# INTRODUCTION

This report is about how our society deals with mental illness and how we can afford them the dignity which is their right. In the first part we tell the story of the intense debate which has been taking place during the last five years about how mental health services should develop in England and Wales, and how legislation should be framed to reflect the needs of patients (often called mental health service users), carers and society as a whole. This part of the story reflects the growth of a profound change in the expectations of the way in which those with mental health problems wish to relate to their fellow citizens. The Human Rights Act is central to this debate - and, in its contribution, the Board for Social Responsibility has sought to bring Christian theology and practice to bear on the imperative of giving full human worth to those who are mentally ill, and to their carers. This is a group which has often felt neglected and ignored in society. This report is above all about their call for dignity, individuality and inclusion in society.

The last such report was in February 1992, when General Synod debated a private member's motion introduced by Janice Price which again called for improvements in funding of Community Care for mentally ill people.[1] Much has happened since that debate eleven years ago. In particular, The Department of Health announced a review of mental health legislation in 1998. The current major piece of legislation is the Mental Health Act 1983. Initially the review went well and Professor Genevra Richardson, who chaired the review as a well-known mental health lawyer, achieved an exceptionally wide range of consultation with different groups. It seemed as if service users were being listened to in a promising way. But things began to go wrong.

[1] General Synod Report of Proceedings vol.23. no.1 pages 174-206.

Eventually the Government's proposals to replace the 1983 Act were to be met with fierce opposition from a wide range of interested parties, including service users and professionals. In 2002 the draft Mental Health Bill was to be condemned by both the Royal College of Psychiatrists and the Mental Health Alliance, the umbrella body representing nearly all the voluntary groups. The submission from the B.S.R. echoed these concerns, and staff members kept in touch with the Royal College and the Alliance.

How could things have developed in this way? In November 2002 the Government withdrew the promised legislation from the Queen's Speech for further consultation. This debate in General Synod is an opportunity for further comment before legislation is finally introduced. The debate therefore takes place at a critical time and will be listened to with great interest by those concerned with mental health. It provides a unique opportunity for the General Synod to make a public response to the proposed legislation.

*Emerging Issues in Mental Health* is also a report which examines the fears of our society about those who are seen as dangerous. The Home Office White Paper in 2000 was entitled *Managing Dangerous People,* and was about providing the public with protection against them. The Board for Social Responsibility has taken great interest in this area and in 2001 held a successful national conference on Personality Disorder under the title *Personality Disorder and Human Worth*. The papers from this conference remain as fresh and relevant today as two years ago, and they are printed as the companion document, G.S. Misc. 703. However many mentally ill people often end up in prison, having committed fairly minor crimes. Mentally disordered offenders, or M.D.O.s, have a hard time in

prison which is still not brought within the working of the National Health Service (N.H.S.), or mental health legislation. However in the last two years joint working between the N.H.S. and the Prison Service has begun. The second part of the report covers these issues.
In the third part of the report we move to the heart of the Christian contribution to this issue - how Christian spirituality can illuminate and be illuminated by mental illness? Many great Christian writers and mystics have suffered from mental illness. The eighteenth century hymn writer William Cowper, famous for the hymn *God moves in a mysterious way*, and a profound depressive, is but one of many. There has been a huge growth in the dialogue between faith communities (including Islam and Judaism) and those concerned with mental health in the last decade.

The Board for Social Responsibility and the Hospital Chaplaincies Council have been engaged in a major project to provide parishes with appropriate literature and training resources. The project is called *Promoting Mental Health: A Training Resource for Pastoral Care*. The report is being written, with their active involvement, by a mental health charity called Mentality. The National Institute for Mental Health in England (N.I.M.H.E.) which is an NHS agency, is also involved and co-funding the project. This work will continue under the new Mission and Public Affairs Division. The report ends on this hopeful note and the Synod motion refers to this literature.

## PART ONE

## The 1983 Mental Health Act

In the mid-1950s the Government undertook a fundamental review of mental health services, and eventually passed the 1959 Mental Health Act. This was a far-reaching Act which allowed for the closure of many of the big Victorian mental hospitals in the 1960s and 1970s. The provision of Community Care became the overarching policy for mental health. However even from the outset there were difficulties with funding the care which was actually provided in the community. Many of the hospitals have been closed and converted to other purposes. It was the end of an era but, however bold the initial legislation, the new policy was untried and potentially open to criticism.

Problems and criticisms with the new approach led to a review of mental health services in 1976. However, as Frank Dobson, Secretary of State for Health was to say twenty years later, the 1976 review only " tinkered with the problem." The 1976 review became embodied in the 1983 Act but as time went on the shortcomings of the 1983 Act became more evident. The 1983 Act marked an important advance in the definition of mental disorder and importantly said that sexual deviancy, alcohol and drug dependence should not be regarded as mental disorders. It also covered the issues of admission procedures, including the role of relatives. Compulsory admission and detention were central to the Act, as was seeing the hospital as "a place of safety."

The 1983 Act also gave far more attention to patients' rights but the Act saw rights in a protective manner. For the first time it included consent especially for E.C.T and psychosurgery. It

wished to ensure that treatment given without consent was appropriate and it insisted that there should be some independent review of such treatments. Mental Health Review Tribunals were given greater power and appeals to them have increased. But except for those detained under section two of the 1983 Act (a 28-day order for assessment treatment) there have been long waits before the patient appears before a tribunal. Some of those conditionally discharged patients who were then recalled to hospital by the Home Secretary for committing offences, sometimes fairly minor, have had waits of up to eighteen months before their appeals have been heard.

The role of the Mental Health Act Commission which was reintroduced in the 1983 Act was to oversee the working of the Act. This involves visits to hospitals and the community. This Commission has worked well and has been made up of lay, legal and mental health professionals. The Archdeacon of Lincoln, who will introduce the debate in Synod, and who was previously a mental health chaplain, was a member of the Commission for nine years.

**The Changing Climate in Mental Health during the 1980s-1990s**

The late 1980s and 1990s were a productive period in mental health, which embodied a paradox. It was certainly the case that there was a steady stream of legislation which shaped mental health services in a new way. However this legislation was piecemeal and it also contained two major flaws. First there was no overall vision which could fully match the new spirit of a rights based, community approach which also involved service users and carers in the delivery of programmes.

The growth of service user groups and an awareness of their rights far outstripped the response of the Department of Health and the N.H.S. Secondly there was an acute shortage of funds, beds and community support. When this was combined with some high profile failures of care which sometimes involved homicides there began to be talk, especially in the media, of mental health services in general and Community Care in particular being ' in crisis'. The fact that Community Care is more expensive than institutional care has never been grasped.

