Mental Health Alliance

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

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EXECUTIVE SUMMARY

The Mental Health Alliance believes that the Mental Health Bill as introduced in the House of Lords was deeply flawed and represented a missed opportunity to introduce a radically revised Mental Health Act fit for the 21st century. In doing this the Government ignored the recommendations of its own Expert Committee appointed in 1998 and the Joint Parliamentary Scrutiny Committee in 2004.

The amendments made to the Bill by the House of Lords, however, provide an opportunity for the Government to achieve mental health legislation that is ethical and enjoys the support of patients and their families, professionals and the public. We call on the Government not to squander this opportunity and turn back the clock by reversing these well considered changes to the Bill.

The six key changes made by the House of Lords

1. **Exclusions**

   The Government's original Bill removed most of the exclusions from the 1983 Act which ensure that specific behaviours and preferences are not seen as mental disorders. We believe that exclusions are essential to guard against the inappropriate use of mental health legislation. We therefore welcome the Lords decision to add exclusions to ensure that people are not detained solely because of substance misuse, sexual identity or orientation, involvement in illegal or disorderly acts or cultural, religious or political beliefs.

2. **Impaired decision making**

   The Alliance welcomes the Lords amendment which ensures that people with full decision making ability cannot be forced to have treatment imposed upon them against their will. This would bring the 1983 Act in line with the Scottish Mental Health Act. People who are physically ill and have capacity are not detained in hospital against their will because they refuse to take the treatment that should improve their condition; nor should people with mental illness. Nothing in this provision would "expand the right to suicide" or prevent the treatment of patients who are a risk to others – if a mental disordered person is suicidal or a danger to others as a result of their condition, their decision making is impaired.

3. **The treatability test**

   The Alliance believes that all compulsory treatment should have a health benefit for the patient and that the purpose of mental health legislation should not be to effect the preventative detention of those who cannot benefit from treatment. It is therefore crucial that the House of Lords amendment to reintroduce a treatability test into the 1983 Act is not overturned – this would provide that a person can only be detained if treatment is available which is likely to alleviate or prevent a deterioration of his condition. This provision would not prevent people with a personality disorder – for whom effective treatments are available - from receiving treatment.

4. **Renewal of detention**

   We welcome the amendment passed by the House of Lords to require a medical practitioner to examine the patient and agree to the detention before a renewal of detention can occur. This will ensure compliance with the Human Rights Act, as interpreted in case law, which requires that a decision to renew a detention order is based on 'objective medical evidence of a mental disorder'. We would like the Bill to go further and require two professionals – one of who must be a medical expert - to agree a renewal in every case.

5. Community Treatment Orders

If new compulsory community powers are to be introduced - and many Alliance members oppose this - they should be for a tightly defined group and be accompanied by stronger safeguards. We support the new eligibility criteria for CTOs agreed by the House of Lords – which will limit them to genuine 'revolving door patients' with a history of relapsing after discharge from hospital and who are a danger to others. This is precisely the group of patients the Government says it want this provision to cover. We are also concerned by the excessive scope of the restrictions that can be imposed on a patient's lifestyle and behaviour – and believe that patients should be allowed to appeal against them.

6. Children and young people

We welcome the House of Lords amendments to the Bill which would place health authorities under a duty to admit children to an age appropriate setting and to provide specialist assessment and supervision for detained children. We also welcome the Government's amendment to the Bill to allow 16 and 17-year-olds to override the wishes of their parents if they want to refuse treatment – although we would like this extended to 'Gillick competent' children under 16.

Missed opportunities in the Bill

The amendments made by the House of Lords have improved the Bill significantly but it still needs additional changes to provide for a modern Mental Health Act. The Bill that gets passed could remain in use for up to 30 years and must reflect the needs and expectations we all have of 21st century health care. We believe the Government must take this opportunity to modernise other aspects of the 1983 Act.

1. The nearest relative

The patient's 'nearest relative' has important powers in decisions as to whether they are to be detained or discharged. The Bill makes a marginal improvement to the system by which 'nearest relatives' are identified and if necessary displaced. The Alliance believes the individual patient should be able to nominate the person who can best represent their interests, as is the case in Scotland. We welcome the undertaking given by the Government to reconsider this issue and hope to see progress shortly.

2. Advance decisions

The Bill makes no provision for advance decisions or statements which would give patients the right to give directions about their future treatment – and it is therefore likely that any advance decisions or statements made under the Mental Capacity Act 2005 would be over-ridden if the person becomes subject to compulsory powers. This discriminates against people with mental disorders and we recommend that the Bill should allow people to make advance decisions and statements which must be taken into account by – but not binding on – decision makers determining the provision of medical treatment under the 1983 Act.

3. The right to assessment

Many instances of compulsion could be avoided if patients, and their carers, received services before their illness has deteriorated to crisis point. It is a recurring theme in the small number of tragic cases where violent crimes are committed that services turn people away when they ask for help. We therefore believe that the 1983 Act should – inline with the Scottish Mental Health Act – establish a duty on services to assess and meet the needs of people with mental health problems.

4. Right to advocacy

The Alliance supports amending the 1983 Act to ensure that all patients subject to compulsory powers have a statutory right to an independent mental health advocate. This was one of the few welcome aspects of the Government's 2004 Draft Bill but was later dropped. We welcome the Government's commitment to further consider this issue but we look forward to seeing their detailed proposals, which have not yet been published.

5. Places of safety

We support the Government amendment to the Bill which will allow people to be transferred between places of safety. This will ensure that mentally distressed people detained in police stations can be transferred to a therapeutic environment more speedily than they are now. However the Bill needs further changes to ensure that police stations are only ever used as a place of safety as a last resort.

