



Mental Health Alliance

Report Stage Briefing, House of Commons

Introduction

The Mental Health Alliance is a coalition of 75 organisations working together to secure humane and effective mental health legislation.

The Mental Health Bill widens the circumstances in which hospital admission and treatment can be imposed and provides new powers allowing compulsory treatment in the community. It goes against the recommendations of the Government's expert committee appointed in 1998 and the Joint Parliamentary Scrutiny Committee in 2004. Its approach goes against the grain of other NHS reforms which promote choice, autonomy, non-discrimination and improved health outcomes.

Any discussion of mental health legislation needs to start from an understanding of the experience of compulsory detention and treatment and of the extent of the powers exercised by clinicians under the Act.

Under the powers of the 1983 Act people have their liberty taken away and are treated against their will with powerful medication whose benefits can be uncertain and which can do serious damage. The circumstances in which this occurs can be traumatic with people forcibly removed to hospital and forcibly injected. People's past experience of treatment may be ignored, even when they have had serious adverse effects from treatment. This underlines the importance of a principled and fair approach to the law.

Overall approach of the Bill and Alliance objectives

Unlike the 1983 Act, which was at the time a beacon of good practice internationally, this proposed law still lags behind modern principles for mental health legislation, as the many overseas statutes we have examined demonstrate. The World Health Organisation Resource Book on Mental Health, Human Rights and Legislation 2002, "A Comprehensive Legislative Framework", considers the laws across the world and distils a series of standards. The Bill fails to achieve many of these standards, including statutory principles, rights to treatment and statutory care plans. They include fair criteria for compulsion which balance patients' rights to autonomy and non-discrimination with paternalism and public protection. In Scotland, and as proposed in the recent Bamford Review of Mental Health and Learning Disability for Northern Ireland, all these standards are met.

The new ways of working for mental health professionals are a progressive aspect of the Bill, as would be the expected provision for advocates. However in major respects this is still an over-coercive and stigmatising law which stands in contradiction to the general direction of health policy and legislation in England and Wales, including the new Mental Capacity Act; the principles of choice, autonomy and patient-centred care which underpin the new NHS; and respect for human rights and non-discrimination which are actively pursued in new government initiatives. In addition multidisciplinary working, early intervention teams, home based care, assertive outreach, crisis centres are part of the vigorous new approaches to mental health care which could be jeopardised by this law.

The Alliance believes the following to be essential:

- a carefully framed and fair regime for community treatment orders
- reasonable provisions for patients to choose their nearest relatives that balance concern for carers and the rights of patients
- reasonable provisions around treatment choice for patients that give a status to advance directives
- a right to an assessment of mental health needs
- tight conditions for entry into the compulsory system so that people are not detained when it is not necessary
- proper protections against treatments that may cause harm to patients.

(For information about the content of the Bill, see the Annex, “Main features of the Bill”.)

What the Alliance would like to see

The Alliance recognises the progress that is being made in some aspects of the Bill. In particular, the amendment on therapeutic benefit (discussed in the Annex to this briefing) and expected amendment on age-appropriate accommodation for children and signs of real progress. However, we consider that amendments in the following areas are essential to create an acceptable Mental Health Act fit for the 21st century.

1. Advocacy

When people are at their most vulnerable, having their liberty taken away and treated with powerful medication or electroconvulsive therapy, it is essential that they are able to have someone who can speak for them or help them speak for themselves. A right to independent advocacy was one of the few progressive measures in the 2004 draft bill. It has been introduced for some people who are covered by the Mental Capacity Act, and it is included in the Scottish Mental Health Act. It is one of the main reforms called for by mental health service users.

Advocacy has many benefits, both for patients and for the services that work with them. For the patient, advocates can provide vital information, support and advice. They can be the only person speaking up for the patient while they are deprived of their liberties and unable to express their own wishes. For services, advocates can be a vital link with the individual and help to reduce the risk of mistakes being made in treatment.

