



**TOWARDS A BETTER  
MENTAL HEALTH ACT**

**The Mental Health Alliance  
Policy Agenda**

**July 2005**

## Preface

The Mental Health Alliance has been in existence since 1999. Its role has evolved from one of simple opposition to Government proposals for reform of the 1983 Mental Health Act, to one of “constructive dialogue” with government. As a consortium of organisations representing all those on whom the law will have a direct impact or a role to play in its delivery, we believe there was much value in our seeking to present our own policies to underpin better mental health legislation. Accordingly, through 12 subgroups, we have produced policy papers in key areas, which inform our submissions to Government, most recently to the Joint Committee on the 2004 Draft of the Mental Health Bill. Throughout the document we refer to the Mental Health Act 1983, to the Richardson Expert Committee Report, to Government’s White paper and to the Draft Mental Health Bill 2004.

In this summary of our current positions we have, where possible, taken account of the Joint Committee’s 2005 report. On key issues, however, there has been little reason to amend policies. Indeed the overwhelming evidence presented to the Committee from organisations and individual mental health professionals, service users, carers and academics that are not members of the Mental Health Alliance has shown that there is remarkable agreement within the community for the way forward. This has reinforced our resolve to continue to campaign most energetically to see the kind of Mental Health Act which in our view best meets the needs of patients, their carers, those who work for their better mental health and the wider community.

The purpose of this document is simply to put all the past work together as a single record and as a basis for the next stage of the process when the Government produces its new Bill for entry to Parliament. It remains however work in progress. We continue to develop these policy positions in the light of further available research, legal developments and government responses and to formulate them with specific provisions of a new Bill in mind.

Rowena Daw, Policy Lead and chair of the Mental Health Alliance Policy Group 1999-2005

## Contents

1.	Preface	p. 2
2.	Introduction	p. 4
3.	Principles	p. 8
4.	Code of Practice	p. 15
5.	Human Rights	p. 19
6.	Issues relating to BME communities	p. 22
7.	Definition of Mental Disorder and exclusions	p. 26
8.	Conditions for compulsion	p. 30
9.	Non-resident orders	p. 48
10.	Patients within the Criminal Justice System	p. 59
11.	Right to an Assessment for Mental Health Service	p. 77
12.	Advance Statements	p. 79
13.	Nominated Persons	p. 87
14.	Advocacy	p. 101
15.	Tribunals	p. 111
16.	Continuation of care	p. 124
17.	Treatment safeguards	p. 128
18.	Children and young people	p. 140
19.	Workforce	p. 147
20.	Inspectorate	p. 152
21.	Annexes	p. 155

### ***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.<sup>1</sup>*

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 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.

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<sup>1</sup> Membership lists correct at time of going to press.

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.*"<sup>2</sup> The Social Exclusion Report found stigma to be the biggest problem people with mental health problems face as a group.<sup>3</sup>

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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<sup>2</sup> *Attitudes to Mental Illness 2003 Report*, p.9

<sup>3</sup> *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.<sup>4</sup> Mental health service funding has undoubtedly increased in recent years, but below the rate for the rest of the NHS.<sup>5</sup> 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
- Advocacy

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<sup>4</sup> 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.

<sup>5</sup> 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)

- 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.

## Principles

The Mental Health Alliance believes that the stated principles on the face of the Draft Bill (least restriction, patient involvement in decision-making and fair and transparent processes) are commendable but insufficient as a framework for legislation.

The Bill also refers to “*general principles*” relating to decision-making under the Act which will feature in the Code of Practice. We believe that the Bill should contain this 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 in the Bill’s aims to safeguard patient autonomy, least restriction and public safety, but like the Joint Committee, we support the Mental Health Act Commission’s view that the very existence of different and potentially conflicting objectives in the Bill provides all the more reason for principles to be set out on its face.<sup>6</sup> In England and Wales, both the Children Act 1989 and more recently the Mental Capacity Act 2005 set out principles within the legislation itself, as does the Scottish Mental Health Act. There is widespread agreement, as expressed in submissions to the Joint Committee, that principles need to be stated to give all users of the law (including service users and their families) confidence in the law, to support and guide professionals, to assist Tribunals in laying down principled and consistent case law and to inform the exercise of discretion under the law. If the principles are set out in an Act of Parliament, they have the force of an Act of Parliament. If they are set out in a code of practice which can be changed by a member of the executive, they lack the legitimacy that those principles should have.

Furthermore, the Government believes that principles that restate rights and duties in other legislation should not appear on the face of this Bill. We disagree. Where these principles are relevant to the current legislation, they should be restated and the Mental Health Bill should also be cross-referenced to the Race Relations (Amendment) Act 2000, the Disability Discrimination Acts, the Children’s Act 1989 and the Human Rights Act 1998.

Clause 4 allows for the general principles to be disapplied. We do not consider it acceptable that principles can be disapplied for a certain category of patients, or where they are deemed 'inappropriate' or 'impractical'; nor that they can be excluded from applying to functions of the Secretary of State in making certain regulations or directions. This gives the legislator the power to stigmatise service users from the outset. As Professor Richardson has said, “*Principles do not have to be absolute to be effective*”,<sup>7</sup> and the Joint Committee has taken the view that “*the legal principle of proportionality will ensure a degree of flexibility when fundamental principles are in conflict*”<sup>8</sup>

### **Alliance position**

In our view the ten principles below need to be in place on the face of the Bill.<sup>9</sup> Each principle carries equal weight. Implicit within these principles is the notion that therapeutic benefit is derived by patients.

<sup>6</sup> Report of the Joint Committee on the Draft Mental Health Bill, 2005. Volume I p. 24, para 63

<sup>7</sup> Professor Geneva Richardson, Report of the Joint Committee on the Draft Mental Health Bill. Volume II, 20 Oct 2004. Ev.4.

<sup>8</sup> Report of the Joint Committee on the Draft Mental Health Bill, 2005. Volume I p.28, para 75

<sup>9</sup> This list has been developed since the Alliance gave evidence to the Joint Committee on the Draft Mental Health Bill to include a principle of ‘child welfare’. The work on principles within the Alliance’s policy group is ongoing.

- I. Patient autonomy
- II. Treatment being provided without recourse to compulsion
- III. Most effective and least restrictive and least invasive alternative
- IV. Reciprocity
- V. Non-discrimination
- VI. Respect for diversity
- VII. A holistic approach
- VIII. Right to information to enable full participation in care and treatment
- IX. Respect for carers
- X. Child Welfare

## I. Patient autonomy<sup>10</sup>

Respect for patient autonomy has been defined as “*the freedom to decide for oneself, the ability to make choices which others will respect*”.<sup>11</sup> The Code of Practice to the 1983 Act expresses the principle as the right to be treated, “*in such a way as to promote to the greatest practicable degree their self determination and personal responsibility.*” This in turn demands that a person’s view of himself or herself, their wishes and preferences must not be overridden without very good reason and if they have full capacity to make choices for themselves those choices must prevail, as they do for people with physical health problems.<sup>12</sup> It follows that patients must be fully involved in decisions about their care and treatment.

Health services increasingly adopt this approach<sup>13</sup> and the law states: “*A competent patient has an absolute right to refuse to consent to treatment for any reason, rational or irrational or for no reason at all even when the decision may lead to his or her death.*”<sup>14</sup> The corollary that advance refusals and advance statements should in general be upheld is gaining recognition.<sup>15</sup>

The Alliance strongly believes that where possible the principles governing mental health care should be the same as those which govern physical health. Any departure from this needs to be justified by a relevant difference between the nature of illness or service provision. The refusal to incorporate capacity as part of a test for compulsory powers promotes discrimination between mental and physical health.<sup>16</sup>

<sup>10</sup> The Expert Committee report recommends a principle of **consensual care** (programmes of care, treatment and support should as far as possible reflect the preferences of the service user, even where intervention in the absence of consent is expressly permitted by law). Whilst the Alliance has not adopted this principle, it is understood in the respect for autonomy principle. *Review of the Mental Health Act 1983*, November 1999, para 37.

<sup>11</sup> *Review of the Mental Health Act 1983*, November 1999, para 2.2

<sup>12</sup> Baroness Hale stated: “*I see the logic of saying that treatment for mental disorder should be no different from treatment for physical disorder. If so, it can only be given with the consent of a capable patient or where it is necessary in the best interests of an incapable one. The use of compulsion also raises some more fundamental questions about discrimination between people with mental disorders and everyone else. Why should the criteria for treatment for mental disorder be different from the criteria for treatment for physical disorder? In other words, why should not this too depend upon consent or incapacity? And why should capacitated people be able to make advance directives about treatment for future physical disorder but not about treatment for future mental disorder? If incapacity were the criterion, rather than the severity of symptoms or the prospect of harm to others, then some people might be given the help they need before their situation became too desperate.*” Paul Sieghart Lecture, 8th July 2004

<sup>13</sup> The recent Government document on choice *Fair for all personal to you* (2003) states “*Our ultimate objective is to improve patient and user experience and build new partnerships between those who use health and social care and those who work in them.*”

<sup>14</sup> *Ms. B (Consent to treatment: capacity) Re* (2002) EWHC 429, Dame Butler Schloss

<sup>15</sup> *R (on application of Burke) v General Medical Council* [2004] EWHC 1879

<sup>16</sup> The Social Exclusion Unit’s report into Mental Health and Social Exclusion found stigma to be the greatest problem faced by people with mental health problems. The Mental Health Act Commission reports, “*Of all mental health patients, none are so stigmatised as those who receive treatment under compulsory powers, because of widespread ignorance and fear regarding the purpose and usual causes of detention under the Mental Health Act 1983.*” MHAC 9<sup>th</sup> Biennial Report p72, para 6.34

This principle is also important because patients should be able to retain as much autonomy as possible even if they are subject to compulsion. The need for compulsion in some aspects of their care does not mean that the person should lose autonomy in all aspects of their lives and decision-making.

Finally, it is important that patients should be able to express their views openly, without fearing that stating their opinions will be misunderstood by others as being evidence of non-compliance or challenging behaviour. This issue is particularly significant for people detained in forensic secure services.

## **II. Wherever possible care, treatment and support should be provided without recourse to compulsion<sup>17</sup>**

Mental health legislation with provision for the use of compulsory powers has a specific role to play in the healthcare of patients with mental disorder, but it should only apply after all other alternatives have been exhausted. There are compelling reasons for this:

- A compulsory admission has been described by many patients as humiliating, deeply stigmatising and traumatic for them and those close to them;
- Use of coercive powers may not be therapeutic and may hinder recovery and the fear of compulsion may drive people away from services;
- A compulsory admission carries immediate legal consequences<sup>18</sup> and it can bring about discrimination in employment and housing;
- Research studies show that patients, service users and carers want to share in decisions about their treatment and care and this results in improved outcomes.

There is also a pragmatic reason for the numbers of people under compulsion to be restricted. The compulsory process is resource intensive. It takes front line staff away from voluntary patients and adds to over-stretched health and legal aid budgets. Legislation that sets a framework for a potential increase in compulsion can therefore exacerbate problems in mental health for patients, staff and the public, rather than diminish them.

## **III. Most effective and least restrictive and least invasive alternative**

This principle is acknowledged in the Draft Bill as one of the general principles to be covered in the Code of Practice. We believe it should be on the face of the Bill. The most effective treatment should be provided in the 'least invasive' manner as well as in the 'least restrictive' manner and environment, compatible with the delivery of safe and effective care and the safety of other patients, carers and staff. Treatment that is provided through psychological interventions such as talking treatments should be promoted as non-invasive and non-restrictive.

Compulsion should not be an alternative to lack of appropriate resources. This may occur, for example, when a patient is unwilling to be admitted to, or stay in, hospital because the fabric of the environment or the level of care has fallen below Department of Health guidance standards.

## **IV. Reciprocity**

Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on health and social care authorities to provide appropriate services, including aftercare. The Government is placing

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<sup>17</sup> The Expert Committee and the Mental Health Act Commission also recommend this principle.

<sup>18</sup> Including implications with relation to the DVLA, insurance providers and public office.

much store in individuals having ‘respect and responsibility’ and we believe that these concepts should be mirrored on the part of mental health and social care services. The Government considers that the Bill meets the requirement of reciprocity but we do not agree. For example, the Bill contains no right to treatment and the provisions for aftercare are extremely limited. The Court of Appeal has recently reaffirmed this principle in respect of aftercare<sup>19</sup> and the House of Lords concurred in deciding that aftercare should be provided free of charge. The Alliance believes that that this principle should include a statutory duty on the authorities to assess the person's health and social care needs and then provide after care services once the person ceases to be detained.

## V. Non-discrimination<sup>20</sup>

The Mental Health Alliance supports the wording suggested by the Mental Health Act Commission: *“All powers under the Act shall be exercised without any direct or indirect discrimination on the grounds of physical ability, age, gender, sexual orientation, race, colour, language, religion or national, ethnic or social origin.”*<sup>21</sup>

We believe that social justice demands fair treatment for all people with mental health problems. In particular, given the extent of discrimination faced particularly by people from black and minority ethnic backgrounds, a statement of non-discrimination would give these groups a basis for confidence in the law.<sup>22</sup>

The Alliance is concerned that mental health legislation should be implemented equally among all groups in society. There is considerable evidence that the current Act is applied more heavily among African and Caribbean people than within other groups.<sup>23</sup> It is vital that the face of the Bill contains a statement about non-discrimination and the promotion of race equality. Beyond such a general statement, each stage of the process must have built-in safeguards for ethnicity. This may include, for example, the provision of advocates from different ethnic groups and who can interpret for those whose first language is not English. It should also be specified that services people are compelled to use must be gender sensitive<sup>24</sup> and culturally appropriate. The detail of these provisions may be best placed in the Code of Practice.

## VI. Respecting diversity

As the Mental Health Act Commission has suggested, the Alliance believes that in particular service users should receive care, treatment and support in a manner that accords dignity and, *“respect [for their] individual qualities, abilities and diverse cultural and religious backgrounds and that properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background, without making general assumptions on the basis of any of these characteristics.”*<sup>25</sup> Examples include: means ensuring that female only wards are made available for all women patients; making patients aware of their right to apply to be moved to another hospital where there is a

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<sup>19</sup> R v Manchester City Council exp Stennett et al (2000) QB 370

<sup>20</sup> The Expert Committee called this principle ‘Equality’

<sup>21</sup> Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev.15, para.1.6.

<sup>22</sup> The Expert Committee supported this principle, but said that it should be in the Code of Practice and not on the face of the Bill. Their reasoning was that non-discrimination followed to the letter would not be congruent with treating people against their will under any circumstances whilst they retain capacity to refuse, whilst it is widely accepted that serious risk of harm to self or others is an acceptable condition for compulsory treatment to be imposed.

<sup>23</sup> For example in *Breaking the Circles of Fear*, Sainsbury Centre for Mental Health 2002

<sup>24</sup> The need for services to be gender sensitive is highlighted in several recent Government documents including: the NSF Mental Health; *Safety, Privacy & Dignity in MH Units 2000*; *Into the Mainstream: The Strategy for Woman's Mental Health* DOH 2002/03

<sup>25</sup> Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev. 17, para 1.6.

greater ethnic mix,<sup>26</sup> or the recognition that Gillick competent children should be empowered to make the same decisions as a competent adult.

## **VII. A holistic approach**

The approach to care, treatment and support in mental health should be holistic, incorporating a service user's social care needs as well as medical treatment. A multidisciplinary approach should be central to patients' care and treatment as provided in the care plan.

## **VIII. A right to information to enable full participation in care and treatment<sup>27</sup>**

Service users should be provided with all the information necessary, in a format they can understand, to enable them, as far as possible, to participate in all aspects of their assessment, care, treatment and support. This information should also be provided in the appropriate format for the patient and take into account those with literacy problems.

## **IX. Respecting carers**

Those members of families, friends or partners, who provide care to service users on an informal basis should receive respect for their role and experience and have their views and needs taken into account. They provide the bulk of care in the community, whether or not the patient lives with them. They have much experience to give to professional staff through their long association with the patient.

## **X. Child Welfare**

The Alliance welcomes the government's recognition that the Bill needs to have special provisions for children. In our view this should form a separate division of the Bill. In addition to being cross referenced to the Principles of the Children Act 1989, mental health legislation should contain an explicit principle about child welfare, and recognition that decision makers take account of the child's wishes and feelings, in line with the White Paper.<sup>28</sup> The latter would mirror the Children Act section 1(3) (a). "*When either informal or compulsory care, and treatment of a child is considered, the child's welfare shall be the paramount consideration. In all decisions relating to a child decision makers shall have regard to the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding).*"

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<sup>26</sup> The latter is one of the recommendations of the Inquiry into the death of David 'Rocky' Bennett.

<sup>27</sup> The Expert Committee is more explicit in calling for a principle of '**participation**' rather than the right to information which might enable such participation.

<sup>28</sup> *Reforming the Mental Health Act 1983- Part I*, Dec 2000, p.15, para 2.10.

### **The Draft Code of Practice must be made available**

The Draft Code of Practice must be made available alongside the Bill in order to fully understand the scope of its provisions and to interpret broad concepts that may or may not be amplified within the Code of Practice. There are numerous examples of vague and general concepts in the Draft Bill that will require further clarification, for example that a patient under a Non Resident Order will be prohibited from “specified conduct”; consultation with patients must not be “inappropriate or impracticable” and a “reasonable request” for an assessment must be acted upon. Therefore it is essential that the Draft Code of Practice must be published at the same time as the Bill. Without further clarification these provisions may lack the certainty required to comply with human rights law.

The Mental Health Act Commission pointed to four key areas with clear human rights implications which will appear in the code rather than the Bill itself, namely:

- a) the principles upon which the law is to be interpreted;
- b) seclusion and restraint;
- c) other control and discipline issues, such as searching of patients or control and confiscation of patients’ property;
- d) consent to treatment issues, including the regard to be given to questions of mental capacity, refusal of consent and advance directives; the framework for consent to psychiatric medication for people subject to compulsion; and the emergency administration of psychiatric medication (for which the Bill proposes no powers, so that the common-law will be relied upon).<sup>29</sup>

As Professor Richardson stated in her evidence to the Joint Committee: “*You are going to be in a very difficult position if you do not have the Codes of Practice or some clear idea of what will be contained in the Codes of Practice, particularly in relation to the relationship between the Mental Capacity Bill and the Mental Health Bill, where a Code of Practice will be available.*”<sup>30</sup>

### **The Code of Practice should be statutorily enforceable**

The status of the Code of Practice is central to the proper safeguarding of patients’ rights under the Bill. As the Mental Health Act Commission has stated:

*“Government therefore has a role through its Code of Practice in providing guidance and standards to ensure that rights are respected by different authorities; to provide transparency and predictability in the operation of the law; and, not least, to help authorities avoid spending time and other resources ‘re-inventing wheels’ in drawing up policies and attending to their own practice.”*<sup>31</sup> Provided that it has an adequate status, detailed issues can be left to the Code of Practice.

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<sup>29</sup> Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev. 13, para 7.3.

<sup>30</sup> Professor Geneva Richardson, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, 20 Oct 2004. Ev. 4.

<sup>31</sup> *Placed Amongst Strangers: Twenty Years of the Mental Health Act 1983 and Future Prospects for Psychiatric Compulsion: Tenth Biennial Report 2001-2003*, Mental Health Act Commission 2003. Page 68, para 6.23

The Alliance believes that the Bill should specify that the Code of Practice is statutorily enforceable. This means that:

- a) compliance with the Code would be binding on practitioners unless there was a good reason to disregard it; and
- b) there should be a formal procedure for its promulgation or amendment.

The Expert Committee decided against recommending that the Code should have statutory force because some parts of the Code operate more as good practice than as details of the implementation of the Act itself. However this may not necessarily be an obstacle if it were clearly stated which parts of the Code were to have statutory force (e.g. seclusion and restraint provisions) and which were to operate as 'good practice'. The Part III Code of Practice of the Disability Discrimination Act 1995 is an example of a Code that successfully combines good practice with interpretation of legal obligations.

A Code which has no enforceable status cannot reasonably be said to fulfil the Government's stated objectives of ensuring patients are lawfully and fairly treated with respect for their human rights. Those with responsibility for administering the new legislation would be able to pick and choose when to comply with the Code at their discretion. Such a "toothless" code is an illusory safeguard which merely creates a mirage of rights protection.

### **Clause 1(2) should be strengthened**

Clause 1(2) of the Draft Bill merely requires people acting under the Act to "have regard to" the Code of Practice. As the Bar Council stated in its oral evidence to the Joint Committee:

*"What it means is that the code of practice is a relevant consideration but the weight to be given to that relevant consideration is for the practitioner to determine. That means that if it says, for example, that one must not carry out searches of patients except in certain specified circumstances, if the hospital has had regard to the code of practice but has decided nonetheless that they are going to go ahead and search, one cannot say that they have acted unlawfully; whereas, if it says on the face of an Act of Parliament that you cannot carry out a search except in these circumstances, if they do, it is unlawful."*<sup>32</sup>

This creates a far weaker requirement than that laid down by the Court of Appeal in *R (Munjaz) v Mersey Care National Health Service Trust and others* and *R (S) v Airedale NHS Trust and others*.<sup>33</sup> The Court ruled that hospitals and professionals are required to follow the Code unless they can show that it is necessary and in accordance with the law not to follow it. This would seem to require that at least, the Code of Practice must be followed unless there is a good reason to depart from it in relation to individual patients. It would not be acceptable to depart from the Code as a matter of general policy. To depart from the Code with no good reason may be a tortious (legally wrongful) act and also may amount to a breach of Articles 3 and/or 5 and/or 8 of the European Convention on Human Rights.

We believe that the phrase "have regard to" should be strengthened by a requirement "to follow the guidance contained in the Code unless warranted by individual circumstances." The Bill should make clear that the Code must be observed by all authorities where there are no such individual circumstances. Where these circumstances do exist, particular departures from the Code should only be permitted in relation to individual patients.

<sup>32</sup> Paul Bowen, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, 3 Nov 2004. Ev.184

<sup>33</sup> *R (Munjaz) v Mersey Care National Health Service Trust and others* and *R (S) v Airedale NHS Trust and others* [2003] EWCA Civ 1036

Breach of the Code should make a decision or action unlawful except where the decision to ignore the code is made in relation to an individual, is documented, and can be justified on this basis. The minimum requirement would be that authorities should record and provide reasons in patients' clinical records for departures from the Code's guidance.

The Joint Committee on Human Rights (JCHR) states in its Report on the 2002 Bill that: *“While the proposed Code has worthwhile objectives breach of the Code of Practice would not seem to make a decision or action unlawful (although the legal status and effects of the Code of Practice are not specified in the Draft Bill, unlike those of the Codes of Practice issued under other legislation such as the Police and Criminal Evidence Act 1984). We note also the Local Authority Social Services Act which obliges authorities to act under the general guidance from the Secretary of State.”*<sup>34</sup>

### **Any amendment of the Code of Practice should be opened to consultation and laid before Parliament**

The Bill should lay down a procedure for amendment of the Code of Practice which involves a duty to consult and a duty to lay the amended Code before both Houses of Parliament. While it is important that the Code of Practice can be updated to reflect changing circumstances we do not think it appropriate for there to be unlimited flexibility and we note the problems caused by the last amendments. We consider that changes must be subject to consultation and be placed before Parliament in order to take effect. A model for this is contained in Section 53A of the Disability Discrimination Act 1995.

In this respect the Draft Bill can be contrasted with section 118(4) of the 1983 Act which obliges the Secretary of State to lay copies of the Code before Parliament and, if either House of Parliament passes a resolution requiring the Code or any alteration in it to be withdrawn, the Secretary of State shall withdraw the Code or alteration. That provision does not exist in clause 1(11) of the Draft Bill, so that the power of Parliament to compel an amendment to the Code of Practice is significantly reduced. We suggest that consideration be given to incorporating section 118 (4) into the Bill.

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<sup>34</sup> 25<sup>th</sup> Report of the Joint Committee on Human Rights, Session 2001-02: Draft Mental Health Bill, 11 November 2002, HL 181, HC 1294, para 21

Human rights compliance is an essential part of Alliance policy and we have never restricted this policy to the state of existing case law from the European Convention of Human Rights (ECHR). We include within our understanding of human rights all standards adopted at an international or regional level, either as binding obligations on the UK or as declarations of principle.

### **Expert commentators have given evidence indicating that it is unlikely that the Bill will fully meet the requirements of the Human Rights Act 1998 (HRA).**

The recommendations of the Joint Committee on Human Rights (JCHR) have not been heeded in the 2004 Draft Mental Health Bill. We draw attention to their views on the status of the Code of Practice, the power to disapply principles, the lack of exclusions, the power to override advance directives and the danger of preventive detention.

### **Preventive detention**

In the view of the JCHR, it is questionable whether the non-therapeutic detention of persons without conviction of an offence, on the grounds of *“speculation about possible future behaviour and resulting risk to identified persons”*, will be compatible with the HRA. The JCHR noted in its report that explicit powers of preventive detention established by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 had been deemed compatible with the (ECHR) Article 5 by the Judicial Committee of the Privy Council, but pointed to the fact that these powers related only to restricted patients who have been convicted of serious offences and set no clear precedent for patients who have had no contact with the criminal justice system.

### **Definition of mental disorder**

It is possible that the wide definition of mental disorder combined with the vagueness and breadth of the key concepts (for instance “appropriate”, “for the protection of”, “treatment”; “all the circumstances of his case”) lacks sufficient certainty to comply with the requirement that loss of liberty must be in accordance with the law. A person must be able to know whether s/he falls within its ambit. We agree with the Bar Council<sup>35</sup> that the criteria for the imposition of detention and compulsory treatment are too vague, the threshold for such imposition is too low and the safeguards against arbitrariness too weak to comply with the provisions of Articles 5 and 8 of the ECHR.

### **Compulsory treatment of competent (capacious) patients without consent**

Recent case law has raised squarely the rationale of the distinction in the law between physical and mental health. People with physical illness may, in all circumstances however serious, refuse treatment if they have capacity to make the decision to do so, but people with a mental disorder do not have that right. To force treatment upon a person with mental ill health can involve force and is inherently demeaning. In some

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<sup>35</sup> Bar Council, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev. 175 para 1 and 3.

circumstances this may violate Articles 3 and/ or 8 and/ or 14 of the ECHR and is certainly contrary to international human rights standards.<sup>36</sup>

### **Criminal justice provisions**

The disproportionate response to people who pose a significant risk to others (by providing that they can be detained despite their willingness to receive treatment),<sup>37</sup> the discriminatory impact of the law for those within the criminal justice system, the powers of the Tribunals to impose the equivalent of civil restriction orders and the power to defer release of patients for 8 weeks may in some cases breach article 5(4) and article 14 of the HRA.

### **Role of Home Secretary**

The Home Secretary has retained the power to order leave or transfer restricted patients and this is likely to be in breach of the HRA.<sup>38</sup> We believe that the retention by the Home Secretary of this power is in any event undesirable. Leave and transfer to lower security accommodation are used as steps towards discharge for patients who are seen to be dangerous. Since the Act will require the legality of a detention to be subject to a judicial decision, we consider that it is only fair that this should also apply to the preliminary decisions towards discharge.

The Bar Council have commented that the Draft Mental Health Bill appears to: “*Violate core human rights values*” and “*fails to set the standards by which civilized nations should treat this vulnerable and stigmatised group.*” They highlight many areas of concern including the following ones:

- The absence of any reciprocal right to treatment of a minimum standard and in appropriate conditions and to suitable aftercare is incompatible with international human rights standards and may violate Articles 5 and 8 of the ECHR.
- The absence of any power in the Mental Health Tribunal to order a patient to be transferred to another hospital or to be given leave of absence in the face of objections from the patient’s doctor or (in restricted cases) the Home Secretary effectively neutralises its function where transfer to lower conditions of security or leave of absence are a necessary precondition to discharge, potentially in breach of Articles 5(4) and 8.
- Inadequate protection is given to the residual rights of detained patients in relation to issues such as seclusion, searching, visiting, access to personal possessions, computers etc, potentially in breach of Articles 3 and 8.<sup>39</sup>

The HRA is a “living instrument” which changes its interpretation over time. There are indications that case law may decide that if treatment is forced on people with capacity to

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<sup>36</sup> The issue is most comprehensively dealt with in *R on the application of b v the Secretary of State for the Department of Health* [2005] EWHC 86 (Admin)

<sup>37</sup> Article 5 cases such as *Litwa v. Poland* and *Pretty v UK* (both cited by Fennell in *Mental Health Law and Human Rights* CCELS, 2004) show that proportionality applies to Article 5 and Article 8 cases.

<sup>38</sup> We are indebted to Professor Genevra Richardson, *Mental disorder and the European Convention* Speech to the British Institute of Human Rights, December, 2002 for raising this issue.

<sup>39</sup> Bar Council, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev 176 para 6.

make their own decisions<sup>40</sup> when they do not present a serious threat to others article 3 and article 8 could also be engaged.

Recent case law from the ECHR demonstrates that early case law can not be relied upon. In *Keenan .v. UK* the court stated: *“For example, in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3. Similarly, treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be capable of pointing to any specific ill-effects.”*<sup>41</sup>

Professor Graham Thornicroft has commented that most of the principles seen as fundamental to good practice in mental health in the relevant national and international policies are neither explicit nor implicit in the Draft Mental Health Bill:

*“In so far as the implicit principle of safety is given salience in the Bill (in relation to risk assessment and risk management), for the whole range of mental disorders, this is likely to reinforce common and stigmatising stereotypes that associate mental illness and violence. This conflicts with the principles of participation, autonomy and empowerment, and dignity. It is also in direct conflict with the policies contained in the Government’s recent policy paper by the Social Exclusion Unit”*<sup>42</sup>

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<sup>40</sup> *R (Wilkinson) v RMO Broadmoor Hospital* [2001] EWCA 1545; [2002] 1 WLR 419

<sup>41</sup> European Court of Human Rights- *Keenan v United Kingdom* (2001) 33 EHRR 38.

<sup>42</sup> Professor Graham Thornicroft, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev 661 para 3.8

## Issues Relating to Black and Ethnic Communities

British society is both multicultural and multiracial, and from this comes the need for mental health legislation that reflects and acknowledges vital issues around 'culture' and 'race', and counteracts institutional racism.<sup>43</sup> The Alliance believes there is a need for an appropriate multi-cultural approach to mental health that aims to provide the creation and delivery of racially and culturally appropriate mental health services.

It is well documented that people from BME communities, and African Caribbean's in particular fare worse under the mental health system. African Caribbean men are five times more likely to be detained on locked wards and are six times more likely to be sectioned under the Mental Health Act 1983 despite having similar rates of mental ill health as other ethnic groups.<sup>44</sup> There is a history of misunderstanding and discrimination when it comes to the use of compulsory powers against African Caribbean's.<sup>45</sup> This 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's are more likely to be misdiagnosed and diagnosed with psychotic conditions and treated using medication, which is often of a higher dosage. Culturally appropriate and acceptable behaviour has also been wrongly construed as symptoms of abnormality or aggression. The recourse to advocacy, tribunals and to appropriate care packages has been slow to positively impact this group.<sup>46</sup>

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

*"There is a history of misunderstanding and discrimination, we would say, when it comes to the use of compulsory powers in the mental health system. There are very complicated reasons as to why that has happened. We are more interested in stopping that happening in the future, and we are concerned about the Bill, as currently drawn, not stopping that in the future."*<sup>47</sup>

### **Principles**

The Alliance believes that the principles of equality, non discrimination and respect for diversity should be included in the Bill and should be in the body of the legislation without any method of dis-application. This will remind professionals when taking important decisions under mental health legislation of the need to give respect to the qualities, abilities and diverse backgrounds of individuals and the need to avoid making general assumptions on the basis for example of ethnic cultural and religious stereotypes.

This should be part of a wider Government commitment to joined-up thinking across departments to ensure that the Bill is linked to other Government initiatives and anti

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<sup>43</sup> Home Office (1999) *The Stephen Lawrence Inquiry Report*

<sup>44</sup> Office of the Deputy Prime Minister, (2004) *Mental Health and Social Exclusion Report*

<sup>45</sup> Sainsbury Centre for Mental Health (2002) *Breaking the Circles of Fear*, SCHM

<sup>46</sup> Songhai, written evidence to the Joint Committee, (2004), EV 1060

<sup>47</sup> Chinyere Inyama (mental health lawyer) oral evidence to the Joint Committee Q872

discrimination legislation, such as the Race Relations Amendment Act, the Disability Discrimination Act, the Children Act and the Sex Discrimination Act.

### **Dangerousness**

We are concerned at the draft Bill's emphasis on the perceived 'risk to the public' and 'dangerousness', in particular the conditions for compulsion and the determination of what is called 'substantial risk of causing serious harm to other persons', will impact disproportionately on people from BME communities.<sup>48</sup>

Previous inquiries have shown, race is often seen as an index of dangerousness. In 1993 there was a major inquiry into the death of three Black men at Broadmoor Hospital, it highlighted the perception of those delivering health care in the mental health system about race as an index of dangerousness.<sup>49</sup> In 2003, with the death of David Bennett, the inquiry report made similar sentiments; and again in May 2004 with the death in similar circumstances of a young Asian man, Azrar Ayub in Manchester.

The Alliance supports the concerns expressed by the National Black and Minority Ethnic Mental Health Network:

*"The Bill's emphasis on the perceived risk to the public chimes with popularly held stereotypes of 'threat' and 'dangerousness' applied to mental health service users, particularly those from BME communities.... The potential for risk assessments to be influenced by stereotypes of 'dangerousness', particularly where African-Caribbean men are concerned makes this provision worrying."*<sup>50</sup>

### **Advocacy**

The right to advocacy is particularly important in the cases of people from BME communities. We consider the right should be for patients to have access to appropriately trained advocates and that training should include training in cultural diversity. Therefore in appointing advocates the appropriate authority should be obliged to appoint a sufficient number of people from diverse communities with adequate training.

### **Non resident orders (NRO)**

We believe non resident orders will disproportionately affect African Caribbean service users and will exacerbate the current over representation of Black people in the mental health system.

The Government's proposals for non resident orders are contrary to the spirit of their attempts to eradicate the ethnic inequalities within the mental health system through strategies such as Delivery Race Equality. The success of such strategies depends on the development of trust and co-operation of African Caribbean communities using and working with mental health services, which is likely to be undermined by the introduction of non resident orders as currently set out in the draft Bill.

We sympathise with the views expressed by Dr Kwame McKenzie: *"Who will have one of these community treatment orders? Clearly people who are not ill enough to be in hospital, people who see things differently from their psychiatrist, people who have a*

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<sup>48</sup> Clauses 9 (7) and (8)

<sup>49</sup> HMSO (1993) *Big Black and Dangerous: Report of the Committee of Enquiry into the Death in Broadmoor Hospital of Orville Blackwood. Review of the Death of Two other Afro Caribbean Patients.* HMSO.

<sup>50</sup> Written evidence to the Joint Committee DMH 241

*different culture and belief on their treatment than their psychiatrist, people who are not satisfied with their treatment and want an alternative. Research shows us that people from minority groups in the system are more likely to fit this description. Because of this you will be more likely to be on an NRO if you are from a black and ethnic minority group”*<sup>51</sup>

However, if the Government does decide to press ahead with the introduction of non resident orders we would like to see safeguards to ensure that people from African Caribbean communities are not disproportionately subject to these provisions on the basis of stereotypical views and institutional racism.