6. Guiding principles

We are disappointed that despite the widespread consensus in the House of Lords the Government still refuses to include a clear set of overarching principles on the face of the 1983 Act – which would guide professionals and tribunals in reaching decisions. We believe that the Government's 'concession' on this issue – which would require the Health Secretary to include certain principles in the Code of Practice – does not go far enough.

7. Consent to treatment

We welcome the Government's amendment to the Bill which will ensure that patients with capacity cannot be forcibly given ECT – however we do not agree such a refusal should be overridden in cases of 'emergency'. We also believe that the Bill should give patients more say in other aspects of their medical treatment – they should have their wishes respected unless there is good reason to override them.

8. BME issues

The Bill also needs further changes to ensure that the 1983 Act tackles discrimination and promotes race equality. The Government's own statistics highlight staggering ethnic inequalities in the use of mental health services. To prevent this from happening in the future the Bill must include: principles of non-discrimination and respect for diversity on its face; a right to advocacy; and restrictions on the use of police cells as places of safety.

9. Criminal justice system

The Alliance is concerned that prisoners with mental health problems are still not getting the specialist medical treatment they need. Despite the policy of diversion of offenders suffering from mental disorder from the penal to the hospital system, the high numbers of such persons amongst sentenced prison populations has been consistently well documented. We believe that the Bill must ensure that people with mental health problems in the criminal justice system are transferred to hospital at the earliest possible opportunity.

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

The Mental Health Alliance supports the safeguards introduced in the Bill for people who lack the capacity to give informed consent to decisions made over their care. We also believe that the safeguards could be further strengthened to give more protection to these vulnerable people – for example where a person is detained in a care home they should not have to pay their accommodation costs and there should be a right to a second medical opinion for any serious medical treatment provided while the person is detained.

Our approach to mental health law reform

1. Access to services

The Government believes that the purpose of mental health law is "not about service provision, it is about bringing people under compulsion."[1] We fundamentally disagree with this approach. Mental health legislation fit for the 21st Century must provide more than just a framework for compulsory hospitalisation and treatment.

The Joint Parliamentary Scrutiny Committee on the Mental Health Bill concluded that:

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

Mental health law authorises the detention and treatment of patients against their will – so the law should also ensure that people with mental health problems receive the services they need at an early stage of their illness, so that the traumas of a health crisis and of being detained are anticipated and prevented where possible. A duty on services to assess people's needs is an important counterbalance to the powers of compulsion in the rest of the Act.

Access to mental health services remains patchy. Many instances of compulsion could be avoided if patients and carers received services before their illness has deteriorated to crisis point. This approach has been adopted in the Scottish Mental Health Act which recognises that In accordance with the principle of reciprocity there should be a duty on services to assess and meet the needs of people with mental health problems

2. Race Equality

The Government's own statistics highlight staggering ethnic inequalities in the use of mental health services.[3] According to the 2006 'Count Me In' census, published last month, inpatients from the Black Caribbean, Black African, and Other Black groups were 19-38% more likely to be detained under the 1983 Act when compared with the average for all inpatients.[4]

There is a history of misunderstanding and discrimination when it comes to the use of compulsory power, which has resulted in the deaths of a number of African Caribbean service users while under the care of the mental health system, highlighted by the tragic case of David Bennett. It is also well documented that African and Caribbean service users are more likely to be misdiagnosed and diagnosed with psychotic conditions and treated using medication, which is often of a higher dosage, and are less likely to get help from their GP or be offered psychological therapies than white people.[5] Culturally appropriate and acceptable behaviour has also been wrongly construed as symptoms of abnormality or aggression.[6]

The Alliance is committed to preventing this from happening in the future and we are concerned that the 1983 Act, unless radically amended, will continue to disadvantage African Caribbean and other BME communities who use mental health services. The Government has published the results of a Race Equality Impact Assessment on its proposals for reform, but has failed to respond to any of its recommendations in the drafting of this Bill. Our concerns are shared by organisations such as the BME Mental Health Network, Songhai, the Transcultural Psychiatry Society and the African and Caribbean Mental Health Commission.

[1] Government response to the Report of the Joint Committee on the Draft Mental Health Bill 2005, para 13.
[2] Report of the Joint Committee on the Draft Mental Health Bill, 2005. Summary page 5.
[3] Count me in: The National Mental Health and Ethnicity Census 2006 Service User Survey: MHAC
[4] ibid.
[5] Sainsbury Centre for Mental Health (2002) Breaking the Circles of Fear
[6] Report into the Death of David Bennett (2003

3. Compulsion as last resort

Mental health legislation gives considerable and unique powers to mental health clinicians to treat patients against their will and to take away or restrict their liberty in order to do so. There is widespread agreement – reflected in the 1983 Act and mental health legislation in other countries such as Scotland, Ireland, Australia, New Zealand, Canada and the USA - that, first, compulsion should only be imposed when other options have been tried, and secondly, that use of this extraordinary power needs to be justified on clear therapeutic grounds and the law must be tightly framed in order to achieve this and no more. In particular the law needs to be balanced by effective checks and balances on the powers of clinicians.

Evidence based practice clearly demonstrates that greater coercion improve does not improve outcomes – as in other areas of medicine outcomes are improved when patients and clinicians work together.

The unnecessary use of coercion contributes to stigma which is a huge source of distress and social exclusion for people with mental illness. Their Social Exclusion and Mental Health Report found that stigma and discrimination were bigger obstacles to social inclusion than any specific factor such as employment, housing or poverty.

