Health and Social Services Committee

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Introduction

In Minds view the current draft of the Mental Health Bill is not significantly better than that placed before us in 2002. Whilst there are some minor changes within this draft that Mind welcomes, many serious concerns remain and overall it remains very stigmatising and overly coercive. Mind believes that the thinking behind the Draft Mental Health Bill is wrong and that the Bill is still about extending the reach of compulsory treatment for mental disorder; that the Bill is still about dangerousness and that the Bill is not about providing care. Mind believes that this is not the answer to the needs generated by mental distress and ill health in Wales. Mind also strongly feels that this Bill is not compatible with the values, direction and spirit of the Wales Mental Health Strategies or the National Service Framework for Mental Health in Wales.

We also consider that an improvement in community and inpatient services would better alleviate some of the problems which the Government is seeking to address by the use of compulsory powers. Indeed the increase in the use of compulsion which will we believe would result from the enactment of this Bill may exacerbate these problems by leading resources further away from the services that most people with mental health problems need.

We also believe that it is crucial that, in view of the length of time it has taken to reach this stage, we guard against ‘legislative fatigue’ in this area and that the Bill is given full scrutiny by those with responsibilities that fall within the impact of its implementation. We must remain mindful that the far reaching implications of this Bill will affect peoples rights, choices and indeed liberty over the next few decades.

Part 1: The Definition of Mental Disorder and Conditions for Compulsory Powers (Criteria for Compulsion) (Draft Bill clauses 2& 9)

The grounds for compulsion remain much broader than at current law. Taken as a whole they are also broader than those in the laws of any of the 20 or so jurisdictions (in Canada, Australia and New

Zealand, Ireland and Scotland) we have examined. The only exception is Newfoundland.

Despite the Government's stated aim to reduce the amount of compulsion used in England and Wales the Bill still **greatly broadens** the grounds for compulsion therefore will lead to increased and unwarranted use of compulsion with all the extra distress to service users, strain on the mental health and Tribunal system and cost that is entailed.

Mind is pleased to note that the threshold for compulsion for people at risk of self-harm has been raised and also that prison has been recognised as not being a therapeutic environment in this context and therefore compulsion in prison is not being pursued.

However the new Bill adds to doctors' existing power to decide whether to assess or give treatment for mental disorder without the consent of the person concerned in the following ways:

- each stage of the three stage process towards compulsory treatment can take place inside a **hospital** ("resident") or in the **community** ("non resident").
- the definition of **mental disorder** is wider.
- the **conditions** that justify compulsory treatment are wider.
- the **therapeutic impact** of treatment that would justify compulsory care is less.

The combined effect of all the extended powers is that more people could fall within the scope of provisions for compulsory treatment for mental disorder.

To summarise, this increase results from:

- A very broad definition of mental disorder (which still covers physiological disorders)
- the failure to include any exclusions. These would have ensured that people without a mental disorder but who are considered socially undesirable because of alcohol or drug taking or who have alternative life styles can not be detained for those reasons alone.
- A very broad set of conditions for compulsion. These would particularly impact on people who need medical treatment "for the protection of others". Particularly because the patient no longer needs to be ill enough to require admission to hospital this could be used against people with mild mental health problems who are seen by others to be a risk. Because:

The broad criteria may have unintended and unwanted consequences.

The broad criteria give great power to clinical staff and the clinical supervisor and reduce their accountability. The patient has the right to challenge the exercise of compulsory powers at a Tribunal hearing but the breadth of the conditions will limit the extent to which the Tribunal can overturn the clinical supervisor's decision. Also a patient applying for a discharge will face difficulties in showing that s/he no longer meets the criteria if the clinical supervisor opposes the discharge. For the same reasons it will be relatively easy for a clinical supervisor to apply successfully for an order to be

renewed.

The Bill imposes treatment on people who have capacity to decide for themselves

Mental illness does not inevitably result in lack of capacity. However, a person with a mental illness can be detained and treated without consent even though that person has the capacity to understand the nature of the illness and the choices of treatment. A person with a physical illness on the other hand has the absolute right to control over his or her own body and this right has been supported in countless legal cases. Mind believes that there is no justification for the continuing legal discrepancy in relation to medical treatment decisions between physical and mental health. This view is shared by all the members of the Mental Health Alliance and is supported by General Assembly resolutions on mental health.

Non Resident Orders (NROs) will increase the use of compulsion and drive people away from treatment.

There have been some changes since the bill first appeared in draft in 2002. Some are purely cosmetic. The Community Treatment Order no longer exists. In its place the government has simply extended all the compulsory treatment provisions that can apply to someone detained in hospital to service users with a new status: **"non-resident" patients**.

