



**Mental Health Bill 2006**  
**House of Commons second reading debate 16 April 2007**  
**Briefing from Mind**

Mind's vision is of a society that promotes and protects good mental health for all, and that treats people with experience of mental distress fairly, positively, and with respect.

The needs and experiences of people with mental distress drive our work and we make sure their voice is heard by those who influence change

Our independence gives us the freedom to stand up and speak out on the real issues that affect daily lives.

We provide information and support, campaign to improve policy and attitudes and, in partnership with independent local Mind associations, develop local services.

We do all this to make it possible for people who experience mental distress to live full lives, and play their full part in society.

Being informed, diversity, partnership, integrity and determination are the values underpinning Mind's work.

**Introduction**

Mind is a founder member of the Mental Health Alliance and has helped formulate the Alliance's policies over several years. Our contribution has been shaped by what mental health service users in our various networks<sup>1</sup> have told us. One overriding message has emerged from our networks over the nine years in which the Government has been developing its plans to reform the 1983 Mental Health Act and it concurs with the finding of the Joint Scrutiny Committee on the 2004 draft Mental Health Bill that "The primary purpose of mental health legislation must be to improve services and safeguards for patients and to reduce the stigma of mental disorder."<sup>2</sup>

The Government disagrees. "The Bill is not about service provision. It is about the legal processes for bringing people under compulsion."<sup>3</sup> We believe this

---

<sup>1</sup> These include 200 local Mind associations across England and Wales; Mind Link, a network of 1500 service users; Mind in Action, a network of 2000 individuals and organisations committed to campaigning on mental health issues; Diverse Minds, our black and minority ethnic network; Rural Minds; and our Mind membership.

<sup>2</sup> Report from the Joint Committee on the Draft Mental Health Bill (HL Paper 79-I HC 95-I), Session 2004-05, published on 23 March 2005

<sup>3</sup> Government Response to the Committee's Report (Cm 6624), published by the Department of Health on 13th July 2005 (ISBN 0-10-166242-4)

approach leads to valuable resources being diverted away from services, focuses too much on the perceived risk posed by people with mental distress and increases stigma.

If there is one measure in the Mental Health Bill that alarms service users in our networks more than any other it is the introduction of Community Treatment Orders (CTOs)<sup>4</sup>. This briefing focuses on that issue and is intended to complement the briefing of the Mental Health Alliance, which we fully endorse.

There is also disappointment at the many missed opportunities in the Bill

- to replace the “nearest relative” with a “nominated person”
- to give legal status to advance decisions and advance statements
- to introduce a right to assessment of health and social care needs
- to introduce a right to advocacy (as included in the 2002 and 2004 draft Mental Health Bills)
- to restrict the use of police cells as “places of safety”
- to introduce a clear set of overarching principles to the 1983 Act
- to provide for more stringent treatment safeguards
- to amend the 1983 Act to tackle discrimination and promote race equality
- to strengthen measures to divert offenders with a mental disorder from the penal system to the hospital system
- to provide even stronger safeguards for people who lack the capacity to give informed consent to decisions made over their care (“Bournewood” patients)

Arguments for these are set out in detail in the Mental Health Alliance briefings.

Mind welcomes the improvements made to the Bill in the House of Lords which

- add exclusions to the definition of mental disorder 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
- ensure that people with full decision making ability cannot be forced to have treatment imposed upon them against their will
- provide that a person can only be detained if treatment is available which is likely to alleviate or prevent a deterioration of his condition
- require a medical practitioner to examine the patient and agree to the detention before a renewal of detention can occur
- limit the use of CTOs to genuine ‘revolving door patients’ with a history of relapsing after discharge from hospital and who are a danger to others
- place a duty on health authorities to admit children to an age appropriate setting and to provide specialist assessment and supervision for detained children

We believe these have produced a better balance between the power of the state to compulsorily treat individuals and the rights of those individuals and safeguards for them. We very much hope the House of Commons retains them.

### **Why Mind opposes CTOs**

We oppose CTOs because we believe they will be over-used; make it more difficult to manage the often severe side effects of medication; be likely to be used disproportionately on members of BME communities; be unworkable in rural areas; be harmful to therapeutic relationships; and divert resources away from

---

<sup>4</sup> Also known as Supervised Community Treatment

services. We do not think they will protect the health and safety of the patient or that of others. Even if only used on a strictly defined group and accompanied by stringent safeguards (we welcome the Lords amendment to the Bill that achieves this) we believe their use is unacceptable.

