



# Mental Health Act Commission

## POLICY BRIEFING FOR COMMISSIONERS

November 2006

## The Mental Health Bill 2006

The following notes set out the main proposals of the new Mental Health Bill with a few comments on immediate matters of concern that occur to the Policy Team. What follows is not, therefore, an MHAC 'line' on the Bill – indeed we hope that it will stimulate discussion amongst Commissioners on the proposals.

### Part I – amendments to the MHA 1983

#### Chapter 1 - Definitions & Criteria for Compulsion

##### 1. Removal of categories of mental disorder (clauses 1 – 2)

The Bill removes the categories of mental illness, mental impairment, severe mental impairment and psychopathic disorder from the 1983 Act, relying instead on a generic definition of mental disorder, being 'any disorder of mind or brain'. The MHAC's previous position on this has been to ask whether the remaining criteria for detention or treatment are sufficient to prevent over-inclusiveness in the potential applicability of the Act's powers to mentally disordered people.

However, the Bill retains a behavioural test for people with learning disability that reserves MHA powers to such patients whose disability is "associated with abnormally aggressive or irresponsible conduct". This will continue to prevent Guardianship powers (or admission to hospital under MHA powers) being used for the protection of LD patients who do not meet such a behavioural criterion but are vulnerable to exploitation and abuse.

##### 2. Exclusions

Government has conceded an exclusion to the definition of mental disorder regarding dependence upon alcohol and drugs (clause 3). As the Explanatory Notes acknowledge, addictions fall under clinical classifications of mental disorder (i.e. under ICD-10 or DSM-IV), but this exclusion clause prevents them from falling within the scope of the Act. Government has not, however, conceded calls for similar exclusions relating to "sexual behaviour or orientation; or commission, or likely commission, of illegal or disorderly acts" (MHAC 2005). The Government's line on this is, firstly, that disorders of sexual preference such as fetishism and paedophilia should be within the scope of the Act, and secondly, that there is no longer any need to specify that "immoral conduct" or "sexual orientation" is not a mental disorder because there is no danger of these being construed as such in today's clinical practice (Explanatory Notes para 31-5). Nevertheless, a version of the remaining exclusions is given in the Code of Practice (para 1B.15-6).

There may well be calls for the principles contained in the Code of Practice to be elevated onto the face of the Bill, taking the Scottish legislation or the Mental Capacity Act as models.

##### 3. Criterion of "appropriate treatment" (Clauses 4 – 6)

###### 3a. Test of 'availability' of appropriate treatment as criterion for compulsion

The Bill replaces the 'treatability test' (i.e. the requirement that detention or treatment should 'alleviate or prevent a deterioration' in the patient's

condition) with a test that 'appropriate treatment is available'.

The main potential concern over this replacement of the current 'treatability' test with the test of 'availability', at least in relation to the criteria for detention (see point (b) below on treatment), should be that the latter could be used to legitimate the exclusion of patients with 'difficult' profiles. This, of course, is exactly the opposite of the intention behind the change.

In its evidence to the Joint Committee on the Mental Health Bill (JCMHB) the MHAC said that:

services for types of patient (such as people with personality disorder or dual diagnosis) can be relatively scarce, and we believe that, under the present law, it is scarcity as much as misunderstanding of the law that excludes such patients from services. We would be concerned that the requirement of availability should not be open to misuse to exclude patients inappropriately from services by limiting services' responsibilities.

Whether our concerns over weaknesses in the proposed "appropriate treatment" test are valid or not, it is important to recognise the inherent weaknesses of the current 'treatability' test:

- it only applies as a criterion for initial and continuing compulsion in the case of psychopathic disorder and mental impairment;
- although it is one criterion for the renewal of compulsion in the case of mental illness or severe mental impairment, it does not have to be met in such cases if the alternative criterion can be claimed instead (the other criterion is that the patient would be unable to care for himself if discharged, or unable to obtain appropriate care, or would be at risk of exploitation);
- the treatability test can in any case be met in practice by claiming that treatment may extend 'from cure to containment' (*Reid v Secretary of State for Scotland* [1999] 1 All ER 481).