Coercive powers must be reserved for the situations in which there is a significant risk to the health or safety of the patient or others if the treatment is not provided. Bringing too many people in to the system skews the use of resources towards one set of patients and is costly in terms of the time of mental health professionals, lawyers and Tribunals. It takes resources away from early intervention and other services which can prevent the sort of deterioration in a person's mental health which may lead to the need to use coercion.

The original Bill as unamended gave too wide powers to clinicians with too little opportunity for the checks of the Tribunal to operate. These are powers which the clinicians – doctors, nurses, psychiatrists, social workers and psychologists - have made clear time and time again they do not want – as their evidence to the Joint Scrutiny Committee demonstrated. Clinicians know that, with the current 'blame culture' and fear of tabloid headlines, they will be under pressure to use powers inappropriately if those powers are available. They also fear that the problem with lack of trust between patients and clinicians in the mental health field will be exacerbated. It is important to all parties that the rules relating to detention and compulsory treatment are clear and unambiguous and not seen as being left to the whim of the clinician.

The Government's approach to mental health law reform

1. "Every restriction is a person not treated"[7]

The Government claims that restricting the application of the Act will stop people getting necessary treatment. This is both dangerous and illogical. Taken to its conclusion it suggests doctors should have no limits to what they can do if it's good for you. Apart from the issues of civil liberties for patients, clinicians given unchecked clinical discretion are more likely, in a risk averse society, to invoke compulsory powers rather than risk the criticism of inquiries and public opinion if things go wrong. Restrictions on the use of compulsory treatment are essential to protect vulnerable people from inappropriate, abusive or dangerous treatment.

We also do not accept that the Bill as amended denies treatment to patients. The Government continues to confuse access to services with the need for coercion in order to assure the services are provided. This is a serious error. The main function of the health services is to ensure that the appropriate services exist with a sufficient well trained workforce to ensure that people receive the help they need when the need it. Coercive powers do not necessarily achieve that goal and can at times undermine it.

2. Public safety

It is unfortunate that in her speech to the Local Government Association Rosie Winterton once again attempted to whip up fears for public safety in support for the Government's proposals. Such views are based on two incorrect perceptions - that mental ill-health, particularly in its most severe forms such as schizophrenia, is linked to violence, and that violence, and homicide in particular, is a rising problem, caused by the introduction of 'care in the community' and 'loopholes' in the current Mental Health Act. None of these assumptions is supported by the facts. The facts are:

- About 5% of homicides are committed by people who have had contact with mental health services. The number of such cases has stayed the same (about 50 a year) for the past 50 years. Many more homicides are associated with drink and drugs than with mental illness.

- The number of homicides recorded by police by people currently with a mental health problem is lower still, and has remained at about 30-40 a year since 1997 (according to Home Office figures) while overall homicide rates have increased by around 30%.

- Mental illness is not a predictor of violence although for the small percentage with psychotic illness there is a modest increase in levels of violence.

- Some 630,000 people are today in contact with mental health services, the vast majority of whom live safely in their own homes. Only one person in 20,000 with schizophrenia commits homicide.

The inquiries that take place into each homicide by a person with a mental illness show consistent results. They frequently find that tragedies happen when:

- Services communicate poorly with one another;
- Community service provision is inadequate or early intervention does not occur;
- Overstretched professionals fail to head warnings from patients or their families;
- Care planning is poor or not implemented properly;
- The Mental Health Act is misinterpreted by practitioners (i.e. the law is not inadequate; it is just inadequately used).

[7] Prof Louis Appleby, speech to All-Party Parliamentary Group on Mental Health, 30 January 2007

This has recently been borne out by the Michael Stone inquiry[8] which found that despite much intervention by services on his behalf there were institutional and communication failures, including a lack of appropriate inpatient services that contributed to his commission of homicides. The Report did not recommend a change to the law

The Government proposes to improve public safety through increasing the scope of compulsory powers and bringing people into compulsion even if they cannot gain any therapeutic benefit from it.

This approach will not reduce risk, and could in fact increase it, because:

- It is based on the wrong model. The belief that it is possible to predict who, out of a population of people with a history of violence, will commit a violent offence is false. Using the most accurate risk assessment predictors it would require the detention in hospital of at least 2,000 people to prevent a single homicide[9]. This is impractical AND
- The added use of resources for compulsory care will diminish availability of other community services that could better avert crisis and danger. Dangerousness is not an enduring trait. It can be exacerbated by some factors (e.g. drugs and alcohol) and restrained by others and can be modified over time. There is evidence that quality of care rather than risk assessment makes the biggest difference to offending behaviour[10].
- Psychiatrists and service users make clear that a more coercive system will scare more people away from services, stopping them from seeking help early on for fear of excessive coercion.
- Only one person in 20,000 with schizophrenia commits homicide. This legislation must also work for the other 19,999, not drive them away from services or unnecessarily exclude them from the chance of an ordinary life.

Nothing that the Government proposes in the Bill will lead to the prevention of a single murder. We need humane and workable mental health legalisation which will decrease the stigma associated with mental illness and will not deter those who experience mental health problems from seeking help.

'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 people away from service I have to say, increases risks for everybody and damages health.... we need to get people to come and see us.' Dr Anthony Zigmond, Vice President Royal College of Psychiatrists

[8] Report of the Independent Inquiry into the Care and Treatment of Michael Stone (September 2006) published by South East Coast Strategic Health Authority, Kent County Council and Kent Probation Area.