Advocacy has particular benefits for some of the most marginalised groups of mental health service users: people from Black and minority ethnic communities, children, older people, deaf people and those in the criminal justice system.

Ministers have, on a number of occasions, indicated their support for mental health advocacy. The Alliance welcomes this commitment. We believe that an amendment to the Bill is vital to secure a statutory right to an advocate from the moment a person is brought under compulsion. This should be supported by an amendment to ensure they are informed about this right at the earliest opportunity and at other crucial points during detention.

2. Choice of ‘nearest relative’

The Nearest Relative is a key person in the 1983 Mental Health Act. Identified from a fixed hierarchical list, the Nearest Relative is kept informed about and involved in decisions about a person subject to the Act. The patient has no choice over who is appointed.

The Bill changes the current Act to allow a patient to displace their automatic Nearest Relative. But this must be done through the County Court and can only be on the grounds of unsuitability, which according to the draft Code of Practice is intended to apply when the

nearest relative has been or may be abusive to the patient. Few people will be able to make use of this power not only on this basis but also because the County Court is inaccessible and incomprehensible for people who are mentally unwell.

We believe that this position needs to be improved. It should at the very least be possible for patients to make a choice, when they have their full decision-making capacity, from the list of Nearest Relatives plus their carer of who is most suitable to represent them. This choice should only be made in writing and in advance of any detention.

This provision is important for a number of reasons. It will make it more likely that a person is chosen who has a good relationship with and cares about the patient. This will improve the effectiveness of the role as a safeguard and should improve the quality of decision-making at key times in a person's life. Making this amendment would also give more recognition to carers, many of whom may not be a person's automatic Nearest Relative. It will help to minimise the number of patients left without a representative because they have lost contact with their nearest relative. And it supports the Government's overall policy of increasing choice in health and social care.

One service user's experience of the Nearest Relative system:

My mother is my nearest relative but she is 76 years old and lives 150 miles away from me. My sister has an eating disorder and is currently in hospital receiving treatment for it – she is likely to be there for at least 6 months. For these reasons, I have changed my next-of-kin to someone who lives close to me, someone who knows me well and with whom I have a good relationship. This person not related to me in any way. My mortgage provider and other financial institutions have accepted this change as indeed has my GP. Therefore as far as anything to do with my financial assets, my property and my physical health is concerned this non-blood relative will be contacted, but when it comes to my mental health and my nominating the same person to be contacted and consulted about my care and treatment should I become unwell and/or sectioned is impossible. This is just not logical.

3. Advance statements and patients' wishes

Requiring clinicians to have regard to patients' valid advance decisions, and to consider patients' wishes, would promote patient autonomy and help clinicians to make better decisions.

People can make advance statements to say how they would like to be treated if and when they become too ill to make informed decisions about their care. These may include advance decisions refusing particular treatments.

In Scotland, people have a right to draw up statements about their treatment when they have full decision-making capacity. Such statements must be considered by health care staff when they are detained under their 2003 Mental Health Act. A similar right exists in England and Wales through the Mental Capacity Act of 2005 for people who lose capacity to make decisions due to any kind of mental impairment, eg brain injury or dementia.

Advance statements have many merits. They are likely to improve the treatment people receive. Many people who use mental health services over long periods have expert knowledge of what works for them and what does not, for example in terms of medication. They would go some way to achieving equality for people with mental health conditions to those with other illnesses that affect a person's decision-making abilities.

A service user explains the benefits of advance statements:

We drew up an Advance Statement which was updated only 2 months ago by my current psychiatrist and myself. Of course, we both know that it's not legally binding – ahem, yet! – but none-the-less we stick to what WE have agreed to regarding my treatment should I become unwell again and what my care team can and cannot provide at these times.

When I do become unwell these days I am no longer frightened to ask for help or to access services because I know what will happen to me if I do and what care and treatment I will receive. My care team know what to take account of when planning what care they can give me and they know that by taking into consideration my wishes (which they have agreed to), I am far more likely to seek and comply with treatment.

