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Reform of the *Mental Health Act 1983*: the draft Mental Health Bill

In June 2002, the Government published a draft *Mental Health Bill* for consultation. This Research Paper provides background on the genesis of the draft Bill, summarises its main provisions and highlights some of the issues which have generated comment or concern. Although no mention of a *Mental Health Bill* was made in the Queen's Speech, the Secretary of State for Health has since made clear that a Bill will be presented during this parliamentary session, once the Department has had a chance to consider the responses to the consultation draft. The proposals cover England and Wales only.

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Summary of main points

- The Government announced in December 1998 that it intended to introduce a new legal framework governing the compulsory treatment of people suffering from mental disorder, to replace the *Mental Health Act 1983.* In particular, it wished to break the link between detention in hospital and compulsory treatment, believing that in many cases treatment could more appropriately be given in the community. Since then, the Department of Health has published a report from the Expert Committee established to make recommendations in this area, a Green Paper, a White Paper and a draft Bill.

- During this period, the Home Office has also consulted on the development of a new legal framework for people with severe personality disorder who are regarded as dangerous, with the aim of ensuring that such individuals may be detained for public safety reasons, even if their condition is not treatable. The two consultation exercises, on mental health law in general and on the detention of "dangerous severely personality disordered (DSPD) individuals", were later drawn together, with the White Paper and the draft Bill making provision in both areas.

- Both the general review of mental health law, and the particular issues surrounding how DSPD individuals should be managed, have proved highly contentious. Whilst initial anger among users at the possibility of treatment being imposed on patients living in the community was partially dispelled by the recommendations of the Expert Committee, the proposals since put forward by the Government in the Green and White Papers and the draft Bill have had a hostile reception among both professionals and user-groups. Although certain aspects of the proposals, including the requirement that compulsory treatment could continue after 28 days only if authorised by an independent body and a new emphasis on the importance of advocacy for mental health service users, have been welcomed, there has been widespread concern as to the breadth of the criteria to be used when determining who may be treated against their will. In particular, it has been argued that the "capacity" of the patient (that is, their ability to understand treatment decisions and make a valid choice) should be taken into consideration when determining whether or not treatment should be imposed. Arguments have also been put forward that any new legislation in this area should include more positive rights for those suffering from mental disorder, including the enforceable right to have their needs assessed at an early stage which, if coupled with appropriate services, might forestall any later need for compulsion.

- The proposals concerning DSPD patients have also been widely criticised, both on the basis that mental health law should not be a vehicle for introducing "preventative detention" for criminal justice purposes, and because of doubts as to the accuracy with which such risk assessments can, in fact, be made.

- No mention of a *Mental Health Bill* was made in the Queen's Speech on 13 November 2002. However, the Secretary of State for Health has since made clear that a Bill, extending to England and Wales only, will be presented later this Session.

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I Introduction

A. Government policy on mental health

In December 1998, the Government published the policy document *Modernising mental health services: safe, sound and supportive*, setting out a "new vision" for mental health services in England. This document promised a new approach to mental health services, encompassing:

- a "National Service Framework" for mental health, setting out service models and national standards that the NHS would be expected to achieve (subsequently published in September 1999[1]);
- new investment of £700 million over three years underpinning improved services both in hospitals and in the community; and
- a new legal framework to replace the *Mental Health Act 1983*, which is described as "outdated" in its focus on care in hospitals, rather than in the community. *Modernising mental health services* hinted, and health ministers made clear, that a key element of the new legal framework would be the possibility for compulsory treatment to be given to patients living in the community, replacing the current requirement that such treatment can only be given if patients are detained in hospital.

This Paper concentrates on the third initiative and aims to summarise the work which has been undertaken so far to develop the new legal framework: the work of the Expert Committee commissioned to put forward proposals for that new framework,[2] the Green Paper published in November 1999,[3] the White Paper published in December 2000[4] and the draft Bill and associated consultation paper published in June 2002.[5] Responses to the consultation paper were requested by 16 September 2002 and the Department is currently considering almost 2,000 replies.[6]

Shortly after the publication of *Modernising mental health services*, the Home Office produced a paper on the future treatment of a specific group of mentally disordered persons: those who suffer from personality disorder, who are believed to be dangerous, but who are not regarded as "treatable".[7] Individuals who are not "treatable" are currently excluded from detention under the 1983 Act, and the aim of the Home Office proposals is

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1 Department of Health, *National service framework for mental health: modern standards and service models*, 1999

2 Department of Health, *Review of the Mental Health Act 1983: report of the expert committee*, November 1999

3 *Reform of the Mental Health Act 1983: proposals for consultation*, Cm 4480, November 1999

4 *Reforming the Mental Health Act: Part I: the new legal framework*, Cm 5016-I, December 2000

5 *Draft Mental Health Bill & Mental Health Bill: consultation document*, Cm 5538, June 2002

6 HC Deb 25 November 2002 c138W

7 Home Office, *Managing dangerous people with severe personality disorder*, July 1999

to close what ministers regard as a loophole in the law. While the Home Office consultation document was initially separate from the work on the general reform of the mental health legislation, the Green Paper promised that responses to the two sets of proposals would be considered together. The subsequent White Paper was published in two parts, the first covering the general reform of the mental health law and the second looking specifically at the position of those with personality order who are regarded as dangerous.[8] The draft Bill covers both parts of the White Paper proposals.

The following sections provide brief background firstly on care in the community and previous attempts to separate the link between compulsory treatment and detention in hospital, and secondly on the issue of people with severe personality disorder who are regarded as dangerous.

B. Care in the community

There has been a fundamental shift in mental health policy since the early 1960s, with large psychiatric institutions being closed down, and individuals with mental health problems being cared for "in the community" as much as possible. This shift reflects both the state of modern psychiatry (with modern drugs in some cases able to control mental illness without the need for hospital-based care) and also a change in perception of mental disorder: mental illness is now regarded as an illness like any other, rather than a reason for locking people away indefinitely. The *Mental Health Act 1983* (much of which derives from the *Mental Health Act 1959*) focuses however almost entirely on the position of patients in hospital, setting out both the circumstances in which patients may be detained and treated against their will and the safeguards in place to prevent abuse. The 1983 Act is not, in general, concerned with the provision or adequacy of services to patients, with the exception of section 117 which places a duty on Health Authorities and social services authorities to provide "after-care" services to those who have been released from detention under the Act.

The interest in developing a legal framework which permits compulsory treatment for people living in the community reflects both the policy shift away from hospital care and concerns as to how well the policy is working in practice. In particular there have been fears that both a lack of support in the community and an unwillingness on the part of some patients to keep taking medication (especially when they feel better and the medication has unpleasant side-effects) leads to some people suffering from mental illness becoming a danger either to themselves or to others. Indeed, *Modernising mental health services* controversially declared that "taken overall, the policy of care in the community has failed".[9] This claim was firmly criticised by the Health Select Committee in its report in July 2000 in mental health services, which stated:

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8 *Reforming the Mental Health Act: Part II: high risk patients*, Cm 5016-II, December 2000

9 Department of Health, *Modernising mental health services*, 1998, p24

> There have been undeniable failures in service since the policy of care in the community was first launched. But we feel that it is both misleading and unhelpful to state that the policy of care in the community has failed, as the Government has done on a number of occasions. We urge the Government to make clear in the language it uses (as indeed it has already done in the policies it has embraced), that care in the community is a positive policy and one which it supports.[10]

The previous Conservative Government looked at the issue of compulsory treatment in the community in 1993, after the Royal College of Psychiatrists had proposed a new "community supervision order" which would require patients discharged from mental hospital to continue taking their medication, with the sanction that those who did not could be recalled to hospital.[11] The Department of Health review of the law in this area concluded that the proposals, in the form put forward by the Royal College, might potentially contravene the European Convention on Human Rights, in that they would set a lower threshold for hospital admission than is currently found in sections 2 & 3 of the *Mental Health Act 1983*.[12] The legislation resulting from the review, the *Mental Health (Patients in the Community) Act 1995*, stepped back from creating any form of compulsory treatment order: instead, it created the concept of "aftercare under supervision" under which a patient discharged from hospital could be required to live in a certain place or attend at particular times and places for treatment or occupation, but could not actually be forced to accept treatment.

C. "Dangerous people with severe personality disorder"

The Home Secretary announced in February 1999 that the Government would be consulting on proposals to introduce a form of detention for people suffering from personality disorder (also known as psychopathic disorder) and deemed highly dangerous, but who could not be detained under the current provisions of the *Mental Health Act 1983*. The background to this announcement appeared to be cases like that of Michael Stone. Stone, who later went on to commit murder, had had a history of psychiatric problems, but had not been detained in hospital under the *Mental Health Act 1983* on the basis that his disorder could not be treated.

Although "psychopathic disorder" is included within the definition of "mental disorder" used within the 1983 Act, the basic rationale of the Act is that patients are being detained in order to be treated, not just contained. If patients are deemed "untreatable", then under current provisions their detention under the Act must cease. At the time that Michael Stone was jailed for the murder of a woman and her child, the then Home Secretary, Jack Straw, was quoted as saying:

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10 Health Select Committee, *Provision of NHS mental health services*, HC 373-I 1999-2000, July 2000, pxxii, para 39

11 Royal College of Psychiatrists, *Community supervision orders*, 1993

12 Dept of Health, *Legal powers on the care of mentally ill people in the community*, August 1993, p27

> It is the opinion of many experienced observers of the system that psychiatrists are all too often using the treatability test in the Act as a way of absolving themselves from their duty of providing health care. Psychiatrists have a duty to ensure that they use the existing legal framework responsibly in ways that enhance rather than undermine public safety.[13]

This statement generated some anger among psychiatrists, who felt both that under the existing provisions of the *Mental Health Act 1983* it would be unlawful for them to detain patients who, in their clinical opinion, were not treatable, and also that resources in mental health were stretched to such an extent that people were being denied treatment and care "every day of the week".[14] The resources issue could be particularly relevant in cases where the individual concerned is actually seeking treatment; although "untreatable" individuals cannot be detained under the Act, there is nothing to prevent them remaining in a mental health hospital as a "voluntary" patient. In reality, however, there is likely to be pressure on them not to remain voluntarily if there is local pressure on beds.

II The Expert Committee report and the Green Paper

A. The proposals

The Government initiated the review of the *Mental Health Act 1983* by an Expert Committee in September 1998, appointing Genevra Richardson, Professor of Public Law at Queen Mary and Westfield College, University of London, as its chair.[15] Announcing Professor Richardson's appointment, the then health minister Paul Boateng made clear his desire to see a "root and branch" review, focusing as much on the safety of the public as on the needs of patients:

> Our new policy aims must be underpinned by modern and robust legislation. Moreover, with our safety-plus approach, the law must make it clear that non-compliance with agreed treatment programmes is not an option. We will look to Professor Richardson and her colleagues for clear advice on how to take forward a root and branch reform of the law.
>
> We are determined to develop comprehensive mental health services that are safe, sound and supportive. They must protect the public, and provide safe and effective care for mentally ill people. New legislation is needed to support our new policies, for example to provide extra powers to treat patients in a range of

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13 "Treatability row leads to war of words over service funds", *Community Care*, 5-11 November 1998, p1

14 *ibid*

15 Department of Health press notice 1998/391, 22 September 1998

> clinical settings, including, where necessary, in the community, and to ensure a proper balance between the interests of the public and the rights of the individual.
>
> Carers too should have rights, as well as responsibilities. Too often they have been left to pick up the pieces, but were never given any rights at the moment of a crisis affecting those for whom they have been responsible.[16]

The Committee published proposals for consultation in April 1999,[17] with their final report being published alongside the Government's Green Paper in November 1999.[18]

The Expert Committee devoted the first part of their report to the "general principles" which should underpin mental health legislation, looking at how principles such as respect for patient autonomy (which would entail accepting a competent patient's refusal of treatment), the safety of the individual patient, and public safety should inter-relate. According to the report, a few of the respondents to the Expert Committee's consultation document felt that patient autonomy should always be given precedence: if a patient who was capable of giving or refusing consent refused to accept treatment, then that refusal should always be respected, in the same way as it should be for treatment of physical illnesses.[19] Most, however, felt that where patient autonomy came into conflict with public safety, then some level of compulsion was acceptable. The issue of harm to the individual presented a "much more intractable dilemma", with no consensus emerging as to when it was right to over-rule a competent patient's refusal of treatment in what an outsider would see as that individual's own best interests. The Expert Committee finally argued that some level of compulsion was acceptable to prevent self-harm for the following "mixture of principle and pragmatism":

