Parliamentary News

The Mental Health (Amendment) Bill

The Bill was introduced in the House of Lords on 10 November 1981 by Lord Elton, Parliamentary Under-Secretary of State at the DHSS. It received its Second Reading in the Lords on 1 December.

Along with the text of the Bill there has been published an explanatory White Paper entitled 'Reform of Mental Health Legislation', and the Bill itself has an attached memorandum of explanation, giving the gist and purpose of each clause. The following summary of what appear to be the principal changes to be effected has been prepared directly from the text, and it is hoped it will be found useful by members of the College. Further explanations by the Minister in charge will be found in the report of the Second Reading debate below.

Members may like to know at the outset that the College's proposal for the setting-up of a Mental Health Commission has been adopted in part and that the Government's original scheme for decisions on treatment to be made by multi-disciplinary panels has been abandoned in favour of the College's alternative of a second medical opinion. Somewhat strangely, the clauses dealing with restrictions on treatment appear in the last part, Part VI, of the Bill, headed 'Miscellaneous and Supplementary', instead of in Part II under 'Care and Treatment'.

It should be mentioned next that this is an *amending* Bill, and so all changes are made by substitutions, additions or deletions to sections of the 1959 Act. It is intended that once the Bill has become law a Consolidating Act will be prepared, as was done in 1890 following the Amendment Act of 1889.

In the first part of the Bill some changes are made in the definitions of mental disorder. 'Subnormality' and 'Severe Subnormality' become 'Mental Handicap' and 'Severe Mental Handicap' and are defined by reference to (severe) impairment of intelligence and social function. Sexual deviance and alcohol and drug dependence are specifically excluded from the definition of mental disorder.

In Part II, 'admission for assessment' replaces 'admission for observation'. Patients so admitted may now apply to a Mental Health Review Tribunal within 14 days of their admission. There are closer time limits governing Section 29 recommendations.

There are new provisions under Section 26. The recommendations must now state that the treatment necessary for the health of the patient, etc., cannot be provided unless he is detained; and in cases of psychopathic disorder or mental handicap that treatment is likely to alleviate or to prevent deterioration.

Under certain conditions (e.g., part-time), both recommendations may be given by doctors of the receiving hospital. The problem of dealing with an informal patient who wishes to leave but ought to be detained (Section 30 (2)) is solved in two ways; the RMO may nominate other doctors on the staff to act for him, and if no doctor is immediately available a registered mental nurse may detain the patient for up to six hours.

The initial period of detention and the period of first renewal are reduced from one year to six months. The renewal report's wording is altered to coincide with that of the original recommendation ('treatment likely to alleviate', etc), and this replaces the age limits previously applying to subnormal and psychopathic patients. But for patients with mental illness or severe mental handicap an alternative statement can be made, namely that 'the patient, if discharged, is unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation'. (There is no mention here of the protection of others.)

There is a change in the definition of the 'nearest relative': the relative with whom a patient has been residing or who has been caring for him will have preference over others.

Mental Welfare Officers must interview the patient before making their applications and must satisfy themselves that admission to hospital is the most appropriate action. But Mental Welfare Officers are to be superseded by competent social workers, as will appear later.

Part III on Mentally Disordered Offenders is very lengthy, and many of the changes are procedural or consequential on those in earlier parts of the Bill. The following are some changes of substance.

A notification to the Home Secretary that a patient who has been transferred from prison to hospital no longer requires treatment can be sent by a doctor not the RMO or by a Tribunal, and the notification may state as an alternative that no effective treatment can be given in the hospital. The same applies in some other similar circumstances.

Section 65 (1) is amended by specifying that 'the protection of the public' is protection from serious harm. RMOs will send reports on restricted patients at least once a year to the Home Secretary.

Courts may send convicted persons to hospital under an 'interim hospital order' for up to six months in order to test the appropriateness of a full hospital order.

The principal changes concerning Mental Health Review Tribunals are set out in clauses 34 and 35 of the Bill. Tribunals must have regard to the same criteria as are specified for renewals of authority to detain. And if a patient does not himself exercise his right to apply, the managers of the hospital must under certain conditions refer his case to a Tribunal. The patient may authorize a doctor to visit and examine him and inspect his records for the purpose of

giving information to the Tribunal.

