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# EDITORIAL

# A new Mental Health Act for England and Wales[1]

Tony Zigmond

Over 5 years ago the UK Government announced its intention to reform the Mental Health Act 1983 in England and Wales and established an Expert Committee, under the Chairmanship of Professor Genevra Richardson, to undertake a review and make recommendations. The Report of the Expert Committee was followed by a Green Paper, a White Paper and, in June 2002, a draft Mental Health Bill. It is beyond the scope of this editorial to detail the recommendations of the Expert Committee and the subsequent development of the Government's plans as their proposals have passed through each of these stages. The College's submissions may be read from the College website (http://www.rcpsych.ac.uk/college/parliament/index.htm).

## The issues

I presume that most readers in England and Wales are familiar with the proposals in the draft Bill. The main issues are set out in Box 1. Further details can be found at http://www.publications.doh.gov.uk/mentalhealth/draftbill2002/consdoc.htm and on the College website (address as above).

1. This editorial pertains only to England and Wales. Scotland's new Mental Health (Care and Treatment) (Scotland) Act has attained Royal assent and is due to come into force in April 2005. Ireland has a new Mental Health Act. A review of Northern Ireland's Mental Health Act is under way. In addition to reform of mental health law, the Scottish Parliament and the UK Government determined that there should be legislation for the care, treatment and financial arrangements of adults who lack capacity. The Adults with Incapacity Act became law in Scotland in 2000. In England and Wales we have a draft Mental Incapacity Bill on which a Joint Select Committee of both Houses of Parliament has taken evidence and published a report (Joint Committee on the Draft Mental Incapacity Bill, 2003). We await publication of an Incapacity Bill.

**Box 1 The main issues in the draft Mental Health Bill for England and Wales**

- Examination for a compulsion order at the request of 'any person'
- Criteria for compulsion:
  - broad definition of mental disorder
  - absence of 'incapacity or impaired decision-making/judgement'
  - absence of a 'treatability' test
  - absence of a 'therapeutic benefit' test
  - absence of 'best interest'
  - absence of exclusions
- Lack of discretion as to whether or not to make an order if the criteria are met
- Removal of independent approved social workers (ASWs)
- Reduction in level of risk leading to a breach of confidentiality
- Non-medical clinical supervisor
- Non-medical tribunal
- Loss of absolute right of discharge by responsible medical officer/clinical supervisor for civil patients
- Loss of right of discharge by nearest relative/nominated person
- Loss of right of relative/nominated person to object to a 'treatment' order
- Broad definition of medical treatment?
- Psychosurgery for mental disorder for incapacitated patients with the authority of the court
- Limit of two emergency electroconvulsive therapy treatments (while waiting for a tribunal)
- Treatment orders authorised by a judge
- Compulsory medical treatment in prison

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Some of the proposals, such as the right to advocacy and tribunals authorising longer-term compulsion, have been broadly welcomed (at least in principle, even if there are grave reservations about the workforce implications). Others, such as the duty of a trust to arrange the psychiatric examination of a person at the request of any other person and the loss of discretion regarding whether or not to make an order if the criteria are met, have been widely condemned. The majority of issues have both supporters and detractors. Community treatment orders are a case in point. Users are firmly against. Carers seem largely to be in favour. Psychiatrists are divided. Of course, the issue is less clear-cut than this. Are we talking about community treatment orders being used at any time or only after an in-patient assessment? Should the patient have to have relapsed previously owing to failure to comply with a treatment plan in the community before a community treatment order could be authorised?

Some concerns have centred around omissions from the draft Bill. Everyone wants some exclusion criteria. The College's Substance Misuse Faculty has advised that misuse of alcohol or drugs should not, by itself, be grounds for compulsion. Two national charities in these fields firmly disagree. The absence of a 'treatability' test has caused concern to most people (although not all), while everyone has stated the need for intervention to be in the person's best interest. There are, however, many opinions as to the meaning of the term 'best interest'. For example, the draft Mental Incapacity Bill states that in assessing 'best interest' the previous wishes, if known, of the incapacitated person should be taken into account. Indeed, it goes further by giving statutory authority to advance directives. A person could not then be given identified medical treatment under particular specific circumstances. Would colleagues wish advance directives to have authority for those under the compulsion of a Mental Health Act? If so, it may be illogical to permit any compulsion in the face of capacitous refusal. To date, the College has argued this only in relation to electroconvulsive therapy.