> They [the reasons given for rejecting the full implications of autonomy] include a belief that the consequences of untreated mental disorder may impact more directly and significantly on carers and relatives than do the consequences of untreated physical disorder, and a disinclination to allow someone with a mental disorder, whether or not they formally retain capacity, to deteriorate beyond a certain point. There is also the practical concern that a failure to allow intervention to protect the patient from serious harm despite his or her capable refusal will lead in practice to the adoption of a very broad definition of incapacity.[20]

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16 *ibid*

17 Mental Health Legislation Scoping Study Review Team press notice, 15 April 1999

18 Department of Health, *Review of the Mental Health Act 1983: report of the Expert Committee*, November 1999 & *Reform of the Mental Health Act 1983: proposals for consultation*, Cm 4480, November 1999

19 Under the common law, a refusal of treatment by a competent adult *must* be respected, even if the consequences could be the patient's death – see for example *Re MB (an adult: medical treatment)* (1997) 38 BMLR 175 and *Ms B v An NHS Hospital Trust* [2002] 2 All ER 449

20 Dept of Health, *Review of the Mental Health Act 1983*, November 1999, para 2.9

The Expert Committee went on to emphasise that a number of express principles should be set out in a new Act to give a clear steer to implementation. Proposed principles included: respect for and enhancement of patient autonomy; the provision of care on a consensual basis wherever possible; the provision of care on the basis of choosing the least restrictive and least invasive alternative; and "reciprocity" – the idea that if individuals were to be treated against their will, then society owed them an obligation in return to ensure that they had adequate services. Noting the difficulty that individuals often encounter in accessing mental health services when they first feel they need them, the Committee also recommended that individuals and their carers should have the right to request an assessment of their needs, with the aim of ensuring that individuals receive services before the need for compulsion arises.[21]

On the criteria to be used when determining whether a patient should be subject to compulsory powers, the Expert Committee suggested that a broad definition of "mental disorder" should be used, to ensure that particular individuals in need of care were not excluded solely on the basis of their diagnosis, but that this should be coupled with relatively tightly-drawn criteria based on need. The Committee suggested that the Law Commission definition of mental disorder, put forward in 1995 as part of their proposals on mental incapacity[22], of "any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning" would be equally appropriate for mental health legislation. They did, however, suggest that further discussions with Scottish colleagues would be helpful, given Scotland was also looking at law reform in this area and a common definition would be useful. A patient who came within this diagnostic criterion would then have to meet the following conditions before compulsory treatment could be imposed:

- s/he should need care and treatment under the supervision of specialist mental health services; **and**
- this care and treatment must be the least restrictive and invasive alternative available consistent with safe and effective care; **and**
- this care and treatment must be in the patient's best interests; **and *either***
- where the patient lacked capacity to consent, compulsory care and treatment must be necessary for the health and safety of the patient, the protection of others from serious harm or the protection of the patient from serious exploitation; ***or***
- where the patient did have capacity to consent (and was withholding that consent) there must be a substantial risk of serious harm to the health or safety of the patient or the safety of other persons if s/he remained untreated, and there must be positive clinical measures in the proposed care which were likely to prevent deterioration or secure improvement in the patient's mental condition.[23]

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21 *ibid*, paras 3.21 & 3.22
22 *Mental incapacity*, HC 189 1994-95, March 1995
23 *ibid*, para 5.95

A clear distinction was therefore made in the Expert Committee's proposals between patients who are unable to give or withhold consent to treatment (for example because they are too ill to weigh up the consequences of accepting or refusing treatment) and those who do have that mental capacity to make decisions, and for whom a higher threshold for compulsion was therefore seen as appropriate.

The Expert Committee also proposed a whole new system of entry to compulsory mental health services. Currently, patients may be admitted to hospital under the 1983 Act under sections 2, 3 or 4 (for assessment, for treatment and under emergency circumstances), with slightly different provisions applying in each case. Moreover, as noted earlier, there is no provision for treatment to be provided compulsorily in the community. The Expert Committee proposed a single point of entry to the system, with an application for assessment which could last for up to 7 days. The proposed criteria for entry to "compulsory assessment" (which differed slightly from those for compulsory treatment, as full information about the patient's condition may not be known at that point) were that:

- the person was suffering from a mental disorder requiring care and treatment under the supervision of specialist mental health services; **and**
- in the interests of the patient's health or safety or for the protection of others from serious harm or for the protection of the patient from serious exploitation, the mental disorder required assessment; **and *either***
- the patient lacked the capacity to consent to care and treatment for mental disorder; ***or***
- where the patient did have capacity to consent (and was withholding that consent) there was a substantial risk of serious harm to the health or safety of the patient or the safety of other persons if s/he remains untreated, and there were positive clinical measures in the proposed care which were likely to prevent deterioration or secure improvement in the patient's mental condition.[24]

During the 7 day period, patients would be thoroughly assessed, an outline care programme produced and, where the criteria for compulsory treatment were met, an application for a "provisional order" made. Compulsory treatment could not routinely be used during this 7 day period, although the Committee recommended exceptions where treatment would save the patient's life, prevent deterioration of their condition or prevent suffering, or in cases where the patient was already well known to psychiatric services. If an independent reviewer confirmed the provisional order, this would be in force for up to a further 21 days, making a maximum of 28 days from the point when the assessment was first initiated. Finally, if compulsory care and treatment was to continue, then a "mental disorder tribunal" would have to hold a hearing to authorise the application. Slightly different procedures could apply for the first 24 hours in emergency crises, but after this 24 hour period the ordinary procedures would apply.

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[24] *ibid*, para 5.18

There are at least three fundamental differences between current procedures and the Expert Committee's proposals. Firstly, the onus would be shifted on to health professionals to convince external reviewers, both after 7 days and after 28 days, that the criteria for compulsory treatment were met, while at present patients are usually obliged actively to apply to "mental health review tribunals" to consider their cases (and there are frequently significant delays in setting them up). Secondly, no distinction at all would be made between compulsory care in hospitals and in the community: the assessment process could be carried out in the community just as much as in hospital, and the care plan to which the 21 day order and any subsequent orders would relate could also specify solely treatment in the community. It seems likely that this unified system would meet the concerns about possible conflict with the European Convention on Human Rights which were highlighted by the Department of Health review in 1993.[25] Thirdly, a distinction would be made between patients with the capacity to make their own decisions, and those without.

In its Green Paper, the Department of Health summarised the Expert Committee's proposals for a new admission and assessment process and sought comments, particularly on whether there was a need for an independent review at 7 days, and on the possible make-up of the tribunals considering orders after 28 days. More generally, on the issue of the criteria for compulsory treatment, the Department expressed serious doubts about the Expert Committee's emphasis on "capacity": while the Expert Committee had suggested that if a competent patient (that is, one who understand the consequences of acceptance or refusal) refused treatment, the criteria for imposing it should be more stringent than in cases where the patient was not competent to accept or refuse treatment, the Department felt that "degree of risk" (either to self or others) was the crucial factor, not capacity. The Department also felt that, while it was appropriate to express a number of key principles on the face of the future Act, the full list of principles suggested by the Expert Committee would be better placed in a Code of Practice, leaving a more focused list in the legislation itself. Moreover, the Department suggested including specific reference to the "key importance" of the safety of both the individual patient and the public in determining whether compulsory powers should be imposed, an issue not included in the Expert Committee's list of guiding principles, which focused more on respecting the dignity of the individual patient.

B. Responses

When the Government initially made clear that the review of the *Mental Health Act 1983* to be carried out by the Expert Committee would almost certainly lead to compulsory

[25] The major point of concern at that time was the fact that criteria for recall to hospital after failure to abide by the proposed community supervision order would have been set at a lower level than normal admission under the 1983 Act

treatment in the community,[26] there was an outcry among some of the voluntary organisations representing people suffering from mental illness: Mind reportedly accused Mr. Boateng (then the health minister responsible for mental health) of "jumping the gun" of the review, while the chief executive of SANE ("Schizophrenia - a national emergency") was quoted as saying "We have always been, and remain, opposed to compulsory treatment outside a hospital or equivalent setting - nor do we want a mental health system that increases coercion".[27] The same article reported Mind's concerns that the possibility of compulsory treatment in the community would drive potential users away from using the service and would be disliked by health professionals who did not want to work in a coercive way. The NHS Confederation, however, which represents NHS trusts and Health Authorities, only commented that they welcomed ministers' intentions "to develop a legislative framework consistent with the development of mental health services".

Mr. Boateng's views were later repeated by John Hutton, his replacement at the Department of Health, in a speech to Mind. According to an article in the *Health Service Journal*, this reiteration of the intention of creating compulsory treatment in the community led to the resignation of one member of the Government's "independent reference group" on mental health (which was created to give professional organisations, voluntary groups and service users the opportunity to influence mental health policy). Five others reportedly considered their positions.[28] According to the health press, initial concern about the introduction of compulsory treatment in the community became much more subdued after the Expert Committee published draft proposals in April 1999, with an emphasis on patients' rights and the necessity of an adequate level of services.[29] However, the publication of the Green Paper, with its greater focus on risk, regenerated concerns from those representing the users of mental health services. Three charities, the National Schizophrenia Fellowship, the Manic Depression Fellowship and the Mental After Care Association made the following comments in a letter to the *Guardian*:

> The government's proposals for the reform of the mental health act are long overdue. But the government is missing the opportunity of a generation by placing the focus of attention on compulsory treatment rather than the chance to give the people most affected rights to decent care and treatment. The green paper includes references to advance agreements, right to advocacy and second opinion, which are all welcome. Yet once again the agenda seems to be set by compulsion for the few rather than care for the many, compulsion which is all too often the

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[26] Dept of Health press notice 98/391, 22 September 1998

[27] "Mental health groups condemn 'coerced' community treatment", *Health Service Journal*, 1 October 1998, p7

[28] "Service user quits mental health group in fury over Hutton speech", *Health Service Journal*, 12 November 1998, pp4-5

[29] eg "Charities say draft proposals will prune back intended root and branch reforms, *Community Care*, 22-28 April 1999, p1; "Critics of forced treatment tone down criticisms following report", *Health Service Journal*, 22 April 1999, pp6-7; "At last, a real step forward for mental health policy", *Health Service Journal*, 22 April 1999, p19

> cheap and easy resort of services, not the last resort which is where it belongs. This week we handed in a petition to the department of health of 20,000 service users, carers and concerned professionals calling for rights to care and treatment. It is not too late to hear their voice.[30]

The Department of Health reportedly accepted that the Green Paper had focused too much on protecting the public and not enough on the needs of mental health services users, with a civil servant commenting to a National Schizophrenia Fellowship[31] conference in April 2000 that the Department had "been given a presentation lesson" and insisting that any new legislation would be a "health act for vulnerable people in need", rather than a public safety bill.[32]

C. The view of the Health Select Committee

In January 2000, the Health Select Committee launched an enquiry into the provision of NHS mental health services, including consideration of the proposed legislative changes. The Committee's report was published in July 2000, and was critical of the Green Paper in a number of respects.[33] Highlighting comments from members of the Expert Committee that the Green Paper proposals were an "unfortunate hybrid" which had accepted the structural changes recommended by the Expert Committee but had set them "in a context of a very different emphasis and value structure",[34] the Health Committee recommended that:

- the principles of respect for autonomy and respect for non-discrimination should appear on the face of the Act, to provide a clear steer that the refusal of treatment by a competent individual should be taken very seriously and over-ridden only with good reason;
- while the consideration of risk would always be a key factor in determining whether compulsory treatment was necessary, the focus of mental health legislation should be on the therapeutic benefit to the patient;
- an objective test for capacity, as recommended by the Expert Committee, was "desirable as long as it was workable in practice" and should be further investigated;
- the new legislation should include provision for "advance directives" and "crisis cards", enabling patients, when well, to set out how they would wish to be treated should they suffer further episodes of illness in the future;
- there should be further public discussion on whether or not competent patients who were refusing treatment should be forced to accept it when the rationale for the treatment was to protect their own health or safety, rather than the safety of

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30 Letter to the *Guardian*, 19 November 1999, p25
31 now renamed "Rethink"
32 "Users' rights move up agenda", *Community Care*, 6-12 April 2000, p4
33 Health Committee, *Provision of NHS mental health services*, HC 373-I 1999-2000, 13 July 2000
34 *ibid*, pxliii, para 108

others. The Health Committee agreed with the Expert Committee that this was a "serious moral issue" and expressed concern that it was not addressed at all in the Green Paper (which assumed without discussion that compulsory treatment was appropriate in such situations);

- the requirement that a patient must be likely to derive health benefit from compulsory treatment should be made much more explicit in the criteria for compulsion;
- there should be a statutory right to advocacy for individuals subject to compulsory powers.