## **Criminal Justice System**

The Alliance is opposed to the new police power to enter premises and forcibly remove a patient from their home without a warrant. We believe it is highly likely that this power will be disproportionately used against African Caribbean communities who are already subject to over policing and further damage the relationship between BME communities and the police.<sup>52</sup> Black people are six times more likely and Asian people almost twice as likely to be stopped and searched by the police as white people.<sup>53</sup> In light of the negative experiences of people from African and Caribbean communities have with the police these additional powers would further disadvantage them.

We are also concerned by the use of police stations as a '*place of safety*'; for example Mind estimates that, despite the Mental Health Act Code of Practice stating that police cells should generally not be used in practice, police cells are used in about 80% of occasions when section 136 powers are evoked.<sup>54</sup> This is particularly concerning given that this will disproportionately affect people from BME communities.

The Stephen Lawrence Inquiry exposed the institutional racism within the Metropolitan police service across England and Wales, and also acknowledged that the police, particularly custody officers, do not have adequate training, if any, about mental health issues and especially when a person is distressed and causes disturbed behaviour<sup>55</sup>.

## **Tribunals**

Membership of the MHT does not specifically include people from black and ethnic minority groups and we believe this is crucial to ensure that the Tribunals are able to take full account of a person's culture and circumstances, e.g.:

- the degree of involvement with both the culture of origin and the host culture, taking special recognition of language abilities and preferences
- the predominant idioms of distress through which symptoms or the need for social support are committed, e.g. possessing spirit, somatic complaints, inexplicable misfortunes
- culturally relevant interpretations of social stressors, social support, levels of functioning disability
- cultural elements of the relationship between the individual and the clinician and the problems these may cause in diagnosis and treatment.

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<sup>51</sup> *Joint Committee on the Draft Mental Health Bill: Evidence EV 554*, Supplementary memoranda from the BME Network (DMH 445), *Addendum Three: Diverse Minds*. Contribution by Marcel Vige, Diverse Minds Manager.

<sup>52</sup> The 1990 Trust, (2004) *Stop and Search: A community evaluation of Recommendation 61 in the London Borough of Hackney*. A study conducted for the Metropolitan Police Authority

<sup>53</sup> *Race and the Criminal Justice System: an overview to the complete statistics 2003/2004*(Home Office 2005) (statistics from section 95 of the Criminal Justice Act 1991)

<sup>54</sup> Lord Adeboule – Q875 Evidence to the Joint Committee

<sup>55</sup> Home Office (1999) *The Stephen Lawrence Inquiry, McPherson Report*, Home Office.

We therefore recommend that Tribunals should include BME representation where appropriate. This is especially important considering that under the 1983 Act, African-Caribbean people are more likely to be detained and receive higher doses of medication than the population as a whole. We recognise and welcome that the Expert Panel will include people with experience in ethnic minority issues but there is a danger that such issues will be seen to be of secondary importance or treated in a superficial way unless Tribunals include BME representation.

### **Current Law**

In the 1983 Act, mental disorder is sub-divided into four categories:

- mental illness;
- mental impairment;
- severe mental impairment; and
- psychopathic disorder.

The category of mental illness is the diagnosis identified in the overwhelming majority of formal admissions under the 1983 Act and is not defined. In 2001 roughly 98 per cent of people detained for treatment under section 3 were categorised as mentally ill. The absence of a definition, along with guidance from the Courts, has enabled a practical and developmental use of the category to ensure that when patients are described as mentally ill it is in line with developing practice.

In relation to learning disability, the definitions in the current Act for mental impairment and severe mental impairment include the requirement for the person to have "abnormally aggressive or seriously irresponsible conduct" in addition to having a learning disability.

The 1983 Act also excludes certain behaviours from being seen in themselves as mental disorders. These are promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

### **2004 Draft Mental Health Bill**

The Draft Mental Health Bill defines mental disorder as "an impairment of, or a disturbance in, the functioning of the mind or brain resulting from any disability or disorder of the mind or brain".

The Draft Mental Health Bill has no exclusions.

### **Alliance position**

#### ***The Alliance accepts a broad definition of mental disorder but only alongside strict conditions for compulsion***

The Alliance agrees in principle with the replacement of the 1983 definition of mental disorder by a broad definition in the 2004 Draft Bill. The new definition is said to focus on the effect (the presence of psychological dysfunction) rather than the cause (disability or disorder). The Alliance, however, doubts that the redrafting achieves this aim.

The broad definition of mental disorder would include neurological and other causes of brain dysfunction including intellectual impairment, head injury, multiple sclerosis, learning disabilities, people on the autistic spectrum and people with drug and alcohol dependence. Whilst it is clear that this definition would not result in any inappropriate exclusion it undoubtedly gives the potential for serious over-inclusion. This appears to be in conflict with the principle of least restrictive alternative. We believe that the broad definition of mental disorder in the Draft Bill would only be satisfactory if combined with extremely tight conditions and limitations, including exclusions conditions.

As the Bar Council stated in their evidence to the Joint Committee:

*“The ‘first ‘relevant condition’ includes a definition of mental disorder that is very broad, potentially including those with addictions and learning disabilities. A broad definition is justifiable only if suitable exclusions and other strict threshold criteria are also in place; this was the basis upon which the Richardson Committee proposed a broad definition of mental disorder.”<sup>56</sup>*

### **The Bill must include an exclusion clause**

It is vital that such a broad definition of mental disorder sets some clear boundaries (as is the case in the 1983 Act and the law of other countries including Scotland, New Zealand and Australia) through a series of exclusions. 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 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.

This is supported by the UN’s *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* which requires that: *“No person or authority shall classify a person as having, or otherwise indicate that a person has a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.”<sup>57</sup>*

As Alcohol Concern has put it:

*“We would recommend that it is made explicit that intoxication alone should not be viewed as a mental disorder; it was clearly not the intention that being drunk and being reckless should bring an individual under the scope of the Mental Health Act.”*

*“In addition, the Bill should make it clear that intoxication, although not a mental disorder in itself, should not be a reason to deny an individual assessment under the Act if there is suspicion of other mental disorder. It is important that individuals who are experiencing mental disorder and are posing an acute risk to themselves or others, do not fall through the net of the Act simply because they are intoxicated.”<sup>58</sup>*

Having decided that clinicians have misunderstood the 1983 Act as a bar to the detention of persons with problems of substance misuse, the Government does not favour exclusions in the new Draft Bill. The Alliance believes that this rationale is spurious.

Existing law does not prohibit treatment of a mentally disordered person who also has other behavioural issues.<sup>59</sup> If the current law was merely misunderstood, the problem could and should be addressed by information and training, and if necessary by a rewording of the 1983 Act.

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<sup>56</sup> Bar Council, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev. 176 para 11.2.

<sup>57</sup> Principle 4 (5), *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* Adopted by General Assembly resolution 46/119 of 17 December 1991

<sup>58</sup> Alcohol Concern, *Report of the Joint Committee on the Draft Mental Health Bill, Volume III*, Nov 2004. Ev.1056, para 1.2-1.3.

<sup>59</sup> *W (a patient) v Secretary of State for Scotland* (Times April 21 1999) made clear that, “the provisions meant that a person could not be detained by virtue of a sexual deviancy that was unrelated to a mental disorder; but detention was not prevented where the disorder manifested itself in deviate sexual behaviour”.

For instance:

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*A person shall not be deemed to be suffering from mental disorder for the purposes of the Act solely on the grounds of his:*

- *dependence upon, or use of, alcohol or drugs;*
  - *sexual behaviour or orientation; or*
  - *commission, or likely commission, of illegal or disorderly acts, although the presence of one or more above grounds does not exclude the possibility of concurrent or underlying mental disorder within the Act.*<sup>60</sup>
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Besides, the Mental Health Act Commission points out that there is no evidence that the law is a problem:

*“The Government justification for its proposal to set aside exclusions is that the excluding clause has been widely misunderstood by clinicians as a bar to the detention of persons with drug or alcohol problems under the current law, even in the face of a coexisting mental disorder. We are not aware of strong evidence that the law is the real problem here: it is quite possible that mental health services seek to turn away such persons, or divert them to addiction services, but this may be more to do with practical resource limitations than mistaken ideas about the limit of mental health powers.”*<sup>61</sup>

The exclusions should make clear that:

- a diagnosis of substance or alcohol abuse or sexual behaviour does not preclude an additional diagnosis of mental disorder, even if the primary diagnosis is the former.
- a person shall not be considered as suffering from mental disorder solely on the grounds of the commission, or likely commission, of illegal or disorderly acts

The impact of a broad definition without exclusions could be the over-inclusion of people who do not suffer from a mental disorder, in particular those who have issues of behaviour or conduct. Some service providers have pointed out that, while it may seem unacceptable in principle to put under compulsion a person with drug or alcohol dependence, at least it will ensure that s/he receives treatment and it will assist in the development of these services as a whole. However, legislation should not be used as a lever to improve service provision, nor should people be subject to social control and loss of liberty to get the help they need. Furthermore, the use of compulsory powers over recalcitrant drug or alcohol users will be more likely to backfire than to succeed, as cooperation is a key component of behavioural change. There could also be a confusing overlap between the powers proposed in the Draft Bill and drug treatment and testing orders (DTTOs). For this group there is no substitute for targeted and well-resourced voluntary programmes.

### ***Recommendations of the Joint Committee on the Draft Mental Health Bill 2004***

The Joint Committee agreed with the Alliance’s position on the need for exclusions: *“[W]e also accept the view of the Mental Health Alliance that if exemptions are seen to be misused, that is a matter which should be rectified through training and carefully worded*

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<sup>60</sup> Adapted from the Mental Health Act Commission’s recommendation, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev.19, para 2.5.

<sup>61</sup> Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev.18, para 2.4.

*codes of practice...We conclude that a broad definition of mental disorder in the draft Bill must be accompanied by explicit and specific exclusions which safeguard against the legislation being used inappropriately as a means of social control*<sup>62</sup>

They also supported the Alliance's concerns about the use of mental health legislation for substance misuse. *"We recommend that a specific exclusion on the grounds of substance misuse alone (including dependence on alcohol or drugs) be inserted into the Bill."*<sup>63</sup>

### **The impact of the definition on people with learning difficulties needs to be examined**

The impact of the wide definition is of particular concern for people with learning difficulties. Under the 1983 Act a person with a mental impairment ('being a state of arrested or incomplete development of mind') is only included if their impairment is associated with abnormally aggressive or seriously irresponsible conduct.

In the view of the Royal College of Psychiatrists this issue may also need to be addressed through the exclusion clauses. The College proposes that people with a learning disability should only be liable to compulsion under the Act if they have a mental disorder in addition to their learning disability. This could be achieved by adding to the list of exclusions, "[solely on the grounds of] impairment of intelligence". It is Government policy, as set out in *'Valuing People'* that people with learning disability should access services in the same way as anyone else, and this proposal would achieve that aim.<sup>64</sup>

If the 'impairment of intelligence' exclusion is not included, then the definition of mental disorder in the draft Bill would include almost all people with learning disability, who would then be liable to compulsion at any time they decline medical treatment (including education and training). Leaving aside the serious ethical issues, this would lead to the inappropriate detention of more people with learning disability, and the growth of institutional care. This would not be in keeping with the aims of *'Valuing People'*.

In addition to these exclusions from the definition of mental disorder, other strict threshold criteria are needed in order to make the broad definition of mental disorder acceptable. These are discussed in the next chapter.

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<sup>62</sup> *Report of the Joint Committee on the Draft Mental Health Bill, 2005. Volume I, p.40.*

<sup>63</sup> *Report of the Joint Committee on the Draft Mental Health Bill, 2005. Volume I, p.40.*

<sup>64</sup> *Valuing People: A New Strategy for Learning Disability for the 21st Century, DH, March 2001, p.63.*

## Conditions for Compulsion

### **Current law**

The Mental Health Act 1983 sets out the criteria for compulsory admission to hospital as follows:

- The person must be experiencing a mental disorder of a nature or severity to make admission appropriate;
- If the person is being detained because of psychopathic disorder or mental impairment there must be treatment which will improve or prevent deterioration in the person's condition;
- Voluntary admission must have been refused;
- All options for a less restrictive alternative must be explored;
- Admission must be in the interest of the person's own health or safety, or for the protection of others;<sup>65</sup>
- Persons may not be dealt with under the Act by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

The reduction in the number of hospital beds has made it harder to be admitted to hospital, so people are often admitted at a later stage of a crisis. There have also been a number of high profile incidents where people with personality disorder have been turned away by services because their condition is not treatable and they have then gone on to commit violent crimes. These situations have spurred demand for change to the law.

### **White Paper policy – reduction of compulsion**

*“Grievous is the wrong of unjust imprisonment of an alleged criminal. I apprehend that its colours pale beside the catastrophe of unjust imprisonment on an unfounded finding of insanity. .... It is the effect on the mind sane, even if feeble, that knows itself wrongly adjudged unsound that produces the most poignant suffering.”<sup>66</sup>*

The Government's White Paper of December 2000 states as its aim the reduction of compulsion. The reasons for a reduction in compulsion are compelling. Compulsory admission can be a traumatic experience for the person being admitted, and for those close to them. The fact of compulsory admission can have a damaging effect on the person's condition, and can delay recovery.

### **2004 Draft Bill**

The Bill lists the following conditions:

- A) The first condition is that the patient is suffering from mental disorder.

<sup>65</sup> Compulsory admission can be for assessment (section 2), which can last for up to 28 days; or for treatment (section 3), which can last for up to six months and can be renewed for a further six months initially and for further periods thereafter. Criteria which must be fulfilled for renewal to be lawful include that the treatment must alleviate or prevent deterioration in the patient's condition or, for those suffering from mental illness, that continued detention will prevent serious abuse or neglect. There are also powers to make an emergency admission (section 4), which can only last for 72 hours unless a second medical recommendation is obtained, which converts the admission to one for assessment.

<sup>66</sup> Atkin L.J. *Everett (pauper) v. Griffiths* 1920

- B) The second condition is that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.
- C) The third condition is that it is necessary –
  - (1) For the protection of the patient from –
    - Suicide or serious self-harm, or
    - Serious neglect by him of his health or safety, or
  - (2) For the protection of other persons, that medical treatment be provided to the patient.
- D) The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.
- E) The fifth condition is that medical treatment is available which is appropriate in the patient’s case, taking into account the nature or degree of his mental disorder and all other circumstances of his case.
- F) The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons.<sup>67</sup>
- G) For the purposes of this Part, a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.

### **Alliance position**

While the 2004 Draft Bill has tightened the conditions for compulsion in relation to those set out in the 2002 Draft (which the Alliance welcomes) they remain broader even than those in the current law, let alone those delineated by the Expert Committee. We have not discovered any other developed country with a Mental Health Act which has such an all embracing definition of mental disorder combined with such loose criteria.<sup>68</sup> The Draft Bill provides the legal framework for an increase rather than a reduction in the amount of compulsion.

In particular:-

- (i) The Bill significantly lowers the threshold for compulsion because it simply requires the disorder to be “of nature or degree to warrant...medical treatment” rather than “of nature or degree to *require compulsory detention in hospital*”.
- (ii) There will be increased use of compulsion over people with a mental disorder who are seen to pose a threat, however slight, to others. This also contrasts with the higher threshold for those who are a risk to themselves.

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<sup>67</sup> It should be noted that this deviates from the ‘least restrictive option’ principle.

<sup>68</sup> For a discussion of Canadian jurisdictions see Gray and O’Reilly, *Clinically Significant Differences Among Canadian Mental Health Acts*, Canadian Journal of Psychiatry, Vol.46 No 3, p.315. Of 12 jurisdictions one (Newfoundland) has arguably broader powers: See also the Irish Mental Health Act ; Scottish Mental Health Act(2003); NSW Mental Health Act(1990); S.A. Mental Health Act 1993; Australian jurisdictions.

- (iii) A person who poses a significant risk of serious harm to others would need to be detained despite his/her willingness to receive treatment on a voluntary basis.
- (iv) There is no residual discretion for the decision-makers to not treat a patient compulsorily if s/he fulfils the criteria but has the capacity to accept treatment voluntarily.
- (v) Because the criteria for compulsion are so broad it will be difficult for a patient to establish the grounds for his/her discharge if the clinical supervisor opposes it.
- (vi) Unlike the 1983 Act, compulsory powers can be used for people who are not ill enough to warrant admission to, and compulsory treatment in, hospital but who will be assessed and treated in the community.
- (vii) The broader criteria for “appropriate treatment” fail to require a person to receive a benefit from treatment.

Overall, we believe that this will lead to increased demands on a health and tribunal system that is already over stretched and characterised by patchy services.

**Cases where the law will be practicable due to the loose criteria for compulsion:**

*The depressed woman who fails to keep her appointments with the psychiatrist because she doesn't think the medication is helping her; the woman with a dual diagnosis of drug addiction and depression who is self harming but wants to be left alone to be with her boyfriend; the young woman with learning difficulties whose unruly behaviour is offending the neighbours; the young person with behavioural problems at school and a diagnosis of attention deficit disorder who is aggressive to other children and the school feels that he needs clinical treatment; the man with schizophrenia who, although he has gone off his medication and is hearing voices, is managing to cope with the help of a support group but whose mother is worried he will relapse; a young woman with a borderline personality disorder who is acting aggressively and whose relatives want her out of the way.*

Each of these people may well need supportive mental health services – home treatment, assertive outreach, early intervention, or crisis resolution services- but none of them might be considered ill enough to warrant hospitalisation. However if they refuse to take the treatment proposed for them and come into contact with inexperienced professionals they could be, indeed might have to be, made subject to compulsion. People in this situation tend to disengage from services. Disengagement may mean that someone who, with the appropriate support and treatment, could have been reintegrated back into, and contributed to, society, instead loses that potential and becomes a cost to society.

***The need for hospital***

While we appreciate that community services are being developed to cater for people in crisis we remain persuaded that admission to hospital is an appropriate threshold. We do not believe that compulsory powers should be used for patients who do not need hospital attention at least in the initial stage.

## **Capacity and impaired decision-making**

The British Psychological Society evidence to the Joint Committee states:

*"[W]e note that the Human Rights Act legitimises such compulsion only in the case of "persons of unsound mind". As psychologists, it is axiomatic that being "of unsound mind" equates to being significantly impaired in decision-making—in this case being harmfully and significantly influenced by the mental disorder.*

*We believe that the vast majority of patients currently detained under the Mental Health Act (1983) who have serious mental illnesses would quite clearly be demonstrably and significantly impaired in their decision making because of their mental disorder. We believe that psychologists and psychiatrists already make these judgements frequently in their clinical practice. Therefore, we do not believe that such a criterion would be unworkable in practice.*

*As healthcare professionals, we are naturally distressed when we hear of those very few patients who threaten, or commit suicide and who appear unimpaired in their decision-making. We do not believe that these people should merely be "allowed to kill themselves". We believe that these issues can best be addressed through the provision of appropriate consensual services. We think that all necessary services should be available, offered and assertively provided. Indeed, it is important to stress that the Mental Health Act does not prevent suicide. If it were implemented perfectly, it could not prevent all suicide. Unfortunately, the best quality available treatment frequently does not prevent suicide. We should not bias the Mental Health Act inappropriately away from the principle of autonomy, in a vain attempt to do the impossible.<sup>69</sup>*

## **The conditions for compulsion should include the need to show that the person has significantly impaired decision-making capacity in relation to treatment**

The current Act treats people with mental illness differently from those with physical illness- this is discriminatory. People who are physically ill 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 Expert 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 could not be shown to lack 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.

Dr Tony Zigmond of the Royal College of Psychiatrists has stated: "One of the acknowledged difficulties with the current definition of "incapacity" is that it relies almost

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<sup>69</sup> British Psychological Society, *Report of the Joint Committee on the Draft Mental Health Bill, Volume II*, Nov 2004. Ev. 606-607.

*entirely on a person's ability to think, what we call cognitive ability, and we recognise that in the field of mental health, of course, emotions play a large part, and so at a very practical clinical level we think that the notion of impaired decision-making by reason of mental disorder would be much easier for people to understand and relate to patients with mental health problems and, of course, it would keep us in line with the provisions in Scotland.*<sup>70</sup>

The Scottish Mental Health Act permits compulsion only if the person has impaired decision-making in relation to medical treatment. Under the Scottish Mental Health Act, a compulsory treatment order requires that:

- i. The patient has a mental disorder;
- ii. Medical treatment:
  - a. would be likely to prevent the mental disorder worsening or alleviate any of the symptoms or effects of the disorder;
  - b. is available for the patient;
- iii. If the patient is not provided with the treatment there would be a significant risk to health, safety, welfare of the patient or safety of others;
- iv. Because of the mental disorder the patient's ability to make decisions about the provision of such treatment is significantly impaired;
- v. That making the order is necessary.

This approach was supported by the Joint Committee:

*"We recommend that the Bill, as in the Mental Health (Care and Treatment) (Scotland) 2003 Act, include a condition at clause 9 that by reason of mental disorder the patient's ability to make decisions about the provision of medical treatment is significantly impaired".*<sup>71</sup>

**There should be room for discretion on the part of decision makers, including the tribunal, over whether to subject to compulsion a patient who meets the conditions.**

The Bill makes clear that while there is room for clinical judgement as to whether the person is at risk, or treatment is "appropriate", if the conditions are met there is no residual discretion for the decision-makers (Clause 16). Under the 1983 Act the presence of the conditions permits but does not compel detention, and the absence of a condition does not prohibit it. The British Association of Social Workers has stated that in their view, with the removal of the discretion which at present allows them to take into account the person's capacity and other circumstances of their case, they will be forced to detain, "*very large numbers of people suffering from self neglect caused by drug or alcohol misuse but who retained capacity to make their own decisions and would not be seen as detainable at present.*"<sup>72</sup> Given that hospitals could not cope with the numbers of people involved, examiners would have to use non-resident assessment and treatment even where this was impracticable because of the patient's situation.

In further explaining the situation Roger Hargreaves for BASW said:

*"The discretion can only be exercised to a limited extent within each condition and not globally. In particular, it cannot be used to take into account factors that are not envisaged in the conditions, capacity being one of them, the views of relatives and carers being another. There is very extensive provision in the Bill for consultation with relatives and*

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<sup>70</sup> Tony Zigmond, Royal College of Psychiatrists, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, 27 October 2004, Ev.80

<sup>71</sup> *Report of the Joint Committee on the Draft Mental Health Bill*, 2005. Volume I, p.55

<sup>72</sup> British Association of Social Workers *Report of the Joint Committee on the Draft Mental Health Bill*, Volume II, Nov 2004. Ev..578, para.10.

*carers, but if all the conditions are satisfied and the carers nevertheless say, "We would like to carry on caring", the discretion to allow that to happen does not exist because there is no provision for that to be taken into account. At the moment that is one of the main reasons why ASWs do not proceed with an admission."*<sup>73</sup>

### **The conditions should include the need to show that it is necessary to use compulsory powers in order to effect treatment in all cases**

We disagree with the decision to impose compulsion on those in the more serious category of risk irrespective of their willingness to comply with medical treatment. Case law makes clear that practitioners can impose compulsion on patients whose fluctuating or perhaps self-serving consent (as shown by past history) makes it unreliable.<sup>74</sup> No extension to this should be permitted. It is also unnecessary since professionals can always use compulsory powers if cooperation changes to resistance. If people are partners in their care and treatment, they will take responsibility; coercion where it is not needed disregards personal autonomy and may contravene human rights.

### ***Treatment and notion of therapeutic benefit***

The Alliance supports the inclusion of psychological treatment in the definition of treatment. It is recognised that drug treatment alone may not be the best treatment and is considerably more effective if combined with talking therapy.

However, treatment in the Draft Bill is very broadly defined - to include education and training, habilitation (including social skills) and rehabilitation.<sup>75</sup> This is to take place under an approved clinician who, unlike now, may not be a psychiatrist. With the breadth of the definition as it is, "*a person who is drug-dependent and whose behaviour is anti-social and alarming may be said to have a mental disorder that warrants providing medical treatment, in the form of work training or social skills training, under psychological supervision.*"<sup>76</sup> Coupled with a vague notion of "appropriateness" it will provide any "clinician" with sweeping requirements to detain. What may seem "appropriate" to the clinicians may not be so for the patient.

### **The conditions should state that the use of compulsory powers must have a therapeutic benefit for the patient**

Therapeutic benefit could be defined as treatment which is likely to bring about an "improvement in the symptoms, or signs, of mental disorder, or reduce or prevent deterioration in the person's mental health".

The vagueness of the fourth condition falls short of a requirement to show that the individual will receive some benefit from the treatment. Given the breadth of the concept of treatment we consider it essential to include a concept of benefit. Again this view is supported by the Joint Committee:

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<sup>73</sup> Social Services Inspectorate (SSI) report "Detained", published in February 2001 was based on an inspection of ASW services in 10 local authorities. This found that 35% of patients assessed by ASWs for possible compulsory admission were not subsequently detained in hospital.

<sup>74</sup> *Jones Mental Health Act Manual*, 8th Edition, 2002, p33.

<sup>75</sup> "The court's interpretation of treatment under the 1983 Act is so wide that it has reduced the requirements of the necessary effect of that treatment to the point where it is difficult to exclude anything done to the patient within the hospital from its ambit as long as a person is contained in a therapeutic environment." A. Foster QC, *Treating People: Conflict of Rights* Conference Paper, 15 Oct 2004.

<sup>76</sup> IMHAP, *Report of the Joint Committee on the Draft Mental Health Bill*, Volume II, Nov 2004. Ev..93.

*“We recommend that the Government amend the fifth condition at clause 9(6) of the draft Bill so as to include a test of therapeutic benefit as used in the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003.”<sup>77</sup>*

Without it, the possibility of the Act being used as a form of preventive detention cannot be excluded. It is important to avoid the situation where people with severe personality disorders, deemed to be dangerous, are made subject to compulsion with a view to indefinite containment without a demonstrable benefit to them. The Joint Committee is quite clear that such people should not be dealt with through mental health legislation: *“We conclude that people with serious mental disorders who cannot benefit from treatment pose a very challenging problem, but recommend they be dealt with under separate legislation.”<sup>78</sup>*

It is an unethical use of resources for mental health facilities to be used to warehouse dangerous people. Given the scarcity of hospital beds, this could only occur at the expense of those patients who could be helped but for whom no bed is available. Indeed, Professor Eastman in his evidence argued that one, *“should never use civil powers for preventive detention where there is no therapeutic benefit”<sup>79</sup>* for a number of ethical and practical reasons.

Extra support for this argument can be found from a human rights perspective. Although ministers have made clear their view that their proposals are compatible with human rights legislation, the Alliance believes the Draft Bill’s proposals for non-convicted offenders are particularly open to challenge in this respect. Psychiatric units, if retaining patients they can no longer treat, will be seen as facilities practising a form of social control, rather than health care. Mental health legislation must not be misused for detention simply to address failings of the criminal justice system in containing dangerous individuals. Such extension of an exception to the right to liberty and security was severely criticised by the European Court in the case of *Guzzardi v. Italy* (in which an admitted Mafioso was detained beyond any sentence on the supposed grounds of being a “vagrant”).

Not including a treatability clause would also give too much leeway for disputes between lawyers and clinicians at tribunal hearings. The Expert Committee considered the need to show positive clinical measures which were likely to prevent deterioration or secure improvement in the patient’s mental condition and concluded that *“a health intervention of likely efficacy”* was required.<sup>80</sup>

### ***Risk and Dangerousness***

The Draft Bill is distorted by an emphasis on the protection of others from dangers posed by those with mental disorder. Throughout the legislation the duty to detain dangerous people (i.e. those who pose a significant risk of serious harm) takes precedence over both the human rights of the detainees<sup>81</sup> and the clinical judgment of the decision-makers.<sup>82</sup> As the Joint Committee stated, *“The primary purpose of mental health legislation must be to improve services and safeguards for patients and to reduce the stigma of mental disorder.*

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<sup>77</sup> *Report of the Joint Committee on the Draft Mental Health Bill*, 2005. Volume I, p.50

<sup>78</sup> *ibid.*

<sup>79</sup> Professor Nigel Eastman, *Report of the Joint Committee on the Draft Mental Health Bill*, Volume II, 8 Dec 2004. Ev. 347

<sup>80</sup> *Review of the Mental Health Act 1983*, November 1999, para 5.98.

<sup>81</sup> The right to detain a person who is willing to accept treatment, but also the right to disapply general principles to this group.

<sup>82</sup> By permitting the Tribunal to reserve to itself the power to discharge a patient who has not committed a criminal offence.

<sup>83</sup> The Alliance acknowledges that the protection of others is a legitimate goal of the law. However, we believe that the overemphasis on risk is misplaced and will backfire and far from protecting public safety, it will undermine it.

As the Institute of Mental Health Act Practitioners states:

*“Even if people are inadequately protected from the actions of people who have a mental disorder, this may not be a fault of our laws. It may be due to insufficient resources, poor government, poor service management, poor risk management, faulty practice, a faulty understanding of the law, or simply part of the human condition. In other words, a problem or limitation that is to a significant extent replicated across a world full of different mental health laws.”*

*“Implicit in any discussion about the need for new laws is the assumption that modifying their content modifies outcomes. However, the extent to which this is true is unclear. Legislation is actually a relatively ineffective means of modifying behaviour. Although it can provide a framework for managing violence associated with mental disorder, it cannot significantly reduce these risks. That this is so is clear from the many homicide inquiry reports. Had the professional carers foreseen what was about to happen, they already had power under the present law to intervene. That they did not intervene was due, not to any lack of legal powers, but to the fact that they did not foresee what was about to occur. Yet no amount of new legislation can improve foresight.”<sup>84</sup>*

The Bill bases the need for compulsion on the risk that a person poses to themselves or to others as a result of their mental disorder. In the case of people who pose a risk to others there are two categories- those who need compulsion for the protection of others and those who are deemed to be *“at substantial risk of causing serious harm to other persons.”*

King’s College London states:

*“Thus, the ‘protection of others’ applies to risk which may be substantial but not serious, or serious but not substantial, or neither serious nor substantial. It is thus very unclear what it meant by the ‘protection of others’ and what others are to be protected from.”<sup>85</sup>*

**The Alliance supports the recommendation of the Joint Committee: “We recommend that the criterion at clause 9(4)(b) of the draft Bill be changed to read “for the protection of other persons from significant risk of serious harm.”<sup>86</sup>**

To apply the provisions set out in the Draft Bill, practitioners will need to use very refined tools of risk assessment which are generally impracticable due to time constraints and lack of information and inaccurate when applied to large populations, as opposed to their considerable value in the confined setting of long stay forensic patients in high and medium security hospitals. As the Joint Committee stated, *“Nor are we persuaded that current techniques of risk assessments are so precise and reliable, or seen as such by professionals and the public, as to be reliably used to determine anything other than the most imminent and serious scenarios.”<sup>87</sup>*

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<sup>83</sup> Report of the Joint Committee on the Draft Mental Health Bill, 2005. Volume I, p. 5

<sup>84</sup> IMHAP, Report of the Joint Committee on the Draft Mental Health Bill, Volume II, Nov 2004. Ev.103.

<sup>85</sup> King’s College London, Report of the Joint Committee on the Draft Mental Health Bill, Volume III, Nov 2004. Ev.780, para.2.4.1

<sup>86</sup> Report of the Joint Committee on the Draft Mental Health Bill, 2005. Volume I, p.47

<sup>87</sup> *ibid.*

As the MHAC points out:

*"...it is difficult to arrive at a clear conceptual picture of a patient who may be made subject to civil compulsion "for the protection of other persons" (clause 9(4)(b)) who does not pose, "a substantial risk of serious harm to others", although the Bill appears to intend the latter group as an especially dangerous subset of the former. The courts have interpreted "substantial risk" as a risk that is more than remote and not merely minimal, which we believe should be the standard for any definition of risk that meets the most basic threshold for the civil use of psychiatric compulsion. It is similarly difficult to accept that harm which is not "serious" can, or should be, considered to provide justification for compulsory powers. As such the Bill appears either to provide a wide-ranging exception to the principle of last resort, or, in an attempt to specify a particular group of patients posing a risk to others, extends too greatly the potential meaning of "protection of others" as a basic reason for the civil use of mental health law."*<sup>88</sup>

Much of the application of the Draft Bill hinges on assessing whether a person poses 'a substantial risk of causing serious harm'. However, there are significant problems with current risk assessment tools. These are not sufficiently accurate to ensure that only people who pose an unacceptable danger would be incarcerated under the proposals. Many believe that current methods lack sufficient sensitivity and specificity, but despite this, some people have unrealistic expectations of what they can do. Professor Eastman concluded that; *"it would be wrong to put great store by substantial improvements on risk assessment being on the horizon."*<sup>89</sup>

Furthermore, professionals themselves are sceptical of their ability in predicting risk as Dr Anthony Zigmond clearly stated in his oral evidence to the Committee: *"...the notion of predicting that somebody is a clear danger either to themselves or, indeed, anybody else, I have to say, is rather a fallacious one. My colleagues and I are not good at it."*<sup>90</sup> Professor Nigel Eastman echoed this concern: *"The difficulty with this Bill is that it... suggests that mental health professionals can predict a whole range of events before they happen."*<sup>91</sup>

The most frequently cited principle on risk assessment is that *"nothing predicts behaviour like behaviour."* George Szumkler estimates for example that using the most accurate data available, if 5 per cent of the population of interest is violent, the test will be wrong 92 times out of 100.<sup>92</sup> It would require the unnecessary detention in hospital of between 2000 and 5000 people to prevent a single homicide. Over-reliance on risk assessment may divert scarce resources towards those assumed to be 'high risk' and away from the majority of those with mental illness, who pose no danger. The NHS Confederation reports that around 2000 additional people with personality disorders, currently not liable for detention, will be eligible under the Draft Bill.<sup>93</sup> At the same time it will be ineffective since there is no reliable way of assessing risk for people who have not yet committed an offence. It will also deter people from seeking help and increase risk for that reason.

Dangerousness is not an enduring trait. It can be exacerbated by some factors and restrained by others and can be modified over time. There is evidence that quality of care

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<sup>88</sup> Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev.22, para. 2.23.