The claim that there was a crisis in Community Care was a gross exaggeration but there was enough truth in the allegation for there to be profound unease at how mental health services were responding to the needs of those who were vulnerable. It was because of this that at the end of the 1990s all political parties, mental health professionals and voluntary groups came to feel that root and branch reform was needed. But before the 1998 review is discussed it is important to summarise the changes in the period 1983-1998,and in particular The NHS and Community Care Act 1990.

The 1990 Act enacted a needs-based approach to care, involving service users and carers in the assessment of their needs and planning of care. As a result in 1991 the Department of Health introduced the Care Programme Approach (C.P.A.) giving Health Authorities responsibility for ensuring that this was delivered " in conjunction with local authority social services." By 1997 mental health services were primarily organised around a Care Programme, although there were some difficulties with the extent to which local doctors in the community were aware of the issues in mental health. A second concern was the extent to which local authority social services departments could co-operate with health authorities.

Sometimes there was either a duplication of services or a failure to co-operate as fully as was needed. Also relevant was the Disability Discrimination Act 1995 and the subsequent creation of the Disability Rights Commission. Another piece of legislation was the Carers (Recognition and Services) Act 1995 but voluntary groups representing mental health service users argued that more needed to be done on this. It was felt that this Act gave carers no powers of enforcement of their rights.

There was, then, a considerable amount of legislation in this period. There was also a significant reduction of long-stay hospital beds which was indeed the objective of the 1959 Act. This however went too far. It became clear that there were insufficient beds in the community; insufficient acute hospital beds and inadequate community support. Part of the response to this was yet more legislation. The Mental Health (Patients in the Community) Act 1995 saw the introduction of supervised discharge and supervision registers which led to an emphasis on risk management and assessment. This was an over enthusiastic response to one incident when a person climbed into the lion's den at London Zoo.

There have been many examples of adverse and unfounded media portrayal of mental health patients as violent killers. Recent surveys have shown increasing fear in society of mentally ill people and a rise in the stigma attached to mental illness. This has affected both mental health patients and professionals, and encouraged defensive practice for fear of legal consequences. It also made it harder for those with mental health needs to receive appropriate treatment. The stigma of being "sectioned" has created many difficulties, including discrimination by insurance companies and employers, as well as the personal distress for individuals, and restrictions on travel. While compulsory treatment will always remain

necessary for some individuals it is important that steps are taken to reduce the stigma associated with this. This stigma can be countered by a programme of education, as well as by legislation against discrimination, and the final section of this report shows how the churches are working with the National Health Service and independent charities in a programme of education.

Perhaps the greatest change in the last fifteen years has been the development of a profound awareness that those with mental health problems had a right to be treated in the same way as everyone else. There was a recognition that paternalism, however well intentioned, was not enough. Myra Fulford writes of her work with The Manic Depression Fellowship (M.D.F.) that in the 1990s M.D.F. began to be run by service users themselves:

> "This paradigm shift resulted in increased confidence in their own skills on the part of the membership, a recognition of the potential for individuals to learn and develop strategies for mentioning episodes of mental ill health, and a significant growth in the membership of the charity."[2]

The new climate in the 1990s also included the growth of the mental health service user movement, and the awareness of the importance of civil rights. The Human Rights Act has encouraged this development, where rights are not seen simply in a protective way but also include the involvement of service user (or patient) views when planning new services, and their monitoring of services, as the 1990 Act allowed. Charters were

[2] Myra Fulford ' The Prisoner as Volunteer' in P .H Sedgwick and C. Jones *The Future of Criminal Justice* (S.P.C.K., 2002) page 106.

introduced to meet this demand at local and national levels, including a charter for Community Care.

Alongside the legislation has come the vision of an advocacy-based approach to mental health, where service users could have someone to argue their point of view. There was also the need to pay attention to the tension which can arise between the wishes of service users and those of their relatives or carers by clarifying which should take precedence. This was so especially in relationship to compulsory admission or medical treatment. The charity Mind argued throughout the last decade that as the 1983 Act could be used to detain so it could also be used to ensure treatment and care were available as of right. Given this, there is a real question whether some of the legislation in the 1990s was necessary.

As already mentioned, there were great shortages of hospital beds for acute treatment, especially in London, throughout the 1990s, and chronic underfunding. There was also no right to aftercare except under Section 117 of the 1983 Act (which placed a joint responsibility upon health authorities and social services to provide appropriate aftercare for patients on the longer sections of the 1983 Act). This often proved unsatisfactory in practice. Housing and accommodation are important to good community care. Housing legislation created difficulties with access to appropriate housing for mental health service users. It was not easy for mental health users to claim a right to housing.

Another issue arises in relation to the rights of children and adolescents. There was confusion in the last decade caused by the different bases for giving parental consent between the Children Act 1989 and the Mental Health Act 1983. Clearer legislation, and a discussion of the difficulties might lead to

help being available earlier for families in trouble, especially where there were also issues to do with drugs and alcohol (dual diagnosis).

There was also the need to ensure that where a parent had a psychiatric illness and was being cared for by a young person that the needs of both parties were met, especially the needs of the young person. All this meant that by the mid 1990s there was an increasing sense that reform of the 1983 Act could not be put off. But what sort of reform On this there were different voices to be heard. Some wanted greater protection for the public in the wake of some high profile homicide cases, and the Zito Trust and Sane campaigned for this.

Christopher Clunis, who was a mentally ill patient released into the community, killed Jonathan Zito at a railway station and the ensuing inquiry found that service providers had failed to collaborate effectively. Jane Zito, his widow, founded the Zito Trust to campaign for change in the law. Other homicide inquiries followed, revealing further failures in collaboration.

Others wanted greater power to require the mentally ill to agree to treatment when their refusal arose from their inability any longer to make appropriate judgements. The tragic case of Christopher Edwards illustrated this. Christopher Edwards refused to take his medication, assaulted a police officer, was arrested and refused bail, committed on remand to prison and locked up with another mentally ill patient overnight. His fellow inmate, Richard Linford, then murdered him in his cell. There was a failure to realise that Richard Linford was a high-risk prisoner, so Christopher Edward's death was a tragedy for both families. It was a grave mistake for them to share a cell.

