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Mental Health Alliance supporters spell out their fears as the Mental Health Bill becomes law



What gains and losses will the new Mental Health Act bring? Catherine Jackson reports

GOOD in parts

The Mental Health Act 2007 finally became law on 19 July, in a flurry of final amendments that, says the Mental Health Alliance (MHA), have made some significant improvements to what it has always dubbed 'a lost opportunity' to modernise the legal framework governing the detention and compulsory treatment of people with mental health problems.

Key concessions won from the government in last minute trading between the Department of Health and the House of Lords include the statutory right to advocacy for all detained patients, a 'treatability test' clause ensuring any compulsory treatment is strictly therapeutic, and the requirement that children and young people cannot be treated on adult mental health wards (see box). The breakaway Mental Health Coalition, formed earlier this year by the nursing, occupational therapy and psychology professional organisations, has given the Act a warm welcome: 'It should be welcomed by professionals and service users alike in promoting modern, accessible, multidisciplinary patient-centred

care,' says Peter Carter, general secretary of the Royal College of Nursing. But the MHA, in a final report summarising the gains and losses over the past nine years, has pronounced the 2007 Act 'overall a disappointment'. Says Andy Bell, chair of the MHA: 'Our already outdated law has at best been mildly improved.'

Chief among these disappointments, in the Alliance's view, is the new community treatment order (CTO). The Department of Health has always argued that CTOs will only be used for a very small number of so-called revolving door patients with a long history of defaulting on treatment following discharge from hospital. The Alliance says the breadth of the definition of 'mental disorder' and the conditions where a CTO can apply present a very different scenario.

Equally disappointing is the refusal by the Department of Health to follow Scotland's example and include 'impaired decision-making capacity' as a condition for compulsory treatment, which would have placed mental health on a par with English law relating to treatment for physical illness.

Says Alliance vice-chair Rowena Daw: 'The Act is still dominated by concern for the few people with personality disorder who are actively dangerous, which is why the government didn't want any exclusions, and wanted such a broad definition. The CTO conditions are broader than pretty well every other international jurisdiction that has them. When you put together the defensive practice that is so prevalent, the problems of NHS funding, and the wide definition of mental disorder, the possibility of CTOs being really over-used is very strong. Professionals may say they won't use them inappropriately, but to set up a framework that is so broad and lacks any recognition of civil rights issues is just not good.'

Her concern is that England will follow the path taken in Australia, where, after 20 years of CTOs, 'the mental health service is in total chaos', she says. 'The newspapers are full of headlines saying people have been abandoned in the community. Community services are doing a great job here, but they are struggling with the patient numbers they have got. A

lot of trusts are trimming back services to go for foundation status. If you are going to have more ill people in the community, you are going to need more services in the community.'

Tim Spencer-Lane, a fellow Alliance vice-chair and policy advisor on mental health and learning disabilities at the Law Society, is more upbeat. 'We have got a better Act, and there is a lot to be thankful for – particularly the treatability test. We were surprised the government agreed to that, and also to the right to advocacy.' He also believes it is significant that the Act now specifies what the purposes of CTO conditions should be, rather than the kinds of behaviour that they can cover. 'You can still impose an Asbo condition covering a person's conduct and behaviour, but you have to justify that it is necessary to ensure they don't relapse,' he says.

Another very important last minute victory is the statutory status of the code of practice, which will set out the set of principles the Alliance wanted in the legislation itself. This, says Spencer-Lane, offers opportunities to soften the harsher edges of the Act.

But he shares Daw's fears that CTOs will quickly become routine practice, rather than being kept for patients at greatest risk of relapse. In Scotland, the numbers of patients on a compulsory community treatment order (CCTO) have accumulated steadily since their introduction in October 2005. The total tally now stands at some 280, well above the Scottish Executive's estimate of a maximum of 200 at any one time. Moreover, new research by the Mental Welfare Commission in Scotland has found that the primary reason for placing people on a CCTO is risk to others, not to themselves – the opposite is the case for hospital detentions. 'It's going to be a very brave clinician who doesn't put someone on a CTO when they are to be discharged,' says Daw. 'Evidence from Scotland is that even there they are not being restricted to that small group of revolving door patients. The numbers there reached their anticipated threshold within three months of implementation,' Tim Spencer-Lane says. 'We would be very disappointed if the CTO were seen as the norm.'

