Date:	**Wednesday 11 September 2002**
Venue:	**Committee Rooms 3&4, National Assembly for Wales**
Title:	**Mind Cymru**

Introduction

It is apparent that there is a groundswell of opposition in Wales to the core nature of the Mental Health Bill. While it is recognised that some components are welcomed the focus on compulsion may well limit their capacity to work effectively. Mind, along with the vast majority consulted at recent meetings sees the bill as unworkable and regressive. Mind also strongly feels that this bill is not compatible with the values, direction and spirit of the Wales Mental Health Strategies or the Mental Health National Service Framework. We applaud recent AM speakers in the Plenary Debate on the Mental Health Bill who spoke out strongly about the lack of focus on human rights in the Bill.

We also consider that an improvement in community and inpatient services would better alleviate some of the problems which 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.

Part 1: The Definition of Mental Disorder and Conditions for Compulsory Powers (Criteria for Compulsion) (Draft Bill clauses 2, 6, 7)

The grounds for compulsion are made much broader

Despite the Government's stated aim to reduce the amount of compulsion used in England and Wales the Bill **greatly broadens** the grounds for compulsion therefore it is likely to lead to increased and unwarranted use of compulsion with all the extra distress to service users, strain on the mental health and Tribunal system and cost that is entailed.

This results from:

- A broader definition of mental disorder.

- A broader set of criteria for compulsion

The broad criteria may have unintended and unwanted consequences.

The broad criteria give great power to clinical staff and the clinical supervisor and reduce their accountability. The patient has the right to challenge the exercise of compulsory powers at a Tribunal hearing but the breadth of the conditions will limit the extent to which the Tribunal can overturn the clinical supervisor's decision. Also a patient applying for a discharge will face difficulties in showing that s/he no longer meets the criteria if the clinical supervisor opposes the discharge. For the same reasons it will be relatively easy for a clinical supervisor to apply successfully for an order to be renewed.

The Bill imposes treatment on people who have capacity to decide for themselves

Mental illness does not inevitably result in lack of capacity. However, a person with a mental illness can be detained and treated without consent even though that person has the capacity to understand the nature of the illness and the choices of treatment. Mind believes that there is no justification for the continuing legal discrepancy in relation to medical treatment decisions between physical and mental health.

Community Treatment Orders (CTOs) will increase the use of compulsion and drive people away from treatment.

Community treatment orders 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.

Black and Minority Ethnic Communities are likely to be worst affected by any increase in the use of compulsory powers

Previous research has shown that black peopleare more likely to be

- perceived as dangerous
- take to hospital by the police, even if they agree to go voluntarily
- detained
- prescribed higher doses of medication and older forms of major tranquillisers
- kept in secure, locked wards
- prescribed anti-psychotic drugs and less likely to receive non-drug therapies

Any expansion of the grounds for compulsion is a cause of concern for minority ethnic people and the extension of compulsion into community settings is likely to exacerbate this situation further.

The provisions for high-risk patients are flawed.

The Government aim is to use the new Mental Health Act to protect the public's safety from people who are dangerous and have a personality disorder. People who fall into this category are often "treatment resistant" so the definition of treatment has been broadened to include "habilitation" and the 1983 Act requirement that "treatment is likely to alleviate or prevent a deterioration in condition" has been removed. Treatment is defined so widely that it will cover almost any programme to manage or alter behaviour, however limited or ineffective. It also covers "care" which need not involve a therapeutic programme at all.

However, while Mind agrees with the government's desire to protect the public from dangerous people we consider the proposals in the Bill fundamentally flawed. High-risk patients are a low incidence group. The heavy-handed solution in the Bill will be expensive and unworkable.

- Because they rely on a psychiatrist's prediction of risk that someone poses a significant risk of serious harm.
- There has in Mind's view been serious misreporting in the media of the risks represented by people with mental health problems. These proposals reinforce the common but false perception in the public's mind that people with a mental illness are dangerous.
- The scheme is unjust. Why should this group alone be subject to a preventive detention regime when other groups that pose as high – if not higher risks – are not covered? **Is this really the remit of mental health law?**
- They further stigmatise people with personality disorder and will not provide the consensual treatment that would benefit this much neglected group.
- The extent of the problem is greatly over estimated – if improvements were made in services for early intervention, if better use was made of criminal justice powers, if greater training for the judiciary in sentencing options was provided, much could be achieved. Many of the notorious cases concern people who could have been detained under current law.
- The proposed powers are likely to impact disproportionately on certain groups such as black and minority ethnic communities and reinforce the discrimination which they already experience in the mental health system.
- It is likely to be very costly to adequately treat.