### **What it means to be sectioned**

Something that is often omitted from debates on definitions of mental disorder, criteria for compulsory treatment and the arguments for and against CTOs is what they actually mean for the person being subjected to them.

Being “sectioned” is in itself a distressing experience for someone who is already in distress. For many – often because they have already tried to access mental health services but without success – this will be their first experience of the mental health system. It may involve the police. It will involve being taken away from home. It will almost certainly involve a lesser or greater degree of force. Later, if detention results, there will be financial difficulties, perhaps loss of job, difficulty keeping up a home and a host of problems to be overcome on discharge, not least of which is stigma. Small wonder that mental health services are viewed afterwards with suspicion and wariness. The Mental Health Bill does nothing to address this and the spectre of CTOs makes it worse.

I was put under section, then I was put under medication. I was discharged. The medication had absolutely horrific side effects, which got worse, and when I said that I didn't want to take it, I was put under another section and forced to take it. I felt as though my skin had been peeled back and all my nerves were exposed. I felt as though electric shocks were being put through me. This went on for two or three months. I was told I would get used to it. In the end I was able to get off the section and off the medication because with help I was able to explain to the psychiatrists calmly and rationally what it was doing to me. Because I was calm and rational, they saw not only that I did not need the medication, but also that I did not need to be on a section.

Another time I was put in seclusion – simply because I had complained – and I was put on another form of medication. All the muscles in my shoulders and neck twisted and locked. I couldn't move my head or mouth. I was in agony.

These days I manage my illness via my local Mind and with the help of people I've met here. I won't approach psychiatric services because of the horrific way they've treated me in the past. I don't want someone seeing the words personality disorder in my notes, making assumptions based on that and then dictating to me. If I'm having problems I don't go to my GP, because I don't want to be sectioned.

Yes of course I want to be treated in the community. I want to be treated in hospital too. I want the choice of where I am treated and how I am treated. I certainly don't want to be forced. But most of all I want to be safe. I want to be safe from the medical profession, from the psychiatrists, from the wrong drug treatments, from the social workers, from my family and the rest. I want to know that the people caring for me do care for me, that they are keeping me safe, that they have my best interests at heart.

**Mary, 25, a service user, Mind in Darlington**

### **Overuse**

Mind has serious concerns that CTOs will be overused by practitioners acting defensively to avoid liability. It is likely to be the case that where a service user experiences relapse after discharge the question will be asked whether the psychiatrist should have put the service user on a community treatment order. It is easier to force compliance than to put trust in a patient. It is likely that such trust will be particularly lacking in cases where there are cultural differences.

There is also a circular argument about effectiveness of community treatment orders: if a patient does not relapse, does this suggest that the order is justified and is working, and therefore should be continued, or that it has achieved its outcome and should be discontinued? It is difficult to see at what point a defensive clinician would deem it to have become unnecessary for the health and safety of the patient to have the power of recall should the patient's condition deteriorate. According to this principle, and without the natural cap on hospital sectioning provide by the finite number of beds, Mind believes that community treatment orders will be used for too long, for too many people.

In the Regulatory Impact Assessment published with the Bill on 18 November, the Government itself acknowledges that the average length of time spent on SCT is likely to be around 9 months, compared to 109 days under a hospital order. Even if, as the Government assumes, there will be no increase in the number of detentions under the Act as a result of the amendments currently before Parliament, the increased length of orders for those on CTOs means that the overall level of compulsion will be greatly increased.

Mind would also challenge the assumptions about the numbers of people likely to be put on CTOs. The Government's RIA suggests that 2% of patients currently under s.3 or Part 3 will be transferred to a CTO in the first year, and that over five years this will steadily increase to 10%, where it will stabilise. It is worth considering that in Scotland, the rate of take-up of CTOs has been much quicker, with just under a quarter of all patients being put on a CTO in the first six months of their use (*Community-based Compulsory Treatment Orders in Scotland: The early evidence*. King's Fund, 2006). These early figures suggest that the use of CTOs in England and Wales is likely to be greater than predicted.

### **Making it more difficult to manage side effects**

I am currently on a medication break because the anti psychotics I was on were poisoning me and I had to fight three psychiatrists to get the blood tests done to prove this. If I was under compulsory medication in the community I believe it would have been harder for me to negotiate stopping my medication.

