Draft Mental Health Bill, Letter From Campaign Headquarters, Number 8

Those with long memories will recall that in 1998 the Government established an Expert committee, again choosing its membership, to advise on mental health law reform. The Green and White papers and the 2002 and 2004 draft Mental Health Bills which followed clearly established that the Government had paid little heed to the recommendations of the Expert group.

In autumn 2004 Government sent the 2004 Draft Bill for scrutiny to a Joint Committee of MPs and Lords (Scrutiny of Draft Bills is a relatively new parliamentary procedure used for legislation which is not 'party political'). Committee members are appointed in proportion to party strengths in Parliament so that there was a majority of Labour party members on the committee. Lord (Alex) Carlile, a barrister and Lib-Dem peer, was elected Chairman of the Committee with Government approval. The Joint Committee received over 400 written submissions and took oral evidence from 124 expert witnesses. Government has now responded to the Joint Committee's report.

The Committee made 107 recommendations. Rather than transcribe the whole document here I have concentrated on responses to the College's recommendations. You may recall that the College submitted 17,000 words of evidence – most of it set out in a way which would give the College's answers to the specific questions asked of us by the Committee. The questions can be read in the College's submission.

- In our introduction we said that the Mental health Bill should help reduce stigma and support services.
  The Joint Committee said that the Bill should help improve services.
  The Government disagreed stating that these subjects were not relevant to a Mental Health Bill.

- We argued that the Bill focussed too much on public protection and not enough on health.
  The Joint Committee agreed.
  The Government disagreed.

- We noted that a Mental Health Act needs to be drafted in such as a way that doctors, and others, would be able to read and understand it.
  The Joint Committee agreed.
  The Government interpreted this as suggesting that the Bill should be longer which they felt wasn't appropriate.

In response to the Questions we said:

- The draft Codes of Practice must be made available, alongside the draft Bill, in order to fully to understand the provisions of the Bill.
  Joint Committee Agreed.
  Government Agreed.

- Principles should include: non-discrimination, respect for diversity, respect for personal autonomy, informal care where possible, reciprocity, least restrictive alternative, patient participation and consensual care where possible, respect for carers, patient benefit, child welfare.
  Joint Committee Agreed.
  Government accepts that principles should be on the face of the Bill (rather than relegated to the Code of Practice). However it has not said which principles it accepts.
  Note: The Colleges recommendations are based on the Scottish Act.
  This was supported by the Joint Committee.
  The Government has specifically rejected the Scottish principles.

- The definition of mental disorder in the draft Mental Health Bill is satisfactory ONLY if combined with extremely tight conditions and limitations. Otherwise either the New Zealand or Australian definitions of mental disorder should be adopted.
  Joint Committee agreed.
  Government agreed with preference for broad definition of mental disorder but with tight conditions and exclusions.

- The Bill should contain the following exclusions: Nothing in the conditions for compulsion shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder solely by reason of: cultural, political or religious beliefs or promiscuity, sexual deviancy or other immoral conduct or dependence on, or misuse of alcohol or drugs or impairment of intelligence or the commission, or threat, of illegal or disorderly acts.
  Joint Committee agreed in relation to political/cultural beliefs (it said that this included religious beliefs), alcohol/drug misuse and sexual orientation but not deviancy. In relation to people with impairment of intelligence the Joint Committee recommended compulsion only if the patient also displayed "seriously aggressive or severely irresponsible" behaviour.
  Government disagreed with all except for alcohol/drug dependency (rather than misuse).

- Use of the Act should be prohibited in cases where the capacitous patient willingly accepts assessment and treatment as recommended by the medical practitioner.
  Joint Committee agreed.
  Government said they would look at this again.

- Patients who lack decision-making capacity must not be excluded from receiving treatment because they resist treatment and yet present only moderate risk to their health.

Joint Committee made no comment.
Government made no comment.

