

# Mental Health Law for the 21st Century?

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Lord Shaftesbury complained that it took him 'seventeen years of labour and anxiety' to get the Lunacy Act 1845 onto the statute books<sup>2</sup>. The revision of the Mental Health Act 1983 is also turning out to be a long and difficult process, both for Government and for those that it calls 'stakeholders' in mental health services. What follows does not seek to examine that process, although it relies heavily on the public sessions of the Joint Committee on the draft Mental Health Bill (hereafter 'the Joint Committee'). Nor will I attempt to summarise the Mental Health Act Commission's public comments on the draft Bill of 2004, which are readily available<sup>3</sup>. My conclusions, especially insofar as they exhibit a certain pessimism over the future direction of mental health law, are a personal view rather than one which is necessarily held by the MHAC.

## Human rights and the reach of mental health law

Many service users and mental health professionals appear to view with some scepticism the Government's claim that a concern with human rights lies at the heart of its drive for a new law.<sup>4</sup> But the current law has taken quite a battering from challenges under the Human Rights Act 1998, being the most found-against law on the statute books to date in terms of incompatibility declarations.<sup>5</sup> Although remedial action has been taken in some cases to patch up the 1983 Act after such judicial declarations of its incompatibility with the tenets of the European Convention

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2 Mental Health Act Commission (2003) *Placed Amongst Strangers: Tenth Biennial Report*. London, Stationery Office, p 290.

3 Joint Committee evidence DMH 20, DMH 90. Available from [www.mhac.org.uk](http://www.mhac.org.uk)

4 For the Government view, see Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 19 January 2005, Q814 (Ms. Rosie Winterton MP). Uncorrected transcript of oral evidence to be published as HC 95-x. For examples of scepticism, see the responses to the Joint Committee on the Draft Bill's consultation question 9 at DMH24 (Royal College of

Psychiatrists); DMH 105 (Mental Health Alliance); and DMH 111 (Law Society).

5 If, that is, the measure is of frequency of findings rather than profundity of offence against human rights. The most profoundly incompatible statute, given the issues involved and the tone of the judgment, must be the Anti-Terrorism Crime and Security Act 2001 (ATCSA). However, the Mental Health Act 1983 shares in some of the ignominy of ATCSA, given that four ATCSA detainees were transferred to hospital under the powers of the 1983 Act in conditions that, in the view of the MHAC, denied any effective review mechanism under the 1983 Act's powers. The MHAC gave evidence of its concerns about this to the Joint Committee of Human Rights in June 2004, which was published in the Committee's report *Review of Counter-terrorism Powers* (HL Paper 158, HC 713, pp63) and visited and monitored the care of the patients.

on Human Right (ECHR),<sup>6</sup> the prospect of continued rearguard action of this sort is unlikely to be palatable to Government ministers. The temptation to wipe the slate clean and rebuild the law with a specific focus on ECHR compliance must be great for that reason alone.

Even those who are sceptical over the continued role of human rights legislation have called for legislative reform. The Conservative party has indicated that it would consider repealing the Human Rights Act to 'check the escalating volume of 'rights' claims against the criminal justice system and other public bodies' and 'retain proper parliamentary oversight of our justice system'<sup>7</sup> (thereby potentially rooting out the causes of ministerial discomfort in the courts by other means). But it has also claimed that 'we desperately need an update to the 1959 and 1983 mental health legislation'.<sup>8</sup> It seems that, despite disagreement over the appropriate mechanisms of protecting individual rights, there is consensus, at a rhetorical level at least, that what is needed in mental health law is a new focus on patients as individuals and new safeguards to support this focus.<sup>9</sup>

Such rhetoric, in any case, takes place at a level abstracted from the real tensions that pull upon the drafting of this legal framework. After all, the purpose of mental health law is not simply to protect liberties, but also to empower authorities to take them away. The roots of Government action over the 1983 Act extend back to the announcement of the Home Secretary, more or less contemporaneously with the enactment of a domestic human rights law, that something would be done over the group of patients given the political label of 'dangerous severe personality disorder' who were perceived to be excluded from psychiatric compulsion or intervention.<sup>10</sup> Many of the most contentious aspects of the draft Bill emanate from Government's aim of providing a civil form of preventive detention for this group of people.

The challenge facing the Government is to balance the need to establish parameters for psychiatric compulsion whilst facilitating such compulsion where it is proportionate and justifiable. It is

6 The finding in *R (on the application of H) v MHRT, North & East London Region* [2001] EWCA Civ 415; [2001] MHLR 48 was addressed in the Mental Health Act 1983 (Remedial Order) Order 2001 (SI 2001/3712), which amended ss 72 and 73 of the 1983 Act to shift the burden of proof in Tribunal appeals. A Consent Order subsequent to *R (on the application of SSG), v Liverpool City Council, the Secretary of State for Health and LS (interested party)* October 22 2002 ensured that MHA 1983 s26(6) should be read to apply to homosexual partners. The finding of *Bennett J in R (on the application of E) v Bristol City Council (Administrative Court, 13 January 2005)* may have resolved some Article 8 issues regarding Nearest Relatives (*R (on the application of M) v Secretary of State for Health* [2003] EWHC 1094 (Admin); [2003] 3 All ER 672) although, even if ASWs choose not to contact a 'Nearest Relative' on the grounds of objections by the patient, there still remains no mechanism to remove the designation of 'Nearest Relative' from someone on the grounds of a patient's wishes. Government has yet to provide a solution to the determination in the ECtHR judgment *HL v UK* [2004] that the current legislative framework fails to protect the rights of incapacitated but compliant patients, or to the lack of Tribunal access for a patient whose section 2 detention is extended through a s.29

*application (R (on the application of MH) v Secretary of State for Health* [2004] EWCA Civ 1609).