In past submissions on legal reform the MHAC has suggested that coercive interventions should be justifiable against some level of *therapeutic benefit* for the patient concerned. It may be argued that the

difference between such a phrase and 'appropriate treatment' is unclear when each is placed in context, and certainly either would have to encompass not only notions of 'cure' but also the alleviation of symptoms and preventive measures to stop a condition deteriorating. But the meaning of 'therapeutic benefit' might be argued to be more transparent than that of 'appropriate treatment'.

#### **b. Replacement of treatability test by appropriate treatment as the criterion applied by SOADs.**

The Bill proposes to change the current criterion for SOAD approval of s.58 treatments (and also general approval of s.57 treatments) from

"...having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given"

to

"...it is appropriate that the treatment should be given"

The definition of "appropriate" would be defined (circularly) in the following:

"it is appropriate for treatment to be given to a patient if the treatment is appropriate in his case, taking account the nature and degree of the mental disorder from which he is suffering and all other circumstances of the case"

Is this too loose a definition? Case law since *R v Wilkinson* [2001], (which is summarised at pages 317-21 and 328-29 of Jones' *Mental Health Act Manual*, Tenth edition) suggests that an appropriate test, which would reflect the real protections that the law should offer to patients, would be that a proposed treatment must be both in the patient's **best interests** and a **medical necessity**. These terms appear in the draft Code of Practice, but should they be also be used in the legislation?

#### **4. Change in definition of "medical treatment" (Clause 7)**

The proposal is to change the current s.145 definition

“medical treatment includes nursing, and also includes care, habilitation and rehabilitation under medical supervision

to the following:

“medical treatment includes nursing, psychological intervention, and specialist mental health habilitation, rehabilitation and care”

It appears (in part from the Explanatory Note, 49) that the intention here is to specifically indicate psychological interventions as valid medical treatment for mental disorder, and thus reinforce the fact that personality disorders fall within the reach of the Act’s powers. It also removes the requirement that such treatment is given under a doctor’s supervision, which is discussed at 5 below.

## Chapter 2 – Professional roles

### 5. Approved clinicians and responsible clinicians (Clauses 8 – 16)

The Bill provides that professionals who are not registered medical practitioners (i.e. doctors) can be section-12 approved and also take on the ‘RMO’ role. The major legal concern is whether a professional who is not medically qualified to practice as a doctor can provide the ‘objective medical expertise’ to establish that a person of unsound mind suffers from a true mental disorder, so justifying lawful detention under Article 5 of the ECHR (i.e. *Winterwerp v Netherlands*: see Jones p.818). Government lawyers may have concluded that ‘medical expertise’ can be had from a non-medical authority, but such a view will be contentious. Indeed, the proposals leave some of the more obvious decisions about detention in the hands of doctors (as the Mental Health Bill 2004, cl.14(4), similarly required doctors to undertake the ‘medical recommendations’ for detention), but approved clinicians and responsible clinicians are still left to provide expertise or make decisions that could engage Article 5 issues:

a. **Approved Clinicians.** Whilst the amendment proposals do not allow non-doctors to make the medical recommendations for detention under section 2 or 3, it does allow that they might

exercise holding powers (s5(2)); be the independent assessor of the need to terminate remand hospital orders (ss.35,36); determine that prison transfers should be returned to prison (s.51, 53); and to report on the need for a Tribunal application or provide information to a Tribunal (ss.67,76).

b. **Responsible clinicians.** The RMO’s role also potentially engages Article 5 issues (perhaps more so that for approved clinicians in the practical circumstances in which non-doctors might undertake it under the amended Act). Under the proposals non-doctors could be responsible for leave arrangements, including revocation of leave (s.17); initiating community treatment orders (with a AMHP’s support – see section 8 below) and recalling a person subject to a community treatment order to hospital (17A,E as proposed); renewals of civil detention (s.20); extending detention for patients returning from leave (s.21B); discharging patients (s.23); restricting discharge by a Nearest Relative (s.25); providing reports on an accused’s mental condition, including advising on the termination of remand to hospital or interim hospital orders (s.35, 36, 38); reporting to the Home Office on restricted patients or patients subject to s.45A (s.49, 45B); and determining that prison transfers or remands from court no longer require hospital treatment (s.51, 52, 53).