<sup>89</sup> Professor Nigel Eastman, *Report of the Joint Committee on the Draft Mental Health Bill*, Volume II, 8 Dec 2004. Ev. 347

<sup>90</sup> Tony Zigmond, Royal College of Psychiatrists, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, 27 October 2004, Ev.81

<sup>91</sup> Professor Nigel Eastman, *Report of the Joint Committee on the Draft Mental Health Bill*, Volume II, 8 Dec 2004. Ev. 347

<sup>92</sup> George Szumkler: *Risk assessment: 'numbers' and 'values'*, 2003. *Psychiatric Bulletin* 27, p.205

<sup>93</sup> Tessa Crilly, *NHS Confederation Assessment of Implications of New Mental Health legislation on Mental Health Service Organisations Report*, 2<sup>nd</sup> edition, May 2003

makes the biggest difference to offending behaviour. Analysis of 40 homicide enquiries between 1988 and 1997 concluded that in 11 cases (27.5%) violence could have been predicted, but in 72% there had been insufficient evidence to alert professionals. Even more significantly, the findings suggest that *“more homicides could have been prevented by good mental health care which detected relapse earlier (17 cases) than would be averted by attempts at better risk assessment and management (11 cases).”*<sup>94</sup>

### **The Bill will lead to greater stigma attached to mental disorder**

The bias in the Draft Bill reinforces the common but false perception in the public's mind that people with a mental disorder are dangerous. In fact they are broadly speaking about as prone to violence as the rest of the population, although for people with psychotic illness there is a modest increase in levels of violence. Being young, male and of low social status are far more important factors than psychotic illness.<sup>95</sup> In that respect people with mental illness have been unfairly singled out for preventive detention.<sup>96</sup> This is borne out by Taylor and Gunn's research: "That compared with about 40 homicides by the mentally ill per year, the public is at risk from 600-700 offences per year recorded as homicide"<sup>97</sup> and by other studies in the UK and abroad. We question whether the provisions in the Bill are a proportionate response to the issue that Government wants to address, i.e. protecting the public from around 40 homicides a year by detaining thousands of people.

It will particularly stigmatise people with personality disorders, most of whom live safely in the community but who may be wrongly labelled as being dangerous.<sup>98</sup> The NIMHE Personality-Disorder Capabilities Framework states: *"In recent years, the emphasis on risk and dangerousness associated with a very small number of people with a personality disorder has obscured the fact that very many people with the diagnosis are highly vulnerable to abuse and violence themselves - and to self-harm and suicide."*<sup>99</sup>

Reinforcing such misconceptions only strengthens a vicious circle: negative views in the community deter people from seeking treatment, when we know that seeking help early on a voluntary basis and receiving prompt care is the best way to stop problems escalating and to minimise risk. Both service users and clinicians report that the development of a trusting and non coercive relationship is the most effective way to reduce risk.

Dr Anthony Zigmond considered the issue of risk assessments for mental health professionals in the Royal College of Psychiatrist's evidence to the Joint Committee: *"...the only way that I can generally decide that somebody is a danger to themselves is because they have come to see me, I have interviewed them and they have told me what is in their mind. If they do not do that, I will not know about it; and so any law that drives*

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<sup>94</sup> Munro & Rumgay: *Role of risk assessment in reducing homicides by people with mental illness*, 2000. British Journal of Psychiatry 176, p.116-120

<sup>95</sup> Walsh and Fahy, British Medical Journal, 7 September 2002; with reference to Applebaum, Robbins and Monahan, *Nacro Report on Violent Offenders*, American Journal of Psychiatry 2000, 157;1998

<sup>96</sup> George Szukler: *Mental Health Legislation is now a harmful anachronism*, 1998. Psychiatric Bulletin 22, 662-665.

<sup>97</sup> Taylor & Gunn, *Homicides by people with mental illness: myth and reality* 1999. British Journal of Psychiatry 174 9-14.

<sup>98</sup> The Health Select Committee in July 2000 took this view: *"we are concerned at the use of what could be described as a "quasi-medical" definition [of Dangerous Severe Personality Disorder], which runs the risk of being highly stigmatising for the many people suffering from personality disorder who are not judged by anyone to be dangerous."* *Provision of Mental Health Care Services*, Health Select Committee First Special Report, Jan 2001

<sup>99</sup> NIMHE: *Breaking the cycles of rejection: The Personality Disorder Capabilities Framework*, Nov 2003, citing Paul Moran, *The epidemiology of antisocial personality disorder*. (1999) Social Psychiatry & Psychiatric Epidemiology. 34, 231-242

*people away from the service, I have to say, increases risks for everybody and damages health, and so on; so we need to get people to come and see us.*"<sup>100</sup>

### **The conditions should include the need to show that the protection of others is from "significant risk of serious harm"**

The application of the conditions to people who are at risk of harming others is most worrying. It differentiates between levels of seriousness of risk to others. "For the protection of others" is an extremely broad category embracing emotional as well as physical harm, as demonstrated by interpretation of the 1983 Act. Compulsory powers should not be used in these circumstances. They will particularly impact on people who misuse drugs or alcohol, those with learning disabilities or a personality disorder who react aggressively to attempts to control their behaviour or who have done so on some previous occasion. In the context of a history of misunderstanding and discrimination in the use of compulsory powers on people from black and minority ethnic backgrounds, we can see that it could perpetuate that discrimination all too easily. We note that legislation in other jurisdictions tends to require "imminence" and "seriousness" of harm to others to justify the intervention of compulsory powers.<sup>101</sup>

### **Clause 9(8) should be removed**

Clause 9(8) states that "...a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case."

The purpose of this clause is unclear. It appears to require practitioners to consider risk to others as the overriding consideration. This small group of patients should not be overemphasised in this way- it exemplifies the distorted picture of the nature of mental disorder in this Bill. The Joint Committee considered this clause to be 'obsolete'.<sup>102</sup>

### **The most appropriate place for setting out legislation to deal with issues of dangerousness for those who are accused of an offence is the criminal justice system, not the health system.**

Professor Nigel Eastman has stated: "*I gave evidence to the Home Affairs Select Committee in relation to the DSPD proposals some years ago now, and in front of me Mr Boateng said the problem is that judges will not make enough life sentences. In fact, the Home Office's own paper at that time said that the judges made a life sentence on 2 per cent of occasions when they could make a life sentence, including in relation to people with personality disorder. That rather starkly, if you like, puts the issue. What I said to the Select Committee then, which was rather incautious of me, was that lots of psychiatrists and other mental health professionals in hospitals were saying that the Government essentially were saying "We cannot get the judges to roll over, so let's get the shrinks to roll over."*"<sup>103</sup>

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<sup>100</sup> Dr Anthony Zigmond, Royal College of Psychiatrists, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, 27 Oct 2004, Ev.81.

<sup>101</sup> For instance 10 of (the then) 15 States in the EU specify a level of danger that is "serious", "immediate", "significant" or "substantial"; the US law specifies a higher level of danger -for instance suicidal behaviour or harmful attacks- and provides clear time frames for this behaviour. *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients –Legislation and Practice in EU-Member States*, European Commission, 2002, p23

<sup>102</sup> *Report of the Joint Committee on the Draft Mental Health Bill*, 2005. Volume I, p.53.

<sup>103</sup> Professor Nigel Eastman, *Report of the Joint Committee on the Draft Mental Health Bill*, Volume II, 8 Dec 2004. Ev. 344.

The Alliance believes that, for people with mental disorder who have capacity, criminal law should provide for sentencing options that balance public safety with individual rights. However, we strongly support the general assumption that *“when people break the law, the law takes its course and the disposal at the end of the process may well be influenced by whether there is a mental disorder.”*<sup>104</sup>

The criminal justice system already has adequate options for protecting the wider public from people who have already committed serious violent or sexual offences and are considered dangerous, without recourse to mental health legislation.

- The Criminal Justice and Court Services Act 2000 places a statutory duty on police and probation services to assess and manage relevant sexual, or violent sexual or violent offenders.<sup>105</sup>
- The Criminal Justice Act 2003 gives courts the option of imposing indeterminate sentences and extensions to mandatory life sentences for dangerous offenders, including where the offences relate to mental disorder.<sup>106</sup> Where an offender is found guilty of a serious violent or sexual offence, the Court is obliged to consider the risk of further offences and danger to the public. Courts must assume that there is a risk unless it considers that it would be unreasonable to conclude that there is such a risk.
- The Sex Offences Act 2003 does not specifically mention mental disorder but it does allow for longer sentences for people who commit violent sex offences, some of whom may also have a mental disorder.<sup>107</sup>

In Scotland, separate legislation for offenders provides for indefinite detention for those who may not be treatable. The Mental Health (Public Safety and Appeals) (Scotland) Act 1999 has been upheld as compatible with the European Convention on Human Rights.<sup>108</sup> The Home Office should undertake a review of existing provisions to assess the need for more criminal legislation of this kind.

People with a mental disorder who harm others in circumstances in which they lack the capacity to be responsible for their own actions clearly need the care and protection of mental health law. The conditions we propose (in which an incapacitous patient with a mental disorder who poses a serious danger to others can be detained if there is a therapeutic benefit and if s/he is not accepting treatment on a voluntary basis) together with discretion in the clinician and the development of more robust risk prediction tools are the best way to keep such people engaged but not deter them from seeking help.

### ***Non-resident orders for compulsory assessment and treatment***

The Alliance’s arguments against the provisions for non-resident orders are explained in greater depth elsewhere.

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<sup>104</sup> Professor Tony Maden, *Report of the Joint Committee on the Draft Mental Health Bill*, Volume II, 8 Dec 2004. Ev. 346.

<sup>105</sup> Under the Act, the relevant statutory agency will then refer the individual for an official and initial assessment and then the normal provisions for others will apply. Those already within the prison system will also be able to be referred by the Home Secretary for assessment.

<sup>106</sup> (Part 12, Sections 205-207).

<sup>107</sup> The offences of rape and sexual assault by penetration carry a mandatory life sentence. These provisions ensure that all those convicted of these serious crimes will always be sentenced. Those who are also mentally disordered can only access treatment in hospital via a transfer and not an order.

<sup>108</sup> *Anderson, Doherty and Reid v Scottish Ministers & Advocate General of Scotland*, (2003) 2 A.C. 602

## **We believe that the conditions should include that the patient requires assessment in hospital**

Any form of compulsory order in the community should require narrower conditions for compulsion, be of a finite time and only as ordered by Tribunal when particular criteria are satisfied. These are:

- A history of several previous admissions within a short period of time;
- Impaired decision-making;
- Demonstrated capability of community services to deliver;
- That if there was no order, the person's condition would deteriorate; and
- Capability of the patient to undertake the treatment and supervision required, taking into account his personal circumstances.

## **Conditions for assessment and care of Part 3 patients**

### **The conditions for compulsion under Part 3 are too wide**

The exercise of compulsory powers under Part 3 over people within the criminal justice system is a cause of concern. The conditions for remand or committal for medical treatment are significantly broader than the relevant conditions for compulsory treatment under Part 2. A person can be detained irrespective of whether it is necessary for their own protection from suicide, serious self harm or serious neglect or for the protection of other persons. This applies to people on remand as well as those who have been convicted of an offence.

The Bill's definition of mental disorder, coupled with the wide definition of treatment and the loose criteria for compulsion could have a significant impact on the number of people subject to the provisions of Part 3. As Professor Maden stated: "*I have seen no sensible discussion within the Department of Health of how the mental health services will guard against the wholesale transfer of prisoners, for example – most of whom have a mental disorder – straight into health service beds.*"<sup>109</sup>

## **Discharge from compulsory treatment**

### **The Draft Bill makes it difficult for a patient to oppose detention or to be discharged from a compulsory order**

The vagueness and breadth of the key concepts (for instance "appropriate", "for the protection of", "treatment", "all the circumstances of his case") increase the difficulty for the patient to oppose his/her detention. As Fennell states "*The Tribunal is more likely to respect the view of the supervisor that the patient whose symptoms are in remission is benefiting from medication and that without it he would relapse than the view of the patient that he no longer needs treatment. It is difficult to see what convincing evidence the patient could bring in support of his own position.*"<sup>110</sup>

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<sup>109</sup> Professor Tony Maden, *Report of the Joint Committee on the Draft Mental Health Bill*, Volume II, 8 Dec 2004. Ev.340

<sup>110</sup> Phil Fennell: *Balancing care and control: guardianship, community treatment orders and patient safeguards*, 1992. International Journal of Law and Psychiatry;15(2):p.229.

With the absence of any form of capacity test in the Bill, a non-resident order, once applied, might also be too longstanding in its application. Clinicians are likely to face real pressure to continually renew such powers, forcing patients to remain on NROs almost indefinitely. In addition, just as in the case of treatment administered in hospital, the breadth of the criteria for compulsion may make it difficult for a patient to oppose the renewal of an order successfully if the clinical view is that the medication is keeping the patient well.

The Alliance is also gravely concerned that given the breadth of the criteria, compulsion on grounds of risk to others could last for many years and it will be difficult for a person to satisfy the conditions for their release. The annual right of appeal to a Tribunal will be crucial to keep the period of compulsion to the minimum necessary compatible with public safety.

### **Current law**

Under existing law, compulsory treatment can only take place in an in-patient hospital setting. However, as the Royal College of Psychiatrists points out in its submission to the Joint Committee, treatment in the community under compulsion does occur under the 1983 Act in the following circumstances:

- a) Patients subject to guardianship under the Mental Health Act. They may be required to live in a particular place, to attend a health or social care facility for treatment, or education, or training. Patients subject to guardianship must permit access to health or social care professionals. There is no authority to administer medication in the absence of consent or compliance. There is no authority to convey a person.
- b) Section 25 of the Mental Health Act. This is similar to guardianship other than it can only be applied once a person has already been detained in hospital under a treatment order (section 3 or section 37) but it does include a power to convey patients including the authority to compel a patient to attend a health care or social facility. Again, there is no authority to compel a patient to accept medication.
- c) Section 17 leave of absence. Patients detained under section 2, 3 or 37 of the Mental Health Act may be sent on leave. Whilst they cannot be forced to have medication in the community there may be grounds for recall to hospital if the patient does not comply with their medication. Patients certainly believe they will be returned to hospital if they stop their medication. For practical purposes, therefore, this is a form of community treatment order.
- d) Patients detained under section 37 with a 41 restriction order currently on conditional discharge. Such patients are in the same position as those on section 17 leave, i.e. they have a right to refuse medication whilst in the community but most patients feel they would be ill advised so to do given the authority to recall to hospital.<sup>111</sup>

For some time, the Government has been proposing to allow compulsory treatment to take place in the community, arguing that this may address the issue of repeated re-admissions to hospital and provide a less restrictive alternative to in-patient treatment. It is also hoped that this will further the objective of reducing pressure on scarce hospital beds.

### **Draft Mental Health Bill 2004**

The Draft Mental Health Bill states that there shall be resident (in hospital) and non-resident (in the community) status for people subject to compulsory powers. During the examination stage, if any two of the three examiners decides that a person should not be detained in hospital for the assessment, and if that person falls within a group defined in Regulations, then assessment will take place in the community.

In the case of resident patients there is a duty on the clinical supervisor to keep under review whether it is appropriate for the patient to be detained in hospital. If this is not

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<sup>111</sup> Royal College of Psychiatrists, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004, Ev.60 61

appropriate, then the clinical supervisor must discharge the patient from hospital and specify the conditions to be imposed on the patient as a non-resident patient. The clinical supervisor must consult the nominated person and carers before making this determination. The Mental Health Tribunal can also determine that a patient can be assessed or treated as a non-resident patient.

If the patient is treated in the community a range of stipulations may be made in addition to the requirement to receive medical treatment. These may be requirements that the person concerned:

- i. attends a specified place at specified times;
- ii. resides at a specified place;
- iii. makes himself available for assessment during specified periods; and/or
- iv. does not engage in specified conduct.

Subsequent tribunals would then reconsider individuals' cases and decide whether to repeat or alter the assessment or treatment order. At all stages the clinical supervisor appointed over the person's case has a duty to keep under review whether or not a patient should be a resident or non-resident patient.

### ***Alliance position***

#### **The Government should abandon its current approach to non-resident orders.**

Some members of the Alliance- including service user organisations and voluntary organisations representing service users (including Mind and MDF-The BiPolar Organisation) are opposed to NROs in principle as they believe that to bring coercion into community mental health care is misplaced. However, given the Government's commitment to NROs, the Alliance as a whole has agreed on a minimum set of requirements that would be necessary before any form of NROs could be viewed as acceptable and workable.

The current proposals do not meet these requirements. First, it is necessary to set NROs in the context of the gateway into compulsion (the definition and conditions provisions). Secondly, the provisions in the 2004 Draft fail to ensure that only a limited and strictly defined group of patients could be made subject to community treatment orders. The Draft Bill refers to the use of regulations to limit the group of patients who can be compulsorily assessed in the community without an immediately preceding hospital admission but there is no equivalent provision for a non-resident treatment order.

A clinical supervisor is given unfettered discretion to place a patient under compulsion in the community after the initial period of assessment (which may last no more than a day). Thereafter there are no limits on either Tribunal or clinical supervisor to change a patient's status from resident to non-resident. There is also a power for a nominated person to request to the Tribunal that a resident patient become non-resident, but not the reverse. There is no power to challenge this. There is also a real danger that the facility to switch patients between resident and non-resident status could be led by bed shortages rather than patient needs.<sup>112</sup>

Christopher Heginbotham, Chief Executive of the Mental Health Act Commission, reported to the Joint Committee that under the current Act: *"It is fairly evident that leave is used as a way of managing beds at the moment. Many psychiatric units, particularly in our inner*

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<sup>112</sup> The Alliance is also concerned about the provisions for Part 3 patients. This is argued in the chapter on criminal justice.

*cities, run at over 100 per cent bed occupancy. Beds are allocated to two or three patients simultaneously: one is in the bed, one is in the day room and one is out in the community. This is a very significant problem and we think that the non-resident order arrangement may well be used as a way of managing that.*<sup>113</sup>

The Bar Council has also expressed concern about the failure of the Bill to ensure that community treatment orders are only limited to restricted number of patients: *“The Bill provides no additional threshold criteria for clinicians or the Mental Health Tribunal to determine whether compulsory treatment is to be imposed in the community (as a ‘non-resident patient’) or under conditions of detention (as a ‘resident patient’). The ‘relevant conditions’ in Clause 9 require only that the threshold for treatment under compulsion be reached: but a lower threshold is necessarily required for treatment under a non-resident treatment order than for detention. At the assessment stage, if the examiners decide the relevant conditions in Cl. 9 are fulfilled, detention is automatic: see Cl. 16(5) (and bearing in mind the limited category of patients who are to be eligible for assessment in the community under Cl. 15(2)). See also Cl. 17(3) (emergency patients). At the stage at which the Mental Health Tribunal determines whether to authorise an order for medical treatment (Cl. 46) or further assessment (Cl. 49), no additional threshold criteria is required in deciding whether the patient is to be a resident or non-resident patient (Cl. 46(4), 49(4))<sup>114</sup>. On the face of it that is incompatible with Article 5(1). A contrast may be made, for example, with Cl. 147(6). There should be an additional threshold criteria to the effect that the patient must be treated/ assessed as a non-resident patient unless the examiner/ Tribunal are satisfied that treatment can only be given in hospital and it is necessary for the health or safety of the patient or the protection of the public from harm that he receive the treatment as a resident patient.*<sup>115</sup>

Compulsion in the community is one of the most controversial of the new measures in the Bill. If, as the Government proposes, a person complies with a compulsory care and treatment order they are, in effect, doing so voluntarily because enforcement can only take place in a hospital setting. This throws into question their whole rationale. The research evidence has therefore been considered in depth by the Alliance and a view taken that there is no case for introduction of non-resident orders (NROs) in the Bill as drafted.

### **Service user fears**

Service users fear that NROs will increase their chances of being compulsorily detained if they disagree with the treatment recommended by their psychiatrist. Some consider that when they have been very unwell, hospital provided security because it is a contained environment, with regular monitoring of their condition and any medication. NROs cannot provide this, and consequently give rise to fears that compulsion will be used when people are not severely unwell, or that people who are severely unwell will not be given appropriate and sufficient support to help them through this time. *“If I hadn’t decided to stop taking that medication it would still be ruling my life - and ruining my life. My psychiatrist was of course most unhappy. He was sure I wouldn’t cope”.*<sup>116</sup>

Service users consider the element of control of their home life an infringement of their privacy and potentially a breach of their human rights under Article 8 of the European Convention on Human Rights. They fear the impact on other family members who must

<sup>113</sup> Christopher Heginbotham, Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, 20 Oct 2004, Ev.41

<sup>114</sup> The same criticism may be made of mental health orders imposed by the Crown Court: see Cl. 119(1)

<sup>115</sup> Bar Council, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004, Ev.41, para 11.8

<sup>116</sup> Service user comments (anonymous) Mental Health Bill seminar, held by Mind, 14 October 2004

have the burden of their care in a situation in which they are opposing treatment. One service user stated that he thought his marriage would break down if his wife had to look after him at such times.<sup>117</sup> Another said; "*Treatment when you are ill carries bad memories. I would prefer to associate these with a place that is not my home*"<sup>118</sup>, another: "*To be treated at home and that unwell with lots of people coming in attracting attention. If that were to happen again I don't think I could go home. My home is my castle, my husband, my children. I wouldn't want to ruin that for them again.*"<sup>119</sup>

They also fear that it will be difficult to come off an NRO, even if their mental health has improved, because clinical staff will practice defensively and "play safe" by ensuring treatment is continued. Service users fear that once they are placed on an NRO they might never be taken off, as clinicians might see it simply as a way of maintaining the person's "compliance" with medication. They believe that the security of being in a contained environment, with regular monitoring of their condition and any medication, is the safest option in the circumstances when compulsory powers may reasonably be used. The danger is that these quite realistic fears about NROs will further drive people away from the services and the treatment they need.

### **The Lack of a Capacity Test**

With the absence of any form of capacity test in the Bill, such an order, once applied, will be too longstanding in its application. Clinicians are likely to face real pressure to continually renew such powers, forcing patients to remain on NROs almost indefinitely. In addition, given the breadth of the criteria for compulsion, it may be difficult for a patient to oppose the renewal of an order successfully if the clinical view is that the medication is keeping the patient well.

### **Increase in the use of coercion**

Evidence suggests that these orders will increase the use of coercion in treatment of patients. It has been acknowledged that they can, "*tend to add further coercion to the existing inpatient coercion.*"<sup>120</sup> Studies have shown that when benevolent treatment and coercion operate together, coercion tends to become pervasive and treatment remains nominal. If this result is replicated, it is clearly a serious objection. It could impact most on people from black and minority ethnic backgrounds.

### **Focus on drug treatment**

If NROs are used as an alternative to hospital admission they are more likely to be drug-focused as that is the only treatment that can be effectively enforced. They may therefore increase the number of people on long-term medication who derive no benefit from it.<sup>121</sup> NROs are likely to increase the consumption of medications which may have unpleasant, harmful and in some cases irreversible side effects because people would previously have exercised their right to decline to take them. Non-medical forms of treatment, such as psychosocial interventions, need the person to want the treatment to ensure that s/he engages and actively participates. Compulsion does not encourage this.

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<sup>117</sup> Service user comments (anonymous) Mental Health Bill seminar, held by Mind, 14 October 2004'

<sup>118</sup> Service user comments (anonymous) Mental Health Bill seminar, held by Mind, 14 October 2004'

<sup>120</sup> Hoyer & Fernis: *Out patient Commitment: Some reflections on ideology practice and implications for research*, 2001. *Journal of Mental Health Law* 1, 56-62

<sup>121</sup> Moncrieff & Smyth, *Community Treatment Orders- A Bridge Too Far*, 1999. *Psychiatric Bulletin* 23, 644.

## **Disruption of the therapeutic relationship**

The clinical and therapeutic relationship developed between service users and their professional carers could be damaged by compulsory treatment. This relationship is central to the effectiveness of care and the development of successful engagement with services. Such a relationship may take several years to develop, is often fragile and requires an interactive, and participative approach from the clinician and the service user towards a shared goal of recovery. Introducing an element of coercion into this relationship will increase the likelihood of disengagement from mental health services with the risk of relapse and re-admission to hospital. The supervised discharge amendments to the 1983 Act failed largely because of professionals' unwillingness to implement them. *"From the viewpoint of patients admitted to hospital, the distinction between legal compulsion and voluntary treatment is not always clear. Many informal patients feel coerced, and only a minority are confident of their freedom to leave a ward. If compulsory treatment is extended to the community, it may be that even patients who are not in fact subject to compulsion will feel increased coercion in their relationship with services"*.<sup>122</sup>

## **Use of compulsion in the community**

Compulsion in the community is said to offer a less restrictive environment although some commentators dispute this.<sup>123</sup> However, service users want this principle to apply when deciding whether or not someone should be put under compulsory powers rather than where compulsion should occur. For example, the provision of home support may avoid the need for using compulsion; this is very different from imposing treatment at home under compulsory powers.

Developments for the care of people in the community offer alternatives to hospital admission but we are not persuaded that these should in general be linked to compulsory care. They may indeed substantively conflict with positive approaches to engagement and service user autonomy through new services (such as assertive outreach and intensive home treatment services) for a group of people who have often been unable or unwilling to engage with mental health services. The models upon which they are based emphasise a partnership approach with the users of their services, any element of coercion in that equation serving to provide a mixed message.

## **Research evidence of overseas experience**

We have benefited from discussions with overseas experts. Professor Dawson, an international expert who is not opposed to community treatment orders (the commonly accepted term), nonetheless stated at a seminar in London in 1992 that in his view the conditions for success were not in force in the UK.<sup>124</sup> They include:

- Tight criteria for compulsion;
- Well-established community service provision geared towards high-risk groups;
- Public liability insurance; and
- Effective enforcement mechanisms.

The Government points to the reported benefits of community treatment orders in New Zealand and Australia. The Alliance disputes this finding. It is relatively rare for patients to

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<sup>122</sup> Graham Thornicroft, *Supervision and Coercion Studies in Shaping the new Mental Health Act: key messages from the Department of Health research programme*, 2000 p.16.

<sup>123</sup> Davis. *Autonomy Versus Coercion: Reconciling competing perspectives in community mental health*. 2002. Community Mental Health Journal 38, 239-249

<sup>124</sup> Dawson, 2002, *Ambivalence about CTOs*, Institute of Psychiatry IJLP 2003, 243-255.

be placed on a community order in some jurisdictions without first being admitted to hospital because the definition of mental disorder and the criteria are more restrictive in their legislation<sup>125</sup>, and because community services are better resourced and more consistently available than in the UK.

The Orders in overseas jurisdictions are broadly of two types: - those intended to operate after a stay in hospital on a compulsory basis, in order to reduce the chances of readmission and revolving door syndrome, working as a conditional release system (a form of this is in force under the Mental Health Act) and those intended to act as a complete alternative to hospital admission, as a least restrictive alternative. The NRO in the 2004 Draft Bill falls into the first group.

Given the differences between the legal regimes comparison is very difficult, but even in those studies dealing with one jurisdiction the picture remains confused as to whether, and in what circumstances, NROs are effective, and indeed what that might mean for patients' recovery or quality of life. It is also striking that the views of service users do not seem to have been systematically researched. In studies where an arguably positive effect has been found, the community treatment order was combined with extensive community services. A lack of interagency working, communication breakdown, inadequate care planning and poor risk management were more significant issues in a patient's condition than the fact of being on an order.

Evidence shows no significant benefit in terms of hospital admissions. The most recent research found, in a matched-groups study, that community orders in Western Australia did not reduce numbers of hospital admissions or number of days spent in hospital in the year following placement on the order.<sup>126</sup> They further commented that it is impossible to tell whether any beneficial effects are due to the compulsory nature of the order or the increased community services made available. This concurs with most other studies which have shown no significant difference in outcome between provision of well developed services and community based orders.<sup>127</sup>

In conclusion we believe that there is a sufficient evidence base to justify rejecting the proposals in this Bill. These proposals, combining community orders with a wide definition of mental disorder and loose criteria, in an environment in which community services are insufficiently developed and defensive professional practice persists, will not work. The Joint Committee agrees with this saying: "*Non-residential compulsion could be applied to a far wider population than is appropriate, and in circumstances which could be unacceptable.*"<sup>128</sup>

## Is there a way forward?

**Any form of compulsory order in the community should require narrower conditions for compulsion, be of a finite time and only as ordered by Tribunal when particular criteria are satisfied.**

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<sup>125</sup> For example: New Zealand's definition of mental disorder is "an abnormal state of mind shown by delusions or disorders of mood, perception, volition or cognition and; this abnormal state of mind means that either: there is a serious danger to the person's health and safety, or the health and safety of another person; or the person's ability to care for him/herself is seriously reduced". Exclusions: that person's political, religious, or cultural beliefs; or that person's sexual preferences; or that person's criminal or delinquent behaviour; or substance abuse; or intellectual disability.

<sup>126</sup> Preston, N J, Kisely, S, & Xioa, J: *Assessing the outcome of compulsory psychiatric treatment in the community: epidemiological study in Western Australia*, 2002. *British Medical Journal*, 324, 1244-1246

<sup>127</sup> Steadman, H J, Gounis, K, Dennis, D, Hopper, K, Roche, B, Swartz, M, Robbins, P C, *Assessing the New York City involuntary commitment pilot programme*, 2001. *Psychiatric Services*, 52, 330-336.

<sup>128</sup> *Report of the Joint Committee on the Draft Mental Health Bill*, 2005. Volume I, p.70, para.197.

These are:

- A history of several previous admissions within a short period of time;
- Impaired decision-making;
- Demonstrated capability of community services to deliver;
- That if there was no order, the person's condition would deteriorate; and
- Capability of the patient to undertake the treatment and supervision required, taking into account his personal circumstances.

To repeat, some members of the Alliance – including all service user groups - are opposed to NROs in any circumstance. The Alliance recognises that, given the Government's commitment to introducing them, it is necessary to consider how they could be introduced in a constructive manner and with appropriate safeguards. Work by the Royal College of Psychiatrists in the 1980s and 1990s and overseas research gives some credence to the view that there may be a small group of patients for whom repeated access to hospital may not be necessary although compulsion might be beneficial.<sup>129</sup> These patients have multiple compulsory admissions but on discharge they relapse severely because they fail to take the medication which they are considered to need. We recognise that in this small number of cases an NRO may be appropriate as a less restrictive alternative than a long hospital admission.

However both Revolving Doors (see below) and RCN expressed caution about this categorisation in the Joint Committee:

*“Contemporary nursing practice and other disciplines have more to offer and more imaginative ways of assisting individuals than returning them to hospital and close supervision in the way that this is implied. There are ways of working with individuals, carers and families to have a positive impact on what we might call relapse requiring readmission. As a first point there is implicit within here some sort of belief that, if people are properly monitored, they properly consume the drugs for which they are prescribed, they are likely not to be revolving. There is good evidence to show that people who are very compliant with medication still relapse and still become unwell. I do not think it is quite as simple as is implied here... I know there are models of community treatment orders that are argued to be successfully used with a small specific group of clients, but I think the reservation that is strongly expressed by members of the RCN is that this element of supervision and possible coercion could be unhelpful”*

However, it is imperative that there should be more substantive criteria for their application and safeguards for their use and the conditions for compulsion must be narrower than at present. Again, this view is supported by the Joint Committee, who reported:

*“We are clear that for this (i.e. compulsion in the community) to operate satisfactorily it needs to be underpinned by high quality services to support those subject to non-residential orders.”<sup>130</sup>*

We consider that a hospital is a safer environment for the initial exercise of compulsory powers.<sup>131</sup> The decision over whether detention should be in the community or in hospital should be made at the time when the care and treatment order is before a Tribunal. The Tribunal should be guided by strict criteria to limit their discretion.

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For instance, legislation in the Canadian province of Saskatchewan states:

<sup>129</sup> Royal College of Psychiatrists, *Community Treatment Orders: A discussion document*; 1997. 1993 Community Supervision Orders

<sup>130</sup> *Report of the Joint Committee on the Draft Mental Health Bill*, 2005. Volume I, p.73, para.205.

<sup>131</sup> The Expert Committee recommended that there should be a “formal assessment” in the community and a “compulsory assessment” only in hospital. *Review of the Mental Health Act 1983*, November 1999P.51, para 5.25

- i. A person must suffer from a mental disorder, for which he or she is in need of treatment or care that can be provided in the community;
  - ii. In the past two years, the service user must have:
    - Spent at least 60 days as an involuntary in-patient in a psychiatric facility, or
    - Been an involuntary in-patient in a psychiatric facility on three or more separate occasions, (or previously been the subject of a community treatment order);
  - iii. There must be a likelihood that if the person were not to receive treatment while residing in the community, he or she would be likely to cause harm to self or others or suffer substantial mental or physical deterioration as a result of the mental disorder;
  - iv. The services the person requires in order to reside in the community must be available in the community;
  - v. The person is unable to understand and to make an informed decision regarding his or her need for treatment, care or supervision as a result of the mental disorder; and
  - vi. The person must be capable of complying with the requirement for treatment and supervision contained in the order.
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### **Non-resident orders need to be researched further**

The issue of compulsory treatment orders has not been properly analysed by the government. It was not part of the Expert Committee's brief to question their desirability although they did not dissent to their use. Before such a radical shift in policy is introduced we believe that the Government should have undertaken such analysis.

The Joint Committee recommendations dealt with conditions for NROs. These are all welcome limitations on the government's proposals. They include:

- There must be a maximum time limit for treatment under a non-residential order - certainly of not more than three years in any five year period.
- The non-residential order must not authorise the use of force on the patient in the community (i.e. outside hospitals or clinics) beyond the powers currently available in the 1983 Act which provide for a patient to be conveyed to the place he is required to attend for treatment or to be conveyed to hospital. (Paragraph 199)
- We recommend that the provisions for non-residential orders be accompanied by a requirement on health and local authorities to provide adequate care. Further, adequate care means care other than that provided by families and carers, and any provision for non-residential orders must ensure that burdens are not placed upon families and carers that would fall more properly on clinicians, and the health, and social services
- The use of non-residential treatment under compulsion be explicitly limited to a clearly defined and clinically identifiable group of patients. (Paragraph 192)
- We therefore recommend the following series of amendments to the Bill which would focus the provisions of the Bill proper on a clearly defined and clinically identifiable group of patients, for example - patients who frequently relapse - and limit the scope and potential duration of non-residential compulsory treatment. (Paragraph 197)
- The primary legislation and its regulations should provide a robust safeguard against the emergence of any two-tier threshold for imposition of formal powers. (Paragraph 198)

The following parameters for the use of non-residential compulsory powers should be included on the face of the Bill.

- a) A non-residential order should not normally be imposed without previous hospitalisation at least for the purposes of assessment.
- b) There exists evidence of previous responsiveness to, and co-operation with, proposed treatment before a non-residential order is imposed.
- c) Provisions for non-residential orders should be simple and be used to specify only:
  - i. requirements or limitations on a person's place of residence; and
  - ii. medical treatment.
- d) There must be a maximum time limit for treatment under a non-residential order - certainly of not more than three years in any five year period.
- e) The non-residential order must not authorise the use of force on a patient in the community (i.e. outside hospitals or clinics), beyond the powers currently available in the 1983 Act which provide for a patient to be conveyed to the place he is required to attend for treatment, or to be conveyed to hospital. (Paragraph 199)

We recommend that the provisions for non-residential orders be accompanied by a requirement on health and local authorities to provide adequate care. Further, adequate care means care other than that provided by families and carers, and any provision for non-residential orders must ensure that burdens are not placed upon families and carers that would fall more properly on clinicians and the health and social services. (Paragraph 205)

### ***Current law***

The Criminal Justice sections (Part 3) of the 1983 Act have not been subject to detailed scrutiny or public consultation since the Reed Committee Report in 1992. The Expert Committee, which reported to the Department of Health and not the Home Office, was not able to consider Part 3 and stated that this required, "*Far more rigorous and comprehensive consultation and consideration.*"<sup>132</sup> They believed an urgent review was needed and that an independent body should be set up to undertake it in the light of their recommendations. However, this has not occurred. We believe that this is a matter of great regret because mentally disordered offenders and those more generally within the criminal justice system are extremely vulnerable and they also account for many of the people brought within the 1983 Act. They are in contact with the police, the criminal Courts, possibly prison - none of which are specialised in mental health. The new definition of mental disorder has been grafted on to the current provisions in Part 3 of the 1983 Act with very few changes for the purpose of the new draft Bill. While there are some improvements in the procedures for Part 3 patients there are also matters of great concern.