- There should be two important additional conditions for compulsion in the draft Bill:
    - Impaired decision-making by reason of their mental disorder.
    - In relation to a treatment order: therapeutic benefit for the patient.

  Joint Committee agreed with both.
  Government disagreed with both.
  Note: In relation to therapeutic benefit the Government explained why this shouldn't be a condition as follows "However, we do not agree that compulsion should be limited to those cases where the benefit of treatment will be expressed by an improvement to the patient's condition, or by preventing deterioration. In some cases, treatment may need to be given even though the nature of the patient's condition means that the treatment is unlikely either to improve it or to prevent it worsening".

- Community Treatment Orders should be available for patients only on authorisation of the Tribunal after a period of in-patient assessment and whilst the person suffers impaired decision-making by reason of their mental disorder. Leave of absence powers enable assessment and treatment in the community during the assessment period.
  Joint Committee agreed.
  Government disagreed.

- A Tribunal should not be permitted to authorise a treatment order if it is hearing an appeal within the first 14 days of the period of assessment.
  Joint Committee made no comment.
  Government made no comment.

- Compulsion should only be possible, other than in an emergency, if two doctors certify that the patient suffers from a mental disorder satisfying the conditions.
  Joint Committee made no comment.
  Government made no comment.
  Note: This relates to the fact that if the Clinical Supervisor is not a doctor then there may only be one medical recommendation (from the medical member of the expert panel).

- Clinical supervisors must be qualified to assess if a person meets the conditions for compulsion in order to be able to keep under review if the conditions continue to be met.
  Joint Committee disagreed.
  Government disagreed.
  Note: This is the issue that only doctors (registered medical practitioners) are deemed to be qualified to determine if a person meets the criteria for compulsion i.e. can sign 'section' papers yet Clinical Supervisors from other disciplines will have to decide if patients 'continue to meet the conditions'.

- The Mental Health Tribunal should be permitted to authorise specified medical treatments only if they are agreed as necessary by both the clinical supervisor and medical expert panel member.
  Joint Committee agreed.
  Government considering further.

- There should be no limitation of the right to discharge by the Clinical Supervisor for patients detained under civil sections. The College would also wish those rights (and associated limitations) currently available to the nearest relative to be available to the nominated person.
  Joint Committee agreed with both recommendations.
  Government disagreed with both recommendations.

- Transfer between hospitals should require consultation, other than in an emergency, but without specific time limits.
  Joint Committee made no comment.
  Government made no comment.

- Medical treatment, provided it is not irreversible or hazardous, may be given under the direction of a registered medical practitioner, within the first 5 days, if it is necessary to alleviate, or prevent a deterioration, in the patient's condition.
  Joint Committee made no comment.
  Government made no comment.

- Safeguards, both legal and clinical, for persons under 16 years of age must be re-evaluated.
  Note: We recommended that a specialist in CAMH should be required at one of the stages if a young person was being considered for compulsion and, if admission to hospital was required this would have to be to an age appropriate ward.
  Joint Committee agreed with both.
  Government disagreed with both.

- Changes to the medication plan after 28 days should be authorised by a medical member of the Expert Panel, with similar requirements to consultation as specified. If a full Tribunal was to be required there is a real danger that either:
  - necessary changes in medication would be significantly delayed leading to prolonged suffering and increased risks or
  - the initial treatment plans authorised would be very broad giving limited or no protections to the patient.

  Joint Committee made no comment.
  Government is reviewing what will need to be authorised by the Tribunal.

- It should be clear from the legislation, or Code of Practice, that one option for a care plan presented to a Tribunal would include the statement that identified

treatments will only be given with the patient's consent (subject to an emergency treatment clause).
Joint Committee made no comment.
Government made no comment.

- Electro-convulsive therapy (ECT) should only be prescribed by qualified psychiatrists. There should be no compulsory ECT in the face of the refusal of a capacitous patient. The current provision in relation to surgery for mental disorder (requiring capacitous consent) should not be extended.
  Joint Committee agreed with all three points.
  Government agreed ECT should only be prescribed by qualified psychiatrists but disagreed with the other two points.

