

The Law Society's Response to the Draft Mental Health Bill¹

The Law Society has long campaigned for reform of the Mental Health Act 1983 ('the 1983 Act'), which is widely recognised as out of date and not fully compatible with the Human Rights Act 1998.²

However the Law Society believes that the proposals contained in the Draft Mental Health Bill 2004 ('the Bill') are misconceived and fail to provide adequate safeguards to protect the rights of people with a mental disorder.

The relevant conditions for compulsion

Like many other organisations, the Law Society believes that the Bill's criteria for compulsory care and treatment are too broad. This is illustrated by the example of a smoker, who has tried and failed to give up, and would fulfil all the relevant conditions in clause 9:

1. *The patient must be suffering from a mental disorder.* Nicotine dependency is included in the ICD-10 classification of mental disorders (F17) and is listed in the DSM-IV classification (code 305.20)
2. *The mental disorder must be of such a nature or degree as to warrant the provision of medical treatment.* There is no requirement that the person's mental disorder has to justify compulsory in-patient treatment. In this case the addiction warrants treatment (nicotine patches, counseling, etc).
3. *It must be necessary for the protection of the patient from suicide or serious self harm or serious neglect of his health or safety.* Smoking causes serious neglect of the patient's health.
4. *Medical treatment cannot be lawfully provided without the patient being subject to compulsion.* This condition is met because the patient continues to smoke despite being advised of the harm being caused to him/herself.
5. *Medical treatment must be available which is appropriate to the patient's case.* Treatment is available for nicotine dependency.

1 The Law Society gave oral evidence to the Joint Parliamentary Scrutiny Committee on 3rd November 2004 (ref: HC 127-vi). Its written evidence can be found at www.lawsociety.org.uk. Its response to the Draft Mental Health Bill 2002 was published in the JMHL December 2002 at pp 373 – 375. This article was accepted for publication before (a) the Joint Parliamentary Scrutiny Committee on the Draft Mental

Health Bill reported (23rd March 2005), and (b) the Mental Capacity Bill received the Royal Assent (7th April 2005).

2 *R (MH) v Secretary of State for the Department of Health [2004] EWCA Civ 1609* being the latest in a series of declarations of incompatibility between the ECHR and the 1983 Act.

The Government may claim that such situations are unlikely to arise because the good sense and discretion of doctors can be relied upon. However the Bill gives clinicians no discretion about the use of compulsory powers if the relevant conditions are satisfied.³ This is in contrast to the 1983 Act, where even if the relevant conditions are met the clinicians can use their discretion as to whether or not to use compulsory powers. The Law Society believes that patients' rights will only be protected by tightly defined relevant conditions and by providing clinicians with discretion about the use of compulsory powers.

Community Treatment Orders

The introduction of compulsory community treatment orders appears to be based on the misconception that it is a lack of legal powers which places the public at risk from people suffering from mental disorder. The various homicide inquiries overwhelmingly show that it is lack of resources, lack of information and lack of communication that causes care and treatment to break down in such a way as to increase the likelihood of a tragedy.⁴ Increased legal powers, such as community treatment orders, will not improve this situation unless they are backed-up by sufficient resources and if patients in the community are properly supported there would be less need for compulsory powers.

The Law Society is concerned that the Bill fails to ensure that only a limited and strictly defined group of patients could be made subject to community treatment orders. The Bill refers to the use of regulations to limit the group of patients who can be compulsorily assessed in the community without an immediately preceding hospital admission⁵ but there is no equivalent provision for a non-resident treatment order.⁶ The Bill is also silent on the matters that the Mental Health Tribunal will have to take into account in deciding on residence or non-residence as part of the treatment plan. This will mean that the use of compulsory community treatment is not restricted to a tightly defined group of patients and therefore it could be imposed on patients with severe and non severe mental health problems.

The Bill authorises a compulsory community assessment to be carried out without an immediately preceding hospital admission for "revolving door patients".⁷ However the Law Society is concerned that the Government has not clarified what it means by a "revolving door patient" and specifically whether this will be based on previous compulsory admissions. If the definition of revolving door patients includes voluntary admissions, this will make many people with mental health problems reluctant to agree to short voluntary admissions, because they will be 'collecting points' towards a disadvantageous status.⁸

The Law Society also believes that the proposals for community assessment and treatment are impracticable. The experience of supervised discharge under s25A of the 1983 Act illustrates that

3 Clauses 16 and 38

4 See 'McGrath and Oyeboade (2002) Qualitative Analysis of Recommendations in 79 Inquiries after Homicide Committed by Persons with Mental Illness', *Journal of Mental Health Law* – December 2002, pp262–282).

