

# Parliamentary Brief

## Mental Health Bill

### House of Lords, Second Reading – 28 November 2006

(This briefing paper applies to England and Wales)

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#### Introduction

The BMA is an associate member of the Mental Health Alliance, which brings together many organisations from across the mental health spectrum.

Reform of mental health legislation has been under way for about eight years. This programme has included an expert Committee, Green Paper, White Paper, and pre-legislative scrutiny through a First Draft Bill in 2002 and a Second Draft Bill in 2004. The Government is proposing to introduce new mental health legislation based on amendment of the 1983 Mental Health Act. Broad aims of the amendment bill are to ensure that:

- the 1983 Mental Health Act is European Court of Human Rights compliant
- the legislation is capable of delivering the Government’s policy objectives in relation to community-based compulsory treatment
- there is a framework for the management of people with personality disorders
- there is an extension of the professional base of those able to provide services under the Mental Health Act’s powers
- there is provision for people who lack capacity to make decision for themselves, who are deprived of their liberty in care homes or hospitals and are not eligible to receive mental health legislation safeguards (otherwise known as “Bournewood” patients).

The proposed Mental Health Bill presents some problems of interpretation. Attention has been focussed for a long time on the draft Bills, and in assessing the effect of the new proposals, the

impact, both good and bad, of losing those draft bills needs to be considered alongside an assessment of an amended 1983 Mental Health Act.

Approaching the legislation from the perspective of medical ethics entails identifying as far as possible the extent to which it is designed to deliver overall benefit to those patients subject to its powers. Historically, however, mental health legislation has always had a number of competing and at times openly conflicting objectives. Primarily the 1983 Mental Health Act is concerned with managing the deprivation of liberty of mentally disordered individuals rather than in the explicit promotion of mental health. The 1983 Mental Health Act also covers a diverse population and a variety of mental disorders, and its powers extend to the management of mentally disordered offenders. It is this overlap with the criminal justice system, and the requirement that in certain circumstances it be used to manage risk, that has been at the root of many of the ethical difficulties associated with the legislation. Health professionals working with the 1983 Mental Health Act may find themselves subject to dual loyalties, as they try simultaneously to promote the best interests of their patients, and to protect the public interest by restraining mentally disordered individuals who may pose a risk to others.

Another important aspect of any legislation that permits compulsion is the requirement that the use of its powers be independently scrutinised. Clearly this extends further than specifically *medical* ethics to broader issues of social justice. These two areas – risk management and independent scrutiny – were behind many of the criticisms of the two draft bills and remain active areas of concern in this amendment bill.

Furthermore, the BMA is disappointed that the amendment bill does not comprehensively address the needs of children and adolescents. For example, the amendment bill is a missed opportunity to tackle health inequalities with regard to certain groups of children. A BMA report into Child and Adolescent Mental Health stated that around 45 per cent of looked after children in the UK are suffering from some form of mental health problem and mental health services for this group needs to be improved.<sup>1</sup> Further thought should also be given to the improvement of mental health services for children and young people with learning disabilities and those from black and minority ethnic (BME) groups. The proposed wider range of healthcare professionals able to treat such patients would require specialist training in order to help tackle such inequalities.

## **The Government's proposals**

### *Definition of mental disorder*

The definition of mental disorder and the conditions that must be met are central to the operation of the new bill because they identify the group of individuals who can be subject to its powers. The Government intends to introduce a single definition of mental disorder, abolishing the categories listed in the 1983 Mental Health Act and removing most of the exclusions. The Government's cites historical anachronism as the justification for removing the exceptions in relation to promiscuity or sexual deviancy. While this feels broadly right, the Government has also stated that the exclusion in relation to sexual deviance has prevented the detention of people with sexually deviant behaviours who should fall under the Act. It may be that the Government has in mind personality disordered individuals with sexually deviant behaviours.

### *Criteria for compulsion*

Both draft bills and the proposed amendment bill remove the 'treatability' test in relation to psychopathic disorder and mental impairment – i.e. the requirement that treatment must be available

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<sup>1</sup> The BMA's Board of Science published the report *Child and adolescent mental health* in June 2006, which contained several recommendations for action. The report can be accessed on <http://www.bma.org.uk/ap.nsf/Content/Childadolescentmentalhealth>

that is likely to alleviate or prevent a deterioration of the patient's condition. This is to be replaced with a test that "appropriate treatment" must be available. Treatment "includes" nursing, care, cognitive therapy, behaviour therapy, counselling or other psychological intervention, habitation (including education, and training in work, social and independent living skills) and rehabilitation.

This is the central ethical issue in relation to the legislation. By having a broad definition of mental disorder, a loss of exclusions and a wide definition of treatment, the scope for the exercise of compulsion is increased. By removing the "treatability" criterion, the potential is raised for confining people under the Act, even where health benefit cannot be provided. As a result, the legislation can be used as a means of coercion, rather than as an instrument to provide necessary health services to mentally disordered individuals. The BMA strongly advocates the inclusion of a requirement that the use of the legislation must provide therapeutic benefit.

### *Supervised community treatment*

The Government intends to introduce provisions to allow compulsory treatment in the community for some patients following a period of detention in hospital. The intention is to target those 'revolving door' patients who do not continue with their treatment after leaving hospital and whose health deteriorates to the extent that they require readmission. The BMA supports this development subject to the use of safeguards. The use of supervised community treatment must, for example, be very closely focussed on those who have had multiple admissions.