The Board for Social Responsibility supported the Edwards family in their call for an enquiry. The Bishop of Lincoln sponsored a debate in the House of Lords on their case, and the B.S.R. General Synod report *Prisons: A Study in Vulnerability* had a chapter on the case. In 2002 in a landmark judgement the European Court of Human Rights found in favour of the Edwards family and ruled that they had been denied their rights for a full enquiry. In June 2002 the B.S.R. and the Catholic Agency for Social Concern successfully nominated Audrey Edwards for the first Longford prize [3]

Others again campaigned for much greater responsibility to be given to mental health service users, or for greater attention to the needs of carers. This was the message tirelessly argued for by the main mental health charities, such as Mind, Rethink (formerly National Schizophrenia Fellowship), Manic Depression Fellowship and others. Their campaign reflected the profound changes in the understanding of human rights described earlier. The increasing public voice of service users and carers has been an important development. In all of this it was clear that the 1983 Act was insufficient to meet the demands of Human Rights legislation and that there was an urgent need for a substantial increase in funding.

## The review of the 1983 Mental Health Act

It became evident in the 1990s that since the 1983 Act was insufficient for the needs of a changing mental health service, there was a need to take a fresh look at mental health services. Piecemeal legislation and limited funding would not be enough. In effect then the review announced in 1998 took the

[3] Audrey Edwards *No Truth, No Justice* (Waterside Press 2002) tells their story.

Government back to an examination of the past fifty years of treatment and after care. The aims of the 1959 legislation were to be looked at afresh, because it was over forty years since that Act was passed. That is why the five years since the review was announced in 1998 have been so important for the future of mental health services in England, and why it is so timely for the General Synod to debate the issue. The Board for Social Responsibility, guided by its expert Mental Health Interest Group, chaired by Ven Arthur Hawes (membership listed in Appendix 3) has played an active part in responding to the review. Its papers have been widely disseminated and appreciated.

In 1997 the Conservative Government issued a Green Paper on this topic, but left office before it was able to embark on a full-scale review of the issues. Instead this fell to the new Labour Government. On 29 July 1998 the Secretary of State for Health, Frank Dobson announced a review of the Mental Health Act. He said that

> " The law on mental health is based on the needs and therapies of a bygone age. Its revision in 1983 merely tinkered with the problem. What I want now is root and branch review to reflect the opportunities and limits of modern therapies and drugs.
>
> It will cover such possible measures as compliance orders and community treatment orders to provide a prompt and effective legal basis to ensure that patients get supervised care if they do not take their medication or if their condition deteriorates.

> The changes in practice we are seeking will be backed by changes in the law. They will be helped by extra funds for mental health which forms part of the Comprehensive Spending Review settlement for the N.H.S. and local authority social services. Extra funds will be available for the modernisation of services. These will need to be both clinically and cost effective and targeted on evidence based outcomes."

Frank Dobson promised more acute mental health beds, more hostels and support accommodation, improved mental health training for local doctors and others in primary care, extra counselling in health centres, home treatment teams, and 24 hour crisis teams to respond to emergencies. He also promised a new National Service Framework for mental health covering both health and social care providing guidance on the level and balance of services needed in each locality. All this was welcomed by mental health professionals and service users alike. Later the National Institute for Mental Health in England (NIMHE) was established.

As already mentioned in the Introduction, this hopeful beginning was to encounter much opposition. However it is important that many of the advances are recognised and welcomed. The National Service Frameworks established much service user participation without the need for legislation. It is important that a dialogue is maintained with the Government on this issue.

## Issues in the Review of the 1983 Act

A brief history of the review may be helpful. The government called for evidence in October 1998, and set up a review body chaired by Professor Genevra Richardson, herself a Mental Health Act Commissioner. An exceptionally wide consultation with a great number of interested parties took place. Its report (Review *of the Mental Health Act 1983*) was published in November 1999, alongside the government's Green Paper, *Reform of the Mental Health Act 1983.*

Shortly afterwards the Government published another consultation paper on those people with Dangerous Severe Personality Disorders (D.S.P.D.), entitled *Managing Dangerous People*. The B.S.R.'s response to this document is described in Part Two of this report, but it is important to see the story as a whole. In June 2001 the White Paper *Reforming the Mental Health Act* was published followed a year later by the *Draft Mental Health Bill.* The Mental Health Alliance was formed to express the views of service users and carers to this proposed legislation. The B.S.R. submitted responses to all the stages of this process, and collaborated closely with the Royal College of Psychiatrists and the Mental Health Alliance.

## Improvements in the Legislation

The Sainsbury Centre for Mental Health in its analysis of responses to the Bill described these as being almost universally hostile. Some stakeholders saw the Bill as being too draconian and others saw it as being impracticable and unworkable. By prolonging the debate over a long period, and by making little apparent response to issues raised by the mental health community, the Government seems to have lost

the good will and support of many key stakeholders including psychiatrists, carers, nurses, service users and lawyers. However the Sainsbury Centre argued that there appeared to be a level of hysteria about the current Bill which was not fully justified. The review process certainly resulted in some improvements . These included a much greater development of advocacy, an enhanced Mental Health Review Tribunal, additional protection for children, and the inclusion in the legislation of those with organic brain syndrome. In all these aspects the government appeared to have listened to the changes demanded by mental health charities in the last decade.

**Problems with the Legislation**

There were however considerable problems identified with the draft Bill. In essence the Government seemed to have been swayed by those who wanted much greater public protection against the risk of homicide by the mentally ill when care plans break down. The evidence that there was a very low risk of violence associated with those with mental illness was ignored in the debate.

The Government proposed extending compulsory treatment into the community, making orders generic so that clinicians could decide when it was necessary to move a service user to a hospital setting. This represents a potentially large increase in the ability of professionals to intervene in the lives of service users. At the same time the treatment of a person in the community successfully depends on intensive, assertive outreach services being in place, able to respond quickly to a crisis. Such services have been tried out in Birmingham and elsewhere, and far more were promised in the 1998 Government statement. Nevertheless such services are by no

means fully in place, and so service users may well feel that compulsory treatment in the community could be a means of control and the assertion of the priority of public safety.

As long ago as the 1970s the Butler Report recommended building regional secure units. Thirty years later only half have been built. The danger, which has been repeatedly asserted by professionals and the Mental Health Alliance, is that service users may disengage from treatment, thus negating the very idea of assertive outreach. If patients are to be subject to compulsion in the community they must also have a reciprocal right to care.

Other problems with the Bill include such a widespread definition of mental disorder that alcohol and drug dependence, along with sexual deviancy, is no longer excluded from the legislation unlike the 1983 Act.

