

A Sense of 'Déjà Vu' – a preliminary (and immediate¹) response to the Report of the Scrutiny Committee on the draft Mental Health Bill

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Introduction

The draft Mental Health Bill³ was published on the 8th September 2004. In advance of publication a joint committee of both Houses of Parliament was set up to subject the draft Bill to pre-legislative scrutiny and, following consultation, to recommend improvements before a final version of the Mental Health Bill is introduced in parliament.

The Committee first met on the 15th September 2004, and the report was published on the 23rd March 2005⁴. In the intervening period the Committee considered 450 written submissions, heard oral evidence from 124 witnesses (including professionals, carers and service users) and visited three hospitals, including Broadmoor.

The Scrutiny Committee came up with 107 conclusions and recommendations, and I think it would be fair to say that if the Government accepts these, the Mental Health Bill that will be introduced to Parliament will bear very little relationship to the draft Bill published last September. On several occasions the Committee commends the very different approach taken in the Scottish *Mental Health (Care and Treatment) (Scotland) Act 2003* due to be introduced in stages starting in April of this year.

It makes its recommendations under 11 separate headings, which I will follow:

Background

It says that the case for reform of the *Mental Health Act 1983* is “cogent but is by no means overwhelming”; on balance it supports the introduction of new legislation, but it emphasises that the need to incorporate effective risk management and public protection into mental health policy must never be allowed to predominate as the primary objective of reform.

1 This article was written and submitted for publication on the day on which the Joint Parliamentary Scrutiny Committee reported (23rd March 2005) in order to meet the printing deadline for this issue of the JMHL. Footnote 11 was added at the proof-reading stage.

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3 Cm 6305-I

4 HL Paper 79-1, HC 95-1

Principles and Codes of Practice

The draft Mental Health Bill left principles to be developed in codes of practice. The Committee says that fundamental principles should be set out on the face of the Bill, and should not only include a “least restrictive alternative” principle but should also introduce a principle that non-consensual treatment should only be imposed if the patient’s ability to make decisions about his or her treatment is, as a result of his or her mental disorder, impaired. The form of words is adopted from the Scottish Act, and is probably not an exact equivalent of the current definition of lack of capacity, but it is, of course, related to it.

The Expert Committee, chaired by Professor Geneva Richardson, which reported in 1999⁵, recommended the introduction of a capacity test, but this was not accepted by the Government at that time and has continued to be absent from the Green Paper,⁶ the White Paper⁷ and the two draft Bills⁸ that have since been published. Many of us believe that to allow detained patients with capacity the same right to refuse treatment as is enjoyed by every other person with capacity would do more to raise standards, challenge stereotypes and reduce stigma than any other legislative decision. Perhaps the Scrutiny Committee will succeed where the rest of us have failed, and if the Government rejects the recommendation, let us hope that members of both Houses of Parliament will respect the views of their (now very well-informed) colleagues on the Committee, and insist on introducing this proposal.

Definitions and Conditions

The Committee accepts the broad definition of mental disorder contained in the draft Bill, but recommends that the scope of the definition should be narrowed by means of specific exemptions and by placing restrictions on the use of compulsory powers. A specific exclusion on the grounds of substance misuse alone (including dependence on alcohol and drugs) is recommended, as is an exclusion on the basis of sexual orientation (but not sexual deviancy). It also recommends that people with learning disabilities or communicative disorders such as autistic spectrum disorders should only fall within the ambit of the legislation if they also display seriously aggressive or severely irresponsible behaviour as a result of their condition and if such treatment as is properly and reasonably required can only be provided to such patients under conditions of compulsion. In effect, the Committee imports the concepts of mental impairment and severe mental impairment from the 1983 Act, and extends the requirement that there should be seriously aggressive or severely irresponsible behaviour to those with pervasive developmental disorders such as autism, which are classified as mental illnesses under the 1983 Act.

It recommends tightening-up the provisions of Clause 9, which sets out the conditions for compulsory treatment. Most controversially, as far as the Press will be concerned, it recommends that a treatability test should be re-introduced, so that people with severe mental disorders who cannot benefit from treatment will be excluded from this legislation.

The Committee acknowledges that one of the driving forces for the legislation was the case of Michael Stone, who was said to be “untreatable” and therefore undetainable under the 1983 Act. However it accepted the argument that to detain people on the grounds of mental disorder without

5 *‘Review of the Mental Health Act 1983’ – report of the Expert Committee (November 1999)*

7 *Cm 5016-I*

6 *Cm 4480*

8 *Cm 5538-I; Cm 6305-I*

being able to offer any therapeutic benefit goes beyond the business of mental health professionals, and that if the Government wishes to detain such people it must find another way of doing so.

The Committee also considered that it was unacceptable to have in the Draft Bill, a condition that insisted on compulsory treatment even where a patient was willing to accept treatment voluntarily. It also recommended that a new condition should be inserted at Clause 9, without which compulsory powers could not be used: "That by reason of mental disorder the patient's ability to make decisions about the provision of medical treatment is significantly impaired". As mentioned above, this is hugely significant and goes considerably further than the 1983 Act which allows capacitous refusal to be over-ruled if the SOAD agrees with the RMO, and the draft Bill which allows clinicians to treat without regard to the person's capacity.