5 Clause 15 (2) and Explanatory Notes Para. 66

6 Similarly there is also nothing to restrict the circumstances in which a patient who is liable to

assessment is made a non-resident patient by the clinical supervisor for the duration of the assessment period.

7 Clause 15 (2) and Explanatory Notes Para. 66

8 Para. 66 of the explanatory notes mentions patients "who are known to services", "prone to relapse" and "get into a cycle of admission and discharge"; but does not specifically mention previous compulsory admissions

where people in the community are 'required' to comply with certain conditions, this has proved difficult to enforce.⁹ Under the Bill, a clinical supervisor is given the power to 'take and convey' a non-resident patient back to hospital where he/she fails to comply with the conditions, however it is not made clear how this is to be achieved.¹⁰ The use of a warrant under clause 225 may be intended for this purpose but would be dependent on police and ambulance availability and resources. Also, since the patient must be detained within 24 hours, it is likely that a hospital bed must be kept free thus putting extra strain on limited resources.¹¹

It is also of some concern that the legal thresholds for the provision of compulsory community treatment are very wide indeed. Crucially the Bill breaks the link in the 1983 Act between the use of compulsion and the requirement that it is necessary for the patient to receive treatment in hospital. For example, the third condition specifies that medical treatment must be necessary for the protection of other persons, which is a far lower threshold than the 1983 Act which requires that detention in hospital must be necessary for the protection of others. In a risk-averse society such as ours, it is quite easy to imagine that mere nuisance behaviour could be used to justify making a person subject to compulsory powers in the community. This raises the alarming possibility of using mental health legislation to create psychiatric Anti-Social Behaviour Orders (ASBOs).

In addition, the Bill authorises non resident treatment orders to include a condition that 'the patient does not engage in specified conduct'.¹² The meaning of 'specified conduct' is not defined but potentially includes preventing a person going to the pub or associating with certain people. This raises further fears that the Bill authorises psychiatric ASBOs.

Mental Capacity

One of the Bill's major failings is the lack of any reference to a patient's mental capacity to make treatment decisions in the relevant conditions for compulsion. There has been increasing judicial recognition that the imposition of treatment on competent patients raises issues under Article 3 (prohibition of inhuman or degrading treatment) and Article 8 (respect for private and family life) of the ECHR, especially where the person does not present a danger to the health or safety of others.¹³ This is likely to form the basis of future challenges to the Bill.

The lack of explicit reference to mental capacity means that the relevant conditions are fundamentally flawed. For example, the requirement that treatment must protect the patient from 'suicide or serious self-harm, or from serious neglect by him of his health or safety'¹⁴ is too narrow for people who lack capacity and would prevent treatment being provided to an incapacitated patient who resists treatment but presents a low level of risk.¹⁵ On the other hand, where a person has capacity to make treatment decisions this condition is too wide.

9 For example, the power to take and convey has been found to be of 'minimal importance and rarely used (Bindman et al (2001) 'National Evaluation of Supervised Discharge and Guardianship' Report of a study commissioned by the DOH, p.75).

10 Clause 48

11 Clause 48 (7)

12 Clauses 46 (7) and 119(7)

13 See *R (Wilkinson) v RMO Broadmoor Hospital* [2001] EWCA Civ 1545

14 Clause 9(4)

15 For example a person with a learning disability who lacks mental capacity to make treatment decisions and who is being treated by a psychiatrist for challenging behaviour but also suffers from mild depression and refuses treatment. Under the Bill they could not be treated for depression. The Mental Capacity Bill would also not permit forced treatment in these circumstances.

The Bill also provides that a mentally disordered person thought to be at 'substantial risk of causing serious harm to other persons' will not be allowed to receive treatment informally, if the other relevant conditions in clause 9 apply.¹⁶ This will mean that people who have the capacity to consent to treatment and who do consent will still be made subject to compulsory powers. The Law Society believes that this fails the ECHR requirement that any restrictions on liberty must be proportionate to the objective to be achieved.