[9] For instance Szmukler 2003, *Risk assessment: 'numbers' and 'values'* in Psychiatric Bulletin 27, 205-207

[10] 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. The findings state "more homicides could have been prevented by good mental health care which detected relapse earlier (17 cases) than would than would be averted by attempts at better risk assessment and management (11 cases)." Munro & Rumgay: 2000. *Role of risk assessment in reducing homicides by people with mental illness*.
British Journal of Psychiatry 176 116-120

Brief history of the process of reform

In 1998 the Government appointed an Expert Committee, chaired by Professor Genevra Richardson, to review mental health legislation (the Richardson Committee). The Richardson Committee recommended a new Act which would provide a 'single pathway' to compulsory treatment whether in hospital or the community and should be based on notions of autonomy and non discrimination.[11]

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

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

The Mental Health Bill 2006

The Bill as introduced in the House of Lords in November 2006 proposed changes in seven areas of the 1983 Act:

1. A new broad definition of mental disorder and the removal of most of the conditions and behaviours which are specifically excluded from the coverage of the Act

2. The abolition of the 'treatability test' and introduction of an 'appropriate treatment test' which would apply to all the long-term powers of detention

3. A new community treatment order for patients who have been discharged from compulsory treatment in hospital

4. A new right for patients to remove their 'nearest relative' through the county court system

5. The widening of the group of practitioners who can take on the role of approved social worker and responsible medical officer under the Act

6. Provisions to allow a reduction in the time limits for the automatic referral of some mental health patients to the Mental Health Review Tribunal

7. The introduction of safeguards for people in hospitals and care homes who lack capacity and need to be detained in their best interests – through an amendment to the Mental Capacity Act

The Lords subsequently voted for six changes to the Bill:

- Exclusions to the wide definition of mental disorder to ensure that people should not be detained solely on the basis of: substance misuse; sexuality; disorderly acts; and cultural, religious or political beliefs.

- A requirement that people who have full decision making ability to make their own decisions about the provision of treatment can not be forced to have that treatment imposed upon them against their will.

[11] Review of the Mental Health Act 1983, November 1999

- The reinstatement of a ‘treatability test’ – which provides that a person should only be detained if treatment is available which is likely to alleviate or prevent a deterioration of his or her condition.

- A requirement that any renewal of detention or community treatment order must be agreed by a medical opinion.

- A new narrow set of eligibility criteria for community treatment orders to limit them to genuine ‘revolving door patients’ with a history of relapsing after discharge from hospital and who are a danger to others.

- To ensure children detained under the Act are admitted to age-appropriate accommodation by an expert in child and adolescent mental health, not just admitted to an adult ward.

In addition the Government introduced its own changes including:

- A set of principles in the Code of Practice;

- Allowing ‘Gillick competent’ 16 and 17-year-olds to override the wishes of their parents if they want to refuse treatment;

- Protecting patients with decision-making capacity from being given ECT without consent;

- Enabling people to be moved between ‘places of safety’ to reduce the time people spend in police cells;

- Additional safeguards for people detained under the Mental Capacity Act.

What we think about the Bill

The Bill originally introduced in the House of Lords was deeply flawed. It ignored the recommendations of the Joint Parliamentary Scrutiny Committee and included policies which were universally condemned by those, including members of the Alliance, who gave evidence before it. It was disappointing that after so many years and extensive discussion and consultation, and particularly following the report of the Joint Parliamentary Scrutiny Committee, that the Government decided to ignore the vast majority of experts on key issues.

However as a result of the discerning scrutiny of the Mental Health Bill by the House of Lords there does appear to be a way forward – which has cross party support. The House of Lords put forward a constructive case which takes on board the opinion of the vast majority of mental health experts; that the Mental Health Bill as introduced into the Lords would do little to help vulnerable patients and nothing to improve public safety.

The amendments made to the Bill by the Lords provide the Government with an opportunity to achieve mental health legislation that is principled, workable and enjoys the support of patients, carers and families, professionals and the public. The changes would help England and Wales move closer to achieving ethical mental health legislation as enacted in Scotland which now bases compulsion on patients’ impaired decision making ability and provides patients and their carers with a right to assessment for the provision of services. Many of the peers who debated these amendments have years of professional experience in mental health. The Government should respect the expertise shown by the Lords and not seek to reverse the amendments.

The six key changes made by the House of Lords

1. Exclusions from the definition of mental disorder

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

However the House of Lords voted in favour of a modified version of the current exclusions:

- To replace the exclusion in the Bill for dependence on alcohol and drugs with a far more appropriately worded exclusion which covers a state of acute intoxification falling short of dependence.
- To reinstate the exclusion clause in the 1983 Act to cover sexual preferences.
- To substitute for the existing exclusion for immoral conduct a more generic clause to protect mental health law becoming a form of social control.
- To respond to the evidence that people from black and minority ethnic communities are disproportionately subject to the Act and to provide a specific exclusion to address the problem.

The Alliance strongly supports the amendment passed by the House of Lords. The new single broad definition of mental disorder included in the Bill is only acceptable if accompanied by clear boundaries through a series of exclusions - as is the case in the 1983 Act and the law of other countries including Scotland[12], New Zealand[13] and Australia.[14] Exclusions ensure that practitioners carefully consider the basis for compulsory treatment. If there is an underlying mental health diagnosis the person is covered by the 1983 Act. It is unhelpful and inappropriate for people who do not have an underlying mental health diagnosis to have their needs confused with those of people who do have an underlying diagnosis.

