National Assembly for Wales
Health & Social Services Committee
Wednesday September 11 2002

Draft Mental Health Bill Consultation Response

A Social Services Perspective on behalf of the Association of Directors of Social Services in Wales

1.Introduction

The Ministerial Foreword to the Consultation Document outlines the Government's desire to bring the provisions for compulsory care up to date and in line with the ways modern services are provided. The Bill in its current form will not achieve this. The remainder of this paper is divided into two parts. The first part covering views and concerns relating to the Bill itself the second to the additional issues for consultation.

PART ONE

2.Background

The roots of the Bill can be traced back to a number of influencing factors. To begin with, a series of highly publicised Inquiries in the 1990's involving patients living in the Community.The enactment of Human Rights legislation in 1998 and the introduction of a modernisation programme by the new Labour Administration. The latter outlined the Government's intention to improve the way that services respond to people with mental illness and other mental disorders. In England this was detailed in *Modernising Mental Health Services*[1] and in Wales through the strategies[2] for Adults and Children and Young People with mental health problems. National Services Frameworks[3] to improve quality have since followed. The development of a modern legislative framework to complement the changes in service provision has been seen as a key element of the Government's strategy.

Regrettably, it would seem that the central provisions outlined in the Bill will not achieve this end. In particular they work against the principles espoused in the Adult Mental Health Strategy and if enacted are more likely to *stigmatise* and *disempower* people who have mental health needs.

There are some positive aspects to the Bill, but often these do not go far enough and doubt inevitably is cast as to how effective these will be within the proposed framework. It can be further argued that improvements to community and in-patient services are likely to be more successful in mitigating the problems the Government is seeking to tackle through the use of compulsory powers.

3.Positive Aspects of the Bill

As indicated, there are some welcome aspects to the Bill, notably the introduction of independent Advocacy, the proposed safeguards for patients with long-term incapacity, replacement of the 'Nearest Relative' by a 'nominated person', review of continued treatment at 28 days and proposals around the protection of children. However, these too have their limitations. For instance, Advocacy is not included as an enforceable right and therefore availability and development is likely to be patchy. Similarly, in terms of patients with long-term incapacity, the majority will not routinely have their care plans independently reviewed by a Tribunal.

4. Concerns

Notwithstanding the positives, from a Social Services perspective, there remains significant cause for concern over too many aspects of the central provisions of the Bill. These concerns are developed below.

4.1Definition of Mental Disorder and grounds for compulsion

The Government contends that the definition of mental disorder is compatible with Article 5 of the European Convention on Human Rights. However, because the proposed grounds for compulsion are broadened and 'treatability' is now removed, it is inevitable that more people will fall within the remit of the Act leading to an increase in the application of compulsory powers. To add to this, the Bill's companion document consulting on aspects of policy developed since the White Paper *Reform of the Mental Health Act 1983* now proposes to remove the exclusions contained in Section 1 (3) of the current Act. Paradoxically, the Government's stated aim is of course to *reduce* the application of compulsory powers.

4.2 Provisions for High Risk Patients

High Risk Patients fall within the broader definition of mental disorder contained within the Bill. However, the proposals to incorporate separate criteria for those who pose a significant risk of

serious harm to others remains unsound, driven as it by public protection concerns. A Government commitment to protect the public from dangerous people whilst laudable is clearly a responsibility of the criminal justice system and should not be 'offloaded' to services whose principal focus concerns Health and Wellbeing. Furthermore, from a statistical viewpoint high-risk patients remain a low incidence group. A recent analysis of data from Home Office statistics for England and Wales between 1957 and 1995 demonstrated that there has been a steady 3% annual decline in the proportion of homicides committed by people with mental disorders. Attempting to address this complex issue through a Mental Health Bill will serve only to reinforce public perceptions that people with a mental disorder are dangerous.

4.3 Community Treatment Orders

Community Treatment Orders as a concept are not new in the UK. More than 20 years ago BASW promoted use of a community power as a means of transferring resources and patients to community settings. That was in an Age when there was over-provision of in-patient beds. Today we are faced with a situation of under-provision. Given this political reality, there is a real risk that community orders will be opted for due to lack of an appropriate bed. Presumably, to warrant application of compulsory powers the patient will in any case be *bordering* on the need for 'admission.' That being so, assuming responsibility for such an order without the fallback position of a bed would be an extremely risky and perhaps unsafe position to find oneself in as the supervising worker. Yet in the prevailing culture, professionals are unlikely to win public sympathy for failing to make use of the available powers open to them. For this reason, if introduced as planned, ready access to a bed as a contingency would need to be an essential element of any such order.

Secondly, as one would expect, community treatment orders are extremely unpopular with users and engender fear amongst many. There are circumstances currently such as through use of Guardianship where a case can be made that community orders might be seen as a less restrictive alternative. However in terms of community orders as proposed in the Bill are concerned then unless the issue of compulsory medication can be resolved, they are likely to drive people away from services.

4.4The role of Approved Mental Health Professional

The decision to replace the ASW with the AMHP appears to be founded on a pragmatic response to the increase in the number of

assessments and a dwindling/static supply of ASW's. Whilst this may begin to tackle an 'availability' issue it does nothing to address the more fundamental issues which include the increasing complexity of assessments with greater potential of being exposed to violence; the increasing difficulties in obtaining doctors who are willing to attend assessments (and the pressure General practitioners in Wales are under is no secret); and the problems posed by eliciting assistance from our already overstretched ambulance and police services.