**Memorandum from S Banawich (DMH 440) to the Joint Committee inquiry on the 2004 draft Mental Health Bill**

Mind believes supervised community treatment will focus on drugs since this is the only treatment which can be enforced effectively and which is available readily. The use of medication therefore is likely to increase, as it is the "easy option" for over-stretched workers.

Service users fear being forced to take drugs that they know cause them distress. They also fear that there will be no way to monitor side effects or to supervise withdrawal, changes in medication or levels of medication if they are treated in the community. It is highly likely that the most common method for administering medication to someone on a community treatment order would be the use of depot injection. The types of anti-psychotic medication available for depot are of the older atypical variety which can have severe side effects.

People will be effectively prevented from making their own evaluation of the costs and benefits of particular medication. Stopping medication can often be a rational decision and lead to an improved quality of life. Mind's experience is that people usually avoid complying with aspects of their care plan for legitimate reasons, such as the side effects of medication. Someone deemed fit to live in the community should be trusted to make these sorts of decisions, with support, for themselves. The approach should be based on trust; not on compelling people to take medication.

During 2003-04 a team of service user consultants developed and carried out a piece of research for Mind about people's experiences of attempting to stop taking psychiatric drugs. The report <sup>5</sup>, based on quantitative research with 204 people and qualitative research with 45 of those people, all of whom had tried to stop taking psychiatric drugs, successfully or otherwise, suggested that doctors do not always have good judgement about who can safely stop taking their drugs—those who came off against their doctor's advice did as well as those who had their doctor's agreement. This has clear implications for Community Treatment Orders under which it will be even more difficult for people to choose to try to stop taking drug treatments and more people will be taking drugs unnecessarily to the detriment of their health and wellbeing.

In the survey people attempting to come off antipsychotics were particularly likely to find doctors unhelpful. Four fifths who sought help from a psychiatrist said they were unhelpful or made things worse. Yet it is common for people to stop taking psychiatric drugs for good reasons and when asked about the benefits of having come off psychiatric drugs, people in the survey most commonly said: better mental ability, feeling more alive, having taken back power and control, the reduction of side effects, and feeling good about managing without drugs. CTOs would significantly restrict people in their ability to achieve these benefits.

### **Likely to be used disproportionately on members of BME communities**

I would change community treatment orders (CTOs). It undermines my vision of primary care for mental health services. If you look at Black people, they are running away from the hospital experience because they don't like the medication regime. Now there is the potential through the CTOs to force people to take their medication in the community. The Bill isn't dealing with the cause of the problem but instead is putting sticking plaster on the same problem. People need justice and to feel they have a fair chance in life.

---

<sup>5</sup> Jim Read (2004) *Coping with coming off: service users' experiences of attempting to stop taking psychiatric drugs*. Mind.

**Dominic Walker, survivor and an Independent Living Advocate with the Equalities National Council, Diverse Minds magazine, Spring 2006**

Black people, particularly young black men and some other minority ethnic groups are disproportionately represented in the mental health system. The Department of Health's 2006 *Count me in* survey found that African-Caribbean people are up to **38 per cent** more likely than average to be detained under the Mental Health Act.

The lack of an anti-discrimination principle on the face of the Bill, together with the fact that the Government's Delivering Race Equality programme is not making sufficient progress make it inevitable that a disproportionate number of people from BME groups will find themselves on CTOs. This is borne out by research. The Institute of Psychiatry's *International experiences of using community treatment orders* study published last month noted that ethnicity data available from Israel, New Zealand, the United States and Australia "indicate that relative to the proportion of the general population comprised by their ethnic group, most ethnic groups might be over-represented amongst CTO recipients."

**Unworkable in rural areas**

We are concerned that the government has not considered issues around how staff, support services and patients get to see each other in rural areas where transport, access and costs are real issues. This is a very real rural impact of the legislation that needs to be considered and resolved. The implications of not doing so are that people in rural areas will be treated unfairly by being more likely to be subject to detention for failure to comply due to circumstances beyond their control.

We are concerned that the lack of alternatives available in rural areas may lead to greater prescribing of medication and use of compulsory powers as the easiest solutions. This would be unfair. Consideration must be given to how such a situation can best be avoided and how it can be monitored effectively.