Mind's alternative proposals

- **Capacity**
  Mind believes that an assessment of capacity should be the foundation of the compulsion process. 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. 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.

- **Community Treatment Orders**
  We consider that a person should only be subject to compulsory powers if their condition is sufficient to require admission to a hospital or other inpatient setting.
- **More limits on the conditions for compulsion.**
  The Bill should specify the need for objective evidence of mental disorder, as is required under human rights law. We think that this is important especially in the context of stereotyped assumptions made about certain groups. It should specify that that treatment should be "least invasive" as well as "least restrictive"
- **Provisions for high-risk patients**
  Current powers in the Mental Health Act 1983 to detain people should be maintained but not extended in the new mental health legislation. It may well breach human rights law to detain a person or treat them compulsorily in the community only on the basis of a diagnosis of personality disorder and a risk assessment, if they have committed no offence, if compulsion would not be of therapeutic benefit and if they are not before the courts on a criminal charge.

There should be improvements in the current provision of mental health services and in the civil and criminal justice systems. Mind believes that this would have a greater positive impact for this group and for public safety.

Part 2: Applying compulsory powers in civil cases

Preliminary Examination - Stage One (5 days) (Draft Bill clauses 9-16)

The nominated person should be involved at the examination stage. This would be possible if a nominated person has been appointed on a previous occasion, if the person has already expressed his/her choice in an advance agreement or because s/he has capacity to make a choice at the time. Only if none of these applies should an appointment be delayed until the second stage.

An advocate should be sought as soon as the use of compulsory powers is considered. Black and minority ethnic communities particularly value the advocates role in providing a culturally sensitive perspective and preventing the misunderstandings that can lead to a resort to compulsory powers.

Formal Assessment and initial treatment in first 28 Days - Stage Two (Draft Bill clauses 17-27)

The government has not accepted the Richardson Committee Report recommendation that the Tribunal or a court should review the exercise of compulsory powers after 7 days and have a second review at 28 days. Under the current Bill only one application can be made, and this must be in the first 28 days. If for instance the nominated person objects to the preliminary care plan during the assessment period no other approach can be made for discharge until the end of 28 days. At the very least the nominated person as well as the patient should have the right to apply to the Tribunal during the first 28 days.

Furthermore it seems the clinical supervisor will have the sole role in this period. There is no

requirement for a second opinion, nor for a social care assessment. The drawing up of a care plan for the Tribunal will not involve the social perspective if left solely to the clinical supervisor.

While a duty to consult the carer and nominated person is welcome there is no duty to consult either an advance statement nor the patient him/herself, even if the patient has capacity. Nor does the nominated person have an obligation to consult an advance agreement. The Bill also provides for the patient to limit or remove the powers of the nominated person but does not state that in that event the patient should be consulted. In all these ways the patient is the only person whose views appear to be ignored. This is most objectionable and contradicts the Government's stated objectives of involving the patient more in decision making.

The making of a treatment order by the Tribunal – the third stage (Draft Bill clauses 28-50)

Mind is opposed to community treatment orders. It is essential that the circumstances in which police or other agencies have the right to intervene and remove someone against their will are clearly dealt with in legislation, not just left to individual care plans.

The legislation does not provide clear criteria for the Tribunals to consider when authorising care plans.

We support strongly the Richardson Committee recommendation that there is a need to bring into the Tribunal the expertise of carers, users and professionals from outside a hospital. In particular we urge the representation of users, including users from a black and minority ethnic background on the Tribunal.

Police Powers (Draft Bill clauses 140-147)

Mind strongly opposes the proposed extension of police powers to private property since we think it would be open to abuse. It is a fundamental civil right that there should be no power to remove a person from their own property without court authority. If a crime has been committed the police powers for this already exist.

Part 3: Safeguards

Nominated persons (Draft Bill clauses 148-158)

Mind believes the nominated person should have the right to be informed at the time of any examination to receive a copy of the patient's care plan (subject to the agreement of the patient), and to visit the patient at any reasonable time. The one exception would be if this is the first exercise of compulsory powers in which case no one would have been appointed.