More generally, the Health Committee broadly supported the general principle of breaking the link between compulsory powers and hospital detention, as long as sufficient attention was focused on patients' rights:

> There are clearly some very serious concerns about the prospect of compulsory treatment in the community. At the same time, we were impressed by some of the arguments put to us, that the principle of community treatment orders accords with the spirit of treating patients closer to home, and that mental health professionals have always had to juggle the possibility of compulsion with the necessity of building a trusting relationship. We believe that if the Government is to introduce some form of community treatment order, it is imperative that the safeguards set out in the Expert Committee's report, particularly those relating to reciprocity, and the right of the user to request an assessment, should be included. We also reiterate our earlier recommendations that the criteria used for determining who is subject to compulsion should in principle include a recognition of capacity and should require clear evidence of health benefit for the patient. [35]

III Home Office DSPD consultation

In July 1999, the Home Office published the consultation document, *Managing dangerous people with severe personality disorder*, putting forward two possible options to enable individuals suffering from personality disorder to be detained, regardless of whether they were deemed treatable. The first (Option A) would develop existing systems within prisons and hospitals, including extending the use of discretionary life sentences, to ensure that people convicted of serious crimes would not be released if considered still dangerous, and amending the 1983 Act in order to remove the "treatability" requirement for "dangerous severely personality disordered" (DSPD) individuals. The second (Option B) would set up a whole new legal framework to allow DSPD individuals to be detained on the basis of their diagnosis and the assessment of the danger they present to the public, and be held in new facilities separate from both the prison and hospital system.

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[35] *ibid*, plvi, para 146

The Home Affairs Committee held an enquiry into the proposals and noted in its report that, while the consultation document asked detailed questions relating to how services should be provided, what skills would be needed and how assessments should be carried out, responses tended to be more concerned with fundamental questions of civil liberties, resources and medical ethics. In response to these questions, the Committee commented that where individuals have not committed offences "it will prove exceptionally difficult in individual cases to establish that the necessary level of danger exists to justify further detention". It went on to suggest that continuing investment will be required in research to improve assessment methods; that individuals should be detained under the proposals only where "it is almost certain that they will commit a very serious criminal offence"; and that detentions should be subject to regular review by a judicial body.[36] The Committee went on to conclude that:

> On balance we recommend that a separate service as set out in option B is most likely to protect the public, meet the needs of the individuals concerned and satisfy the requirements of the European Convention on Human Rights.[37]

The Health Committee, on the other hand, which considered the proposals as part of its larger enquiry into mental health services, felt unable to support either Option A or Option B for a number of reasons:

- concerns about the robustness of the term "dangerous people with severe personality disorder" which had been widely criticised by psychiatrists;
- the lack of agreement within the psychiatric profession as to whether personality disorder was, or was not, treatable;
- the confusion caused by the different ways the "treatability" criterion in the 1983 Act appeared to be interpreted, with some clinicians apparently regarding patients as "untreatable" because appropriate services were not locally available, rather than because the patient's condition itself was not amenable to any change;
- the fact that the "service enhancements" promised by the Home Office as part of the changes could be provided without any change in legislation;
- the lack of clarity as to how the "interventions" which the Home Office proposals envisaged could help "untreatable" patients.

On this last point, the Committee went on to recommend that the Home Office should:

> clarify whether it sees the "interventions" that it is developing for "DSPD" individuals as being different in kind from the "interventions" that are currently available, albeit patchily, in the NHS. If these interventions can be defined as "treatment" in the very broad sense discussed earlier, and are aimed at individuals

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[36] Home Affairs Committee, *Managing dangerous people with severe personality disorder*, HC 42 1999-2000, March 2000, ppxxv-xxvii, paras 77-87

[37] Home Affairs Committee, *Managing dangerous people with severe personality disorder*, HC 42 1999-2000, March 2000, pxxvi, para 89

> with a recognisable mental disorder, then we would argue that they should be provided by the NHS on the basis of mental health legislation. If, on the other hand, they can be distinguished clearly from any "treatment" that the NHS might provide, then we would argue that they should be made available in prisons, to convicted offenders, as part of the criminal justice system.[38]

The Committee further recommended that research should be initiated on the treatment of anti-social personality disorder, that adequate facilities should be made available within the NHS for those suffering from a recognised disorder who were able to benefit from treatment, and that further thought should be given to the idea of "reviewable sentences" for those within the criminal justice system who were deemed to present a continuing danger to the public.[39]

In October 2000, the Home Office placed a summary of the responses received to the consultation in the House of Commons Library, along with a copy of all the individual responses where respondents had not expressed any objection to publication.[40] Responses were summarised as follows:

> Generally, respondents welcomed the opportunity to comment on the proposals and acknowledged that present arrangements for managing this group are unsatisfactory. Of those who expressed a preference, Option B was favoured in the long-term – as the better option to provide high quality services for this group – with resources in the short term to develop and extend existing services. There was, however, widespread concern at the proposal to detain in civil cases. There was also concern about the reliability of current procedures for accurately diagnosing severe personality disorder and assessing dangerousness.
>
> Respondents welcomed the Government's emphasis on research and in particular the need for further research into risk assessment processes and treatment. There was general support for a multi-disciplinary approach for the assessment and treatment of this group and recognition that specialist training for a multi-disciplinary workforce is essential. The Government's emphasis on prevention was also welcomed.

The Green Paper, *Reform of the Mental Health Act 1983: proposals for consultation*, made clear that the responses to the Home Office consultation would be considered together with the responses to the Green Paper.[41]

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38 Health Committee, *Provision of NHS mental health services*, HC 373-I 1999-2000, July 2000, plx, para 160

39 *ibid*, plxi, para 165

40 Deposited Paper 00/1582, 25 October 2000

41 *Reform of the Mental Health Act 1983: proposals for consultation*, Cm 4480, November 1999, p13, para 18

IV The White Paper, the draft Bill and the *Mental Health Bill consultation document*

The Government published its response to the two sets of consultations in December 2000, in the White Paper *Reforming the Mental Health Act*. The first Part of the White Paper describes the proposed new legal framework,[42] while the second Part deals specifically with "high risk patients" (that is, those described as "DSPD" in the Home Office consultation).[43] Subsequently, in June 2002, a draft Bill[44] was published, accompanied by *Explanatory Notes*[45] and a further consultation paper, eliciting views on specific aspects of the proposals.[46]

The following sections consider first the proposals set out in the White Paper and draft Bill for a new legal framework, and secondly those covering "high risk patients". It should, however, be noted that the proposals for the main legal framework have been drawn up in such a way as to include "high risk patients" within the same legislative structure as other individuals subject to compulsory mental health treatment. There is therefore much cross-referencing between the two Parts of the White Paper, and the draft Bill covers both issues. The policy intentions set out in the White Paper and the actual drafting of the draft Bill are considered together, with apparent differences highlighted where appropriate. Footnote references to paragraph numbers refer to the White Paper, unless it is made clear that they relate to the consultation document. Responses to the individual aspects of the White Paper and draft Bill are included in each section, while a broad-brush overview of responses from political parties and organisations concerned with mental health is given afterwards, in section C below (see page 46).

A. The new legal framework

1. Principles underlying the legislation

The White Paper states that "fundamental principles" underpinning the new legislation will be set out in such a way as to provide a "clear context" for decisions made as to how compulsory powers should be used.[47] Areas to be covered include: the need to make decisions that are appropriate to patients as individuals; the promotion ("to the greatest practicable degree") of patients' self-determination and personal responsibility; the participation of patients in their own care and treatment, including the encouragement of advance agreements; the provision of services to ensure that patients are able to comply with their care plan; and the use of the least degree of compulsion consistent with

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42 *Reforming the Mental Health Act 1983: Part I: the new legal framework*, Cm 5016-I, December 2000
43 *Reforming the Mental Health Act 1983: Part II: high risk patients*, Cm 5016-II, December 2000
44 *Draft Mental Health Bill*, Cm 5538-I, June 2002
45 *Draft Mental Health Bill: Explanatory Notes*, Cm 5538-II, June 2002
46 *Mental Health Bill: consultation document*, Cm 5538-III, June 2002
47 Part I, para 2.8

ensuring that the objectives of the care plan are met. Although reference is made in a later section to risk ("concerns of risk will always take precedence, but care and treatment provided under formal powers should otherwise reflect the best interests of the patient"[48]), consideration of risk is not cited as a fundamental principle.

The draft Bill makes clear that these general principles will appear in a statutory *Code of Practice* rather than on the face of the Bill. However, clause 1 of the Bill sets out that the general principles must be designed to secure that:

> (a) patients are involved in the making of decisions
> (b) decisions are made fairly and openly, and
> (c) the interference to patients in providing medical treatment to them and the restrictions imposed in respect of them during that treatment are kept to the minimum necessary to protect their health or safety or other person.

The House of Lords and House of Commons Joint Committee on Human Rights has expressed "serious reservations" that the principles which are intended to safeguard patients' rights are to be in a Code of Practice, whose legal status is not spelled out, rather than on the face of the Bill.[49] The Law Society, similarly, describes the decision to provide most of the detail on the principles in a Code of Practice as "unfortunate", arguing that research due to be published in the near future had "pointed to a lack of understanding of the purpose of mental health law as a major reason behind the unsatisfactory operation of the *Mental Health Act 1983*".[50] In particular, the Society argued that the principles of reciprocity and non-discrimination should be explicit in the Bill itself.[51] The Royal College of Psychiatrists hopes that the principle that the patient should be treated in the "least restrictive environment possible" should be included on the face of the Bill and expresses disappointment that there is no mention of a principle "relating to the health need of the patient".[52]

2. Pathway into use of compulsory powers

There will be a single pathway for the use of compulsory powers, regardless of whether that care and treatment is to be provided in hospital or in the community.[53] This pathway will have three stages:

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48 Part I, para 2.16

49 Joint Committee on Human Rights, *Draft Mental Health Bill*, HL 181 2001-02, 4 November 2002, p11, paras 21-22

50 Law Society, *The draft Mental Health Bill 2002: the Law Society's response to the Government's consultation process*, September 2002, paras 50-51, available at www.lawsociety.org.uk/dcs/pdf/mentalhealth_mhbill.pdf

51 *ibid*, paras 55 & 64

52 Royal College of Psychiatrists, *White Paper on the reform of the Mental Health Act 1983: response from the College's mental health law sub-committee*, June 2001, available at www.rcpsych.ac.uk/college/parliament/responses/mhbMhlsc.htm

53 Part I, para 3.9

- stage 1 ("examination"): decision to begin assessment and initial treatment under compulsory powers, supported by evidence from two doctors and one social worker or other mental health professional (usually triggered by a request from the patient, their carer or GP, or criminal justice agencies). This decision will then be registered with an NHS trust or other agency which will be responsible for subsequent treatment;
- stage 2 ("assessment"): formal assessment either in hospital or in the community, followed by treatment based on a preliminary care plan, for up to 28 days;
- stage 3 ("order authorising medical treatment"): continuing treatment after 28 days only if authorised by a new Mental Health Tribunal. The Tribunal will be able to make orders for up to 6 months, renewable for a further 6 months and then for up to a year at a time. The content of orders will be based on care plans submitted by the clinical team to the Tribunal and may cover compulsory treatment in the community as well as in hospital.[54]

Many respondents have expressed general concerns that the proposed new pathway into compulsory care, coupled with the wide entry criteria (see sections 3 & 4 below) may lead to a far larger group of patients being subject to compulsion than is presently the case. The Mental Health Alliance,[55] for example, notes that at present "in practice, limits are … posed by bed numbers" and fears that once this limitation is removed the number of people subject to compulsion may be greatly increased.[56] The Alliance further comments:

> Community treatment orders [CTOs] are a major concern to many service users, some of whom fear that CTOs 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.

