

DRAFT MENTAL HEALTH BILL

A submission to the Joint Committee by the Mission & Public Affairs Council of the Church of England

The Mission & Public Affairs Council of the Church of England is the body responsible for overseeing research and comment on social and political issues on behalf of the Church. The Council comprises a representative group of bishops, clergy and lay people with interest and expertise in the relevant areas, and reports to the General Synod through the Archbishops' Council. The Mission & Public Affairs Council is an associate member of the Mental Health Alliance. This submission was prepared with the assistance of the Church of England's Mental Health Interest Group, whose members have professional and ministerial experience in the field, and reflects the Church's extensive involvement through its network of mental health chaplains.

Summary

On the basis of our convictions about human dignity and potential, we believe that mental health care should accord as far as possible with principles of non-discrimination, patient autonomy, consent and reciprocity. We are anxious that the definition of mental disorder and the relevant conditions for formal powers could lead to excessive and inappropriate use of compulsion (though we recognise the difficulty of dealing with a small number of people who are judged to be both dangerous and untreatable). We are concerned that the provisions for assessment and treatment in the community will prove counter-productive in alienating service users and placing extra pressure on staff. We end by expressing a number of reservations on particular issues: the composition of Tribunals, the role of AMHPs, the rights and powers of nominated persons, independent advocates, care of mentally ill people in prison, provision for aftercare, independent monitoring of detained patients, conditions for ECT and neurosurgery, and resources.

Submission

1. The Church's approach to mental health issues is decisively shaped by its conviction that all human beings are created in the image of God and endowed with inalienable dignity. We also believe, because of the ministry of Jesus Christ, that God's purpose for humanity is the restoration of the outcast, the healing of the sick and the liberation of the oppressed. It is our experience that people with mental health problems can offer to others much that is profound, challenging and life-giving.
2. We believe that mental health care should offer to those who suffer compassion and acceptance, protection from stigma, restriction and exclusion, and the hope of freedom and fullness of life. These priorities are consonant with widely-supported principles such as those advanced in the Richardson Report: non-discrimination, as far as possible, between mental and physical health care; recognition and enhancement of patient autonomy; consensual and informal care where possible, with compulsion as a last resort; respect for diversity; and reciprocity between patient and health care obligations.
3. We emphasise the importance of people with mental health problems participating in their own care, treatment and support. Although the term 'service user' has been adopted for good reasons, it does not adequately characterise the identity of human beings as 'subjects of their own history' who must be allowed and enabled to become subjects of their own healing, personal development and growth in relationships.

Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

4. The general principles set out - patient involvement in decision-making, fairness and openness in decision-making, and minimum interference and restriction in medical treatment compatible with protection of the health and safety of the patient or others - are unexceptionable, but their force is neutralised by their relegation to codes of practice and their broad liability to be declared inapplicable. More robust general principles should appear on the face of the Bill to provide guidance and reassurance. It would also be helpful for draft codes of practice to be published alongside the Bill.
5. The operative principles to be inferred from the detailed provisions of the Bill show the marks of its origin in anxiety about protection of the public from people with dangerous severe personality disorders. While public safety remains an inescapable consideration in a relatively small number of cases, allowing the risk posed by a minority to mould legislation for the majority carries the danger of excessive and inappropriate resort to compulsion.

Is the definition of mental disorder appropriate and unambiguous?

6. We remain anxious about the breadth of the definition, and seek assurance that it will not embrace people with learning disabilities. We believe that the exclusions in the 1983 Act (preventing diagnosis of mental disorder based solely on substance or alcohol abuse or sexual behaviour) should be retained as a defence against using formal powers as a means of social control.

Are the conditions for treatment and care under compulsion sufficiently stringent?

7. We are concerned that the effect of the conditions will be to bring under formal powers many who ought to be treated informally, particularly when the criterion of 'the protection of others' is invoked. The removal of the requirement to show the necessity of compulsion when a person over 16 is at substantial risk of causing serious harm to others seems to undermine the possibility of that person receiving treatment voluntarily. The option of compulsion must be available but, if the patient consents, alternatives ought not be discounted solely because of risk.
8. The condition that appropriate treatment is available is at first sight welcome, but we believe that to avoid compulsion without an adequate clinical rationale treatment should normally be required to be of therapeutic benefit to the patient. Intensely difficult dilemmas of human rights and professional ethics arise when patients are judged to pose a substantial risk of harm to self or others but their disorder is considered to be untreatable. Any special provision for compulsion to meet this situation should take account of the need to explore richer forms of treatment for intractable conditions, which would probably not be effective without consent and co-operation.
9. The relevant conditions, unlike the Scottish Mental Health Act, take no account of capacity. We think there are moral and practical objections to compelling someone to undergo treatment if they are in a position to understand what is involved and decide to withhold consent – except where there is substantial risk of harm to self or others. The place of capacity and autonomy in the conditions for compulsion should be reconsidered, not least to ensure consistency with the Mental Capacity Bill. We favour advance decisions on treatment when people are willing and able to do so. Such decisions should be capable of being overridden on specific grounds, by professionals or by a Tribunal, but not as an automatic result of compulsion as at present.