It is notable that the Richardson Committee which recommended a single broad definition of mental disorder also suggested retaining the exclusions of the 1983 Act in a modified form.[15] The Joint Parliamentary Scrutiny Committee also recommended specific exclusions on the grounds of substance misuse, sexual orientation, cultural beliefs or behaviours alone.[16]

2. Impaired decision making

The Alliance welcomes the decision of the House of Lords to impose an extra condition before a person may be subject to compulsory powers under Part II of the 1983 Act that the person must have impaired decision making ability. The Mental Health Act applies when a person is objecting to being admitted to hospital for treatment but the clinicians believe that the person is sufficiently ill to require medical treatment in hospital. As a result of this amendment people who are fully able to make their own decisions about the provision of treatment cannot be

[12] Section 328 of the Scottish Mental Health (Care and Treatment) Act 2003 states that a person cannot be treated as mentally disordered only on the basis of sexual orientation; sexual deviance; transsexualism; transvestism; dependence on or use of alcohol or drugs; behaviour that causes or is likely to cause harassment, alarm or distress to any other person; and actions that no prudent person would undertake.
[13] The New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992 provides for exclusions on the basis of a person's political, religious or cultural beliefs; or a person's sexual preferences; or the person's criminal or delinquent behaviour; or substance abuse; or intellectual disability.
[14] In Australia the New South Wales Mental Health Act 1990 provides exclusions on the basis of political opinion or belief; religious opinion or belief; a philosophy; sexual preference or sexual orientation; political activity; or religious activity.
[15] Review of the Mental Health Act 1983, November 1999, para. 5.17
[16] ibid paras. 95 - 118.

forced to have it imposed upon them by a doctor who disagrees with them. A graphic illustration of this occurred in a case involving a man detained under the Mental Health Act who had a gangrenous leg. The doctor believed that he needed to have his leg amputated but because it was a physical problem he could not force it. The man refused, the court upheld his right to refuse and he recovered without the amputation.

The government has objected that this amendment might leave out people who need treatment. “If it cannot be shown that a patient's judgement is impaired, they cannot be detained - regardless of how much the patient needs treatment and however much they, and others, are at risk without it.”

The Alliance believes, as did the House of Lords, that this is completely mistaken. We are clear that in no circumstances would a person with a mental disorder whose condition is serious enough to require the use of compulsory powers, including one who is regarded as dangerous to others or one who is suicidal, be construed as excluded from the Act for this reason. A patient with anorexia for instance who believes she is fat clearly has disordered thinking and as a result has impaired decision making ability.

The test is deliberately less demanding than the test of capacity under the Mental Capacity Act. 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 will however protect the patient from being detained because of a difference of opinion between him or her and the psychiatrist. This approach is used in the Scottish Mental Health Act and anecdotal evidence suggests it is not causing dilemmas for clinicians.

What it does is bring mental health law more closely into line with physical health care, which allow people to refuse medical treatment. In that way it should help to address the stigma of mental illness. There is an exception for people who are sentenced by the courts because such patients cannot choose informal admission and it is important they are not excluded from treatment in hospital.

An impaired decision making test not only has the support of the House of Lords – it was also supported by the Government’s own Expert Committee (the Richardson Committee) and the Joint Parliamentary Scrutiny Committee on the 2004 Draft Bill. It is also included in the Scottish Mental Health Act.

3. The treatability test

The Alliance supports the amendment in the House of Lords to reinstate a treatability requirement into the 1983 Act. It provides that a person should only be detained if treatment is available which is ‘likely to alleviate or prevent a deterioration of his or her condition’. This test can be satisfied by showing that the person detained is likely to benefit from being in a therapeutic environment of a hospital under the supervision of mental health professionals. The Government had introduced a provision that any treatment will simply have to be ‘appropriate‘ for the patient and ‘available’ to him/her. This fell short of requiring any discernible benefit for the patient. It was aimed at a very small group of patients with a dangerous personality disorder who it is said are able to flout the law by refusing to cooperate with treatment and hence claim they are untreatable.

However the test as amended overcomes this problem while protecting those who can gain no benefit from treatment from being detained. It will allow a person to be detained if treatment is available even if the person is not receiving the treatment at present because he/she refuses to engage with what is offered. It is in fact a very balanced amendment that achieves the Government’s aims without broadening the powers of compulsion to permit preventive detention.

The Government claimed that the current treatability test leads to people with personality disorders being discharged or turned away because they are not thought treatable and they cite the Michael Stone case. However the report of the inquiry on the care and treatment of Michael Stone did not point to a problem of the law but a problem of services, and did not recommend a change in the law. Similarly the recent John Barrett inquiry pointed to failures by clinicians to use powers but not a flaw in the existing legislation.

The reasons a person with personality disorder may be turned away from services have more to do with scarce resources in services for people with personality disorder (a situation which the National Director of Mental Health has stated recently is being rapidly remedied), the (out of date) belief that they could not benefit from mental health treatment and the previous lack of effective treatments. All these factors did work against patients with a personality disorder. Now that psychologists and psychological treatments are part of the compulsory framework, that resources are being made available for these treatments, and that community treatment orders will be available for those who pose a danger to others, any "unwillingness" to treat these patients under compulsion when circumstances require it should be a thing of the past.

Above all it should not be thought that the broad test proposed by the government will increase public safety. On the contrary, as the former Chief Executive of Broadmoor Hospital, Alan Franey has put it, it is certain to drive mental illness underground because people in need of help would be too afraid to seek it for fear being treated against their will.

Again this provision is also supported by the Richardson Committee which considered that a health statute should only authorize the overriding of patient autonomy if there are "positive clinical measures included within the proposed care and treatment which are likely to prevent deterioration or secure improvement in the patient's mental condition."[17] It is also supported by the Joint Parliamentary Scrutiny Committee which recommended the same therapeutic benefit test as used in the Scottish Mental Health Act.

4. Renewal of detention

The Alliance again welcomes the amendment passed by the House of Lords to require a medical practitioner to examine the patient and agree to the detention - before a renewal of detention can occur. This would ensure that before a patient's detention is renewed, it receives a similar degree of consideration as did the original order for detention. Initial detention under the 1983 Act as amended will still be based on objective medical expertise in the form of reports from registered medical practitioners.