4. Tighter criteria for Community Treatment Orders (CTOs)

Community treatment orders (CTOs) are a key part of the Bill and represent its biggest change. The Alliance has major concerns about the circumstances in which such orders can be used. The Bill as it stands will introduce the widest community treatment orders of any comparable jurisdiction. Many service users see them as an extension of coercion from which it may be very difficult to break free, unduly interfering with their right to run their own lives.¹

Research² commissioned by the Department of Health and released in March 2007 did not find evidence in favour of CTOs' effectiveness. The most comprehensive study of CTOs to date, it concluded: "...there is very little evidence to suggest that CTOs are associated with any positive outcomes and there is justification for further research in this area. In terms of outcomes research, CTOs need to be compared with alternative interventions for which there is already good evidence of efficacy, or which might be more acceptable to patients and service providers".

CTOs' disadvantages include their over reliance on drug treatments³, and the extent to which they damage the therapeutic relationships with patients⁴ and bring a degree of coercion into the delivery of community care.⁵ Fears that CTOs may be used disproportionately for BME service users are borne out by the international study.

The Lords amendment that was voted out by the Public Bill Committee defined the group for whom CTOs could be used more closely, ensuring that they apply to "revolving door" patients. Otherwise CTOs could be used very extensively. Although a patient must first be detained in hospital before they can be placed on an order, the conditions for being detained in the first place are very wide indeed. The requirement in the original Bill that it must be necessary for a patient to be liable to be recalled to hospital is too vague. The Bill's framework for CTOs goes wider than any other CTO regime in the 52 jurisdictions which have them.

To ensure that CTOs are only used for the small group who may benefit from them, the

¹ This is evidenced by contributions at public meetings, participation in rallies and lobbying, and many submissions by individuals to the Joint Committee on the Draft Mental Health Bill.

² Churchill, R, Owen, G, Singh, S, and Hotopf, M (2007) International experiences of using community treatment orders, Institute of Psychiatry, Kings College London.

³ Moncrieff & Smyth, *Community treatment orders- A Bridge Too Far*, 1999. Psychiatric Bulletin 23, 644.

⁴ Dawson, 2002; *Ambivalence about CTOs*, Institute of Psychiatry IJLP 2003, 243-255.

⁵ 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. Hoyer & Fernis: *Out patient Commitment: Some reflections on ideology practice and implications for research*, 2001. Journal of Mental Health Law 1, 56-62

Alliance believes that additional criteria are essential. First, the person should not be well enough to make their own decisions about treatment (ie have 'impaired decision-making'). Second, the treatment should be necessary to prevent others from serious harm. The Alliance understands MPs' wish to include also serious harm to self, and although we do not agree that CTOs are the right response to suicidal people we reluctantly accept that this may be a necessary concession in order to reach an agreed way forward. Third, there should be evidence from past experience to support placing the person on an order. This would be shown by the patient having on at least one occasion prior to the current admission, refused treatment resulting in significant relapse so as to justify compulsory admission to hospital. In addition, and medical treatment following compulsory admission must have helped their condition.

The Government's view is that placing additional restrictions on the use of CTOs would prevent people from receiving treatment. However it must be remembered that CTOs concern compulsory treatment, and it is important that there are restrictions on the use of compulsion. There is nothing to prevent people being provided with support and treatment that they are willing to accept, or detaining people when the criteria for compulsory admission are met.

The Minister of State criticised the House of Lords for failing to grasp the "implications of denying treatment for patients". This is to confuse availability and access to services with the need for coercion in order to ensure patients accept services which are offered. It is a serious error. The main function of health services is to ensure that the appropriate services exist with a sufficient well trained workforce so that people receive the help they need when they need it. Coercive powers do not necessarily achieve that goal and can at times undermine it.

A service user's view about CTOs:

I speak as a service user with over 30 years experience of manic depression. For most of that time, I have controlled the mood swings without medication and had a successful career as a soldier and as a lawyer specialising in legal ethics. Now I choose to use medication because of a deterioration in my mental state...