7 Conservative Party press release, 23 August 2004.

8 Hansard HC 3 Dec 2003, col.517 (Mr Tim Yeo MP). Mr Yeo prefaced his comment with the caveat that the Opposition 'have repeatedly said that the Government's draft mental health Bill is not the answer'.

9 Conservative Party press release, 8 September 2004: Shadow Health Minister (Tim Loughton MP) has stated that "we have waited too long already to update our mental health laws, which mainly hark back to the 1950s", but that the draft Bill is overly focused on the dangers to the public rather than the medical needs of the patients: "the Government have still failed to grasp that mental illness is a medical condition requiring treatment like any other physical problem rather than a criminal offence demanding incarceration. Compulsion should be a means of last resort".

10 The Guardian, 19 July 1999: Straw unveils plan to lock up 'dangerous' mental patients before they commit crimes. See also House of Commons Home Affairs Committee (2000) First Report of session 1999-2000. Managing Dangerous People with Severe Personality Disorder. March 2000, Introduction p.v-vi.

important that the law sets no arbitrary or unhelpful limitations on mental health services (as, for example, might be argued to result from the current Act's apparent exclusion of patients with acquired brain injuries). It is equally important, however, that this does not lead to the structure of the law being wide open to abusive practices. Where basic definitions must remain relatively broad, robust principles of application, explicit exclusions, and appropriate regulation of practice are means for Government to fulfil its obligation to ensure that powers used in its name are implemented in accordance with human rights principles.

In its aim to ensure that its legislation is 'inclusive'<sup>11</sup> (i.e. wide-ranging in scope), Government displays its determination that nothing in its Bill should be a hostage to future legal challenges of the right of the State to intervene in patients' mental healthcare. But this nervousness may be self-defeating: where the Bill fights shy of setting parameters through loosely drafted or implied powers it is most vulnerable to future judicial interpretation. A balance must be reached between 'inclusive' legislation and a meaningful framework of defined powers and duties, unless Government wishes to abrogate the role of establishing law to the judiciary.

In responding to points raised during consultation and scrutiny, Government understandably seeks to give a positive presentation of the measures that it proposes. But in doing so it may overlook the potential for use of powers in ways other than it intends. It is not difficult to envisage the inappropriate use, however well meant, of mental health legislation for disproportionate medical interventions in the lives of the mentally disordered, or for non-medical purposes of social control. The duty provided by the Human Rights Act 1998 upon public authorities to construe (so far as it is possible to do so<sup>12</sup>) the powers of mental health legislation in a way compatible with the ECHR does not necessarily restrict the potential for overly broad interpretation of mental health powers. The Convention itself can be interpreted quite widely in terms of acceptable interventions regarding the mentally disordered.<sup>13</sup>

I think that we must reject the premise that the wide powers proposed in the Bill should be curtailed solely through the checks and balances of professional judgment and the Tribunal. For the law to be of value – to patients, State administrators, mental health professionals, the police, the courts or the Tribunal – its meaning cannot rest upon the discretion of those working within its framework.

### **Out-dated legislation?**

There is, in both Government and its opposition's repeated emphasis on the current Act's origins in the 1950s, a sense that something has changed materially in services since that time and that the law has not kept pace. In this sense the 2004 Bill stands as the latest in a string of attempts to

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11 For instance, *Improving Mental Health Law: Towards a New Mental Health Act*, para 3.20.

12 s.3 (1) Human Rights Act 1998

13 *The European Convention does of course allow for the lawful detention of persons of unsound mind, alcoholics or drug addicts or vagrants (Article 5(1)(e)), and allows restrictions on liberties as prescribed by law for the protection of health or morals (Articles 8(2), 10(2)). The Convention itself could not therefore be*

*relied upon to exclude the use of mental health law to incarcerate drug addicts, alcoholics or other persons where the law itself made no clear limitation on such use. Although the interpretation of Convention rights is dynamic in nature, leading cases such as *Herczegfalvy v Austria* (1993) have also shown that treatment which falls below acceptable practice standards may nevertheless not be in breach of the Convention.*

formulate law regarding psychiatric compulsion that can be applied in community-based settings.<sup>14</sup> It is possible, however, that these attempts are themselves based upon a questionable premise, which is that compulsion must or indeed should follow services out of hospitals.<sup>15</sup> As no medical professional will countenance administering psychiatric medication under some form of restraint without the patient first being removed to a medical facility that, in practical reality, is as likely to be a hospital as not, such powers of compulsion are not really about 'community treatment', but rather they circumscribe the limits of extended leave of absence or conditional discharge from hospital inpatient treatment. The concessions and reassurances offered over non-residential orders in the draft Bill – such as that these will normally be imposed only after a period of in-patient assessment<sup>16</sup> – indicate that the new powers it proposes may turn out to be no different in overall structure to those that already exist.

