MENTAL HEALTH ALLIANCE

Mental Health Bill House of Commons second reading summary briefing

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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[1].

Reform of mental health law gives an opportunity to bring improvements to the lives of patients, to the work of professionals and to services and the public. 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]

We agree. In the view of the Mental Health Alliance the following aims should be part of any reform of mental health law.

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[1] 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; 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.

[2] Report of the Joint Committee on the Draft Mental Health Bill, 2005. Summary page 5.

- It should support the Government's own health agenda. This favours choice and autonomy for patients[3], seeks to reduce the stigma of mental illness[4] , promotes human rights[5] and race equality and empowers and protects people who may at times lack mental capacity.
- It should involve an efficient use of resources and not favour any group of patients against another.
- It should not encourage excessive use of compulsion. Compulsion can do harm as well as good[6].
- It should be effective – and thus provide patients with timely help.
- It should command the support of those who work with it and those affected by it.

In the light of these aims we were very disappointed with the Mental Health Bill introduced in the House of Lords in November. It retained some of the flaws of the previous 2004 Bill but jettisoned its good features. The Government, which had ignored almost all of the recommendations of its own Expert Committee appointed in 1998, had now ignored all but a few of the 107 recommendations of the Joint Parliamentary Scrutiny Committee in 2004.

The amendments which we supported in the House of Lords and those which we hope to promote in the House of Commons are all designed to meet these aims.

The 1983 Mental Health Act

The 1983 Mental Health Act provides a legal framework for the use of compulsory powers. In the interests of their health or safety or for the protection of others, people who have committed no crime can lose their freedom, potentially for an indefinite period, and can be treated against their will, if necessary by force.

These are exceptional powers given to doctors and psychiatrists which should only be used when other options have been tried (which is why the Code of Practice states that compulsion should be the last resort). Use of these powers needs to be justified on therapeutic grounds and the law tightly framed to achieve this through robust safeguards and clear definitions of who can be subject to the Act. Under these circumstances the use of compulsory powers may be beneficial for patients, their families and, at times, the wider public.

The overuse of compulsory powers can involve significant dangers for all of these groups. First, the use of compulsion - sometimes with the police involved - is often traumatic and distressing for the patient. The threat of it can drive patients away from the services that can help them, and can destroy the trust between a patient and doctor.

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[3] As the *Choosing Health* white paper puts it, the Government believes its role is 'to empower people, support people when they want support and to foster environments in which healthy choices are easier.'

[4] Stigma and discrimination has increased over the last decade – by the government's own admission. It is shown through various studies most recently the Social Exclusion Task force .Stigma has direct consequences for health for employment and for relationships in life.

[5] "Human Rights in Healthcare - A Framework for Action", DH and BIHR, March 2007

[6] Volume III of the Evidence to the Joint Scrutiny Committee is full of moving submissions from patients and carers which testify to that

The use of compulsory powers is resource-intensive involving the scarce resources of psychiatrists, social workers and others in bureaucratic procedures and requiring the costly interventions of lawyers and Tribunals.

Overuse of compulsory powers can skew resources towards the acute end of care and away from other services such as early intervention which is shown again and again to be the most beneficial and the most cost effective. It can damage professional morale because of the excessive pressures it places on professionals in a risk averse 'blame culture' to protect the public at all costs. It can damage recruitment into professions that are already struggling to retain staff and damage therapeutic relationships.

Yet the original Bill before the Lords amended it would have led to overuse of the Act as many more patients would become eligible for compulsory powers. The Bill widened the gateway into compulsion and narrowed the gateway out – it is the lobster pot scenario expressed by Genevra Richardson. It gave wider powers than before to detain patients in hospital and in the community. It greatly skewed the balance between clinical power and the checks and balances on that power in favour of wide clinical discretion. With its vague and loose language[7] it gave the widest powers to clinicians which Tribunals would be hard pressed to keep under meaningful review.

The House of Lords

Far from destroying the balance in the Bill, the amendments in the Lords have restored some balance to the 83 Act. In our engagement throughout the long process of reform of the Mental Health Act we have only promoted policies that have the active and solid support of all the interest groups within the Mental Health Alliance. We have tried to respond constructively to objections raised by government officials and to seek compromises. This occurred in the House of Lords where we had discussions with peers from across the political spectrum – many of whom have great expertise in this area – during the Bill's Lords stages. We supported a number of amendments that they wished to see to improve the Bill.

We believe these amendments go some way towards producing a fair and workable Bill that both protects the public and helps patients and their families. We urge MPs of all parties not to overturn them.