Withholding of patients' correspondence is limited to cases where the addressee has made a written request for letters not to be sent to him, and this power will apply to detained patients only. Letters *to* patients in Special Hospitals may be withheld from them in a number of specified circumstances.

We now come to the clauses (38 and 39) in which the Bill attempts to deal with the controversial subject of treatment without a patient's consent. The clauses deal with detained patients only; it seems to be assumed, without real justification, that informal patients are all capable of giving valid consent.

Surgical treatment or diagnostic procedures, medication and ECT are specified as subject to the provisions of clause 38. Consent to these treatments cannot be assumed, but must be certified in writing by (usually) the RMO. Alternatively, a 'second opinion' can be sought from a specially appointed doctor, who can certify that the patient is incapable of consenting or does not consent but that the treatment should nevertheless be given.

Besides this, the Secretary of State may make regulations by which specified treatments may only be given with the patient's consent, certified as above.

But there is a let-out subsection allowing treatment to be given if necessary to save life; to prevent a serious deterioration; or as the minimum necessary to prevent violence or danger. However, in the second case the treatment must not be 'irreversible' and in the third it must be neither 'irreversible' nor 'hazardous'. These words are defined, but in almost tautological terms.

This is not the end of the matter, for under clause 39 the Secretary of State is to issue a code of practice in regard to treatment, and other treatments that may 'give rise to concern' may be restricted; however, there is to be consultation with the professions before the code is issued or revised.

And now the good news! There is to be a special health authority to be known as the Mental Health Act Commission (clause 42), and they will perform on the Secretary of State's behalf functions specified in the preceding clause (41): to visit and interview patients and investigate complaints which may not have been satisfactorily dealt with by the managers. They will also have certain powers in relation to treatment; here there is some discrepancy: the text says only that they are to appoint the 'second opinion' doctors, whereas the explanatory memorandum states that the new authority will 'perform on his [the Secretary of State's] behalf the functions set out in clauses 38, 39 and 41'. The discrepancy appears to be reconciled in the White Paper, which states that the Commission will be asked to prepare and revise from time to time the statutory code of practice.

Lastly, clause 43 provides that Mental Welfare Officers shall within two years from the passage of the Bill be replaced by approved social workers, and these social workers must have 'appropriate competence in dealing with persons suffering from mental disorders'; the Secretary of State may give directions as to other matters that should be taken into account.

The Second Reading

LORD ELTON,* in moving the Second Reading of the Bill, explained its general principles and the provisions of each clause, substantially as described above. He made the following additional points:

Most of the recommendations of the Butler Report were included in the Bill, and others would be implemented administratively.

On mental handicap, he anticipated the views of Lord Renton and others who advocate separate legislation or the abolition of compulsory powers for this category. He emphasized that there were a number of persons for whom compulsory detention was essential and for whom no other diagnosis than mental handicap was possible. He had a catalogue of such cases to deploy in Committee. He also quoted in support the 'weightiest opinion that I can find'—that of the College. Further, to separate the two conditions into two different Acts was impracticable for want of Parliamentary time, but they could, if desired, be separated within the Consolidation Act.

Section 29 of the 1959 Act had been used far more frequently than was intended, hence the stricter provisions in the new Bill.

The Mental Health Act Commission would consist of about 70 members. The 'second opinion' doctor to be appointed by the Commission might very often be one of its members.

Lord Elton then mentioned a matter not included in the Bill as drafted, but to be the subject of a Government amendment at a later stage. Following the judgement of the European Court of Human Rights, Section 65 patients would be able to be discharged by a Tribunal without needing the consent of the Home Secretary. In such cases the Tribunal would include a lawyer with experience at recorder level.

Finally, Lord Elton pointed out that all but three of the Bill's provisions were to come into force by September 1983, by which time the Consolidating Act would have been passed and various administrative and transitional matters would have been dealt with.