Mind also believes that the appointment of a nominated person should not lapse with a person's discharge from compulsion but should remain until the patient makes another choice.

Mental Health Advocates (Draft Bill clause 159)

The provisions fall short of providing the individual with an enforceable right to an advocate, which Mind considers essential from the earliest stage The presence of advocates at all stages is central to the effective operation of the new regime.

We are unclear about the meaning of the word "representation". If this means articulating the views, wishes and feelings of the patient, we are in favour of it; if it means a substitute for legal representation we consider this would be in breach of the Human Rights Act and could not be supported.

Advance statements

There is no mention of these in the Bill and no obligation to refer to these agreements when choosing a nominated person or when making treatment choices. The government says that the Code of Practice will cover advance statements. Mind believes that an obligation on the clinical team to discuss advance agreements and to give help with their preparation should be on the face of the Bill.

Aftercare

Under the 1983 Act a patient discharged from compulsory powers has a right under S.117 to the services that s/he needs, "until such time as the [Health Authority] and the local social services authority are satisfied that the person concerned is no longer in need of such services free of charge". These services, as recently affirmed by the House of Lords must be provided free of charge. There is no reference to this in the Draft Bill.

A Bill that, according to the White Paper, was designed to improve the provision of care and treatment for patients on compulsion is taking away an important **right to services** and providing a perverse incentive for a person to remain under compulsion so that services will be available.

While it is welcome that the Tribunal should have an overview in the provision of aftercare it will have limited value if the Tribunal has no power to enforce any perceived shortfall in the aftercare package. Individuals discharged from compulsion should also have a legal remedy in the event of inadequate ongoing support being provided.

Part 4: Offenders

Offenders before the courts (Draft Bill clauses 57-106)

Given the breadth of the definition of mental disorder 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. There appears to be no right of appeal, and no requirement for medical evidence.

In general we believe that the provisions applying to offenders should mirror those available under the civil system.

We are therefore opposed to the introduction of a single power of assessment and treatment of up to 16 weeks for any offender even before conviction. Such extension should in our view be subject to an overall maximum of 8 weeks, in line with recent human rights case law. Secondly we consider that as in the civil system there should be a role for the nominated person and for the advocate, as well as for the solicitor. Thirdly a social care perspective should be part of the assessment.

Part 5: Treatment safeguards

Psychosurgery (Draft Bill clause 117), Electro-convulsive therapy (ECT) (Draft Bill clauses 118-120)

Mind opposes this new power. We have serious doubts about the continued use of psychosurgery at all in the absence of clear evidence that it is effective. We believe that until there is a rigorous review to determine whether continued use is justified it should be prohibited.

Mind's view is that stronger safeguards are needed for ECT. It is an intrusive treatment and many people have been caused long term harm by it. In Mind's view no one who is capable of giving informed consent should have ECT against their will. Those who are incapable of informed consent should only have it in cases of urgent necessity provided they do not object. ECT should not be given to children or young people under 16, and guaranteed standards of ECT administration should be built into the legislation. Steps also need to be taken to ensure that, where consent is given, it is properly informed.

Polypharmacy and high drug doses

Mind's view is that there should be legally binding safeguards to protect people from these potentially hazardous practices, and specifically that doses above BNF limits should not be given without informed consent.

Long-term treatment without consent

In relation to time periods, the Bill is an improvement on the current situation in which drug treatments can be given without a second opinion for three months. However Mind's view is that people with capacity should not be treated without their consent.

Part 6: Safeguards for patients with long-term incapacity (Draft Bill clauses 121-139)

This is a very welcome improvement in the position of long-term incapacitated patients. However the legal framework for people with long term mental incapacity is inadequate and until an Incapacity Act is

introduced there will be significant limits to the usefulness of these provisions.

The level of scrutiny of care plans is significantly lower for people in this group than those treated under formal powers, in that the Tribunal is not routinely involved. In Mind's view there the medical adviser should be required to consult with non-medical professionals who know the patient, and there should be criteria laid down for the medical adviser to consider in approving the treatment.

Conclusion

Mind calls for an about face on the **lead** that the Mental Health Bill takes. We ask that **rights** to prompt, appropriate service be the prime focus of this Health legislation. Compulsion must only occur in the context of comprehensive Mental Health services and in circumstances where capacity is the main criteria for assessment.