The Mental Health Foundation in evidence to the National Assembly for Wales said "We are particularly concerned about the proposals for supervised community treatment, and do not believe that adequate community based services are in place to offer an appropriate context to make these a positive intervention. This is a particular problem in Wales, where it is acknowledged that community based mental health services are not well developed." This position is not unique to Wales and applies to many rural areas of England also.

**Harming therapeutic relationships**

If illness has reached the stage where compulsory treatment is needed the correct environment for this is hospital not the community. In hospital you are monitored and have access to professionals 24 hours a day. In the community the burden of compulsory treatment will fall on the individual and his or her family. This is an unfair and potentially frightening situation. My father had a severe breakdown and prior to his admission to hospital—which did not happen early enough in his illness—he had some treatment at home. The impact on the family was immense and compulsory treatment at home would mean that the strain of

dealing with mental illness would be passed back almost entirely to the family members at a time when they are least able to deal with it.

**Memorandum from Isobel McEwen (DMH 110) to the Joint Committee inquiry on the 2004 draft Mental Health Bill**

"Trust is the key to therapeutic relationships. Compulsory community treatment orders would destroy it."

**Service user at a Mind seminar on the 2002 draft Mental Health Bill**

"Counselling or psychotherapy can be so helpful but it won't work if you don't want to be there."

**Service user at a Mind seminar on the 2002 draft Mental Health Bill**

I have been sectioned a number of times and certainly have been seen as a non-compliant, revolving-door patient; but, from my perspective, the problem was not with me but it was with the services not listening to what I was saying my needs were and also not providing the services that they said they would. I cannot see that would change under the new Bill. The new Bill frightens me even more, simply because of the proposed Community Treatment Orders. I have no doubt that I would have been put on a community treatment order if they had been available under the new Act, and I would be very afraid of the services. I would not trust them. I would basically do all I could to disengage. I would also be very concerned about the impact it would have on my family. I am married and I have two children. To feel that my husband had the added pressure to have to police me would be quite worrying.

**Kay Sheldon of Mind Link, giving oral evidence to the Joint Committee inquiry on the 2004 draft Mental Health Bill**

Many of the people we speak to find the current relationships they have with their mental health professionals generally helpful, and feel these would be harmed by the increased threat of compulsion with mental health professionals being turned into "Mental Health Act police officers". Many fear that the new measures will increase their chances of being subject to compulsion if they disagree with the treatment recommended by their psychiatrist. They also feel that being treated in the community would lead to less personal support and less immediate access to medical expertise.

Mental health problems commonly put pressure on family and other supportive personal relationships. When CTOs are used, carers, friends and family may become involved in trying to ensure that the conditions of an order are followed. This has the potential to undermine family relationships and support networks and the therapeutic benefits they can offer.

### **Therapeutic services are the key to preventing re-admission**

My own 34 years of experience of mental health issues including my mother's and my own is that compulsory treatment works as a last resort where there is crisis and danger, however, IN HOSPITAL. In fact I believe it has saved my life in the past. I would also like to say that had this compulsory treatment taken place in the isolation of my flat with all the associated problems of discrimination and

abuse from "normal" people in the community it would have been much more likely to cause and result in suicide.

**Memorandum from Mark Vero (DMH 430) to the Joint Committee inquiry on the 2004 draft Mental Health Bill**

Mind believes that compulsory treatment should only ever be used as a last resort and when it does take place it should be in hospital. We are well aware of the many shortcomings of mental health accommodation and have campaigned for many years for improvements in inpatient care<sup>6</sup>. However, if a person's condition is so severe that it requires compulsory treatment and other forms of voluntary crisis care have been exhausted then we believe that the levels of care and treatment required can only be provided in a high quality hospital setting. The resources that that will be diverted to the introduction of CTOs would be better targeted on improving hospital environments. A more positive experience of hospital treatment would make it less likely that people disengage from services following discharge.

We further believe that the key to preventing re-admission to hospital is to provide better aftercare, early intervention services and assertive outreach services relevant to people's needs. These should be easily accessible and properly resourced. People must not be made to engage with these services under threat of re-admission (ie through CTOs). Engagement comes from time and resources, not coercion.

---

<sup>6</sup> See for instance our 2004 *Ward Watch* campaign  
<http://www.mind.org.uk/News+policy+and+campaigns/Campaigns/Ward+Watch/Minds+Ward+Watch+report+key+findings.htm>