

# A Nasty Act?

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Like most newly-appointed cross-bench peers, I went into House of Lords with the expectation and intention that whilst there I will be able to do something to the good in the areas for which my professional background has prepared me. That background includes five years as MHAC Chairman, and a number of years as a member of the MHAC before that.

I am not aware of any planning, on the part of anyone, behind the fact that my entry into the House of Lords was, more or less, coincident with the introduction of the Mental Health Bill. But whereas I might otherwise have looked to my first months of Westminster life as a time to become gently acclimatised to the Upper House, instead I was faced with a very steep learning curve and a Bill that touched very directly on my professional background and concerns.

The highly stylised forms of language and behaviour in the House of Lords take some getting used to. The House strives towards courtly manners, consensus and multi-partisan co-operation<sup>2</sup>, but it occasionally erupts into more recognisable Westminster hostilities, especially when a member calls for a vote (a 'division'). Towards evening, when there are fewer Lords around, such a call is unlikely and debates can take on the unreal aspect of phoney war. But up until dinner-break the House may erupt into its great set-piece divisions, with the party-affiliated troops marshalled by their respective whips through one or the other voting lobby. A vote late in the day can appear to be less a test of the merits of an argument, than a test of the relative strengths of the whips offices to have persuaded party-affiliated members to remain in the vicinity of the House.

From such a combination of diplomatic compromise and tests of numeric strength emerges what Lord Carlile memorably described as "that often hilarious concept – the intention of Parliament"<sup>3</sup>. But however much the results of votes may depend upon all sorts of extraneous factors, it seems clear from the tenor of its debates that the Upper House demanded and, however temporarily, won some important amendments to the Government's proposals.

Viewed from the time of writing, the Bill still has an uncertain future. Before the Upper House had done with the Bill, the Minister in the Commons announced her intention to undo its key amendments<sup>4</sup>. This may signal some rough water ahead, whether or not such intransigence leads in the Commons to any significant revolt of back-benchers from the Government whip<sup>5</sup>. There is no guarantee that the Upper House will be prepared to give way on some issues of principle. The late and very much lamented Lord Carter, who was a member of the Joint Committee scrutinising the draft Mental Health Bill of 2004, noted in the context of another debate that "It is a curious feature of our constitution that, once a Government have a working majority in the Commons, the separation of powers between the executive

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2 Hansard HL 19/02/07, col 925/6 (Earl Howe)

3 *Ibid.*, col 890 (Lord Carlile)

4 Rosie Winterton, Minister of State for Health Services: Local Government Association conference, Mental Health Bill, 1 March 2007. Downloaded on 2 March 2007 from [www.dh.gov.uk](http://www.dh.gov.uk)

5 *Openmind 144 (March April 2007)* 'Government will extend compulsion powers, says MP'

and the legislature is more evident in the Lords<sup>6</sup>. Indeed, Lord Owen warned Government at the start of our debates that it has already lost Bills in this area and could well lose this one unless it showed “a good deal of feeling and understanding for expert opinion”<sup>7</sup>.

On some matters, the Ministers in the Lords did listen to expert opinion and relatively happy compromises were reached over some questions, such as the legal basis for the admission of minors<sup>8</sup>, or the introduction of an ability to transfer between places of safety<sup>9</sup>. Indications have been given that further Government amendments will appear in the Commons to address the call for patient choice in identifying Nearest Relatives<sup>10</sup> and for some statutory provisions around advocacy<sup>11</sup>. Alongside some of the uncontested ‘tidying up’ provisions in this Bill (notable amongst which is a reversal of the current restrictions over who may sit on a Foundation Trust managers’ review hearing<sup>12</sup>), these amount to some good reasons to hope that the Bill is not, in the end, lost.

What follows is a step back from the fine detail of the Bill and its amendments, to enable a wider view of the polarised positions occupied by Government and its detractors.