For the Opposition, LORD WALLACE OF COSLANY welcomed the Bill. He criticized the omission of an item in the 1978 White Paper concerning the duty of hospitals to inform patients of their rights. He stressed the need for high standards and adequate resources for the training of the new approved social workers. He thought that the responsibilities

*Lord Elton, previously at the Northern Ireland Office, succeeded Sir G. Young as Parliamentary Under-Secretary of State, DHSS, in September 1981.

and powers of the Commission would constitute an immense job for 70 part-timers and leave members little time for their professional work. The right sort of people must be obtained—'we need the best and we must pay for the best'.

The ensuing debate ranged over a wide field, and much of what was said had little direct bearing on the provisions of the Bill, but concerned the problems and shortcomings of what speakers still described as the Cinderella of the Health Service. Some thought that improved resources were more important than changes in the law—'the cart was being put before the horse'. Well-worn subjects were ventilated, such as the allocation of funds between health and local authorities, poor conditions in psychiatric hospitals and the retention in prison of mentally ill offenders. BARONESS MASHAM OF ILTON quoted the revelations of recent TV programmes, and her observations were refuted by BARONESS FISHER OF REDNAL from her experience of services around Birmingham. BARONESS VICKERS called for the reinstatement of medical superintendents and matrons, who she said were very much missed by both patients and staff.

The main subjects discussed, however, were the position of mental handicap in the legislative framework, and the Bill's clauses relating to treatment. The proposed Mental Health Act Commission, the intended replacement of mental welfare officers by approved social workers and the powers of Mental Health Review Tribunals also came under discussion.

Mental handicap

The complete and immediate separation of mental handicap from mental illness legislation was (as in previous debates) strongly urged by LORD RENTON. The mentally handicapped should only be sent to hospital if they suffered from superadded mental illness. He again condemned the College's 1979 Report, which he said was now discredited. He was supported by several other speakers, particularly by LADY KINLOSS, and LORD ELYSTAN-MORGAN. It was not always clear whether what was desired was parallel but similar legislation, or no legislation at all. One peculiar feature was the repeated suggestion that separate legislation would help to clear up the confusion in the public mind between mental handicap and illness, ignoring the fact that separate legislation existed for some 45 years previous to 1959 without having any such effect.

Treatment

Clause 38 of the Bill received a good deal of criticism. The first speaker to voice this was BARONESS ROBSON, who queried whether the decision on treatment without consent should be exclusively medical. But the most vigorous onslaughts were made by Lord Kilmarnock and Lord Hooson. LORD KILMARNOCK 'questioned very seriously whether in a free country the Government should ever have the power' to impose treatment. The Bill 'introduced a new principle into English law'. Something introduced 'no doubt with the best intentions' might become 'the tool of future abuse: Some of the provisions for emergency treatment were dangerously loose or meaningless.' LORD HOOSON took a similar line in a speech of great eloquence. He drew analogies between decisions on treatment and decisions on other matters concerning a patient's capacities, such as the management of his affairs, testamentary capacity and fitness to stand trial, in none of which cases was the decision exclusively medical. He strongly favoured the multi-disciplinary panel proposed by the previous Government. BARONESS MASHAM and LORD ELYSTAN-MORGAN supported these views, the latter suggesting that a second opinion by another psychiatrist could not be truly independent.

On the other hand, BARONESS LANE-FOX gave praise to modern physical treatments. Patients should not be denied their chance to escape from their misery and decisions should be made by psychiatric experts.

Mental Health Act Commission

The criticisms here were of the creation of yet another 'quango' with functions appearing to overlap with those of other bodies, such as the Health Advisory Service and the National Development Group. More information was requested as to the Commission's structure, and its function of appointing 'second opinion' doctors was attacked by those opposed to this procedure. LORD CAMPBELL OF CROY reported on the success over the years of the Scottish Commission. It was left to BARONESS FAITHFULL to wonder whether, considering the number of people (i.e., overlapping official bodies) with which psychiatrists would have to deal, they would be able to do their work.