Interface with Mental Capacity Bill⁹

The Committee recommends that a clearer analysis of the inter-relationship between the Mental Capacity Bill and the Mental Health Bill should be provided, so that clinicians would know which piece of legislation they should be using when a patient could be subject to either. They propose that the respective codes of practice should have a common part to deal with this. They also recommend that the Government brings forward "a comprehensive and universal set of proposals to deal with hospitalisation and treatment of patients affected by the Bournemouth judgement"¹⁰ and they say that legislation should be brought forward that would enable people to make advance statements and to record advance decisions, particularly if there is a treatment that they would prefer not to receive. Advance directives feature in the Mental Capacity Bill and the committee was clearly convinced by witnesses that there was a very good case for extending these provisions to all people likely to be subject to compulsory powers.¹¹

Compulsory Treatment in the Community

The Committee accepts the principle of compulsory community treatment, but considers that it is unlikely to be appropriate or satisfactory for anything other than a small minority of patients and it therefore recommends that it should be explicitly limited to a clearly defined and clinically identifiable group of patients who have previously been hospitalised, and who have previously responded to and co-operated with treatment. In addition, the areas of compulsion should be limited to medical treatment and a person's place of residence only, rather than the proposals in the draft Bill that could mean that a person's every hour and every activity could be controlled. Furthermore, there must be a maximum time limit for compulsory community treatment – certainly not more than 3 years in any 5 year period. Finally, a non-residential treatment order must not be able to authorise the use of force on the patient in the community, other than allowing someone to convey the patient to a hospital or clinic for treatment.

A complaint of many of those who gave evidence to the Committee was that compulsory community treatment did not carry with it a reciprocal obligation to provide good community services, and there was a real risk that families and carers would have to shoulder the burden of ensuring compliance with the order. The Committee has responded by saying that the use of non-

9 *Mental Capacity Bill 2004*

10 *H.L. v U.K. (ECtHR – 5/10/04)*

11 *Since the Scrutiny Committee reported, the Mental Capacity Bill has received the Royal Assent, and the "Bournemouth" Consultation has been published by the Department of Health.*

residential orders must be accompanied by a requirement on health and local authorities to provide adequate care, other than that provided by families and carers, on whom unreasonable burdens should not be placed which should fall more properly on clinicians and the health and social services.

Children and Adolescent Mental Health Services

The Committee recommends: improving the safeguards for 16 and 17 year olds who are being treated under compulsion by giving them the same safeguards as those under 16 in addition to the rights they share with adult patients; that under-18's should be accommodated in age-appropriate facilities; that at least one of the medical assessments prior to the imposition of compulsory treatment should be by a clinician specialising in child and adolescent mental health services; that the tribunal considering the case of a child or adolescent patient has to seek the advice of a medical member of the Expert Panel who is a doctor specialising in child and adolescent mental health services; that child welfare principles be included on the face of the Bill; that, when someone under 18 needs compulsory treatment for mental disorder, this is provided under the terms of mental health legislation, with all its safeguards, rather than under the *Children Act 1989*; and, finally, that in relation to the right to education and safeguards for ECT, 16 and 17 year olds should have the same entitlements as those under 16.

Patients Concerned in Criminal Proceedings, Restricted Patients and Victims

The Committee starts off by recommending that the drafting is improved so that people can understand this part of the Act. It then recommends that the Bill provides a mechanism to ensure that a prisoner who needs treatment is not denied that treatment because of a dispute between Trusts as to who is responsible for him or her; that when a prisoner is recommended for transfer to hospital the Home Secretary has to agree to the transfer; that a mental health order or hospital direction should only be made if the prisoner's mental disorder is of a nature or degree which makes treatment under compulsory powers appropriate; and that when considering assessments of risk, those carrying out the assessments should disregard whether that risk could be minimised by the imposition of a prison sentence. These recommendations are needed to deal with the very unsatisfactory provisions of the Draft Bill which combine the right to impose treatment on prisoners, regardless of the nature or degree of their disorder with a lack of any provision that would entitle such a person to access proper care and treatment.

Rather spectacularly, the Committee also recommends that mental health tribunals be given the power to order the transfer and leave of absence of restricted patients. The logic of this recommendation is inescapable; in the draft Bill the Mental Health Tribunal is given the power to retain control over the care plans of some unrestricted patients if they give special cause for concern, and it must follow that, despite the Home Office's unwillingness to surrender any of its powers over restricted patients, a tribunal which is to be trusted with such a responsibility with some potentially dangerous patients should be trusted with all of them.

In relation to the making of care plans by Judges, the Committee recommends that the Expert Panel should have to be consulted, and that when care plans are being prepared for restricted patients, the usual consultations should take place as if the patient were a non-offender patient.

