

Draft Mental Health Bill, Letter From Campaign Headquarters, Number 3

Scotland: Congratulations. The Bill is passed (awaiting Royal Assent). Whilst not wishing to make light of the undoubted difficulties which lie ahead in relation to implementation, all the major elements of a modern Mental health Act are included: Compulsion only if the patient has impaired decision making; requirement for therapeutic benefit; a definition of mental disorder which not only excludes “dependence on, or use of, alcohol or drugs” but also “behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person” as sole grounds for compulsion; and community treatment only after in-patient assessment. I urge colleagues to read it.

Meanwhile a silence may appear to have descended over England and Wales. We are assured that the DoH is working hard on their review of the Bill. The promised publication of the 2000 responses to the Draft Bill and the Government’s response has failed to materialise.

Despite the silence two ‘modifications’ to the Draft Bill have been shared (whether these changes are ‘permanent’ I cannot say). The first is that the “duty” to make an order if the criteria are met has gone. Discretion is to return. Whilst this is undoubtedly to the benefit of our patients it has been argued that it might make life more difficult for us – damned if we do make a recommendation, damned if we don’t.

The second is that at a recent meeting with officials from the Home Office they confirmed a change in relation to what is Part 111 of the current Act. Currently, and in the Draft Bill, Courts can only make a MHA order if the person is charged with, or convicted of, an offence which is punishable with imprisonment. This has been changed so that Courts will be able to order compulsion under the Mental Health Act no matter how trivial the offence.

Meanwhile the College, in conjunction both with the Alliance and other organisations (such as the BMA)) has been working on the details of the Bill in order to be in a position to brief lawyers and MPs on suggested amendments as the Bill passes through Parliament (see newsletter number two). There is a temptation to assume that the majority of the amendments will be generated by the Alliance. It is worth noting that in Scotland, with a Bill which had wide approval, there were 1,500 amendments tabled, most by the Scottish Government. Reading and responding to this number (let alone an equivalent number for England and Wales) will sorely test our capacity. Ideas as to how this may be managed would be welcome.

Overall the issues remain the same. Many are listed below.

Examination for a compulsion order at the request of ‘any person’?

Possibly lack of discretion as to whether or not to make an order if the criteria are met?

Criteria for compulsion:

Absence of ‘incapacity or impaired decision-making/judgement’?

Absence of a ‘treatability’ (alleviate or prevent a deterioration) test?

Absence of a ‘therapeutic benefit’ test?

Absence of ‘Best Interest’?

Absence of exclusions?

Removal of independent ASW?

Reduction in level of risk leading to a breach of confidentiality?

Non-medical Clinical Supervisor?

Non-medical Tribunal?

Loss of absolute right of discharge by RMO/Clinical Supervisor for civil patients?

Loss of right of discharge by nearest relative/nominated person?
Loss of right of relative/nominated person to object to a 'treatment' order?
Broad definition of medical treatment?
Surgery for mental disorder for incapacitated patients with the authority of the court?
Limit of two emergency ECT treatments (whilst waiting for a Tribunal)?

How would you prioritise these issues? Over which issues would you draw the line in the sand: 'This far and no further'? Do you positively agree with some or all of these?

Particular attention is being given in the following areas:

Definition of Mental Disorder: Should drugs, alcohol and sexual deviancy be excluded? One suggestion is that abuse of alcohol and drugs should be excluded other than to save life, the patient's or other persons'.

Criteria for compulsion. One of the current suggestions (not the precise wording):

A person with a mental disorder can be subject to compulsion if

- S/he is at substantial risk of suicide or death (the situation is life threatening) as a result of the mental disorder OR
 - S/he poses a substantial risk of serious harm to others and compulsion is necessary to protect others OR
 - S/he is at significant risk to health or safety of others and has impaired decision-making capacity OR
 - S/he is at significant risk to health or safety of self and has impaired decision-making and it is in his/her best interests
- AND
- The exercise of compulsion must be necessary in order for treatment to be given.
 - Plus current exclusions (alcohol, drugs, sexual deviancy), plus 'a person shall not be considered as suffering from mental disorder solely on grounds of the commission, or likely commission, of illegal or disorderly acts'.

It will be noted that impaired decision-making does not apply at the highest risk category. Is this a reasonable compromise? Or should compulsion only ever be possible if the patient has impaired decision-making? Are there circumstances when compulsion need not be in the 'best interest' of the patient? Is this question irrelevant because preventing a person from harming someone else is always in the former's best interest? The same may be asked in relation to 'therapeutic benefit'.

Community treatment orders. There are a number of options here. The question relates to which stage it should be possible to order compulsion in the community.

Options:

- A "non-resident" order (CTO) should not be available during the assessment period.
- A "non- resident" order may be made by a Tribunal only after a period of compulsory assessment in hospital.
- A "non- resident" order may be made by a Tribunal only after period of compulsory treatment (i.e. post first Tribunal) in hospital. Note: This might apply on each occasion or on only the first occasion a person needs compulsion.

- A “non-resident” order may be made by a Tribunal only after the assessment period. However this could be carried out informally in the Community.
- As in the Bill.
- No CTO.

On the one hand there are fears, not only in relation to the ethics of compulsion in the community, but also as to how to manage the loss of the ‘severity test’ (seriously ill enough to require admission to a hospital for assessment or treatment) if a CTO can be made without prior admission to hospital being a requirement. On the other hand there is the issue of least restrictive alternative.

Please email me with comments, suggestions etc. on these or other related issues.
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Despite the absence of any indication as to when the Bill will be presented we must be ready to lobby MPs. I ask you all to be on standby.

Roger Freeman and I will be at the College stand at the Annual Meeting in Edinburgh. We look forward to hearing your views.

In the meantime

Tony Zigmond
College lead on the Mental Health Law reform
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