26 July 2002

To: Chief Executives of Mental Health Trusts in England;
Chief Executives of Trusts in Wales

Dear Colleague

Draft Mental Health Bill

The Royal College of Psychiatrists believes this Bill to be ethically unacceptable and practically unworkable. We are opposing it both in our individual response and together with the users and carers organisations in the Mental Health Alliance, the Law Society, the BMA, the professional bodies representing nurses, psychologists, social workers and community psychiatric workers, and key elements of the media.
A summary of key changes is set out on the back page of this letter.

We understand that Mental Health Trust Boards are being invited to respond to the consultation document. We hope that this letter will help to inform that response. Please do not hesitate to contact us for further information. Our own full response will appear on the College website shortly at www.rcpsych.ac.uk/college/parliament

In particular, we wish to draw to your attention the following issues:

1. The 'consultation' process

- The Royal College of Psychiatrists has long campaigned for a change in Mental Health legislation to reflect changes in psychiatric practice since the '83 Act.
  We would therefore have welcomed proper consultation about a measure that would dramatically affect the lives of our patients and their carers for the next twenty years.

- In the foreword to the consultation document, the Ministers state that *'we are confident that the reforms set out in the Mental Health Bill demonstrate the value of this consultation with all the key stakeholders'*. In fact, the Government showed little inclination to accept opinion from any of the parties to 'consultation' from the Green Paper onwards. Most of the 'key stakeholders' are dismayed to find that the proposals in the Bill are even further from that opinion than the White Paper of eighteen months ago.

- This current 'consultation period' is brief, and is taking place over the summer holiday period. Each of the specific issues in the consultation document is important but they do not represent the essential content and spirit of the Bill as a whole. That Bill is long, complex and largely inaccessible to the lay reader. There are areas not yet drafted at all, in which we can only guess at the intent. Much of the final legislation would be made by way of Regulation after the Bill had been through Parliament and would therefore be open to no consultation whatsoever.

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2. Ethical Unacceptability

- In essence, this is a Public Order Act. Mental Health legislation under which patients are offered treatment in return for their loss of liberty, has been hijacked to allow the preventative detention of a small number of people perceived to be a danger to the general public – those with so-called Dangerous Severe Personality Disorder ('DSPD'). This 'diagnosis' is not recognised anywhere in the world, the link between personality disorder and dangerousness is tenuous, and prediction is fraught with difficulty. This is a criminal justice issue and should form no part of general Mental Health law. Psychiatrists are doctors who diagnose and treat the mentally ill, not another arm of the criminal justice system.

- The term DSPD has disappeared from the Bill but the damage has been done. In order to accommodate it, a broad definition of Mental Health Disorder has been coupled with such loose criteria for compulsion that an enormous range of problems, including physical diseases with cerebral components such as multiple sclerosis, Parkinson's disease or the epilepsies could fall within its remit. The College is already getting letters from people with such disorders who are deeply distressed at the possibility. There is no real test of severity as exists in the '83 Act. Currently, the patient must be ill enough to need admission to hospital; this criterion is not in the Bill. There are no exclusion criteria to do with addictions or sexual deviancy and people with learning disabilities would be permanently liable to compulsion. Neither the initial applicant nor the Medical Tribunal are given discretion as to whether to make an order; if the patient fulfils the criteria the order must be made. The Clinical Supervisor (who might not be a Psychiatrist) loses the absolute right to discharge a patient or send him/her on leave and the nearest relative loses most rights to any say at all.

- With legislation of such broad scope, in a climate of blame and with the onus on him or her to say why they did not opt for compulsory treatment, most duty doctors will adopt an over-cautious approach. The result is that the number of patients admitted under 'Section' to the ward or community teams is likely to escalate even further, those teams will be stretched beyond breaking point, they will be unable to supervise safely the numbers of patients in their care and the level of risk will be increased, not decreased. Coupled with the fact that this legislation would be so deeply stigmatising to the vast majority of those with a mental illness (who are no danger to anybody) that they will be unlikely to come forward for early treatment, and you can see that this Bill would defeat even the Government's intentions.