We also urge the government to return to those remaining issues which it adopted as policies in the 2004 Bill, in particular to the right to advocacy.

Finally we would like to see in the Bill some improvements that modernise the law – to bring it into line with modern values and services.

The Bill as amended

- ensures that people who have the full ability to make their own decisions about their health needs cannot be forced to have treatment against their will

[7] For example, " appropriate" treatment; "in all the circumstances of the case"; "necessary to be subject to recall to hospital"; and its wide definitions (eg of medical treatment)

- ensures that people can only be treated under compulsory powers if the treatment being given is "likely to alleviate or prevent a worsening of his condition"
- limits supervised community treatment (SCT) to genuine "revolving door patients" with a history of relapsing after discharge and who pose a risk to others
- only allows a period of detention or SCT to be renewed if a doctor authorises it
- ensures that children detained under mental health legislation are admitted to age-appropriate settings and are treated by professionals who specialise in their care

Exclusions from the definition of mental disorder

The Government has proposed a broad definition of mental disorder, with only one exclusion – dependence on alcohol or drugs. We agree in principle with a single broad definition of mental disorder but believe it must be accompanied by clear boundaries through a series of exclusions - as in the current Act and the law of other countries including Scotland, Ireland, New Zealand and all the Australian states. Exclusions ensure that practitioners carefully consider the presenting behaviour of the person and the signs and symptoms of their condition to rule out other causes of them. Only if there is a mental health diagnosis is the person covered by the 1983 Act. Exclusions also guard against the inappropriate use of the clinician's powers of detention as a form of social control. 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.

Impaired decision-making

Forcing people who are fully able to make their own decisions about their health to take treatment against their will is unique to mental health patients. No doctor can force a cancer patient to have chemotherapy even if it will shorten their life without it. Yet the drugs to treat mental conditions are also potentially toxic and have severe side effects. This difference is unjust and stigmatising of mental health patients. It does not lead to better outcomes and may deter patients from seeking help. That in turn leads to their condition worsening and the need for more extreme and costly interventions. We therefore believe that only when someone is ill enough for their judgement to be impaired should they be treated against their will and we welcome the Lords' decision to make this a condition of compulsion.

The question of "treatability"

We believe that the purpose of mental health legislation should not be to effect the preventative detention of people who are unlikely to benefit from treatment. When the state takes away a person's liberty on health grounds then that person is owed some benefit to their health in return. The so-called "treatability clause" in the 1983 Mental Health Act ensures that this is the case, but the Mental Health Bill as introduced removes this. The Lords voted to reinstate a requirement that a person can only be detained if treatment that is likely to alleviate or prevent a deterioration in their condition is available. We hope MPs will retain this amendment. For a doctor to detain a person without offering them treatment that is likely to help them is wholly unethical.

Restricting the use of supervised community treatment (SCT)

Supervised Community Treatment is the Government's response to the perceived problem of the so-called "revolving door patient". The Government's Bill proposed a new Community Treatment Order 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.

We are not satisfied that the case has been made for the replacement of the current regime with such broad powers. The Government's own research has not provided evidence that Community Treatment Orders work for this group of patients. Furthermore, we are concerned that the proposals for supervised community treatment orders will merely deflect attention and resources from the real issue and the best solution to the 'revolving door' problem - the quality and availability of aftercare and support services in the community and the need to provide a more effective bridge between acute treatment and community.

Under SCT patients outside hospital would be required to take treatments imposed by clinicians. What constitutes treatment in this context is extremely broad and all sorts of restrictions could be placed on a patient's lifestyle, associations and activities, enforceable under the threat of compulsory hospitalisation. This has led to Community Treatment Orders being dubbed "psychiatric ASBOs".

For the small group of patients who are constantly in and out of hospital, who relapse because they do not follow prescribed treatment and then cause a serious risk to others, we conceed that there may be a role for SCT. But it should only be used for this very small group. We hope that MPs will support the amendment passed in the Lords that restricts the use of SCT in this way.

Further improvements needed

In addition to the amendments made in the Lords we believe the Bill could be further improved by:

- reinstating a right to independent advocacy services for those subject to compulsory powers which the government included in the 2004 Bill;
- introducing legal recognition of people's advance decisions about their care and treatment;
- enabling patients to have greater choice in the person who exercises the powers currently granted to the nearest relative;
- improving treatment safeguards for patients on long term medication;
- providing patients with a right to an assessment of their mental health needs.

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