From the change in the interpretation of the 1983 Act in 2002,<sup>17</sup> there may already be an increasing number of patients managed outside hospital under legal conditions that closely approximate those proposed as 'non-residential' orders. However, the draft Bill proposals do widen the group of patients who may be given extended leave. At present, extended leave is not easily applicable to patients detained under section 2 of the 1983 Act, whose detentions are neither renewable nor, if such a patient is on leave at the time, convertible to section 3, although there is little to stop an inpatient's detention under section 2 from being converted to a section 3 with the aim of granting long-term leave.<sup>18</sup>

The draft Bill proposals could therefore lead to more patients being made subject to compulsion than at present, with the increase being cumulative as community orders are used to free hospital places through what used to be tastelessly referred to as 'long-leash' arrangements. If non-residential orders are used simply to enforce medication regimes, the relatively loose criteria for continuing such orders and the restrictions on the Tribunal's discretion to discharge them could make it difficult for patients to return to informal status. In addition, of course, both the MHAC and the Law Society have raised the prospect of non-residential orders operating as a form of psychiatric Anti-Social Behaviour Order, as there will be no restrictions on the sorts of requirement that may

14 *Guardianship has been an available but lightly used form of psychiatric compulsion from the Mental Deficiency Acts of the early twentieth century. Reviews of the 1959 and 1983 Act expressed a hope that its use might increase overall and also extend to more mentally ill patients as well as the learning disabled. Practice has generally not met these aspirations. The 1983 Act defined and restricted the powers available to guardians (who until its passing previously had legal rights over a patient equivalent to a father's powers over a child of 14) to powers to require residence at a specified place, attendance at specified places for treatment and access for professionals. No power of imposing treatment is given, and there are no sanctions for non-compliance with any requirement, although detention in hospital under the Act could be an available option if conditions for this are met. A similar but medicalised framework of powers, applicable only to patients subject to s117 aftercare but with a power of conveyance, was introduced through 'aftercare under supervision' (supervised discharge) in*

*the Mental Health (Patients in the Community Act) 1995. In common with community treatment order proposals in the draft Bill, Supervised Discharge was targeted at 'revolving door patients'. Other means of coercive community treatment already exist: since the enactment of the Mental Health Act 1959, at least 40,000 patients have been required to undergo psychiatric treatment as a condition of probation orders (author's own research).*

15 A similar question is posed in Cavadino, M (1989) *Mental Health Law in Context: Doctors' Orders?* Aldershot: Dartmouth p159

16 *Improving Mental Health Law para 3.37*

17 *R (on the application of D.R.) v Mersey Care NHS Trust [2002] August 7 2002, QBD.*

18 *Similarly, a patient detained under section 2 may not be discharged under supervised discharge arrangements, and it is, in theory at least, unlawful to convert a detention from section 2 to section 3 for the sole purpose of initiating supervised discharge*

be made on a patient subject to such an order. The Joint Committee's Chairman has suggested that the use of the Bill's powers as an ASBO might be addressed by ensuring that the thresholds for application of powers to protect others from harm are sufficiently robust.<sup>19</sup>

### **The scope of compulsion – definition of mental disorder and exclusions**

The Bill's definition of the term 'mental disorder' is intended to ensure that this term is used as 'a neutral description of the gateway to the use of formal powers'<sup>20</sup>. The Bill's initial scope, as defined with this term, must therefore be read to extend to alcoholism, addictions, 'disorders of sexual preference' etc.<sup>21</sup>

This would *perhaps* be all very well if the effect of the 'relevant conditions', when considered as a whole, created further definition and an appropriate threshold for compulsion. It is notable that, even though the Richardson Committee was satisfied that its proposals would establish 'sufficiently demanding' conditions for compulsion that would justify a broadly defined criterion of mental disorder, it nevertheless suggested retaining the exclusions of the 1983 Act in a modified form.<sup>22</sup> Professor Richardson has made it clear that she does not view the Bill's conditions for compulsion to be as demanding as those suggested by her Committee.<sup>23</sup>

The Government's justification for its proposal to set aside exclusions is that under the current law these have been widely misunderstood by clinicians as a bar to the detention of persons with drug or alcohol problems, even in the face of a coexisting mental disorder. There is scant evidence that the law is the real problem here: it is quite possible that mental health services seek to turn away such persons, or divert them to addiction services, but this may be more to do with practical resource limitations, or notions of clinical appropriateness, than mistaken ideas about the limit of mental health powers. Even if some practitioners are misapplying the current law through ignorance, this is a training issue rather than a justification for reducing the protections established against misuse of mental health powers.