Under the Government's proposal a renewal of detention will be carried out by the responsible clinician – and if the responsible clinician is not a doctor then he/she will be required to consult a medical practitioner but there is no duty to take account of the practitioner's opinion. The House of Lords amendment would require – in these circumstances - a medical practitioner to examine the patient and the responsible clinician and the medical practitioner to agree before a renewal of detention can occur. The Alliance would like to see this amendment go further and require two examiners to agree to every renewal.

5. Community treatment orders

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

[17] Review of the Mental Health Act 1983, November 1999, para. 5.95.v.

The Alliance is extremely concerned that the Government has proceeded with these proposals despite the results of their own research which shows no reliable evidence that CTOs work. The recent international review of 72 studies of CTOs by the Institute of Psychiatry, commissioned by the Department of Health, concluded that "there is no robust evidence about the effects of CTOs on key outcomes, such as hospital readmission, length of stay, medication compliance, or the patients' quality of life." The report also stated that enhanced community services, such as assertive outreach teams, should be considered as a better way of achieving the goal of increasing compliance and reducing relapse. It warned that "CTOs might be used as an alternative to providing a comprehensive package of effective community mental health services."

We believe that the Government needs to put clear limits on who can be given a community treatment order. Only the small number of people who would benefit from such an order should have their freedom restricted in this way. We therefore welcome the House of Lords decision to insert a new set of narrow criteria for a patient's entry onto a CTO - to limit their use to people who can be described as ' revolving door patients' as has been the stated intention of the Government previously. These are:

- that a person cannot be placed on a CTO if they have full decision making capacity;
- that a medical practitioner opinion be sought if the responsible clinician is not a doctor;
- that an assessment of the nature and degree of the mental disorder and the likelihood of compliance with medication, together with the risk of the patient relapsing, must take place; and
- the retention of supervised discharge as a less coercive means of keeping a patient who has been discharged under supervision.

We are also extremely concerned by the broad scope of the restrictions that may be imposed on patients on CTOs, which would allow all sorts or restrictions on a patient's lifestyle, associations and activities – such as specifying that a person cannot go out to the pub or cannot go out after a specified time. Such restrictions may also limit the freedom of movement of families and carers – placing those close to the patient under punitive conditions. This raises the possibility of the inappropriate use of CTOs as a form of psychiatric ASBO. We believe that the condition should be removed which would allow a responsible clinician to require a patient on a CTO "to abstain from particular conduct". In addition – and in line with the recommendation of the recent report of the Joint Committee on Human Rights – the Bill should be amended to allow a patient to appeal to the Mental Health Review Tribunal against any of the conditions imposed on them.

6. Children and young people

The Alliance is concerned that the 1983 Act fails to provide children and young people who are subject to compulsory care and treatment with appropriate safeguards. Despite government policy, young people are still regularly admitted inappropriately to adult wards, paediatric wards and occasionally to Local Authority Secure settings. Children and adolescent mental health service (CAMHS) units are not always the most appropriate setting for older adolescents but there must be an assessment of the therapeutic benefit and safety of a young person before they are admitted to an adult ward. We therefore welcome the House of Lords amendment to the Bill which would place health authorities under a duty to provide admission to an age appropriate setting for children and young people under 18 and for the assessment for admission to be carried out by at least one CAMHS specialist. This amendment would also require the responsible clinician for such a patient to be a CAMHS specialist - which would help to ensure that inpatient services cater to the specific needs of children with serious mental health problems.

We also welcome that the Government has agreed to place an amendment to allow 16 and 17-year-olds to override the wishes of their parents if they want to refuse treatment, and would encourage the government to include 'Gillick competent' children under 16 in this amendment. The Government has also agreed that if a young person didn't have a CAMHS responsible

clinician that the young person would have access to an independent CAMHS specialist who would present evidence to the tribunal. The Alliance strongly supports this concession.

We also believe the 1983 Act should be amended to provide extra safeguards for under 18s who may require ECT, ensuring an automatic second opinion and that parents or the High Court are in agreement with the treatment for under 18s who are not capable of consent. We believe that it is critically important for under 18s who are receiving inpatient care have access to independent advocacy in line with the rights of looked after children. We believe the right to advocacy will go some way to addressing the fear that many have of the inpatient services, particularly those in some Black and minority ethnic communities.

Missed opportunities in the Bill

While the Bill has improved in important ways in the House of Lords, it is still a long way from guaranteeing a twenty-first century Mental Health Act. The Bill that gets passed this year could last for up to 30 years. It should be robust enough to reflect emerging practice in health care and lead mental health services into better ways of working.

1. The nearest relative

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

The issue of who is identified as the nearest relative is one of the most complex in the 1983 Act and one of the commonest area where mistakes are made. The nearest relative is normally identified by reference to a list of 'relatives' in the 1983 Act, ranked in order of priority, and the 'nearest relative' is the person nearest to the top of the list. The nearest relative will not necessarily be the person identified by the patient as their next of kin, and indeed the patient has little control over who will be seen in law as the nearest relative. The nearest relative may be someone the patient dislikes and does not want involved in their life, let alone decisions about hospitalisation – and the patient has no power to apply for the displacement of an unsuitable nearest relative. This inflexibility has been upheld, in different decisions, as incompatible with Article 8 of the Human Rights Act 1998.[18]

The Bill proposes that patients should be allowed to apply to the county court for a displacement of their nearest relative in certain circumstances. It also updates the nearest relative list to include civil partners.