There are also widespread fears that the Mental Health Review Tribunals will prove unworkable, or will become reliant on a single lawyer certifying people as being of unsound mind - a reversion to nineteenth century legislation. There are far too few psychiatrists at the moment to staff such tribunals. The loss of confidence of the Royal College of Psychiatrists will certainly affect the implementation and effectiveness of the legislation. Equally the removal of the Approved Social Worker from the process of approving a section under the 1983 Act could lead to the loss of an independent perspective. So too the abolition of the Mental Health Act Commission could be a sensible move if there was to be an overarching Health Inspectorate, as is proposed, with visitorial functions. But again the danger is that valuable expertise could well be lost.
In sum , this draft Bill has resulted in many professionals and service users being very concerned that an emphasis on public

safety dominates every thing .This may prove an unfounded fear, but it is one that is widely shared in the mental health community. In response to these fears the Synod is invited to endorse clauses (a) and (b) of the motion which deal with these issues.

## PART TWO

## Criminal Justice and Mental Health

### 1. Personality Disorder and Mental Health

Every individual has a unique personality which is demonstrated in a person's interaction with the rest of the world. Extremes in some personalities have been considered by mental health professionals as appropriate to classify as "personality disorder". This has long been recognised in international medical practice. Such people have a "callous unconcern for the feelings of others…gross and persistent attitudes of irresponsibility…an incapacity to maintain enduring relationships …a low threshold for the discharge of aggression…an incapacity to experience and to profit from experience…persistent irritability" (definition in ICD10, International *Classification of Diseases*, World Health Organisation, 1992).

People with personality disorder are difficult to treat, and psychiatrists have usually been clear that they could not be subject to compulsory treatment orders unless they has concomitant mental illness. The 1983 Act makes it very clear that the person can only be detained in hospital if they are likely to benefit from treatment.

Most psychiatrists will therefore not admit people with personality disorder to hospital unless they also suffer from mental illness. In brief, personality disorder is not as such a mental illness. However there have been those who have alleviated this condition, sometimes to a high degree, by therapy and other practices. A recent court judgement has extended the notion of treatment.

In 1999 the government estimated that there was a small group of people, probably fewer than three thousand, who suffered from what they called Dangerous Severe Personality Disorder, or D.S.P.D. This was neither an agreed medical nor legal term but it indicated the area in which the government wished to legislate.

The Home Office proposed preventative detention when the person was neither mentally ill, for which they could be treated by clinicians, nor had committed a crime, for which they could be imprisoned. For the first time since wartime and anti terrorist legislation they could be detained indefinitely because of what they might do. They were perceived to be potentially high-risk offenders and, as such, should be detained for their own safety and that of the public.

The 1999 Home Office document *Managing Dangerous People* provoked a storm of protest and a confrontation with the Royal College of Psychiatrists, who said that the proposed legislation turned them into gaolers. They claimed that it was impossible to predict with any accuracy what people would do, and as a result some people would commit crimes and others would be undetected. Most seriously, it removed the treatability criteria for detention which was specifically mentioned in the 1983 Act. Nevertheless the government

persisted with its plans, and began to spend considerable sums both on commissioning research on this issue and on piloting two centres at Whitemoor, which is a maximum-security prison, and Rampton which is a special hospital. Whitemoor is under the jurisdiction of the Home Office and Rampton is in the N.H.S. The proposals still existed in the draft Mental Health Bill in June 2002. The treatability clause in the 1983 Act was to be reworked so that any care, education or nursing could count as treatment.

Considerable opposition continued to come from the Mental Health Alliance, the Sainsbury Centre for Mental Health and the B.S.R. The B.S.R's reservations are spelled out in Appendix One of this report and in the companion volume of papers, *Personality Disorder and Human Worth* G.S.Misc 703. It is acknowledged that the care of those with personality disorder remains a difficult and complex business, but the essays by James Naylor, Tim Newell and others in the companion volume show what can be done. Dr Aggrey Burke, a consultant psychiatrist and member of the B.S.R. Mental Health Interest group, has worked with such people for many years using therapeutic methods.

The Synod motion addresses these issues in part (b), where it asks the Government to retain the 1983 Act's requirement that a person must be able to benefit from psychiatric intervention before they can be detained.

## 2. Prisons and Mental Health

It has been known for many years that the 1959 Act increased numbers in the Prison System. Juliet Lyon, the director of the Prison Reform Trust, argues that

> "A key factor in the upsurge in the prison population was the government decision, following political debate, to close many of the large, long-stay psychiatric hospitals and to create instead a system of care in the community. The strategy failed because adequate systems of treatment and specialist support were not put in place and vulnerable people looking forward to independence found only isolation and lack of care. Significant numbers continue to find their way into the criminal justice rather than the mental health system".[4]

There is a deep paradox in all this. Throughout the 1990s both Sir Stephen Tumin and Sir David Ramsbotham, Chief Inspectors of Prisons, criticised the prison system for very low levels of care, especially in mental health. There is now much greater investment in mental health services in prisons, and while conditions still remain very poor in some areas there is the prospect of real improvement which is long overdue. The first paradox is this. First, should mentally ill people be in prison at all? There are court diversion schemes operating in some areas to divert those with mental illness but they do not always work. There are also voluntary groups and charities such as Revolving Doors which befriends those who leave prison with mental illness and attempt to ensure that they do not return through the familiar (revolving door) syndrome of becoming homeless, or feeling inadequate, committing a minor crime perhaps while drunk or under the influence of drugs, and returning to prison. But in spite of this there are still many people with mental illness in prison.

[4] Juliet Lyon 'The Political Debate' in Sedgwick and Jones op.cit. pages 26-27.

The second, and deeper paradox, is whether it is correct to treat people in prison for severe mental illness. In his final contribution as Bishop of Lincoln to a debate in the House of Lords on 11 July 2001, the last Bishop to Prisons, Bishop Bob Hardy, raised the question of the relationship of prisoner and doctor inside a prison:

> "I believe that the 1999 National Framework for Mental Health now applies to prisoners as much as to anyone else. That means that local prisons have to be considered when the NHS draws up its local plans. That is surely a timely and welcome step forward, as is the news that by 2004 funding will allow 300 extra staff to work in prisons in mental health. In addition, no one with severe mental illness will be discharged from prison without a care plan and a named co-ordinator.
>
> But severe problems remain which demand urgent attention. I believe that many existing prison doctors do not hold a GP qualification. Medical staff are often clinically isolated and the heavy pressure of work makes it difficult for them to continue with their professional development. Many health centres in prisons remain relatively poorly equipped. There are insufficient inpatient units and more attention is needed to provide secure adolescent mental health services.
>
> Behind the need to improve healthcare facilities lie some important questions. First,

> is the prisoner to be regarded as a patient, with the same status as a patient in a GP surgery? What rights do they have? Can the Minister give us some information on that?"