To send people to hospital for not taking medication, where they are not a risk to themselves or anyone else, ie where the current sectioning process would not cover the situation, is to use hospitals as prisons. This is inappropriate and will take up valuable scarce beds.

Just as a minority of psychiatrists abuse existing sectioning processes, so a minority of psychiatrists will abuse CTOs. But under the current system of only being forced to take medication when in hospital, there are more checks and balances and more opportunities for other professionals to observe and censure inappropriate drug use.

C Perris, Evidence to Joint Scrutiny Committee

5. Reform of CTO conditions

The Alliance is also very concerned about what happens to people once they are placed on CTOs. The Bill allows the responsible clinician (the person who coordinates the compulsory treatment of a patient) to set the conditions for how they must behave in the community. These can include not just compliance with treatment but also where the person lives and rules over their conduct – such as setting curfews or forbidding them from certain areas. There is no opportunity for the patient or their family to challenge or even be consulted about these conditions. Yet the responsible clinician is able to vary them at any time and there is no limit on how long a person may be placed on such powers. Should the patient not comply with these conditions, their responsible clinician may consider that they need to return to hospital

and use their power to recall them to hospital under detention.

We believe that any condition imposed on a community patient must be clearly linked to the person's health and treatment. Patients and nearest relatives should be properly consulted about the orders and should have recourse to the Mental Health Review Tribunal to challenge the conditions under which they must live.

6. Exclusions from the definition of mental disorder

The Alliance believes there should be clear exclusions to the definition of mental disorder for substance misuse, disorders of sexual preference or gender identity (excluding paedophilia), disorderly acts, and cultural, religious or political beliefs. Their purpose is to set boundaries to the legislation, making it clear that no one may be detained solely on these grounds. With the new, wide definition of mental disorder these limits are essential. In all cases exclusions act as a check on clinical discretion and protect clinicians and their patients from any pressures to use the Act improperly. They ensure that practitioners consider carefully the basis for compulsory treatment, which is essential in legislation that gives clinicians such extensive powers over individuals' liberty and physical integrity.

The Government's main objection to this amendment is that it might exclude people from treatment. Training and guidance are the proper ways to ensure that the law is correctly applied. For example psychosis caused by substance misuse would still be covered by the Act.

The Government also claims this amendment could result in premature discharge of dangerous patients. There is no reason for a dangerous person who does not have a mental disorder to be subject to the Mental Health Act – this is the province of the criminal justice system - and there is no reason to believe that a dangerous person with a mental disorder would be discharged on the basis of these exclusions.

The Richardson Committee, which advised the Government on reform of the Mental Health Act, and the Joint Scrutiny Committee on the Draft Mental Health Bill, both recommended exclusions. They are a feature of the legislation in the comparable jurisdictions in the common law world, including recent laws introduced in Ireland and Scotland.

The effect of the Bill will be to extend the scope of clinical discretion. The new powers it creates are ones that most practitioners believe are far too widely drawn. They give the potential for overuse of the Act. In a risk averse culture where media headlines are so influential, and the public and politicians expect clinicians to act in a public protection role, the discretion to detain someone who falls within the parameters of the law feels more like duty. This can create ethical dilemmas for clinicians and undermine confidence in their professions, which in turn can affect morale and recruitment. This is why the rules relating to detention and compulsory treatment need to be clear and unambiguous.

7. Impaired decision-making

The Alliance believes that a person with full decision-making capability should not be compulsorily detained as a civil patient. This would be a genuinely modernising measure, putting non-discrimination at the heart of mental health law. It would bring people who are fully capable into the same position with regard to both physical and mental health treatment – since no-one who is fully capable and is eligible for physical health treatment can be forced to have it. It would shift the doctor-patient relationship away from paternalism, in keeping with the Government's agendas of choice and patient empowerment.

Mental health treatments involve powerful drugs which may be uncertain in their benefits, damaging in their adverse effects and therefore in some cases do more harm than good. People who are able to make their own decisions should not be compelled to accept such

treatments.

