Introduction

The Mental Health Alliance

The Mental Health Alliance consists of 32 core and 41 associate members. It is a unique alliance of user groups, psychiatrists, social workers, nurses, psychologists, lawyers, voluntary associations, research bodies and carers' associations. The core members are:

Afiya Trust; British Association of Social Workers; British Psychological Society; Caritas-Social Action; College of Occupational Therapists, Ethnic Health Forum North West; GLAD; Institute of Mental Health Act Practitioners; King's Fund; Maca; Manic Depression Fellowship; Mental Health Foundation; Mental Health Nurses Association; Mind; National Autistic Society; Prevention of Professional Abuse Network; Rethink severe mental illness; Revolving Doors; Richmond Fellowship; Royal College of Nursing; Royal College of Psychiatrists; SANE; The Sainsbury Centre for Mental Health; SIRI; Turning Point; UK Federation of Smaller Mental Health Agencies; UKAN; UNISON; United Response; US Net; Voices Forum; YoungMinds.

Associate members are: *1990 Trust; Advocacy Learning and Skills Partnership, African Caribbean Community Initiatives; Age Concern England; Alcohol Concern; AWAAZ (Manchester); AWETU; The British Deaf Association; British Medical Association; BME Mental Health Network; Carers UK; Church of England Mission and Public Affairs Council; Confederation of Indian Organisations; Democratic Health Network; Depression Alliance; Drugscope; East Dorset Mental Health Carers Forum; Family Welfare Association, Footprints (UK); General Medical Council; Hafal; Having a Voice; Homeless Link; Imagine; JAMI; Justice; Law Society; Manchester Race and Health Forum; Mencap; NHS Confederation; Race on the Agenda; RADAR; Refugee Action; Royal College of General Practitioners; Sign; Social Action for Health; Somali Mental Health Project; Supporting Carers Better Network; UK Council for Psychotherapy; West Dorset Mental Health User Forum; WISH.*[1]

The Mental Health Alliance formed in 1999 in opposition to the Government's response to the *Report of the Expert Committee: Review of the Mental Health Act 1983* (hereafter the Expert Committee Report). Since then the Alliance has responded to the consultations on the White Paper and the 2002 Draft Bill and developed its own policies on key areas of reform of the 1983 Act. In November 2004 the Alliance submitted both written and oral evidence to the Joint Scrutiny Committee on the 2004 Draft Bill.

Towards a better Mental Health Act

The degree of consensus among the different professional sectors and between the professionals and service users who make up the Alliance has been surprising. It has reinforced our belief that we have found, in broad terms, the way forward. Many of the recommendations of the Expert Committee, the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003 (hereafter the Scottish Mental Health Act), together with

[1] Membership lists correct at time of going to press.

laws from other common law jurisdictions, tend in the same direction. It would be hard to imagine how legislation could work better than through such widespread consensus.

In essence our agreement over details of the Bill derives from a shared belief in the values that should underpin such a law (which we state as our general principles). The Alliance is united in its belief that based on these values, humane and effective mental health legislation for the 21st century is achievable. This document provides a critique of the Government's plans for mental health legislation as set out in the Draft Mental Health Bill 2004, and sets out the Alliance's alternative proposals.

Background to the Alliance's position

1. Service provision

The Alliance welcomes Government policy initiatives on mental health which have been introduced through the National Service Frameworks, the Choice agenda and anti-stigma campaigns. We welcome positive developments for mental health patients in service delivery. There are also new horizons in psychiatric and psychological practice, healthcare programmes, user action and legal rights.

Nevertheless, mental health patients continue to be poorly served within the NHS and by community care. Mental health service funding has undoubtedly increased in recent years, but below the rate for the rest of the NHS. Mental health care is difficult to access and highly stigmatised. People are frequently turned away when seeking help in the early stages only to become so ill that compulsory treatment is considered. Those developing a psychosis typically do not receive specialised help until 12-18 months after clear signs and symptoms have developed. Those developing more common mental health problems may get no specialist help at all. As a result it is likely that a patient's first experience of specialist help will be under compulsory powers – a traumatic experience that may poison relationships with the professionals s/he depends on for care.

Follow-up care for those admitted to psychiatric hospitals is patchy and inadequate. The existence of powers to compel individuals to accept treatment against their will without matching powers to secure the help they need has distorted mental health care. A new Mental Health Bill should tackle this problem but the Bill as presently drafted will compound it and, rather than supporting the positive developments in policy and practice, will set them back.

