improve their condition; nor should people with mental illness.

The Alliance accepts the view of the Richardson Committee that, in the face of a mentally ill person at risk of committing suicide for example, professionals would find it difficult to just stand by on the grounds that the person had capacity. The temptation to broaden the definition of incapacity might be considerable. In the light of the clear definition of capacity in the Mental Capacity Act 2005, it would be unfortunate to cause confusion around this concept and to create a situation where different approaches to the same concept were used for different groups of patients.

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 may permit 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, rather whether their ability to make decisions is "impaired". The more serious the decision, the less evidence of impairment may be required. It also relates more closely to the way in which clinicians assess patients for clinical reasons. This approach is used in the Scottish Mental Health Act which permits compulsion only if the person has impaired decision-making in relation to medical treatment.

Treatment safeguards

Psychiatric medication can cause a wide range of adverse effects including major weight gain and obesity, heart problems, low blood pressure, osteoporosis, seizures, Parkinsonism, tardive dyskinesia (involuntary movement disorders) and a range of other problems. In some cases, it can lead to sudden death. These effects can occur at normal doses, but it is particularly important to protect patients from being exposed to greater risks by being forced to have drugs at higher than recommended doses.

The Alliance recommends reducing the period of drug treatment before which a second opinion is required from three months to 28 days, requiring clinicians to have regard to the patient's views and provide written reasons for refusing a requested treatment, and prohibiting treatment with drugs over recommended limits except with consent or to prevent serious risk to the life of the patient.

Electroconvulsive therapy (ECT) is an invasive procedure whose adverse effects can include permanent loss of memories and other cognitive impairment. It can cause great psychological distress to be forced to have it involuntarily. Alliance recommendations include the right for a person with decision-making capacity to be able to refuse ECT and not have that over-ridden, limiting emergency ECT to those who lack capacity and only if their life is in danger, and enforceable advance refusals of ECT.

Race Equality

The Government's own statistics highlight staggering ethnic inequalities in the use of mental health services.²¹ According to the 2005 'Count Me In' census, inpatients from the Black Caribbean, Black African, and Other Black groups were 33-44% times more likely to be detained under the 1983 Act when compared with the average for all inpatients.²² The rate of detention for inpatients from the Other White group was also slightly higher than average. Differences among other minority ethnic groups were not statistically significant. There is a history of misunderstanding and discrimination when it comes to the use of compulsory power, which has resulted in the deaths of a number of African Caribbean service users while under the care of the mental health system, tragically highlighted by the death of David Bennett. It is also well documented that African Caribbean service users are more likely to be misdiagnosed and diagnosed with psychotic conditions and treated using medication, which is often of a higher dosage.²³ Culturally appropriate and acceptable behaviour has also been wrongly construed as symptoms of abnormality or aggression.²⁴

The Alliance is committed to preventing this from happening in the future and we are concerned that the 1983 Act, unless radically amended, will continue to disadvantage African Caribbean and other BME communities who use mental health services. In this we share the concerns expressed by organisations such as the BME Mental Health Network, Songhai, the Transcultural Psychiatry Society and the African and Caribbean Mental Health Commission.

The Alliance considers it a top priority to ensure that changes are made to the 1983 Act which tackle discrimination and actively promote race equality. The Government has published the results of a Race Equality Impact Assessment on its proposals for reform, but has failed to respond to its recommendations in the drafting of this Bill. The Alliance is calling in particular for a principle of non-discrimination and respect for diversity on the face of the Bill, a right to advocacy for all involuntary patients and restrictions on the use of police cells as places of safety, which will help promote the rights of BME service users.

Safeguards for children

We are concerned that the 1983 Act fails to provide children and young people with appropriate safeguards. For example patients under 18 may be treated under the common law or under the authority of those with parental responsibility who can override the young person's refusal – and will have no recourse to the Mental Health Review Tribunal to challenge detention or to a second opinion doctor to challenge treatment without consent. It is disappointing that the Government has decided to abandon its 2004 proposals to create separate and distinct arrangements for people under 18 – such as an individual care plan; a regular review every three months; representation by a nominated person; a right of access to the tribunal and the right to advocacy. The Alliance believes that the 1983 Act must be amended to provide special safeguards for children including: the right for children to be admitted to a unit which will meet their particular needs, be it a specialist child and adolescent mental health facility or an adult ward; the right to be assessed prior to compulsion and subsequently have their care supervised by a child and adolescent mental health professional; and the removal of the anomaly that exists whereby 16 and 17 year olds who are deemed competent can consent to admission to hospital and treatment but if they refuse treatment they can be admitted under parental authority.

²¹ Count me in: The National Mental Health and Ethnicity Census 2005 Service User Survey: MHAC

²² *ibid.*

²³ Sainsbury Centre for Mental Health (2002) *Breaking the Circles of Fear*

²⁴ Report into the Death of David Bennett (2003)

Advance decisions and advance statements

We believe that advance decisions and advance statements are important mechanisms for safeguarding and promoting a patient's interests and health. An advance decision allows a person to refuse specific treatment in the future should they lose capacity to consent. Advance statements are a means of giving details of the care and treatment a patient would like to receive should they lose capacity at some time in the future, including whom they wish to act as a nominated person. Both of these mechanisms can help can promote individual autonomy and empowerment; they can enhance communication between patients and those involved in their care; and they can protect individuals from receiving unwanted or possibly harmful treatment.

The Alliance welcomes provision in the Mental Capacity Act for advance decisions and some legal recognition for advance statements when determining someone's best interests. We believe that to ensure equity and parity in both legal and practical terms, advance decisions and advance statements must be included in the Mental Health Act.

The Mental Health Act Commission

The Alliance believes that the Mental Health Act Commission has played a critical role in improving compliance with the 1983 Act and in safeguarding and ensuring the rights and welfare of people detained in hospital under the Act. We are concerned that the Government proposals to merge the health and social care inspectorates could lead to a loss of skills and expertise that currently resides with the Mental Health Act Commission, and ultimately less protection to people subject to compulsion. The Alliance is not persuaded that that its unique functions would be replicated or sustained if it should be placed in a wider health inspectorate and we support the retention of a stand-alone body to monitor patients subject to compulsion.