Are the provisions for assessment and treatment in the community adequate and sufficient?

10. There are two possible approaches to these provisions: one, adopted by the Government, is to regard them as implementing the ‘least restrictive’ principle: milder interventions, to be applied primarily to those who have previously been treated in hospital. The other is to see them as lowering the threshold of compulsion, inducing fears and negative responses among service users, and thereby compromising co-operation and the success of treatment.
11. The provisions are designed for ‘revolving door’ patients – those prone to cycles of discharge, relapse and readmission – to reduce disruption to their lives and relationships. This is commendable in theory, but we agree with the Mental Health Alliance that in practice there may be considerable problems. From the patient’s viewpoint, compulsory treatment in hospital may often be less restrictive and more supportive than compulsory treatment in the community.
12. Although compulsory treatment will not be enforced at home, troubling elements of coercion remain. Police powers of entry into premises and conveyance to a place of safety threaten to increase fear and stigmatisation, and require safeguards in their application to private property, e.g. the need for a warrant (compare Section 135 of the 1983 Act). Mental health staff therefore face heightened conflict between responsibility for care and ‘policing’ of patients’ compliance with imposed requirements.

Are the proposals in the Bill necessary, workable, efficient and clear?

13. Some proposals either build on the strengths of the 1983 Act or remedy its weaknesses. The use of Tribunals to determine longer periods of detention is a welcome reinforcement of patients’ rights, provided that the system is adequately resourced and efficiently operated. It is a matter of grave concern that Tribunals may sometimes be reduced to one member with legal expertise and no access to clinical input.
14. The principle of multi-disciplinary decision-making at the point of assessment in order to review a patient’s total circumstances is good, but it entails that the contribution currently made by Approved Social Workers must be preserved. While the preference for ‘competence-based’ qualification over fixed roles is justified, it is vital that Approved Mental Health Professionals should be able to assess social care needs and to exercise judgment in independence from employers or clinical staff.
15. The replacement of the ‘nearest relative’ by the ‘nominated person’ corrects a defect in the 1983 Act but we consider that the rights and powers of the nominated person in respect of assessment, admission and discharge fall short of what is desirable. Restrictions on appointment on grounds of ‘suitability’ should be formulated very carefully.

16. The affirmation of independent advocacy is good, but we deprecate any tendency to distance advocates from the perspectives and interests of service users by professionalising them. Advocates should be involved as early as possible in decisions about assessment, treatment and discharge.
17. We welcome the framework in Part 3 for dealing with offenders through mental health orders and hospital directions, and are relieved by the abandonment of proposals to extend formal powers to prisons. However, it is essential that people in custody should have access to care equal in quality to that enjoyed by civil patients.
18. Best practice indicates that independent monitoring of detained patients is a crucial element of mental health care. We believe that the transfer of the Mental Health Act Commission's functions to the Healthcare Commission and the abolition of managers' hearings would greatly weaken the monitoring system.
19. We are seriously concerned by the removal of the duty of health and social services under Section 117 of the 1983 Act to provide free aftercare for as long as it is needed, and by its limitation, where it is offered, to six weeks. Should this destabilise patients' recovery, it will prove a false economy.

Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?

20. We welcome the provision for patients with capacity to refuse consent to ECT. We believe that where capacity is lacking, a Tribunal should authorise ECT only in case of urgent need. The safeguards relating to psychosurgery should be more stringent. Despite the argument from best interests, we believe that Type A treatment (psychosurgery/NMD) should never be undertaken without informed consent.

Conclusion

21. We consider it essential that the impact of the legislation should be carefully and publicly monitored. High quality services cannot be achieved without adequate resources. It will be a test of the Government's seriousness in reforming mental health law whether it is able to make available the financial and human resources necessary to deliver the services required.

The Rt Revd Tom Butler
Bishop of Southwark
Vice-Chair (Public Affairs)
Mission and Public Affairs Council
Church House
Great Smith Street
London SW1P 3NZ

October 2004