The Government's proposal would leave as a matter of professional discretion (possibly guided by a Code of Practice, and no doubt liable to judicial interpretation) whether dependence on or harmful use of psychoactive substances, or disorders of sexual preference, etc, could be construed as the sole basis of mental disorder and thus compulsion under mental health law.<sup>24</sup> This *could* in theory lead to counterproductive compulsion being imposed on the basis of

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19 For the MHAC comment, see *Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 20 October 2004, Q40 (Chris Heginbotham), uncorrected transcript of oral evidence to be published as HC -ii. For the Minister of Health's discussion with the Joint Committee Chairman on 'psychiatric ASBOs' see uncorrected transcript of oral evidence to be published as HC 95-x, 19 January 2005, Q836 et seq (Ms Rosie Winterton MP).*

20 *Improving Mental Health Law, para 3.12*

21 *World Health Organisation (1992) The ICD-10 Classification of Mental and Behavioural Disorders. WHO, Geneva*

22 *Department of Health (1999) Review of the Mental*

*Health Act 1983: Report of the Expert Committee (the Richardson Report), page 49 para 5.17, and page 38 -39, paras 4.9 et seq.*

23 *Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 20 October 2004, Q1 (Professor Richardson), uncorrected transcript of oral evidence to be published as HC -ii.*

24 *It is notable in this context that recent mental health legislation in Scotland (Mental Health (Care and Treatment) Scotland Act 2003) and the Republic of Ireland (Mental Health Act 2001) has contained explicit exclusions from the definition of mental disorder (see note [21] below on the use of mental health powers to detain intoxicated persons In Eire prior to this change).*

substance misuse alone.<sup>25</sup> There is no evidence, however, that medical and other professionals who work in addiction services actually want powers of compulsion under a mental health act, or that psychiatric services want to treat addiction or alcohol problems under such powers. Leaving aside the ethical question of incarcerating persons with addictions under mental health powers, it has been prevailing wisdom for almost half a century that removal of responsibility from such persons is likely to be counter-productive to therapeutic effect: this point was made by Government advisors in the review of the 1959 Act and was then accepted.<sup>26</sup>

It may be argued that, if clinicians do not want to abuse the powers that the draft Bill would hand to them, clinical discretion can in fact be relied upon as the gatekeeper for compulsion over this issue. But this perhaps overlooks the fact that clinicians are not the sole gatekeepers of psychiatric compulsion: there are also the police (at least for place of safety detentions), the courts and the Home Office. Compulsion in the treatment of drug-addicts is already a factor in criminal law (particularly through probation 'treatment orders'). The Home Office-sponsored Drugs Bill now before parliament would provide powers of compulsory drugs intervention parasitic on the making of an ASBO under the Crime and Disorder Act 1998<sup>27</sup>. This appears to mark an extension in powers to order the compulsory treatment of addiction beyond the sphere of criminal disposals upon conviction to matters dealt with in civil cases. It is perhaps conceivable that in this climate the use of mental health powers for the compulsion of addicts also becomes an acceptable policy aim, particularly if such powers are used to impose ASBO-like conditions upon patients' behaviour.

Such speculation is perhaps besides the point, given my earlier statement over the need for the law to establish boundaries regarding the limits of compulsion. The Home Office estimate that 90% of prisoners suffer from a mental disorder is arrived at through the inclusion of drug-addicts and alcoholics in that category. Professor Nigel Eastman alluded to this statistic in his evidence to the Joint Committee, suggesting that it is unclear "how mental health services will guard against the wholesale transfer of prisoners...straight into mental health beds". The point that Professor Eastman was making was not that such a transfer is a real or immediate danger, but rather that the Bill provides no boundaries in the legal framework to prevent it: "...that is not going to happen, but the way in which it is not going to happen is not at all clear at the moment"<sup>28</sup>:

25 *In one health district studied in Eire between 1989–91, alcoholics accounted for 24% of all compulsory admissions under mental health powers and it is suggested that 'certification was being used as a way of dealing with social and behavioural crises in relation to intoxication' (Carey, T and Owens, J (1993) "Involuntary admissions to a district mental health service – implications for a new mental treatment act". Irish Journal of Psychological Medicine, 1993 October; 10(3):139–144). The UK Government's 1978 White Paper Review of Mental Health Act 1959 (Cmnd 7320) stated that "powers of compulsory admission or detention [are] sometimes usefully employed in relation to alcoholics or drug addicts. The power compulsorily to admit for observation (under s25) a person suffering from 'any other disorder or disability*

*of the mind' seems often to be invoked to provide temporary protection for an alcoholic or addict who is a danger to himself and to determine whether there is an underlying mental disorder' (para 1.28), but accepted nonetheless that what became the 1983 Act should include a specific provision excluding alcohol and drug dependency from its scope (para 1.30).*

26 *Review of Mental Health Act 1959 (Cmnd 7320), para 1.29*

27 *Drugs Bill, introduced 16 December 2004 [Bill 17].*

28 *Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 8 December 2004, Q461 (Prof Nigel Eastman). Uncorrected transcript of oral evidence to be published as HC 95–iii.*

## **The Tribunal as a safeguard over the imposition of treatment**

It is probably fair to say that the benefits to *civil* patients from the draft Bill's proposed legal framework of compulsion will stand or fall on the practical effect of the Tribunal established as the gateway into long-term compulsion. The Bill misses some opportunities to extend the safeguards of the Tribunal to patients entering psychiatric compulsion through the criminal justice system. In particular, it is disappointing that criminal courts are given the job of authorising patients' care-plans before such patients are diverted from the criminal justice system, and that the decision to sanction transfers or discharges of patients where such courts make restriction orders will continue to be taken by a politician with executive powers. The new Tribunal system could have been charged with establishing the details of court orders, and with taking decisions over restricted patients (no doubt with the Home Office retaining a monitoring role and interested party status at hearings), so that all mentally disordered persons coming under the powers of the Act would have its full protection.