Moreover, further clarification is needed regarding the treatment of children and adolescents in the community. It is essential for looked after children and adolescents with mental health disorders to have correctly adapted community treatment in place for them.

The amendment bill seems to separate adult and child community patients with an adult being someone who has attained the age of 16 years, and a child as someone who has not. This makes no consideration for 16 and 17 year olds who may not be mature enough to be treated as an adult especially where they have a long-term mental disorder. The BMA believes that provision of appropriate mental health services to 16 and 17 year olds must be improved as young people should not be receiving adult care when they are not mature enough to do so. Child and adolescent mental health services should be extended to encompass this age group in all areas. Collaboration must be improved between adult and child mental health services.

### *Nearest relatives*

Following case law in the European Court of Human Rights, the Government has undertaken in the amendment bill to extend to patients the right to make an application to displace their Nearest Relative and to enable county courts to displace a Nearest Relative where there are reasonable grounds for doing so. However, more clarification is needed with regards to the rights of children and the ability to apply to have their nearest relative displaced. Would children be able to apply to the county court to have their mother or father displaced?

### *Professional roles*

Traditionally, certain areas of expertise in mental health service delivery have rested with psychiatrists as a consequence of their highly specialised training. The Government is proposing to widen roles within the amendment bill and, given the multi-disciplinary nature of mental health service delivery, it is important that any future move to widen professional roles ensures that the highest standards of patient care are maintained.

For example, the Government is seeking to broaden the group of practitioners who can take on the role of the approved social worker (ASW) and responsible medical officer (RMO). The ASW will be replaced by the Approved Mental Health Professional (AMHP). The functions will remain the same

as in the 1983 Act but will be opened up to a wider group of professionals such as nurses and occupational therapists. However, in order to sustain the highest standard of care, there are crucial issues to address including training.

The RMO will be replaced by the responsible clinician and will be opened up to appropriately trained professionals including psychiatrists, psychologists, nurses, social workers and occupational therapists.

With respect to child and adolescent mental health, it is also essential that all professionals providing child and adolescent mental health services receive adequate training and support enabling them to work effectively together. The amendment bill should also address the need for innovative services to meet the needs of young people as they differ greatly to those services directed at adult patients.

### *Mental Health Review Tribunals*

The amendment bill states that for patients under the age of 16 years, if a period of more than one year has elapsed since their case was last considered by a mental health tribunal then it is the duty of the hospital manager to refer the patient's case to such a tribunal. For patients over the age of 16 it is a period of three years which must elapse. Patients who are 16 and 17 years old should ordinarily be considered as not mature enough to be treated with the same regulations as adults, and therefore be considered for the one year rule.

### *Bournewood*

Following a judgement in the European Court of Human Rights, the Government intends to use the amendment bill to amend the Mental Capacity Act 2005 to provide additional safeguards for mentally incapacitated adults who lack the capacity to consent to the arrangements for their care, and whose treatment amounts to a deprivation of liberty - these patients are sometimes referred to as 'Bournewood' patients. Where a hospital or registered care home identifies such patients, they must apply to a 'supervisory body' for the authority to continue such care and treatment. For care homes in England the supervisory body will be the local authority, and for hospitals it will be the Primary Care Trusts. In Wales it will be the National Assembly for Wales.

However, attention must be drawn to why the Bournewood provisions are only going to apply to people aged 18 and over, when the Mental Capacity Act more generally covers persons aged 16 and over. What is the reasoning behind ruling 16 and 17 year olds ineligible for the proposed new safeguards?

### **Provisions lost with the draft Bills**

In opting for an amendment bill, the Government has abandoned a number of provisions that would create greater reciprocity, i.e. would give patients certain powers and benefits in exchange for the loss of rights that flow from compulsion. Provisions that have been lost include:

- The ability of a third party to request an assessment of the needs of a person who may be mentally disordered
- Advocacy services for compelled patients
- The requirement that Tribunals authorise compulsion after 28 days
- Safeguards for children treated on the basis of parental consent – these are to be dealt with by an amendment of the Children Act 1989

### *Tribunals*

One of the important innovations of the 2004 draft Bill was a significant increase in quasi-judicial oversight of the use of compulsory powers by the Tribunal. This would ensure ECHR compliance and

provide considerable protection for patients subject to the Act. As indicated above, these provisions have been lost along with the draft Bill. The amendment bill will introduce compulsory review of detention at 6 months and there is an undertaking to reduce this time limit as resources allow. It is important that health professionals have confidence in the integrity of independent oversight of decisions to deprive individuals of fundamental rights, and careful scrutiny must be given to the operation of the tribunals.

## Conclusion

The central ethical concern about both draft Bills has been the lack of any requirement that compulsion should be allied to therapeutic benefit. Ethically the removal of fundamental rights must be justified by the reciprocal provision of health benefit, or it ceases to be health legislation and becomes a tool for maintaining social order. This would create clear ethical conflicts for health professionals. In addition to this, the loss of some additional patient safeguards that were outlined in the draft bills suggests that the Government is developing coercive legislation to manage the risk presented by mentally disordered individuals, rather than looking at overall health benefit. If people are deemed a danger to others, criminal proceedings need to be implemented if appropriate.

Finally, greater consideration also needs to be given to the treatment of children and adolescents under the proposed legislation.

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