Interface with the Mental Capacity Bill

The Law Society is concerned that the relationship between the Draft Mental Health Bill and Mental Capacity Bill will be complex and confusing. The Draft Mental Health Bill provides that an individual cannot be subject to compulsory powers unless "medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part".¹⁷ This means that if a person lacks capacity and can be treated under the Mental Capacity Bill, he/she cannot come under the Draft Mental Health Bill. It is therefore likely that the Bill will mainly be used to impose treatment on people who have capacity but refuse treatment.

Under the Mental Capacity Bill a doctor can treat an incapacitated person in his/her best interests.¹⁸ This includes using restraint, whether or not the incapacitated person resists, if this is necessary to prevent harm and is proportionate to the likelihood of the incapacitated person suffering harm and the seriousness of that harm.

Under the Draft Mental Health Bill, the clinical supervisor must discharge a treatment order if at any time he/she is not satisfied that all of the relevant conditions are met in the patient's case.¹⁹ This means that if the patient loses capacity and can be treated under the Mental Capacity Bill, he/she must be discharged from the Draft Mental Health Bill.²⁰ Therefore the clinical supervisor must keep the patient's capacity under constant review and may be required to discharge the patient as soon as he/she becomes aware that the patient has lost capacity to make treatment decisions.

If the incapacitated person has an Attorney or a court appointed deputy who objects to treatment, the Mental Capacity Bill cannot be used to authorise treatment and they would be subject to the Draft Mental Health Bill if the other conditions under clause 9 are met. Furthermore, if the person has made a valid advance decision under the Mental Capacity Bill refusing admission to psychiatric hospital and/or the provision of psychiatric medication should they lose capacity in the future, they could only be treated under the Draft Mental Health Bill, so long as all the relevant conditions in clause 9 applied.

The Law Society believes that the relationship between the two Bills is so complex that, in many cases, it would be practically impossible to work out when one Act should be used and the other should not.

16 Clause 9 (7)

17 Clause 9 (5)

18 Clause 5, *The Mental Capacity Bill 2004*

19 Clause 60

20 This is because in accordance with clause 9 (5) lawful treatment can be provided under the Mental Capacity Bill and therefore the relevant conditions in the Mental Health Bill are not met.

HL v United Kingdom²¹

The case of HL has created further confusion about the interface between the two Bills. The decision makes clear that a person who lacks capacity to consent to his/her admission to hospital but who does not object, can nevertheless be 'deprived of his liberty' within the meaning of Article 5(1) ECHR. Moreover, the legal framework provided by the common law doctrine of 'necessity' and 'best interests' contains inadequate procedural safeguards to protect such patients. This could apply to incapacitated informal patients in hospitals and people who lack capacity and are living in nursing homes or care homes whose particular circumstances may amount to a deprivation of liberty.

In future, such patients will need to be detained under a properly regulated system in order to guarantee them the kind of safeguards that are lacking at common law. It was implicitly accepted by the Court that the proper procedure need not be the full compulsory admission procedure of the Mental Health Act 1983. The Law Society accepts that the Mental Capacity Bill could be amended to provide the necessary Article 5(1) ECHR procedural safeguards to avoid arbitrary detention. These safeguards should include clear conditions for detention, a formal assessment process and the appointment of a representative for the patient.

However, if the Mental Capacity Bill were amended in this way, there would also be a need for further amendment to include the review safeguards necessary under Article 5(4) ECHR. In principle the Court of Protection provisions would provide sufficient safeguards. However, in practice it is unlikely that the Government would wish to use a High Court procedure to deal with thousands of routine decisions, many of which will be uncomplicated, uncontroversial and uncontested. The regulatory impact assessment for the Mental Capacity Bill suggests that it was only anticipated that the Court of Protection would deal with about 200 cases a year.²²

The alternative option would be to substantially amend the Mental Health Act 1983 (and the Mental Health Bill) and widen its ambit to cover all those who lack capacity and need treatment for mental disorder in hospital. This would provide sufficient Article 5 safeguards, for example by providing access to the Mental Health Review Tribunal, and would increase the numbers of patients entitled to free section 117 aftercare services. However, this option would also have substantial resource implications and does not address the needs of incapacitated people who are not in hospital but are living in circumstances amounting to a deprivation of liberty.

What is clear is that the Government needs to urgently address this issue because there will be many people who are "HL" detained but who do not meet the criteria for the use of compulsory powers under either the current Mental Health Act or the Draft Mental Health Bill.