Non Resident Orders (previously Community treatment orders) are a major concern to many service users some of whom fear that NROs will increase their chances of being subject to compulsion if they disagree with the treatment recommended by their psychiatrist. The danger is that this quite realistic fear will drive people away from the services and the treatment they need. There is no evidence from research studies done overseas that compulsion in the community helps outcomes for patients. Service users fear the intrusion into their lives by having compulsory order imposed while they are living at home. They fear that NROS will impede any of their efforts to withdraw from drugs they dislike as the option of a compulsory order will be there.

Non-resident patients won't have their own special type of treatment order. But they could have their own special conditions imposed on them, even before doctors have decided to apply to the tribunal for an order. During the examination period, doctors must decide whether the conditions for a compulsory assessment apply. In the examination stage, a non-resident patient could not only be told to attend specific appointments, they could also be told where they must live, and they could be told what behaviour they must not engage in. (clause15) These conditions can also apply during the assessment stage.

Non-resident status must be kept under review, and the patient can be transferred if doctors believe they should be in hospital. By the same token, the status of resident patients must also be kept under review. So that if doctors believe a person does not meet a certain threshold demanding hospital detention, they do not need to be discharged from compulsory care. They can just be sent home – still under compulsory treatment powers. Once a person is on a NRO it could be quite difficult to be discharged from it.

As a result doctors will have much greater flexibility to control patients and move them between hospital and community than ever - even before the tribunal has been asked to make an order.

This combination of flexibility of movement between hospital and community, and the potential restrictions on the personal liberty of non-resident patients is an enormous encroachment on the autonomy and freedom of people who are not believed to be sufficiently unwell to need hospital treatment.

Black and Minority Ethnic Communities are likely to be worst affected by any increase in the use of compulsory powers

Minds concerns regarding the needs of black and minority ethnic people remain that previous research has shown that black people are more likely to be

- perceived as dangerous
- take to hospital by the police, even if they agree to go voluntarily
- detained
- prescribed higher doses of medication and older forms of major tranquillisers
- kept in secure, locked wards
- prescribed anti-psychotic drugs and less likely to receive non-drug therapies

Any expansion of the grounds for compulsion is a cause of concern for minority ethnic people and the extension of compulsion into community settings is likely to exacerbate this situation further.

The provisions for high-risk patients are flawed.

The Government aim is to use the new Mental Health Act to protect the public's safety from people who are deemed to be dangerous and have a personality disorder. People who fall into this category are often deemed "treatment resistant" so the definition of treatment has been broadened to cover psychological interventions and the 1983 Act requirement that "treatment is likely to alleviate or prevent a deterioration in condition" has been removed. However, while Mind agrees with the government's desire to protect the public from dangerous people we consider the proposals in the Bill fundamentally flawed. High-risk patients are a low incidence group. The heavy-handed solution in the Bill will be expensive and unworkable.

- Because they rely on a psychiatrist's prediction of risk that someone poses a significant risk of serious harm.
- There has in Mind's view been serious misreporting in the media of the risks represented by people with mental health problems. These proposals reinforce the common but false perception in the public's mind that people with a mental illness are dangerous.
- The scheme is unjust. Why should this group alone be subject to a preventive detention regime

when other groups that pose as high – if not higher risks – are not covered? **Is this really the remit of mental health law?**

- They further stigmatise people with personality disorder and will not provide the consensual treatment that would benefit this much neglected group.
- The extent of the problem is greatly over estimated – if improvements were made in services for early intervention, if better use was made of criminal justice powers, if greater training for the judiciary in sentencing options was provided, much could be achieved. Many of the notorious cases concern people who could have been detained under current law.
- The proposed powers are likely to impact disproportionately on certain groups such as black and minority ethnic communities and reinforce the discrimination which they already experience in the mental health system.
- By driving people with personality disorder away from services the problem is likely to be exacerbated rather than improved.

Mind's alternative proposals

Capacity

Mind believes that an assessment of capacity should be the foundation of the compulsion process. As in cases of physical health, treatment should require consent unless the person lacks capacity. Where the person does lack capacity then, subject to certain safeguards, treatment should be allowed in a person's best interests under the Capacity Bill. If the person is resistant and compulsion becomes necessary there must be a therapeutic benefit to any treatment imposed. **Advance directives** should retain their legal status at common law under the Bill and only be overridden by strict clinical necessity.

Non Resident Orders

We consider that a person should only be subject to compulsory powers if their condition is sufficient to require admission to a hospital or other inpatient setting.