Social workers

Several speakers pointed out the difficulties involved in making the change. LORD WELLS-PESTELL was certain that it could not possibly be made within two years. BARONESS FAITHFULL, a former Director of Social Services, admitted that the Seebohm generic social worker was now recognized to be an impossibility, and gave a vivid account of the dilemmas and muddles involved in 'sectioning' a patient, but was pessimistic about the chances of recruiting and training 'competent' social workers. BARONESS FISHER also dealt with the training problem. None of the speakers mentioned the former mental health courses which produced well-qualified psychiatric social workers.

Tribunals

LORD KILMARNOCK and others urged that legal aid should be extended to MHRTs to enable patients to be legally represented. It was also suggested that Tribunals should have a 'third choice' of discharging a patient with directions as to residence and after-care.

LORD CULLEN OF ASHBOURNE replied to the debate in a somewhat discursive speech, reverting more than once to the same subject. As regards mental handicap, he pointed out that separation would be difficult in an amending Bill, but promised that the Government would see whether 'we can break out of this situation'. Details of social workers' training would have to be worked out locally. He confirmed that the 70-strong Commission would be split up into five groups around the country. Lord Cullen said hardly anything on the treatment question, but, in a previous intervention, Lord Elton had mentioned the practical difficulty of assembling a multidisciplinary team, of even two persons, in cases where there was any degree of urgency.

The Bill was then committed to a Committee of the whole House.

It is perhaps noteworthy that none of the medical peers took part in the debate.

ALEXANDER WALK

The Scottish Psychiatric Research Society

R. E. KENDELL, Professor of Psychiatry, University of Edinburgh

The Society was founded at a meeting in the Royal Edinburgh Hospital in December 1961. Most of the twenty-one foundation members, who came from all four Scottish university medical school centres, were young men, lecturers or senior registrars for the most part. They elected John Smythies president and Ian Oswald secretary and drew up a constitution which committed the society to meet 'at least twice a year . . . in the four Scottish universities in rotation', other centres also being asked to act as host from time to time. The primary aim of the society was 'to promote and encourage research into psychiatry and allied disciplines' and it was a multidisciplinary society from the beginning. Two of the foundation members were clinical psychologists and for some years a biochemist, Dr Todrick, was president.

The society has remained remarkably faithful to its original objectives. In the twenty years since its foundation it has held 40 scientific meetings, the most recent at Gartnavel Royal Hospital in October 1981. The Crichton Royal Hospital in Dumfries was brought into the rotation at an early stage, and since then meetings have been held twice a year in Edinburgh, Aberdeen, Glasgow, Dumfries and Dundee in sequence, usually in the spring and autumn.

One of the society's main functions has always been to provide a forum in which relatively inexperienced research workers could describe the results of their endeavours, and it is interesting to see the names of young men like Ashcroft, Eccleston, German, Oswald and Timbury in the programmes of the early days. Usually half an hour is allotted to each paper—twenty minutes for delivery and ten for discussion—and between eight and ten papers are read in the course of a day. Attendance has varied from as few as 20 to 90 or more, the majority usually coming from the host centre and a group of committed enthusiasts making the journey from the other four.

Although the original constitution refers to an annual subscription, voting rights, a quorum and the other accoutrements of constitutional propriety, the society seems to have settled down to a stable and effective *modus operandi* without any subscription or formal list of members. Most of its business is conducted by a secretary, usually a senior registrar or lecturer, in each of the five centres, and a president who is generally a senior member of one of the four University Departments. Each secretary is responsible for drumming up offers to give a paper at the next meeting, passing these offers to the secretary in the centre acting as host for that meeting, and circulating the programme. The president, currently myself, serves for three or four years, takes the chair at one of the two scientific sessions at each meeting (the other being the responsibility of a senior member of the host department) and provides transport to and from meetings for those less wealthy than himself.

Looking back over the past twenty years the society has served its purpose very well. Although it is impossible to tell to what extent it has stimulated people to do research they would not otherwise have done, it has certainly provided young men and women with an opportunity to describe their work to a wider audience than their own departments. It has also provided a convenient meeting ground for all Scottish psychiatrists and clinical psychologists interested in research and enabled them to keep abreast of developments in other parts of Scotland.

The next meeting of the Society will be at the Crichton Royal on Friday 16 April 1982. Further details from the local secretary, Dr Diana Morrison, Crichton Royal Hospital, Dumfries.