The draft Mental Health Bill of June 2002 proposed allowing compulsory treatment orders to apply in prison. Prison is, however, a wholly unsuitable environment to administer long term compulsory treatment. Many argued that if a prisoner was ill enough to require compulsory treatment he or she should be transferred to hospital. This proposal would place a burden on prisoners, prison staff, relatives and health care staff. One suggestion was that the Bill should be amended to allow compulsory treatment for up to 72 hours in prison after which a hospital transfer must follow.

The number of prisoners with mental health problems is not small. The official figures from from the 1997 survey of the Office of National Statistics are [5]:

| | *Adult Males* | | *Adult Females* | |
|---|---|---|---|---|
| | Sentenced | Remand | Sentenced | Remand |
| Neurosis | 5% | 15% | 13.2% | 27.7% |
| Personality Disorder | 7% | 9.9% | 8.4% | 13.5% |

The Prison Reform Trust estimate that of the 4,000 women in custody in England and Wales 40% have been mental health patients, 20% have been in-patients in a mental hospital and 33% have attempted suicide, sometimes more than once. The figure for physical and sexual abuse is also very high. Without appearing to condone their crimes it must be asked if prison is

[5] *Prisons: a Study in Vulnerability* (G.S.Misc.557) 1999 page 59

the appropriate place for such people. There are similarly shocking figures for young people in prison.

The rate of mental illness for these offenders is no less than fifty times higher than for young people at home. 10% of sentenced young offenders suffer from a serious psychotic illness, such as schizophrenia which is often exacerbated by high levels of drug taking and alcohol consumption. Sir David Ramsbotham referred to prisons in a recent essay as " wells of psychiatric morbidity." Suicide figures for young prisoners are now at an all time high, having increased dramatically in the last two years. This is in spite of strenuous efforts made by the Prison Service to prevent suicide and self- harm. The harsh fact is that the sheer overcrowding of prisons, with some prisoners being moved around the system far from families simply to find a spare bed, mean that preventative systems will fail because of pressure of numbers.

Many prison chaplains spend hours befriending those prisoners who are mentally ill, working with those at risk of self-harm and providing spiritual and counselling support. It is a very encouraging sign that prison mental health care is at long last being improved, with significant sums being spent on their rehabilitation. Nevertheless it is all too often the case that some of those who are committed to prison in the twenty-first century are little different to those who were sectioned to the old lunatic asylums in the early twentieth century. Prisons remain an area of mental health where there is a long way to go before they cease to be institutions which should trouble the nation's conscience.

The General Synod motion refers to these concerns in part ( c).

## PART THREE

## Spirituality and Mental Health

There has been a huge increase in the recognition given to spirituality by the mental health community in the last decade. This was due to the pioneering work of mental health chaplains, especially (but by no means solely) John Foskett, the staff at the Maudsley Hospital, alongside the work of the Mental Health Foundation, the Bishop Robinson fellowship and many others. The result of this activity was that voluntary bodies, such as Rethink (formerly National Schizophrenia Fellowship), could issue a briefing paper on the importance of paying attention to the place of spirituality in the treatment of mental illness. Also significant was the publication of a joint document in 1999 between the B.S.R., the Jewish Association for Mental Illness (J.A.M.I.) and the Health Education Authority called *Promoting Mental Health: the role of faith communities - Jewish and Christian perspectives*. This was the first time that an official body like the Health Education Authority had collaborated with a religious organisation in promoting mental wellbeing.

The tide has now well and truly turned. Among many instances it is worth mentioning that the Royal College of Psychiatrists now has a special interest group on spirituality with a section of their website devoted to papers from this group, co-ordinated by Dr. Andrew Powell at http://www.rcpsych.ac.uk/sig/spirit. Their website speaks of

> "the growing professional recognition of spirituality as a relevant mental health factor in clinical care and research, and the need to discuss some of the recent changes in

> residency training and clinical assessment so that this includes patient spirituality. Findings include positive clinical associations of spirituality with mental health in the areas of 1) prevention, coping, and recovery from depression, 2) suicide prevention, 3) substance abuse prevention and treatment, 4) coping with surgery and severe medical illness, 5) enhancing health behaviours, and 6) links with longevity. Research also identifies potential harmful aspects of some spiritual/religious beliefs or attitudes."

Another major contributor is Vicky Nicholls, who has managed the Mental Health Foundation (M.H.F) project on how people in distress manage their mental illness. *Knowing our own minds*, published in 1997, was the initial document on how alternative therapies, religion, and spirituality could help with recovery. The next document was a series of interviews with the mentally ill, entitled *Strategies for Living*.

After this came *the courage to bear our souls*, published in 1999 which again showed the importance of religion in the lives of those with mental illness. Finally there came a long-term study of some thirty patients in Somerset which recorded how they saw their illness, how seriously mental health professionals took the role of spirituality and religion in their recovery, and praised the work of chaplains. This study was published in April 2002, and was called *Taken Seriously: the Somerset Spirituality Project.*

There is now a huge interest in the subject. A mental health-spirituality forum meets regularly in London, hosted by a charity called Mentality which arose out of the Health

Education Authority. Mind's branch in Croydon is also making a video on mental health and spirituality, and other examples of the recognition of the role of religion and spirituality occur every few months.

So where are the churches in all this interest in a holistic approach to mental wellbeing? Chaplaincy has always promoted a holistic understanding of the patient and the College of Health Care Chaplains has long had a mental health section. Their work has now spread into the community, and some dioceses such as Lincoln have chaplains who work primarily outside the hospital setting. Other dioceses such as Guildford and Southwark have had project officers in Social Responsibility who promote an interest in mental health. Bishop Stephen Sykes made a well regarded video on the importance of including those with mental illness in the Christian community in the 1990s called *With a little help from my friends*. This was widely distributed, especially by the Association for Pastoral Care in Mental Health.

What is now taking place is a sustained dialogue between the churches, theologians and mental health professionals. Only a few instances can be given, but it is important that the whole church recognises that this is an emerging area of debate and dialogue. Examples of theologians who have written in this area include Archbishop Rowan Williams (*Lost Icons,* and many other books ), Alison Webster (a recently published book from a feminist perspective on spirituality entitled *Wellbeing*), and John Swinton ( *Spirituality and Mental Health Care).*

There are also chaplancies and institutions which promote this dialogue. Among them would be Julia Head at the Bishop Robinson Chaplaincy at the Maudsley Hospital and the St. Marylebone Healing and Counselling Centre, in London. In

Norwich there are the Anne Frank annual lectures founded by Arthur Hawes. In Thirsk, North Yorkshire, Holyrood House provides residential care, counselling and courses which promote dialogue between spirituality and mental health. Finally in 2000 the General Synod debated *A Time to Heal* the report of a working party chaired by Bishop John Perry.