### Libertarians and Paternalists?

The Conservative front bench has accused the Government of starting from “a profoundly paternal attitude towards mental health patients...that accepts only grudgingly that the autonomy and decision-making ability of those with a mental illness matter at all and ... would actually much prefer these people to jolly well accept what is good for them whether they like it or not”<sup>13</sup>. The Minister, of course, disputed this<sup>14</sup>. Government’s general response to this charge has been to argue that it has struck an appropriate balance between coercive powers and protective limitations on such power. Thus the Government characterises the real contention as between its Bill, which seeks to establish specific safeguards and thresholds in the working criteria for compulsion, and the Bill’s critics, who are seeking either unnecessary and dangerous limitations on psychiatric power, or else declaratory but essentially otiose phrases and words that would signal good intentions but have little practical effect<sup>15</sup>.

I have great sympathy for Lord Hunt’s position as the responsible Government Minister in the House of Lords debate, who has a long-standing interest in mental health service provision, is highly regarded by noble Lords on all sides of the House<sup>16</sup>, and who inherited this Bill with his re-appointment to the front benches. I have *some* sympathy with the general proposition that a good mental health law would be drafted to be so explicit in its applicability that there should be little need for it to contain declaratory statements of intent. But, even if such legislation *can* be drafted, I do not believe that this Bill is it. In any case, there continue to be worrying signals from the Government camp that the intention behind the Bill is *actually* to leave the scope of compulsory powers to be determined by professional discretion rather than by any meaningfully restrictive statutory criteria.

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6 Hansard HL 21/01/07, col 583 (Lord Carter)

7 *Ibid.*, col 582 (Lord Owen)

8 Hansard HL 26/02/07, col 1462 (Lord Hunt)

9 *Ibid.*, col 1467 (Lord Hunt)

10 Hansard HL 06/03/07, col 135 (Baroness Royall)

11 Hansard HL 26/02/07, col 1484 (Baroness Royall)

12 Mental Health Bill [HL as amended on report] clause 43

13 Hansard HL 26/02/07, col 1414 (Earl Howe)

14 *ibid.* col 1414-5 (Lord Hunt).

15 *see, for example, Hansard HL 19/02/07, col 920* (Baroness Royall).

16 *See Hansard HL 06/03/07 cols 122–135*

Before the Lords debated and voted upon the question of whether the Bill should set out more explicit exclusions to the scope of Mental Health Act powers<sup>17</sup>, an all-party group meeting was told by the Government's mental health *czar*, Professor Appleby, that "every exclusion is a person not receiving the treatment they need"<sup>18</sup>. A similar argument was whispered to my colleagues in the corridors of the Palace of Westminster to warn against *any* amendments seeking to restrict the scope of the general criteria for compulsion. The response to Government defeats in the Upper House by the Minister in the Commons (the Rt Hon Rosie Winterton MP) took the same line, stating that "every barrier that is put in the way of getting treatment to people with serious mental health problems puts both patients and the public at risk"<sup>19</sup> and, rather curiously (given that the context here was the scope of community treatment orders, which even under Government plans could only be imposed upon a patient who is already detained in hospital under the Act), "every restriction is a patient untreated, a family in distress"<sup>20</sup>.

The assumption that the law should not fetter clinicians in helping those who need help has a superficial reasonableness (or at least anyone challenging it will feel the chill of shrouds being waved in his or her direction), but in the context of mental health law concerned with compulsion it actually has rather ominous implications. Not least, it conflates the notion of receiving treatment for mental disorder with the notion of *compulsory* treatment for mental disorder, and therefore appears to assume that people with serious mental health problems cannot be helped unless they are 'helped' by force. Of course the 1983 Act is built upon the legal reforms of the 1950s which took precisely the opposite view, and elevated informal treatment as the basis upon which mental health services should be provided unless and until compulsion could be justified in any individual case. There is a risk in the Government's stance of not so much updating the law for the start of our new century as pushing it back to the early years of the last century, when 'voluntary' status as a psychiatric patient was a privilege. If this is really the direction that Government wishes to travel, what would a potential patient have to demonstrate in order *not* to be 'helped' through compulsory psychiatric intervention, especially given the inherent difficulties of predicting actual risk to the public from individuals with mental disorder? And what signal does the Government's apparent focus on compulsion as the only means of service provision send to all those outreach workers whose daily professional lives focus on helping patients access services before compulsion becomes necessary?