We are disappointed that the Government rejected amendments put forward in the House of Lords to replace the nearest relative with a 'nominated person'. This provided that where a patient has capacity to make this decision, they should have the right to choose their nominated person. The nominated person is more likely to be someone in whom the patient has trust and confidence, and someone who will safeguard the best interests of the patient. This would also provide greater legal clarity about who is the patient's representative and would avoid the need for intrusive questioning during the sectioning process – such as 'who is your eldest parent' or 'were your parents married when you were born'. It would also avoid unnecessary legal costs of requiring the patient to go to court to displace a nearest relative they disagree with. Where there is no nominated person, we believe that the patient's carer should assume the role of default nominated person. A similar system already operates under the Scottish Mental Health Act which provides for the patient to appoint a 'named person' who is given specific rights and powers in relation to the patient.

The Government has agreed to give further consideration to a proposal that a patient should be able to choose their nearest relative – but only from the current list of eligible nearest relatives and the named person would then be subject to approval by the hospital managers or local social services authority. Although this falls short of what we would like to see, we welcome the decision by the Government to reconsider the issue of patient choice of nearest relative – albeit a restricted choice – and await the detail of any new proposals with interest.

2. Advance decisions and advance statements

We believe that advance decisions and advance statements are important mechanisms for safeguarding and promoting a patient's interests and health. An advance decision allows a person

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

to refuse specific treatment in the future should they lose capacity to consent. Advance statements are a means of giving details of the care and treatment a patient would like to receive should they lose capacity at some time in the future, including whom they wish to act as a nominated person. Both of these mechanisms can help can promote individual autonomy and empowerment; they can enhance communication between patients and those involved in their care; and they can protect individuals from receiving unwanted or possibly harmful treatment.

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

3. Right to Assessment

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

4. Right to Advocacy

The Alliance strongly believes the 1983 Act must be amended to ensure that all patients subject to compulsory powers have a statutory right to an independent mental health advocate and that they are made aware of their right to independent advocacy when key decisions are being made in respect of their care or treatment. This proposal was present in the Government's 2002 and 2004 Draft Bills and was also supported by the Joint Parliamentary Scrutiny Committee, which concluded that mental health legislation should include an individual right to independent advocacy for people at all stages of the process of assessment and treatment under the Mental Health Act.

In the House of Lords the Government agreed to consider this amendment and bring in changes during the Bill's passage through the House of Commons. The Alliance welcomes the Government's apparent change of heart on this issue and awaits the detail of any new proposals with interest. A right to advocacy is of fundamental importance for many service users and must be enshrined in mental health legislation. For a frightened and mentally distressed person who distrusts authority and who may have no one to support him or her, an advocate can make a real difference, particularly at the initial stage when a person presents for admission for the first time or is detained in a place of safety.

5. Places of safety

Police officers have a power under section 136 of the Mental Health Act 1983 to take a person, who is in a public place and appears to be suffering from a mental disorder and to be in need of immediate care or control, to a place of safety – which can be a police station or hospital. The Alliance is concerned about the use of a police cell as the place of safety. This is not a

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

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

therapeutic environment for someone experiencing mental health problems and could delay the provision of effective treatment and indeed exacerbate their illness. The Alliance welcomes the Government's amendment to the Bill to allow transfers between places of safety. This is an important safeguard and will ensure that people with mental health problems can be transferred from police cells to a therapeutic environment without having to wait for an assessment by 3 mental health professionals. We also believe that legislation should ensure that a person detained in a police cell should be either transferred or assessed at the earliest possible opportunity.

We would also like to see a change in the definition of a place of safety to ensure that as far as possible it should not be a police cell and should instead be a therapeutic environment and a reduction in the time period for patients detained by the police in a place of safety under section 136 from 72 hours to 24 hours. These proposals have been developed by the Alliance with the assistance and support of the Police Federation, the Association of Chief Police Officers and the Independent Police Complaints Commission.

6. Guiding principles

The debates in the House of Lords showed an overwhelming support for the proposal that the 1983 Act should contain a set of general principles on its face and that, as in the Scottish Mental Health Act, the Act should stipulate that practitioners 'must have regard to' them. In England and Wales, both the Children Act 1989 and more recently the Mental Capacity Act 2005 set out principles within the legislation itself. There is widespread agreement that statutory principles would give confidence to service users and be a valuable guide to practitioners and tribunals in applying and interpreting the 1983 Act. In response the Government has amended the Bill to place a requirement on the Secretary of State and Welsh Ministers to include a statement of principles in the respective codes of practice – and sets out the matters that these principles must address.

We are disappointed that despite the widespread consensus on this issue, the Government still refuses to include a clear set of overarching principles in the 1983 Act. We recognise the Government's concerns that there are inherent tensions the aims of mental health legislation to safeguard patient autonomy, least restriction and public safety, but like the Joint Parliamentary Scrutiny Committee, we support the view that the very existence of different and potentially conflicting objectives provides all the more reason for principles to be set out on its face. Furthermore, given the widespread concerns among service users about the nature and purpose of compulsory powers, inclusion of principles at the start of the Act would help to break these circles of fear which are especially prevalent among black and minority communities and to promote engagement with treatment.

7. Consent to treatment

Psychiatric medication can cause a wide range of adverse effects including major weight gain and obesity, heart problems, low blood pressure, osteoporosis, seizures, Parkinsonism, tardive dyskinesia (involuntary movement disorders) and a range of other problems. In some cases, it can lead to sudden death. These effects can occur at normal doses, but it is particularly important to protect patients from being exposed to greater risks by being forced to have drugs at higher than recommended doses. Yet it is not uncommon for high doses of medication to be administered, and research shows African and Caribbean people experience this disproportionately.

The Alliance recommends reducing the period of drug treatment before which a second opinion is required from three months to 28 days, requiring clinicians to have regard to the patient's views and provide written reasons for refusing a requested treatment.