The Government estimates that its current proposals would lead to a total of about 42,000 Tribunal hearings each year; provided that the numbers of people subject to formal powers does not increase under the new legal framework. In 2004 there were slightly less than 13,000 Tribunal hearings, although Government has estimated that there are, in addition to this figure, some 10,000 managers' hearings.<sup>29</sup> There seems to be a widespread pessimism amongst Tribunal users, particularly amongst professionals who seek to arrange or attend at hearings under the current Act, that the new Tribunal can be resourced to meet the administrative challenge of a greater number of more complicated Tribunal hearings. In part, this is because some of the resources needed (such as doctors' time to prepare cases and attend hearings) are finite and, at the moment, inadequate. The 'nightmare scenario'<sup>30</sup> is that this administrative burden could reduce the quality of patient care rather than enhance it.

The Council on Tribunals has supported the principle of having an independent judicial body confirm the need for continued compulsion after the initial 28 day period, particularly in light of what it views as a significant reduction in other safeguards available to patients under the draft Bill compared to the 1983 Act. (In its evidence the Council has cited the abolition of managers' hearings and Nearest Relatives' rights of discharge, reduced consent to treatment safeguards and a reduction of the visiting function as presently carried out by the MHAC as examples of such reduced safeguards).<sup>31</sup> The liaison judge for the Mental Health Review Tribunal (MHRT) and the current MHRT Chairs are less supportive of the new Tribunal proposals, in part because of their concern they require the Tribunal to first authorise and then hear any appeal against compulsion,<sup>32</sup> and have therefore proposed relatively minor changes to the current legislation (such as moving forward the point at which an uncontested detention is referred to the MHRT for appeal) as an alternative to the new Tribunal role.

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29 *Resources and the Regulatory Impact Assessment: Further Memorandum from the Department of Health to the Joint Committee on the Draft Mental Health Bill*, 14 December 2004. DMH 404, Q33.

30 *Minutes of Evidence, Joint Committee on the draft Mental Health Bill*, 12 January 2005, Q724 (Judge Sycamore – Liaison Judge, MHRT service) *Uncorrected*

*transcript of oral evidence to be published as HC 95–ix*

31 *ibid*, Q737 (Ms Letts)

32 *ibid*, Q724, 726, 727 (Judge Sycamore). The MHAC raised similar concerns over the Tribunal's dual role (i.e. authorising detention and hearing appeals against such authorisation) in its submissions to the Richardson Committee.

## The Tribunal and care-planning

The clinical supervisor will drive the care-planning process relating to compulsory orders, which may be (and indeed may have to be) quite separate from the CPA process driven by the care co-ordinator. It is likely that the role of clinical supervisor is likely to be applicable to a narrower range of professionals than the role of care co-ordinator, perhaps particularly for non-resident patients. This raises the possibility of a patient's care being the responsibility of two different professionals, which could be deleterious to the effectiveness of the CPA policy overall. It may also imply that patients could have more than one 'care-plan'. It seems unlikely that a care-plan whose purpose is to describe the limits of compulsory powers for judicial authorisation can also serve as the co-ordinating document for CPA processes. Whilst the Tribunal should want to know that CPA arrangements are in place and appear to be roughly adequate, the CPA documentation is likely to go well beyond those elements of compulsion in a patient's care that the Tribunal must ultimately decide whether or not to sanction. This could be damaging to the centrality of CPA care-planning where compulsion is involved. CPA planning may also suffer from the Bill's removal of current legal duties to plan, provide and pay for aftercare services.

The chairs and the Liaison Judge of the MHRT appear uncomfortable with the Tribunal's proposed role in approving care plans. This may well involve a 'case conference' scenario, where the Tribunal is expected to adjudicate between competing clinical views as to appropriate treatment at a quite detailed level. The concern is that this might detract from the question of whether the conditions for compulsion are in fact met.<sup>33</sup> I think that this concern has a sounder basis as a question of resources than as a question of principle: since the *Wilkinson* case, the courts have been prepared to adduce oral evidence with cross-examination over disputed issues of fact and opinion on the appropriate treatment of a detained patient, but they do so rarely.<sup>34</sup> I know from experience that the hearings are long and complex affairs, and that these could not be replicated for a great number of patients.

The Tribunal process for authorising amendments to care-plans certainly appears to be cumbersome, as it involves three stages (the doctor applies to the Tribunal; the expert visits and reports to the Tribunal; the Tribunal agrees any amendments with the doctor) where we currently have a single stage (SOAD visit). It is questionable whether there is likely to be any real advantage to the more complex procedure and it perhaps should be reconsidered, if only from a resource point of view.

The Tribunal system is bound to be resource-intensive and there must be a danger that its procedures could become formalised and perfunctory.<sup>35</sup> One immediately obvious danger is that care-plans submitted for approval by the Tribunal may be very broadly drawn and over-inclusive. This problem is likely to be exacerbated by the reduced consent to treatment safeguards in the draft Bill's provisions.