In reality, of course, the criteria for psychiatric intervention of any sort is often determined by questions of resources. Where patients are left untreated in the care of, or to the distress of their families, it is more likely to be because they are waiting for an over-subscribed hospital bed, or in contact with similarly overstretched or underdeveloped community teams. Ministers quite understandably become peeved that not enough credit is given to Government for the ways in which it has sought to increase resource levels on the ground. It is unfortunate for them that the legislative agenda over the last seven years has distracted both attention and, in the end, resources, from continuing initiatives to establish specialist services for previously marginalised diagnostic groups, such as people with personality disorder, and suitable services for previously ill-served demographic groups, such as women or children. It is something of a political feat to have alienated such a comprehensive body of user, carer and professional mental health groups in the midst of such a development programme.

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17 Amendment No.3 at report stage: see Hansard HL 19/02/07, cols 906–925

18 Hansard HL 19/02/07, col 910 (Baroness Barker)

19 Press Association, 19/02/07 "Peers inflict three defeats over mental health powers"

20 *ibid.*, n.4 above.

### Discretionary powers: clinician knows best?

Although the ministerial line is that the Bill struck a “balance between getting treatment to those who need it, putting in place patient safeguards and minimising the risk to the public”<sup>21</sup>, it seems to me that the Government’s approach is in fact skewed by a dangerously paternalistic view of the purpose of mental health legislation. I accept, of course, that there is a balance to be struck between the areas that the Minister mentions. It has also been argued that striking the right balance between paternalism and protection, on the one hand, and patient determination and autonomy on the other, is as achievable as finding the Holy Grail<sup>22</sup>. That may be so, but I do not think that the Government’s Bill would, at least in its original state, have improved upon such balance as there already is in the provisions of the 1983 Act. In its desire to ‘help’ mentally disordered persons (or to keep them from the public) by catching them in a broad-cast net of compulsion, Government failed to pay sufficient attention to the need for the law to protect personal autonomy from unwarranted interference from the state.

Certainly the criteria for compulsion that were first proposed under the Bill did not establish such safeguards, but instead relied on ill-defined and therefore highly subjective terms such as ‘appropriate’ at their core. This leaves too much to the discretion of those operating coercive powers. In contrast to the Government’s apparent approach, the great majority of those who spoke in the House of Lords’ debates addressed the proposed changes in the law from a starting point that assumes that mental health legislation cannot be simply an enabling Act to provide powers for the interference of health bodies in the lives of people of this country, but must also be a means of circumscribing and limiting those powers. They have pointed to areas where the Government’s proposals created ill-defined powers that would rely heavily on the discretion of practitioners, and suggested and voted for ways in which to tighten the criteria. I am therefore deeply disappointed that the Minister in the *other place* announced her view that “for the sake of mental health patients themselves and the safety of the public, these changes must be overturned” even before the Upper House had completed its reading of the Bill<sup>23</sup>. Government seems to be incapable either of listening or understanding the very real concerns that were set out in the debates of the Upper House.

### The purpose of psychiatric compulsion

One area in which the Minister signalled her intention to overturn the House of Lords’ vote was with regard to its determination that therapeutic benefit should form a criterion for compulsion under the Act. The Minister’s statement does not acknowledge the fact that the Lords voted upon an amendment that was already a compromise solution aimed to meet Government half way<sup>24</sup>. It instead relies upon the same arguments, although still no actual evidence, for the need to reverse the Lords’ vote as were originally employed against the test of ‘treatability’ that the Bill was designed, in part, to remove. Firstly, it is suggested that patients and their lawyers’ are scheming of ways to convince the courts that the tests must be interpreted in some way as to ‘secure premature discharge for some of the most dangerous patients’<sup>25</sup>. This is unnecessarily alarmist, there being very little prospect that the courts would reverse precedent interpretations of ‘treatability’ that include not only symptomatic treatment but even the beneficence of care in a structured environment. Secondly, and here I find either muddled logic or else an outrageous sleight of hand in the Government’s argument, it is suggested that mental health professionals

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21 *ibid.*, n.19 above.