Electroconvulsive therapy (ECT) is an invasive procedure whose adverse effects can include permanent loss of memories and other cognitive impairment. It can cause great psychological distress to be forced to have it involuntarily. We welcome the Government's amendment to the Bill which would provide that in non-emergency situations people with capacity to make treatment

decisions could not have ECT administered without their consent, and those who lack capacity could not have ECT administered to them in the face of a valid advance decision, or decision by the Court of Protection. However we do not agree that the patient's refusal should be overridden in cases of 'emergency' – the provision of emergency ECT should be limited to those who lack capacity and where their life is in danger.

8. BME issues

The Government's own statistics highlight staggering ethnic inequalities in the use of mental health services.[21] According to the 2006 'Count Me In' census, published last month, inpatients from the Black Caribbean, Black African, and Other Black groups were 19-38% more likely to be detained under the 1983 Act when compared with the average for all inpatients.[22]

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

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

9. Diversion from the criminal justice system

The Alliance is concerned that prisoners with mental health problems are still not getting the specialist medical treatment they need. The Office for National Statistics survey of mental ill heath in the prison populations in England and Wales in 1997 indicated that 90% of prisoners have at least one mental health or related problem, including personality disorder, psychosis, depression, anxiety, alcohol misuse and drug dependence. If a measure of the success of the policy of diversion is the numbers of mentally disordered offenders who end up in prison, then there is a good argument to say that the policy has failed. Despite the policy of – and the numerous mechanisms to secure the practice of – diversion of offenders suffering from mental disorder from the penal to the hospital system, the numbers of such persons amongst sentenced prison populations has been consistently well documented.

The Alliance believes that the 1983 must be amended to address this problem – for example

- To provide a power for the court to arrange to receive a report on the mental health of a person who is remanded on bail rather than in custody.
- To provide that where courts wish to send an offender on remand to a hospital and hospital trusts cannot agree to which hospital the person should be sent, there is a duty placed on the Home Secretary to resolve the dispute.
- To provide that where those exercising the function of responsible clinician form the view that a prisoner or person on remand should be transferred to hospital, a duty is placed on the Home Secretary to order his transfer to hospital.

[21] Count me in: The National Mental Health and Ethnicity Census 2006 Service User Survey: MHAC
[22] ibid.

10. Safeguards for people who lack mental capacity (Bournewood patients)

The Mental Health Bill proposes a new legal framework that will be inserted into the Mental Capacity Act 2005 to allow people in hospitals or care homes and who lack capacity, to be deprived of their liberty if it is considered to be in their 'best interests'. The changes are a response to the 'Bournewood judgement'[23], which concerned an autistic man who lacked decision making capacity and was detained in hospital under the common law (with no legal safeguards). In accordance with established clinical practice the Mental Health Act was not used because the person was not actively objecting to detention. In 2004 the European Court of Human Rights held that the common law was not enough for these patients: it was too vague and had too few safeguards to comply with the Convention.

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

The Mental Health Alliance supports the safeguards introduced in the Bill for people who lack the capacity to give informed consent to decisions made over their care. The Making Decisions Alliance (a consortium of 40 charities set up to campaign for new legislation on mental capacity and to support the implementation of the Mental Capacity Act) shares our views on these proposals. We also welcome the flexible and co-operative approach adopted by the Government on this issue – which has led to a number of important concessions that we have called for and fully support. These include:

- an enabling power to allow the maximum length of authorisations to be reduced if monitoring of the operation of the safeguards shows this is necessary
- a requirement that the supervisory authority inform all interested parties when an unlawful detention is taking place
- allowing third parties to request an assessment of whether a person is being deprived of their liberty
- a commitment to introduce improved advocacy safeguards for Bournewood patients when the Bill reaches the Commons

The Alliance also believes that the safeguards could be further strengthened to give more protection to these vulnerable people. For example:

- Where a person is detained in a care home they should not have to pay their accommodation costs. The recent report of the Joint Committee on Human Rights supported this by pointing out it would be discriminatory if a person deprived of liberty in their own best interests in a hospital will not be charged for the detention whereas a person detained in their own best interests in a care home will have to pay.[24]

- There should be a right to a second medical opinion for any serious medical treatment provided while the person is detained. The Joint Committee on Human Rights report also identified this area as an omission that would have promoted or enhanced human rights. They argue for "effective supervision and review of decisions to give treatment without consent for mental disorder where that involves psychotropic medication or other significant interferences with physical integrity, such as Electro Convulsive Therapy."[25]

[23] HL v United Kingdom [2004]
[24] Ibid page 31
[25] Ibid page 32

Role and scope of the Mental Health Alliance

The Mental Health Alliance is a coalition of 79 organisations working together to secure humane and effective mental health legislation. It is the broadest coalition in the mental health world - a unique alliance of: service users; psychiatrists; social workers; nurses; psychologists; lawyers; voluntary associations; charities; religious organisations; research bodies; and carers' groups.

The members are:

Core members:

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

Associate members:

The 1990 Trust; African Caribbean Community Initiatives; Age Concern England; Alcohol Concern; Association of Directors of Social Services; AWAAZ (Manchester); AWETU; 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; Haldane Society of Socialist Lawyers; Having a Voice; Homeless Link; Imagine; JAMI; Justice; Law Society; Liberty; Local Government Association; Manchester Race and Health Forum; Mencap; Nacro, NHS Confederation; Race on the Agenda; RADAR; Refugee Action; Royal College of General Practitioners; Sign; Social Action for Health; Social Perspectives Network; Somali Mental Health Project; Supporting Carers Better Network; UK Council for Psychotherapy; West Dorset Mental Health User Forum; WISH.

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

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

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