**With this in mind, the Mental Health Alliance believes that there is a need for greater consultation and scrutiny of the criminal justice provisions in the draft Bill.**

### ***Alliance position***

The Alliance shares the concerns of Revolving Doors on the status of Part 3 patients under the draft Bill:

*"Those principles are not lawful because they are going to form part of the Code of Practice, and basically go out of the window when you get to Section 3 ... if you are going to have principles, you are going to have principles and they are going to go through the Bill or they are not. What happens is that once you commit a crime suddenly the risk element goes away and the last resort, in that there is no other option for you to engage with, has to be force because you are refusing to engage. This group want to engage but those services are not there for that to happen. What this Bill is suggesting is that the way ahead is to say, "As soon as you have committed a crime let us compulsorily treat you". I would make it very clear that this is not for our clients at all."*<sup>133</sup>

The Alliance believes that Part 3 of the draft Mental Health Bill should reflect the following principles:

- the conditions for compulsory treatment of an accused person and a convicted person should mirror those available under the civil system.
- Criminal Courts should not be able to make care and treatment orders. These should, in all cases, be made by a Mental Health Tribunal (MHT).
- when considering disposal and sentencing the Courts should base their decisions on the presumption in favour of least restrictive regime.
- people within the criminal justice system should have the right to an assessment of their mental health needs and access to appropriate care and treatment.
- any person who appears to be suffering from a mental disorder should have the right of access to specialist mental health advocacy in a police station.

<sup>132</sup> November 1999. *Review of the Mental Health Act 1983*. Para.15.4

<sup>133</sup> Nick O'Shea, Revolving Doors Agency, Dec 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Ev.366

## **Criteria for compulsion**

The conditions for remand or committal for compulsory medical treatment under Part 3 of the draft Bill are significantly broader than the criteria for compulsory treatment under Part 2. This provides greater opportunities to subject people to compulsory treatment as an alternative or in addition to a criminal disposal.

A person could be brought within the exercise of compulsory powers who is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment and where appropriate medical treatment is available. This is irrespective of whether treatment is necessary for their health or safety or the protection of others. In cases of remand, this would apply even if the person were not subsequently convicted of the offence.

## **We believe that the conditions for compulsory treatment of an accused person and a convicted person should mirror those available under the civil system.**

People within the criminal justice system should only be subjected to compulsory treatment under the same criteria as those available under Part 2 of the draft Bill. The Alliance proposes the following criteria:

- the person is suffering from a mental disorder which is of such seriousness that s/he requires care and treatment under the supervision of specialist mental health services; and
- the care and treatment proposed for, and consequent upon, the mental disorder is the least restrictive and invasive alternative available consistent with safe and effective care; and
- there is a proposed care and treatment plan of direct therapeutic benefit to address the mental disorder; and
- the person has impaired decision making ability by reason of mental disorder and
- it is necessary for the health and safety of the person or for the protection of others from serious harm, that s/he be subject to such care and treatment, and that such care and treatment cannot be implemented unless s/he is compelled.

The Joint Committee agreed to a large extent with the Alliance in their recommendations they state:

*“We recommend that when Courts are considering whether to make a mental health order or hospital direction, there be a requirement that the mental disorder of the offender/patient should be of a nature or degree which makes treatment under compulsory powers appropriate. If the offender/patient is to be resident, then the disorder should be of a nature or degree warranting detention”. (Paragraph 271)*

“We recommend, in the interests of non-discrimination, that the Bill proper and accompanying codes of practice be drafted in such a way as to make clear that Courts, in making a mental health order or hospital direction, should base their assessment on whether the offender's mental disorder renders him a risk to self or others, irrespective of whether that risk could be minimised by a prison sentence. (Paragraph 272)”

## **Remands on bail and to hospital**

### **We welcome the new power to remand on bail for a mental health report**

The draft Bill introduces a new power for the Court to remand on bail for a mental health report. The Court must be satisfied, on the evidence of a single registered medical practitioner, that there is reason to suspect the person is suffering from a mental disorder. The Alliance welcomes this proposal which is consistent with Courts favouring the least

restrictive regime. Although the Courts already have the power under the Bail Act 1976 to attach conditions to a bail order, such as requiring attendance for a mental health report or treatment, we believe this provision will remind Courts of less restrictive alternatives to remanding to hospital.

### **The time limit for remand to hospital for a mental health report should not be extended**

The draft Bill retains the existing power of the Crown Court and magistrates' Courts to remand to hospital for a mental health report and extends this to the Court of Appeal. This must be based on the evidence of a single registered medical practitioner that there is reason to suspect the person is suffering from a mental disorder. The remand will be for a maximum of 28 days and be renewable by the Court at 28-day intervals for up to 16 weeks. This is a substantial lengthening from the current time period of 12 weeks and the Alliance opposes this extension.

### **The magistrate should be satisfied that the person committed the offence before remanding to hospital for a report**

We are concerned that the draft Bill drops the requirement in the 1983 Act that an accused person cannot be remanded to hospital by a magistrate without the bench being satisfied that they committed the offence or if the accused person consents to the remand. We believe this is an important safeguard and should be reinstated.

We also recommend, as did the Joint Committee, that, where a Court wishes to send an offender or person on remand with a mental disorder to a hospital and hospital Trusts cannot agree to which hospital the person should be sent, the Bill contain a duty for the strategic health authority (or authorities, if more than one is concerned) to resolve the dispute.

## **Treatment under compulsion**

### **The compulsory treatment of a patient who has been remanded to hospital for a report should only be authorised under Part 2 provisions**

Under the 1983 Act, when a person is remanded to hospital for a report Part 4 provisions on consent to treatment do not apply. Therefore, the defendant can not be compulsorily treated. This has led to the practice of using Section 2 or Section 3 to run alongside Section 35 (therefore the same definitions and conditions as apply for Part II patients). The draft Bill changes this by allowing the Court to authorise compulsory medical treatment to a person who is remanded for a mental health report based on the evidence of two registered medical practitioners. The Alliance is concerned that these patients will lose the right of appeal to a MHT and that the broader Part 3 criteria for compulsory treatment will be applied. We therefore believe that compulsory treatment should only be carried out under Part 2 where a person has been remanded to hospital for a report.

### **Courts should not have the power to authorise compulsory treatment on a remanded patient**

The draft Bill retains the existing power of the Crown Court to remand to hospital for medical treatment and also allows the Magistrates' Courts to remand or commit someone for medical treatment. This must be based on the evidence of two registered medical practitioners that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment. Appropriate treatment must be available and admission must take place within 7 days. The Alliance opposes this provision, believing that ordinary criminal Courts should not be able to authorise compulsory medical treatment

on a remanded patient. This should only be provided under Part 2, where the narrower criteria for compulsion would be used and the patient would have the right of appeal to the MHT.

### **Treatment under compulsory powers in the community**

The Alliance is extremely concerned about the use of non-resident orders for Part 3 patients. Revolving Doors argued the case in their oral evidence to the Committee: *"We are concerned by the emphasis in this Bill on compulsion and we think that compulsory powers should be used as a matter of last resort. The sorts of clients that Revolving Doors have been talking about very often have very chaotic lifestyles. They need a high degree of support, as has been indicated, from a variety of perspectives, not just from a mental health perspective but also help more generally in accessing services such as housing benefit and so on. In our view these are the types of people who are the most unsuitable candidates for compulsory treatment in the community. Non-compliance with medication and a failure to co-operate with aspects of care and treatment are not a recipe for a successful management structure in the community and we think that people who are so disordered or so mentally ill that they need compulsory treatment require that treatment to be provided in a hospital environment"*.

*"We understand the views of those who think that there is a problem in getting people into hospital, but, in our view, this is not an issue for legislation; this is an issue for resources because one of the key problems is that there is a lack of resources in terms of community mental health services in existence at present. The services provided are variable and patchy. In some areas they are very good; in other areas they are not very good. A lot of these people need much more help than perhaps just a visit from a key worker once a week or once a fortnight. If the resources were provided to give a comprehensive structure of assertive outreach services, crisis teams and so on, we think that it is far more likely that it would be possible to engage with service users on a voluntary basis so that they could be helped to maintain their lives in the community without the use of compulsion and you would only then be talking about a smaller number of people whose illness might deteriorate to the point where compulsory treatment in hospital became necessary."*<sup>134</sup>

### **Orders and Directions**

#### **Criminal Courts should not be able to make care and treatment orders. These should, in all cases, be made by a Mental Health Tribunal.**

The draft Bill provides a power for the Courts to issue mental health orders (MHO) for up to 6 months on a person subject to criminal proceedings. This has replaced the Hospital Order under Section 37 of the 1983 Act. This can authorise the provision of medical treatment as a resident or non-resident patient. The MHO is based on the evidence of two registered medical practitioners and an approved mental health professional that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment and that appropriate medical treatment is available. A care plan must be submitted to the Court by an approved clinician and the Court may appoint members of the Expert Panel to assist it in determining whether to approve the care plan. The Alliance strongly opposes giving criminal Courts the power to issue MHOs. We are concerned about the role of ordinary Criminal Courts in approving care plans and believe they lack the benefit of the experience and expertise of the MHT.

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<sup>134</sup> Sue Kesteven, Revolving Doors Agency, December 2004. *Report of the Joint Committee on the Draft Mental Health Bill, Volume II*, Ev.365-366

The Joint Committee was also concerned about the role of criminal Courts and to the need to avoid discrimination. For instance they stated:

“We recommend that there be a duty on judges to consult a member of the Expert Panel when considering a care plan”.

“We recommend that, when drawing up care plans for patients involved in criminal proceedings, Courts (directly or indirectly via the member of the Expert Panel) and clinical supervisors be subject to the same duties to consult as apply to non-offender patients”.

### **Restricted patients should be entitled to a nominated person and rights for their carers**

We welcome Schedule 8 which provides that unrestricted patients under a mental health order have broadly the same rights to a nominated person and as civil patients under Part 2. Similar duties to consult carers also apply. However we believe that a restricted patient should also be entitled to a nominated person and to consultation with his/her carer and nominated person about his/her care plan.

As Dr John O’Grady stated, *“The Mental Health Act in its draft form at least, in relation to mental health review tribunals, properly puts in three members. It very properly looks at treatment in the wider sense, not just medication but psychological treatment, habilitation, rehabilitation and all aspects of a patient’s care. If it is right for most patients when we look at a care plan to have that level of specific expertise in the mental health review tribunal to address a care plan, why is it different in part three?”*

*“It does not make sense and there does not seem to be any particularly practical reason for it. The Court’s main determination is: is a mental health order the best disposal for this offender and is it in that person’s interests and in the interests of society to proceed in that way? That is their expertise. Why get the Court involved in looking at treatment issues when you have a much better system in the Act in relation to mental health review tribunals? An obvious way of doing it would be to parallel the procedures for part two and simply give the Courts the job of determining the detention and, say, 28 days later asking a mental health review tribunal to address the care plan that the care team draws up. Given that it is a very positive aspect to the Bill that you have mental health review tribunals properly addressing care plans, why not apply that to mentally disordered offenders?”<sup>135</sup>*

### **Decisions regarding restriction orders should only be taken by the MHT**

The draft Bill provides the Crown Court with the power to make a restriction order where it makes a MHO. The special restrictions are that the patient can only be given leave of absence, be transferred to another hospital or be treated as a non-resident patient with the agreement of the Home Secretary. The restriction order must be based on the additional (oral) evidence of at least one of the registered medical practitioners who have already given evidence about the suitability of a MHO that this is necessary to protect the public from serious harm. These are the same grounds that currently exist under Section 41 of the 1983 Act. Under these provisions the Home Secretary’s consent is required for the discharge of restricted patients, granting leave or transferring a restricted patient to another hospital or transferring a prisoner to a psychiatric hospital or vice versa. The Alliance believes it is essential that such decisions are taken by an independent judicial authority, i.e. The MHT.

We believe that the Bill should provide an enforceable right to treatment in the least restrictive environment which is consistent with the needs of the patient and the need to

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<sup>135</sup> Dr John O’Grady, 27 October 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II, Ev.87*

protect the public. The problem of patients stuck in inappropriately high conditions of security is longstanding<sup>136</sup> and while we welcome Government policy to increase the provision of medium and low secure facilities, we consider that these decisions are of such importance to the individual's liberty that they should lie in the hands of the MHT. We concede that Article 5(4) of the Human Rights Act, as currently interpreted, does not require the Tribunal to have jurisdiction to take such essential decisions.<sup>137</sup> Nevertheless, detention of a patient in inappropriate conditions of security may violate their rights under Article 8 of the Act. The Tribunal is best placed to make decisions about the level of security a patient requires having heard all the medical evidence with representations from the patient, and it is both wasteful and unjust not to allow the Tribunal to act upon that information.

We support the recommendation of the Richardson Committee that the Tribunal should have power not only to order a restricted patient's discharge but also to order such steps as are a necessary precondition to the patient being discharged, in particular a power to order transfer between hospitals and leave of absence.

### **The Alliance welcomes the abolition of specified restriction orders**

Under the 1983 Act, restriction orders can be for a specified or unlimited period. The draft Bill only allows for restriction orders of an unlimited period, which can be discharged by the Home Secretary or the MHT. The Alliance welcomes the abolition of specified restriction orders, which according to research were only applied to a small minority of all restriction orders and were often issued against medical advice by the trial judge to introduce a punitive element to treatment orders<sup>138</sup>.

### **Criteria for hospital and limitation directions should mirror the criteria for compulsory medical treatment in Part 2**

The Bill provides the Crown Court with the power to issue a hospital direction when imposing a prison sentence (except where sentence is fixed). The person would be removed and detained in hospital and be subject to special restrictions. To issue a hospital direction the Court must have considered making a MHO before it decided to impose a sentence of imprisonment. The hospital direction must also be based on the evidence of two registered medical practitioners and an Approved Mental Health Professional that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment. Appropriate medical treatment must also be available and admission must take place within 28 days. The Alliance believes that the criteria for these orders should mirror the criteria for compulsory medical treatment set out in Part 2. We welcome the inclusion of a right of appeal to the MHT.

### **The Government should consider re-introducing Interim Hospital Orders**

We are disappointed that the draft Bill makes no provision for Interim Hospital Orders. These have proved a useful option under the 1983 Act to send a convicted offender to hospital initially for up to 12 weeks to assess the treatability of their disorder and the appropriateness of making a hospital order or direction. The Alliance notes that hospital and limitation directions are rarely used at present and suggest that an Interim Hospital Order can be a more useful alternative.

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<sup>136</sup> Department of Health, February 2000. *Report of the Review of Security at the High Security Hospitals.*

<sup>137</sup> *Ashingdane v United Kingdom*

<sup>138</sup> Romilly et al, 1997. *Limited Duration Restriction Orders*, *Journal of Forensic Psychiatry* 8(3).

## **Transfers to hospital**

As under the 1983 Act, the draft Bill provides that offenders can be simultaneously liable to serve a prison sentence and be subject to compulsion. The Alliance believes this issue should be viewed against the assumption that the best place for the treatment of mentally disordered offenders is in hospital (albeit on occasions in a secure facility) rather than in prison.

## **We welcome the power to transfer sentenced persons for a mental health report**

The draft Bill introduces a new power for the Home Secretary to direct the transfer of a prisoner for the purposes of a mental health report for up to 16 weeks. This must be based on the evidence of a registered medical practitioner that there is reason to suspect that the prisoner is suffering from a mental disorder. This can last for up to 16 weeks. The Alliance welcomes this power, which will provide a less restrictive alternative to transfer for treatment.

## **Criteria for transfer for medical treatment should mirror the criteria for provision of medical treatment under Part 2**

The draft Bill also provides that a prisoner can also be transferred for the provision of medical treatment, including those remanded or committed in custody. This must be based on the evidence of two registered medical practitioners that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment and that appropriate medical treatment is available. The Alliance believes that the criteria for transfer should mirror those for the provision of medical treatment those under Part 2.

## **Improvements are needed to the provisions for transfer between prison and hospital**

The Alliance also remains concerned that despite advances in recent years the process of transferring mentally ill prisoners remains slow and characterised by unacceptable delays at each stage of the process. Consideration should be given to reducing the transfer period for sentenced prisoners from 14 to 7 days in line with remands to hospital, time limits on the period between medical recommendations and an increase in the provision of secure units.

## ***Criteria for compulsion***

The conditions for remand or committal for compulsory medical treatment under Part 3 of the draft Bill are significantly broader than the criteria for compulsory treatment under Part 2. This provides greater opportunities to subject people to compulsory treatment as an alternative or in addition to a criminal disposal.

A person who is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment, and where appropriate medical treatment is available, could be brought within the exercise of compulsory powers. This is irrespective of whether treatment is necessary for their health or safety or the protection of others. In cases of remand, this would apply even if the person were not subsequently convicted of the offence.

## **We believe that the conditions for compulsory treatment of an accused person and a convicted person should mirror those available under the civil system.**

People within the criminal justice system should only be subjected to compulsory treatment under the same criteria as those available under Part 2 of the draft Bill. The Alliance proposes the following criteria:

- the person is suffering from a mental disorder which is of such seriousness that s/he requires care and treatment under the supervision of specialist mental health services; and
- the care and treatment proposed for, and consequent upon, the mental disorder is the least restrictive and invasive alternative available consistent with safe and effective care; and
- there is a proposed care and treatment plan of direct therapeutic benefit to address the mental disorder; and
- the person has impaired decision making ability by reason of mental disorder and
- it is necessary for the health and safety of the person, or for the protection of others from serious harm, that s/he be subject to such care and treatment, and that such care and treatment cannot be implemented unless s/he is compelled.

### ***Remands on bail and to hospital***

#### **We welcome the new power to remand on bail for a mental health report**

The draft Bill introduces a new power for the Court to remand on bail for a mental health report. The Court must be satisfied, on the evidence of a single registered medical practitioner, that there is reason to suspect the person is suffering from a mental disorder. The Alliance welcomes this proposal which is consistent with Courts favouring the least restrictive regime. Although the Courts already have the power under the Bail Act 1976 to attach conditions to a bail order, such as requiring attendance for a mental health report or treatment, we believe this provision will remind Courts of less restrictive alternatives to remanding to hospital.

#### **The time limit for remand to hospital for a mental health report should not be extended**

The draft Bill retains the existing power of the Crown Court and Magistrates' Courts to remand to hospital for a mental health report and extends this to the Court of Appeal. This must be based on the evidence of a single registered medical practitioner that there is reason to suspect the person is suffering from a mental disorder. The remand will be for a maximum of 28 days and be renewable by the Court at 28-day intervals for up to 16 weeks. This is a substantial lengthening from the current time period of 12 weeks and the Alliance opposes this extension.

#### **The magistrate should be satisfied that the person committed the offence before remanding to hospital for a report**

We are concerned that the draft Bill drops the requirement, in the 1983 Act, that an accused person cannot be remanded to hospital by a magistrate without the bench being satisfied that they committed the offence or if the accused person consents to the remand. We believe this is an important safeguard and should be reinstated.

We also recommend that, where a Court wishes to send an offender or person on remand with a mental disorder to a hospital and hospital Trusts cannot agree to which hospital the person should be sent, the Bill contains a duty for the strategic health authority (or authorities, if more than one is concerned) to resolve the dispute.

## ***Treatment under compulsion***

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Under the 1983 Act, when a person is remanded to hospital for a report Part 4 provisions on consent to treatment do not apply. Therefore, the defendant can not be compulsorily treated. This has led to the practice of using a Section 2 or Section 3 to run alongside Section 35 (therefore the same definitions and conditions as apply for Part II patients). The draft Bill changes this by allowing the Court to authorise compulsory medical treatment to a person who is remanded for a mental health report based on the evidence of two registered medical practitioners. The Alliance is concerned that these patients will lose the right of appeal to a MHT and that the broader Part 3 criteria for compulsory treatment will be applied. We therefore believe that compulsory treatment should only be carried out under Part 2 where a person has been remanded to hospital for a report.

### **Courts should not have the power to authorise compulsory treatment on a remanded patient**

The draft Bill retains the existing power of the Crown Court to remand to hospital for medical treatment and also allows the magistrates' court to remand or commit someone for medical treatment. This must be based on the evidence of two registered medical practitioners that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment. Appropriate treatment must be available and admission must take place within 7 days. The Alliance opposes this provision and believes that ordinary criminal courts should not be able to authorise compulsory medical treatment on a remanded patient. This should only be provided under Part 2, where the narrower criteria for compulsion would be used and the patient would have the right of appeal to the MHT.

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The Alliance is extremely concerned about the use of non-resident orders for Part 3 patients. Revolving Doors argued the case in their oral evidence to the Joint Committee: *"We are concerned by the emphasis in this Bill on compulsion and we think that compulsory powers should be used as a matter of last resort. The sorts of clients that Revolving Doors have been talking about very often have very chaotic lifestyles. They need a high degree of support, as has been indicated, from a variety of perspectives, not just from a mental health perspective but also help more generally in accessing services such as housing benefit and so on. In our view these are the types of people who are the most unsuitable candidates for compulsory treatment in the community. Non-compliance with medication and a failure to co-operate with aspects of care and treatment are not a recipe for a successful management structure in the community and we think that people who are so disordered or so mentally ill that they need compulsory treatment require that treatment to be provided in a hospital environment"*.

"We understand the views of those who think that there is a problem in getting people into hospital, but, in our view, this is not an issue for legislation; this is an issue for resources because one of the key problems is that there is a lack of resources in terms of community mental health services in existence at present. The services provided are variable and patchy. In some areas they are very good; in other areas they are not very good. A lot of these people need much more help than perhaps just a visit from a key worker once a week or once a fortnight. If the resources were provided to give a comprehensive structure of assertive outreach services, crisis teams and so on, we think that it is far more likely that it would be possible to engage with service users on a voluntary basis so that they could be helped to maintain their lives in the community without the use of

compulsion and you would only then be talking about a smaller number of people whose illness might deteriorate to the point where compulsory treatment in hospital became necessary.”<sup>139</sup>

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We welcome Schedule 8 which provides that unrestricted patients under a mental health order have broadly the same rights to a nominated person and as civil patients under Part 2. Similar duties to consult carers also apply. However we believe that a restricted patient should also be entitled to a nominated person and to consultation with his/her carer and nominated person about his/her care plan.

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*“It does not make sense and there does not seem to be any particularly practical reason for it. The Court’s main determination is: is a mental health order the best disposal for this offender and is it in that person’s interests and in the interests of society to proceed in that way? That is their expertise. Why get the Court involved in looking at treatment issues when you have a much better system in the Act in relation to mental health review tribunals? An obvious way of doing it would be to parallel the procedures for part two and simply give the Courts the job of determining the detention and, say, 28 days later asking a mental health review tribunal to address the care plan that the care team draws up. Given that it is a very positive aspect to the Bill that you have mental health review tribunals properly addressing care plans, why not apply that to mentally disordered offenders?”<sup>140</sup>*

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<sup>139</sup> Sue Kesteven, Revolving Doors Agency, December 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Ev.365-366

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The draft Bill provides the Crown Court with the power to make a restriction order where it makes a MHO. The special restrictions are that the patient can only be given leave of absence, be transferred to another hospital or be treated as a non-resident patient with the agreement of the Home Secretary. The restriction order must be based on the additional (oral) evidence of at least one of the registered medical practitioners who have already given evidence about the suitability of a MHO that this is necessary to protect the public from serious harm. These are the same grounds that currently exist under Section 41 of the 1983 Act. Under these provisions the Home Secretary's consent is required for the discharge of restricted patients, granting leave or transferring a restricted patient to another hospital, or transferring a prisoner to a psychiatric hospital or vice versa. The Alliance believes it is essential that such decisions are taken by an independent judicial authority, i.e. The MHT.

We believe that the Bill should provide an enforceable right to treatment in the least restrictive environment which is consistent with the needs of the patient and the need to protect the public. The problem of patients stuck in inappropriately high conditions of security is longstanding<sup>141</sup>, and while we welcome Government policy to increase the provision of medium and low secure facilities, we consider that these decisions are of such importance to the individual's liberty that they should lie in the hands of the MHT. We concede that Article 5(4) of the Human Rights Act, as currently interpreted, does not require the Tribunal to have jurisdiction to take such essential decisions.<sup>142</sup> Nevertheless, detention of a patient in inappropriate conditions of security may violate their rights under Article 8 of the Act. The Tribunal is best placed to make decisions about the level of security a patient requires having heard all the medical evidence with representations from the patient, and it is both wasteful and unjust not to allow the Tribunal to act upon that information.

We support the recommendation of the Richardson Committee that the Tribunal should have power not only to order a restricted patient's discharge but also to order such steps as are a necessary precondition to the patient being discharged, in particular a power to order transfer between hospitals and leave of absence.

## **The Alliance welcomes the abolition of specified restriction orders**

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## **Criteria for hospital and limitation directions should mirror the criteria for compulsory medical treatment in Part 2**

The Bill provides the Crown Court with the power to issue a hospital direction when imposing a prison sentence (except where sentence is fixed). The person would be removed and detained in hospital and be subject to special restrictions. To issue a hospital direction the Court must have considered making a MHO before it decided to impose a sentence of imprisonment. The hospital direction must also be based on the

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<sup>142</sup> *Ashingdane v United Kingdom*

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evidence of two registered medical practitioners and an Approved Mental Health Professional that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment. Appropriate medical treatment must also be available and admission must take place within 28 days. The Alliance believes that the criteria for these orders should mirror the criteria for compulsory medical treatment set out in Part 2. We welcome the inclusion of a right of appeal to the MHT.

### **The Government should consider re-introducing Interim Hospital Orders**

We are disappointed that the draft Bill makes no provision for Interim Hospital Orders. These have proved a useful option under the 1983 Act to send a convicted offender to hospital initially for up to 12 weeks to assess the treatability of their disorder and the appropriateness of making a hospital order or direction. The Alliance notes that hospital and limitation directions are rarely used at present and suggest that an Interim Hospital Order can be a more useful alternative.

### ***Transfers to hospital***

As under the 1983 Act, the draft Bill provides that offenders can be simultaneously liable to serve a prison sentence and be subject to compulsion. The Alliance believes this issue should be viewed against the assumption that the best place for the treatment of mentally disordered offenders is in hospital (albeit on occasions a secure facility) rather than in prison.

### **We welcome the power to transfer sentenced persons for a mental health report**

The draft Bill introduces a new power for the Home Secretary to direct the transfer of a prisoner for the purposes of a mental health report for up to 16 weeks. This must be based on the evidence of a registered medical practitioner that there is reason to suspect that the prisoner is suffering from a mental disorder. This can last for up to 16 weeks. The Alliance welcomes this power, which will provide a less restrictive alternative to transfer for treatment.

### **Criteria for transfer for medical treatment should mirror the criteria for provision of medical treatment under Part 2**

The draft Bill also provides that a prisoner can also be transferred for the provision of medical treatment, including those remanded or committed in custody. This must be based on the evidence of two registered medical practitioners that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment and that appropriate medical treatment is available. The Alliance believes that the criteria for transfer should mirror those for the provision of medical treatment those under Part 2.

### **Improvements are needed to the provisions for transfer between prison and hospital**

The Alliance also remains concerned that despite advances in recent years the process of transferring mentally ill prisoners remains slow and characterised by unacceptable delays at each stage of the process. Consideration should be given to reducing the transfer period for sentenced prisoners from 14 to 7 days in line with remands to hospital, time limits on the period between medical recommendations and an increase in the provision of secure units.

## **Police powers (Part 7)**

### **The Bill should provide the right to advocacy at the place of safety**

Under the draft Bill the police will continue to have power, currently provided for under Section 136 of the 1983 Act, to remove a person from a public place who appears to be suffering from a mental disorder and in need of immediate care and control, to a place of safety for assessment. The power will as now last for up to 72 hours. A person can also be removed to a place of safety where a magistrate has issued a warrant under clause 400 authorising entry to premises if need be by force. The place of safety can be a hospital or police station. The Alliance believes that the draft Bill should provide the right of access to specialist mental health advocacy from the moment the person arrives at the place of safety, whether it is a psychiatric hospital or police station.

### **The place of safety should, wherever possible, be a psychiatric hospital**

The Alliance is concerned about the use of a police station as the place of safety. This is not a therapeutic environment for someone experiencing mental health problems and could delay the provision of effective treatment. As Lord Adekebowale said in his evidence to the Joint Committee: *“While there are no official figures, we do know that Section 136 could be used as many as 10,000 times a year”*.

*“The detention of people with mental health problems in police cells has hit the headlines, and Nick Hardwick, who is the co-chair of the Police Complaints Commission, estimates that 50% of deaths in police custody have involved people with mental health problems. He puts it quite bluntly: ‘Whatever a police cell is, it is not a place of safety for people with mental illness’. Despite the fact that the current Code of Practice states that police cells should not generally be used, in practice they are”*.

*“Mind estimates that police cells are used in about 80% of occasions when section 136 powers are invoked. This is very relevant to African and Caribbean communities, given the fact that black people are more likely, as you have already heard, to have a negative experience with the police and to be over-policed—without opening up that whole debate again, recalling the McPherson report and the death of Stephen Lawrence, et cetera. Racism aside, it acknowledges that the police, particularly custody officers, do not have adequate training, if any, about mental health issues, especially when a person is distressed and causes disturbed behaviour. To add to that, the Mental Health Act Commission has repeatedly stated in their biannual reports, as many other stakeholders have mentioned, that police stations should not be regarded as places of safety. A police station is not an appropriate place for the care of someone with a serious mental disorder. It is not appropriate for someone to be held there for up to three days whilst arrangements are made for their examination, and the Bill should state that, because we know it disproportionately affects members of BME communities.”<sup>144</sup>*

The Bill should include a requirement that the place of safety must, wherever possible, be a psychiatric hospital.

### **Where a police cell is used as a place of safety, preliminary examination or transfer should occur within a 6 hour limit**

Where this is not possible there must be clear time limits to arrange an assessment and transfer the person to hospital. We welcome the provision in the draft Bill allowing patients to be moved from one place of safety to another, which should mean that patients originally taken to the police station could be moved, if appropriate, to another, more

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<sup>144</sup> Lord Victor Adekebowale, 26<sup>th</sup> January 2005. Evidence given to the Joint Scrutiny Committee.

suitable, setting. The White Paper stated that where a police cell is used as the place of safety there will be a duty on the local Trust to arrange a preliminary examination within 6 hours or to transfer the person to hospital for examination during that period<sup>145</sup>. This was a welcome limit but this has been dropped. The Bill should also address the problem of where assessments are made within 6 hours but the patient remains in the police station awaiting a bed. We therefore suggest a time limit for transfer, if appropriate, to hospital.

### **We oppose the new police power to enter premises and remove a patient without a warrant**

The draft Bill provides a new power for the police to enter premises without a warrant and remove a person suffering from mental disorder. This must be based on the evidence of an Approved Mental Health Professional that the patient is in urgent need of care and control to prevent serious harm to him/herself or to other people, and that the urgency makes their removal under a warrant impractical. The person can be detained at a place of safety for up to 6 hours, which can be extended by a magistrate for up to 72 hours. The Alliance strongly opposes this extension of police powers since we believe it would be open to abuse. It is a fundamental civil rights principle that there should be no power to remove a person from his or her own property without Court authority. If a crime has been committed, the police powers for this already exist.

We are concerned that this power may be used simply to avoid the trouble of obtaining a warrant and this is a potential violation of human rights. Under Section 17 of the Police and Criminal Evidence Act 1984 the police already have the power to enter premises for the purpose of saving life and limb or preventing serious damage to property. We believe this power to be a disproportionate and unnecessary interference with the right to family and private life under Article 8 of the Human Rights Act.

### **Diversion schemes in police stations should be properly funded and developed**

The Alliance recognises the important development of diversion schemes set up in police stations. These have helped to ensure that people can be screened for mental health problems at an early stage and diverted, where appropriate, to the care of mental health services. We call for such schemes to be properly funded and developed in all police stations across the country.

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<sup>145</sup> December 2000. *Reforming the Mental Health Act 1983- Part I*, para 3.84

## Mental Health Act Assessment

### **We believe that the Bill should include a test or safeguards in the Bill to prevent vexatious, malicious or frivolous requests.**

The Bill provides that any person can request, from the appropriate authority, a determination as to whether all of the relevant conditions for the use of compulsory powers “*appear to be met in a patient’s case*” (clause 14 (1)).<sup>146</sup> If the authority determines that all the relevant conditions appear to be met it must arrange an examination.

However, it is difficult to gauge how the appropriate authority will be able to form a view on whether the relevant criteria are met. It is likely that authorities will have to tie up considerable resources responding to requests, some of which may be improperly motivated. For example, it may be used by a neighbour who has a grudge against a person with mental health problems who is behaving strangely or causing minor nuisances. This is of concern to the Alliance and we believe that the Bill should include safeguards against vexatious, malicious, or frivolous requests for an assessment. This is in line with a recommendation of the Joint Committee to the same effect.

### **The Assessment Process**

Proposed changes to the assessment process for treatment under the Mental Health Act raise a number of issues upon which the Mental Health Alliance has developed policy lines. These issues are listed below, and cross-referenced to the relevant chapters of this policy document.

- |  |                         |
|--|-------------------------|
| • Who can make a request for an assessment   | Right to assessment     |
| • Consequences of failure to meet the conditions for treatment under the Mental Health Act   | Right to assessment     |
| • The role of the AMHP in the examination and assessment process in the first 28 days  | Role of the AMHP        |
| • Consequences of meeting the conditions for treatment under the Mental Health Act   | Criteria for compulsion |
| • The role of the advocate at the examination stage  | Advocacy                |
| • The appeal mechanism within the assessment period and the disincentive for the patient to apply for discharge for fear of being placed under a long term treatment order | Tribunals               |
| • Access permitted to the nominated person during the assessment period  | Nominated Persons       |
| • The procedure for non-resident assessment, including the role of the clinical supervisor   | Non-Resident Orders     |

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<sup>146</sup> Department of Health, 2005 *Mental Health Draft Bill*

The Government accepts that compulsory powers should be a last resort. One of the central aims of the National Service Framework for Mental Health is, “*To ensure that each person with severe mental illness receives the range of mental health services they need; that crises are anticipated or prevented where possible.*”<sup>147</sup> For the principle to be matched by practice, the NHS and local authority social services should ensure that a person’s mental health needs are met in a timely fashion. The statistic that one in three people are turned away when they seek help makes clear that this is far from the case at present.<sup>148</sup> The likely result for those denied help is that their condition deteriorates, making compulsion more likely. Indeed, people can end up under compulsion in order to receive services.

The Draft Bill provides that any person may request an assessment for the use of compulsory powers and this triggers a duty on the appropriate authority to make a determination. However the same statutory force is not accorded to a request made for an assessment of a person's health or social care needs. 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.