22 Unsworth, C (1987) *The Politics of Mental Health Legislation*. Oxford University Press.

23 *ibid.*, n.4 above

24 Hansard HL 19/02/07, col 927(Lord Carlile)

25 *ibid.*, n.4 above.

misinterpret the existing test and incorrectly exclude potential patients as a result, and therefore the test must be expunged from the Act to remove this excuse for services to deny services to patients. It is by now a well-worn, if still important, argument against the muddled thinking that, if professionals are misinterpreting the Act, this is a matter for training rather than new legislation. In the words of one of the qualified psychiatrists on the Lords' benches, 'bad psychiatry does not justify bad legislation'<sup>26</sup>.

To be worthwhile legislation, the Mental Health Act must provide a check against unfettered clinical discretion and delineate the powers given to mental health professionals over patients who cannot or do not consent. The Bill is better in this regard following the amendments made in its passage through the Lords: no doubt it could be better still. Whilst some practitioners and commentators have questioned what all the fuss is about on the issue of 'treatability', given the current very broad definition of that term, my own view is that here is an issue where Parliament needs to set down a specific view, and articulate that in legislation, so that the law is explicit in its intention and in its basis as a health measure. Government would have Parliament remain silent over the purpose of the use of compulsory psychiatric intervention, and this is not acceptable.

### Countering institutional racism in psychiatric coercion

The fact of gross overrepresentation in the detained patient population of patients from Black and minority ethnic groups is now generally recognised. It is also generally agreed that there is an urgent need to do something about this, although of course what exactly is to be done is a more contentious matter. It is, I think, a valid question to ask whether there is anything that can be put into mental health legislation that can address this problem in any practical way. After all, the overrepresentation takes place in a legal context where public authorities are already under a specific duty not only to eliminate racial discrimination, but also to promote equality of opportunity and good race relations<sup>27</sup>. I take the view that a declaratory statement in the 1983 Act would serve to remind practitioners that they operate under this general duty, and can only strengthen whatever effect it does have.

The compromise reached over the question of whether there should be a statement of principles on the face of the Act will at least guide practitioners towards a similar message in the Code of Practice, but the Code already contains an anti-discrimination principle<sup>28</sup> and it could be said that this has not proved effective up to now. Perhaps more importantly, given that decisions regarding psychiatric coercion are inevitably value-judgments, the most important task of a responsible legislature to avoid perpetuating or fostering discrimination would be to make the criteria for such decisions as precise – and justiciable – as possible. By contrast, the open-textured nature of legal powers in the Bill as presented to Parliament could have removed some existing checks on further overrepresentation of Black and minority ethnic patients.

### Legislating for services

One other way in which the provisions of a Mental Health Act could ensure that patients receive appropriate treatment is, of course, by establishing some kinds of reciprocal duties upon services to provide such treatment to those in need.

Government has very emphatically rejected some amendments that aimed to make such duties explicit

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26 *Hansard* HL 10/01/07, col 312 (Lord Alderdice)

27 *Race Relations Act 1976, s.71, as amended by Race Relations (Amendment) Act 2000, s.2.*

28 *Department of Health (1999) Mental Health Act Code of Practice, para 1.1*

in this Bill, including my own amendment that would have given statutory force to the requirements of care-planning. The argument against such amendments is that ring-fencing or prioritising one aspect of the health or social care service may be at the cost of other aspects of such services, and that legal requirements to concentrate resources on specific aspects can distort local planning and accountability, or even fetter the legal discretion of the Secretary of State<sup>29</sup>.

Such a proposition is irrefutable at an abstract level, but the realities of health and social care service provision are already subject to some such pressures, and some of these stem directly from legislation. A straightforward example is section 4 of the NHS Act 1977, which establishes a duty to provide 'special hospitals' for dangerous and offender patients. Furthermore, there is a sense in which the Mental Health Act 1983 itself can be seen as a series of legal requirements for the provision of particular services, such as the assessment of specifically qualified professionals, as a condition of using coercive powers of detention. The 1983 Act also sets out explicit duties, such as the duty under section 117 to provide aftercare to some detained patients upon discharge; the requirement to specify hospitals that have arrangements for admitting emergencies (section 140) and the duty to provide sufficient numbers of approved social workers (section 114).

Although it may be ungracious to point this out, the Government position is also inconsistent in its approach to this issue, as is evidenced, for example, by its concessionary offer to look again at making specific provision in the Bill requiring authorities to provide advocacy services for detained patients in response to amendments tabled by Lord Williamson and myself. Of course, this is hardly a revolutionary use of the law: section 35 of the Mental Capacity Act 2005 establishes a clear precedent for the use of mental health legislation to establish such a positive duty to provide advocacy services to vulnerable patients.

