Draft Mental Health Bill, Letter From Campaign Headquarters, Number 6

I'm sorry if this newsletter is not up to the usual standard (you may feel the phrase 'up to' isn't appropriate). I am extremely busy trying to read the 300 pages of the revised Draft Mental Health Bill, 140 pages of explanatory notes and several other accompanying documents. Made worse because the Bill is very difficult to read and some of the 'easier to read documents' aren't entirely truthful (e.g. ECT cannot be given to a person who retains capacity and refuses – this is wrong. The capacitous patient can be given ECT in an emergency). In addition I have undertaken numerous press/media interviews and written 2 articles in the last 6 days. This isn't strictly relevant but my schedule was such on the day the Bill was published that our President got up at 5.00 am to make my breakfast!

The Bill (published 8th September) is available from the Department of Health website. The publication was brought forward from the previously specified date to the same date as the first day of the Michael Stone appeal. Coincidence? Interestingly the news media did not relate the two items.

There are a number of differences from the first draft Bill. I cannot list them because of space, time and the fact that I haven't completed my reading of the Bill (but your editor has ordered me to write this promptly).

Some differences:

1. The definition of mental disorder has been amended so that it now reads that mental disorder "*means an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain*."

I am not convinced that this difference in definition is meaningful.

2. The criteria have changed:

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

The second condition is that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.

The third condition is that it is necessary –
- *a) For the protection of the patient from –*
  - *i) Suicide or serious self-harm, or*
  - *ii) Serious neglect by him of his health or safety, or*
- *b) For the protection of other persons, that medical treatment be provided to the patient.*

The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.

The fifth condition is that medical treatment is available which is appropriate in the patient's case, taking into account the nature or degree of his mental disorder and all other circumstances of his case.

The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons.

For the purposes of this Part, a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.

It can be seen that the threshold in relation to risk to self has been significantly increased. There has been no change in respect of risk to others. Rather oddly, this now means that if a person lacks capacity but resists medical intervention (and so the Mental Capacity Act cannot be used) then we will not be permitted to interfere solely in the interest of the person's health.

The fifth condition seems rather unfathomable. Is this 'treatability' or 'therapeutic benefit' by another name. Professor Appleby says it gives clinicians clear grounds for refusing to make an order if this criterion isn't met. It was unclear at the Department of Health briefing if anyone fully understands this paragraph. One interpretation is that it means that the decision rests solely with the psychiatrist thus enabling a clear apportioning of blame should there be any adverse event.

The final statement (you will note it is not listed as a condition) talking about substantial risk of causing serious risk to other persons being treated as part of the determination as to whether all of the relevant conditions appear to be met, would appear to suggest that dangerousness per se must be seen as mental disorder.

There continue to be no exclusion criteria. There is no criterion of impaired decision-making by reason of mental disorder.

In relation to Community Treatment Orders the proposal for compulsion in prison has been removed. The explanatory notes accompanying the Bill suggest that patients will only be able to be put on a Community Treatment Order after they have had at least one admission to hospital (it is unclear whether or not this has to be within a defined time of the proposal for the Community Treatment Order) but this is absent from the Bill itself. It is stated that these additional conditions relating to CTOs will be in regulations.

Clinical supervisors, appeals, membership of Tribunals and expert panels are unaltered.

Minors aged 16 and 17 are treated as adults. For those under 16 first reading suggests that the Act may not be used if one parent consents on behalf of the child. Sue Bailey is investigating further.

The 'forensic' sections are generally welcomed. There are more opportunities for treatment without recourse to an additional civil section. Concerns include the even wider criteria for compulsion (than for other people) and the Courts authorising care plans. John O'Grady is advising.

One issue not mentioned in the first draft is that of section 139. It may not be appropriate to worry about protections for staff at this stage. Nevertheless this is the change. Section 139, you will recall, protects staff in two of ways. First by requiring the patient to prove that the member of staff was not acting in good faith. Secondly by requiring the permission of the Director of Public Prosecutions prior to a criminal prosecution or a High Court judge prior to

civil proceedings. The new clause excludes entirely protection for staff in relation to criminal proceedings, it reverses the current process so as to place the onus on the person complained against to prove that they acted in good faith and with reasonable care and it removes the need for High Court approval in relation to civil proceedings.

There are many other issues to discuss but, for the moment, I will have to leave it there. What happens next?

This Draft Bill will go before a Joint Select Committee of both houses of Parliament for pre-legislative scrutiny. Membership of the scrutiny committee can be obtained from the Parliamentary website. The Committee's first meeting, in private, should take place on September 15th. Following this we should hear who is to Chair the committee and dates in relation to written and oral evidence. To give some timeframe we expect the written submission to be required by the end of October and oral evidence to be taken from mid November (but please remember these are guesses). The Committee have to report by the end of March 2005. It is extremely unlikely we will get a Mental Health Bill (as opposed to the draft Bill) before the next General Election.

The College's submission to that Committee will be available on the College website once it has been submitted. We have requested that we the opportunity to submit oral evidence.

When membership of the Committee was first published I wrote to each MP and Peer asking if the College could assist them with the important work they faced. I'm pleased to report that a number of them have requested written information and personal meetings – these are currently being arranged.

Finally I must mention that Roger Freeman, Agnes Wheatcroft and I will be doing the usual round of lobbying, sorry educating, at the Party Conferences. Then there's the Queen's Speech – don't ask.

Tony Zigmond
September 2004