The Board for Social Responsibility has now handed over to the new Division of Mission and Public Affairs (M.P.A.) a major project to write a training resource for parishes on religion and mental health. This will be funded by a number of parties including M.P.A., the National Institute for Mental Health in England (NIMHE) and the charity Mentality. It is entitled *Promoting mental health: A Training Resource for Pastoral Care.*

This project will lead to the development of materials which can be use by mental health chaplains, parish clergy and laity and mental health professionals. It is also a project which will pioneer the way forward into greater collaboration. NIMHE, as part of the modernisation agency of the N.H.S., hopes to work shortly on a project which will give official recognition not only to the pastoral care which chaplains have provided for many years but also to the role of spirituality in promoting the recovery of the whole person.

The public debate about mental health represents an opportunity and a challenge to the churches, to theologians and to chaplains and other carers to create an understanding of spirituality which is true to its Christian heritage but which can also enter into a dialogue with other faiths and with mental health professionals. It is very exciting that the Division of Mission and Public Affairs has this opportunity to bring together its constituent parts of mission, public affairs and

hospital chaplancies in a project which will assist parishes while being in dialogue with mental health professionals.
There are four themes which are worth highlighting in the dialogue between religion, spirituality and mental health. These are as follows:

- Faith communities have a great potential for increasing the public understanding of mental health issues.
- Religious faith gives many service users a reason for living when all else seems to have gone. This resource cannot be underestimated.
- The relationship between spirituality and theology has become pivotal for religious practice. Lay people as well as clergy are central in expressing this relationship.
- There is a need to educate social care staff and mental health professionals in this new area. The interest of the National Institute for Mental Health in England may well be crucial here.

Lynne Friedli, Director of Mentality, has written:

> "Recognition of how common mental health problems are and the shared experience of distress within a congregation can provide a strong foundation from which to explore the meaning and value of mental health promotion within the expression of religious faith. From this perspective faith communities have an important role in increasing understanding of mental health

issues and challenging stigma and discrimination."[6]

This shows how congregations, and indeed other religious faiths, are able to explore mental health issues. Chaplains have a crucial role here in assisting parishes in this work, as can adult education, social responsibility and training officers. It is one ministry in which different aspects of the church can engage with this issue.

The second theme is how greatly service users value their faith. Alison Webster brings out this dimension skilfully in her book *Wellbeing*, showing how much the institution can find it hard to accommodate the insights and gifts to which their new experience has given them access.[7] Yet the experience of spiritual writers, poets and hymn writers across the centuries is shot through with a profound experience of encountering illness and being held there by the love of God. Some of the greatest writers on spirituality in recent times from Henri Nouwen to Gonville ffrench -Beytagh, who was forced to go into exile from South Africa because of his opposition to apartheid, suffered from depression .This encounter with illness was not incidental but central to their understanding of religious faith.

The third theme is that the enormous growth in spirituality in recent years is important for those both in religious institutions and those outside. Webster quotes Dan Hardy who points out that spirituality is often a haven for those who have freed themselves from conventional religious practice and its

[6] L. Friedli ' Social and Spiritual Capital Building:' *Political Theology* , 4 ( 2001) page 61 cited Alison Webster *Wellbeing* (scm press 2002) page 98
[7] Webster op.cit. , especially page 96.

underpinnings in theology. [8] This is a great challenge for the churches, and the new Diploma /M.A course at the University of Leeds for health care chaplains (developed with the Hospital Chaplaincies Council) has some valuable insights on this. Chaplains can work with those service users who may appear far from conventional religious practice but are searching for an answer to their spiritual needs.

Finally there is the need to educate mental health and social care professionals. Again Alison Webster points out that many young staff have grown up far removed from religious faith, with only a text book knowledge of the major religions. However it would be wrong to end on a downbeat note. The National Institute for Mental Health In England, which is part of the modernisation agency of the N.H.S., sees this area as crucial for its future work. It is actively engaged in promoting this dialogue, and has co-funded the new training resource for parishes. Some of its staff will be listening to the debate today and this represents a real opportunity for dialogue.

The Synod is therefore invited to pass the motion which expresses its support for this dialogue, using the resources from all three areas within the Division of Mission and Public Affairs of Mission, Public Affairs and Hospital Chaplaincies Council.

[8] Webster op.cit. page 117 quoting Dan Hardy *Finding The Church* (scm press 2000 ) page 95.

**APPENDIX 1**

# Church of England Board for Social Responsibility

# Response to

## The Draft Mental Health Bill June 2002

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### Introduction

1. The terms of reference of the Church of England Board for Social Responsibility require it 'to co-ordinate the thought and action of the Church in matters affecting the life of all in society'. The Board reports to the Archbishops' Council and, through it, to the General Synod.

2. The Board welcomes the Government's invitation to comment on the Draft Mental Health Bill. The Board has a long-standing interest in mental health policy and responded to the three documents issued in the past three years: the Richardson review of the Mental Health Act, the 1999 Green Paper, and the 2000 White Paper. Our response to the draft Bill builds on our earlier responses.

3. Our response is organised under particular headings. Before responding to the questions on pages 11-15 of the Consultation document, we wish to make some initial comments. These reflect the approach which we have adopted in the responses we have given over the last few years. We regret the very limited time made

available for a comprehensive consultation - a point emphasised by the Royal College of Psychiatrists.

## Issues of principle

4. There is a need to underline issues of redemption and freedom. Our concern must be that the overall thrust of the Bill is preoccupied with issues of public safety. This concern has been expressed by the Mental Health Alliance, to which the Board belongs as an Associate Member. It is echoed in the letter of 26 July 2002 from the President of the Royal College of Psychiatrists to Mental Health Trusts in England. In this letter the Royal College argues that 'in essence this is a Public Order Act'. We share these concerns. In the words of the briefing prepared by the Alliance, we too are ' most disappointed that key points expressed in recommendations of the Richardson Committee, expert opinions and our responses to Government have not been accepted in this Bill. We have grave disquiet about its central provisions, which we consider are unworkable and regressive. There are some welcome aspects of the Bill but we fear that these may fail to work effectively in the proposed framework'.