- The College believes the principles underpinning the legislation should be on the face of the Bill, as with the Mental Capacity Bill
  Joint Committee agreed.
  Government agreed with where the principles should be expressed but not with what the principles should be.

- The rights, and safeguards, for patients should be the same under the Mental Capacity and the Mental Health Bills.
  Joint Committee made no comment.
  Government made no comment.

- The Mental Health Act for England and Wales must meet the requirements both of Human Rights legislation and the recommendations of the Council of Europe.
  Joint Committee agreed with the former but did not mention the latter.
  Government agreed with the former but did not mention the latter.
  Note: They did no agree with each other as to whether or not certain provisions would be compatible with the ECHR.

- Further research is required to assess the realistic likely impact of the proposals, on the workforce, in relation to numbers, recruitment and morale.
  Joint Committee agreed.
  Government agreed saying this work is being undertaken.

  Note: the Government employed a consultancy firm to undertake this work. They have reported suggesting that the Government's initial calculations were correct. For example they agreed with Government that there would not be an increase in numbers of people made subject to the Act.

  It is perhaps also worth noting that the Government response includes the sentence "Discussions have taken place with key bodies, including the Royal College of Psychiatrists, on how to ensure that consultants are available to carry out statutory functions". I am not sure how this statement fits with the Joint Committee view: "We recommend that no new Act be introduced without

assurances that the increased workforce requirements in the legislation will be met and, moreover, that the additional requirements will not be met at the expense of other parts of the mental health service, in particular the non-compulsory services".

- A review of the of the Bill's workforce and service impact in Wales should be undertaken.
  Joint Committee agreed.
  Government agreed.

- The principles and essential provisions of mental health legislation should not differ significantly between different parts of the United Kingdom.
  Joint Committee did not specifically comment although there are a number of occasions when it suggests following the Scottish Act.
  Government made no comment.

Other significant recommendations (colleagues may well disagree with my choices) of the Joint Committee include:

That safeguards for 16 and 17 year olds should be the same as for younger minors.

That, where a court wishes to send an offender or person on remand with a mental disorder to a hospital and hospital Trusts cannot agree to which hospital the person should be sent, the Bill contains a duty for the strategic health authority (or authorities, if more than one is concerned) to resolve the dispute.

That, where those exercising the functions of clinical supervisor form the view that a prisoner or person on remand meets the conditions at clause 137 and recommend that he is transferred to hospital, the Bill proper contain a duty requiring the Home Secretary to order his transfer to hospital.

That when courts are considering whether to make a mental health order or hospital direction, there be a requirement that the mental disorder of the offender/patient should be of a nature or degree which makes treatment under compulsory powers appropriate. If the offender/patient is to be resident, then the disorder should be of a nature or degree warranting detention.

That the Mental Health Tribunal be given the power to order the transfer and leave of absence of restricted patients.

That there be a duty on judges to consult a member of the Expert Panel when considering a care plan.

That no more than two ECT may be given as an emergency.

That medication should be limited to within BNF dose range unless authorised by a Tribunal.

All rejected by Government.

NEXT STEPS

We await publication of the Mental Health Bill (expected around November time). The

passage of the Bill through Parliament will follow the procedure set out in a previous newsletter (available on the College website, details can also be found on Parliament's website). Our role is to continue with our education of MPs and Peers and, through them, attempt to introduce amendments. Your participation is required in two ways. First, please let me know, directly or through the Divisions and Faculties, what you think is important. What amendments would you like to see? Which changes are imperative (in your opinion) and which just desirable? Secondly we will need all the help we can get to lobby individual members of parliament and renew contacts with friends or contacts in either House.

I look forward to hearing from you.

Tony Zigmond
July 2005