While the Alliance does not directly express opposition to the *principle* of CTOs, it does argue that assessment and initial treatment should always take place in a hospital setting, as should all treatment of patients who are being treated under compulsory powers for the first time. The LGA similarly argues that an assessment in a non-residential setting seems "highly impractical", although it believes that some patients would benefit from community treatment orders, in particular where the nature and management of their condition is well understood after an admission to hospital.[57] The Zito Trust firmly

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54 Part I, para 3.10ff & clauses 9, 17, 20, 30, 34 & 37

55 a broad alliance of over 50 organisations concerned with mental health, including user/carer groups, research organisations and Royal Colleges - see below page 48

56 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002, available at www.mind.org.uk/take_action/mha.asp

57 LGA, *Draft Mental Health Bill consultation: Local Government Association response*, 13 September 2002, p3, available at www.lga.gov.uk/Documents/Briefing/Our_Work/social%20affairs/mhbc.pdf

supports the principle of CTOs, criticising the approach that "we should allow people to deteriorate in the community to the point where they become psychotic before intervention".[58] The Royal College of Psychiatrists also agrees with the idea of a single pathway into compulsory care,[59] but expresses concern that there appears to be little scope for clinician discretion in moving from one stage to another. In particular it suggests that the duties placed on NHS trusts to move from one stage to the next where the very loose criteria are met (see next two sections) will start an "automatic chain reaction" which will "very frequently result 'inevitably' in compulsion under the Act".[60]

The Law Society highlights that although Ministers have made clear that treatment would never actually be administered against a patient's will in his or her own home, this safeguard does not appear in the Bill itself.[61] This point is also raised by the Mental Health Alliance which urges that the principle be made explicit.[62] The Law Society further expresses doubts as to how workable in practice it may be to convey such a patient to hospital for treatment, given that the current powers to "take and convey" patients, introduced in 1995, are seldom used.[63]

Concerns have also been expressed that the role currently carried out by an approved social worker may in future be carried out by other mental health professionals, and hence the involvement of social workers is not guaranteed. The Local Government Association argues that "there is a unique and individual contribution to be made by approved social workers", highlighting in particular the importance of a patient's social needs being considered as well as their medical needs.[64] The Law Society argues that, under the 1983 Act, approved social workers bring independence to the system and that it would be a matter of concern if this independence were to be lost.[65]

The powers of the Tribunal are considered in section 6 below (see page 31).

3. Definition of mental disorder

The White Paper stated that the compulsory powers in the new legislation would be based on the "broad definition" of mental disorder put forward in 1995 by the Law Commission and endorsed by the Expert Committee[66]: "any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental

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58 letter to *Guardian* from Director of Zito Trust, 28 June 2002, p17

59 Royal College of Psychiatrists, *White Paper on the reform of the Mental Health Act 1983: response from the College's Mental Health Sub-Committee*, June 2001

60 Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: response to the draft Mental Health Bill and consultation document*, 13 September 2002

61 Law Society, *op.cit.*, para 89

62 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002

63 Law Society, *op. cit.*, para 90

64 LGA, *op. cit.*, p3

65 Law Society, *op. cit.*, paras 126-128

66 see page 12

functioning". This precise wording has been carried forward into the draft Bill.[67] The consultation paper further seeks views on whether certain conditions such as drug and alcohol misuse or sexual deviancy should explicitly be excluded from this definition, as they are in the *Mental Health Act 1983*.[68] The policy intention is that it would never be appropriate to use compulsory powers solely because of an individual's substance misuse or sexual behaviour, but that it should be clear that compulsory powers could be appropriate if such an individual were *also* suffering from a recognisable mental disorder.

The Joint Committee on Human Rights expresses grave concerns about the proposed definition of mental disorder, arguing that it is so widely drawn that it could draw in not only people with learning disabilities and addiction disorders, but also possibly those with epilepsy or diabetes, as these conditions can interfere with brain functioning. Suggesting that the possibility of drawing such patients into the ambit of compulsory treatment is "unattractive", risking "over-inclusive" mental health legislation, the Committee recommends that the definition should be reviewed.[69] The Law Society similarly highlights the possibility of the scope of the definition having "unintended consequences" such as the inclusion of those who are temporarily intoxicated, and feels that despite Government assurances that this is not the policy intent, nevertheless re-drafting would be appropriate.[70] Other respondents, such as the Royal College of Psychiatrists, emphasise that a broad definition of mental disorder is not problematic in itself, as long as it is coupled with tight criteria for the use of compulsory powers, as recommended by the Expert Committee.[71]

In response to the Government's consultation point on whether specific conditions, such as drug and alcohol misuse and sexual deviancy should be excluded on the face of the Bill, as in the 1983 Act, most organisations consider that such conditions should continue to be explicitly excluded from the ambit of the legislation.[72] The Mental Health Alliance, for example, argues that removing the exclusions "will make it easier for doctors to detain people and may lead to discrimination". It goes on to suggest that if the Government's concern is to ensure that those with dual diagnosis (for example of drug misuse and mental disorder) are not excluded, then it could state in the Bill that a "diagnosis of substance or alcohol abuse or of sexual deviancy does not preclude an additional diagnosis of mental disorder".[73] The Law Society urges that learning disability should also be explicitly excluded where not accompanied by another mental disorder.[74]

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67 Part I, para 3.3 & clause 2(6)

68 *Mental Health Bill: consultation document*, Cm 5538-III, June 2002, paras 3.18-3.26

69 Joint Committee on Human Rights, *op. cit*., pp12-13, paras 29-30

70 Law Society, *op. cit.*, para 48

71 Royal College of Psychiatrists, *White Paper on the reform of the Mental Health Act 1983: response from the College's Mental Health Sub-Committee*, June 2001

72 eg LGA, *op. cit.*, p4 & Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: response to the draft Mental Health Bill and consultation document*, 13 September 2002

73 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002

74 Law Society, *op. cit.*, para 81

4. Criteria to be met in order for compulsory powers to be used

Reflecting the two-stage approach taken by the Expert Committee, the White Paper proposed two sets of criteria, the first of which would need to be met in order for initial examination to begin, and the second (more tightly drawn) to be met in order for assessment to continue and for an order authorising medical treatment to be requested. The Bill, however, sets out just one set of "relevant conditions" to be used at all stages of the process. The two approaches are contrasted below.

a. White Paper proposals

Under the White Paper proposals, the criteria to be met at stage 1, before an initial decision can be taken to undertake an assessment, would be that:

- the patient is suffering from a mental disorder that is sufficiently serious to warrant further assessment or urgent treatment by specialist mental health services; and
- without further intervention, the patient is likely to be at risk of serious harm (including deterioration in health) or to pose a significant risk of serious harm to other people.[75]

The clinical team would be required to prepare a preliminary care plan during the first three days, unless this was impractical for exceptional reasons. If, at any point during the first three days, the patient no longer met the original two criteria for assessment, he or she would have to be discharged. Until a written care plan had been completed, treatment could only be given with the consent of the patient, unless it was deemed to be urgently necessary. This would appear to replace the initial 7-day stage envisaged by the Expert Committee.[76]

After the first three days, the criteria to be met in order for the use of compulsory powers to continue would be the same as those to be considered by the Tribunal in any future application for a care and treatment order:

- the patient would have to be diagnosed as suffering from a mental disorder within the meaning of the new legislation;
- the mental disorder would have to be of such a nature or degree as to warrant specialist care and treatment. This might be necessary in the "best interests" of the patient and/or because without care and treatment there was a significant risk of serious harm to other people;

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[75] Part I, para 3.15
[76] Part I, para 3.17 & 3.38

- a plan of care and treatment would have to be available to address the mental disorder. In cases where the use of compulsory powers arose primarily in the patient's own best interests, the plan would be expected to be of direct therapeutic benefit to the individual concerned. In cases where compulsory powers were sought primarily because of the risk that the patient posed to others, the plan would have to be considered necessary directly to treat the underlying mental disorder and/or to manage behaviours arising from the disorder.[77]

The White Paper went on to suggest that the legislation would set out certain considerations which would have to be taken into account when determining patients' "best interests". These would include how patients had responded to treatment in the past, whether their mental disorder affected their capacity to make decisions about their own care, their expressed wishes and preferences and (where patients could not decide or communicate their own wishes at the time of the assessment) information about their past wishes and preferences. Account should be taken of any "advance agreements" made by the patient in the past setting out what kind of treatment they preferred when ill. Thus, while the White Paper did not set different criteria for compulsion for those with capacity to refuse treatment, as suggested by the Expert Committee, it did make clear that a patient's capacity to make their own decisions should be a factor in determining their "best interests".[78]

b. Draft Bill proposals

The draft Bill, on the other hand, sets out the following criteria both at the initial "examination" stage and further along the pathway of compulsory powers:

- the patient is suffering from mental disorder; **and**
- the mental disorder is of such a nature or degree as to warrant the provision of medical treatment to the patient; **and *either***
- where the patient is at substantial risk of causing serious harm to others, the treatment is necessary for the protection of others; ***or***
- it is necessary for the health or safety of the patient, or the protection of others that medical treatment is provided, and it cannot be provided in any way other than under the Act; **and**
- appropriate treatment is available for the patient.

Both the White Paper and the draft Bill criteria cover situations where an individual is at substantial risk of causing serious harm to others: that is, "high risk" patients or "DSPD" patients. While the criteria in the draft Bill do not make explicit reference to treatment for such patients managing their *behaviour* as an alternative to treating the underlying condition itself, the definition of "medical treatment" in clause 2 of the Bill achieves the

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[77] Part I, para 3.18
[78] Part I, paras 3.23ff

same result by stating that "medical treatment" covers "habilitation" (defined as including education, and training in work, social and independent living skills) as well as nursing, care and rehabilitation. The term "medical treatment" thus covers interventions designed to change behaviours as well as treat recognised conditions.

The criteria in the draft Bill refer to the need for "medical treatment", rather than "specialist" care and treatment in the White Paper, and make no reference either to the need for treatment being linked to the "best interests" of the patient or to the care plan being of "direct therapeutic benefit" to the patient. It is not clear whether this reflects incomplete drafting (the consultation paper emphasises that the draft Bill is not yet complete[79]) or a change in policy. The Royal College of Psychiatrists strongly criticises these apparent changes, arguing that "the very broad criteria to which the College objected in the White Paper have now been widened even further", and urging that reference to "specialist" medical treatment should be re-inserted.[80] A number of respondents pointed out that where patients pose a substantial risk of serious harm to others there is no requirement that their treatment could not be provided other than under the Act, thus removing the emphasis on the "least restrictive alternative" for this group of patients.[81]

Many other organisations share the Royal College's concern with the breadth of the criteria, highlighting issues such as the lack of reference to health benefit for the patient[82] and the lack of reference to treatment being the "least invasive" available.[83] The Mental Health Alliance emphasises that this latter point is "an important issue, for example in relation to the overuse of depot medication and sedating injections".[84] Both the Mental Health Alliance and the Royal College of Psychiatrists in its separate response (the Royal College is also part of the Alliance), give examples of types of patient who they believe could be inappropriately subject to compulsory powers under the Bill, as currently drafted. The Mental Health Alliance suggests, for example, that a "seriously depressed woman who persistently fails to keep her appointments with the psychiatrist because she doesn't think he is helping her" could be included, as might a "young black man who has been diagnosed with schizophrenia and gets lippy with the police when he is arrested for an offence he claims he did not commit". The Royal College of Psychiatrists argues that:

> The criteria are so broadly drawn in the Bill that it is difficult to imagine many circumstances where a patient who suffered from "mental disorder" for which there was "appropriate medical treatment available" would not potentially be

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79 *Mental Health Bill: consultation document*, Cm 5538-III, June 2002, para 4.1

80 Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: response to the draft Mental Health Bill and consultation document*, 13 September 2002

81 eg Law Society, *op. cit*., para 74; *Mental Health Alliance briefing on proposed Mental Health Act reforms.*

82 Law Society, *op. cit*., para 70

83 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002

84 *ibid*

> subject to compulsion. This is likely to be a particular problem for people with long-term mental health problems such as learning disability, dementia or personality disorder, who could be subject to compulsion at any time.[85]

The Mental Health Alliance continues to argue, as first suggested by the Expert Committee,[86] that "an assessment of capacity should be the foundation of the compulsion process",[87] a view shared by the Law Society, which also emphasises that the parallel proposals in Scotland include reference to "impaired judgement".[88] Arguing for broad equivalence with the common law position covering consent to treatment for physical disorders, the Mental Health Alliance states:

> 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. While there is a case for the White Paper proposal that where a person has capacity, compulsion should also be used if s/he is at significant risk of suicide, compulsion should **never** be used to impose treatment on a person with capacity simply for that person's health or safety. A person with capacity who is assessed as posing a high risk to others may be subject to compulsion on grounds of public safety where treatment is available.[89]

The Alliance further argues that the imposition of treatment on people with capacity merely for the sake of their *own* health (as opposed to protecting others) may not be compliant with the *Human Rights Act 1998*. This issue has been considered in more depth by the Joint Committee on Human Rights, which comments that "the less favourable treatment of mental health patients as compared to other patients in terms of the administration of compulsory treatment needs to be justified" if it is to be lawful under the 1998 Act. The Committee concludes that differential treatment *is* justifiable where the patient does have "impaired judgement":

> Where a patient is suffering from a condition which seriously impairs his or her mental capacity to choose whether to accept treatment, there seems to us to be a rational and objective justification for treating that person differently, in relation to decisions about treatment, from someone whose mental capacity for decision-making is not so seriously impaired. This consideration seems to us to justify the liability of mentally disordered patients to non-consensual medical intervention where other patients would not be so liable.[90]