Secondly, whilst it is recognised that a non-medical/social approach to care is no longer the exclusive preserve of social work, it would be misguided to assume that the development of such an ethos in nursing practice is universal. It is also the case that nurses are still expected to defer to Doctors on clinical matters. As the largest professional group within mental health services, there is clearly a role for nursing skills and practice within any new legislation. Whether the role of AMHP should be it however is perhaps open to question.

To some extent the role of ASW under the current Act was envisaged as a counter-balance to the medical model, and the Draft Bill's proposals bring this issue to the fore again. Whilst it might be churlish to claim that in an increasing multi-disciplinary environment impartiality can only be secured (if it ever could) through an ASW, there remain some persuasive arguments in favour of retaining the role. These are not solely to do with employment contracts but are as much about professional ethos and training.

4.5 Application of Compulsory Powers

Despite the increasing scope for applying compulsory powers, there is not a concomitant increase in rights. There is no provision for an automatic review of compulsory powers before 28 days even though in terms of the current Act statistically most people are detained and discharged within this period. Furthermore, it seems the sole role during this period rests with the clinical supervisor, with no requirement to consult with anyone other than the nominated person in the preparation of a care plan. This is unlikely to augur well for the inclusion of a social perspective and cuts across the Government's stated desire to involve patients to a greater degree in decisions.

Concerns are further raised by the lack of a requirement in the new Tribunal process for an assessment of social circumstances or even a hearing of the views of other disciplines. Many non-medical staff

already believe that current Tribunal practice gives too much weight to medical evidence and issues when availability and quality of community support are frequently as important if not more so in the decision making process. This will be even more relevant given the proposed introduction of community orders. One final point in relation to Tribunals is resourcing the new system. Despite assurances from the Government that there are enough people within the system to cope with the extra demand this is debateable and we would argue that extending their responsibilities will require significant investment. Without such investment there is real cause for concern that more and more decisions could eventually be vested in the judgement of one Tribunal Member.

4.6 Patients concerned with criminal proceedings.

The Bill proposes that any court will be able to remand a person for a mental health report initially for 28 days, renewable at 28 day intervals for up to 16 weeks. Here again, because of the broader definition of mental disorder in the Bill, potentially far greater numbers of people before the courts could find themselves subject to this requirement. (Mind for example have referred to a 1997 ONS survey that found significant neurotic symptoms amongst 58% of male remand prisoners and 75% of females.)

Within these provisions there also appears no reference to incorporating a social perspective in assessments for the purposes of court reports. There also appears to be no role for the Nominated person.

Proposals within the companion consultation document concerning compulsory treatment within prison settings are inappropriate. If a patient meets the criteria for compulsory powers then under these circumstances it would be preferable for treatment to continue to be provided in a hospital setting.

4.7 Powers of entry, conveyance and detention

These proposals are broadly similar to provisions within the current Act. However, there is a new power proposed for the police to use in extreme emergencies. This allows for entry to private premises without a warrant in order to remove a person who appears in need of immediate care and control. Apart from the potential for misuse, this is unnecessary and implies a greater degree of difficulty in obtaining warrants than may actually reflect current practice.

4.8 Aftercare

Compared with the present Act, there is no equivalent aftercare provision within the proposed Bill. In this respect the Bill appears to be removing an important right to services for certain categories of patient.

PART TWO

5. Specific Consultation issues

5.1 Scrutinising the Proper application of the Act

The principle of replacing the Mental Health Act Commission with an arm of a new Health Inspectorate, carries some merit although clarity is sought on its remit in relation to:-
Social care services; purchasing and commissioning processes; links with existing Inspectorate functions in Wales.

5.2 Protecting Children with Serious mental disorders

As referred to in the early part of this document, these proposals are welcomed as a positive initiative, helping to clarify the position for 16-17 year olds and providing the protection of a Tribunal for treatment beyond 28 days for children under 16.

5.3 Respecting the Legal Rights of Patients and Health Care Workers.

It is recognised that this reform offers better protection for patients, but due account must also be given to spurious or unfair complaints made against staff at times when the patient may not be mentally competent.

5.4 Removing Exclusions

As indicated earlier, there are concerns that this will have a significant impact on the numbers of people who may be brought within the remit of the Act.

5.5 Sharing Of Information Relating to Risk.

Good information sharing protocols can potentially improve patient care although there is a concern that the proposals could again cast the net too wide and allow for inappropriate exchange of confidential details.

5.6 Better Care for Prisoner Patients

The Government's commitment to address the increasing incidence of mental disorder amongst the prison population is welcomed. However,as detailed earlier there are reservations concerning this proposal. In particular, where a person is so ill as to require treatment and community treatment is by definition not an option, then it is submitted that a therapeutic environment would be far more appropriate in ensuring they get the help they need.

5.7 Patients Correspondence

This proposal potentially improves upon existing arrangements. There is a view that decisions to interrupt and monitor mail should be included in the care plan and open to scrutiny by the Mental Health Tribunal.

5.8 Mental Health Tribunals- Single Member Sittings

As indicated earlier there are concerns that matters that are more than just procedural will eventually be referred to Single Member sittings on the grounds of expediency. This should be guarded against.

Summary

Within the time allowed for presentation the above represent a selection of concerns and issues from a Social Services perspective. The Bill requires far more work and should not in its current form be enacted if Government's intended policy is to be complemented.

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[1] Modernising Mental Health Services, Department of Health 1999

[2] Adult Mental Health Strategy for Wales : Equity, Empowerment, Effectiveness, Efficiency, National Assembly,2001
Child and Adolescent Mental Health Services: Everybody's Business, National Assembly, 2001

[3] Adult Mental Health Services: A National Service Framework for Wales, National Assembly 2002.

Reform of the Mental Health Act 1983, Department of Health 1999.