33 *Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 12 January 2005, Q724, 733, 743-747 (Judge Sycamore). Uncorrected transcript of oral evidence to be published as HC 95-ix.*

34 *R (on the application of Wilkinson) v the Responsible Medical Officer Broadmoor Hospital, the Mental Health Act Commission Second Opinion Appointed Doctor and the Secretary of State for Health [2001] EWCA Civ 1545; [2002] 1 WLR 419. See also R (on the application of N) v Dr M [2002] EWCA Civ 1789; MHLR 157.*

35 *The MHAC evidence to the Joint Committee pointed to the study of the Los Angeles mental health court's use of the Californian Lanterman-Petris-Short Act (LPS) as discussed in Scull A (1989) Social Order / Mental Disorder, Anglo-American Psychiatry in Historical Perspective. University of California, p287-289 as an example of such degeneration of legal procedure.*



When the 1959 Act was in force, the Government advised parliament and practitioners that detained patients' consent to treatment was simply not required.<sup>36</sup> This position was challenged or queried by, amongst others, MIND, the Butler and Davies Committees and the Royal College of Psychiatrists. In 1977 legal advisors to the Confederation of Health Service Employees warned that the 1959 Act should not be taken to confer upon staff any right to impose treatment without consent.<sup>37</sup> Government used the 1983 Act to define the extent to which treatment could be imposed, but also introduced safeguards such as second opinion authorisation of certain treatment without consent. The medical professional bodies resisted Government's initial suggestion that such an opinion should be provided by a multi-disciplinary panel, and the current position (whereby a doctor appointed by the MHAC provides the second opinion and has duties to consult across disciplines) is a compromise position.<sup>38</sup>

There is an echo of the pre-1983 position in the wording of clause 199 of the draft Mental Health Bill, which allows that consent 'is not required' for any treatment being neither ECT nor psychosurgery, provided that this is described on a care plan. In this way, the very fact of compulsion (involving as it could the approval of a generic care-plan) could once again become the authority for imposing treatments.

Government may of course argue that the resemblance between the pre-1983 position and the Bill is superficial and that the authorisation of a care-plan by the Tribunal provides the safeguard now supplied by second opinions under section 58 of the 1983 Act. Indeed, it could be argued that we are at long last to have a properly multi-disciplinary panel decide whether to sanction treatment. But if care-plans are too broadly drawn, this safeguard is nothing more than a rubber-stamp. The risk that Tribunals will not be able to have proper oversight of treatment that will actually be administered upon their authority is exacerbated by two changes that the draft Bill would make to current consent to treatment provisions:

- (i). The Bill provides no emergency power to provide medication for mental disorder equivalent to s. 62 of the 1983 Act. This may encourage practitioners to try to anticipate many eventualities in the treatment plans submitted for Tribunal approval, rather than rely on common-law powers at moments of necessity. If the treatment plans are too broadly drawn and all-inclusive, then the Tribunal practitioner is in effect seeking a free hand to administer whatever treatments he or she thinks necessary.
- (ii). Under the current law a doctor must certify on a statutory form any ECT or psychiatric medication that is consented to by a patient. The Bill retains this for ECT, but leaves consent to medication as a matter for the common law. This may lead to Tribunals having incomplete information about a patient's proposed or actual treatment at the time of the care-plan's submission. It will also hinder effective monitoring by hospital managers and outside bodies of the realities of consent and of the sorts of treatment given. Mental Health Act Commissioners take a great interest in the statutory recording of patient's consent status, and of the procedures that lead to such certification. Whilst, generally speaking, practice is

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36 *In 1973 the Secretary of State for Health, Keith Joseph, replied to a parliamentary question (23 January) to the effect that where detained patients were concerned, consent to medical treatment for mental disorder was not necessary but that it was normal*

*practice to try to obtain the patient's agreement if he or she was capable of understanding the treatment.*

37 *Review of the Mental Health Act 1959 (Cmnd 7320, 1978) para 6.14.*

38 *Review of the Mental Health Act 1959, para 6.28*

probably better now than it has ever been before, there is no reason for complacency over how this is done in many cases.

Some of the uncertainties that the 1983 Act sought to clarify could be reintroduced by the consent to treatment provision at clause 199 of the draft Bill. For example, the authority for interventions such as control and restraint or seclusion probably falls to the approved care-plan under clause 199 of the draft Bill, just as it may stem from section 63 of the current Act. But it would surely be a retrograde step if every patient's care-plan were to anticipate seclusion or restraint on a 'just in case' basis. Even if it is possible to derive 'implied' authority for restraint such as that which is proportionate to administer an authorised injection on the basis of this being ancillary to an authorised treatment,<sup>39</sup> this implied authority may not easily extend to wider control and management issues, such as seclusion. This could be an early judicial test of the draft Bill's provisions. It would seem more appropriate for the Bill to make specific provision outlining the legal authority for such control and management issues whilst providing a framework of safeguards against misuse (including, as a minimum, statutory requirements for recording seclusion episodes so that these are open to scrutiny and hospital managers can be accountable for staff actions).

### **Tribunals and discharge from compulsion**

The broad criteria for imposing compulsion also, of course, raise the possibility that patients will find it harder to achieve discharge from compulsory powers. In any appeal against compulsion, the burden of proof must technically rest with the detaining authority for continuing powers over a patient, but the legal thresholds established by the criteria for compulsion and discharge could make this burden relatively undemanding. Under the draft Bill, when the Tribunal considers an appeal it is required to refuse the application where all the conditions for compulsion continue to be met.<sup>40</sup> Under the 1983 Act (as amended), the Tribunal is told to discharge a patient where it is not satisfied that treatment under compulsion is necessary for a patient's health or safety, or the safety of others, and it has discretion to have regard to whether treatment is likely to be effective and whether a patient might manage if discharged.<sup>41</sup> The Bill therefore changes the emphasis of the Tribunal and provides it with less discretion than is provided to the MHRT under current law.