Aside from Article 5 issues, the Bill (clause 11) proposes that non-doctors (who are nevertheless ‘approved clinicians’) could take decisions about medical treatment. Under s.57, the MHAC could appoint a non-doctor to take the traditionally medical role in considering authorisation of s.57 treatments. Under s.58, a non-doctor could complete a Form 38 (which technically is only a record of consent to medication or ECT, and not an authorisation of such treatment, but this raises the question of whether a non-doctor is sufficiently expert to explain medical procedures and determine a person’s capacity and consent to such procedures). Non-doctors would be able to authorise the continuance of treatment under s.62 whilst waiting for SOAD authorisation (i.e. if a patient withdraws consent, or the three-month period expires etc). Non-doctor approved clinicians

will be responsible for authorising treatment under s.63. They may also direct the treatment of a person subject to a community treatment order and change such treatment requirements by written order (s.17B as proposed).

## **6. Approved Mental Health Professionals (clauses 17 – 20)**

The Bill widens the role of Approved Social Workers to Approved Mental Health Practitioners: i.e. professionals other than social workers – including mental health nurses, OTs etc - can undertake the role. Approval would be by the LASS. This has raised some concerns over whether this could damage the perceived or actual independence of this function under the Act. In the past, the MHAC has suggested that this concern might be addressed through rigorous training requirements. At least the Bill now retains personal accountability and professional discretion for those taking on the old ASW role.

## **Chapter 3 – Nearest Relatives**

### **7. Nearest Relatives (clauses 21-24)**

Other than to recognise civil partnerships, the Bill does not amend s.26 and the hierarchical list in that section remains to automatically appoint a Nearest Relative irrespective of a patient's wishes. The Bill amends s.29 to add patients themselves to the people who may apply for the displacement of a Nearest Relative, and adds the criterion of being “otherwise not a suitable person to act as such” to the existing criteria for displacement<sup>1</sup>. The Bill rewords the provisions allowing that the application can name a replacement to allow that, if there is no-one named, the court can specify anyone willing to undertake the role that it finds suitable.

Therefore a patient can nominate their Nearest Relative only through making a court application that declares the person identified through the hierarchical list as “not a suitable person”. This stops short of providing patient choice in the identity

<sup>1</sup> The existing criteria are: 1. the Nearest Relative doesn't exist; 2. s/he is incapacitated; 3. s/he unreasonably objects to an application; 4. s/he exercises discharge powers without regard to patient or public welfare)

of their Nearest Relative (indeed, the draft Code (33A.3) states that “a nearest relative cannot be rendered unsuitable on the basis that another person is deemed to be more suitable”). It may be that Government lawyers are wary of disputes over who is suitable if a patient gets to pick without formality (i.e. and thus chooses a friend over a parent, with the consequent disempowerment of that parent to be consulted, effect discharge, etc). It is notable, however, that a person deprived of his or her liberty under the new ‘Bournewood’ provisions can, if s/he has capacity to do so, choose his or her ‘representative’ (see 12 below), where the representative has a broadly similar role.

It would seem likely that an amendment may be tabled at some point of the progress of this Bill to propose giving a choice in identifying their Nearest Relative.

## **Chapter 4 - Supervised Community Treatment**

### **8. Community Treatment Orders**

This new power creates a version of supervised discharge with a power to require compliance with a treatment regime, and powers of recall in the face of default or for other reasons of concern. The order is made by the responsible clinician (who may not be a doctor, see 5 above) if s/he has a supporting AMHP's recommendation. That no doctor may be involved in making such an order may cause serious problems with ECHR Article 5 and the need for objective medical expertise around the presence of mental disorder (especially as mental disorder of a suitable nature or degree is the first criterion for making this order).