Interestingly, the Committee points to the fact that although the focus of much of the draft Bill is on the assessment and control of risky behaviour, the role and needs of victims are not specifically

addressed. The Committee therefore recommends that where the patient subject to compulsory powers has been responsible for violence which has resulted in death or serious injury, the authorities must place a written "victim impact" statement before the Court or tribunal so as to aid in the assessment of risk; and that victims should be defined widely to cover people who are subject to threats or attacks from mentally disordered people, and the family of anyone who has been killed or seriously injured by a mentally disordered offender.

Institutional Safeguards

The Committee is extremely sceptical about the Government's calculations regarding the extra resources that will be needed to provide the safeguards (primarily the Mental Health Tribunal), which are such a central feature of the draft Bill. It suggests that the Government does its sums again, and gets better information before reaching any conclusions, and it recommends that no new Act be brought into force until the Government can demonstrate that sufficient resources are available, both financial and human, to allow for the proposed extensions in hearing numbers and remit.

It also recommends a clearer distinction between the roles of the tribunal as a detaining body and as a review tribunal, and it proposes a number of procedural changes to improve the quality of decision-making.

It also suggests that the successor to the Mental Health Act Commission has a duty similar to the visiting duty currently imposed on the Mental Health Act Commission, and that the successor body has a responsibility to investigate and report on the Secretary of State's management of restricted patients, and that the successor body should be better resourced, to enable it to carry out its functions properly.

Other Rights and Safeguards for Patients, Carers and Relatives

The Committee makes 30 separate recommendations under this heading: to improve the rights of patients to assessment and treatment; to improve their involvement in the preparation of care plans; to improve the safeguards in relation to certain forms of compulsory treatment, including ECT; to re-introduce the safe-guarding function of the current SOAD system and give it to the new Expert Panel; to require the recording of details of treatment being given with consent during assessment, and details of the consent; to restrict the ability of clinicians to prescribe doses above BNF levels; to regulate the use of seclusion and mechanical restraint; to monitor the use of such seclusion and mechanical restraint; to provide for the review of emergency administration of medication for mental disorder; to look into the costs of setting up a discrete mental health advocacy service; to require local authorities and health authorities to provide local advocacy plans for the development and funding of independent health advocacy services; to provide independent mental health advocates to meet the reasonable requirements of patients as soon as any statutory procedure with regard to the potential exercise of formal powers in their cases commences; to ensure that independent advocacy is available to all people with a mental disorder; to give the nominated person broadly the same rights and powers as those currently enjoyed by nearest relatives, including ordering the discharge of a patient; to allow patients to appoint an enduring nominated person; to restrict the circumstances in which the Approved Mental Health Professional is able to disqualify a patient's choice of nominated person; and to improve the rights of carers to be consulted unless the patient is expressly opposed to it. It seems very likely that both carers and users will be considerably reassured by this recognition of their legitimate concerns with the draft Bill.

Resources and Professional Roles

The Committee expresses concern at the adequacy of the Regulatory Impact Assessment that has been provided with the draft Bill, and suggests that it be redone, taking into account the various recommendations of the Committee and the likely cost of them, and it makes a recommendation that no new Act be introduced without assurances that the increased work-force requirements in the legislation will be met and, moreover, that the additional requirement will not be met at the expense of other parts of the mental health service, in particular the non-compulsory service. It suggests that the best way to do this is for the Act to be implemented in several stages and it says that it is very important that Approved Mental Health Professionals have the right training to ensure that they are able to carry out their functions satisfactorily.

The Committee accepts that in appropriate cases professionals other than psychiatrists should be able to act as clinical supervisors, and recommends that regulations stipulate the appropriate standards and competencies clinical supervisors will need to demonstrate following training. It invites the Government to reconsider whether clinical supervisors with non-medical backgrounds should be able to prescribe ECT.

The Application of the Bill in Wales and Devolved Issues

The Committee considers that the standard of mental health services in Wales needs to be at least as good as it is now in England before the provisions in the draft Bill could be implemented, and increased resources should be allocated to enable the service to be brought up to English standard.

My Conclusions

- 1) The system of pre-legislative scrutiny is A Good Thing.
- 2) The recommendations of the Scrutiny Committee bear a striking resemblance to the proposals and recommendations made to the Department of Health by the Expert Committee in 1999 and by interested parties engaged in the endless consultations since that time. I spoke to Professor Richardson on the 23rd March and she said that reading the Report of the Scrutiny Committee brought on a distinct feeling of 'déjà vu'. If the Department of Health had listened to what has been said to it, repeatedly, over the years, the draft Bill would not have met with such hostility and huge amounts of public money, time and energy would have been saved. Whichever financial watchdog looks into Departmental wastes of money should be looking into this.
- 3) The Government should seriously consider adopting the Scottish Act; lock, stock and barrel.
- 4) If the Government does not accept the main recommendations of the Scrutiny Committee, no-one should deceive themselves that there would be any point in engaging in further consultation with the Department of Health.
- 5) The alliance between users, relatives, carers and professionals that has developed over the last few years to oppose the various attempts at "reform" should be nurtured in the interests of improved patient care and in the interests of improving the status of people with mental health problems.
- 6) Active attempts to amend and improve the 1983 Act should continue, as problems with resources make it most unlikely that new legislation will be arriving any time soon.