

Summary of key points made by the Parliamentary Joint Scrutiny Committee on the Draft Mental Health Bill 2004

The Joint Committee on the Draft Mental Health Bill reported on 23rd March 2005, concluding that the legislation was “fundamentally flawed” and badly written. They made 107 conclusions and recommendations for improving the legislation, which are summarised below. Over 90 of these are in line with College and Mental Health Alliance recommendations.

Background:

- Case for reforming MHA 1983 is not overwhelming though on balance a new, better Bill would be welcome.
- Issues of risk and public protection should not dominate the legislation.
- A new Bill should be clearer and easier to read

Principles and Codes of Practice:

- Fundamental principles should be set out on the face of the Bill.
- The Scottish model should be used as a starting point for creating these principles.
- Include a concept of capacity, “significantly impaired decision-making”.
- Would have liked to have seen the Draft Codes and Regulations at the same time as the Draft Bill.

Definitions and conditions:

- Definition should be tightened through exemptions (substance misuse, sexual orientation and cultural/political beliefs) and by the conditions for compulsion.
- People with learning disabilities or communicative (i.e. autistic spectrum) disorders should only be liable for compulsory treatment if “seriously aggressive” or “severely irresponsible”.
- Compulsory powers should only be used to provide medical treatment for therapeutic benefit.
- Tighter criteria needed around harm to self and harm to others.
- Those who cannot benefit from treatment should be dealt with under different legislation.

Interface with Mental Capacity Bill:

- Further analysis of the interrelationship between the bills is needed.
- Legislation is needed to enable people to make advance statements. These should be taken into account, but not binding, on clinicians.
- Proposals to deal with the Bournemouth Gap must be introduced through amending the Mental Capacity Bill or as an addition to the Mental Health Bill.

Compulsory Treatment in the Community:

- Non-residential treatment should be very limited, i.e. previous hospitalisation, evidence of responsiveness to treatment, provisions to cover only place of residence and medical treatment, maximum time

limit and no powers beyond taking a patient to the place he is required to attend for treatment or to hospital.

- Health and local authorities must provide adequate care.

Children and Adolescent Mental Health Services:

- Same rights for 16 and 17 year olds as for under 16 year olds in addition to adult safeguards.
- Age-appropriate facilities for under 18 year olds.
- Assessment with Child and Adolescent clinician, also such a clinician should sit on the Expert Panel for a tribunal.
- Child welfare principles should be on the face of the Bill.
- Compulsory treatment should be subject to the provisions of the Bill.
- Care planning process to be multidisciplinary, regularly reviewed and advocacy-based. Appropriate education provision to be ensured.
- ECT only to 16 and 17 year olds in line with safeguards in Bill for under 16 year olds.

Patients concerned in criminal proceedings, restricted patients and victims:

- Strategic Health Authorities should resolve any dispute about where a person should be sent to following a court's decision to send a person with a mental disorder on remand to a hospital.
- The Bill should contain a duty on the Home Secretary to order the transfer of a person on remand to hospital whose clinical supervisor considers meets the conditions at clause 137 and recommends such transfer.
- When courts consider making a mental health order/hospital direction the mental disorder should be of the nature to make compulsory powers appropriate. Assessment should be based on whether the offender's disorder makes him a risk to self or others.
- Tribunal should be given power to order transfer and leave of absence for restricted patients.
- Duty on judges to consult a member of Expert Panel about care plan. Courts and clinical supervisors should consult on a care plan as they would for non-offender patients.
- When death or serious injury has been caused, authorities should place a victim impact statement before the court or tribunal when assessing risk.
- Victims should also include those who are subject to threats or attacks and the family of anyone killed or seriously injured by a mentally disordered offender.

Institutional safeguards:

- Government should speedily complete studies into the length of tribunal hearings under the new Bill and then re-assess the workforce implications in discussion with doctors. Resources should be in place before the new system is implemented.
- There should be a clearer distinction between the roles of tribunals as a detaining body and as a review tribunal. The tribunal should continue

to have discretionary powers to discharge a patient even when the detention criteria are met as appropriate.

- Panels should consist of three people; it is not appropriate for a single member panel consisting of a lawyer to make clinical decisions. NHS Trusts should be able to appeal to the tribunal on a point of law.
- A specialist system to monitor patients subject to detention should be retained and the Mental Health Act Commission should be reformed and retained for this purpose and given more resources.

Other rights and safeguards for patients, carers and relatives:

- Requests for examination of a person should be tested or safeguarded to prevent malicious requests.
- Following examination, if the person does not meet the conditions for compulsion but does need treatment they should have access to an assessment. If a voluntary assessment is declined when asked for, the authorities must write to justify their decision, i.e. there should be a right to assessment, a duty to provide a discharge plan and free aftercare based on need.
- Tribunals should consider social and housing needs as well as medical matters.
- The Codes of Practice should include guidance on care plans including treatment and possibly privacy, safety and dignity of the patient. The care plan should be discussed with the patient unless patient lacks capacity. Health and local authorities should have a duty to provide the care.
- Psychosurgery should not be given to those lacking capacity.
- Use of emergency ECT should be limited to two treatments.
- The current safeguarding function of the SOAD should be transferred to the new Expert Panel.
- Details of consent and treatments given should be recorded and treatment should be audited including compulsory treatment in the community.
- Doses of treatment above BNF levels only allowed in exceptional circumstances, authorised by tribunal as a final resort.
- Bill should regulate the use of seclusion and mechanical restraint and such interventions should be reported to the Expert Panel. If use of these methods is prolonged then a member of the Expert Panel should visit the patient.
- There should be a framework for reviewing the emergency administration of medication, possibly by the tribunal.
- The Government should investigate setting up a mental health advocacy service. Health and local authorities should be obliged to produce local advocacy plans for all health service users. The MHAC should set standards for mental health advocates.
- The nominated person should have broadly the same rights as the nearest relative under the 1983 Act. The patient should be able to appoint an enduring nominated person. If they lose capacity and have not appointed someone then the Scottish model should be followed, i.e. first choice the carer, second the nearest relative.

- There should be a presumption to consult a patient's carer when examinations and assessments are carried out unless the patient is expressly opposed to it.

Resources and professional roles:

- Call for the Government to reconsider the Regulatory Impact Assessment (RIA) in light of the broader scope this Bill would have and improve methods used in producing the RIA.
- Do not introduce the Bill until the workforce is in place to implement it. Possibly implement it in stages.
- The Government should increase efforts to monitor mental health funding.
- National training standards should be created to ensure the quality of the Approved Mental Health Professionals.
- When appropriate, professionals other than psychiatrists could act as clinical supervisors if they meet a set of standards and competencies. Government should reconsider allowing non-medical clinical supervisors to be able to prescribe ECT.

The Application of the Bill in Wales:

- Resources should be allocated to Wales to bring the standard of services up to the level in England and services should be available in English and Welsh. The Committee is concerned about the patchy level of mental health services in Wales.

Mentally ill legislators:

- Department of Health should reconsider issues about legislators who become mentally ill and discuss them with devolved legislatures.