



## Mental Health Bill House of Commons Second Reading supplementary briefing:

### Setting the record straight

#### Introduction

The Mental Health Act governs the use of compulsory powers for assessing and treating mental health problems. It determines who can be subject to compulsion, in what circumstances and in what ways. It sets out what compulsory powers can be used for and where they can be exercised as well as the safeguards to protect those deprived of their liberty.

The Bill, published in November, set out major changes to the Act, including:

- A simpler definition of what constitutes a ‘mental disorder’: which determines who can be detained;
- Removing the requirement a person must be ‘treatable’, instead requiring only that treatment is ‘available’;
- Extending the use of compulsion outside hospital through setting up ‘supervised community treatment’ (SCT) orders.

Taken together, these changes represent a significant widening in the likely use of compulsory powers and come without any proportionate increase in the safeguards that protect people from abuse or neglect.

The House of Lords made a number of amendments to the Bill. The Government also put forward its own amendments, many of which are welcome.

The amendments the Lords voted on were:

- To set out a list of exclusions from the definition of mental disorder, to stop a person being brought under the Act on the basis of substance use, disorderly conduct, sexual orientation or cultural, religious or political beliefs.
- To protect people with full decision-making capacity from being detained.
- To require some likelihood that a person’s health will benefit from treatment.
- To limit the use of SCT to those who would otherwise be in and out of hospital and who cannot otherwise be discharged from hospital safely.
- To require a medical opinion before detention can be renewed or a person placed on SCT.
- To ensure children detained under the Act are placed in age-appropriate accommodation and cared for by specialist in child and adolescent mental health.

The Mental Health Alliance believes that the changes brought about in the Lords have significantly improved the Bill. The minister, Rosie Winterton MP, however, claims they have “seriously weakened the protection for both patients and the public”.

We do not agree. There is no evidence that the Government’s Bill would have made either patients or the public any safer. And there is no reason to believe that the amendments would make them any less safe. In fact, they would bring the law in England and Wales closer to the Act passed in Scotland in 2003 with broad support from experts and politicians. This briefing examines the truth behind the claims made about the Mental Health Act, the Bill, and the people whose lives they affect.

## 1. Treatability and therapeutic benefit

*“This safeguard has, on occasions, been misinterpreted as meaning that patients can only be detained if they can be cured, rather than treated. This confusion has led to too many patients with personality disorders – which can be treated but not cured – being turned away from services.” Rosie Winterton MP, speech to Local Government Association conference, 1 March 2007*

**If existing law is being misinterpreted, it needs to be better explained and enforced, not changed.** It is unclear why clinicians would confuse “treatable” with “curable”, since all clinicians routinely treat conditions which are not curable, but for which treatment is nevertheless appropriate, helpful and worthwhile.

The Lords amended the Bill to protect **people who can gain no benefit from treatment**, without preventing practitioners from detaining anyone who can gain any benefit from treatment. The Lords amendment achieves the Government’s stated aim of making it clear that people with a personality disorder are covered by the Bill, but without unintentionally broadening the powers of compulsion to cover preventative detention.

People with personality disorders may currently be turned away from services because of scarce resources or because of an outdated belief that there is a lack of effective treatment available. But the compulsory mental health system should *never* be used to solve the problem of people being turned away from services – this is a question of resources, not of the law.

*“Every restriction is a person not treated” Prof Louis Appleby, speech to All-Party Parliamentary Group on Mental Health, 30 January 2007*

The Government claims that restricting the application of the Act will stop people getting necessary treatment. This is a dangerous and illogical notion. Taken to its conclusion it suggests doctors should have no limits to what they can do if it's good for you. Restrictions on the use of *compulsory* treatment are essential to protect vulnerable people from inappropriate, abusive or dangerous treatment.

Everyone wants mentally disordered people who might kill to be locked up and, if necessary, forced to have treatment. But no-one wants their anxious or grieving parent to be locked up and forced to take medication if they are not a threat to anyone. So all we are really discussing is where we draw the line. The Government has drawn the line too far to one side.

Professor Appleby’s argument is that the treatability test “puts clinicians in a legal grey area” and excludes those with ‘the wrong kind of mental disorder’ (APPG-MH, 30 January 2007). Again, the allusion is to individuals with personality disorders avoiding compulsion by exploiting loopholes in the law. There is no evidence to support this view. Nonetheless, the therapeutic benefit test proposed by the Lords does not have such a loophole: if a treatment is available that would help a person, even if they do not want to comply with it, they can still be detained if the other conditions in the Act are met.