Aside from other concerns over the powers given to non-doctor responsible clinicians to require medical treatment (see 5 above); the following areas may cause some debate:

#### Relationship with s.17

- A ‘community patient’ (i.e. one subject to a CTO) is not included in any reference in the 1983 Act to a patient ‘liable to be detained’ (clause 17D(2)(b))

- Once recalled, a patient can be kept for 72 hours unless the CTO is revoked (at which point s/he returns to detained inpatient status. Revocation of a CTO, in common with its initiation, must be supported by an AMHP (clause 17E,F).
- There will be no legal reason why responsible clinicians might not choose to give detained patients leave under existing section 17 powers as an alternative to using CTOs. Under s.17 leave, a patient remains 'liable to be detained' and can be recalled back to hospital by a written order without any further formality. The Bill would amend s.17 leave powers only to the extent that the responsible clinician must "first consider whether the patient should be dealt with" under a CTO before authorising leave of an unlimited duration or of a duration in excess of seven consecutive days (clause 26, draft Code Chapter 67B). Therefore, clinicians will be free to choose between two legal frameworks of similar effect but differing levels of bureaucracy, where the older system (s.17 leave) may be less cumbersome to operate than the powers introduced as its effective replacement. This runs the risk that CTOs will replace one under-used community power (supervised discharge) with another.

#### Consent to treatment provisions & CTOs

- Although the responsible clinician may specify that the patient receives medical treatment in accordance with his/her directions whilst on a CTO (clause 17B(3)(c)), that patient is not technically subject to Part IV powers and treatment cannot be given against the patient's will<sup>2</sup>. Instead, the proposed new Part 4A will apply. Part 4A technically 'trumps' Mental Capacity Act powers, but largely reproduces them in relation to treatments other than medication for mental disorder and ECT.

<sup>2</sup> Although, if a patient is incapacitated, then their resistance to treatment can be overcome by force whilst they remain on a CTO. Although technically this takes place under 'emergency' powers, as with the current s.62 the scope of such powers is rather broad. We note with some confusion the Explanatory Note's statement that "in other circumstances, force may be used to treat a patient who has not been recalled to hospital if the patient does not object" (para 108). This may not bode well for clearly defined limits on the forcible treatment of patients in the community.

- Part 4A is convoluted in its drafting and it is unlikely that mental health professionals will be able to interpret the statute without detailed explanatory guidance. We set out below our interpretation of this clauses; the Department of Health's tabulated account of them is at para 111 of the Explanatory Notes.

#### **Adult CTO patients (16 years or older):**

Medical treatment that is *neither* medication for mental disorder after first month of CTO, *nor* ECT at any time,

Treatment may be given under Part 4A if

- the patient has capacity and gives consent; or
- the patient lacks capacity and a donee or the court of protection consents to it on his or her behalf; or
- the patient lacks capacity, does not resist the treatment, and the treatment does not conflict with any advance directive or decision made by a donee or the court of protection; or
- the patient lacks capacity and may resist the treatment but force may be justified as proportionate response to the likelihood of serious harm to the patient, and the treatment is either immediately necessary to save the patients life; or (not being irreversible) is immediately necessary to prevent serious deterioration; or (being neither irreversible nor hazardous) is immediately necessary to alleviate serious suffering; or (being neither irreversible nor hazardous, and the minimum interference necessary) is immediately necessary to prevent the patient from behaving violently or being a danger to her/himself or others.

#### **Child CTO patients (under 16 yrs):**

Medical treatment that is *neither* medication for mental disorder after the first month of CTO (or three months after the first administration under MHA powers, whichever is later), *nor* ECT at any time

Treatment may be given under Part 4A if:

- the patient has capacity and gives consent; or
- the patient lacks capacity but either does not object to, or does not physically resist the administration of the treatment; or

- the patient lacks capacity and may resist the treatment but force may be justified as proportionate response to the likelihood of serious harm to the patient, and the treatment is either immediately necessary to save the patient's life; or (not being irreversible) is immediately necessary to prevent serious deterioration; or (being neither irreversible nor hazardous) is immediately necessary to alleviate serious suffering; or (being neither irreversible nor hazardous, and the minimum interference necessary) is immediately necessary to prevent the patient from behaving violently or being a danger to her/himself or others.