The concept of “impaired decision-making” is used in the amendment we propose so as to include people in the Act who may be able to reason but whose mental or emotional state impairs their ability to make decisions about treatment. This will include people whose mental disorder is so serious that they are regarded as a danger to others or themselves. A patient with anorexia for instance who believes she is fat clearly has disordered thinking and as a result has impaired decision-making ability.

This approach has been supported or adopted by the Richardson Committee⁶, the Scottish Mental Health Act⁷, and the World Psychiatric Association and the General Assembly of the United Nations. It would also be in keeping with the United Nations Convention on Disability Rights, which the Government has just signed, in particular Article 5 on equality and non-discrimination and Article 17 on protecting the integrity of the person.

8. Race equality

The 2006 “Count me in” census shows continuing over-representation of some Black and minority ethnic groups in the mental health system, particularly in its most coercive aspects⁸, which is not explained by prevalence studies of mental disorder.⁹ BME groups are less likely to be offered psychotherapy and more likely to be given drugs and to be treated coercively.¹⁰

The Government’s programme Delivering Race Equality can only be part of the answer when much of the inequality is caused by mental health legislation – not only over-representation in admissions but also seclusion, restraint and high security care. The legislation itself must promote race equality. This can be done through such measures as a principle of non-discrimination on the face of the Act, excluding cultural and religious beliefs from the definition of mental disorder, a right to advocacy, restricting community treatment orders, and a right to an assessment.

9. Children and young people

The Alliance strongly supports the inclusion in the Bill of a provision for the age-appropriate assessment and placement of children and young people (whether voluntary or detained patients).

10. Renewal of detention

The Alliance has agreed a set of principles against which amendments on this issue should be judged. The position under the 1983 Act, whereby a single doctor decides whether or not to renew a patient’s detention for up to twelve months, is unacceptable. It is an outdated and inadequate procedure when a person’s liberty is at stake. The tribunal process recommended by the Richardson Committee and proposed under the 2004 draft Bill would have addressed this but the current Bill does not - the responsible clinician takes on the role undertaken by the

⁶ The Expert Committee set up by the Government to review the Mental Health Act 1983, chaired by Professor Geneva Richardson, and reporting in 1999.

⁷ The Mental Health (Care and Treatment (Scotland) Act 2003 includes a criterion that “because of the mental disorder the patient’s ability to make decisions about the provision of medical treatment is significantly impaired”.

⁸ Count me in: results of the 2006 national census of inpatients in mental health and learning disability services in England and Wales, 2007, Healthcare Commission. Admission rates to mental health wards were three or more times higher than average in the black African, black Caribbean and white and black Caribbean mixed groups. People from these groups were more likely to have been admitted involuntarily, more likely to be admitted via the criminal justice system and those in the black Caribbean group were likely to have the longest stays in hospital.

⁹ McKenzie, K and Bhui, K, Institutional racism in mental health care, *BMJ* 2007; 334:649-650.

¹⁰ *Ibid*

responsible medical officer under the current Act.

The Alliance believes reform is needed that would satisfy the following principles - at least two professional opinions should agree the detention, with those opinions coming from different disciplines, and at least one of them providing the 'objective medical expertise' required by human rights legislation.

11. Treatment safeguards

Under the 1983 Act, medication can be given against the patient's will and without any external scrutiny for three months. Only after that time is a second opinion sought if the patient does not consent to the treatment. The Joint Committee on Human Rights has pointed out that this issue is, "how long it is reasonable to expect a patient to endure treatment which he or she is resisting without any opportunity to seek review of the need for that treatment". Given that the JCHR recommends that the waiting period be reduced to one month, the Alliance can see no valid objection to a reduction from three months, and is suggesting a two month period.