## 2. Supervised Community Treatment (SCT)

*“Supervised community treatment... will deal specifically with what are often dubbed revolving door patients – those who are in hospital, start to get better, are discharged, fail to take their medication or stay in touch with health services, relapse, and have to be brought back into hospital for treatment, hopefully before harming themselves or the public.” Rosie Winterton MP, speech to Local Government Association conference, 1 March 2007*

In the original Bill, SCT did not deal specifically with so-called “revolving door patients”. There was no restriction on which patients could be placed on SCT. The Lords amended the Bill to limit SCT to patients with a history of relapsing after discharge from hospital – precisely the group the minister says she wants the measure to cover. **No ‘revolving door patient’ would be excluded**

**from treatment by the Lords amendments.** Those that present a danger to others could be placed on SCT. Those that do not could be released on supervised discharge.

*“The result [of the Lords amendments] will inevitably be either that patients have to spend longer in hospital, or be discharged without proper supervision. The result again may be that they become a danger to themselves or others. Every restriction is a patient untreated, a family in distress.” Rosie Winterton MP, speech to Local Government Association conference, 1 March 2007*

**This is an emotive argument, but it is not true.** We should not confuse access to services with the use of compulsion. Patients who are not receiving compulsory treatment are not necessarily untreated. Patients on existing supervised discharge arrangements are not “without proper supervision”. To say that voluntary patients who are referred to community teams are “untreated” and that their families are “in distress” does a great disservice to the hundreds of community teams who do a good job for the people they serve.

*“[Supervised Community Treatment] is good for the patient who can return earlier than they might otherwise have done to their homes. It is good for their families and friends, to know that the support framework is there to help. And it is good for society to know that action is being taken to prevent relapse and the scope of harm associated with relapse.” Rosie Winterton MP, speech to Local Government Association conference, 1 March 2007*

These claims are without foundation. The Bill does not contemplate that people will be discharged earlier if there is a CTO regime. Under the Bill a CTO is only available if they are no longer so ill as to require hospital treatment. Research commissioned by the Government into international experience of Supervised Community Treatment found that there was no sound evidence of its effectiveness.<sup>1</sup> It stated: **“It is not possible to state whether Community Treatment Orders (CTOs) are beneficial or harmful to patients...[There is] very little evidence of positive effects of CTOs in the areas where they might have been anticipated”.**

### **3. Impaired decision-making**

*“If [a patient’s judgement] cannot be shown to be impaired, then detention will be forbidden – however much the patient needs treatment and however much they or other people will be at risk without it. The implications are clear. Not all suicidal patients have impaired judgement. The Lords in effect are expanding the right to suicide.” Rosie Winterton MP, speech to Local Government Association conference, 1 March 2007*

**This misrepresents the impaired decision-making test.** It is explicitly not the same as a test of mental capacity. The test is already in operation in Scotland, under the Mental Health (Care and Treatment) Act 2003, and there is no evidence that it has had adverse effects there.

The Lords made it clear that a test of impaired decision-making does not “expand the right to suicide” or prevent the treatment of patients who present a risk to others. If a person with a mental disorder is suicidal, or they present a risk to others as a result of their condition, their decision-making is impaired.

The purpose of the test is to ensure that compulsory treatment, against the patient’s will, can only be provided where the patient’s own ability to make decisions about the treatment they need is impaired.

### **4. Exclusions**

*“...by adding a range of unnecessary exclusions, the changes forced through by the Lords will inevitably open up new avenues for patients and their lawyers to use to try to secure premature discharge for some of the most dangerous patients.” Rosie Winterton MP, speech to Local Government Association conference, 1 March 2007*

The exclusions agreed by the House of Lords ensure that the very considerable powers conferred by the Mental Health Act will not be used inappropriately. They ensure the new, broad definition of mental disorder is not applied to people spuriously. It does not stop people who have coexisting mental health and other problems being detained but it offers important protection for people whose behaviour or beliefs could be misunderstood or misconstrued as a sign of mental illness.

We should not scare the public into thinking that a necessary safeguard that exists in most comparable jurisdictions (including Scotland) would put our safety at risk.

## **5. Children and young people**

The minister claimed that the amendment requiring children to be placed in age-appropriate accommodation would cause delays in getting help. This is missing the point of the amendment. For many young people, being detained on an adult ward is a distressing experience. It is vital that under-18s are provided with accommodation that is suitable across the country. If such provision is not available it should be a priority for services to fill the gap. It is unacceptable for any child to be placed in unsuitable accommodation. Given how frequently this happens at present, we believe legislation is the only way to protect young people against this practice.

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<sup>1</sup> Rachel Churchill, Gareth Owen, Swaran Singh, Matthew Hotopf, *International experiences of using community treatment orders* (2007) <http://www.dh.gov.uk/assetRoot/04/14/38/75/04143875.pdf>