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85 Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: response to the draft Mental Health Bill and consultation document*, 13 September 2002

86 see pages 12-13

87 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002

88 Law Society, *op. cit.*, para 70

89 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002

90 Joint Committee on Human Rights, *op. cit.*, p16, para 40

However, the Committee goes on to highlight the fact that many patients with mental disorder will have fluctuating capacity, and even if they are not able to take decisions when particularly ill, will have "lucid intervals" when they are able to make decisions about future treatment, or non-treatment. On such "advance statements", it comments:

> We have doubts about whether it should be possible to override the wishes of the patient, expressed when capable of making a decision, about treatment. The ECHR permits treatment (including forced feeding through a naso-gastric tube) to keep a person alive against his or her will, if he or she is suffering from a mental disorder at the time, because the state can rely on its positive obligation to preserve life. The same duty would justify the state in compulsorily providing treatment to someone who would otherwise be likely to cause death or serious harm to others. But we have doubts as to whether the same principle would justify overriding a direction given with proper capacity when the patient later became ill, but not a threat to others.[91]

Although the Committee cites an ECHR judgement in 1992[92] as authority for the principle that treatment may be forced on a mentally disordered patient in order to save their own life, a recent English case (considered after the *Human Rights Act 1998* came into force) confirmed the English common-law position that a competent patient may refuse any treatment for a physical disorder, even if it leads to their death.[93] It seems possible that a challenge to the criteria for compulsion in the draft Bill, if enacted, might conceivably be made under Articles 8 and 14 of the European Convention: Article 8 protects a patient's right to respect for their private and family life (a right which has been interpreted as including respect for physical integrity and hence is relevant to compulsory medical interventions[94]) and, while contracting states may legitimately interfere with this right in certain limited circumstances, the requirement of non-discrimination in the enjoyment of Convention freedoms found in Article 14 would require them to do so in a non-discriminatory way.[95]

Finally, the Law Society, the Royal College of Psychiatrists and the Mental Health Alliance all argue that it would be helpful if the Government's promised legislation on mental incapacity were to be brought forward at the same time as the *Mental Health Bill*, so that the wider issues concerning the care and treatment of incapacitated persons could be properly considered.[96]

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91 Joint Committee on Human Rights, *op. cit*., p19, para 49

92 *Herczegfalvy v Austria*, ECHR judgement 24 September 1992, 15 EHRR 432

93 *Ms B v An NHS Hospital Trust* [2002] 2 All ER 449

94 *eg Handyside v UK* (1976) 1EHRR 737, pp753-54

95 A parallel argument has been put forward in a recent textbook on human rights as regards the currently differential treatment of adults with capacity who refuse treatment and children with capacity who refuse treatment – Garwood-Gowers et al, *Healthcare law: the impact of the Human Rights Act 1998*, 2001, p239.

96 Law Society, *op. cit*., para 106; Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: response to the draft Mental Health Bill and consultation document*, 13 September 2002; *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002

5. Care planning

As noted above, the White Paper envisaged that the new legislation would create a statutory requirement to create care plans for patients subject to compulsory powers, with a preliminary plan usually in place within three days of the start of the patient's assessment. The draft Bill retains the requirement for a care plan to be produced but extends the time limit for its production to five days from the beginning of the assessment period.[97] Where a patient is discharged from an order, a written care plan must be produced setting out any aftercare to be provided.[98]

While the initial care plan may be quite simple, the White Paper makes clear that after the full assessment has been completed the plan should set out in detail what care and treatment is to be provided, on the same basis as the "Care Programme Approach" used at present for patients living in the community who are in contact with specialist mental health services. This approach requires patients to have a written plan covering factors such as the care to be provided, the assessment of any risk posed, action needed to support them in practical ways (covering issues such as income, housing and employment) and the date of the next planned review. The White Paper makes clear that the care plan must also indicate what symptoms or behaviours it is intended to address, to make clear the link between the patient's disorder and the care or treatment being provided.[99] The draft Bill includes explicit requirements that the plan must include information about the treatment to be provided, but otherwise requires the "appropriate Minister" (ie the Secretary of State in England and the National Assembly in Wales) to make regulations governing the form of the care plan and the information to be contained within it. The Health Secretary, Alan Milburn, has emphasised that it would never be appropriate for treatment to be provided forcibly in a person's own home, if a patient refuses to consent to treatment specified in the care plan.[100] The care plan will specify what should happen if such a situation were to arise: for example whether the patient should be taken to a clinic for the treatment to be administered, or readmitted to hospital as a resident patient.

The Law Society suggests that it would be helpful for the care planning process described in the Bill and the Care Programme Approach to be amalgamated, so that the latter acquires a statutory basis;[101] the Royal College of Psychiatrists similarly highlights a lack of explicit cross-referencing in the Bill between the two processes.[102] Mixed views have been expressed as to the level of detail that should be in the care plan presented to the

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97 clause 26
98 Part I, paras 3.65-3.66
99 Part I, para 3.19
100 HC Deb 25 June 2002 c767
101 Law Society, *op. cit.*, para 58
102 Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: response to the draft Mental Health Bill and consultation document*, 13 September 2002

Tribunal: the Royal College of Psychiatrists expresses doubt as to the appropriateness or practicality of Tribunals approving detailed plans, while the Law Society argues that it is "vital … to ensure that these care plans detail the care that services intend to provide for patients, rather than allowing broad brush statements to be used".[103] The Society also suggests that the care plan should be enforceable through the courts, if necessary, if the promised services do not materialise.[104] The Mental Health Alliance is concerned that there appears to be no requirement for a *social* care assessment to take place, as it is the clinical supervisor who is responsible for the care planning process.[105]

A number of respondents argue that, following the principle of reciprocity, the Bill should continue the duty on health and social services currently found in the 1983 Act to provide free "aftercare" to patients who have been subject to compulsion.[106] The Bill as drafted requires patients being released from compulsion to have a care plan but does not appear to make this a legally enforceable right or require that it be free of charge.

6. Independent scrutiny and discharge

Patients will be discharged from compulsory assessment or treatment by their "clinical supervisor" (the consultant responsible for their care) when he or she believes they no longer need to be subject to compulsion, unless the terms of their order restrict discharge to the Tribunal. However, patients will also be able to ask the Tribunal to review their case once within the initial 28 day period, and then once during the period of any order authorising medical treatment. These safeguards are in addition to the requirements (set out in section 3 above - see page 23) that compulsory treatment orders must be routinely authorised by the Tribunal first at 28 days and then at 6 month and 1 year intervals.[107]

The Tribunal will be made up of a legally-qualified chair and two other members with experience of mental health services, one with a clinical background and the other (usually) with a background in community or voluntary sector service provision. When a Tribunal considers whether a order authorising medical treatment is justified, it will make arrangements for the patient to be seen by an independent doctor drawn from an expert panel. The expert panel will also include expertise in ethnic minority issues, social care, learning disability nursing, mental health nursing and the probation services, to be drawn on as necessary.[108] The consultation paper accompanying the draft Bill raises the question of whether it might occasionally be appropriate for the legally-qualified chair to sit alone: for example where the application relates to a simple issue of fact.[109]

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[103] Law Society, *op. cit.*, para 59
[104] *ibid*, para 61
[105] *Mental Health Alliance briefing on proposed Mental Health Act reforms,* August 2002
[106] eg Law Society, *op. cit.*, para 111 & *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002
[107] Part I, para 3.12 & clauses 20, 28, 42, 44 & 45
[108] Part I, paras 3.44-3.46 & clauses 3, 5 & Schedule 1
[109] *Mental Health Bill: consultation document,* Cm 5538-III, June 2002, paras 3.47-3.49

The White Paper made clear that there would be a right of appeal (but only on a point of law) against an order made by the Tribunal for care and treatment under compulsory powers.[110] The draft Bill sets out two stages to this process: patients may appeal to the "Mental Health Appeal Tribunal" on a point of law if given leave to do so either by the chair of the original Tribunal or by the Appeal Tribunal itself; and patients may appeal to the Court of Appeal against a decision of the Appeal Tribunal if granted leave to do so by the Appeal Tribunal or by the Court of Appeal.[111]

The Law Society "broadly welcomes" the general principle that treatment for longer than 28 days will only continue if a Tribunal agrees,[112] as does the Mental Health Alliance.[113] Both, however, argue that the powers of the Tribunal to safeguard patients will be very limited if the criteria for compulsion remain as wide as currently drafted.[114] The Zito Trust, on the other hand, is satisfied that the safeguards are sufficient to ensure patients are not inappropriately detained.[115]

A common concern among a number of respondents to the Bill has been the fact that the Tribunal will both authorise treatment in the first place and then hear appeals against that decision.[116] The Local Government Association, for example, suggests that "this could lead to an unhelpful client perception that the appeal process is a meaningless formality",[117] while the Mental Health Alliance argues that this aspect of the proposals "clearly breaches human rights principles and must be changed".[118] The Joint Committee on Human Rights does not comment on this point, but emphasises that in order to meet the requirements of the *Human Rights Act 1998* the independence of the tribunals must be guaranteed.[119] The Law Society suggests that one way of achieving this would be to move responsibility for the Tribunal from the Department of Health to the Lord Chancellor's Department.[120] The Joint Committee also expresses concern that in some case the Bill, as currently drafted, appears to place the burden of proof on a patient to demonstrate to a Tribunal that the conditions for compulsion are *not* met, rather than vice-versa, and recommends that the relevant clauses be "redrafted to make it clear that the person

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110 Part I, para 3.64
111 clauses 160-164
112 Law Society, *op. cit.*, para 94
113 *Mental Health Alliance response to the consultation on proposed Mental Health Act reforms*, www.mind.org.uk/take_action/Alliance%20response%20-%20final.doc
114 Law Society, *op. cit.*, para 103 & *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002
115 Zito Trust, oral briefing to Library, 5 December 2002
116 eg Royal College of Psychiatrists, *White Paper on the reform of the Mental Health Act 1983: response from the College's Mental Health Sub-Committee*, June 2001
117 LGA, *op. cit*., p4
118 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002
119 Joint Committee on Human Rights, *op. cit*., pp11-12, para 26
120 Law Society, *op. cit.*, para 95

advocating compulsory assessment bears the burden of persuading the tribunal that the relevant conditions are met".[121]

Considerable comment has been made on the membership of the Tribunals and of the expert panel on which they will call. The Royal College of Psychiatrists expresses concern both as to the possible effect on psychiatry if doctors are to serve as clinical members of Tribunals on a regular basis ("put bluntly, there would have to be a cancellation of out-patient clinics and reduction of other care to formal and informal patients alike") and as to the ability of the Tribunal properly to scrutinise a care plan *without* a medical member, or at least a medical expert panel member, present.[122] On the other hand, the Mental Health Alliance emphasises the value of the "clinical" member being defined to include professionals from social work or other backgrounds, hence broadening the expertise available to the Tribunal.[123] Similarly, the Alliance argues that users of services should be involved as lay members, with particular emphasis on involving black and minority ethnic users and ensuring that, where the Tribunal is considering the case of a woman patient, at least one woman is on the panel.[124] A mixed response has been given to the idea of "one person" tribunals where only simple issues of fact are at stake: the Alliance has no objection in the case of purely procedural or other technical hearings,[125] while the Law Society and the Local Government Association regard single-person sittings as undesirable.[126]

The Mental Health Alliance notes that the additional safeguard suggested by the Expert Committee, that of an independent review at seven days, has not been accepted, and expresses concern that only one application to a Tribunal is possible within the first 28 days, pointing out that if objection is made unsuccessfully to the preliminary care plan during the assessment stage, no further request for discharge can be made until the end of the 28 day period.[127] The Alliance further highlights that no timescale within which hearings must take place is indicated on the face of the Bill,[128] a point picked up by the Law Society which comments that recent judicial review cases have held that undue delay in establishing tribunals may contravene the European Convention on Human Rights.[129]

7. Safeguards for patients

Proposed safeguards for patients, in additional to the independent scrutiny role of the Tribunal, include:

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121 Joint Committee on Human Rights, *op. cit.*, p22, paras 59 & 61
122 Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: response to the draft Mental Health Bill and consultation document,* 13 September 2002
123 *Mental Health Alliance briefing on proposed Mental Health Act reforms,* August 2002
124 *ibid*
125 *ibid*
126 Law Society, *op. cit.*, para 98 & LGA, *op. cit.*, p5
127 *Mental Health Alliance briefing on proposed Mental Health Act reforms,* August 2002
128 *ibid*
129 Law Society, *op. cit.*, para 99