The Alliance believes that all people with mental health problems should have a statutory right to a comprehensive, holistic assessment of their health and social care needs with a further right to receive services to meet those assessed needs.

Such a principle would:

- Uphold the principle of the least restrictive alternative;
- Encourage preventive care and earlier intervention, avoiding hospital admissions;
- Remedy the imbalance between psychiatric and non-psychiatric care;
- Reduce dependence on medication;
- Make the system more efficient by intervening as early as possible;
- Support carers in looking after people with mental health problems;
- Be more likely to result in positive outcomes; and
- Combat social exclusion.

### **Current Law**

At present, mental health legislation does not give any right to an assessment nor a duty on authorities to address a request. There is a general right to an assessment for people with both physical and/or mental health needs who appear to be in need of services under section 47 of the NHS and Community Care Act 1990.<sup>149</sup> Although this is a duty on social services, the Act also provides that if during the assessment a “*health care need is identified*” the health authority must be notified (although they are not under a duty to respond).

<sup>147</sup> Department of Health, 1999. *National Service Framework for Mental Health: modern standards and service models*, p41.

<sup>148</sup> Rethink (National Schizophrenia Fellowship) 1999. 35% of respondents in the survey conducted. *Better Act Now!*

<sup>149</sup> This provides the right to an assessment where the individual appears to be in need of community care services.

## Expert Committee Proposals

The Expert Committee recommended that in accordance with the principle of reciprocity there should be a duty placed on the NHS and social services jointly to assess and meet the needs of people with mental health problems, with reasons if their needs could not be met.

*It stated that: “The proposed right to assessment would supplement any rights contained elsewhere, e.g. section 47 of the NHS and Community Care Act 1990. It would be a right to assessment in relation to mental health needs. It would apply to those in contact with services who might, for example, believe that their condition is deteriorating, and to those unknown to services who believe that they need an assessment in the interests of their own mental health, safety or for the protection of others. The right would reside in the user or potential user and would impose a duty on the relevant health or social service authority. We did not envisage the right as a personal right enforceable by the user in private law, but rather as a right giving rise to a public law duty on the relevant authority.”*

*“The individual should be entitled to have those needs assessed by an appropriately trained professional and to be told the outcome. The precise details of how the scheme would work would have to be supplied in the Code of Practice, and would have to include a system for recording any unmet assessed needs and the provision of guidance as to how to deal with those who in effect abuse the right.”*

## National Service Framework for Mental Health

### NSF standard 2:

Any service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed; and
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

### NSF standard 3:

Any individual with a common mental health problem should:

- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care; and
- be able to use NHS direct ... for first level advice and referral on to specialist helplines or to local services

## Alliance position

**The Alliance believes there should be a duty on the NHS and the local authority jointly to assess the needs of people with mental health problems.**

We do not agree with the Government that the right to assessment has no place in mental health legislation, and note that it is provided in the Scottish Mental Health Act. The Bill should include a duty on the NHS and Social Services jointly to assess, and meet the

needs of people with mental health problems. The Joint Joint Committee also accepted that there is a compelling argument for balancing the provisions in the draft Bill by including a duty to provide appropriate and adequate mental health services which are easy to access, and which focus on prevention and early intervention. The Committee recommended that the Bill should include a duty on public services to assess and to seek to meet the mental health needs of people with mental health problems.

People with mental health problems meet greater obstacles in gaining access to health and social care services than people with physical health problems. Although entitled to a community care assessment under the NHS and Community Care Act 1990, there is much evidence from individual case histories that this is routinely denied to people with mental health problems. The National Service Framework for Mental Health requires primary care services to assess a person's needs, yet in practice many GPs do not have the time, or skills, to make a full assessment. Unlike people with physical health problems who have direct access to specialist care through hospital A&E units, there are currently few open-access specialist mental health services. A right to seek help directly from specialist services – and to have an initial assessment of needs within a specified time – would help to put this right.

### **The assessment should lead to statements of health and social service provision**

The assessment should lead to statements of health and social service provision to meet that need, similar to the rights accorded in Part 2 of the Bill for patients preparing for discharge or being discharged from compulsory treatment. Such assessments and statements would be provided on establishing a threshold of presenting need and should also apply to prisoners, children and young people.

### **Any decision to decline such an assessment should be justified in writing**

The Alliance believes that the NHS and local authority should be required to justify in writing any decision to decline such an assessment. Local authority social services can prevent hospital admissions by providing support for families under pressure, by offering respite for carers and by combating isolation and social exclusion. The social costs of an emergency hospital admission are high. Although Government policy supports both statutory joint assessments and a Care Programme Approach that integrates health and social care on discharge from hospital, there is nothing in the draft Bill to promote preventive services and early intervention.

Although there are some good examples of jointly provided community mental health care, there is great under-provision of social care to mental health service users. The draft Bill recognises this and makes unique provision for health and social care on discharge. Under this provision hospital managers and the local authority must provide the Tribunal with statements of services needed on discharge, including:

- facilities “for the prevention of illness, the care of persons suffering from illness or the after-care of persons who have suffered from illness”, and
- services provided by local authorities.<sup>150</sup>

By contrast, no such statements would be required or permitted as part of the examination or assessment processes under the Bill when compulsory treatment is *first considered*. The Bill makes no provision for health and social care provision (or, where appropriate, a referral to the Community Mental Health Team) for:

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<sup>150</sup>Including accommodation and welfare services under Part 3 of the *National Assistance Act 1948*; section 45(1) of the *Health Services and Public Health Act 1968* and section 21 and Schedule 8 *NHS Act 1977*; section 29(1) *Children Act 1989*. These are some key statutory social care provisions.

- those who are examined, who are found not to meet all the conditions for compulsory care, but who nevertheless are in need of services;
- those who are assessed for or given compulsory treatment as non-resident patients.

The new Approved Mental Health Professional under the Bill will be a competence, rather than professionally-based appointment. The current Approved Social Worker is a social worker who would have had training in order to, and owe a more general professional duty to, refer mental health clients for a social care assessment. This change could serve to reinforce the absence of a social care dimension to a person's assessment and care.

### **The Bill should make provision for the following provisions**

- Where, on examination, a patient does not meet all of the relevant conditions described in Clause 9, the Approved Mental Health Professional must consider a referral of the patient for an assessment of health and social service need, or alternatively, make a determination to refer the patient to the Community Mental Health Team (or the tier 3 team with reference to children and young people);
- Where a referral has been made by the Approved Mental Health Professional for an assessment of health and social care needs, this must be arranged as soon as practicable after the request has been made;
- Where a determination is made on examination to carry out an assessment under clauses 22 to 33, the care plan made under clause 31 shall include information stating:
  - a) what services in the community the patient will need to support his recovery if the relevant conditions are not met; or
  - b) whether services provided by the relevant local authority and the appropriate authority would secure that the patient could receive treatment in the community other than by order of the Tribunal.

### **Recommendations of the Joint Committee on the Draft Mental Health Bill**

The Joint Scrutiny Committee supported the Alliance's recommendation to include a right to assessment for access to mental health and social care needs. It stated that:

*"Where the outcome of the examination is that the conditions for compulsion are not met but that the person appears mentally-ill, the examiners have discretion to refer for a mental health assessment."*

*"The evidence presented to us of people seeking help voluntarily, only to be turned away and then committing an offence and ending up detained under the Mental Health Act leads us to recommend that service users have a right to ask for an assessment of their need for mental health care as a resident or non-resident patient, and that the authorities be required to justify in writing any decision to decline such voluntary assessment."*

*"...the Bill should include a duty on public services to assess and to seek to meet the mental health need of people with mental health problems."*

## Advance Directives and Advance Statements

Advance directives and advance statements are documents drawn up by individuals when well to express their wishes as to their future care and medical treatment, when they may be unable to express those wishes themselves. The term 'advance directive' is most commonly used to refer to the anticipatory refusal of medical treatment. 'Advance statements' are more general expressions of an individual's choices about what they would like to happen in regard to their personal and home life, including their wishes related to their culture and religious beliefs, should they come to lack capacity. They may also include reference to particular treatments that an individual does or does not want and specify whom they wish to act on their behalf when unwell, including the choice of a nominated person.

Advance directives and advance statements are important mechanisms for safeguarding and promoting a patient's interests and health. They should have a significant place in the care and treatment of people who fall under the Mental Health Act, for example:

- if a person lacks capacity and is in need of care and treatment, the advance directive would indicate whether the patient had stated that a treatment was to be refused. Advance refusals of treatment would be legally binding unless there were extra reasons why this should be overridden.
- where there is a duty to consult the patient's wishes and feelings, this should include the duty to consult an advance statement.

**An advance directive is binding under common law and soon will be binding under statute law. However, an advance directive can be over-ridden if the person is subject to compulsory treatment under the Mental Health Act 1983.**

We believe that this discriminates against people with mental health problems. This seems particularly anomalous when the Government is allowing advance refusals in the Mental Capacity Act which would allow people to exercise some dignity and control at the end of their lives, yet is not allowing similar dignity or control over treatment for people in non-life threatening situations, by virtue of them having a mental disorder.

We believe that in the draft Mental Health Bill 2004 an important opportunity has been missed to include, as part of primary legislation, a legal basis for the use of advance directives and statements. The importance of advance directives and statements for patients should not be underestimated: they 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; they allow a patient to specify whom they wish to act as a nominated person should they become unwell; they 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.

It is also likely that the patient's recovery will be assisted by the knowledge that their health, social and personal affairs are being attended to in a way that they have agreed to beforehand. Service users, who have confidence that their doctors will abide by their wishes when they become unwell, experience less concern and stress about future relapses. This is backed up by recent research which has shown that advance statements

in the form of crisis plans can be effective in reducing the number of compulsory admissions to hospital.<sup>151</sup>

The Joint Committee on Human Rights, in its report on the 2002 draft Mental Health Bill, recommended that, “*the rights of patients to give directions about their future treatment, during periods when they are capable of doing so, should be respected where doing so would not present a threat of death or serious harm to the patient or anyone else.*”<sup>152</sup>

### **Current law**

Under English common law the unambiguous and informed advance refusals of treatment of competent adults are legally binding after the loss of capacity. The judgements given in *Re T (Adult: Refusal of Treatment)*<sup>153</sup> and *Airedale NHS Trust v Bland*<sup>154</sup>, set out that an advance refusal of treatment which is ‘clearly established’ and ‘applicable in all the circumstances’ is as effective as the decision of a capable adult. An advance directive:

- can only be effective if it was made when the patient had the capacity to make it;
- need not be in writing;
- cannot be used to require a doctor to carry out a positive act which is contrary to his clinical judgement;
- can be overridden by the Mental Health Act (1983) so that a directive which refuses any treatment for mental disorder will be rendered ineffective;
- will be ineffective if at the time when it was made the patient did not appreciate the implications of refusing treatment;
- can be made by a detained patient who possesses the required capacity; and
- can be revoked if the patient has the necessary capacity to do so.

Advance refusals of treatment will be provided for under statute law when the Mental Capacity Act 2005 comes into effect.

However, advance requests for treatment are not legally binding in that no one can require that particular medical treatment be given. The Mental Capacity Act 2005 provides that when determining an incapacitated person’s best interests, any written statement made when they had capacity should be considered.

The decisions made in an advance directive can be ignored by a doctor if the Mental Health Act 1983 is used to override a person’s express wishes regarding treatment. A patient who is detained under certain sections of the Mental Health Act (for example Section 2, Section 3, Section 37) can have their refusal to have a specific treatment overridden if the proposed treatment is for ‘mental disorder’. However, their treatment preferences should always be considered with respect by mental health professionals.

### **The Mental Capacity Act 2005**

The Mental Capacity Act 2005 for England and Wales provides a statutory basis for advance decisions to refuse treatment (advance directives). Under the Act, if an advance

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<sup>151</sup> Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K, Szmulker G. (2004) *Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial*. British Medical Journal, July 2004;329(7458):p122-3.

<sup>152</sup> 25<sup>th</sup> Report of the Joint Committee on Human Rights, Session 2001-02: Draft Mental Health Bill, 11 November 2002, HL 181, HC 1294, para 91

<sup>153</sup> Re T (Adult: Refusal of Treatment) [1992] WLR 782

<sup>154</sup> Airedale NHS Trust v Bland [1993] AC 789

refusal is deemed valid (i.e. a true representation of someone's wishes) and applicable (i.e. is specific to the circumstances and treatment being proposed), it must be adhered to even when it involves life-sustaining treatment. The Act also provides a number of safeguards to ensure that advance directives are not misused, for example allowing a doctor to treat if there is uncertainty about the directive.

However the Act also provides that an advance directive can be overridden if the person is subject to compulsory treatment under the Mental Health Act 1983. This would therefore appear to discriminate against people with mental disorders who should have the same rights as people with physical disorders; unless there are exceptional circumstances such as the likelihood of causing imminent and serious harm to self or others. This seems particularly anomalous when the Government is allowing advance refusals in the Mental Capacity Act which would allow people to exercise some dignity and control at the end of their lives, which many members of the Mental health Alliance fully supports, yet seems to be allowing no dignity or control over treatment for people in non-life threatening situations, by virtue of them having a mental disorder.

Section 4(6)(a) of the Mental Capacity Act explicitly states that when determining a person's best interests when that person lacks capacity, any written statement made when they had capacity should be considered. Although this does not go as far as Scottish mental health legislation (for example, there is no requirement to record why, if a different course of action was taken, the wishes expressed in an advance statement were overridden), it does provide further legal support for a person's right to choice, autonomy and self-determination in deciding in advance the type of care and treatment they would like, should they lose capacity to do so in the future.

### ***Expert Committee Recommendations***

The 1999 Expert Committee Review of the Mental Health Act addressed the issue of what they termed 'advance healthcare statements'. They considered recommending that advance directives be given statutory recognition in any future mental health legislation but concluded that it would be difficult to accord statutory recognition only to directives about care and treatment for mental disorder.

They recommended that the necessary provision be introduced in statute and complemented by the Code of Practice. The details of the form to be taken by advance agreements and the matters they might include should be contained in the Code of Practice, together with guidance as to how an advance agreement can be constructed. These ways would achieve recognition in law to ensure both that the creation of an 'advance agreement about care' is routinely considered by care teams and patients and that when created these agreements would have sufficient formality to be regarded as proper statements of a patient's capable wishes.

They recommended that an obligation be placed on the care team to provide all patients, prior to discharge from compulsion, with information about, and assistance with, the creation of an advance agreement regarding care and, further, that any discussion concerning an advance agreement should involve the patient's nominated person and/or advocate and, with the patient's consent, any relevant carer. The Committee concluded that the creation and recognition of advance agreements about care would greatly assist in the promotion of informal and consensual care. Patients and care teams would become used to negotiating an agreed package of care to be implemented in the case of relapse.

## ***White Paper proposals***

The White Paper (2000) acknowledged that advance agreements about the types of treatments an individual would prefer should they lose capacity in the future may be an important factor in determining what care and treatment is in a patient's best interests. No mention was made, however, of advance refusals to treatment. The White paper agreed that clinical teams should be expected to help patients develop advance agreements. It further stated that when a patient is subject to assessment and initial treatment under compulsory powers, the clinical team would be expected to take account of any recent advance agreement developed in consultation with specialist mental health services. Guidance on advance agreements would be included in the Code of Practice on the new legislation.

## ***The Mental Health (Care and Treatment) Scotland Act 2003***

The Scottish Mental Health Act provides for advance statements that specify:

- how a person wishes to be treated for mental disorder; and
- how that person wishes not to be treated.

According to the Act:

- a person giving medical treatment authorised by virtue of the Act shall have regard to the wishes specified in an advance statement; and
- where the Tribunal or designated medical practitioner takes a decision that conflicts with those wishes, they are required to record the reasons for this, to notify the person who made the advance statement and to place a copy of that record in the person's medical records.

## ***Draft Mental Health Bill 2004 proposals***

There is no mention of advance statements or advance directives on the face of the draft Mental Health Bill and no obligation for clinical teams to refer to them when choosing a nominated person or making treatment choices. There is, however, a duty in the draft Bill "*to consult the patient's wishes and feelings.*" The Government says that the Code of Practice will cover advance statements.

## ***Recommendations of the Joint Committee on the Draft Mental Health Bill***

The Committee considered the interface between the Mental Capacity Bill and the draft Mental Health Bill. It recommended that, before the Bill passes through Parliament, a clearer analysis of the interrelation between the two pieces of legislation be presented. The Committee recommended that the Government should bring forward legislation, either in the Mental Health Bill or separately, which would enable people to make advance statements and to record advance decisions, particularly if there is a treatment they would prefer not to receive. The Committee also recommended that the arrangements provide for these statements (in relation to further mental health treatment) to be taken into account by, but not become binding on, clinicians in determining the provision of medical treatment for mental disorder under the Act. They also recommended that patients be able to appoint an enduring nominated person which could be done through an advance statement.

## **Alliance policy**

The Alliance welcomes provision for advance directives and some legal recognition for advance statements when determining someone's best interests in the Mental Capacity Act, although we would have liked to see these being given legal status, more akin to advance statements as in the Scottish Act. However we remain concerned that advance statements are not included in mental health legislation. To ensure equity and parity between the two Acts in both legal and practical terms advance statements must be included within future mental health legislation. This would also be in keeping with the Alliance's demands for principles to be incorporated at the beginning of any new mental health legislation, including a principle of non-discrimination. For the same reasons we believe that mental capacity legislation should be implemented at the same time as or before mental health legislation.

The Mental Health Alliance seeks the following provisions on the face of the Mental Health Act:

### **The clinical team should discuss advance directives and statements with the patient prior to discharge and help with their preparation.**

In the Alliance's view, patients should be encouraged by professionals to develop advance directives and statements with the knowledge that these will be taken into account when making treatment decisions. As the White Paper (2000) states, the clinical team should be obliged to discuss advance statements with the patient as a component of care planning prior to discharge and to give help with their preparation. This would bring legislation into line with the principle of patient involvement and patient choice.

### **The clinical team should consult an advance directive/statement at all times in the exercise of compulsory powers.**

Mental Health Foundation researchers have reported that service users are discouraged from preparing advance statements because they are aware that they are not followed if they are sectioned.<sup>155</sup> We see no reason why England and Wales should not follow the example set by Scotland in its Mental Health Act, whereby the right to make advance statements was included in legislation. The Alliance recommends that there should be a duty on the clinical team to consult an advance directive/statement at all times in the process of the exercise of compulsory powers. This duty should be in addition to the requirement to consult the nominated person.

Wishes expressed in an advance directive or statement should be a part of the information taken into account by professionals involved in drawing up a preliminary care plan and for nominated persons and advocates to take into account when carrying out their legal responsibilities. It is also particularly important that the Tribunal should be required to take account of any advance directive or statement when making a treatment order.

### **An advance directive to refuse medical treatment for physical or mental disorder should be legally binding on the clinical team**

The fact that an advance directive is in most circumstances legally binding, but can be overridden if a person is subject to compulsory powers under the Mental Health Act, gives too little acknowledgement of the patient's wishes at the time when that patient had capacity.

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<sup>155</sup> The Mental Health Foundation, 2005. *Advance Statements in Mental Health Practice – Lessons from Bradford*.

Alliance members have consulted widely on this issue. The ideal position would be that as a general rule an advance directive to refuse medical treatment for physical or mental disorder should be legally binding on the clinical team, in situations where it is clear they were intended to apply, whether or not the individual is subject to compulsory powers under mental health legislation. We acknowledge however that a person with capacity, but with impaired decision making capacity in relation to treatment for his mental disorder, can have his/her consent overruled if s/he is subject to compulsion. It would be anomalous for there to be a completely different regime for those who lack capacity but who have indicated in advance their refusal of treatment. There needs to be a mid point between consulting an advance refusal and being automatically bound by it. Accordingly we believe that before a refusal is overridden extra safeguards are required. At the very least in this situation, the clinical team should be required to consider all alternative courses of action and record reasons for overriding the advance directive.

**In overriding an advance directive the professional should be required to consider all alternatives and, in recording reasons for overriding the advance refusal, indicate why alternatives have been rejected.**

In this situation the Tribunal should be required to take account of any advance directive/statement in making a care and treatment order. Any decision to override an advance directive/statement should only be taken by the Tribunal (except in the situations described above), who should record decisions for doing so.

**The advance nomination of a person to act on the patient's behalf should only be over-ridden by a Tribunal.**

Any decision to provide treatment under compulsory powers which conflicts with an advance directive should only lie with the Tribunal, with opportunities for the patient and the nominated person to have any objections heard. This measure would help to reassure service users that advance directives will be given the weight that they deserve and would also accord with the principle of participation. If the Tribunal overrides an advance directive/statement, they should record their reasons for doing so.

The Mental Health Alliance seeks the following provisions in the Code of Practice of a new Mental Health Act:

**The Code of Practice should set out the legal requirements for an advance statement/advance directive**

The Code of Practice should set out that advance directives/statements should be in writing, meet minimum standards of completion and allow the person to express their reasons for the views expressed. They should be witnessed by a suitable person who should certify that, as far as they are aware, the maker has mental capacity.

**The Code of Practice should provide that assessments of people's health and care needs and care plans should include consideration of making advance directives/statements.**

We believe that a formal link should be established between the care programme approach and the formulation of advance statements to ensure that all people under mental health services are given the opportunity, if they wish to so, to make legally binding advance statements and directives.

### **Current law**

The term “nearest relative” was introduced in the Mental Health Act 1959 and modified in the Mental Health Act 1983. It is defined in Section 26 which provides a list of people considered to be nearest relative, who are ranked in order of priority. This inflexibility has caused problems and been upheld, in different decisions<sup>156</sup>, contrary to Article 8 in the Human Rights Act. The nearest relative may not necessarily be the person identified as next of kin. Nor is the nearest relative always the best person to take on these powers, either from a patient’s point of view or from their ability to fulfill the role. The patient has no right to seek the displacement of an abusive or unsuitable nearest relative.

The Act gives the nearest relative the following main rights and powers:

- to apply for admission to hospital (Sections 2, 3 and 4) and for guardianship under Section 7;
- to be informed of an admission for assessment and to be informed of their right to discharge a patient;
- to be consulted before a Section 3 admission for treatment and to block the admission if he or she objects, although this objection can be overridden by a court displacing him or her and appointing a substitute ;
- to require a local authority to direct an approved social worker to consider the need for admission to hospital and to be given written reasons if an application is not made;
- to discharge the patient from either an assessment or a treatment section or guardianship. This can be blocked by the RMO only if there is evidence that the patient is a danger to himself and/or others;
- the right to apply to the Mental Health review Tribunal if discharge is blocked; and
- to be given 7 days notice of the intended discharge of a patient and to be involved in aftercare planning unless the patient objects.

The Government’s White Paper of December 2000 stated: *“New legislation will [introduce] provisions for nomination of a person to be consulted by the clinical team in all cases where a patient is subject to care and treatment under compulsory powers. The process of nomination will, in the first instance, be the responsibility of the social worker/other mental health professional responsible for co-ordination of action following the decision to apply compulsory power.”*<sup>157</sup>

### **Draft Mental Health Bill 2004**

The draft Mental Health Bill 2004 states that the patient must be given a reasonable opportunity to select a nominated person, and that if the patient is capable of making a selection and selects a person who is suitable and eligible, then the appointer must appoint that person. The Government expects that in the majority of cases the nominated person will in fact be the patient’s nomination. Legally, though, it is the mental health professional and not the patient who, in the proposed new legislation, will appoint the nominated person.

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<sup>156</sup> SSG v Liverpool City Council, October 22 2002. The judgment clarified that Section 26 must be read as giving equal status to gay unmarried couples and heterosexual unmarried couples.

<sup>157</sup> *Reforming the Mental Health Act 1983- Part I*, Dec 2000, p.43, para 5.6

Persons under 16 cannot choose their own nominated person but must be consulted before any appointment is made and their wishes and feelings must be taken into account.

The nominated person has the right to:

- be consulted at different stages of the process when a person is put under compulsory powers;
- apply to the Mental Health Tribunal on behalf of the patient, usually only with leave of the Tribunal; and
- visit the person at any reasonable time

In short the draft Bill provides that individuals will be able to choose a “nominated person” and they will perform a similar but diminished role to the nearest relative.

### ***Alliance position***

The Alliance is concerned that this draft Bill involves a significant loss of powers for the family members of people with mental disorder, and in particular that the nominated person lacks the powers of the nearest relative. Neither carer nor nominated person can adequately safeguard the interests of the patient. Indeed we question whether the role as set out in the draft Bill warrants the degree of regulation and bureaucratic requirements that are promised.

We support the replacement of the nearest relative with the nominated person; the nominated person is likely to be someone in whom the patient has trust and confidence, someone who s/he believes will safeguard his/her interests and someone who can provide emotional support at a time of crisis. However, the Alliance feels that the provisions need to be strengthened to protect this choice. Unless the role carries with it real powers, it is unable to act as a counterweight to the powers over service users given to professionals under the draft Bill.

The power to object to the use of compulsion or to discharge the patient is a vital safeguard; this can draw the attention of busy professionals to a changed situation and make them think critically about their decisions. They are a check on a misuse of discretion or a failure to act and may prevent unnecessary compulsion. They are useful in assisting a person’s discharge without recourse to a Tribunal.

The Alliance also believes that the rights of carers should be enshrined in any Mental Health Act and calls for a clearer definition of the term ‘carer’ in relation to rights under the Mental Health Act, which takes into account first time assessments and, in ongoing situations, allows for fluctuations in providing care.

### **Appointment of the nominated person**

#### **There should be no suitability clause**

The Bill requires the nominated person to be “*suitable*”- a term which will be interpreted in the Codes of Practice. We do not accept that there should be any other criterion for “*suitability*” than the relationship or connection with the patient which is already within the Bill. Giving the appointer (a mental health professional) discretion over the “*suitability*” of the nominated person will reduce the likelihood that the patient’s choice is respected.

As the Mental Health Act Commission states:

*“Although the Bill leaves the ‘suitability’ of a patient's preferred ‘nominated person’ to the discretion of the professional who acts as appointer, regulations are also promised that will set out ‘certain categories of people’ who will be automatically disqualified from being eligible for appointment as nominated persons. It would appear that Government wishes to establish beyond doubt certain legal categories of unsuitable person so that their exclusion from the role of nominated person would not rely upon the exercise of the professional discretion that the Bill provides. We are not at all convinced that it is easy to establish categories of such unsuitable persons that will not arbitrarily discriminate against people who might be categorised as unsuitable due to, for example, their having a criminal record of a certain kind. It will be vital, not least to ensure that the law relating to the appointment of a patient's nominated person is not in breach of Article 8 of the ECHR, that genuine and appropriate nominations are not fettered by arbitrary constraints of law.”<sup>158</sup>*

### **Incapacity to act as a nominated person should follow the definition of capacity set out in the Mental Capacity Act 2005**

A person is also disqualified to act if *“he appears to the appointer to be incapable because of illness or mental disorder.”* A patient may wish to choose someone with a mental disorder – indeed, people who have direct experience of mental disorder and of the mental-health system might be particularly effective nominated persons. It needs to be clear that a person can only be incapable if s/he lacks capacity according to the definition set out within the Mental Capacity Act 2005: *“A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.”*

### **The criteria for appointment should be willingness, capacity and relationship with the patient**

Three criteria are needed:

- that the person chosen by the patient to be the nominated person is willing to perform the function,
- that that person has capacity, as defined in the Mental Capacity Act 2005; and
- that a person who is not related or connected to the person should not be appointed

### **The nominated person should have a role where possible at the examination stage**

The Government has said that it would be impractical to appoint the nominated person before or during the initial examination because, *“An initial examination often needs to take place very quickly, particularly in emergency cases.”<sup>159</sup>* This is true in some cases but not all. For example the patient may already be an informal hospital inpatient. Even in the case of emergencies the draft Bill nevertheless states that if practicable the examiners should consult the patient's carer. We agree with this provision, and believe that if it is possible to consult the patient's carer it should also be possible to appoint a nominated person – after all, in many cases the nominated person may be the patient's carer.

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<sup>158</sup> Mental Health Act Commission, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Ev.28-29, para.4.8. The Mental Health Act Commission adds: *“The Bill's Explanatory Notes on how “certain categories of people” are to be defined as disqualified gives as an example “a convicted child abuser in the case of a child patient” (para 414).[...] The Government's example is relatively sensible, but very specific. We do not see how the principle that appears to underlie it can easily be extended to adult patients and their relationships with other people in their lives. We would be very concerned if, as has been mooted during the development of this policy, conviction of any serious criminal offence automatically disqualified a person from nomination by a patient.”*

<sup>159</sup> Department of Health, 2004. *Improving Mental Health Law – towards a new Mental Health Act*, para. 4.10, p. 37.

**Where there is no nominated person, the carer should assume the role of default nominated person.**

A person's carer is often the best informed source of advice and assistance during that person's mental health crisis and as such has an independent role. S/he also has a vital interest in the person's welfare and recovery. The draft Bill acknowledges the carer's role by requiring consultation with carers during the process of applying compulsory powers. However, the draft Bill fails to give adequate recognition to the position and expertise of carers, and to their key role in a person's recovery. While carers must be consulted at the examination stage, they are not formally a substitute for the nominated person. However, in the absence of a nominated person, that role should default to the carer.

If there is neither a nominated person nor a primary carer, the Approved Mental Health Professional (AMHP) should appoint any other person who s/he considers to be the most suitable. The patient could appeal against either the appointment of the carer as nominated person or the AMHP's choice of nominated person a Mental Health Tribunal.

**The appointment should not lapse on discharge**

The appointment of a nominated person ceases when the patient is discharged (242(4)). As a result, the whole process (including a possible delay in appointment at the assessment stage) has to be started again in the event of a further need for compulsion. The Alliance proposes that a nominated person should remain in post after discharge from an order, subject to the agreement of the patient, though their powers would be held in abeyance. If s/he requires a different nominated person next time s/he could be permitted to specify a person at the point of discharge. That person's name would be included in the patient's records or in an Advance Statement. This proposal has been strongly supported by user groups who are members of the Alliance and who have surveyed their members on the issue.<sup>160</sup>

**Patients should also be given the option to state the name of their primary carer in an advance statement.**

**The patient should be able to revoke the appointment which s/he has made**

There will remain the need for a displacement process, a power to change the nominated person in certain circumstances. At present, arrangements for replacing a "nearest relative" involve going to a county court, which will be generally unfamiliar with the circumstances and which does not allow the patient to be represented. This is unsatisfactory.

The Alliance proposes that a displacement process should only be considered by a Tribunal. The application may be made by the clinical team or the patient. Patient, nominated person and clinical team would be able to put their views to the Tribunal, which would need to be satisfied with the reasons for displacing the current nominated person and the suitability of the proposed new nomination. In deciding these questions, there should be an emphasis on those who have most daily contact with the patient and those who have existing responsibilities in respect of the patient. As with the original nomination, the patient's choice of replacement would be accepted unless there were exceptional circumstances.

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<sup>160</sup> Survey by JAMI of their members in 2002.

Despite a recommendation to this effect in the Joint Committee on Human Rights (JCHR) Report it has not been taken up in this Bill.<sup>161</sup>

To ensure a patient did not make too frequent applications to change their nominated person, we suggest setting a minimum limit of three months between applications unless there are urgent reasons for a more immediate hearing.

### **Rights and powers of the nominated person/ carer**

The White Paper states:

*“Patients with serious mental disorder often need the help of someone who knows them well to represent their views and wishes in discussions with the clinical team. This is important if, particularly in the early stages of assessment under compulsory powers, a patient is too ill to participate fully in decisions about his or her care...”*<sup>162</sup>

This makes clear that the nominated person’s role is to act as proxy for the patient, putting forward the patient’s views, or what they believe are the patient’s views. The role is not about the nominated person’s own views of what would be “*in the best interests of the patient.*” The Alliance agrees with this approach.

The nominated person is likely to be someone in whom the patient has trust and confidence, someone who s/he believes will safeguard their interests and someone who can provide emotional support at a time of crisis. It also needs to be someone who has personal knowledge of the patient (so that completely uninformed choices are not made) and who is able to represent the patient’s views and wishes.

### **This principal role of the nominated person should be on the face of the Bill**

The Alliance believes that the principal role of the nominated person should be enshrined in primary legislation, to give confidence to service users that, should they fall subject to the Act, their views about treatment will be fully taken into account. Under the 1983 Act the nearest relative has a significant role (see above). However, in the draft Bill those “*nearest relative*” powers have been significantly curtailed. The net effect of this is to diminish the patient’s protection at the critical times, when compulsory powers are first being considered and at the point of discharge.

As the Institute of Mental Health Act Practitioners puts it:

*“These powers recognise the importance of the family in people's lives, and the need to limit the circumstances in which the state may interfere with individual and family life. A balance is achieved between the state's claim to provide protective compulsory care and the right claimed by families to care for their loved ones, and to cope with and manage behaviour that mostly affects only them.”*<sup>163</sup>

### **The nominated person and the carer should have a right to apply for an assessment of the patient and a right to written reasons for a failure to detain**

The right for a nominated person to request a decision as to whether “*examination*” will take place is much weaker than the nearest relative’s right to require the local authority to direct an approved social worker to consider an application for admission. This removes an important safeguard. The carer and the nominated person should both have the right to apply for assessment and the right to a justification if they are not successful.

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<sup>161</sup> Joint Committee on Human Rights, November 2002. *25<sup>th</sup> report of the Joint Committee on Human Rights, Session 2001-02: Draft Mental Health Bill*, 11, HL 181, HC 1294, para 64

<sup>162</sup> *Reforming the Mental Health Act 1983- Part I*, Dec 2000, p.43, para 5.4

<sup>163</sup> IMHAP, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill*, Volume II. Ev.99.

At the examination stage the nominated person (if already appointed) has no rights at all, the carer has a diminished role and the advocate is not included. If the person has no carer or does not want the carer to be involved s/he is completely unprotected. The nominated person should be included at this stage, as should the advocate if the patient requests him/her. The role of the nominated person is to act as a knowledgeable friend to give advice, information and an opinion about the patient; the advocate's is to explain the process and speak for the patient. We do not consider this to be unnecessary duplication of effort because it may calm a crisis and help to avert unnecessary use of compulsion.

### **The nominated person/carers should have a right to block an admission to hospital**

The carer or nominated person should have the right to block admission. The person who knows the patient best is more able to assess the seriousness of a situation and its likely course than a busy professional unacquainted with the patient's case. It is a useful power for a caring friend or relative and assists professionals. Under current law the nearest relative can be displaced by an application to the county court if it appears s/he is not acting in the patient's best interest in blocking admission. This could be replicated under the new Bill, although the Tribunal would be the appropriate forum for this process.

### **The nominated person and carer should be able to attend the Tribunal**

The nominated person should be able to attend any Tribunal hearing and to apply to the Tribunal on behalf of the patient for review of the use of compulsory powers. If the patient is not able, because of mental incapacity or for other reasons, to instruct a lawyer to represent him or her at the Tribunal, the nominated person should have the power to do so on his or her behalf.