5. In terms of Christian theology the proposed legislation represents an unwelcome move from 'grace' to 'law' in that it is more unforgiving. A richer assessment of the needs of the individual is necessary, if the importance of allowing the individual as much freedom as possible under the care plan is not to be forgotten. The point behind the principle that psychosurgery should not be undertaken without the patient's consent, for example, is of more general relevance in this field. A Christian

approach stresses the importance of allowing individuals to make choices, and to progress, renew and change their lives.

6. The draft Bill also treats mental illness exclusively as a medical condition and so fails to acknowledge the relevance of factors such as spirituality, race, gender, and culture, in both assessing and treating mental illness. These factors are also important in maintaining good mental health.

**Social deprivation**

7. In general, we greatly regret the fact that so much in the proposed Bill fails to address the shortcomings in existing mental health provision, and may even exacerbate the situation. The proposed legislation fails to address the causal link between social deprivation and mental illness and the cultural factors involved in perceptions and diagnosis of mental illness. It is, for instance, a matter of great concern to us that 50-70% of patients in London are black, and that they are over-represented among detained patients.

8. Many patients complain about abuse of all kinds. The system ought to have a duty to provide a safe environment for detained patients. It remains the case that where some patients need to be detained on wards, other patients are also restricted even when there is no such need.

9. We also believe that the disparity in provision of mental health services is unacceptable. The environment in

which patients are detained ought to be modern, of a high standard, with single sex wards.

**Partnership**

10. It is essential that mental health staff, patients and their family and friends who support them work closely together. To do this it is necessary for patients and their carers to be provided with information in a format that they can understand. A duty should be placed on managers to provide this information.

**Overseeing the implementation of the new Act**

11. We believe that the role of hospital managers should be extended to the community. They might be called instead Mental Health Act managers. We see their duties as including the provision of a safe environment in hospital and providing information to patients and to carers; protection of the patient's right not to be discriminated against; and ensuring that a patient's cultural needs and spiritual beliefs are respected. They should be responsible for the scrutiny of all documents relating to detention, and treatment.

**The Criteria for compulsion**

12. We wish to comment on the four conditions set out for compulsion. These appear to suggest that decisions about detention will depend on the availability of resources. A much more specific definition of mental disorder is needed, and this needs to be explicitly set out in the legislation, rather than in a code of practice, where it might not be subject to consultation. The new

Bill offers a much more general definition of mental disorder. In addition it defines a far broader set of criteria for compulsion, since the requirement of hospital admission is removed. The current requirement of treatability and treatment for some patients has also been removed. There is no requirement to exhaust less restrictive options first if the person is considered a danger to others. We also have concerns that, unlike the 1983 Act, alcoholism, drug misuse, and sexual deviance have not been excluded from the Bill. (Consultation Document Sections 3:24 to 3:26)

13. Richardson proposed a reciprocal right of treatment. We support this. People subject to compulsory powers should receive free health and social care including free medication for as long as health and social services consider that they need it. This should extend beyond the compulsory period to a further period of continuation of care along the lines of Section 117 of the present Act. People subject to compulsory powers should not be expected to pay for their medication. After-care ought to be available until it is deemed to be no longer necessary.

14. The Bill does not deal with transfer. We agree with the Mental Health Alliance 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 for assessment. Hospital is also a safer environment for the initial exercise of compulsory powers when assessment is taking place and the first period of treatment is to be given.

## Prisoners

15. There are too many mentally ill people in prison who have not been assessed or treated properly. They should be given rights under mental health legislation. Their care at the moment falls significantly below the standard provided by the NHS. Facilities need to be improved much more, though we welcome the progress made in the last two years. Occupational therapy facilities should be provided.

16. Mentally ill prisoners should be treated like any other person with mental health problems. In particular we feel that, although the preliminary assessment has to take place in prison, there should be a time limit for this. Compulsory assessment should take place in mental health settings.

17. Mental Health Tribunals, rather than courts, should authorise compulsory treatment and care plans beyond 28 days. We do not believe that prison is the right place for mentally ill people, but if compulsory treatment is to be provided in prison, mental health legislation should be correspondingly extended to cover prisoners. Compulsory treatment should not be used either as a threat or a punishment. Any compulsory treatment in prison should be authorised by a Mental Health Tribunal and be subject to monitoring by a Mental Health Act manager. If it is not possible to implement the care plan in a prison setting, the prisoner should be treated in an NHS setting with an appropriate level of security. Prisoners who have been subject to compulsory powers in a mental health setting, and are then returned to prison to complete their sentence,

should receive appropriate aftercare when they return to prison.

**Personality disorders**

18. There is a need to define 'personality disorders.' Some psychiatrists fear that, under the new proposals, the psychiatric profession could become an enforcement agency. In our view, the proposals for detention in the Bill should not address the issue of dangerous severe personality disorders. It would be better for this to form part of a Criminal Justice Bill dealing with people who have been charged with specific criminal offences. We note that this is also the view of the Mental Health Alliance. However we also wish to argue, as we have done in the past, that people with such disorder*s* ought to have access to treatment. At the moment they only receive secondary access. We also think that it should be recognised that personality disorder often coexists with other disorders. We welcome the proposals for further research in this area.

**Monitoring**

19. The Bill needs to specify who will provide a framework of reporting, because very clear safeguards are needed in the area of the authorisation of compulsion. Monitoring needs to include a visitorial function, as currently obtains with the Mental Health Act Commission. It is important for adequate monitoring that patients are seen face to face, as opposed to their being assessed through paper report. Safeguards are needed to ensure that doctors and managers do not detain people without adequate justification.

## Tribunals

20. We wish to raise questions about the tribunals: who forms them, who selects the members, and what criteria are used. We also wish to ask how sufficient numbers of people with appropriate experience will be identified, trained and paid to staff these tribunals. Single person tribunals are both flawed and open to compromise: the person forming the tribunal is most likely to be a lawyer, without expertise in mental health; and there is a risk that in some cases with a one person tribunal the procedure will be rushed. Tribunals need specialists but they also need to include members with a range of perspectives, for example, legal, clinical and lay. They also need access to expertise relevant to the patient being considered, for example, expertise in cultural or spiritual issues, or substance abuse. It is clear that there can be important gender issues related to mental health (and in some cases these are also bound up with cultural influences) - examples include issues of fertility, parenthood, privacy and safety, and hormonal imbalances. At least one member of the tribunal should, therefore, be of the same gender as the patient.