12. Right to a community care assessment

One of the most effective ways to ensure that people get the treatment and support they need would be to provide a right to an assessment. Currently up to a quarter of people are turned away because they are not ill enough and because of a lack of available services.¹¹ This could reduce the need for compulsion and ensure timely help for people at an earlier stage, making recovery or successful management of the condition more likely. It can be very difficult for people with mental health problems to get access to services when they need them. A procedure that reinforced authorities' existing duties would be a fair and reasonable response to this inequity.

Conclusion

There is a significant risk that the Bill will undo much of the Government's good work in recent years of improving mental health services and relationships between service users and providers. There is a real risk of investing in a new regime of compulsion that will have a counter-productive effect – alienating people with mental health problems rather than engaging with them and possibly increasing rather than reducing patient and public safety. It is only by incorporating the improvements listed above that we can achieve a better Act for the next generation.

¹¹ Rethink (2003) Just one per cent: the experiences of people using mental health services.

Annex

Main features of the Mental Health Bill

The Bill amends the current Act, so the structure of the legislation, and the criteria for admission remain the same. It introduces a single broad **definition of mental disorder**. This is problematic because, combined with other changes such as removing most of the **exclusions from the definition**, it widens the scope of the legislation. The Alliance considers that exclusions¹² are necessary to set boundaries on the Act and ensure that those operating it think about the basis for their decisions.

The Bill removes the requirement that those with learning disability, personality disorder or who are detained long-term may only be detained if treatment is likely to alleviate or prevent deterioration of their condition. The Bill changes this to “**appropriate treatment**” which must be available for anyone to be detained. The same test is used when second opinion doctors authorise treatment without consent. The Alliance considers that there should be a much stronger link to therapeutic benefit when people are detained and given treatment against their will. An amendment has been tabled defining medical treatment as “medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations”. The Alliance welcomes this although we have some concerns about the concept of “manifestations” and would want ministerial assurances that it what it refers to is clearly part of the mental disorder.

The Bill introduces a new regime of supervised community treatment under which people can be discharged on a **community treatment order**, have various conditions imposed on them and remain liable to be recalled to hospital. This is a very significant change that has caused much alarm and anger among mental health service users. Although the Government has said that these orders are aimed at so-called ‘revolving door’ patients they are not focused in this way. The Alliance considers that the criteria for their use should be much more tightly defined so that they can only be imposed on the small group of people who may benefit from them.

The Bill provides a right for the patient to displace their ‘nearest relative’ through the county court. This is an improvement but does not do enough to ensure that this important role is fulfilled by the person best placed to and most likely to act in the patient’s interests. Currently, and in the Bill, the person is identified from a fixed hierarchy of relatives.

The Bill provides for a wider range of mental health professionals to undertake statutory roles. The Alliance broadly welcomes this.

The Bill introduces a legal framework of safeguards for people who are deprived of their liberty in their best interests under the Mental Capacity Act. The Alliance broadly welcomes the safeguards though would like to see some further improvements.

The Bill provides for shortening the period before people get an automatic tribunal hearing if they have not applied for one. This is a small but welcome improvement.

What the Bill does not do

The Bill does not tackle the inequality in the Mental Health Act that allows people with full decision-making capability to be detained and treated against their will.

It does not require clinicians to consider patients’ wishes or have regard to their legally valid advance decisions.

¹² The Lords amendment specified that no-one should be considered mentally disordered for the purposes of the Act solely on the basis of substance misuse, sexual orientation, disorderly acts, or cultural, religious or political beliefs. The Bill allows only for the exclusion of dependence on alcohol or drugs.

It provides patients with no right to advocacy.

It provides patients with no right to an assessment of needs when they or their carer ask for one.

It does nothing to tackle race inequality in the mental health system.

Mental Health Alliance membership

The Mental Health Alliance has 75 member organisations. They are:

Afiya Trust; British Association of Social Workers; Caritas Social Action; Ethnic Health Forum North West; Hafal; Institute of Mental Health Act Practitioners; King's Fund; Manic Depression Fellowship; Mental Health Foundation; Mind; National Autistic Society; NUS; Witness; Rethink severe mental illness; Revolving Doors Agency; Richmond Fellowship; 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.