### **The nominated person should have the power to make an order for a discharge, subject to 72 hours notice**

Under the 1983 Act the nearest relative has the right to discharge a patient from formal powers subject to giving 72 hours' notice and the agreement of the responsible medical officer. This is not provided in the draft Bill which only allows a nominated person to apply to the Tribunal for a discharge. The Government's reasoning behind this change is that the Bill, "*provides a new legal framework with independent scrutiny by the Tribunal of all compulsion beyond initial assessment period providing, in every case, an important safeguard against the inappropriate use of formal powers*".<sup>164</sup> It is not clear, however, why the right to discharge a patient is incompatible with increased independent scrutiny. Nor do we believe the government understands that, under current law, it is also the case that clinicians must keep the status of the patient under review and discharge a patient who no longer meets the criteria – while not specified in the Act it is a duty arising from human rights law. Furthermore, a mechanism to discharge patients without recourse to the Tribunal would help to reduce the considerable demands on the Tribunal under this new law. Recent research suggests that discharge by the nearest relative against psychiatric advice is not associated with a poor clinical outcome.<sup>165</sup> This seems to indicate that patients' representatives can play a useful role in discharging patients who do not need to be treated under compulsory powers.

### **Carers should be given a separate right to be consulted on discharge of a patient**

Given that the carer is likely to be the one most directly affected by a person's discharge they should be consulted on this issue.

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<sup>164</sup> Department of Health, 2004. *Improving Mental Health Law – towards a new Mental Health Act*, para 4.16, p. 37

<sup>165</sup> Shaw, P, Hotopf, M, and Davies, A, 2003. *In relative danger? The outcome of patients discharged by their nearest relative from Sections 2 and 3 of the Mental Health Act*. *Psychiatric Bulletin*, Volume 27, 50-54.

There also is a wider point to be considered. Many carers would be delighted to have their loved ones back at home to care for them, but not under an NRO which brings an element of coercion to the relationship. The Act should enable the patient to be discharged home rather than obstruct it.

### ***General issues***

#### **The roles of nominated person and advocate should be stated in primary legislation or the Code of Practice.**

We believe that, perhaps in their concern to minimise confusion of roles, the Government has seriously weakened the role of the family (as carer or as nominated person). Even the duties to consult have limited force when they can be dispensed with wherever impracticable or inappropriate. In our view, in order to avoid confusion of roles the principal role of the nominated person and of the advocate, as a proxy for the patient, putting forward the patient's views or what they believe are the patient's views, should be clearly set out, preferably in primary legislation or in the Code of Practice.

#### **There should be a statutory requirement on authorities to provide information for the nominated person and carer, about their legal role**

It is crucial that the nominated person is fully aware of their powers, in language and in a format that he or she can understand, or those powers become pointless in practice. They also need to understand the role of others in the process, such as the tribunal, the clinical team and any carer or statutory advocate. There needs to be a statutory requirement on the authorities to provide this information to the nominated person.

### **Current Law**

At present, mental health legislation does not provide a formal individual right to advocacy and there is no duty on the appropriate authorities to ensure the provision of advocacy services.

The National Service Framework for Mental Health states that health authorities should have in place arrangements for the provision of advocacy services.<sup>166</sup> This builds on the Patients Charter Implementation Guidance (1997) which set a basic standard for informing patients of any local advocacy schemes.<sup>167</sup> It also recognised the importance of independence and of working to instruction, rather than according to 'best interests'.

The Report of the Expert Committee states:

*"We are now satisfied that access to independent advocacy will be vital if the fundamental principles which underlie our recommendations are to be achieved."* It recommended therefore that *"A statutory right to advocacy be created at the earliest opportunity."*<sup>168</sup>

The Government recently highlighted the importance of advocacy for people with learning difficulties.<sup>169</sup> Following the Health and Social Care Act 2000 there are now Independent Complaints Advocacy Services (ICAS)<sup>170</sup>, and there is guidance on the relationship between Patient Advice and Liaison Services (PALS) and independent advocacy.<sup>171</sup>

It also proposed that local authorities and health authorities should be placed under a statutory obligation to produce local advocacy plans. On the issue of monitoring and regulation, rather than an Advocacy Standards Agency, the committee proposed that this function be carried out by the Mental Health Act Commission.

### **Alliance position**

#### **Access to advocacy**

#### **The Alliance strongly urges the government to broaden the access of patients to advocacy services**

The Alliance believes that advocacy is effective in terms of reducing distress and the use of clinical services. Experience shows that early and on-going support from advocates reduces the need for admission to hospital and involvement with other agencies such as the courts and homelessness services. Advocates can help by limiting the escalation of financial, housing, personal, and medication problems. Advocacy also enhances communications between patients and medical and social care practitioners.

Service users regularly report that they were not aware of important procedures and rights when they were assessed under the Mental Health Act 1983 and/or when they were detained under compulsory powers – either the information was not given to them or they did not receive

<sup>166</sup> Department of Health, 1999. *National Service Framework for Mental Health: modern standards and service models.*

<sup>167</sup> NHSE circular EL(97)1 16.1.97

<sup>168</sup> Expert Committee, November 1999. *Review of the Mental Health Act 1983: Report of the Expert Committee*, para.39, p.9

<sup>169</sup> Department of Health, March 2001. *Valuing People: A New Strategy for Learning Disability for the 21st Century.*

<sup>170</sup> Department of Health November 2001. Health and Social Care Act 2001 Section 12; *Involving Patients And The Public In Health Care: Response To The Listening Exercise.1*

<sup>171</sup> NHSE, AAL, Kings College Hospital, January 2002. *Protocol for PALS and Independent Advocacy Joint Working.*

it in a form they understood.<sup>172</sup> This can relate particularly to the medication they are being given. It also applies to whether or not they end up as voluntary patients or under compulsion.

The Alliance supports the principles behind the Government's proposal to introduce independent advocacy for people subject to compulsory treatment, either as civil or forensic patients. However, the provisions fall short of providing the individual with a legally enforceable right to an independent advocate. The Alliance considers an enforceable right is essential because access to advocacy at all stages has a crucial role to play in safeguarding the rights of people subject to the new regime.

The Alliance notes that the Scottish Mental Health Act puts a duty on authorities to ensure that independent advocacy is available to all people with a "*mental disorder*" and that they have an opportunity to use it. We support these provisions. The Joint Committee would appear to have endorsed this view in its recommendation that there be a duty in the Bill on the appropriate authority to ensure that independent advocacy is available to all people with a mental disorder, and that they have an opportunity to use the service. This sits well with the Alliance proposal that patients brought for examination should be entitled to an assessment of needs even if they remain as voluntary patients.

In relation to the use of compulsory powers, the Alliance believes that an individual right to independent advocacy is vital for people who are:

- liable to compulsory treatment;
- at the point of 'examination' for assessment;
- under an assessment order;
- undergoing periods of compulsory treatment; or
- subject to aftercare arrangements.

There should be a duty on professionals to remind patients of their right to an advocate, as the Joint Committee agreed.

In order to make the right of access to independent advocacy meaningful, advocates should be able to:

- attend, where practicable, any consultation, interview or meeting about the person's treatment or support;
- have access to the person at any reasonable time;
- correspond or communicate in any other way with the person on any matter relating to their role as an advocate; and
- receive such information as would assist them to perform their role.

In any meeting or negotiation with clinical or social care staff, a patient should have the right to be supported and, at the patient's request, represented by an independent mental health advocate of his/her choice, in the following circumstances:

- when s/he is receiving in-patient treatment for mental disorder as a formal or informal patient;
- when s/he is receiving care and treatment in the community, whether on leave of absence or subject to a care and treatment order or a supervision order.

Where a person lacks capacity, an advocate's role would be to help the person to participate in the decision-making process to the fullest extent possible and to make sure that their views are heard. Where a patient may not be able to communicate their preferences in conventional

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<sup>172</sup> Discussion on Mental Health Act at Mental Health Alliance People's Parliament, 9 Nov 2002; Mind Seminars on Mental Health Act, 14 Oct 2004; Maca Annual Conference 16 Sept 2004.

ways, the role of an advocate is to safeguard the basic human rights of the person for whom they advocate and ensure that their treatment meets agreed standards of good practice. It should be remembered that because people's capacity may change over time, an advocate's role in working with that person will also change accordingly.

### **Carers should also have a right to advocacy**

The carer has no access to advocacy unless s/he is also the nominated person. This is in spite of the rights identified under the Health & Social Care Act and the practice guidance of the Carers & Disabled Children Act 2000. This is an important issue as carers frequently complain that their requests for help are ignored on the one hand whilst they are expected to pick up the pieces of professional decisions on the other.

### **Functions**

#### **The specific functions of IMHA Advocates should be decided as part of the Department of Health's proposed stakeholder group and detailed guidance developed in the code of practice.**

The Alliance supports the functions of advocates as outlined in the draft Bill and in particular the central role of providing assistance to qualifying patients in obtaining information; however, this function needs to be fully described in accompanying guidance. It is vital that the relevant authorities' duty to provide information is not avoided through a mistaken emphasis on these provisions. It is also vital that IMHA Advocacy support is not defined solely as 'representative', as the key principle of advocacy is that it promotes self-advocacy i.e. it provides support to the qualifying patient to get their voice heard, in the way that they wish to be heard.

### **Access to records**

In general, the Alliance supports the Government's desire to accelerate access to mental health records, as scrutiny by the individual of their records can help to ensure that appropriate and effective treatments are put into place. However, we believe that this would be better achieved by fast-tracking the right of access to records for patients themselves, with the assistance of advocates if they so wish. This access should include social work and nursing records as well as clinical notes.

#### **IMHA Advocates should not be given access to records without the patient's informed consent**

Giving advocates direct access to records, or even having 'regard for the wishes and feelings of the patient' in this matter, is open to abuse and works against the principle of self-advocacy and autonomy. Where a person lacks the capacity to decide whether or not they wish themselves or their authorised advocate to have access to their records, the nominated person should be given the right of access. However, it may be appropriate, in some circumstances, for there to be a duty on the hospital authorities to ensure that key information is communicated to the advocate.

### **Point of access/qualifying patients**

#### **The Alliance believes that the Bill should provide the right to access specialist mental health advocacy during the examination stage**

The draft Bill proposes that patients should only become entitled to information about their right to access advocacy services after the initial examination has taken place and after a formal decision has been reached that the patient needs to be assessed as a resident or non resident patient. The examination process can take place in a variety of different settings and there is a time limit of 120 hours for the examination to take place. The Alliance believes that people undergoing the examination process should be given the information and the opportunity to

contact a mental health advocate if they choose to do so. In extreme emergencies it may not be possible to impart this information in a meaningful way, and occasionally some patients may not be well enough to make use of the information and/or take the opportunity to contact the advocacy service. However, this is also true of some patients when a decision has been taken to undertake the assessment stage. Notwithstanding the condition of the patient, AMHPs are still under a duty to explain the help available from IMHAAs at this point.

Without information about IMHAAs being provided during the examination the patient will be completely isolated. At this time the nominated person will not have been appointed. Hence for five days a person can be examined and administered treatment compulsorily under common law, with no safeguard in place. Providing information at the examination stage will also allow the advocate to be involved at an early stage with patients who are subsequently made liable to assessment. During the first five days, the draft Bill states that the initial care plan must be drawn up, which will allow treatment to be administered without the patient's consent. Delaying giving information about advocacy will inevitably delay meaningful input into this critically important document.

The Alliance cannot see how information about IMHAAs being given at the earliest reasonable opportunity will confuse the detaining/compulsory role, or in any way impede the examination. Providing the opportunity to make contact with advocacy services at this stage will safeguard the patient's rights, assist communication with clinical and care staff at the earliest opportunity, give advocacy services time to ensure patients are seen by advocates sooner rather than later, and may reassure patients at a most distressing time for them. It will also mean advocates can assist in ascertaining who the patient most wants to act as their nominated person, and allow their input into the initial care plan from the outset. It must be emphasised that the proposal is simply to give the patient the option of an advocate not to require an advocate to be present. Nor is it expected that the mental health professionals be required to stall the process unreasonably while an advocate is sought.

## **Information about advocacy**

### **People should also be informed about advocacy at other key stages of the process**

- on admission to hospital;
- whenever special treatments are considered (including electro convulsive therapy (ECT), psychosurgery and the implantation of hormones to reduce sex drive);
- on review of care or treatment;
- at discharge or transfer from hospital or release from compulsion;
- when any other significant decision is being made;
- when a person is in seclusion; and
- when the patient has strong objections to a proposed course of action.

### **Information about advocacy should be clear and in a format that the patient can understand**

Information about independent advocacy organisations must be communicated to people in a way which they can understand and that takes account of any special communication needs they have. This will mean having in mind the needs of people with a visual or auditory impairment, and/or people for whom English is not a first language. In addition, all communication should be written in clear and easily understood language. While it is essential to leave the person with a permanent record of advocacy information, just handing over a leaflet will not be sufficient. Information about advocacy should be displayed in public areas and on wards as well as in a wide range of accessible formats.

## **Nominated person**

### **The advocacy entitlement of the patient should have primacy over that of the nominated person**

The provision of advocacy to both patients and their nominated persons may cause a conflict of interest. The proposed number of advocates will not allow for separate advocates for each. Conflicts may arise where the patient is broadly happy for the nominated person to pursue their role but, where there is a key point of disagreement, the advocate is supposed to continue unless advised by the appointer. The proposals do not reflect the primacy of the wishes/ needs of the qualifying patient.

Ultimately, the point of IMHAA is to act as a patient safeguard. It is not primarily intended to provide support to other safeguarding roles. This should be more accurately reflected in the legislation so that in the event of conflict between the patient and the nominated person, the patient is not left feeling coerced into putting up with a nominated person they are unhappy with for fear of losing their advocacy support. Unless the patient is clear that in the event of conflict it is the patient's entitlement to advocacy which will remain intact, the safeguarding effect of both nominated persons and IMHAAs will be reduced.

## **Right to meet**

### **The Alliance recommends that the right of patients to meet with their advocate in private is reinstated**

The Alliance supports the proposal to enshrine the right of patients to meet with their authorised advocate and is concerned that the right to meet in private, proposed in the 2002 Bill, has been removed. The right should be in line with the rights of Healthcare Commissioners, detailed in particular in Clause 270(3)(a) which enshrines a right to visit, interview or examine in private and 270(3)(b) which requires that commissioners be afforded "*such facilities and assistance...as are necessary to enable him to exercise his powers*". This was supported by the Joint Committee.

## **Regulation**

### **A code of practice and training standards for IMHA Advocacy should be developed in consultation with people who use mental health services and advocacy workers. A dedicated Advocacy Standards Agency should oversee this work**

The Alliance supports the government's proposals to arrange for the regulation of IMHA Advocates. There should be a new agency tasked with overseeing quality measures, ensuring effective scrutiny and overseeing standards setting in mental health advocacy. The agency should be independent but governed by statute and accountable to government.<sup>173</sup> People who use services and advocacy workers themselves should be involved in developing standards.

The Alliance supports the model of advocacy service proposed by Durham University which proposes that IMHA Advocacy should be embedded in existing Mental Health Advocacy Services and should be run according to professional voluntary sector standards. We do not believe that the Healthcare Commission should be given responsibility for giving advice to the appropriate authority on standards for the appointment, training and monitoring of advocates.

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<sup>173</sup> This is already happening in Scotland in the form of the Advocacy Safeguards Agency.

## **Access to advocacy at a place of safety**

### **The Alliance believes that the Bill should provide the right of access to specialist mental health advocacy when the person arrives at the place of safety, whether it is a psychiatric hospital or police station**

Under the Bill, the police will continue to have the power, currently provided under Section 136 of the 1983 Act, to remove a person from a public place to a place of safety for assessment, should they appear to be suffering from a mental disorder and in need of immediate care and control. The Bill also introduces a new power for the police to enter premises without a warrant and remove a person suffering from mental disorder to a place of safety. This must only be based on the evidence of an Approved Mental Health Professional. Furthermore, a person can also be removed to a place of safety where a magistrate has issued a warrant under Clause 400 authorising entry to premises, if need be by force. The place of safety could be a hospital or police station and these powers last for up to 72 hours. We believe that vulnerable people who are detained in these circumstances must have the right to effective safeguards and support. This principle is already recognised under the Police and Criminal Evidence Act 1984 which provides for appropriate adults for vulnerable people who are arrested.

## **Access to advocacy when Courts issue a Mental Health Order**

### **The Alliance believes that where a Mental Health Order is being considered by the court, there should be provision for patient/advocacy involvement in the creation of the care plan.**

The Alliance disagrees with the use of criminal courts to make mental health orders but make its comments on the basis of the current draft Bill. The Bill, does not give any opportunity for patient/advocacy input into the creation of the care plan that must be submitted to the court when it considers issuing a Mental Health Order. The making of a Mental Health Order by the court is conditional upon the preparation and submission to the court of a care plan by an approved clinician. However a patient will only become a 'qualifying patient' when a mental health order is in force. Anyone for whom a mental health order is proposed will not have access to advocacy.

Elsewhere in the Bill, Clause 31(a), it is stated that in preparing a care plan for the patient, the clinical supervisor must consult the patient about the medical treatment to be specified in the plan unless it is inappropriate or impracticable. While schedule 5 states that provisions of part 2 do not apply to part 3 unless specified in part 3, the proposal to consult people subject to treatment under statutory powers appears to create a 'spirit' for the act in keeping with provisions of the Care Programme Approach. It is recommended that Clause 248 be extended to those people for whom a care plan under 115(1) is being drawn up, therefore giving access to an advocate to assist in the preparation of the care plan.

## **Independence**

### **The Bill must establish a truly independent IMHA Advocacy service**

The Alliance supports the government's commitment to the independence of advocacy from services responsible for providing care and treatment. Independence is vital so that the ability of advocacy organisations and advocates to carry out their roles is not compromised. Ideally, independent advocacy should be provided by an organisation whose sole role is advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy.

## **Costs and workforce implications**

### **The Alliance believes that the costing of advocacy under a new Act has been miscalculated and is unrealistic**

It is unclear on what basis the government's figure of £5million has been calculated. This needs to be looked at in relation to the funds made available to implement the '*independent mental capacity advocate*' scheme in the Mental Capacity Act 2005 (believed to be £6.5 million). Using the government's figures that 140 whole time equivalent (WTE) advocates will be needed to implement the Mental Health Bill, produces a sum of £35,174 per WTE advocate per annum. This figure is likely to be a substantial underestimate.

Given that there are some 50,000 uses of the Mental Health Act 1983 each year, the figure of 140 advocates with a duty to provide information and representation appears somewhat conservative. We urge the Department of Health to release information on how this figure was calculated and to ensure that further detailed work on this is undertaken in partnership with advocacy providers and other stakeholders.

It is essential that sufficient resources are provided to implement these proposals. The Alliance supports the Government's apparent intention to ensure that IMHAA Advocacy is provided by properly trained advocates. Advocacy under the Act needs to be delivered by people with appropriate levels of skills and a thorough knowledge of mental health legislation. In addition advocates need to be properly supported and supervised and this requires that advocacy services are properly financed and salaries reflect both market rates and the necessary skills.

The Committee recommended that before the Government introduces the Bill to Parliament, it should review the costs of setting up discrete advocacy services and that this should be undertaken with those providing advocacy services. This should reflect detailed and robust costing, and a sensitivity analysis taking account of, for example, possible variations in the number of persons detained and the provision of advocacy at examination stage, to 'voluntary' patients and to those under compulsion in the community.

### **Carers should also have a right to advocacy**

The carer has no access to advocacy unless s/he is also the nominated person. This is in spite of the rights identified under the Health & Social Care Act and the practice guidance of the Carers & Disabled Children Act 2000. This is an important issue as carers frequently complain that their requests for help are ignored on the one hand whilst they are expected to pick up the pieces of professional decisions on the other.

### **Information sharing**

Where a person lacks capacity and cannot consent to information being shared on their behalf, health and social care staff should make available to the independent advocate such information as is necessary for them to do their job as an advocate effectively. As a minimum, it would be expected that advocates are informed when:

- a person is admitted to hospital;
- there is a review of care or treatment;
- any form of compulsion is considered;
- special treatments are considered; and when
- plans for discharge or transfer are being made.

Giving this information to advocates is permissible under the Data Protection Act 1998, which contains a specific exemption from restrictions on disclosure where the reason for disclosure is to protect a person's vital interests.

## **Advance directives**

Advance directives may be used for people to indicate whether they would wish to have an advocate or not. This would enable hospital managers and others to make a referral, if appropriate, where the person lacks capacity to request or consent to an advocate at a later date. Independent advocates may also assist people to write an advance directive and keep it up to date. However, it would not be appropriate for an advocate to be a witness to an advance statement as this would involve making a judgement about the capacity of the person making the statement.

People should have the right to advocacy support when developing and implementing advance directives. Where someone lacks capacity IMHA Advocates should be consulted to determine the existence of any advance directive.

## **Correspondence**

The Alliance agrees that IMHA Advocates should be included in the list of official communicants in Schedule 11 as this will safeguard the patient's right to correspond with his or her representative without interference by hospital or other authorities.

## **General issues**

### **1. User involvement**

#### **The government should include guidance on user involvement in the Code of Practice**

User involvement should be central to all advocacy practice, and is essential for the healthy functioning of an advocacy service. The Alliance believes that advocacy services must ensure that there are routes to meaningful involvement at all levels of the organisation.

### **2. Informal advocacy**

#### **People should have the right to choose an untrained advocate/friend in place of or in addition to a specialist advocate if they wish**

<p>It is of vital importance that 'informal' advocacy, such as that provided by local support and self-help groups, friends and family is not excluded in favour of professional advocacy. People using mental health services must have the right to bring along a supporter of their choosing to ward rounds, CPAs and other meetings.</p>
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## Mental Health Tribunals

### ***Current law***

Mental Health Review Tribunals (MHRT), comprising of three members, deal with applications and references in respect of patients subject to the provisions of the Mental Health Act, including those subject to compulsory admission to hospital and guardianship. Each Tribunal must consist of a legal member; a medical member (i.e. a registered medical practitioner), and a member with relevant experience (e.g. a knowledge of social services).

Tribunals have the power to discharge unrestricted people from hospital if they are satisfied that the patient is not suffering from a mental disorder of a nature or degree which warrants his/her detention, or their detention cannot be justified under Section 72 of the 1983 Act.

Hospital Managers have the power to discharge unrestricted people, the power being exercised by three or more members of a committee set up for that purpose under Section 23 of the 1983 Act. Tribunals have limited powers to discharge restricted people under Section 73 of the 1983 Act.

Article 6 of the European Convention on Human Rights, which was introduced into English Law by the Human Rights Act 1998, provides for a right to a fair trial, which includes the right to:

- a fair hearing
- a hearing before an independent and impartial tribunal
- a hearing within a reasonable time.

Patients have free legal representation at Mental Health Review Tribunals.

### ***Mental Health (Care and Treatment) (Scotland) Act 2003***

The Act provides for a Mental Health Tribunal for Scotland with a right of appeal to the Sheriff Principal and a further right of appeal to the Court of Session.

Tribunals will comprise a legally qualified Chair; a qualified person in medicine and the diagnosis and treatment of mental disorder; and a person qualified or experienced in providing services to people with a mental disorder.

The role of the Tribunal is to consider whether the conditions for continuing treatment under compulsory powers are met and to authorise a treatment order, which may specify the detention of a patient in a specified hospital or to reside at a specified place.

The responsible medical officer will have power to revoke a compulsory treatment order.

### ***The Draft Mental Health Bill 2004***

The Draft Bill proposes to abolish the Mental Health Review Tribunal system and replace it with the Mental Health Tribunal (MHT) for England and Wales. There will be a President of the Tribunal appointed by the Lord Chancellor and the function of hospital managers in respect of reviewing detention will be abolished.

Under the new system, hearings can be conducted by panels of one, two or three members chosen by the President of that Tribunal. Single member sittings will only be used in circumstances set up in Rules and would include, for example, failure to appoint a nominated person and technical, procedural or preliminary matters.<sup>174</sup>

MHT members must fall within the following categories:

1. Legal members – who must always be included and will chair the MHT
2. Clinical members – i.e. a person with knowledge or experience of the treatment of mentally disordered people (which will include psychiatry, nursing, psychology and other clinical specialisms)
3. General members - i.e. a person with knowledge or experience of providing mental health services.

The main functions of the MHT will be to provide legal authority for compulsory treatment beyond 28 days following applications by the clinical supervisor; and to review patients' cases following applications by the patient, their nominated person and, if the patient is under 16, any person with parental responsibility. The main powers of the MHT will be to discharge the patient from compulsory powers if the relevant conditions are not met, make orders for assessment or treatment and approve the care plan, and determine whether patient should be detained in hospital as a resident patient or dealt with in the community as a non-resident patient.

An application by the patient or nominated person for discharge or change of status to a non resident patient can be made at any time after the patient becomes liable to assessment. The clinical supervisor may bring forward an application for a treatment order so that both applications are dealt with at the same time. Applications to discharge the treatment order can be made once after 3 months but further applications may be made with leave of the Tribunal. Applications to change the status of the patient from resident to non-resident can be made at any time and once before the end of the order. Further applications may be made with leave of the Tribunal.

Hospital managers must ensure that the clinical supervisor makes an application to the MHT for an order authorising medical treatment or further assessment within 28 days. The order for medical treatment may not exceed 6 months. This may be followed by two further orders for up to 6 months and, after 12 months or 3 consecutive orders, a further order can be made for up to 12 months. The clinical supervisor is required to consult the nominated person and any informal carer before an application is made to the MHT.

The clinical supervisor must apply to the Tribunal for the variation of an assessment order or treatment order. The clinical supervisor can grant leave of absence or, in the case of a non-resident patient, suspend any of the conditions imposed on the patient.

The Tribunal will be advised by an independent medical expert drawn from the Expert Panel in all cases involving patients who are detained in hospital as a resident patient or subject to conditions as a non-resident patient. The Tribunal may also appoint other members of the Expert Panel, who may or may not be registered medical practitioners, to provide advice. The panel will include doctors drawn from a variety of backgrounds, including from black and ethnic minorities. It will also include people with experience of ethnic minority issues, social care, learning disability nursing, mental health nursing and the probation service.

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<sup>174</sup> Department of Health, 2004. *Improving Mental Health Law – towards a new Mental Health Act*. Paragraph 9.31

The Tribunal can reserve to itself the power to discharge a patient from assessment or treatment orders and to approve applications for a patient to be transferred or given leave of absence. The reasons for this are to be set out in regulations and the intention is that this power will only be available where a patient poses a significant risk of causing serious harm to others.<sup>175</sup>

There is a duty on the Tribunal to make a 'deferral order' when the Tribunal makes a discharge order in relation to a patient who has been detained for at least 28 days and there is no discharge plan in place, and without after-care the patient is likely to meet all the necessary conditions within 8 weeks. This gives the managers up to 8 weeks to detain the patient in order that a post-discharge care plan can be provided.

The Tribunal also has powers to:

- authorise ECT for adult patients under formal powers who lack capacity to consent or refuse treatment, and for all children under 16
- determine if a child under 16 entitled to special safeguards is lawfully detained
- resolve disputes involving children under 16 entitled to special safeguards where there is disagreement about the approval or review of a care plan
- deal with the appointment or removal or revocation of nominated persons

A Mental Health Appeal Tribunal (MHAT) will provide a second tier of appeal from the MHT on a point of law. The MHAT will comprise of a President and a number of other members who will be experienced and suitably qualified lawyers appointed by the Lord Chancellor. All appeals will be heard by a single member of the MHAT. The MHAT will not be able to discharge patients but it can give recommendations as to the timing of reconsideration of the case by the MHT and it can direct that medical treatment may not continue until the determination by the Tribunal on reconsideration of the case.

### ***Recommendations of the Joint Committee on the Draft Mental Health Bill***

The Committee made the following recommendations:

1. That the MHT be given power to order the transfer and leave of absence of restricted patients.
2. That it shall be a duty of criminal court judges to consult a member of the Expert Panel when considering a care plan.
3. That the Government expedite the completion of its studies into the expected length of hearings under the Bill and, once these studies are complete, that the Government recalculate and republish the workforce and funding implications of the new system in the Regulatory Impact assessment that it presents to Parliament with the Bill proper.
4. Prior to the publication of any future Mental Health Bill and the introduction of the new MHT system, the Government should publish realistic plans detailing exactly from where the increased number of tribunal members will be drawn, and explaining in detail how the new MHT system will administer more than 40,000 hearings a year.
5. That no new Act be brought into force until the Government can demonstrate that sufficient resources are available, both financial and human, to allow for the proposed extensions in hearing numbers and remit.

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<sup>175</sup> Department of Health, 2004. *Improving Mental Health Law – towards a new Mental Health Act*. P.9.

6. That in the interests of ensuring that hearings are both fair and seen to be fair, there be a clearer distinction between the roles of the MHT as a detaining body and as a review tribunal. So, for example, a member of a tribunal that has imposed an order for assessment or treatment should never hear the review or appeal of that order.
7. That the current discretion in Section 72 of the 1983 Act, which permits the MHRT to discharge patients even where the detention criteria are met, be included in the Bill.
8. That, in order to ensure a fair hearing, the MHT, when hearing substantive matters and sitting as a panel, sit only as a panel of three members. The Joint Committee stated that a MHT should be permitted to sit with fewer than three members at case management hearings and it would be wholly inappropriate for a single member panel, consisting of a lawyer sitting in a judicial capacity, to decide substantive clinical issues.
9. That Clause 249 of the Bill should also include provision for NHS Trusts to appeal to the MHAT on a point of law.
10. That the Bill include a requirement on the MHT, when examining care plans, to consider wider concerns and considerations than purely medical matters – e.g. social and housing needs.

### ***Alliance position***

The Alliance supports the general principle that compulsory powers should be exercised beyond an initial period without an order from the newly-constituted MHT. However, we are concerned that the proposals contained in the draft Bill will fail to effectively safeguard the rights of people who are being detained or treated under compulsory powers. We therefore recommend a number of changes to the proposed MHT framework.

Our key concerns are that:

1. Tribunal membership is dominated by the medical profession and does not provide for the inclusion of people who have experienced mental illness nor of women and people from black and minority ethnic communities;
2. Tribunals should not be able to reserve to themselves the power to discharge patients from compulsory orders;
3. The Bill creates a disincentive for patients to appeal against their initial assessment order because this may result in the making of a long term treatment order;
4. Appeals against the use of compulsory powers should not be heard by the same Tribunal that authorised the order;
5. The scope of the care plan to be considered by the Tribunal is too narrow;
6. The Tribunal lacks the power to amend care plans in the face of objections from the clinical supervisor;
7. The Tribunal should retain discretion to discharge civil patients, even where the conditions for the use of compulsory powers are met;
8. The Bill fails to provide clear grounds for the Tribunal when determining whether compulsory treatment should be imposed in the community;
9. The proposals for Deferral Orders are unrealistic and potentially unlawful;
10. The Tribunal should be given the power to discharge and to order the transfer and leave of absence of restricted patients;
11. There must continue to be a right to publicly funded legal representation for MHT hearings; and
12. We share the concerns that the new Tribunal arrangements are likely to be unworkable.

## **Membership of the MHT**

The Alliance believes that each MHT should comprise:

- a. a legally qualified member;
- b. a member with experience of providing mental health services, but not a doctor (the MHT should be advised by an independent doctor from the proposed Expert Panel);
- c. a lay member, who may be a person who has experienced mental illness, an informal carer or someone who represents their interests; and
- d. a children's professional where the patient is a child or young person.

Schedule 2 of the draft Bill states that the new Tribunal should consist of a legal member, a clinical member- defined as a person who has, "*such knowledge or experience of the treatment of mentally disordered persons as the Lord Chancellor thinks fit*" - and another member with such experience who is not a legal or clinical member.

### **Tribunals should require a 'professional member'**

We do not agree with the requirement that the Tribunal must have a clinical member. The MHT is required to make a legal decision which is likely to have significant medical and social consequences. Medical input is already provided by an independent doctor from the Expert Panel. We therefore suggest that membership of the MHT should include a 'professional member' from outside of the medical profession, for example a social worker, occupational therapist or mental health housing worker.

The automatic inclusion of a clinical member will also lead to hearings being based exclusively on the medical model of mental health care: the MHT will contain a clinical member; it is advised by a doctor from an Expert Panel; and the clinical supervisor or junior doctor will attend the Tribunal hearing. This would place too much emphasis on medical views to the detriment of the views of the person whose case is being considered. To have a doctor as a member of a Tribunal would also lead to conflict between their role as an expert and as a decision-maker. We are also aware of the severe practical difficulties in recruiting medical members under the existing Act; this will be even harder under the proposed Bill.

We acknowledge however that there may be circumstances in which a doctor could be a member.

As Mike Shooter of the Royal College of Psychiatrists put it: "*It has never been the assumption of the Royal College, either individually or as part of the Alliance, that there had to be a medical member on the Mental Health Tribunal, as long as the tribunal is in receipt of expert evidence from a medical member of the Expert Panel... We are moving into a situation with new ways of working where other members of the mental health team may well have very highly skilled and trained clinical expertise which they could give to a Mental Health Tribunal.*"<sup>176</sup>

The Mental Health Alliance supports the proposal of the Expert Committee, which suggested that as a way of achieving the necessary independence and expertise, while reflecting the demands of fairness and the realities of consultant ability, Tribunals should not contain a medical member, i.e. a doctor, but have access to independent medical advice.

### **Tribunals should include service users and carers**

We are concerned that the proposed membership of Tribunals does not explicitly include people who themselves have experienced a mental illness or others who may have a lot to offer in terms of their experience of mental illness and mental health services. As a matter of

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<sup>176</sup> Dr Mike Shooter, Royal College of Psychiatrists, on behalf of the Mental Health Alliance, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Ev.162-3.

principle the lay member of the Tribunal should be a person who has experience of mental health services as a user or carer, or a volunteer or employee who works with and can represent any of these groups. This would be consistent with, for example, employment tribunals, which contain representatives of both management and employees.

### **Tribunals should reflect the culture, language and beliefs of the patient**

Membership of the MHT does not specifically include people from black and ethnic minority groups and we believe this is crucial to ensure that the Tribunals are able to take full account of a person's culture and circumstances, e.g.:

- the degree of involvement with both the culture of origin and the host culture, taking special recognition of language abilities and preferences
- the predominant idioms of distress through which symptoms or the need for social support are committed, e.g. possessing spirit, somatic complaints, inexplicable misfortunes
- culturally relevant interpretations of social stressors, social support, levels of functioning disability
- cultural elements of the relationship between the individual and the clinician and the problems these may cause in diagnosis and treatment.

We therefore recommend that Tribunals should include BME representation where appropriate. This is especially important considering that under the 1983 Act African-Caribbean people are more likely to be detained and receive higher doses of medication than the population as a whole. We recognise and welcome the inclusion of people with experience in ethnic minority issues on the Expert Panel but there is a danger that such issues will be seen to be of secondary importance or treated in a superficial way unless Tribunals include BME representation.

### **Tribunals should reflect the gender of the patient**

Tribunals should also specifically contain at least one person of the same gender as the person whose case is being heard. There are particular gender issues to consider including, in respect of medication, sexual functioning, menstruation and risks to a foetus during pregnancy.