### **The criminalisation of the mentally disordered?**

The 1959 Act was specifically designed to end the stigmatising requirements of 'certification' of patients through quasi-judicial process. It could be that the stigma implied in the processes and terminology of 'certifying' under the Lunacy Acts which were in force until 1959 is in no small part responsible for the continuing stigmatisation of patients who have been 'sectioned' today.<sup>42</sup>

The reverse side of the rights-based legalism in mental health compulsion is that the processes through which a patient passes increasingly resemble those of the criminal law.<sup>43</sup> This, it might be argued, is not an inevitable consequence: other court-based systems (such as child welfare) are

39 *B v Croydon Health Authority* [1995] 1 All ER 683, CA

40 i.e. draft Mental Health Bill clause 56(6)

41 MHA 83 s. 72(1)(b), 72(2)

42 The MHAC discourages the use of the term 'sectioned' (rather than, for example, 'detained') in mental health services on account of its inaccuracy and the stigmatising effect.

43 Sometimes this is the result of pressure from civil-libertarian approaches; such as Mind's ongoing legal action seeking the adoption of the criminal burden of proof (i.e. beyond reasonable doubt) for Tribunal determinations.

clearly established as civil processes, although children are, of course, already the ward of someone and the basic issues of personal liberty and detention are not so clearly engaged. In this way it is unfortunate that the draft Bill imports into civil psychiatric compulsion a number of mechanisms that could distort clinical priorities and that give the Bill the flavour of a criminal justice measure. In particular, I would point to:

- The particular provisions in the conditions for compulsion of civil patients who are deemed to be at 'substantial risk of serious harm' to others, above and beyond those provisions that set a threshold for the compulsion of any other civil patient for the protection of other persons;
- The provision allowing the Tribunal to make an order requiring a civil patient to be detained in hospital for a fixed period of time<sup>44</sup>
- The introduction of the equivalent of restriction orders for civil patients deemed to be at substantial risk of serious harm to others, where the Tribunal may reserve powers of leave, discharge or transfer to itself.

### **The relation between the Mental Capacity Bill and the draft Mental Health Bill**

The Mental Capacity Bill codifies (and possibly extends) common-law powers relating to the treatment of patients who lose capacity to provide consent, including powers of restraint and coercive treatment.<sup>45</sup> It has been argued that the Mental Capacity Bill, by enacting such powers as statute law, may come into contention with the draft Mental Health Bill in relation to which authority may appropriately be used, or may be available, for compulsory treatment for mental disorder.<sup>46</sup>

The Government initially rejected that such contention had any real basis, primarily on the grounds that the Mental Capacity Bill is worded carefully to authorise 'restrictions' on liberty, whereas Mental Health Act powers are concerned with 'deprivation' of liberty<sup>47</sup>. Insofar as the case-law of the European Court of Human Rights (ECtHR) makes a clear distinction between restriction of liberty (which does not engage Article 5 rights) and deprivation of liberty (which does engage such rights), this distinction would form the operative threshold between the two Bills. However, the Government now appears to have had second thoughts, and may yet use the Mental Capacity Bill to provide powers to authorise and provide safeguards for the deprivation of liberty of incapacitated patients who are compliant with their care.<sup>48</sup>

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44 Draft Mental Health Bill, clause 46(6).

45 Clauses 5 and 6 of the Mental Capacity Bill provide powers to 'restrain' incapacitated patients, provided that such restraining actions are: (i) believed to be in the patient's best interests; (ii) not in conflict with any decision taken by a donee of lasting power of attorney or a deputy appointed by the court; (iii) believed necessary to prevent harm coming to that patient; and (iv) a proportionate response to the likelihood of that harm and its seriousness. Restraint is defined (clause 6(4)) as the use, or threatened use, of force to secure the doing of an act which the patient resists, or an act which restricts the patient's liberty of movement whether or not s/he resists.

46 See, for example, Joint Committee Evidence DMH 90

(Supplementary memorandum from the Mental Health Act Commission) and DMH 378 (Memorandum from Geneva Richardson)

47 Joint Committee on Human Rights (2005) Scrutiny: First Progress Report. Fourth Report of Session 2004–05. HL paper 26, HC 224, January 2005. See Appendix 4: Mental Capacity Bill. Letter from Baroness Ashton of Upholland to the Chair, response to Q2. See note 45 above for the wording of the Bill.

48 As this issue of the JNHL goes to press, the amendment text of 23 February 2005, proposing a new clause "Protective care for certain persons lacking mental capacity" after Clause 59, had been withdrawn because the Delegated Powers and Regulatory Reform Committee ruled it unacceptable.