More limits on the conditions for compulsion.

The Bill should specify that that treatment should be "least invasive" as well as "least restrictive"

Provisions for high-risk patients

Current powers in the Mental Health Act 1983 to detain people should be maintained but not extended in the new mental health legislation. It may well breach human rights law to detain a person or treat them compulsorily in the community only on the basis of a diagnosis of personality disorder and a risk assessment, if they have committed no offence, if compulsion would not be of therapeutic benefit and if they are not before the courts on a criminal charge.

There should be improvements in the current provision of mental health services and in the civil and criminal justice systems. Mind believes that this would have a greater positive impact for this group and for public safety.

Part 2: Applying compulsory powers in civil cases

Stage 1 - Examination (Clauses 14-21)

Patients need proper safeguards at this stage of the process. At present if there is no carer or the carer does not act there may be a full 5 days in which there is no support for the patient. The nominated person should be involved at the examination stage. This would be possible if a nominated person has been appointed on a previous occasion, if the person has already expressed his/her choice in an advance agreement or because s/he has capacity to make a choice at the time. Only if none of these applies should an appointment be delayed until the second stage.

An advocate should be sought as soon as the use of compulsory powers is considered. Black and minority ethnic communities particularly value the advocates role in providing a culturally sensitive perspective and preventing the misunderstandings that can lead to a resort to compulsory powers.

The nominated person should have the same powers as the nearest relative under current law. They should retain the right to block the patient's admission.

Stage 2 - Assessment in first 28 Days (Clauses 22-37)

Under the current Bill only one application can be made for discharge in the first 28 days. If for instance the nominated person objects to the preliminary care plan during the assessment period no other approach can be made for discharge until the end of 28 days. At the very least the nominated person as well as the patient should have the right to apply to the Tribunal during the first 28 days.

Furthermore it seems the clinical supervisor will have the sole role in this period. There is no requirement for a second opinion, nor for a social care assessment. The drawing up of a care plan for the Tribunal will not involve the social perspective if left solely to the clinical supervisor.

Stage 3 - The making of a treatment order by the Tribunal (Clauses 38-53)

It is essential that the circumstances in which police or other agencies have the right to intervene and remove someone against their will are clearly dealt with in legislation, not just left to individual care plans.

The legislation does not provide clear criteria for the Tribunals to consider when authorising care plans.

We support strongly the Richardson Committee recommendation that there is a need to bring into the Tribunal the expertise of carers, users and professionals from outside a hospital. In particular we urge the representation of users, including users from a black and minority ethnic background on the Tribunal.

Police Powers (Clauses 270-272)

Mind strongly opposes the proposed extension of police powers to private property since we think it would be open to abuse. It is a fundamental civil right that there should be no power to remove a person from their own property without court authority. If a crime has been committed the police powers for this already exist.

Part 3: Patients concerned in criminal procedures (Clauses 86-159)

Offenders before the courts

Given the lower threshold for compulsion for those people before the courts many more people remanded on bail or into custody may find themselves subject to a mental health order by which they can be treated without their consent than would be the case if they were civil patients. As these orders will be dispensed by magistrates courts and the crown courts they will have fewer safeguards(eg nominated persons, advocates) to protect them. They will also not have the benefit of the special expertise of the Tribunals. In general we believe that the provisions applying to offenders should mirror those available under the civil system.

We are opposed to the introduction of a single power of assessment and treatment of up to 16 weeks for any offender even before conviction. Such extension should in our view be subject to an overall maximum of 8 weeks, in line with recent human rights case law. Secondly we consider that as in the civil system there should be a role for the nominated person and for the advocate, as well as for the solicitor. Thirdly a social care perspective should be part of the assessment.

Part 5: Treatment safeguards

Electro-convulsive therapy (ECT) (Clauses 177-190); Psychosurgery (Clause 191-195),

Mind opposes this new power. We have serious doubts about the continued use of psychosurgery at all in the absence of clear evidence that it is effective. We believe that until there is a rigorous review to determine whether continued use is justified it should be prohibited.

Mind's view is that stronger safeguards are needed for ECT. It is an intrusive treatment and many people have been caused long term harm by it. In Mind's view no one who is capable of giving informed consent should have ECT against their will even in an emergency. Those who are incapable of informed consent should only have it in cases of urgent necessity provided they **do not** object. ECT should not be given to children or young people under 16, and guaranteed standards of ECT administration should be

built into the legislation. Steps also need to be taken to ensure that, where consent is given, it is properly informed.

Polypharmacy and high drug doses

Mind's view is that there should be legally binding safeguards to protect people from these potentially hazardous practices, and specifically that doses above BNF limits should not be given without informed consent.