### **Tribunals should not be able to reserve to themselves the power to discharge patients from compulsory orders**

Clauses 46(5) and 49(5) provide that the Tribunal can reserve to itself the power to discharge, transfer or grant leave of absence to certain patients to be defined in regulations. No clear definition is offered as to who this will cover, however the explanatory notes provide the following example:

*“A patient with a long history of schizophrenia and violent behaviour gets a new clinical supervisor when a former clinical supervisor retires. The new clinical supervisor takes a different view about the nature of the patient's condition and decides that the patient no longer meets the relevant conditions and discharges him or her. The patient then comes under formal powers again a couple of weeks later, having attacked someone, and an application is made for a treatment order. The Tribunal might be concerned that the clinical supervisor's view of the patient's condition could result in the patient inappropriately being discharged and would then reserve discharge to itself.”<sup>177</sup>*

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<sup>177</sup> 2004. *Draft Mental Health Bill Explanatory Notes*. p26, Para 121

We are concerned that such an extreme example is being used to justify the creation of a new legal power which could potentially lead to patients being detained even though they no longer meet the relevant conditions for compulsion. The prospect of the clinical supervisor losing control over the care of some civil patients, who will in effect be treated as if they were under a restriction order, is wrong in principle and may violate Article 5 of the European Convention on Human Rights (ECHR). The role of the Tribunal should be to authorise orders and determine appeals against compulsion and should not include consideration of whether to discharge an order in circumstances where a clinician decides that it should end.

### **People should not be discouraged from appeal within the first 28 days**

If the patient appeals within the assessment period, the Tribunal could convert the assessment order into a treatment order. This may be seen as a disincentive to appealing during this period.

The Draft Bill makes it possible for the Tribunal to hear both the appeal against compulsion and an application for a treatment order concurrently. Necessarily, many patients will be wary of challenging their detention, given the purpose and possible consequences of the hearing. This weariness is likely to be reinforced by the fact that their perception of Tribunals will change. Instead of being the independent body that can order their release, it will be seen as the authority that imposes long-term compulsion. It is still doubtful that these provisions satisfy Article 5 of the ECHR.

This proposal would also have a disproportionately negative impact on the vast majority of patients under the 1983 Act who are detained but then discharged or made informal before 28 days. Under the draft Bill these patients would not get an automatic Tribunal and would be deterred from appealing against their detention at an early stage for fear of the MHT imposing a long term treatment order.

The Alliance believes that where a person appeals against an assessment order, the Tribunal should not be empowered to authorise a treatment order.

### **Appeals against the use of compulsory powers should not be heard by the same Tribunal that authorised the order**

The Alliance is concerned at the blurring of the functions given to the Tribunal as a detaining authority, and a review body. This raises questions about the impartiality and independence of the Tribunal when it is responsible for authorising detention and then subsequently acts as a reviewing body on an application by a patient. This would potentially engage Article 6 of the ECHR which provides a right to a fair trial by an independent and impartial court.

The Alliance believes that appeals against a compulsory order should not be considered by the MHT that authorised the order. Instead they should be considered by a differently constituted Tribunal and a member of the Tribunal that imposed an order for assessment or treatment should never hear the review or appeal of that order.

### **The scope of the care plan to be considered by the Tribunal is too narrow**

We welcome the requirement that the clinical supervisor must produce a care plan for each Tribunal but are concerned that its scope will be very narrow, consisting primarily of the medical treatment which may be given in the absence of consent. Clause 39 of the draft Bill states that the contents of the care plan must include a description of the medical treatment and other information which will be laid down in regulations. This contrasts with the approach taken in the White Paper which proposed that the care plan would be modelled on the Care Programme

Approach and we regret that this has been dropped. The narrowness of the care plan may mean that the Tribunal is inadequately informed to make decisions required of it, and it also renders the duties placed on the clinical supervisor to consult the patient, carer and nominated person to be of limited value.

We believe that the care plan must be holistic and include comprehensive reference to all the health, psychological, occupational and social needs of the patient; and that the statute itself should specify that this must be accordance with the Care Programme Approach.

### **The Tribunal lacks the power to amend care plans in the face of objections from the clinical supervisor**

It is apparent that the new MHT will be much more involved in the approval of treatment plans than the current MHRTs. However the Tribunal appears to have no power to order the clinical supervisor to change the proposed treatment plan; only such amendments as are 'agreed' with the clinical supervisor may be made. It is also not clear what the position would be where agreement cannot be reached between the Tribunal and the clinical supervisor. This could present particular difficulties in the case of a resident patient who the Tribunal considers could be treated more appropriately in the community.

The Tribunal may have misgivings about the clinical supervisor's decision as to the appropriate treatment and this view may be shared by the Expert Panel member. However, it appears that the only options would be persuasion or the extreme step of refusing to authorise the entire treatment order. We accept that a clinical supervisor cannot be required to administer treatment which s/he thinks is not therapeutically appropriate, but we believe that as a matter of principle the Tribunal should be able to block specific treatment which it is satisfied is not in the patient's interests. Otherwise it is difficult to see that the role of the Expert Panel member would be of great value. This would ensure that the MHT provides sufficient judicial oversight compatible with Article 6 of the ECHR.

### **The Tribunal should retain discretion to discharge civil patients, even where the conditions for the use of compulsory powers are met**

In contrast to the 1983 Act, the Draft Bill removes any discretion for the Tribunal so that, once the criteria are met, compulsion must follow and the Tribunal is unable to take into account matters not referred to in the Government's test. We believe that the removal of this power will undermine the Tribunal's potential as a genuine safeguard and the effect would make it more likely that those who did not require compulsion would be compelled to receive treatment. Indeed, under the Draft Bill there is a greater need for a discretionary power because the broadly drafted relevant criteria ensure that patients would easily fulfil them and this will limit the ability of a Tribunal to discharge a patient. The Alliance therefore recommends that Tribunals should continue to have a discretionary power to discharge people from compulsion.

### **The draft Bill fails to provide clear grounds for the Tribunal when determining whether compulsory treatment should be imposed in the community**

The draft Bill fails to provide clear grounds for the Tribunal when determining whether compulsory treatment should be imposed in the community. The draft Bill provides no additional threshold criteria for the MHT to determine whether compulsory treatment is to be imposed in the community as a non-resident patient, or under conditions of detention as a resident patient. The relevant conditions in Clause 9 require only that the threshold for treatment under compulsion be reached but no additional threshold criteria is required in deciding whether the patient is to be a resident or non-resident patient. The same

criticism may be made of mental health orders imposed by the Crown Court. This is likely to be incompatible with Article 5(1) of the ECHR. A contrast may be made, for example, with Clause 147(6) which sets criteria for the Tribunal when considering a non-resident order on a restricted patient.

The Alliance is concerned about the Government's proposals for compulsory treatment in the community and we believe that there is a sufficient evidence base to justify rejecting the proposals in this Bill. These proposals, combining community orders with a wide definition of mental disorder and loose criteria, in an environment in which community services are insufficiently developed and defensive professional practice persists, will not work. The Joint Committee agrees with this stating:

*"Non-residential compulsion could be applied to a far wider population than is appropriate, and in circumstances which could be unacceptable."*<sup>178</sup>

However, given the Government's commitment to Non Residential Orders (NROs), the Alliance as a whole has agreed on a minimum set of requirements that would be necessary before any form of NROs could be viewed as acceptable and workable. This would include providing clear grounds for the Tribunal to determine whether to change the status of the patient from resident to non-resident. For example, the Bar Council has suggested criteria to the effect that the patient must be treated/assessed as a non-resident patient unless the Tribunal is satisfied that treatment can only be given in hospital, and it is necessary for the health or safety of the patient or the protection of the public from harm that he receive the treatment as a resident patient.

### **The proposals for Deferral Orders are unrealistic and potentially unlawful**

Where a detained Part 2 patient does not meet the relevant conditions for compulsion in the community, the MHT must in some cases authorise her/his detention for a further eight weeks under a deferral order. This applies where no post-discharge care plan has been prepared by the managers of a hospital or relevant local authority, and where all the relevant conditions will be satisfied within eight weeks if the patient is discharged without post-discharge services.

We are concerned that under this provision a Tribunal would be able to authorise a person's further detention for up to eight weeks when it has just determined that he/she does not satisfy the relevant conditions for compulsion, let alone detention. It is of further concern that this decision will also be based on the Tribunal performing the near impossible feat of projecting 8 weeks into the future to determine whether or not, in the absence of a discharge plan, all the relevant conditions are likely to be fulfilled. This is unlikely to be a precise exercise even in cases with a history of deterioration.

In the absence of a duty on the relevant authorities to provide such services, or a power in the Tribunal to compel such provision, a deferral order is likely to be unworkable, with the consequence of an unreasonable delay in achieving discharge, which would be in violation of Article 5(1)(e) of the ECHR.<sup>179</sup> There is also no indication of what should happen in the event that it takes longer than 8 weeks to organise post-discharge services. The performance of post-discharge planning and the availability of suitable post-discharge services are real issues currently affecting the conduct of Tribunals.

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<sup>178</sup> 2005. *Report of the Joint Committee on the Draft Mental Health Bill*, Volume I, p.70, para.197.

<sup>179</sup> *Johnson v UK* (1997) 27 EHRR 296

It is also worth pointing out that the deferred discharge regime envisages that a patient entitled to discharge and who is unlikely to deteriorate within a short period of discharge, be discharged immediately regardless of the availability of a post-discharge plan. We believe there is no difference between a patient likely to deteriorate within 8 weeks and one who is not, in that both should be entitled to post-discharge care.

### **The Tribunal should be given the power to discharge and order the transfer and leave of absence of restricted patients**

The Draft Bill provides that a restricted patient can only be discharged, given leave of absence, or transferred to another hospital with the agreement of the Home Secretary. The Alliance believes it is essential that the MHT makes these decisions.

We believe that the Bill should provide an enforceable right to treatment in the least restrictive environment which is consistent with the needs of the patient and the need to protect the public.

The problem of patients stuck in inappropriately high conditions of security is longstanding<sup>180</sup>, and while we welcome Government policy to increase the provision of medium and low secure facilities, we consider that these decisions are of such importance to the individual's liberty that they should lie in the hands of the MHT. We concede that Article 5(4), as currently interpreted, does not require the Tribunal to have jurisdiction to take such essential decisions.<sup>181</sup> Nevertheless, detention of a patient in inappropriate conditions of security may violate their rights under Article 8 of the ECHR. The Tribunal is best placed to make decisions about the level of security a patient requires having heard all the medical evidence with representations from the patient, and it is both wasteful and unjust not to allow the Tribunal to act upon that information.

We support the recommendation of the Expert Committee that the Tribunal should have power not only to order a restricted patient's discharge but also to order such steps as are a necessary precondition to the patient being discharged, in particular a power to order transfer between hospitals and leave of absence.

### **There must continue to be a right to publicly funded legal representation for MHT hearings**

People subject to compulsory powers will have the right of access to independent advocacy services under the draft Bill but also need publicly funded legal representation at MHT hearings in accordance with Article 6 of the ECHR. Publicly funded representation is provided for MHRT representation under the 1983 Act and it also needs to be made explicit that this will continue to be the case at both MHT and Mental Health Appeal Tribunal hearings, given the human rights issues that they need to consider.

### **The new Tribunal arrangements are likely to be unworkable**

We share the widely held concerns over the practicability of the new arrangements. There will be a significant increase in the number of Tribunal hearings. There will also be a vast expansion in the types of decisions that Tribunals will be empowered to consider, such as; authorising care plans, displacing nominated persons, authorising ECT and examining whether the relevant conditions apply. This will require a huge change in the culture of Mental Health Tribunals. It is likely that hearings will be significantly longer because they will have to consider

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<sup>180</sup> Department of Health, February 2000. *Report of the Review of Security at the High Security Hospitals.*

<sup>181</sup> *Ashingdane v United Kingdom* (1985) 7 EHRR 528

care plans as well as issues related to compulsory powers and there will be massive implications for recruitment and training. The present MHRT system is struggling to manage the present system with appeals being cancelled and delayed. Delays in tribunal hearings as a result of the over-burdened, under-resourced system as it exists have been found to violate the article 5(4) requirement of a “*speedy review*”, entitling some patients to compensation<sup>182</sup>. We have grave concerns about whether the new expanded system is realistic and practicable. The draft Bill fails to explain how the MHRT administration, which is currently unable to deliver an effective service, will be able to deliver the new expanded Tribunal system. It is also clear from the draft Bill that the MHT is intended to play a pivotal role in protecting patients’ rights; however if, as a result of these practical difficulties, the Tribunals are ineffective, the Bill’s safeguards will be compromised.

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<sup>182</sup> R(KB) and others

### **Current law**

Section 117 of the Mental Health Act 1983 places duties on both health and local social services to provide (free) aftercare services to people detained under Sections 3, 37, 47 or 48 of the Act until they are satisfied that the person is no longer in need of them. Recent court rulings have confirmed that there is no power to charge people for services under Section.117. In the Mental Health Act 1983 “*aftercare services*” are not defined but it tends to be those provided by health and social services for the purposes of the NHS and Community Care Act 1990.

### **The Draft Mental Health Bill 2004**

The draft Bill limits authorities’ duties to provide care to:

- i) the provision of the compulsory components of the care while under a treatment order; and
- ii) a period of six weeks following the date of discharge (Clause 68).

### **Alliance position**

#### **A duty to provide care set out in care plans**

The Alliance believes there is a strong case for imposing a statutory duty of continuation of care on authorities. This should include a duty to provide the care and treatment set out in care plans and a right to ongoing care after discharge – both recommended by the Expert Committee. This is necessary to ensure vulnerable people continue to receive necessary services to avoid relapse.

We know from experience that currently care plans very often fail to be effectively implemented, with many patients not even knowing that they have one.<sup>183</sup> In her 2003 study, Diana Rose found that, on average, awareness of the Care Programme Approach and its elements was less than 50 per cent among service users and could be as low as five per cent.<sup>184</sup> The Government’s view appears to be that current general duties of care on local authorities will suffice to ensure care plans are implemented. However this by no means guarantees the provision of services set out in care plans.

The draft Bill offers a significantly different, and considerably less satisfactory, position to that of the general duties set out in the new Mental Health (Care and Treatment) (Scotland) Act 2003. The Scottish Act places a general duty on local authorities to provide both “care and support services” (S.25) and “services designed to promote well-being and social development” to “persons who are not in hospital and who have or have had a mental disorder”. There is also a duty to co-operate with Health Boards and other services (S.30). Such a general duty means anyone discharged from a compulsory Order in Scotland should by law automatically receive those services they need.

The proposed disparity between England/Wales and Scotland also means that there will be inequalities between people who live in the different countries. This is likely to cause

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<sup>183</sup> *Just 1 Per cent* Rethink, 2003. A survey of 3033 people with severe mental illness of whom 1427 answered questions about care plans. 52% do not know their level of care, 48% do not have or do not know if they have a care plan.

<sup>184</sup> Rose, D., 2003. *Partnership, co-ordination of care and the place of user involvement* Journal of Mental Health, Volume 12 (1) 59-70

particular confusion to both patients and service providers when people move to and from across the border.

### **Care after discharge from a compulsory order**

The current Section 117 duty on authorities to provide aftercare to people who have been detained in hospital is crucial in ensuring people remain engaged with services on discharge, receive continuing support and do not relapse. The Bill's removal of this duty places the burden for continuation of care on a patient's care plan, which authorities will have no statutory obligation to implement.

The six-week period for free continuation of care appears randomly selected and takes no account of individuals' needs, nor of local gaps in service provision. Many people fail to get in place the services they need for recovery for several weeks or even months because of chronic shortages of accommodation, resources and staff in the community. Discharge from a compulsory order on the grounds that the criteria for continued compulsion are no longer met is not the same as saying a person will be fully recovered. In fact, people are often likely to need quite intensive continuing support. The fact that they have been subject to an order necessarily should indicate that they have been seriously ill and may not be good at engaging with services.

Making people pay for their care after six weeks will act as a deterrent to many from continuing to engage with services and could seriously endanger these people's recovery. Treatment regimes that involve psychotherapy or other psychological interventions rather than drugs are not able to be completed in a six-week time span and usually require at least a year.

The right to aftercare flows from the principle of reciprocity. If a person has his/her liberty taken away there is a corresponding duty to provide care for them. As the Richardson Committee stated in 1999:

*"... The obligations flowing from reciprocity do not end immediately on discharge from compulsion. A person who has been subject to a period of compulsion would have a right to ongoing care for a specified period after compulsion, although there would be no obligation in the patient to accept that care... [the rights] would impose duties on health and social services authorities in addition to any general duties they might possess."*<sup>185</sup>

Accordingly, we propose that the six week limit on free aftercare services should be dropped from the Bill.

### **Duration of aftercare**

#### **The Alliance believes that continuation of care should be provided until such time as the patient no longer needs it**

The Alliance's believes that the new Bill should seek to replicate the duties set out in the 1983 Act - i.e. care should be provided *"until such time as [both authorities] are satisfied that the person concerned is no longer in need of such services."*

As the Department of Health has made clear, this duty does not require free aftercare indefinitely but only so long as the need persists.<sup>186</sup> The Government argues that this provision favours detained over voluntary patients - they may even be in adjacent beds at some point. The House of Lords rejected this argument as "too simplistic", holding that compulsorily

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<sup>185</sup> *Review of the Mental Health Act 1983: Report of the Expert Committee*, November 1999, para.3.9, p.28

<sup>186</sup> Department of Health Circular 2000 (3)

admitted patients may pose greater risks upon discharge to themselves and others than compliant patients.<sup>187</sup>

As we have noted, it would be potentially damaging to patients' recovery to remove this current duty, and may lead to people disengaging from services. This argument has been accepted by the Joint Scrutiny Committee in Recommendation 70 of its report:

*"We recommend that there be a duty on health and local authorities in each case to draw up a discharge plan and provide the care in the plan, and that the provisions of Section 117 of the Mental Health Act 1983, relating to free aftercare based on need, be included in the Bill proper when introduced."*<sup>188</sup>

The Expert Committee suggested that the Tribunal, rather than the clinical team, might determine how long free care following discharge from an order might last, with the clinical team given the power to seek an extension if appropriate or to request a formal early termination if the patient indicates a consistent desire to distance him or herself from care. Although the Alliance considers this proposal has some merit, it would add further to Tribunals' and clinical teams' tasks. On balance, the Alliance prefers to support maintaining the present position by a replication of Section 117 of the present Act in the draft Bill, leaving the judgment to local decision.

Any decision to cease 'continuation of care' services to a patient who has previously been discharged from an Order needs to be taken by the care coordinator, since the clinical supervisor may have ceased involvement. There should be a duty on the care coordinator to consult the patient, any significant carer, the nominated person and relevant professional care staff prior to a determination to end the 'continuation of care' requirements.

### **Continuation of care should be free**

Section 117 of the current Act gives no powers to charge for aftercare services provided. This helps to prevent the withdrawal of services in the event of an individual being unable to pay for care. It also recognises that 'continuation of care' services in the community (which may include residential accommodation) are preferable to more expensive residential / hospital alternatives. In addition, the removal of free care after discharge will establish a perverse incentive to maintain people on compulsory orders (where care is free) even if they no longer technically meet the criteria.

### **Further issues**

The following issues are also important to ensure full and effective delivery to people under compulsion:

- A right to 'continuation of care' from the decision to begin assessment and initial treatment, covering all periods (including leave of absence from hospital) where the patient is subject to compulsory treatment under a resident or non-resident Order, and a duty on authorities to provide all care set out in patients' Care Plans.
- A duty on health and local authorities to assess local needs arising from the implementation of new non-residential community orders.

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<sup>187</sup> *R v. Manchester City Council exp Stennet* (2002) UKHL 34

<sup>188</sup> Joint Scrutiny Committee 2003 *Report of the Joint Scrutiny Committee on the Draft Mental Health Bill*, Volume I, p.156.

## Treatment Safeguards

Some treatments used for mental health problems are invasive, even irreversible, and psychiatric medication has the potential to cause very serious adverse effects. These include lethargy, stiffness, parkinsonism, muscle spasms, blood disorders, intense agitation and restlessness, massive weight gain and effects on heart rhythm.

On the loss of the ability to experience pleasure (or ‘anhedonia’), one woman’s evidence to the Joint Committee states: *“I cannot emphasise strongly enough just how debilitating and pervasive this feeling, or lack of feeling, is. You just exist. There is no point being alive... The feeling of anhedonia disappears within days of stopping the medication”*. She goes on to describe other adverse drug reactions – tiredness and lack of energy and the torture of akathisia (an excruciating inner restlessness which can make people suicidal).<sup>189</sup>

Safeguards are needed to ensure that patients’ wishes are respected as far as possible, and that patients receive effective treatments whose benefits to them outweigh their harms.

### **Current law (Mental Health Act 1983)**

The current Act allows detained patients to consent to treatment and uses a second opinion system to authorise certain treatments that the patient refuses or to which they cannot consent:

Psychosurgery (or NMD – neurosurgery for mental disorder), and other treatments categorised as irreversible and hazardous, may only be given with consent and second opinion authorisation.

ECT (electroconvulsive therapy), from the start of the detention, and drug treatment after three months, may only be given with consent, or second opinion authorisation. These treatments may also be given under emergency provisions, with a second opinion obtained as soon as possible thereafter.

Treatments for mental disorder that are not covered by these safeguards may be given without the patient’s consent.

These procedures mean that the patient’s consent with respect to each safeguarded treatment is established and recorded. The second opinions are provided by second opinion appointed doctors (SOADs) who are appointed by the Mental Health Act Commission. They have duties to consult nursing and other non-medical staff who know the patient.

### **Draft Mental Health Bill and Alliance position**

The Alliance’s view is that people who retain decision-making capacity in relation to treatment should not be subject to compulsion (see chapter on conditions for compulsion), and that further treatment safeguards are required.

The draft Mental Health Bill does not make impaired decision-making or mental incapacity a condition for the use of compulsory powers. However it only allows ECT to be given to a

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<sup>189</sup> Kay Sheldon, Draft Mental Health Bill. Para. 377. Ev 226-227

person who has capacity with their consent, except for emergency ECT. Safeguards for drug treatments are much weaker.

### Care plans, criteria for treatment and consent

In the draft bill, after 28 days, treatment may only be given under compulsion if it is included in the care plan approved by the Tribunal. Yet the draft Bill has very little to say about the content of the care plan or the basis on which the Tribunal should authorise treatment.

In evidence to the Joint Committee the Law Reform Committee of the Bar Council states: *“[The tribunal] has been given no criteria whatsoever to apply in determining whether treatment is justified (see Clause 46). Given that compulsory treatment engages profound issues under (primarily) Articles 3 and 8 and a body of case law has now developed as to the approach to be taken by a Court in determining whether such treatment is lawful (in particular the Court of Appeal decisions in R (Wilkinson) v Broadmoor SHA and R (N) v Dr M) we find this oversight startling.”*<sup>190</sup>

The Mental Health Act Commission, in its evidence to the Joint Committee, drew attention to the way that patient protection could be compromised by the adoption of generic care plans allowing wide discretion in prescribing treatments to be given in the absence of consent.<sup>191</sup>

The British Psychological Society said:

*“The Bill should include a clear statement of the principles upon which care plans should be based – for the proposed treatments to be of proven efficacy, to be based on currently accepted professional practice guidelines (e.g. the British National Formulary in respect to drug regimes and guidelines from the National Institute for Clinical Excellence) and for the therapeutic benefits to outweigh the likely cost to the individual.”*<sup>192</sup>

### Alliance position

The Act should set out in general terms the essential elements of a care plan and the principles of treatment, including evidence-based reasons for prescribing a treatment, an assessment of the balance of benefit and harm, and continuing review of this, treatment that is as far as possible consensual, and rapid review following adverse effects. These should be specified in more detail in the Code of Practice and adherence to the Code should be required by the Act (see chapter on Code of Practice). It should include a multidisciplinary approach so that a wide range of treatment options is considered. This can only contribute to the health and safety of the patient, and help to reduce the use of emergency provisions and more invasive treatments. It follows from this basis that care plans should be specific and consent should be sought for each treatment that is being proposed.

The Alliance believes that impaired decision-making by reason of mental disorder should be the threshold for the use of compulsory powers. A person who has impaired decision-making capacity may be able to take part in treatment decisions and express preferences between treatments.

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<sup>190</sup> Ev. 180.

<sup>191</sup> Ev. 30.

<sup>192</sup> Ev. 599.

It is essential that people are as involved in treatment decisions as possible and that they first have the opportunity to receive treatments on a consensual basis before any consideration is given to treating without their consent. The Mental Capacity Act sets out the steps which should be taken to try and ensure people are as empowered as possible in deciding upon treatment options. All patients should be provided with information to standards set out in the Code. If a patient requests a particular type of treatment, or is open to agree to treatments other than those being proposed, then these alternatives should be considered and if they are refused the reasons should be recorded.

Advance directives should not be overridden without extra safeguards being applied. (See chapter on advance statements for further details.) Advance statements requesting a particular treatment should carry due weight. The Mental Capacity Act sets out how to assess the validity of an advance refusal of treatment.

When authorising treatment under compulsion, the Tribunal should do so within limited time frames. The clinical member of the Tribunal's expert panel should be required to consult with staff (including non-medical staff) who are involved in the patient's care, and to interview the patient, subject to their agreement. The clinician's advice must be based on recorded reasons that take into account the patient's views and observations, the clinical supervisor's views and those of other members of the clinical team as well as the clinical member's own conclusions. (This is in keeping with current Mental Health Act Commission guidance following the case of R Wooder v Dr Feggetter and MHAC.) The decision to give a medical treatment must always involve a person qualified to prescribe it. If people are subject to compulsory treatment long-term they should be offered annual checks on physical health as well as reviews of their treatment for mental disorder.

### ***Joint Committee support for Alliance position on care plans***

*"We recommend that the codes of practice contain guiding principles for drawing up care plans which will govern the treatment, and for example, the privacy, safety and dignity of the patient."*<sup>193</sup>

*"We recommend that the Bill transfer to the new Expert Panel the safeguarding function of the current second-opinion doctor (SOAD system), which includes the power to veto treatment."*<sup>194</sup>

*"We recommend that the Bill make provision for the recording of details of the treatment being given under consent during the assessment period and of the details of the consent itself. We believe that treatment should be audited under all circumstances, and we believe this to be particularly important in relation to treatment under the proposed new system of non-residential orders."*<sup>195</sup>

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<sup>193</sup> Joint Committee on the Draft Mental Health Bill 2004. Para 352.

<sup>194</sup> Joint Committee on the Draft Mental Health Bill 2004. Para 370. The issue of vetoing treatment, or other aspects of a person's care plan, is addressed in the chapter on Tribunals. The Alliance wants this power to reside with the Tribunal. However the Alliance position that clinical members of the Expert Panel be required to consult is implicit in the Committee's recommendation.

<sup>195</sup> Para 371. The Alliance has not made this specific proposal but it is consistent with its policy on making treatment as consensual as possible.

## ECT (Electroconvulsive therapy)

The draft bill does not allow ECT to be given to a person with capacity without their consent. The only exception is in an emergency – the draft bill includes a regulation-making power to make it possible to over-ride the patient's refusal in emergencies.

For those lacking capacity, ECT must be approved by the Tribunal before it can be given, except where emergency criteria apply.

### **Need for ECT safeguards**

ECT is an invasive procedure and in consumer surveys many respondents say they found it unhelpful or damaging.<sup>196</sup> Passing an electric current through a person's brain is an invasive intervention by any criteria. A systematic review of ECT found it to be more effective than sham ECT or drug treatment in the short term, but found less evidence that short term benefits compared to alternative treatments are maintained in the long term.<sup>197</sup> A review of the literature about patients' views of ECT, commissioned by the Department of Health, found that at least one third of patients report significant memory loss.<sup>198</sup>

Loss of personal memories can be permanent<sup>199</sup> and has a profound psychological impact, as the following quote from Mind's Shock Treatment survey indicates:

*"[I received] very basic information i.e. it is safe and effective and possible side effect "short term memory loss" which I presumed to be forgetting names etc. No idea of depth of loss, places visited in the past, precious life memories."*

The systematic review states that 'the more effective forms [of ECT] tend to cause more memory impairment'. There is, therefore, a trade-off between making ECT optimally effective in terms of ameliorating depressive symptoms and limiting cognitive impairment as much as possible.'

The adverse psychological effects of ECT are generally disregarded in clinical research. In *Shock Treatment* people wrote about feelings of fear, anxiety and worthlessness resulting from ECT. In Lucy Johnstone's study of people who found ECT distressing<sup>200</sup> participants spoke about fear and feeling humiliated, betrayed, worthless, punished, degraded, stigmatised and assaulted.

The systematic review found no direct evidence to show an increase or decrease in mortality in patients treated with ECT and therefore concluded that 'it cannot be said with certainty whether ECT saves the lives of some patients. It is possible that it does so, by promoting a more rapid response to treatment.'

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<sup>196</sup> Rogers, A, Pilgrim, D, and Lacey, R. 1993. *Experiencing Psychiatry*. Macmillan with Mind: 43 per cent found ECT helpful or very helpful, 37 per cent found it unhelpful or very unhelpful and 20 per cent found it neither helpful nor unhelpful. A UK Advocacy Network survey in 1995 received the following responses: 30 per cent 'helpful', 65 per cent 'not helpful', 35 per cent 'damaged' and 78.5 per cent 'never again'. M Pedler. 2001. *Shock Treatment*. Mind: thirty-six per cent of those respondents who had had ECT most recently found it helpful or very helpful and 27 per cent found it unhelpful, damaging or severely damaging – rising to 43 per cent when considering the long term.

<sup>197</sup> UK ECT Review Group, 2002. Systematic review of the efficacy and safety of electroconvulsive therapy. Review commissioned by the Secretary of State for Health.

<sup>198</sup> Rose, D, Wykes, T, Leese, M, Bindman, J and Fleischmann, P., 2003. *Patients' perspectives on electroconvulsive therapy: systematic review*. British Medical Journal, 326, 21 June 2003.

<sup>199</sup> Squire & Slater. 1983. *British Journal of Psychiatry*. Research that 55 per cent had not regained normal memory function three years after receiving ECT In Mind's Shock Treatment survey over 40 per cent of respondents had permanent loss of past memories.

<sup>200</sup> Johnstone, L. 1999. Adverse Psychological Effects of ECT. *Journal of Mental Health*, Vol 8, no 1, 69-85.

The Northwick Park trial, while finding that very severely depressed patients had some short-term benefits from ECT, concluded that overall, ‘many depressive illnesses, even if severe, may have a favourable outcome with intensive nursing and medical care even if physical treatments are not given’<sup>201</sup>. This suggests the use of alternatives to ECT even for those who are suicidal or are refusing food, who may show short-term benefits from it.

There should be no exception to the requirement of consent where people have capacity.

The Alliance is pleased that patients with capacity will be able to refuse ECT; this is a major change from the 2002 draft bill and the current law. However we believe that this right should hold for all circumstances and there should be no emergency exception. A patient with capacity should not be forced to have any treatment – certainly not such an invasive one. It is also extremely unlikely that ECT would ever be the only alternative. The British Psychological Society, whose position is that no one should have ECT without informed consent, ‘questions the notion of ECT being an immediately lifesaving treatment, when compared with 24 hour one-to-one intensive care for instance.’<sup>202</sup>

The variable use of ECT by some clinicians (some prescribe it rarely or never), and the potential for harm, call into question the necessity of ever giving ECT against a person’s will, even if it were thought justifiable to override the autonomy of a person who retains decision-making capacity in this way.

The Alliance agrees that ECT could be given to people who lack capacity in the following situations:

- a) emergency situations, when the Mental Health Tribunal must be notified immediately and approve continued treatment;
- b) with the express prior approval of the Tribunal.

Emergency treatment should be defined in terms of saving life. It must be shown that all alternatives have been considered. Emergency criteria for the use of ECT are that the course is immediately necessary to save the patient’s life, immediately necessary to prevent a serious deterioration in his condition (and is not irreversible) or (not being irreversible or hazardous) immediately necessary to prevent serious suffering. The Alliance considers that these are too widely drawn. Also the wording implies that the treatment is not in and of itself irreversible or hazardous, but that it might be either or both in any individual case. This may make interpretation of the law unclear and create fear and uncertainty for patients who do not want to have ECT.

Wherever possible the Tribunal must have the opportunity to approve ECT before it is given to a person who lacks capacity, and to consider alternatives. Only where it is absolutely necessary should the clinical supervisor (or treating psychiatrist) go ahead with emergency treatment.

Provisions for advance directives and statements must apply to ECT (see chapter on advance statements). The nominated person should be notified of the intention to recommend ECT. The advocate should be consulted and be invited to be present during treatment without consent, if practicable, and subject to the wishes of the patient.

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<sup>201</sup> Johnstone EC, Deakin JFW, Lawler P, Frith CD, Stevens M, McPherson K, Crow TJ. 1980. The Northwick Park electroconvulsive therapy trial. *Lancet*, 1317-1320.

<sup>202</sup> Ev 599.

Surveys of people who have had ECT underline the need for advocacy and the support of the nominated person. In one survey, over one third (34 per cent) were not aware that they could refuse to give consent to the treatment. Approaching two-thirds (61 per cent) were not, as far as they remember, given any information about possible side effects. Of those consenting to treatment, 48 per cent received, as far as they remember, no information about how the treatment would work, and 45 per cent no information about possible side effects. Only 15 per cent had the opportunity to consult an independent advocate before making a decision about ECT.<sup>203</sup> A review of literature on patients' views on ECT found that approximately half the patients reported that they had received sufficient information about ECT and side effects, and that approximately a third did not feel they had freely consented to ECT even when they had signed a consent form.<sup>204</sup> The authors conclude that neither current nor proposed safeguards for patients are sufficient to ensure informed consent with respect to ECT, at least in England and Wales.

### **Safeguards should apply to 16 and 17 year olds**

The draft bill requires Tribunal authorisation for ECT to be given to under-16s. Because of the seriousness of the procedure, and the greater vulnerability of young people to damage from it, the Alliance believes that ECT should not be given to 16 or 17 year olds either without the authority of the Tribunal. A review of ECT used with children and young people (217 cases in published studies 1947-1996)<sup>205</sup> reported that 'although many children and adolescents had been given pharmacological therapies ... few had received other psychotherapeutic approaches. None had received a range of alternative treatments' (p.460). This underlines the need for scrutiny of the decision to recommend ECT, particularly as suicide and consent were also rarely mentioned in the case presentations in this study.

The Tribunal must include members with experience of, and expertise in, the care and treatment of young people.

### **The law should require compliance with recognised standards for ECT**

No one receiving ECT, especially those who have not consented, should be subjected to the risks of substandard practice. Audits of ECT during the 1990s found many ECT units not meeting basic quality standards of the Royal College of Psychiatrists.<sup>206</sup> For example they found it common for ECT to be given by inexperienced junior doctors who were not supervised by an experienced psychiatrist on their first administration of ECT and who lacked knowledge about one or more basic issues related to the effective administration of ECT.<sup>207</sup>

There should be guaranteed standards of practice with respect to expertise of those administering ECT, equipment and environment. The detail of the standards need not be specified in the Act but compliance with national standards should be required. Standards have been developed and are kept under review through the relatively new and voluntary

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<sup>203</sup> Pedler, M (2001) *Shock treatment, Mind*. The results quoted here are only for those who had had ECT in the previous two years.