**Adult or Child CTO patients:**

Medication for mental disorder after the first month of CTO (or three months after the first administration under MHA powers, whichever is later), or ECT at any time

Treatment may be given under Part 4A if:

- a SOAD certificate is issued authorising the treatment. The SOAD is appointed in the normal way by the MHAC (clause 64K(3)). The criteria for the SOAD authorisation is that "it is appropriate for the treatment to be given" (Clause 64C(4)(a) – see section 3(b) above for commentary on this), but also that the patient either has capacity and consents, or else lacks capacity. The consultative process is described at Clause 64H in terms echoing s.58(4): as with SOADs, the certifying doctor has a duty to consult with two statutory consultees but no duty to consult with either the patient or the responsible clinician (these matters are left to the Code as now); or
- there was such a SOAD certificate, but it has been withdrawn by the MHAC, and the responsible clinician is continuing treatment under the powers equivalent to s.62(2) provided under the Bill on the grounds that discontinuance of the treatment would cause the patient serious suffering; or
- the treatment is immediately necessary and the patient has capacity and consents to its administration;
- the patient lacks capacity and may resist the treatment but force may be justified as

proportionate response to the likelihood of serious harm to the patient, and the treatment is either immediately necessary to save the patient's life; or (not being irreversible) is immediately necessary to prevent serious deterioration; or (being neither irreversible nor hazardous) is immediately necessary to alleviate serious suffering; or (being neither irreversible nor hazardous, and the minimum interference necessary) is immediately necessary to prevent the patient from behaving violently or being a danger to her/himself or others.

**Adult or Child CTO patients, if recalled to hospital or if the CTO is revoked upon recall**

Medication for mental disorder or ECT

The following rules govern the giving of treatment:

- in general terms, the patient is treated for the purposes of consent to treatment as if s/he had remained liable to be detained since the making of the CTO; although
- if the patient was still in the first month of the CTO, or it is not yet three months since the first administration of medication under the Act's powers (whichever is later), then treatment with medication for mental disorder can be given under the authority of the responsible clinician without formality; or
- during the 72 hours of recall, if the CTO has lasted more than a month, and during its duration a Part 4A SOAD certificate has been issued that specifically provides that treatment could continue were the patient to be recalled to hospital, then that certificate would provide the authority for treatment; or
- if there was such a Part 4A SOAD certificate, but it had been withdrawn by the MHAC, the responsible clinician could continue treatment whilst the patient was recalled under powers equivalent to s.62(2) (i.e. on the grounds that discontinuance of the treatment would cause the patient serious suffering); or
- if the CTO has lasted more than a month, and no SOAD certificate under part 4A has been issued (or no such certificate has been issued that specifies what treatment might continue upon recall or revocation of the CTO), or the

CTO is revoked, then any previously extant Form 38 or 39 would regain validity as the authority for treatment; or

- or, if such a Form 38 or 39 had been withdrawn, whether by the MHAC under its statutory powers (Form 39) or by the patient withdrawing consent (Form 38), the provisions of s.62(2) would allow the responsible clinician to continue treatment pending compliance with s.58 if s/he considers that discontinuance of treatment would cause the patient serious suffering.