21. The role of tribunals should be to ensure that patients receive the appropriate care in a suitable setting that is most likely to enable them to recover. Tribunals are likely to be resource intensive. Given the recent High Court decision relating to overlong detention under the 1983 Act, it is essential that tribunals are suitably resourced to carry out their work without undue delay. The tribunal system should not be limited to consideration based on the medical model of care. If doctors are members of tribunals, the tribunal is advised

by a doctor from an Expert Group and the care plan is presented by a consultant psychiatrist. People attending mental health tribunals and mental health appeal tribunals should be entitled to free legal representation. This is important for those who appeal against their detention and treatment under the Mental Health Act. Managers should have the duty of identifying patients who should no longer be subject to compulsory powers.

**Children and Young people**

22. Under the 1983 Act, and in the light of case law, children have some rights to consent to treatment, but not to refuse consent. Currently, treatment may go ahead if the parents consent. The Bill proposes to give 16 and 17 year olds the same legal rights as adults. It has usefully clarified powers of consent for Mental Health Act purposes. Children under 16 will be treated under parental consent for a maximum of 28 days. Thereafter, all further treatment must be authorised by a Mental Health Tribunal. We warmly welcome these extra safeguards for children proposed in the new draft Bill. (Section 3:10 in the Consultation Document). We think that children who are troubled or disordered, but not yet diagnosed as mentally ill, should have access to services.

**Approved Social Workers**

23. If the present role of the Approved Social Worker is to be extended to include other professionals it will be essential to ensure that the strengths of the current system - the independent nature of the assessment - is not jeopardised. The ability of the ASW to act

independently as the approved mental health worker provides an important safeguard for patients. We are concerned, too, that the current training of ASWs in understanding and recognising the importance of social, and family, background might be put at risk.

## Capacity

24. We believe that on issues of capacity and advance directives, more thought is needed for patients who wish to stipulate in advance what treatment they wish to given to them when they are not able to consent. People with long term incapacity need others to take decisions about a range of health, social and personal issues – either through advance statements or other substitute decision making mechanisms.

25. However at present people who lack capacity - whether on account of mental health problems, learning disabilities or physical illness - are left in a legal limbo. This leaves very vulnerable people exposed to exploitation and neglect. Starting with the Law Commission Report in 1995 there have been years of consultation on legislation on mental incapacity. We agree with the Mental Health Alliance that urgent legislation is needed to underpin and provide a wider context for the provisions of the draft Mental Health Bill.

## Nominated persons

26. We believe that more thought needs to be given to the question of the nominated person. The issue of how nominations are carried out, and by whom, needs more

attention. We support advance directives but they are unlikely to be available for a first episode of illness. The basis for choosing a nominated person for an incapacitated person need to be absolutely clear as it was for nearest relatives.

27. The Bill provides for the appointment of a nominated person to act on behalf of the patient. This will replace the nearest relative provisions under the 1983 Act and apply to those subject to compulsion and to those with long-term incapacity.

28. The place of the family when dealing with mental health issues and the question of consent is very important. Sometimes the family *is* not the best resource to determine a nominated person. However they should certainly be involved in any decisions in psychosurgery, detention or compulsory treatment and we ask for more attention to this issue.

29. Relatives, partners and friends provide the bulk of care to people with a mental illness, yet this is barely recognised in the draft Bill. They need to be involved in decisions related to care and to receive information that enables them to provide care appropriately. Providing carers with information should not be confused with confidentiality of information. We accept that personal information should remain confidential but that should not prevent information being available to help carers provide care effectively.

30. The nominated person has a diminished role compared to that of the nearest relative under the 1983 Act, since they cannot object to the exercise of compulsory

powers at the time of an application for assessment .We regret this change. We believe that 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.

31. We believe 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.

**Centres of excellence**

32. Patients should have the right to a second opinion from a centre of excellence.

**Conclusion**

33. The Board shares the view of those who believe that the proposed legislation would have significant resource implications. The existing services are operating under very great pressure and the proposed changes will make greater demands on resources. It is clear to us that there will not be sufficient staff, expertise or resources, to meet the increased need. The Board's comments on the draft Bill make clear that the proposals are seriously flawed and represent a disappointing retreat from the progress apparent in earlier consultations. To this should be added the risk that the Government's stated wish to provide more protection for the public could be undermined by the lack of sufficient resources to provide a comprehensive service.

+THOMAS SOUTHWARK
Chairman,
Church of England Board for Social Responsibility

13 September 2002

**APPENDIX 2**

## MENTAL HEALTH INTEREST GROUP

The Mental Health Interest Group was created in 1997 to advise staff officers of the BSR on mental health legislation. It has reported to the BSR, and will continue under the Division of Mission and Public Affairs.

**Dr Aggrey Burke**. Consultant Psychiatrist at St George's Medical School, Tooting. Member of the BSR Home Affairs Committee 1996-2001.

**The Revd Mary Hancock**. Qualified psychiatric social worker. Formerly Department of Health Social Services Inspector with special responsibility for mental health. Now part-time chaplain in H.M.P. Wandsworth and N.S.M. curate-in-charge of Christ Church, Colliers Wood, Diocese of Southwark.

**The Ven Arthur Hawes**. Chair of M.H.I.G. Archdeacon of Lincoln and Vice-Chair of Lincolnshire Partnership Trust in the N.H.S. Mental Health Act Commissioner 1986-1995. Member of General Synod and BSR since 2000. Member of MPA Council.

**Dr Peter Jefferys**. Consultant Psychiatrist, Northwick Park Hosital, Harrow. Formerly a Mental Health Act Commissioner.

**Mike Took**. Formerly civil servant at DHSS. Following a mental breakdown in 1985, he joined Rethink in 1989, and is now their national policy officer.

**Cathy Wiles**. Member of the group until 2001. Lay chaplain Springfield Hospital, S London.

**The Revd Andrew Howarth**, Methodist Chaplain at Leeds Health Care Trust, specialising in mental health, will join the group in 2003.. He chairs the College of Health Care Chaplains Mental Health Resource Group.

## APPENDIX 3

### WEBSITES ON MENTAL HEALTH

The Mental Health Alliance is at www.mind.org.uk/take-action/mha.asp

Mind is at www.mind.org.uk

The mental health legislation is at www.doh.gov.uk/mentalhealth/draftbill2002/index.htm

Mental Health Foundation is at www.mentalhealth.org.uk

Jewish Association for Mental Health is at www.mentalhealth-jami.org.uk

Rethink is at www.rethink.org

Mentality is at www.mentality.org.uk

Hospital Chaplaincies Council is at http://www.nhs-chaplaincy-spiritualcare.org.uk/

Royal College of Psychiatrists is at http://www.rcpsych.ac.uk/sig/spirit.