<sup>204</sup> Rose D S, Wykes, T H, Bindman, J P, Fleischmann, P S. 2005. *Information, consent and perceived coercion: patients' perspectives on electroconvulsive therapy*. *British Journal of Psychiatry*, 186, 54-59.

<sup>205</sup> Baldwin S, Oxlad, M. 1996. *Multiple case sampling of ECT administration to 217 minors: Review and meta-analysis*. *Journal of Mental Health*, 5, 451-463.

<sup>206</sup> Duffett, R and Lelliott, P. 1998. *Auditing electroconvulsive therapy*. *British Journal of Psychiatry*, 172, 401-405.

<sup>207</sup> Duffett, R and Lelliott, P. 1997. *Junior doctors' training in the theory and practice of electroconvulsive therapy*. *Psychiatric Bulletin*, 21, 563-565.

programme of accreditation run by the ECT Accreditation Service, an initiative of the Royal College of Psychiatrists' Research Unit.

### ***Joint Committee support for Alliance position***

The Joint Committee recommends that:

"It only be possible to administer electroconvulsive therapy (ECT) to 16 and 17 year olds in line with the safeguards currently proposed in the draft bill for those under 16."<sup>208</sup>

The Committee has also underlined the importance of circumscribing the use of emergency ECT by recommending a maximum number of treatments under emergency powers.<sup>209</sup>

### **Psychosurgery (NMD – neurosurgery for mental disorder)**

The draft bill introduces a category of 'Type A' treatments into which psychosurgery is placed. These treatments may only be given under the legislation and not at all to under-16s. They require consent, second opinion and best interests, or where a patient lacks capacity to consent, is not expected to regain capacity and is unlikely to resist treatment, the requirement is second opinion, best interests and a High Court order. This differs significantly from the current position under the Mental Health Act 1983, which does not allow the operation where the patient lacks capacity to consent.

The Alliance opposes psychosurgery for a person lacking capacity under any circumstances and believes the current safeguards should be maintained.

Psychosurgery (the purposeful destruction of brain tissue) is an irreversible, invasive and hazardous procedure. The nature of the procedure precludes trials that could establish effectiveness. The effect on personality is uncertain. There is an insufficient evidence base for psychosurgery to be used without full consent. While advances in surgical techniques coupled with the use of scanners means that it is a less crude and risky procedure than previously, the risk of harm remains high. Possible side effects include fits and cerebral haemorrhage, apathy, excessive weight gain and disinhibition. Subtler effects on personality, being harder to assess, may be less recognised or documented. There are also risks generally associated with anaesthetic and surgery, including infection.

During the period when the Geoffrey Knight Unit (now closed) was forced to suspend operations for technical reasons, they continued to admit patients for trials of high dose and combined antidepressants which has reduced the need for psychosurgery in recent years.<sup>210</sup> At least for some people, it is possible that other treatment options have not always been fully tried before resorting to psychosurgery. Practitioners do not agree with operating on patients who cannot consent: reports on NMD by the Royal College of Psychiatrists<sup>211</sup> and the NMD Unit in Dundee reject this option. In its 2001 report the NMD Service in Dundee explained that they are unable to predict in advance which patients may benefit from NMD, or to predict reliably the likelihood of serious adverse events for any

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<sup>208</sup> Draft Mental Health Bill, 2004. Vol. I para 252.

<sup>209</sup> Draft Mental Health Bill, 2004. Vol I para 368.

<sup>210</sup> Bridges P. K. *Correspondence*, *Psychiatric Bulletin*, 21, 121-122.

<sup>211</sup> Council report CR89. June 2000. Neurosurgery for Mental Disorder: report from the Neurosurgery Working Group of the Royal College of Psychiatrists.

individual patient. Therefore they, “do not believe that it is appropriate to consider the conduct of NMD with patients that are incapable of providing informed consent.”<sup>212</sup>

The Alliance view is that having an irreversible and hazardous treatment like psychosurgery should only ever be decided by the person having the operation, not by another person on their behalf. This is particularly so where there is no clear evidence for the treatment’s benefit in general, or for its likely success in the individual concerned. Service users are likely to feel under threat if there is no clear prohibition on psychosurgery/NMD without consent. The Alliance therefore considers that this provision should not be included in the Bill, and that if psychosurgery is to be used at all, the current restrictions on its use should be maintained.

### **Joint Committee’s support for Alliance position**

The Joint Committee agreed that Type A treatments should only ever be given with informed consent and Tribunal authorisation:

“We believe that treatments such as psychosurgery should only ever be used as a last resort in exceptional circumstances, and then only under the best possible safeguards. We recommend that Type A treatments at clauses 191 to 195 of the draft Bill be under no circumstances used for patients lacking capacity, not even with the consent of the High Court. Where the patient has capacity we recommend that Type A treatment only be given with the patient’s informed consent and furthermore that, given the nature of these procedures, Type A treatments be subject to the ratification of a Tribunal, even if the patient is able to give informed consent.”<sup>213</sup>

### ***Drug treatments***

The Bill has no specific safeguards for drug treatments; it relies on the Tribunal’s authorisation of care plans and other safeguards that are not specific to treatments, such as access to advocacy. The Bill does create a further category of treatments – Type B treatments – to be safeguarded, but neither the treatments covered nor the safeguards are specified. The Government had no plans to use the provision at the Joint Committee stage, but it would provide an opportunity for including further treatment safeguards during the passage of the bill or once an Act is in force.

Drugs used in psychiatric treatment are not effective for everyone and as stated above have a wide range of possible adverse effects from the uncomfortable to the disabling and life-threatening. Even if tolerable in the short term they can have serious long term impact on health. Responses to different drugs vary between individuals and the person taking the drug knows how badly they are being affected (for some reactions at least – there may be long term impacts on physical health and other effects that they are either unaware of or do not attribute to the drug). The Alliance view is that people with full decision-making capacity should be able to consent to or refuse any treatment including drug treatment because they should not be liable to compulsion.

Alliance policy on advance directives and statements should apply to drug treatments as to ECT.

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<sup>212</sup> Matthews, K and Eljamel, M.S. 2001. Neurosurgery for Mental Disorder in Dundee: report to the Scottish Executive. Dundee NMD Service. This policy was affirmed in the 2003 report.

<sup>213</sup> Draft Mental Health Bill, 2004. Vol I, para 360.

In addition to criteria for authorising treatment in a care plan (see above), the Alliance believes there should be specific safeguards against prescribing outside the standard dose range and purpose of drugs.

Doses above British National Formulary limits should only be given with fully informed consent or to prevent serious risk to the life of the patient. In this case the Tribunal should be notified and their approval received in order to continue with treatment for a limited period.

Drug treatments should only be used outside their product licence in the interests of the patient's health if there is no licensed alternative, with fully informed consent or with approval from the Tribunal.

Dose ranges set out in the British National Formulary (BNF) are generally the same as those for which the drug is licensed. Most side effects are dose related and going above licensed limits of itself adds an additional risk. The BNF summarises guidance from the Royal College of Psychiatrists on avoiding and minimising the use of this practice in the case of antipsychotic drugs. Such doses should not therefore be given unless with informed consent or in closely defined circumstances that would justify exceptions to licensed doses. The same applies to going outside the licensed uses of a drug in other ways, such as when prescribing for a child. Such is the potential for harm that these safeguards must be in the primary legislation.

The Code of Practice should incorporate British National Formulary guidance on dose ranges and combinations, and reference guidance developed by the National Institute for Health and Clinical Excellence.

### ***Joint Committee support for Alliance position***

The Joint Committee agreed with the National Voices Forum that doses above British National Formulary levels should only be given with the authorisation of Mental Health Tribunals if lower doses are not working and there is a life-threatening situation: "We recommend that doses of medical treatment above the British National Formulary levels only be allowed in exceptional circumstances. Medication dosage above BNF levels should be authorised by the Tribunals only when all other options have been exhausted."<sup>214</sup>

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<sup>214</sup> Draft Mental Health Bill, 2004. Vol. I, 2004, para 372.

### **Current law**

The Mental Health Act 1983 does not distinguish the situation of children and young people from that of adults, even though people of all age groups are subject to the Act. Most other relevant powers are contained in the Children Act 1989. These include powers to detain through secure accommodation as well as other relevant powers such as care orders. In some cases, secure accommodation under the Children Act would be an alternative for young people who are in fact detained under the Mental Health Act 1983. There is also an overlap with criminal law. As an example of the complexity, a teenager who has been abused, and is in danger of abusing other children in turn, may potentially be subject to all three regimes. Common law and case law elaborates on the relationship between parental and child consent, and in some cases the High Court may use its inherent jurisdiction when no other framework meets the need. All this is framed within the Human Rights Act, particularly the rights on family and private life and liberty (Article 5 and 8 ECHR). In summary, law in this area is extremely complex and would benefit from simplification.

There are four sets of problems with current law that are specific to children:

#### **1. Lack of expertise about children's mental health needs**

Children express their mental health problems very differently from adults, because of their different social situation (e.g. family and school) and developmental level. Yet the current law and the draft Mental Health Bill do not ensure that children are dealt with by children's specialists, whether psychiatrists, advocates, or other professionals.

#### **2. Lack of legal safeguards**

Children who need mental health treatment against their will do not have the appropriate level of protection which is essential for such vulnerable children and which is already provided for in the Children Act 1989. For example, the Children Act and associated case law provide a framework for resolving any tension between a parent's and a child's wishes. It provides a holistic view of the child including his or her family, social care and educational needs in addition to mental health needs. It also provides for a regular formal review of the needs of all looked-after children. This is required by the UN Convention on the Rights of the Child, a requirement that applies equally to a child looked after by health authorities. None of this is provided for in either the current Mental Health Act or the draft Bill.

#### **3. Lack of safeguards for children whose parents consent on their behalf**

Patients under 18 who are treated under the authority of those who have parental responsibility need extra protection for similar reasons to adult patients who are not considered capable of consenting.

#### **4. Lack of provision for children whose parents are mentally ill**

There is no provision for the children of patients subject to compulsory powers in the Mental Health Act, nor in the draft Bill. Children in these families are likely to have significant unmet needs.

## ***Draft Mental Health Bill 2004***

This draft Bill does make improvements in respect of young people over the 2002 draft. Firstly, young people aged 16 and 17 will be able to agree to or refuse treatment for mental disorder and their decision will not be able to be overridden by parental consent (as is the case under the 1983 Act). Secondly, it provides safeguards for children who neither consent nor are sectioned, that is, who are treated under parental consent either because of the child's immaturity or illness.

These include:

- a written care plan approved by an independent medical expert;
- a regular review every 3 months;
- representation by a nominated person;
- the right to go to the tribunal to resolve disputes about the care plan and to review the lawfulness of detention; and
- access to advocacy.

Nevertheless, there are a number of problems specific to children which remain and problems in other provisions, such as the criteria for compulsion, which apply equally to children.

## ***Alliance position***

### ***Legislative framework***

#### **1. Amending the Children Act**

We believe that serious consideration should be given to the possibility of including the powers for compulsory treatment of mentally disordered children in an amendment to the Children Act 1989 instead of the Mental Health Bill. In this case, children would of course have to be specifically excluded from the Mental Health Bill, and in any case it might be appropriate to simplify the law by excluding the (rarely if ever used) possibility of mental health services using secure accommodation powers rather than mental health powers - see Bailey et al, 2002. In this way, the Children Act could provide a much more appropriate framework, containing, for example, the welfare checklist and the concept of 'the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding)'.

Whichever legislation is used for the compulsory treatment of children, it would still be important for the Mental Health Bill to include a duty on the clinical supervisor of a compelled parent to consider family needs (as discussed below).

#### **2. Balance parents' rights with children's rights using the Children Act**

The Children Act 1989 and associated case law, in the context of the Human Rights Act 1998, provide a framework for resolving the tension between parental rights and children's rights in the case of a disagreement. The Alliance believes that this framework should be the one used in the case of mental health law. This could be done through amendments

to the Children Act 1989 or through a principle incorporated into the Mental Health Bill, based on the Children Act section 1(3)(a) and the White Paper<sup>215</sup>, which would state that in all decisions relating to a child, decision-makers 'shall have regard to the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding)'. This proposal would enable the court to allow a child who is 'Frazer competent' to make his or her own decisions to the same extent as if he or she were an adult.<sup>216</sup> There should be a presumption that a child is Frazer competent from the age of 10 or 12.

We welcome the provisions in the 2004 Bill to treat 16 and 17 year olds as competent adults; however, we believe the special safeguards should apply to this group.

We wonder whether this might solve the difficulty as to how to enable 16 and 17 year olds to be treated like adults. It need not prevent other Children Act type provisions applying for this age group. In this context it would be useful for the tribunal to have a duty to consider the rest of the welfare checklist from the Children Act 1989 1(3), which also includes, for example, the child's educational needs and parents' capacity to parent. The welfare principle itself should be included and the Bill should make clear that when either, informal or compulsory care and treatment of a child is considered, the child's welfare shall be the paramount consideration.

### ***Safeguards for children and young people and patients with parental responsibility***

#### **There is a need for specialist child and adolescent care and treatment**

We believe it is essential that a child receiving mental health services should receive them from a person qualified specifically in child and adolescent mental health (CAMH). This is even more essential wherever a child is sufficiently ill to be treated under formal compulsory powers, whether or not formal powers are actually used. The Royal College of Psychiatry's NICAPS study estimated that nearly 600 people under 18 are 'inappropriately' (in the opinion of the lead clinician) admitted to adult psychiatric wards each year, and over 100 are 'inappropriately' admitted to paediatric in-patient units with mental health problems each year.<sup>217</sup> In the case of adult psychiatric units where the child is under compulsion, this is in violation of the UN Convention on the Rights of the Child, Article 37(c).

We believe it should be a legal requirement that a child's clinical supervisor under the Bill must be a specialist in CAMH, except in an emergency if no CAMH specialist is available. An equivalent provision has been made under the Scottish Mental Health Act. If necessary due to a shortage of such specialists and services, this provision might not be brought into force until there are enough specialists and services are available.

Duty psychiatrists should also receive a level of CAMH training to cover emergencies involving patients who are young people. We believe that there should be a statutory requirement to conduct a multi-disciplinary assessment before children are made subject to compulsory powers. The advocate should also, by law, be a specialist in advocating for children and the approved mental health professional should be someone whose background is child and family social work, with appropriate extra training for fulfilling this role. Finally, the expert panel members advising the tribunal, and professionals sitting on

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<sup>215</sup> Reforming the Mental Health Act, 1983. Part I, Dec 2000, p15, para 2.10.

<sup>216</sup> The House of Lords decided that a child was capable of giving consent if he was capable of understanding what was proposed and of expressing his own wishes (All England Law Report, 1983, vol3, p402).

<sup>217</sup> National In-Patient Child and Adolescent Psychiatry Study (NICAPS), Royal College of Psychiatry, 2001. Part 4.5.

the tribunal, should be a CAMH professional and/or a child and family social worker specialising in mental health, and a family law specialist.

**There should be a comprehensive care plan which focuses on the needs of the child**

We are concerned that the individual written care plan take account of the full needs of the child including those outside mental health. This should be the case both for children who are formally compelled and for qualifying children. We propose that the clinical supervisor should draw up the care plan together with a child and family social worker. In practice there should be, and in most cases there is, a child and family social worker in the CAMH clinical team. We propose that in preparing the care plan there should be a duty to consult:

- the child, his nominated person and his advocate;
- a person with parental responsibility;
- the child 's school; and
- other relevant services involved in the child's care and welfare (e.g. social worker, youth offending team, voluntary organisation etc as appropriate).

If a child needs the equivalent of an assessment and care plan under the Children Act or for special educational needs, then agencies should be able to conduct one assessment for both (or all) purposes. The final outcome should be a single care plan to meet all needs (although it would be only a section of that care plan that is compulsory treatment).

**The Bill should establish rights to a review of the care plan**

All looked after children have a right to a periodic review, whether looked after for social or health reasons. This is required under the UN Convention on the Rights of the Child, article 25. The care plan of any child in in-patient care should be subject to review by the tribunal, even if both the child and the parent consent. This is a particularly important safeguard where a child is treated against his or her will under parental consent.

**The Bill should include provision for the family needs of an adult patient**

Where a parent is mentally ill, the family is likely to need various kinds of support. The parent may need support as a parent; the child as a carer; or the child may develop mental health problems in his or her own right. Serious harm or even death of the child has resulted from the failure of services to consider their patients' families. This should be seen as an integral part of working with a mentally ill patient. It treats him or her as a person in a social context and not just as a patient.

In drawing up a care plan for a patient who has parental responsibility, hospital managers should be required to ensure assessment of the family needs of the patient. A care plan must include a record of this assessment, even if the conclusion is that the family has no extra support needs.

**Children should nominate their own nominated person**

In line with Mental Health Alliance policy for nominated persons for adults, we believe the child should be allowed to choose his or her own nominated person. The appointer should tell the child that he or she can choose a parent, or choose someone else, or ask the appointer to choose for him or her.

This should apply either under formal compulsory powers or under the special safeguards for children who are not formally compelled, but object to or are resisting treatment being provided under parental consent.

If the child is not capable of doing this, or chooses not to, then the appointer should choose someone in the same way as for adults. The first person on the list of appropriate people should, in the case of a patient who is a child, be a person with parental responsibility. In other respects the procedure should be the same as under Alliance policy for adults. A child might not want to choose between his or her parents, and it might well be in this situation that the appointer would make the choice between parents on his or her behalf.

### ***Admission to adult psychiatric wards***

#### **There should be a duty on health authorities to provide age-appropriate accommodation for under-18s subject to the Bill or needing in-patient treatment**

In 2002/3, 213 under-18s were placed on adult mental health wards. This is a substantial proportion of all children and adolescents admitted under the Mental Health Act 1983. The Mental Health Act Commission stated that “*it is becoming clear to everyone that this type of admission is inappropriate*”<sup>218</sup>, and it violates the United Nations Convention on the Rights of the Child.<sup>219</sup> There have been cases of a 16 year-old being offered illicit drugs under threat by adults on his ward and of a 17 year-old with a learning difficulty being assaulted by another patient on an adult ward.<sup>220</sup>

The Government agrees that children should be treated by clinicians whose experience and expertise is with children and we believe the same should apply to advocacy (advocates), (employing) approved mental health professionals, and other clinicians under the Act. However, they are unwilling to require this by law because there are too few children’s clinicians, and it is better for a child to be treated by professionals who work with adults than by no one. They argue that this should be addressed through the National Service Framework for Children.

In our view the new law is an opportunity to place an obligation on health authorities to provide appropriate accommodation for children. While we do not expect this to give rise to an enforceable individual right, it would impose a duty on the authorities. This would be similar to the Scottish Mental Health Act. A recent report from the Children’s Legal Centre stated that “*there is no statutory protection from the use of adult wards in the placement of children under compulsion. This is a matter of particular concern in view of the likely delay in introducing background checks in the NHS adult sector*”.<sup>221</sup> At the very least, however, a child specialist should be consulted in relation to the care plan of a child.

### ***Children and parents admitted or compelled to receive treatment: educational and family needs***

#### **Care plan provisions need to cover educational needs, both under compulsion and for qualifying children**

In the provisions of the Mental Health Bill relating to care plans, the “required information” should include:

- if the patient is a child, a description of what is to be provided to meet his educational needs (unless the child has already left education, other than because of his mental health); and/or

<sup>218</sup> Placed among strangers, Mental Health Act Commission, 2003.

<sup>219</sup> Article 37(c), which states that ‘every child deprived of liberty ... shall be separated from adults unless it is considered in the child’s best interest not to do so’.

<sup>220</sup> Children and the use of Mental Health Powers, The impact of the draft Mental Health Bill 2002 on children Children’s Legal Centre, 2004.

<sup>221</sup> Ibid.

- if the patient is a child or has parental responsibility, a description of what is to be provided, if anything, to meet his family needs.

A child and parent patient's mental health needs are closely intertwined with family and occupational needs. A 17 year-old on an in-patient unit may well be missing out on his or her educational opportunities and the knowledge of this can be counter-therapeutic. Typical comments to YoungMinds researchers are that "it would have been good if there had been more contact with school and college" and "one hour a day is not enough to keep up with the 6 hours that I would be doing at school".<sup>222</sup> Failure in this area could be in breach of the child's right to education under the Human Rights Act.

Family is central to the life of anyone who has parental responsibility. The stresses of family life can contribute to mental health problems and mental illness can interfere with the way someone carries out their parenting responsibilities. For example: a parent who is deeply depressed will find it difficult to provide emotional warmth and care; someone with psychosis may struggle to provide consistent parenting. Children may be caring for parents while they are ill. There is strong evidence of links between parental mental health and their children's mental health. In rare cases there are child protection issues, although this should not be seen as the main reason for assessing family needs. Addressing family needs as well as medical treatment would go some way to rectifying this.

Where a parent is made subject to mental health law, therefore, it is important that his or her family needs are assessed. A failure to do this may delay his or her recovery because s/he continues to feel anxious about his or her family needs. It can also be very bad for the child who will possibly need action taken to ensure that adequate care continues despite his or her parent's illness.

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<sup>222</sup> *Where Next?* Report 2, YoungMinds, p 31.

The many professional bodies who have joined the Alliance have expressed their concerns on the effect of the proposals both in terms of the nature of their likely future work and also the undermining impact of the bill on their therapeutic relationship with patients. For many professionals, this feels counter-productive to the current emphasis on choice within mental health and to a more user-focussed mental health service.

The Alliance is convinced that, as a result of the inevitable increase in the numbers of people under compulsion which it will entail, the draft bill will have significant resource and workforce implications.

A thorough examination of the proposals for workforce implications, with detailed explanation of the assumptions made, is needed.

Paragraphs 47-54 of the Regulatory Impact Assessment outline the anticipated additional resource(s) required. It is extremely difficult to understand the rationale which has been applied to calculate these figures.

### **Tribunals**

There will be a significant increase in tribunal hearings. There will also be a vast expansion in the types of decisions that tribunals will be empowered to consider, such as authorising care plans, displacing nominated persons, authorising ECT and examining whether the relevant conditions apply. This will require a huge change in the culture of mental health tribunals. It is likely that hearings will be significantly longer and there will be massive implications for recruitment and training. The present Mental Health Review Tribunal system is struggling to manage the present level of demand, with appeals being cancelled and delayed. We have grave concerns about whether the new, expanded system is realistic and practicable.<sup>223</sup>

This increase in workload and the numbers of hearings will require a large cohort of new members to carry out the additional work.<sup>224</sup> There will also be a need to fully train the additional members of the tribunal as well as provide additional training for all current members to enable them to deal with the new remit. There are major concerns about the availability of sufficient applicants willing to work full time. We are not aware of any research being conducted on the availability of candidates for such posts and there are considerable doubts whether such posts would be attractive.

This view was expressed by the Regional Chairmen of the Mental Health Review Tribunals who described the proposed new tribunal structure as “*unwieldy, unnecessary and unworkable.*”

*“We also believe that the tribunal workforce requirements are in any event an underestimate as they fail to take sufficient account of the likely increased length of tribunal hearings; of the likely implications of the recent European Court ruling in the case of H.L v UK, 5th October 2004 Appl. 45508/99; of the fact that there are increasing disincentives to doctors to offer their services to engage in the tribunal as Expert Panel members or clinical members; and of the fact that no reliable evidence has been produced*

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<sup>223</sup> For further discussion on the issue, we refer you to the evidence of the Sainsbury Centre for Mental Health, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, November 2004, Ev.

<sup>224</sup> Recruitment may also be necessary to fill the places of those members expected to resign, for reasons such as the increased workload, for ethical reasons or because they will be asked to sit alone determining largely medical matters without the benefit of expert advice.

*to give us confidence that there are sufficient number of lawyers who would wish to avail themselves of the opportunity to join this new tribunal, as legal members.*<sup>225</sup>

## **Advocacy**

The Alliance would question the additional number of advocates required, which suggests the need for just 140 new staff. At present, most mental health advocates work across a range of health and social care environments and not just in the compulsory arena. Access to an advocate is a significant safeguard, but becomes meaningless if the person under compulsion is unable to access an advocate when they need them.

Given that there are some 50,000 uses of the Mental Health Act each year, the figure of 140 advocates with a duty to provide information and representation appears somewhat conservative. We urge the Department of Health to release information on how this figure was arrived at and to ensure that further detailed work on this is undertaken in partnership with advocacy providers and other stakeholders.

## **Effects on existing community services and clinicians**

### **Reduction in community support for patients not in crisis**

In addition to the newly identified resources, we would highlight the effect the new proposals would have upon the existing workloads on many clinicians and community services. In human terms this is likely to lead to a reduction in support for those patients who are not considered to be in “crisis” but for whom early intervention and community-based support could prevent subsequent compulsion.

### **Greater workload for psychiatrists and community psychiatric nurses**

According to the Department of Health’s own figures there are significant vacancy rates in England among consultant psychiatrists (9.6 per cent or 334 whole time equivalents (WTEs))<sup>226</sup>, yet it estimates that the new legislation will need an additional 130 psychiatrists.<sup>227</sup> There are also shortages of psychiatric nurses, with the Department of Health figures showing community psychiatric nurses with 1.9 per cent vacancies (235 WTEs) and “*other psychiatry*” nursing staff with 4.7 per cent vacancies (1,282 WTEs) in England. Should the bill become law, community psychiatric nurses would have a major role in monitoring whether people subject to compulsion in the community were adhering to their care plans.

The extra demands on consultant psychiatrists’ time include: more tribunals and appeals; increased numbers of patients subject to the Act; all patients to have formal care plans; expert appeal doctors required after 28 days (rather than 3 months as currently); increased care planning; consultation; and information sharing. The Royal College of Psychiatrists has stated that:

*“Such medical provision could only be acquired at the expense of patient care, particularly to those patients at earlier, less severe stages of illness or not requiring compulsion.”*<sup>228</sup>

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<sup>225</sup> Professor Jeremy Cooper, Mrs Carolyn Kirby, His Honour Judge Philip Sycamore and Mr John Wright, Report of the Joint Committee on the Draft Mental Health Bill: Volume II, Nov 2004. Ev 428, para 8.

<sup>226</sup> NHS Workforce Vacancy Survey, March 2004.

<sup>227</sup> Explanatory Notes to the Bill, p.134.

<sup>228</sup> Royal College of Psychiatrists, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Ev 50, para 72.

## **The creation of the AMHP role will reflect falling numbers of ASWs and put pressure on nursing staff**

Similarly, the British Association of Social Workers has stated:

*“The Government’s assumption about the present number of ASWs who will transfer to AMHP posts is grossly optimistic and flies in the face of recent research evidence, which shows that numbers are still falling rapidly and are likely to continue to do so.”<sup>229</sup>*

The Sainsbury Centre for Mental Health has warned that the creation of AMHPs could be problematic in the short term:

*“The existing shortage of ASWs will be exacerbated by the need to train them in the new role and the likely wastage from that process of those nearing retirement. That will place the greatest pressure on nursing staff, for whom the transition to AMHP status will require considerable training, and whose former roles will need to be back-filled.”<sup>230</sup>*

## **Non-resident orders**

The creation of non-resident orders (NROs) will have a dramatic impact on community mental health teams. The brunt of enforcing NROs could fall on assertive outreach teams, who work with people other services find hard to engage. These teams, recently established across the county, work on the basis of encouraging people to comply with care plans voluntarily. Much of the value of assertive outreach is in building the confidence of clients and helping them get back to an ordinary life. Imposing compulsion in these circumstances could damage those relationships and undermine the basis on which services are currently provided.

## **Alliance position**

The Alliance recognises that our own proposals have cost implications, and that any system will have both an administrative and a resource burden. However, if resources are allocated to prevent compulsion being needed, and the conditions are appropriately set so that compulsion is seen as a last resort, then the resource implications would be more proportionate.

The implications of training and fully implementing the new Act are significant. A key lesson from the 1983 Act was the failure to implement the measures consistently. The proposals in the draft bill have far-reaching consequences. They will require a very significant recruitment of new types of staff (AMHPs and advocates), each of whom will need to be developed. There will also be a significant amount of training for the current mental health workforce and at the local level new bodies will need to be created. This will require considerable time and money. The amount of both will need to be considered carefully in any plans to implement a new Act.

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<sup>229</sup> British Association of Social Workers, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Ev. 580, para.21.

<sup>230</sup> Sainsbury Centre for Mental Health, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Ev 262, para 10.3.

## **The Role of the Approved Mental Health Professional**

We believe that it is essential that the initial entry process be made fully human-rights compliant because the majority of patients will not have the ability to appeal to the Mental Health Tribunal for a review of their detention.

Compulsory admission is an extremely traumatic event (often involving forcible removal from home by the police) and if it was unjustified, the damage cannot be undone by a subsequent Tribunal discharge.

The Alliance believes that the role of the Approved Mental Health Professional 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. BASW have made a number of suggestions about how this should be resolved in legislation, including detaching from the AMHP role, the co-ordinating and transporting functions which would have to be carried out by a Trust employee, and ensuring that the remaining quasi-judicial function is performed by someone who is legally independent of the Trust and free of conflicts.

### ***Current law and legislative proposals***

Monitoring of the Mental Health Act is currently executed by the Mental Health Act Commission. The Draft Bill proposes the abolition of this body and the transferral of most of its current functions for monitoring of the Mental Health Act to the Healthcare Commission.

### ***Alliance position***

#### **Any change to the standards agency monitoring the Act must not compromise the protection of those under the law**

The Mental Health Act Commission has played a crucial role in improving compliance with the Mental Health Act and in safeguarding and ensuring the rights and welfare of people detained in hospital under the Act. These functions need to be preserved in one specialist body. The benefit of a stand-alone Commission is that it has a clear and dedicated focus on the review of the exercise of powers under the Act and has a specific duty towards detained patients. We are concerned that the transfer of powers and responsibilities could lead to a loss of skills and expertise that currently resides with the Mental Health Act Commission and, ultimately, to less protection for people subject to compulsion.

As the Mental Health Act Commission has stated:

*“The benefits of rationalisation amongst health service bodies must be balanced against the need to ensure that the core statutory function and duties towards patients subject to care under the State’s compulsion, including and especially visiting practices, are not lost.”*<sup>231</sup>

The Joint Committee recommended that a new reformed Mental Health Act Commission should be given these powers in order to provide a focused stand-alone body with a high profile and clear title. They expressed the concern that monitoring of mental health legislation will become subsumed into a larger body and that experience shows that mental health services rarely do well in competition for resources and attention.

There may be some merit in the Commission being placed in a wider health inspectorate, such as the proposals to transfer monitoring to the Healthcare Commission, so long as it’s unique statutory functions are replicated and sustained and patients are able to benefit from the available legal safeguards under the Act. However, the Alliance is concerned as to whether the Healthcare Commission will be able to devote adequate attention to its protective duties under mental health legislation, and we fear that the monitoring role could be subsumed under the wider focus of the Healthcare Commission or that resources dedicated to its work would be diverted elsewhere. If a transfer to the Healthcare Commission is implemented, it should be accompanied by specific statutory duties and additional ring-fenced resources to enable the Healthcare Commission to fulfil its specific role in relation to the Mental Health Act effectively.

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<sup>231</sup> Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev 13 para 5.10

### **The inspectorate should retain its duty to visit and interview patients**

One of the most valuable functions of the current Commission is to conduct formal and informal visits to patients and to visit unannounced. The duty to visit routinely and interview patients should be maintained. Under the Bill the Healthcare Commission will have the power to undertake the same visiting functions but it will not be under a duty to visit establishments routinely and interview patients. The Alliance recommends that the power to visit establishments should be a duty to visit to ensure services are regularly inspected.

It is important to distinguish clearly between the role of the Commission and the role of the advocate. An advocate's role is to represent the patient without making judgments about their views. This is incompatible with the scrutiny role of the Commission. An advocate alerts individuals to their rights, takes up individual concerns on instruction and represents that person in a range of contexts. Advocates aim to empower patients to take up their own concerns. However, the role of the Commissioners is to monitor the working of the Act and to visit and talk to individual patients to that end. They use the concerns and experiences of individual patients to highlight general shortcomings in compliance with the Act and to feed back particular or general concerns to local managers so that changes can be promptly made.

It is unreasonable and unrealistic to expect that detained patients should be required to make a complaint before their concerns may be heard. The fact of their ill health and their detention imposes a proactive duty on the public authority to protect their wellbeing. A visiting function is essential to that end.

### **The inspectorate should be responsible for monitoring the management of restricted patients**

We also supported the Joint Committee's recommendation that the responsibilities should include investigating and reporting on the Secretary of State's management of restricted patients. We see no reason why the responsibilities of the inspection body should not include investigating and reporting on restricted patients.

### **The inspectorate should have accountability for monitoring implementation of other legislation in order to protect patients under the Act**

We also consider that the Mental Health Bill should establish in law powers, duties and accountability that would preserve the specialist monitoring focus to protect people detained under legislation. This should extend to review the implementation of other legislation which might affect patients' liability to compulsion, particularly de facto detained patients similar to Bournemouth situations.

The Healthcare Commission would not have the power to review the implementation of other legislation which might affect patients liable to compulsion, such as the Mental Capacity Act 2005. It also does not have any powers in relation to patients detained by the police using emergency powers and in relation to prison authorities where prisoners are assessed for detention under compulsory powers. We believe it is essential that the inspection body should have jurisdiction in these areas.

## **Annex 1: Example of an advance statement**

The following is an example of what might be included in an advance directive/statement:

- 1) *'Should I become incapable of making decisions for myself, I make the following advance statement:*
- 2) *I do not wish to be prescribed the drug Haloperidol because I am thyrotoxic.*
- 3) *I do not wish to be treated by electro-convulsive therapy (ECT) because I become very distressed as a result of it.*
- 4) *I should like my sister, [name] to act as my nominated person under the Mental Health Act.*
- 5) *I agree that my sister [name] and my mother should be involved in assessing my needs and planning my treatment and care.*
- 6) *I should like my mother to be given sufficient information to enable her to care for me effectively but I do not wish any personal information about me to be shared with her*
- 7) *I should like my cat to be looked after by [name].*
- 8) *I should like my social security benefits to be cashed by [name].*
- 9) *I am a vegetarian and wish to eat vegetarian food.*

## Annex 2: Case study

The following was a letter in The Guardian on 12 March 2003:

*As someone admitted to hospital for occasional bouts of severe mental health problems, I have been in the invidious situation of being unable to communicate my needs.*

*Having had bad experiences, I drew up an 'advance directive' with my psychiatrist (who thought that I was being obsessively over-cautious) to try to ensure I would receive the care I needed. Among other concerns, I requested that food be brought to my room, as, when ill, I am terrified of eating in public.*

*This advance directive was mislaid three times by my psychiatrist, and each time I gave her another copy. When finally I was admitted to hospital, no food was brought to me, nor any attempt made to check I was eating. Consequently, I lost one and a half stone in a few weeks and fainted several times while being administered strong medication on an empty stomach. It was clear that my advance directive had never been consulted.*

*I pursued a complaint with the chief executive of the NHS trust concerned and I'm now requesting an independent review. If my long and completely fruitless exchange of correspondence is anything to go by, I don't hold out much hope of steps being taken to protect vulnerable patients.'*