Mental Health Tribunals

The Law Society believes that the proposals to create a new Tribunal system are elaborate and far-reaching. However, there remain serious doubts as to whether it would safeguard patients' rights.

The relevant conditions in the Bill are extremely wide. The Mental Health Tribunal is to have no discretion to discharge if all the relevant conditions are met, and as the conditions are so widely defined, it may be extremely difficult for a person to be discharged once he/she has been made subject to the provisions of the Bill.²³

21 Application no. 45580/09 5 October 2004

23 Clauses 45 and 56

22 Para. 43

The Bill does not address the difficulty that will arise if the Mental Health Tribunal and the approved clinician cannot agree on the care plan.²⁴ If the Tribunal is to have a real role in monitoring the treatment of patients, the care plans will need to be detailed and precise. The opportunities for disagreement will be considerable, not only between any particular Tribunal and the approved clinician, but also between one Tribunal and the next. It will be logistically impossible to ensure continuity of tribunal membership as a patient's care develops. It will therefore be necessary for the approved clinician to re-argue the whole case before each Tribunal, as the new Tribunal members will have to be satisfied on their own account that the treatment plan is appropriate.

Furthermore, although the Bill will require a Mental Health Tribunal to make decisions about a patient's ongoing treatment and to authorise care plans, the Tribunal will not be in a position to monitor or police its decisions. This may result in considerable amounts of litigation when the arrangements go wrong and people suffer as a result of a Tribunal decision. Equally, there are likely to be many appeals to the Mental Health Appeal Tribunal.²⁵ The Law Society therefore has grave concerns about whether the new expanded system is realistic and practicable.

The proposals are extremely resource intensive, both in terms of time and money. The Mental Health Review Tribunal system is struggling to manage at present with many appeals being cancelled and delayed.²⁶ The Bill will lead to a significant increase in the numbers of hearings and a vast expansion in the types of decisions that tribunals will have to consider, such as authorising care plans, displacing nominated persons, authorising ECT and examining whether the relevant conditions apply. This will require a major change in the culture of Tribunals.²⁷ It is also likely that hearings will be significantly longer, which will have massive resource implications for recruitment and training. Each hearing may last at least 50% longer, due to the Tribunal's extended remit to include consideration and approval of the care and treatment plan, so there will be fewer hearings carried out per panel, per day.

The Law Society believes that the Bill will only be workable if there is a dramatic increase in resources. For example, the new Mental Health Tribunal system would require a significant increase in the numbers of mental health professionals, approved clinicians, tribunal members and expert panel members, together with proper administrative support. However it seems unlikely that resources will be available in the foreseeable future given the current staff shortages in the provision of mental health services.²⁸

Article 5 (4) of the ECHR requires that a person deprived of their liberty shall have the lawfulness of their detention decided speedily by a court. Court judgements have recognised that the current Mental Health Review Tribunal system has been beset with resource and administration difficulties that have led to delays and cancellations of hearings which have seriously prejudiced

24 For example, clauses 45 and 56 assume that the Tribunal and clinical supervisor will agree

25 For example, it is well established that the 'reasonableness' of an action taken by a person carrying out a public function, such as an approved clinician or a Mental Health Tribunal, is a point of law.

26 The Institute of Mental Health Act Practitioners

(2004) has recently documented this in a survey of 11 Mental Health Trusts between May–August 2004.

27 The main function of the current MHRT is to review justification for continued detention. This is far narrower than the proposals in the Bill.

28 See 'National Service Framework for Mental health: Five Years On' (2004) MIND publications.

patient's interests.²⁹ We are concerned that the Bill will put additional stress on this system and unless considerable resources are made available, patients will continue to be denied a speedy review of their detention.

It is clear from the Bill that the Tribunal is intended to play a pivotal role in safeguarding the interests of detained patients. However, the Law Society believes that the proposed Tribunal structure is unworkable. If we are correct, then the main safeguard for patients will fall away, patients will be left in a vulnerable position and the exposure to human rights claims will be very serious.

Conclusion

Mental health legislation is in need of reform but the Bill is not an improvement on the existing law. The Law Society's view is that the Government should focus on amending aspects of the 1983 Act and, before introducing any major reform, should monitor the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, which is due to come into effect in October of this year.

²⁹ For example, *R v MHRT London South and South-West Region*, ex p. C [2002] 1 WLR 176 and *R v MHRT and Secretary of State for Health*, ex p. KB [2002] EWHC 639.