- the involvement of a "nominated person" in the patient's care (appointed by the approved mental health professional but ordinarily chosen by the patient);[130]
- provision for specialist independent advocacy;[131]
- encouragement to develop (non-legally-binding) "advance agreements" with clinical staff as to the care they would prefer in future episodes of illness;[132]
- requirements relating to patient consent and/or second medical opinions for certain kinds of treatment, which broadly parallel existing arrangements under the *Mental Health Act 1983*.[133]

The principle of a "nominated person" role has been welcomed by the Mental Health Alliance,[134] although both the Alliance and the Law Society comment that the nominated person will have fewer rights than are currently accorded to a detained patient's "nearest relative" under the 1983 Act: in particular the nearest relative's right to discharge the patient from compulsion in certain circumstances is removed.[135] The Mental Health Alliance further emphasises that it would be helpful for the patient's nominated person to be involved as early as possible in the process to safeguard the patient's interests.[136] The Local Government Association suggests that the role of nominated person, as currently envisaged, could lead to difficult tensions between a patient's carer and the nominated person, and also highlights the burden on local authorities in making the appointments.[137]

The *principle* of providing advocacy services has likewise been warmly welcomed; however the Mental Health Alliance argues that the proposals as they stand fall short of providing the individual with an enforceable right to an advocate.[138] The Alliance fears that without such an enforceable right, the funds will not be made available to secure adequate provision of services. The Local Government Association has also expressed concerns that dealing with referrals to advocacy services will be a considerable burden on local authorities.[139]

The role of advance statements has been the subject of considerable comment among respondents (see also section 4 above for the Joint Committee on Human Rights' comments in the context of the rights of patients with capacity). The Law Society argues that the provisions for advance statements should be set out on the face of the Bill "as a

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130 Part I, paras 5.5ff & clauses 14 & 148
131 Part I, para 5.10 & clause 159
132 Part I, paras 5.14-5.15
133 Part I, paras 5.16ff & clauses 112-120
134 *Mental Health Alliance response to the consultation on proposed Mental Health Act reforms*
135 Law Society, op. cit., para 118 & *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002
136 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002
137 LGA, *op. cit*., pp2-3
138 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002
139 LGA, *op. cit*., p2

demonstration of the Government's commitment to the principle of patient involvement".[140] The Royal College of Psychiatrists suggests that there is a "clear case for suggesting all advance agreements should have equal authority whether they relate to physical or mental disorder"[141] (which as noted above would mean that an advance *refusal* of treatment would have to be accepted, if the patient had capacity at the time of making the advance refusal), while the Mental Health Alliance suggests near equivalence:

> "There should be an obligation on professionals wishing to treat under a preliminary care plan to abide by any refusal to accept treatment that has been stated in the advance statement unless it can be shown that there is a change of circumstances that makes the refusal not in the person's best interest.[142]

The suggested safeguards relating to consent and/or second medical opinions before some kinds of treatment for mental disorder can be given, although similar to those currently found in the 1983 Act, have also generated comment. One significant change to the current situation, which would permit psychosurgery on a person unable to consent if authorised by the High Court (currently such treatment can only be given with the consent of the patient, and hence can never be given to incapacitated patients) is energetically opposed by the Mental Health Alliance which expresses "serious doubts" as to the continued use at all of psychosurgery.[143] The Alliance argues for stricter safeguards on the use of electro-convulsive therapy (ECT), proposing that ECT should *never* be given to a patient against his or her will if the patient has the capacity to give or withhold consent. Under the proposals in the Bill, ECT could be given to a patient against his or her will if authorised by the Tribunal or in cases where it was regarded as immediately necessary, for example to save the life of the patient or to prevent him or her from behaving violently.[144] Similarly, the Alliance believes there should be special safeguards against polypharmacy (combinations of the same class of drug) and very high dose drugs.

The Joint Committee on Human Rights comments that while dispensing with consent for certain kinds of hazardous treatment such as ECT *may* be justifiable under the *Human Rights Act 1998*, such interference with respect for the patient's private life (Article 8) must be proportionate. The Committee suggests that clause 119, which sets out the circumstances when treatment may be regarded as "immediately necessary" should be redrafted; in particular it queries whether the possibility of violence is sufficient to justify treatment if not accompanied by a significant risk of significant harm to others, or in cases where other less hazardous means of restraint are available.[145]

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[140] Law Society, *op. cit.*, para 54

[141] Royal College of Psychiatrists, *White Paper on the reform of the Mental Health Act 1983: response from the College's Mental Health Sub-Committee*, June 2001

[142] *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002

[143] *ibid*

[144] clauses 118-119

[145] Joint Committee on Human Rights, *op. cit.*, p26, para 72

8. The future of the Mental Health Act Commission

The White Paper proposed there should be a Commission for Mental Health (effectively a slimmed-down Mental Health Act Commission) with responsibility for monitoring the implementation of the safeguards set out in the new legislation, collecting data and overseeing standards of specialist advocacy, but without the Mental Health Act Commission's current role of visiting detained patients.[146] However, in between the publication of the White Paper and the draft Bill, in April 2002, the Secretary of State for Health announced an expanded role for the NHS-wide body, the Commission for Health Improvement:[147] a new "Commission for Healthcare Audit and Inspection" (CHAI) is intended to combine the health-related roles of the Commission for Health Improvement, the National Care Standards Commission[148] and the value-for-money studies carried out by the Audit Commission when legislation permits.[149] The consultation paper accompanying the draft Bill highlights the potential role of this new body which it suggests would be better placed than a separate organisation to ensure effective scrutiny of all aspects of the mental health system.[150] The consultation paper also seeks further views on the most appropriate mental health scrutiny functions to give to CHAI under the new legislation, suggesting the following three elements (which diverge slightly from those proposed in the White Paper):

- collecting information about the use of compulsory powers;
- visiting patients when there is cause for concern about their care;
- acting on what it learns through its monitoring function: investigating complaints and circumstances of deaths, reporting on the use of the Act and advising on standards for advocates.

In response, the Local Government Association argues that the Mental Health Act Commission should be reformed, rather than disbanded, on the basis that the new health inspectorate might be too general a body to carry out such a specialist role.[151] The Law Society is similarly concerned that mental health scrutiny might become "less of a priority within a larger and more generalised health inspectorate" and notes that not all the Mental Health Act Commission's functions, in particular proactive visiting rights, are to be transferred under the proposals.[152] The Mental Health Alliance, on the other hand, while agreeing with the Law Society that the Commission's "unique functions should be replicated", sees "some merit in it being placed in a wider inspectorate.[153]

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146 Part I, paras 7.5ff
147 currently responsible for reviewing the quality of care provided by NHS bodies
148 currently responsible for regulating the private health sector
149 see Library Research Paper 02/30 for further information
150 *Mental Health Bill: consultation document,* Cm 5538-III, June 2002, paras 3.1-3.4
151 LGA, *op. cit*., p4
152 Law Society, *op. cit*., para 109
153 *Mental Health Alliance briefing on proposed Mental Health Act reforms,* August 2002

The Joint Committee on Human Rights comments that it can only be a "matter of speculation" whether the Government's proposals still provide as close regulation of the system as could be exercised by a specialised Commission but argues that it is "vital" for there to be a body capable of taking an overview of the mental health system, based both on the collection of statistics and reports and on visits to particular places and people.[154] The Royal College of Psychiatrists similarly emphasises the importance of both data collection and individual patient visits for effective scrutiny and comments that the Commission for Health Improvement tends to focus on *systems* in hospitals rather than on making visits to individual patients.[155]

9. Interaction with the criminal justice system

As in the *Mental Health Act 1983*, the proposals in the White Paper and the draft Bill make provision for individuals to become subject to compulsory powers via the criminal justice system. The criteria to be used in determining whether compulsory powers may be used are similar to those for patients accessing the system via the "civil" procedures: there is, however, no reference made in the Bill to the treatment being necessary for the health and safety of the patient or others.[156] An additional practical condition is that arrangements have actually been made to admit the patient to hospital or arrange suitable services in the community. Under the provisions set out in Part 3 of the draft Bill, courts would be able to:

- remand individuals on bail or to hospital for mental health reports;[157]
- remand or commit individuals to hospital for medical treatment, in place of remanding or committing them in custody;[158]
- make a "mental health order", based on a care plan (which could relate to compulsory care and treatment to be delivered in the community as well as in hospital) submitted to the court, in place of sending a convicted offender to prison;[159]
- make a "restriction order", in addition to a "mental health order", to ensure that the Home Secretary will be closely involved in the management of the patient: for example the patient could only be transferred to another hospital or given leave of absence with the consent of the Home Secretary;[160]

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154 Joint Committee on Human Rights, *op. cit*., p31, paras 88-89

155 Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: response to the draft Mental Health Bill and consultation document*, 13 September 2002

156 Part I, para 4.3 & clauses 64 & 78

157 Part I, paras 4.5-4.7 & clauses 57 & 59

158 Part I, paras 4.5-4.7 & clauses 62-64

159 Part I, para 4.10 & clause 78-79

160 Part I, para 4.10 & clause 86; clause 86 sets out details of the "special restrictions", which include those cited above, but also permits the Secretary of State to make Regulations setting out further provisions relating to those under restriction orders. Such further provisions could cover areas such as arrangements for patient advocacy, the role of the clinical supervisor and the involvement of the Mental Health Tribunal.

- make a "hospital and limitation direction", under which the convicted person would be sent first to hospital for treatment but could later be transferred to prison if treatment was no longer necessary or beneficial.[161]

Mentally disordered prisoners (or those where mental disorder is suspected) may also be transferred from prison to hospital, either for medical reports or for treatment.[162] Such transfer orders will usually be accompanied by a restriction order, as described above, to ensure that the Home Secretary remains involved in decisions about their management.[163]

If a "mental health order" is made without "restrictions", individuals effectively pass out of the criminal justice system and into the "civil" system: their clinical supervisor must discharge them as soon as she or he is satisfied that the conditions which led to the order being imposed are no longer in force. Also, in order for compulsory treatment to continue after six months, a Tribunal must confirm that the "civil" criteria (ie those set out in clause 6 which apply to non-offender patients) are met.[164] However, where offenders are subject to restrictions (including those subject to a "hospital and limitation direction"), the role of the Tribunal will be broadly similar to the current function of the Mental Health Review Tribunals under the 1983 Act: it will not be required to confirm each new order, but will simply be required to review intermittently whether the criteria for the order are still satisfied. If the criteria are not satisfied, then the Tribunal will be able to order the individual's discharge, either absolutely or with conditions.[165] However, where the patient has been transferred from prison, or sentenced by a court with a hospital and limitation direction, "discharge" will be back to prison, not to the community.[166]

The consultation paper accompanying the draft Bill further seeks views on whether it would be appropriate for compulsory powers to be used for prisoners within prisons, so that a care plan could stipulate particular treatment without the need for the patient to be transferred to hospital.[167] While comparing this approach with the position of patients being cared for compulsorily in the community, rather than in hospital, the consultation document acknowledges that safeguards may be necessary:

> Considerable work will be needed to ensure that appropriate safeguards are in place, both for the prisoner patient and for those providing treatment, so that prisoners are not disadvantaged simply because they are prisoners. For example, it will be important to safeguard against compulsory treatment orders being used

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[161] Part 1, para 4.10 & clause 89
[162] Part 1, para 4.11 & clauses 92 & 94
[163] Part I, para 4.12 & clause 98
[164] clause 83 & Schedule 5
[165] Part I, para 4.15 & 4.18 & clause 104
[166] clause 105
[167] *Mental Health Bill: consultation document*, Cm 5538-III, June 2002, para 3.42

> as an alternative to transfer to NHS hospitals where that is what the prisoner patient really needs.[168]

Views are invited on what safeguards would be required, and on what alternatives there might be to compulsory treatment in prisons which would ensure that prisoners obtain the mental health care they require.

The main provisions concerning offenders appear to have generated much less comment than other aspects of the draft Bill. The Mental Health Alliance comments that "there appears to be too little thought given to offenders in this Bill", with many of the provisions carried through without change from the 1983 Act, and goes on to argue that if the wide definition of mental disorder in the Bill were to be retained "fewer than half those appearing before the courts are likely to escape the possibility of being sent for a mental health report under this provision".[169] Particular points of concern for the Alliance are the apparent lack of a right of appeal against been sent for a mental health report and the fact that there is no requirement that the treatment be necessary for the health or safety of the patient or safety of others:

> Does this mean for instance that a depressed woman on a shoplifting charge or a substance abuser on a charge of possession of illegal drugs could find themselves put on a community treatment order – and even if they are not convicted of the offence?[170]

In addition, the Alliance opposes the provision that assessment under these provisions could continue for up to 16 weeks, arguing for a maximum period of 12 weeks, and expresses some doubts that courts will have the necessary skills to scrutinise care plans.