The following observations on the above may help foster debate amongst Commissioners:

- (i) the Bill creates a capacity test in relation to treatment whilst the patient is on a CTO: even to the extent that there is no provision to provide such emergency treatment in the face of a refusal by such a patient whilst s/he remains in the community. It would seem likely that this is because the need to give emergency medication without consent is perceived as a trigger for recall to hospital, where emergency powers under section 62 would apply (Government has, after all, assured users and professionals that there would be no forcible administration of medication over patients' kitchen tables, although there will be legal powers to forcibly treat incapacitated patients in some circumstances without recall to hospital). But should the changes establish a capacity threshold in relation to this part of the Act whilst resisting calls to establish capacity tests governing forcible treatment in all circumstances? What is the justification for a partial implementation of a capacity threshold for compulsion?
- (ii) The proposed relationship between the 'three-month rule' under existing consent to treatment provisions and the equivalent one-month period for CTO patients could be problematic. A patient who is given a CTO whilst the three month rule is still in force could, if the three-months are nearly over at that time, have that period extended by up to almost another month (treatment can be given without a SOAD certificate for three months from the first

administration under the Act, or for the first month of a CTO, 'whichever comes later' (Explanatory Note, 109)). This could be difficult to administer, but it also mixes up a period whereby treatment can be given without consent (the three-month rule) with a period where it cannot (the CTO one-month rule).

In its past submissions to the legal reform process, the MHAC has suggested shortening the 'three-month' period. This could be an opportunity to achieve this.

- (iii) The Bill's proposals may be rather wasteful of SOAD resources, in that SOADs must certify that a CTO patient consents to treatment falling within section 58, whereas of course the responsible clinician can do so for inpatients liable to detention. The apparent justification for this (e.g. Explanatory Note, 110) is that the Government envisages SOADs making quite complex authorisations that anticipate, for example, the patient's recall to hospital, as SOADs (but not responsible clinicians) will be empowered to authorise, in advance, that treatment without consent may be administered in such circumstances. It may be questionable whether a SOAD certification that a patient consents to treatment, which also authorises the compulsory administration of that treatment in hospital should that patient withdraw consent or compliance, can be reconciled with the Code of Practice principle that "permission given under any undue or unfair pressure is not consent" (15.13)).

The proposals also have an odd effect of the criteria for certification of a consenting patient's treatment. The SOAD is not merely recording the patient's consent, but stating that it is "appropriate" for the treatment to be given (clause 64C(4)(a)). Thus the criteria for certification go beyond the simple fact that the patient consents - this makes the CTO s.58 arrangements appear closer to section 57 safeguards than it is to section 58 as applied to inpatients.

It is not clear what justification there is for this, other than the fact that SOADs may be certifying both that a patient currently consents

and what will happen if and when they cease to do so. There could be an argument for the removal of RMOs' ability to certify their own patients' consent, so that the law required an independent overview of this, but if so the need would be arguably greater for inpatients and, in any case, this would be likely to be very expensive in doctors' time and NHS funds.

## **9. Chapter 5 - MHRTs (clauses 30 – 31)**

The Bill will provide a power to reduce the period before an automatic MHRT referral takes place. The MHAC could have a useful role, alongside our MHRT colleagues, in ensuring that the use of this power is kept under active consideration.

## **10. Chapter 7 – Restricted Patients (clauses 33-34)**

The Bill would abolish time-limited restriction orders (Clause 33). Although this means more indeterminate restriction orders, there is an argument that time-limited restriction orders are in effect a form of sentencing tariff and as such are incompatible with measures that should have a clinical justification at root.

## **11. Chapter 8 – Miscellaneous: Foundation Trusts (clause 35)**

The Bill will reverse the limitations on Foundation Trusts' powers regarding managers' hearings (see Policy Briefing 15).

## **Part 2 – amendments to the MCA 2005**

### **12. Hospital and Care Home Residents – Deprivation of Liberty**

As enacted, the Mental Capacity Act was not designed to authorise any deprivation of the liberty of incapacitated patients. Clauses 38 – 39 of the Mental Health Bill amend the Mental Capacity Act to allow that: a person may be lawfully deprived of his or her liberty under MCA powers if:

- (i) this is necessary for life-sustaining treatment or any vital act (i.e. an act required to prevent serious deterioration in a patient's condition), in which case the deprivation may be justified on grounds of necessity;
- (ii) such deprivation is giving effect to a relevant decision of the Court of Protection; or
- (iii) the deprivation is authorised under the new 'Bournewood' procedures introduced into the MCA by the Bill.