Whilst I can sympathise with ministerial exasperation over the stream of claims for priority in terms of resources from this or that aspect of the health service or from various patient groups, the position of a detained psychiatric patient is unique amongst health service recipients and the law already discriminates, in various ways, such a patient from the rest of healthcare provisions. I very much welcomed the amendment aiming to provide that child patients should be accommodated in suitable facilities<sup>30</sup>. It is Government policy that this should be so, but in the current financial climate it is difficult to see how the many health authorities who are looking for substantial financial savings will turn that policy into a reality. It is obvious that such authorities who are faced with difficult decisions over balancing their budgets will, of course, look for savings in those parts of their service that are neither their core business nor a legal requirement. In the absence of any legal requirement to provide services, development in these areas may stall and existing services will always be under threat. These threats are very real. In relation to children's services, the House of Lords heard that between 1999 and 2006 there has been only a four per cent increase in general child and adolescent mental health beds between 1999 and 2006<sup>31</sup>. In relation to advocacy services, as I write this I have a letter on my desk announcing the closure after ten years' work of one London-based advocacy group, because the Primary Care Trust (which is looking to make substantial savings to reduce its overspend) has withdrawn funding.

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29 *Hansard* HL 26/02/07, col 1374 (Lord Hunt)

31 *Hansard* HL 16/02/07, col 1375 (Baroness Meacher)

30 *Hansard* HL 26/02/07, cols 1365-1378

## A nasty Act?

Late in the evening of the House of Lords' penultimate day of debate at report stage of the Bill, I suggested to a slightly startled House that the differences in provisions made regarding advocacy services in the Mental Health Act and Mental Capacity Act are

*not only unethical in terms of equity of provision but dangerous. It is dangerous because we run the risk of having two statutes that have considerable overlap. The Mental Capacity Act is, and is seen to be, forward-thinking, concerned with patient rights and protections, and so on, whereas the Mental Health Act appears to be a set of second-rate provisions, outdated attitudes and the shifty machinations of a Home Office forever seeking unfettered powers of social control.*

*Every time we allow some unjustifiable inequity between the way in which these two statutory frameworks deal with patients, we move a step closer towards the Manichean system of a nice mental health law and a nasty mental health law. The danger, as this House has heard before, is that the nasty mental health law drives away those whom we would wish to seek early treatment, not least on grounds of safety.<sup>32</sup>*

I stand by these words, notwithstanding the eyebrows that were raised at their tone. I think that there is a real danger in the Government's announcements over its Bill, as exemplified by Rosie Winterton MP's response to the Lords' amendments, of creating a perception – and it was *perceptions* that I spoke of in the House – that the 1983 Act is all about controlling the actions of dangerous people, or solely concerned with the prevention of homicide and suicide. Of course, no-one could argue for a moment that this was the reality of the Act – obviously it is concerned with much else besides, and its powers are far wider than that would imply. But there is a sense in which any law that seeks to guide professional action, or perhaps any sort of human agency, has an important symbolic aspect. Many people who are professionally involved with the Act do not know its detail, and a great many people who are made subject to its powers, or who know someone who is, will have neither opportunity nor inclination to understand the context or extent of those powers. The Government's Bill unbalanced the Act by casting aside some of its definitional safeguards, and its presentation of its case for doing so has further characterised the Act as being concerned, above all else, with public safety. This has been the most indelicate handling of legislation that in fact requires the most delicate of balances to be made.

This is why I supported those amendments to the Bill as presented to Parliament that Government dismissed as 'declaratory'. That is also why it is important that the Mental Health Act, like the Mental Capacity Act, should be principled legislation that sets out the value of personal autonomy and the need to use the least restrictive option when intervening for the health of patients, or the protection of patients or others. And, finally, that is why Government needs to temper its reaction to the reasoned debates over its Bill, and listen to the weight of expert opinion that is behind the Lords amendments and, I hope, further amendments to come.

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<sup>32</sup> *Hansard HL 26/02/07, cols 1482-3*