2. Stigma

Stigma against people with mental health problems in society has increased rather than declined. The current 1983 Act reinforces discrimination against people experiencing mental ill health through its failure to address the issue of capacity. The Department of Health's study of public attitudes to people with mental illness found that "*levels of fear and intolerance of people with mental illness have tended to increase since 1993*" and particularly that "*attitudes towards people with mental illness…have become less positive between 2000 and 2003*."[2] The Social Exclusion Report found stigma to be the biggest problem people with mental health problems face as a group.[3]

The current Draft Bill will do nothing to redress this problem. We are particularly disturbed by the over-emphasis in the Draft Bill on protection of the public from "dangerous" people and the disastrous impact this will have on those people it targets and on the vast majority of mental health patients who pose no danger to anyone.

3. Resources

It is clear from our membership that the proposed law does not have the support of the people who will use it, both as patients and as professionals. It is in danger of diverting even more resources into compulsory care at the expense of voluntary patients and of setting up new structures in place of those in the 1983 Act that may be of little real value. Above all it is likely that the aim of health legislation to improve the lives of people with

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[2] *Attitudes to Mental Illness 2003 Report*, p.9

[3] *Mental Health and Social Exclusion,* Social Exclusion Unit Report, June 2004 (hereafter the *Social Exclusion Report*), p.95

mental health problems will be jeopardized by those parts of the law that remain stigmatising and overly coercive.

Vacancy rates across the full range of mental health professionals remain a major cause for concern.[4] Mental health service funding has undoubtedly increased in recent years, but below the rate for the rest of the NHS.[5] Many of the pressures on Mental Health Trust spending are caused by staff shortages. Some Trusts are spending millions of pounds each year on bank and agency staff. Imposing a Bill that entails considerable extra work for health professionals upon a system that is already experiencing acute staff shortages, and funding problems, risks causing major problems in the system. Additional pressures on staffing would be felt if the new Act did not enjoy the confidence or support of staff. If the Act contradicts professional ethics or damages working relationships it is likely to result in high staff turnover and a significant loss of experienced workers.

Positive aspects of the 2004 Draft Bill

We welcome in broad terms the following aspects of the new Bill, which are improvements on the 1983 Act:

- The provision for advocates;
- The role of the Mental Health Tribunal and the provision for an Appeal Tribunal;
- The single assessment process for civil patients;
- The ability to appoint a "nominated person" (but not its reduced role);
- Improvements to treatment safeguards for patients undergoing ECT;
- Special provisions for children and young people;
- Enhanced powers in the criminal courts to acquire mental health reports;
- The duty to consult the patient where appropriate.

Key Concerns

In the following chapters, the Alliance sets out its concerns relating to a number of key issues in the Draft Bill 2004 and presents alternative proposals. These key issues are:

- Principles
- Code of Practice
- Human Rights
- Issues relating to black and minority ethnic communities
- Definition of mental disorder and exclusions
- Conditions for compulsion
- Non-resident orders
- Patients within the criminal justice system
- Right to assessment for mental health service
- Advance statements
- Nominated persons

[4] The Government's own figures (which measure three-month vacancy rates) show rates of 11.5% in psychology, 3% nursing, 5% allied health professionals (including occupational therapists), 6-9% (adult) social workers and between 3 and 9% in psychiatry.

[5] In 2003/04, the NHS received a real-terms increase of 5%, while for mental health care the figure was just 1.6% (*Money for Mental Health,* SCMH, 2003)

- Advocacy
- Tribunals
- Continuation of care
- Treatment safeguards
- Children and young people
- Inspectorate
- Workforce

In view of the fundamental nature of our proposals for change and of the different context brought about by the Mental Capacity Act 2005 the question arises whether this Bill can be salvaged. This is not a question that we believe it is our place to answer. However, in order to implement the changes we propose, a different Bill which is closer to the Expert Committee Report or the Scottish Mental Health Act is clearly called for.

Finally, the Bill is complex and unduly complicated in its drafting. The Explanatory Notes do not greatly assist its understanding and in places are misleading. How lay people will be able to apply it is unclear. This also raises an issue of principle – that a law which is inaccessible is also unworkable.