#### *Criteria & Procedure*

A person (P) must be aged 18 or over, suffering from mental disorder, and incapacitated to decide about residency to be eligible under the new provision listed at (iii) above. If the circumstances amounting to a deprivation of liberty would conflict with any advance decision made by P, or any decision made by P's attorney or deputy under the MCA, then the new power cannot override that refusal. If P objects to the circumstances of his or her deprivation of liberty, and could be detained under the MHA, then the MHA should be used. On the other hand, if P's objections conflict with a decision made by an attorney or deputy, they can be overridden on that basis and the new MCA power used for authority.

The standard procedure for authorising deprivation of liberty is that, on the request of the hospital or care home managers, the commissioning PCT (for hospitals in England), or local authority (for care homes) must appoint independent persons to undertake separate mental health and best interests assessments. If the assessors (the details of which are to be established in regulations not yet available) determine that P is suffering from mental disorder, lacks capacity to consent to residence in a hospital or care home, and that residence amounts to a deprivation of liberty that is in P's best interests, necessary to prevent harm to P, and a proportionate response to the likelihood of such harm, the PCT or local authority will authorise the deprivation of liberty. It may make conditions, and may vary the length of the authorisation for up to a year (determined by the best interests assessor). A review of an authorisation can be required at any time by P, his or her representative, or the detaining body. Assessors are allowed to rely upon 'existing assessments' that are no more than a year old. If

any assessment determines that the conditions of lawful deprivation of liberty are not met, the hospital or care home would have to review P's situation and ensure that no deprivation of liberty continues.

#### *Urgent Procedure*

There is also an urgent procedure, in which the hospital or care home managers can authorise themselves to deprive P of liberty for up to seven days. The supervising authority (the commissioning PCT or local authority) can extend this for a further seven days whilst the standard authorisation assessments are carried out.

#### *Representatives & advocates*

P's 'representative' can be chosen by P if P has capacity to make that choice, or by P's attorney or deputy (if there is one); or by the best interests assessor or the supervisory body. The representative is expected to support P in matters relating to the authorisation of deprivation of liberty, and has a right to require a review or appeal to the Court of protection on P's behalf. Where there is no representative, the supervisory body must appoint an independent mental capacity advocate to undertake the function.

#### *Monitoring*

The Bill will provide for regulations requiring one or more (as yet undetermined) bodies to monitor, and report on, the operation of the new powers. The monitoring body or bodies will have rights of access (including a visiting role) similar to that set out for the MHAC at s.120. We understand that the monitoring bodies are likely to be specified as PCTs or LASSs - there could be a valuable role for the MHAC to play in undertaking an independent monitoring role.

#### **Some comments on the proposed framework**

- (i) Is it clear whether to use these provisions or detention under the MHA in many cases? Will the courts accept two parallel systems for detaining patients in hospital?
- (ii) Because the Government has put a potentially onerous burden on supervising authorities, by allowing them no discretion over review upon any request by the patient, representative or

hospital, it has allowed that assessments may rely on prior assessments provided that these are less than a year old. But a year seems a very long time for a best interests assessment, or an assessment of capacity, for example, to be considered to reflect the patient's current situation.

- (iii) The supervisory body authorises deprivation of liberty and appoints 'independent' mental capacity advocates to be the patient's voice. How well will assertive advocates fare in such a system, given that their assertiveness may lead them to make repeated requests of the supervisory body to review its authorisation?
- (iv) Does the Bill provide a strong incentive to take cases to the Court of Protection? And can the new Court cope with the likely demand?

It seems possible that Government seriously underestimates the likely numbers of patients who will fall within the scope of this framework. The Minister (Rosie Winterton) stated on the BBC R4 *Today* programme (17/11/06) that there are only about 5,000 people to whom these measures will need to be extended. Other estimates have put the numbers much higher.

This briefing is intended for, but not restricted to, internal distribution and use. No legal responsibility is accepted for the accuracy of information contained herein. This briefing was prepared by Mat Kinton, Senior Policy Analyst (mat.kinton@mhac.org.uk).