Perhaps the most difficult and important area relates to the conditions necessary to make a person subject to compulsion. How should 'mental disorder' be defined? What should the criteria be? What should be the extent of the exclusions? These issues, along with options for community treatment orders, will be discussed further in a subsequent editorial.

Maybe because they are not central to the objections to the draft Mental Health Bill (the inordinate focus on risk, the 'catch all' criteria and the reduction in opportunities for discharge), a few of the proposed changes have received limited discussion, despite their radical nature. That the person in charge of the compelled patient's care and treatment, the clinical supervisor, need not be medically qualified and the absence of a psychiatrist from the Mental Health Tribunal are two such issues. Only registered medical practitioners may recommend compulsion (owing to the European Convention on Human Rights). It should also be noted that a psychiatrist member of the Expert Panel will be required as part of the Mental Health Tribunal process. What are colleagues' views?

Space precludes discussion of many other important areas. Further information may be obtained from the College website.

## Progress of the draft Bill

Since the publication of the draft Mental Health Bill there have been countless meetings within the College and between the College and other members of the Mental Health Alliance (an alliance of over 60 user, carer, voluntary and professional organisations). There have been 'stakeholder' and 'road-testing' meetings between members of the Alliance and the Department of Health (I am unable to be clear about the purpose or value of the meetings).

In November 2003, immediately after the Bill failed to be mentioned in the Queen's Speech, the Government announced that a revised draft Mental Health Bill would be put to a Joint Select Committee of both Houses of Parliament for pre-legislative scrutiny. This is a relatively new procedure. It is used when the aim of a Bill is not controversial but is complex and difficult to achieve (an early example was the Adoption Bill, more recently the draft Mental Incapacity Bill). The Committee takes both written and oral evidence and then publishes recommendations. At the time of writing we are awaiting publication of the revised draft Mental Health Bill and details of the Joint Committee. I am currently writing and consulting on the College's submission.

Following this, although we have no indication of timescale, a Mental Health Bill will be introduced to Parliament. The process is set out in Box 2. Intervention during these stages is made only by Members of Parliament (of both Houses). It can be seen that the College's written and oral evidence to the Joint Select Committee is likely to be the last time we have direct access to the parliamentary process.

I hope I have outlined the process of law reform and where we are within it. Formulation of proposals continues and further details will be given in a subsequent editorial. Colleagues' views are always welcome.



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**Box 2 Outline of the process by which the draft Mental Health Bill will be introduced to Parliament**

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| *House of Commons* | |
| First Reading | The formal reading out of the title of the Bill by a clerk. |
| Second Reading | Two weekends later. This is the main opportunity to debate the Bill. A parliamentary division represents a direct challenge to the principle of the Bill. |
| Committee stage | Two weeks after Second Reading. The Bill is examined line by line. |
| (i) Committee of Whole House | For constitutional Bills and parts of the Finance Bill |
| (ii) Standing Committee | The most usual procedure. Involves 16–50 Members of Parliament, in proportion to overall party strengths. |
| (iii) Select Committee | Infrequently used. |
| (iv) Special Standing Committee | Rarely used. This has powers to send for persons, papers and records; it holds four sittings and hears oral evidence in private and in public. |
| Report Stage | Two weekends later. A further chance to consider amendments, new clauses and, for Members of Parliament not on the Committee, to propose changes. |
| Third Reading | Usually immediately after the Report Stage. The final chance to debate the Bill. |
| *House of Lords* | |
| First Reading | Formal. The Bill is reprinted in the form finally agreed by the House of Commons. |
| Second Reading | Two weekends after the First Reading. Government Bills included in the election manifesto are, by convention, not opposed at the Second Reading, but 'reasoned' amendments may be tabled as a means of indicating dissent and can be voted on. |
| Committee Stage | Fourteen days later. |
| Report Stage | Fourteen days later. |
| Third Reading | |
| Passing | The final opportunity for peers to comment and vote on the Bill. |
| Consideration of amendments | Depending on which House the Bill started in, each House now considers the other's amendments. Bills with contentious amendments pass back and forth between the Houses until agreement is reached. |
| Royal Assent | The Queen's assent is formally notified to both Houses. |
| The Bill becomes an Act | |

## Reference

Joint Committee on the Draft Mental Incapacity Bill (2003) *Joint Committee on the Draft Mental Incapacity Bill – First Report*. London: Stationery Office. http://www.publications.parliament.uk/pa/jt200203/jtselect/jtdmi/189/18902.htm



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