Nor is he happy with the Bournemouth safeguards, introduced via an amendment to the Mental Capacity Act for people with a mental disorder who lack mental capacity. The Act requires care homes to request an assessment from their local primary care trust or local authority if they suspect a patient who lacks mental capacity may be deemed to be 'deprived of their liberty'. Critics say this does not provide a sufficiently independent safeguard. 'Whether you get "Bournewooded" or the Mental Health Act is going to be a matter of judgement. And it is still unclear what is and isn't deprivation of liberty. There's also the fact that patients detained in care homes under the Bournemouth provisions will still have to pay for their care – effectively paying for their compulsory detention,' Spencer-Lane says.

Meantime, black and minority ethnic groups continue to argue that CTOs will be used disproportionately on black people. Says Matilda MacAttram, director of Black Mental Health UK: 'That is what the international evidence shows. Considering that the mental health services are institutionally racist, and there is no proper training in cultural competence or understanding, and you are going to have even more professionals who can use these new powers, we think the Act is discriminatory.'

The Commission for Racial Equality is currently in the process of conducting a formal investigation into the Department of Health's race equality impact assessment (REIA) on the Mental Health Bill. The CRE has 'significant concerns' about the REIA's compliance with the law, a spokesperson told MHT. 'The CRE is saying CTOs are racist,' MacAttram argues. She says that privately the CRE, which from October merges with the Equal Opportunities and Disability Discrimination commissions into one Equalities Commission, has advised black groups to seek a judicial review of the Act. 'But no one's giving us a blank cheque. It's very unsatisfactory that the government is responsible for ensuring race equality but it is falling on individuals to make sure the law works for them.'

The draft code of practice will be published for consultation in October. Says Rowena Daw: 'The Alliance will probably continue in some form after the code is agreed. Certainly there needs to be a voice for the patients and carers.' ■

New powers, new rights

Passed into law on 19 July, the Mental Health Act 2007 introduces the following main changes to the Mental Health Act 1983:

- the new power of supervised community treatment, applicable to patients detained in hospital for treatment (ie. under section 3)
- the right to advocacy for all detained patients
- extension of powers to non-medical professionals to act as 'responsible clinicians' (replacing the 'responsible medical officer'), with powers to impose a CTO
- extension of the role of approved social worker to nurses, OTs and other non-medical professions, retitled approved mental health practitioners (AMHP)
- a single definition of mental disorder – 'any disorder or disability of the mind' – with alcohol and drug dependence retained as the sole explicit exclusion
- a new 'treatability' clause stating that the purpose of medical treatment must be 'to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations' – but not necessarily to treat the disorder, or cure it
- medical treatment must be 'appropriate... taking into account the nature and degree of the mental disorder and all other circumstances of [the patient's] case', and can include 'nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care'
- patients under section to have the right to apply to the county court to displace their 'nearest relative' (but – unlike those subject to the Mental Capacity Act – not to nominate their preferred choice). Nearest relative to include partners, not just spouses
- children and young people aged under 18 cannot be treated on adult wards (treatment settings must be 'age-appropriate')
- ECT cannot be given without consent if the person has decision-making capacity; emergency ECT only permitted without consent where it is necessary to save life or prevent serious deterioration
- code of practice to have statutory status (ie. professionals must treat it as legally binding, not simply advisory), and to include a set of principles to guide use of the Act (ie. respect for patient's wishes, minimal restriction of liberty, involvement of patients, respect for diversity)
- code of practice to state that advance decisions should be taken into account when deciding treatment (although the Act makes them a statutory right for people who lack mental capacity)
- code of practice to specify that police stations should only be used as places of safety in exceptional circumstances; amended Act to allow patients to be transferred between places of safety (ie. from police station to hospital without need for medical assessment)
- amendment of the Mental Capacity Act to introduce new 'Bournewood' safeguards for people who lack mental capacity to refuse or consent to treatment (ie. people with dementia; people with severe learning disability).

The main provisions of the new Act will come into effect in October 2008. For details of the CSIP/NIMHE implementation programme, visit <http://mhact.csip.org.uk>