Long-term treatment without consent

In relation to time periods, the Bill is an improvement on the current situation in which drug treatments can be given without a second opinion for three months. However Mind's view is that people with capacity should not be treated without their consent.

Part 8: Safeguards for Adults

Nominated persons (Clauses 232-246)

Mind also believes that the appointment of a nominated person should not lapse with a person's discharge from compulsion but should remain until the patient makes another choice. There is concern that the nominated person is only entitled to be 'consulted' and has no powers to take steps to discharge a patient under compulsion - as does the nearest relative under current legislation.

Mental Health Advocates (Clause 247)

The provisions fall short of providing the individual with an enforceable right to an advocate, which Mind considers essential from the earliest stage The presence of advocates at all stages is central to the effective operation of the new regime.

We are unclear about the meaning of the word "representation". If this means articulating the views, wishes and feelings of the patient, we are in favour of it; if it means a substitute for legal representation we consider this would be in breach of the Human Rights Act and could not be supported.

Advance statements

Advanced statements typically set out what treatment should and should not be given when a person is not well enough to express their wishes. This right will be taken away under the Bill once the person is subject to compulsion. There is no mention of these in the Bill and no obligation to refer to these agreements when choosing a nominated person or when making treatment choices. The government says that the Code of Practice will cover advance statements. Mind believes that an obligation on the clinical

team to discuss advance agreements and to give help with their preparation should be on the face of the Bill.

Aftercare (Part 2, Clause 68)

Under the 1983 Act a patient discharged from compulsory powers has a right under S.117 to the services that s/he needs, "until such time as the [Health Authority] and the local social services authority are satisfied that the person concerned is no longer in need of such services free of charge". These services, as recently affirmed by the House of Lords must be provided free of charge. Under the Bill the right to free aftercare is restricted to just 6 weeks – this is a negligible period of time for the type of adjustment that many long term inpatients must make on discharge.

A Bill that, according to the White Paper, was designed to improve the provision of care and treatment for patients on compulsion is taking away an important **right to services** and providing a perverse incentive for a person to remain under compulsion so that services will be available.

While it is welcome that the Tribunal should have an overview in the provision of aftercare it will have limited value if the Tribunal has no power to enforce any perceived shortfall in the aftercare package. Individuals discharged from compulsion should also have a legal remedy in the event of inadequate ongoing support being provided.

Issues for specific consideration in Wales

There is concern from the national mental health voluntary organisations in Wales (Wales Alliance for Mental Health) that the Bill will not work in Wales. The Government has been at pains to suggest that the implementation of National Service Frameworks will be the counterbalance to legislation, ensuring that compulsion is reduced through provision of improved services. However:

- the Welsh National Service Framework is under review and the timetable for its implementation is not expected until Spring 05; the Commission for Health Improvement (a UK Government agency) has said that services in Wales are generally behind those in England. In addition in Wales there is an acute shortage of psychiatrists.
- Enactment of the proposed Bill will result in a major diversion of resources into its implementation, starving early intervention in order to deliver compulsion. These problems will no doubt arise in England but Wales will be severely disadvantaged with regard to this as a mechanism for achieving the UK governments intended balance of services and legislation.

Issues of Welsh language (and for that matter access to services under the Bill in other languages) are not referred to on the face of the Bill – when in fact this is referred to within current legislation. The Bill makes no reference to the changed legislative context in Wales and there is no evidence that the needs of Welsh speakers have been taken into account at all.

It is also not evident that rural issues have been addressed appropriately by the draft Bill – in that the models of intervention and systems of implementation reflect an urban basis. An example would be regard being given to how Tribunal system will work for rural populations with regard to access/travel etc.

There is a need to emphasise, as outlined above, that whilst also relevant in England, the workforce deficit has particular significance in Wales – and the impact of implementing the requirements of the legislation, again such as Tribunals, is of concern in how this will result in draining already limited resources.

There is concern that the lack of appropriateness within the Bill in relation to Wales' needs may undermine the growing consensus in Wales between the Welsh Assembly Government, professionals, people with mental health problems, and families who are all committed to mental health services based on empowerment and choice.

One opportunity for Wales must be the rigorous development of a Welsh specific Code of Practice with broad involvement of all stakeholders in Wales, particularly service users and carers.

Conclusion

Mind calls for an about face on the **lead** that the Mental Health Bill takes. We ask that **rights** to prompt, appropriate service be the prime focus of this Health legislation. Compulsion must only occur in the context of comprehensive Mental Health services and in circumstances where capacity is the main criteria for assessment.