The suggestion in the consultation paper that prisoners could be subject to compulsory treatment for mental disorder while remaining in prison has, however, received considerable attention, with the general reaction being that this would be quite inappropriate. Both the Law Society and the Joint Committee on Human Rights suggest that such treatment might breach the European Convention, pointing to the case of *Aerts v Belgium*[171] which held that compulsory treatment in an inappropriate therapeutic environment could constitute inhuman and degrading treatment (as prohibited by Article 3 of the Convention).[172] The Zito Trust, which otherwise supports all aspects of the Bill, opposes this suggestion, on the grounds that patients with mental disorders warranting compulsory treatment should not be in prison.[173] The Mental Health Alliance agrees with other respondents that it would be "entirely inappropriate" to allow compulsory treatment

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168 *Mental Health Bill: consultation document*, Cm 5538-III, June 2002, para 3.38
169 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002
170 *ibid*
171 *Aerts v Belgium* [1988] EHRLR 777
172 Law Society, *op. cit*., para 122 & Joint Committee on Human Rights, *op. cit*., p25, para 67
173 Zito Trust, oral briefing to Library, 5 December 2002

in prison, pointing out that none of the support or safeguards promised for patients subject to compulsion in the community would be in place in prisons and, moreover, if patients were so ill then "by definition they should be in a therapeutic hospital environment, not a prison".[174]

10. Other issues

This Paper cannot exhaustively cover the provisions set out in the White Paper and the draft Bill. The following bullet points briefly highlight other aspects of the proposals:

- There will be statutory provisions to ensure that information is shared between health, social care and criminal justice agencies where disclosure is in the best interests of the patient or to prevent a significant risk of serious harm to others.[175] The consultation paper highlights the Government's concerns that currently information is not always being shared "because the rules governing confidentiality are misunderstood between professionals", and seeks views on whether the creation of a general duty to co-operate in the supply of information will "do enough to ensure that information will be shared to improve patient care and to minimise risk to patients and others".[176] In response, the Law Society argues that consent to such information-sharing should still be sought,[177] while the Royal College of Psychiatrists expresses concerns that some patients, particularly those taking illicit drugs, would be discouraged from seeking help if they knew that information about them would be passed to the police.[178]

- The Government intends to include provisions in the Bill which would give the victims of mentally-disordered offenders the right to certain information about the offender, such as notification of release dates from hospital.[179] The Law Society has argued that these provisions should not exceed those which already exist for victims of serious crimes under the criminal justice legislation.[180]

- There will be new safeguards for "Bournewood" patients: that is, those who are living in a mental health hospital on a voluntary basis, rather than under compulsory powers, but who lack the mental capacity to make their own health and welfare decisions. These provisions are discussed further in a Library standard note.[181]

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174 *Mental Health Alliance briefing on proposed Mental Health Act reforms,* August 2002
175 Part I, para 5.33
176 *Mental Health Bill: consultation document*, Cm 3358-III, June 2002, para 3.32
177 Law Society, *op. cit.*, para 85
178 Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: response to the draft Mental Health Bill and consultation document*, 13 September 2002
179 *Mental Health Bill: consultation document*, Cm 5538-III, June 2002, para 4.2
180 Law Society, *op. cit.*, para 87
181 *"Bournewood" patients and the reform of the Mental Health Act 1983*, SN/SP/153

- The consultation document seeks views on how the new mental health legislation should apply to children, and how the need to recognise young people's own rights can be balanced with the need to respect the rights of their parents to be involved in treatment decisions. In particular, it suggests that children of 16 and 17 should be treated on the same basis as adults, while children under 16 who have the capacity to make their own treatment decisions should only be treated on the basis of their parents' consent for a maximum of 28 days, with special safeguards applying thereafter.[182] The Mental Health Alliance welcomes this approach but feels that it does not go far enough, in that children under 16 may still be treated against their will for up to 28 days, even if they have the capacity to consent for themselves, without any recourse to a Tribunal.[183]

B. High risk patients

As discussed in Part III of this Paper (see page 17), the Home Office consultation paper, *Managing dangerous people with severe personality disorder*, sought views on two possible ways of detaining and managing such individuals: Option A, which would involve building on existing services in the NHS and prison service, but making changes to the legal framework to permit the detention of "untreatable" individuals with personality disorder; and Option B which would require the development of a new "third" service, separate from the NHS and the prison service, precisely for individuals in this category.[184] Acknowledging the concerns many respondents had expressed about the proposals, in particular how widespread the use of the powers would be for non-offender patients, the White Paper stated:

> The Government has decided that before taking final decisions on how best to provide services for this group in the long term, it needs to pilot and evaluate the assessment process and the various treatments available for this group within existing service structures. At the same time, we will bring forward those legislative changes that will be required whether Option A or Option B is adopted. Our proposals for reform of the *Mental Health Act 1983* will provide a new framework of powers which will provide for the detention of dangerous people with severe personality disorder in a therapeutic environment for as long as they pose a risk to others as a result of their mental disorder.[185]

The two sections below highlight firstly those aspects of the draft Bill which particularly address the Government's concerns as to the management of high risk patients and comments made on them during the consultation period, and secondly the service developments which are taking place under current legislation.

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[182] *Mental Health Bill: consultation document*, Cm 3358-III, June 2002, paras 3.6-3.10
[183] *Mental Health Alliance briefing on proposed Mental Health Act reforms,* August 2002
[184] see above p18
[185] Part II, para 2.12

1. Draft legislative provisions

As described in section IVA4 above (see page 25), the criteria for the use of compulsory powers in the draft Bill are drafted in such a way as to include both individuals who are judged to need treatment for their own benefit, and those who are regarded as a high risk to others because of the nature of their mental disorder. Under clause 6 of the draft Bill, "high risk" individuals could be subject to compulsory powers (either in the community or in hospital) on the basis that:

- they are suffering from a mental disorder; and
- the mental disorder is of such a nature or degree as to warrant the provision of medical treatment; and
- where the patient is at substantial risk of causing serious harm to other persons, it is necessary for the protection of those persons that medical treatment is provided; and
- appropriate medical treatment is available in the patient's case.

Where individuals are judged to be "at substantial risk of causing serious harm to other persons", the criteria would therefore permit treatment to be given compulsorily, regardless of whether or not it was of direct therapeutic benefit to the individual.

While at first glance the "treatability" criterion which Ministers criticised in the 1983 Act would appear still to be present in the new conditions for compulsory treatment, the definition of "medical treatment" is wide enough to include interventions aimed at modifying the *behaviour* of individuals:

> "Medical treatment" means treatment for mental disorder provided under the supervision of an approved clinician; and for this purpose "treatment" includes –
> (a) nursing
> (b) care
> (c) habilitation (including education, and training in work, social and independent living skills), and
> (d) rehabilitation (read in accordance with paragraph (c))[186]

This would appear to clarify the issue raised by the Health Select Committee as to how the "interventions" envisaged by the Home Office were different in kind from the "treatment" which was regarded under the 1983 Act as not benefiting the patient (see above pages 18-19).

The White Paper suggests that the assessment process currently being piloted to determine whether an individual is "high risk" and what "treatment" would help manage

[186] clause 2(5)

that risk may take up to three months.[187] The draft Bill therefore allows for a patient's clinical supervisor to apply to the Tribunal for further orders authorising assessment if it is not possible after the initial 28 days to seek an order authorising treatment. However, the total assessment period may last no more than three months after the first application to the Tribunal.[188] Similarly, individuals before the courts could be remanded for assessment for up to 16 weeks.[189]

The White Paper also highlights that the *Mental Health Act 1983* permits convicted prisoners to be transferred from prison to hospital for "treatment", but not for what it describes as a "period of specialist assessment without treatment".[190] The draft Bill would permit transfer from prison to hospital for up to sixteen weeks for a "mental health report", in addition to permitting transfer for treatment, as at present.[191] The White Paper also envisages that specialist assessment centres would be developed within prisons, so that prisoners could be assessed without the need for such a transfer.[192]

The proposals for "high risk" patients have continued to generate strong views, despite the fact the controversial term "DSPD" is not used in the draft legislation. The Law Society argues that the Bill's perceived focus on danger will reinforce the stigma often associated with mental disorder, suggesting that "this may well discourage people with mental health problems for seeking help".[193] The Royal College of Psychiatrists similarly argues that the provisions may lead to the stigmatising of psychiatry and "aversion to approaching services" on the part of patients, resulting in "reduced patient benefit and public safety".[194] In addition to these concerns as to the effect that the provisions for "high risk" patients may have on other mental health patients, a number of organisations have been highly critical of both the philosophy behind the provisions and detailed aspects of them.

The Royal College of Psychiatrists believes that it is not appropriate to compel individuals into treatment or hospital solely to prevent criminal behaviour.[195] This view is echoed by the pressure group Liberty, which has been quoted in the *Health Service Journal* as arguing that:

> The bill blurs the distinction between treatment and care to get round the point, basically suggesting that because you can conceivably care for some one with

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187 Part II, para 6.42
188 clause 32, 35 & 40
189 clauses 59 & 61
190 Part II, para 4.11
191 clause 92
192 Part II, para 4.11
193 Law Society, *op. cit.*, para 73
194 Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: response to the draft Mental Health Bill and consultation document*, 13 September 2002
195 *ibid*

> DSPD, then you are right to detain them. But you can ask any doctor or nurse, any clinician, and treatment and care are fundamentally different.[196]

The Royal College has, indeed, described the proposals as "internment without trial".[197] Michael Howlett of the Zito Trust, on the other hand, has written to the *Guardian* to defend the principle of assessing the risk of those with severe personality disorder in advance of any offence being committed if this is done with a view to providing that person with treatment.[198]

The Mental Health Alliance describes the proposals as "fundamentally flawed", asking why mentally disordered individuals should be "subject to a preventive detention regime when other groups that pose as high – if not higher – risks are not covered?"[199] The Alliance further expresses fears that such detention could be a breach of the *Human Rights Act 1998*. The Joint Committee on Human Rights is of the view that the detention of a person suffering from a recognisable mental disorder may be lawful under Article 5 (right to liberty and security) of the European Convention, even if there are no effective therapeutic interventions available to treat him or her, if there is objective evidence that this is necessary to protect the public. However, the Joint Committee also points out that Article 3 of the Convention, which forbids inhuman or degrading treatment, could potentially be breached if such patients are not held in an appropriate therapeutic environment with access to specialist psychiatric expertise.[200]

Finally, the issue of risk has been hotly debated, with respondents arguing both that the risk posed to the public by those suffering from severe personality disorders has been significantly exaggerated and that the enormous difficulties inherent in making accurate risk-assessments should not be overlooked.[201] The Law Society, for example, argues that "in our view the emphasis on risk is misplaced and the Government should redraft its proposals accordingly"; in particular, the Society highlights figures given earlier in the year in parliamentary answers which suggested that the Government expects only an additional 124 people per year to come under these "high risk" provisions, on top of those who could currently be detained under the "treatability" requirements of the 1983 Act.[202] The Royal College of Psychiatrists argues that the difficulties involved in predicting risk of either suicide or homicide are such that, even taking just the high-risk group, one hundred patients would need to be detained unnecessarily in order to prevent one suicide, while (even using far more sensitive tests than are currently available) 5,000 people

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196 "Danger signals", *Health Service Journal*, 4 July 2002, pp10-11

197 Royal College of Psychiatrists, *White Paper on the reform of the Mental Health Act 1983: response from the College's Mental Health Sub-Committee*, June 2001

198 "The case for compulsion", *Guardian*, 28 June 2002, p17

199 *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002

200 Joint Committee, *op. cit*., pp14-15, paras 34-35

201 eg *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002

202 Law Society, *op. cit.*, paras 75-79 & HL Deb 22 July 2002 ccWA4-5

would need to be detained to prevent one homicide.[203] The Joint Committee on Human Rights similarly notes that "there would be serious problems of risk assessment" in the proposed system and suggested that:

> In relation to the compulsory detention of dangerous people with severe personality disorders, we recommend that the Government should make publicly available an account of risk factors to be used in assessing such cases and their reliability, when introducing the Bill to Parliament.[204]

Finally, concerns have been expressed about the practicality of the proposals, with the Law Society and the Mental Health Alliance commenting on the cost (with the suggestion that the funding would be better spent on early intervention services)[205] and the Royal College of Psychiatrists expressing the fear that the provisions would resulting additional pressure on "already over-crowded and ill-equipped facilities".[206]