This, perhaps, still assumes too readily that the distinction between restricting and depriving liberty can be applied easily to practical examples of health and social care interventions in the lives of the mentally disordered. In *HL v United Kingdom* the Court determined that 'the distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance' but found that deprivation of liberty had resulted in the case they were considering as 'health care professionals treating and managing the [patient] exercised complete and effective control over his care and movements'<sup>49</sup>. It seems likely that this description could be applied very widely to the practical arrangements for managing mentally disordered patients in and out of hospital environments. Furthermore, as Government 'is minded' to allow an aspect of clinical discretion over whether any particular patient falls within the frameworks of either mental health or mental incapacity law (similar to the scope for discretion in using child protection powers or the 1983 Act in certain circumstances)<sup>50</sup>, it will be for the practitioners themselves to decide whether their actions amount to deprivation of liberty and should be subject to the formal admission and review mechanisms that are required following the ECtHR ruling last year.

The European Court has therefore necessitated a refocus on the 'Bournewood gap' at a relatively late stage in the development of both mental capacity and mental health legislation. This may have serious consequences for the landscape of our mental health law that were not a part of the original intentions of legislators or those who called for reform. In particular, though, it may exacerbate the potential consequences of mental capacity legislation narrowing the scope of mental health law.

Not all interventions under the draft Mental Health Bill would necessarily involve a deprivation of liberty. Indeed, one of the motivations of new law was that it would no longer be necessary to detain patients in hospital to treat them under mental health act powers<sup>51</sup>, and the Bill will require that its powers must be operated according to a principle of using the least restriction necessary<sup>52</sup>. Because a condition of treatment under the draft Bill's powers will also be that no other legal authority for such treatment exists<sup>53</sup>, any alternative legal frameworks that can be used to impose either restrictions or deprivation of liberty in providing psychiatric care will always have to be used in preference to mental health act powers. At the very least this would militate against the use of mental health powers to provide incapacitated patients with care short of detention. The Mental Health Act's full range of powers could consequently become reserved for the imposition of treatment to mentally capable patients and, perhaps, to mentally incapacitated patients who pose 'a substantial risk of serious harm to others'.

This separation between the two legal frameworks might appeal to some supporters of capacity-based criteria for psychiatric compulsion, but I think that it contains the seeds of the most illiberal mental health laws that this country has ever seen. There would be a sad irony if, at the end of this process of 'reforming' the framework established by the 1959 and 1983 Mental Health Acts, we were left with a new Mental Health Act whose *entire* focus was the civil extension of criminal justice powers to confine the 'dangerous'.

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49 *HL v United Kingdom* (2004), Application no. 45508/99, decision of 5 October 2004. Paras 89 & 91.

50 *Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 19 January 2005, Q847* (Ms Rosie Winterton MP, Professor Appleby). *Uncorrected transcript of oral evidence to be published as HC 95-x*.

51 *Department of Health* (2004) *Improving Mental Health Law: Towards a New Mental Health Act* (Summary) p 4

52 *Draft Mental Health Bill clause 1(3)(c)*

53 *Draft Mental Health Bill clause 9(5)*

### **Future monitoring of mental health legislation in practice**

The MHAC would not have sought its own demise, although it has acknowledged potential efficiencies in a single body of healthcare inspection. It has considerable worries that its core remit, and perhaps just as importantly the unique way in which it carries out that remit through visiting detained patients in private, may be lost or diminished in the transition to a wide-based health (and now also social care) inspectorate<sup>54</sup>. Hopefully this concern has been recognised by officials of the Healthcare Commission and there may yet be safeguards put in place to address it, although there are perhaps fundamental differences in approach to be overcome. More could be done with the Bill itself: although many of the powers of the MHAC were restored to the draft Bill of 2004 after having been omitted from the previous draft, the duty of keeping the powers of the Act under review and of visiting are still not explicit.

I am struck by the analogy between MHAC concerns over future mental health monitoring and the concerns of the Chief Inspector of Prisons (Ms. Anne Owers) over plans for a new super-inspectorate for the criminal justice system<sup>55</sup>. Ms. Owers told the press of her concerns that a human rights inspectorate may be marginalised in such a body, with fewer inspections that are reduced to measuring whether government performance targets are met, and that the ability and resources to go into any prisons at any time without warning with a sharp focus on inspecting individual places of custody could be lost. Ms Owers said that genuinely independent inspection “lifts the lid on closed institutions on behalf of the public, pulls out common practices, and exposes them to the light of what is normal, and what is right.” That is also a fair summation of the job of the MHAC.

The increasing prominence of criminal-justice concepts and measures in mental health law for civil compulsion, and the strong possibility that the increase of community facilities may result in many inpatient units becoming increasingly custodial-based and ‘total institutions’ than at present, perhaps suggests that any future monitoring body for mental health law should be given full independence from Government and be remodelled in the mould of the current prison inspectorate, rather than dissolved into a general health and social care inspectorate. Of course, the content of this article does give a particularly dystopian reading of future mental health law and practice: but if any of this is even half-right, a specialist human rights watchdog will be needed more than ever in the coming years.

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54 *The Chancellor's budget speech of 16 March 2005 announced the Government's intention to merge eleven public sector inspectorates into four broadly based organisations, including a single social care and health inspectorate created from the merger of the Healthcare Commission and the Commission for Social Care Inspection.*

55 *The Guardian, 11 January 2005: Prison inspectors warn on merger plan. The budget speech announcement (note 54 above) confirmed that Government intends to create a single criminal justice inspectorate, although it has promised consultation (The Guardian, 17 March 2005: Time called on inspectors).*