3. Resource Implications

- Fifteen percent of current Consultant Psychiatrist posts across England and Wales are vacant; in some areas and some sub-specialties it is far worse. Put off by poor resources, public stigma and political castigation, too few students are coming into the profession and too many Consultants are leaving prematurely. The result is long waiting lists, little face to face time with patients and over 90% of Mental Health Review Tribunals, even under the current Act, cancelled because it has been impossible to find a medical member. The courts have declared the delays unlawful under human rights legislation and ordered compensation to be paid.

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- The proposals in the Bill would make this situation far worse. Trusts will have an obligation to arrange an assessment of any individual at the request of any other individual or organisation, so that the number of staff required to fulfil those assessments is bound to increase. No attempt has been made to find out if community psychiatric nurses are willing to take over the role of Approved Mental Health Workers, making applications for compulsion under the proposals. Given the increased rates of compulsion envisaged, no modelling has been made of the medical manpower costs of writing reports for and attending the increased numbers of tribunals that will result. There is no indication of where the extra psychiatrists are going to come from to sit on the new tribunals or act as part of the Expert Panel to those tribunals when we can barely furnish the system as it is at the moment. When recruitment and retention are further worsened by dissatisfaction with these proposals, no amount of extra money (even if it were available) would raise the necessary workforce.

- The Royal College and other parties to the 'consultation', have consistently asked the Department of Health for an estimate of the extra mental health personnel that would be required to operate these proposals and for a comparative costing of these proposals against the '83 Act.
  The Department has refused to give either. The only figure let slip by the Department's negotiating team was one of 600 extra psychiatrists – a figure now hastily disowned by the Ministers, Jacqui Smith and Alan Milburn. In truth, whatever the figures, these proposals are practically unworkable.
  The Government have admitted that by saying that there will be a long (1½ to 2 years) interval between Royal Assent and implementation to allow these resource issues to be looked at. Even then, they say, if the Act was not operable, then it would sit on the shelf. What kind of legislation is that?

Thank you for taking the time to read this letter. The feelings within it are not just those of the Royal College of Psychiatrists but of organisations working throughout the Mental Health field.
The Government has managed to unite us all in opposition to this Bill. Please submit your own response too. Remember that it may contribute towards something that will affect the lives of patients, their carers and your services for a very long time. We do need new Mental Health legislation but it must be fair and workable. This Bill is neither.

Yours sincerely

Dr Mike Shooter
President

Dr Tony Zigmond
College lead on the Mental Health Bill

BRIEF SUMMARY OF CHANGES

	CURRENT	PROPOSED
Criteria for detention	• Largely defined by practice • Personality disorders only if can be helped by being in hospital • Clear exclusion criteria.	• Very widely defined. Some people (eg learning disabled) would be liable to detention if they ever declined medical treatment • No exclusion criteria • No requirement that treatment will help the patient
Severity	Must be ill enough to require treatment in hospital	No severity test
The applicant	• Has discretion whether or not to apply for an order. • Approved Social Worker.	• No discretion. If the criteria for compulsion are met an order must be made. • Any healthcare worker
Nearest relative	• Can discharge a patient (subject to safeguards) • Can object to an order lasting more than 28 days (subject to safeguards)	• Right lost • Right lost
Person in charge of patient's treatment	Psychiatrist	Psychiatrist, Psychologist and others by regulation
Discharge (unless convicted of a serious offence)	▪ Psychiatrist ▪ Tribunal ▪ Statutory managers ▪ Nearest relative	▪ Psychiatrist can be prevented indefinitely from discharging a patient (who has done nothing wrong) ▪ Tribunal
Mental Health Tribunal	• Must include a doctor • When requested by a patient.	• Usually won't include a doctor • Whether requested or not
Psychiatrists duties include	• Undertaking assessments when requested by a GP or other medical practitioner • Writing reports for Tribunal • Attending Tribunal • Serving on Tribunal.	• *As now plus* • Many more Tribunals (more detained patients and occur whether wanted or not) • Undertaking assessments when requested by anyone. • Serving on expert

		panel
Duration of compulsion in the community	• Up to one year for medical treatment	• Indefinitely for medical treatment even if symptom free