**For links to the Mental Health Bill and its supporting documentation, go to:**

[http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/MentalHealthArticle/fs/en?CONTENT\\_ID=4140596&chk=GudftE](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/MentalHealthArticle/fs/en?CONTENT_ID=4140596&chk=GudftE)



# WHAT THE PAPERS SAY

## The Mental Health Bill's press reception

### **Labour faces defeat over mental health MPs to debate bill on compulsory treatment**

Ministers are facing the prospect of an embarrassing defeat over plans to introduce tough new mental health laws, as the leading charities and opposition MPs this weekend threatened to use full scrutiny powers to derail the plans.

On Tuesday MPs will debate proposals to introduce powers of compulsory community treatment for patients who have stopped taking their medication ... Psychiatrists have opposed the measures, arguing that they will turn them into jailers, and charities believe that the much greater need for patients is to modernise existing care and provide proper 24-hour facilities.

The mental health bill - the government's third attempt in eight years to reform the 1983 Mental Health Act - will be introduced into the Lords in a fortnight. However, the Conservatives said this weekend that they would ask that the Lords reconvene the original committee which was set up to scrutinise previous proposals along the same lines. If the bill is defeated by the peers, the government cannot force it through by using the Parliament Act because it initially introduced the proposals through the Lords rather than the Commons.

**Jo Revill, [The Observer](#), 19/11/06**

### **Mental health needs money, not bills**

...the proposed Mental Health Bill cynically dodges the real issue: the inadequacy of long-term care for the mentally ill. There is a desperate shortage of beds and mental health services are on the front line of cuts because they are labour-intensive and do not deliver the sort of results that are easily enumerated by managers. There is not much point strengthening doctors' powers to section patients when there are no hospital places for them...

**Leader comment, [The Observer](#), 19/11/06**

### **An Affront to Human Decency**

The [John Barrett inquiry] makes the case not for changing the law but for making the existing law work better ... the report did not say that the authorities lacked the legal power to detain Barrett. The criticism was that Barrett, having been detained, was allowed out into the hospital grounds, unsupervised, and was then allowed to walk free. The failures of the mental health care system in this country may be systemic, but legislation is not the answer.

...the new Mental Health Bill retains the worst features of its predecessors. It provides for the permanent detention of people who have not committed a violent

offence if doctors say that they might.... Mental health charities accept that there may be a small number of cases for which such measures might be fitting, but the Bill is drawn too wide and contains inadequate safeguards.

A new Bill is needed to give mental health patients more rights ... Working with mental health charities and concerned individuals, we helped kill off its predecessors ... we intend to see this Bill off too.

**Leader comment, [Independent](#), 19/11/06**

"... this Bill ... contains a much wider provision for community treatment orders than our select committee ever envisaged as appropriate ... This is the ... spectre of widespread community treatment orders involving far more people being sectioned than was ever the case under the 1983 Act ... The danger is that people who want to look for help become ever more afraid of being sectioned and so will not look for help."

**Lord Carlile of Berriew, [Independent](#), 19/11/06**

Professor Sheila Hollins, President of the Royal College of Psychiatrists said: "We will work with Parliament on the Mental Health Bill to ensure a modernised framework to deliver a safe and effective service for people with mental health problems. The College is particularly concerned that any compulsory treatment should have a clear clinical purpose, and be of benefit to the patient."

The College has other significant concerns:

- a.. compulsion should be used as a last resort
- b.. patients and carers must receive a full assessment of their health and social needs when they request it, and these assessments must be adequately resourced
- c.. detained patients should have a right to advocacy
- d.. patients should be able to decide whether or not to accept medical help if they have the capacity to make the decision for themselves

Rethink are calling for people with mental illness who are detained for treatment in England and Wales to be given the same rights as people in Scotland including:

- Legal representation
- A right to a review of their treatment in a reasonable time
- A right to services they need
- A choice to say, when well, what they want when ill; including which family members they want to be involved in their care.

**From [Community Care](#) online, 17/11/06.**