2. Service development

Chapter 6 of Part II of the White Paper provides details of the service developments being planned and piloted by the Government, pending a decision on whether or not it would be appropriate to develop a new service for DSPD individuals, separate from the NHS and the prison service. Emphasising that before new legislative powers can be applied "safely and ethically" to such individuals, appropriate services must be created, the White Paper sets out the following developments and proposals:

- pilot assessment centres in Rampton Special Hospital and HMP Whitemoor, where "over the next three years, new approaches to assessment and treatment will be piloted and systematically evaluated in new facilities";
- 140 additional secure places in the NHS for DSPD individuals by April 2004;
- 75 specialist rehabilitation hostels by April 2004, to support personality disordered patients who are assessed as safe to be rehabilitated in the community;
- 80 refurbished places for DSPD individuals in prisons by October 2001;
- 110 new places for DSPD individuals in prisons to be open by April 2003;
- research on the most appropriate services for the limited number of women regarded as DSPD;
- better co-ordination between services in prison and in the NHS, with a focus on shared standards and closer links between practitioners;

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[203] Royal College of Psychiatrists, *White Paper on the reform of the Mental Health Act 1983: response from the College's Mental Health Sub-Committee*, June 2001

[204] Joint Committee, *op. cit.*, p18, para 47

[205] *Mental Health Alliance briefing on proposed Mental Health Act reforms*, August 2002 & Law Society, *op. cit.*, para 124

[206] Royal College of Psychiatrists, *White Paper on the reform of the Mental Health Act 1983: response from the College's Mental Health Sub-Committee*, June 2001

- a project team drawn from the NHS and the prison service to oversee the transition from the pilot stages to the new legislative and service framework.[207]

Pending the proposed legislative changes, any such services within prisons can only be provided on a voluntary basis, as competent individuals cannot currently be forced to accept compulsory treatment in prison. However, the White Paper envisages that in future it would be possible for the Home Secretary to order the transfer of a prisoner for a "mental health report" either to an NHS facility or to a specialist facility in prison.[208] The White Paper suggests that, should the Government decide to proceed with Option B (the "third service"), the new facilities being developed could provide the core of that service.[209] The consultation document accompanying the draft Bill also seeks views on whether, in any case, it would be appropriate to introduce measures permitting individuals to be treated without their consent in prison (see above p29).

C. General responses to the White Paper and draft Bill

Detailed comments on specific aspects of the proposals have been included in section 4A above, in the commentary on the main provisions of the draft Bill. This section provides a general overview of the opinions expressed about the White Paper and the Bill as a whole, both in the press and by a range of interested organisations.

1. Initial responses to the White Paper

Much of the initial press comment on the White Paper focused more on the proposals relating to high risk patients than on the wider details of the new legislative framework, with a wide range of opinions on whether the need to protect the public justified the civil liberties implications of the proposals.[210] On the wider issues, the *Health Service Journal* reported concerns among mental health charities that "concessions in the Government's mental health white paper do not go far enough to balance the rights of the individual against powers for compulsory treatment", with particular anxieties about the lack of a right to an assessment which might enable people suffering mental distress to seek help before the use of compulsion became necessary.[211] In a letter to the *Times*, on the other hand, the charities Mind, the Mental Health Foundation, United Response and the National Schizophrenia Fellowship (now known as "Rethink") suggested that, while the White Paper was seen as an improvement on the Green Paper, much would depend on the actual services available to patients:

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[207] Part II, paras 6.23 – 6.36

[208] Part II, para 6.29

[209] Part II, para 6.29

[210] eg "'Campus care' for psychopaths", *Guardian*, 21 December 2000, p8; "Attacks overshadow the thousands of suicides", *Independent*, 21 December 2000, p6; "Dangerous mental patients may be detained indefinitely", *Telegraph*, 21 December 2000, p2; "Incarceration is no substitute for a mental health policy", *Independent*, 21 December 2000, p3 of Review section

[211] "Users 'lack rights in white paper'", *Health Service Journal*, 4 January 2001, pp4-5

> What a shame that coverage of the Government's White Paper on mental health concentrated so heavily on plans for the small number of people with so-called dangerous severe personality disorder (DSPD), rather than the impact upon millions of people who experience mental health problems each year.
>
> This is primarily a health reform, not a public safety law. Focusing so much on the proposals for DSPD under the heading of mental health law reform supports the misconceived view that mental health walks hand-in-hand with danger.
>
> One person in six experiences mental health problems and around 630,000 people are in contact with mental health support services at any one time. The DSPD proposals will touch just a fraction.
>
> The White Paper has laudable aims – raising service quality, expanding the number of services and improving access to them, as well as improving safeguards for individuals.
>
> It also states the aim "to reduce, wherever possible, the number of individuals who are subject to the use of powers for compulsory care and treatment" and to take on the stigma that turns people with mental health problems into easy targets for discrimination.
>
> These reforms will stand or fall by whether the laudable aims are turned into reality.[212]

A similarly mixed response was found in the *BMJ*, where a commentator described the prospect of compulsion in the community as "controversial", but felt that the White Paper's emphasis on patients' "best interests", and the definition of best interests to be used, was a sign that the Government was now more sympathetic to the initial thinking of the Expert Committee:

> Of major importance is the distinction, commendably drawn, between treatment in the patient's "best interests" and compulsory powers sought because of risk to others. The former looks at best interests from the patient's perspective, including taking account of any advance agreements and the views of others about the patient's past and present wishes and feelings. The care plan must be of "direct therapeutic benefit". This is getting close to legislation centred on "capacity", as supported by the Richardson expert committee and others. Though capacity itself receives scant attention, this is nevertheless a welcome advance.
>
> When detention is on the grounds of risk to others, if the care plan cannot directly address the underlying mental disorder it may instead address the management of "behaviours arising from the disorder" – an often repeated and apparently key

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[212] Letters to the Editor, *Times*, 29 December 2000, p25

> phrase. It means that "treatability" is not necessary. The tension between compulsion in the interests of the patient's health and compulsion to protect others is rightly exposed – distinct ends are involved. The government holds that a mental health act is a legitimate means to achieve both ends.[213]

The chair of the Expert Committee, Professor Richardson, however, was reported as describing the White Paper proposals as an "unacceptable step back in time", fearing that failure to tighten the central criteria for compulsory treatment would "fling open the door" to widespread use of professionals' powers to impose treatment, and arguing that it was crucial for compulsory detention in NHS units to be permitted only if there was a direct "health benefit" to the patient.[214]

2. General responses to the Bill

The publication of the draft Bill has generated a hostile response from the Mental Health Alliance, an umbrella group of around fifty organisations, including the British Association of Social Workers, the King's Fund, the Mental Health Foundation, Mind, Rethink, the Royal College of Nursing, the Royal College of Psychiatrists and SANE. The Alliance's briefing on the Bill begins with the following general commentary:

> The Alliance is most disappointed that key points expressed in recommendations of the Richardson Committee, expert opinions and our responses to Government have not been accepted in this Bill. We have grave disquiet about its central provisions, which we consider are unworkable and regressive. There are some welcome aspects of the Bill but we fear that these may fail to work effectively in the proposed framework.
>
> We are also concerned that the Bill does not appear to be joined up with the progressive developments initiated by the government in service provision. The implementation of the National Service Framework would ensure better care for service users and lead to less need for compulsion while the Bill appears to tend in the opposite direction. We consider that an improvement in community and inpatient services would better alleviate some of the problems that the Government is seeking to address by the use of compulsory powers. Indeed the increase in the use of compulsion which will we believe 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 fear that this Bill is not workable because of the resources it will require. The Royal College of Psychiatrists has estimated that it will require 600 more psychiatrists, other areas of the mental health work force are already understaffed and vacancies exist in current staffing.[215]

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213 "A new mental health (and public protection) act", *BMJ*, 6 January 2001, pp2-3
214 "Door slammed", *Guardian*, 17 January 2001, p4 of Society section
215 www.mind.org.uk/take_action/MHA_full_consulataion_briefing.htm

The Alliance organised a lobby of Parliament on 23 October 2002 to protest against the draft Bill.[216] It has also published a list of "common concerns" shared by Alliance members which highlight the approach they would like the Government to take to mental health law reform:

> **Common Concerns**
>
> Members of the Mental Health Alliance share the following views on reform of the Mental Health Act:
>
> - The aim of the new legislation should be to reduce the need for using compulsory powers.
> - The new legislation should offer people an individual enforceable right to a comprehensive assessment of their needs; and to have their identified needs met with appropriate and good quality services.
> - A free independent advocate should be made available to everyone at all times, from the point of assessment; and the Government should provide adequate resources for this on a national basis.
> - The current law takes insufficient account of people's capacity to make their own treatment decisions and leaves those deemed to lack capacity without proper protection. New legislation must address both these issues in conjunction with wider incapacity legislation. Incapacity must not be equated with disagreeing with your doctor and must be sensitive to cultural differences.
> - People with mental health problems should have the right to draw up advance statements on their care and those they want involved in such care. Such statements should be legally enforceable such that a person who has lost capacity (whether detained or not) has the same rights as someone who has retained capacity.
> - There should be a duty for full information to be provided on any proposed treatment and for informed consent to be sought in every case. Special safeguards should continue to apply to psychosurgery, ECT and long-term drug treatment and should be extended to polypharmacy, prescribing above BNF levels and force feeding. [217] Where treatment is given without consent it should be subject to independent review including a second medical opinion and involving consultation with patients and their representatives.
> - We support the formation of new independent tribunals as long as they reflect the community they serve, comprise a breadth of experience (including that of service users) and receive appropriate training. There

[216] "MPs to be told truth about draft Bill by real mental health experts", Mental Health Alliance press notice, 23 October 2002

[217] The British National Formulary (BNF) is a guide for general practitioners setting out recommended dose levels for medication. We define polypharmacy as the concurrent administration of two or more drugs for mental disorder from the same BNF class [footnote from original source]

should be an independent appeals procedure against the Tribunal's initial decision.

- Whilst we recognise the Government's concern about public protection, we continue to have doubts about the need for the powers proposed in relation to high risk patients. In particular we have concerns about:
  i. The application of the powers to non-offenders regardless of whether or not they can be treated.
  ii. The availability of sufficiently accurate risk assessment procedures to ensure that only people who pose an unacceptable danger would be incarcerated under the proposals.
  iii. The introductions of powers before there is an adequate evidence base and without the existing pilots being evaluated.
  iv. The disproportionate impact of such powers on groups who already face discrimination in the mental health system.[218]

A number of commentators in the health press have noted that the proposals in the draft Bill have united organisations which usually take up very different stances on mental health issues, with the *Health Service Journal*, for example, quoting a Royal College of Psychiatrists' spokesman as saying:

> The government appears to have had one enormous success – we are all opposed to this, all the mental health professionals and the mental health alliance.[219]

It should, however, be noted that at least one high-profile mental health organisation, the Zito Trust, has not joined the Alliance, and supports virtually all aspects of the draft Bill.[220]

Despite rumours that the absence of a *Mental Health Bill* in the Queen's Speech meant that the proposals had been dropped, the Secretary of State for Health, Alan Milburn, made very clear during the debate on the Address that the Government intended to "press ahead with reform of the mental health laws" and that a Bill would be brought forward during the 2002-03 Session, as soon as all the responses to the draft Bill had been considered.[221] The Liberal Democrat health spokesperson, Dr Evan Harris, welcomed the fact that the Government appeared to be re-considering aspects of the Bill and hoped that it would "bring back the Bill in a more acceptable form".[222] The Conservatives have similarly expressed opposition to the draft Bill as it currently stands, with their health spokesman, Liam Fox, tabling an EDM summarising the nature of their concerns:

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218 www.mind.org.uk/take_action/MHA_Common_Concerns.asp

219 "Danger signals", *Health Service Journal*, 4 July 2002, pp 10-11; see also "Draft mental health bill unites critics", *BMA News*, 6 July 2002, p3

220 "The case for compulsion", *Guardian*, 28 June 2002, p17 & Zito Trust, oral briefing to Library, 5 December 2002

221 HC Deb 14 November 2002 c170

222 HC Deb 14 November 2002 c192

That this House expresses grave disquiet at the curtailment of liberty involved in proposals in the Government's draft Mental Health Bill, which would permit the detention of individuals who had not committed a criminal offence, nor were suffering from a mental disorder requiring therapeutic treatment; considers that the wide extension of powers of compulsion to patients in the community will impose unfair burdens on staff and damage relationships between patients and clinicians and dissuade patients from seeking help; congratulates the Mental Health Alliance on their campaign against the draft Bill; and calls on the Government to withdraw it and come forward with a bill that meets the need for modern procedures, whilst recognising the right of users of mental health services to prompt assessment and dignified treatment, which is the least restrictive and invasive that is appropriate and necessary.[223]

[223] EDM 12 of 2002-03

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