

Legislation to Law: Rubicon or Styx?

*Alex Carlile*¹

I wrote this article as a reflection on the activities of the Joint Scrutiny Committee on the Draft Mental Health Bill 2004². My credentials for authorship are that I acted as the Chair of the Committee, elected by the Committee at the beginning of its proceedings.

An important factor in recent events is the placing of the draft Bill before such a committee. What is a Scrutiny Committee?

Normal Parliamentary procedure for legislation involves sequentially five stages in each House of Parliament – first reading (publication without debate); second reading (debate on principles on the floor of the House); committee stage (clause by clause analysis, usually by a Standing Committee in the Commons and in committee of the whole House in the Lords); Report stage on the floor of the House, with some major amendments debated; and third reading (final set piece debate with vote as to whether the Bill as amended should be passed) . With arcane exceptions and variations all Bills have to go through these procedures prior to receiving the Royal Assent. Implementation may be delayed thereafter, and often is to enable structures to be established so that the new laws can be effective. Delay in implementation may be of especial importance where there is significant change to an old set of standards or public bodies.

Relatively new procedures allow for a prolonged but better informed procedure. By resolution of the Houses of Parliament a special Select Committee, described as a scrutiny committee, can be established to consider and advise on a draft Bill. This route to new legislation is intended to be of especial utility where the reform of the law does not involve significant party political controversy, and where a powerful evidence base would be advantageous in determining the final shape of the Bill. It is useful too on an issue like the compulsory use of mental health powers, where there are well-informed groups with divergent opinions. A conventional legislative Standing Committee does not receive and hear evidence in the normal course of events. A Scrutiny Committee does.

Our report on the Draft Mental Health Bill followed a call for papers to which over 450 responses were received. Having seen them all I know their range, from comments faxed on the front of a cereal packet to hefty policy papers. All interested public bodies contributed, many practitioners, and a considerable cohort of service users. From the respondents we invited 124 witnesses to give oral evidence, taken at some speed but after full consideration and analysis of their written submissions.

¹ Lord Carlile of Berriew, Q.C.

² Draft Mental Health Bill Cm6305-1

We made 107 recommendations for change to the Draft Bill³. That there were so many changes to be made was surprising given that there had been a previous attempt at a Bill⁴, and before that, the detailed advice of an expert committee chaired by Professor Genevra Richardson, of London University⁵. Our proposed changes dealt with many matters of detail, but with some core issues too. For the purposes of this article, I focus on three areas that caused us especial pause for thought.

A significant part of the Bill is designed to deal with the small group of severely disordered patients often described as suffering from Dangerous Severe Personality Disorder [DSPD]. This group can represent a totally unpredictable and very real danger to the life and safety of others and themselves. There have been some very well publicised cases of DSPD sufferers who have been known to mental health services, been detained and/or treated and at some later time have murdered others either close to them (including in at least one case their social worker) or some member of the public chosen more or less at random. Naturally there is a desire at large to anticipate and limit the damage DSPD cases may cause. The stories make good news copy, lend themselves to exaggeration in terms of the mental health treatment potential available, and worst of all excite all too easily demands by elected politicians that “something should be done”, usually equated with the assumption that something can be done.

The Committee was firmly of the view that where there is treatment available and a degree of therapeutic benefit, compulsory powers may well have a part to play in DSPD. This conclusion was consistent with the position in Scotland following recent legislation there. However, the Committee was always clear that the Bill was fundamentally flawed and too focused on addressing public misconception about violence and mental illness, in effect creating mental health ASBOs. We had no doubt that hospitals and their clinical staff should not be placed in the position of least worst jailers without any realistic medical intervention taking place.

The second area I would highlight here relates to the proposals for the use of compulsory powers in the community. These proposals, which reflects changes in (for example) parts of Australia, were drafted in an unrestricted way that could have the effect of hugely increasing the number of patients subject to compulsory powers. After hearing evidence almost all pointing in the same direction, the Committee was clear on this issue. It would be unacceptable to have thousands of new compulsory patients, hitherto considered as not requiring compulsion, who would be in the community but with a Sword of Damocles hanging over them should they put a foot wrong, psychiatrically speaking.

The Committee’s view was that there may be some cases for whom community powers would be useful, but they would be few in number and circumscribed by the Act and Codes of Practice. A good use of such powers might be to ensure the continued use of critically important medication, including depot injections.

The third area I highlight is the important issue of the change from Mental Health Review Tribunals [MHRT] to Mental Health Tribunals [MHT]. It is accepted by all informed sources that an effect of the proposed new legislation would be to increase enormously the number of sittings of the new MHT, and the need for legally qualified chairs and other members. This produced

3 *Joint Committee Report on the Draft Mental Health Bill 23rd March 2005*

5 “*Review of the Mental Health Act 1983*” – report of the Expert Committee (November 1999)

4 *Draft Mental Health Bill 2002 Cm 5538-I*

powerful evidence from the MHRT regional heads, and a real concern in the minds of the Committee members that there would be chaos unless the MHT was staffed and funded properly before the system comes into force.

The government response to our report was mixed⁶. At the time of its publication on the 12th July 2005, I accepted that the government had responded with significant improvements, but said that there was still a long way to go.

On the DSPD issue, although the language of the response could be taken as a rejection of the Committee's views, in fairness I consider that there is far less difference in substance than in language, once one jumps off the head of a semantic pin. Our insistence on therapeutic benefit was rejected. However, clarification on the floor of Parliament of what Ministers intend may well lead to the conclusion that the language of detention will reflect a reality of treatment. There may be some differences as to what therapeutic benefit consists of, for example if effectively it merely sedates or changes mood without addressing the underlying condition to any meaningful extent. However, I am hopeful that no clinician of whatever kind will be required by law to detain any patient in what might generally be described as an ethically unacceptable framework.

On the question of compulsion in the community, it was accepted that the principles for this new regime should be set out on the face of the Bill. This is certain to have the effect of limiting the scope and range of such orders, so that they will be used in a modest number of cases and hopefully to good effect.

On the third issue raised above, the government agreed to look again at the existing model for mental health tribunals, to see whether alternative options were available to safeguard patients' rights, while being more practical. There is a commitment that the tribunals must be ready to meet the new legal framework. My informal soundings leave me in no doubt that a good deal of work is being done on this within government, but that there is limited confidence amongst tribunal members that the new system will be fit for purpose on the day it opens for business.

Space does not permit a more detailed analysis of the government's response. We hope that they mean what they say about welcoming our recommendation that national training standards are created in the move from approved social workers to approved mental health professionals; and the need to review the costs of setting up mental health advocacy services; and that the Codes of Practice should restrict the use of compulsion for people suffering from learning disabilities, or from communicative disorders such as Autism or Asperger's Syndrome.

We hope too that Parliament as a whole, when debating the subject, will look with analytical determination at the report of their own Scrutiny Committee, made up of 24 interested and united members of both Houses, some with real material professional expertise, who considered and reported on a solid and representative evidence base. There is unlikely to be another major legislative slot for compulsory mental health powers in the next 20 years. This opportunity must not be wasted.

6 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm6624 (July 2005)*