

# An Inconvenient Mirror<sup>1</sup>

## Do we already have the next Mental Health Act?

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### I. Introduction

The Government intends to replace the Mental Health Act 1983, and the most recent of its proposals were contained in the Draft Mental Health Bill published in June 2004.<sup>3</sup> (The Draft Bill has undergone ‘pre-legislative scrutiny’, and the Joint Committee appointed to perform the task published its report on 23 March 2005.<sup>4</sup> The Government published its response to that report on 13 July 2005.<sup>5</sup>)

The 1983 Act is now very different to the statute introduced at the end of 1982. Parliament and the courts have made a number of significant changes over the last 20-odd years, and they have brought us a lot closer to the next Mental Health Act than many people – and possibly even the Government – suppose. In fact, those changes may have brought us rather close to the Draft Mental Health Bill. That will be an uncomfortable thought for many people.

This paper will consider five key aspects of the Draft Mental Health Bill:

- the provisions dealing with *risk* and *treatability*;
- the notion of compulsion in the community;
- the status of the Code of Practice; and
- the abolition of the Approved Social Worker.

The paper will ask whether, because of the changes of the last two decades, the current Mental Health Act has already arrived at much the same point. In addition, the paper will consider the position of incapable patients. Although the Draft Bill contains precious few proposals about

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3 Department of Health, *Draft Mental Health Bill*, September 2004, Cm 6305-I; *Ibid*, *Draft Mental Health Bill: Explanatory Notes*, June 2004, Cm 6305-II; *Ibid*, *Improving Mental Health Law: Towards a new Mental Health Act*, September 2004

4 Joint Committee on the Draft Mental Health Bill, Session 2004–2005, *Draft Mental Health Bill*, Volume I, HL Paper 79-I, HC 95-I, Volume II, HL Paper 79-II, HC 95-II, Volume III, HL Paper 79-III, HC 95-III. (A detailed paper on the Joint Committee’s report may be found at [www.hempsons.co.uk](http://www.hempsons.co.uk))

5 Department of Health, 2005, *Government response to the report of the Joint Committee on the draft Mental Health Bill 2004*, July 2005, Cm 6624

them, the paper will ask whether recent developments have made a broad definition of mental disorder all but essential.

## **2. The Relevant Conditions**

The Draft Mental Health Bill is about far more than ‘detention’. The powers it contains will be capable of being used, not just in hospitals, but also in the community. A patient against whom the expanded powers are used will be said to be “subject to compulsion”.

Once a person is found to be suffering from mental disorder, as that term is to be broadly defined, it will be possible under the Draft Bill to make him subject to compulsion if each of the Relevant Conditions is met.<sup>6</sup> There are five Relevant Conditions, and some of them are extremely controversial.<sup>7</sup>

### **(a) Risk**

It is the Third Relevant Condition that deals with the *risk* a person must pose, either to himself or others, before he can be made subject to compulsion.<sup>8</sup>

It will be possible to make a person subject to compulsion if that is necessary for the protection of other persons.<sup>9</sup> That proposal is controversial in itself,<sup>10</sup> but the proposal concerning people whose only risk is to themselves is equally so.

For compulsion to be possible in those circumstances, the Third Relevant Condition says it will have to be “necessary, for the protection of the patient from suicide or *serious* self-harm, or *serious* neglect by him of his health or safety, [...] that medical treatment be provided” to him.<sup>11</sup>

The Government says that in comparison to the 1983 Act, “the threshold of harm to self has been raised”.<sup>12</sup> It is certainly true that the current Mental Health Act affords the patient much less leeway: in allowing him to be detained for his own health or safety, it doesn’t require that the risk is ‘serious’.<sup>13</sup> Yet, for all that, it seems likely that the Draft Bill would do no more than give statutory recognition to the present state-of-affairs. Even now, there are so few in-patient beds that they can usually be given only to people who present a risk of suicide or a *serious* risk of self-harm or a *serious* risk of neglect.<sup>14</sup>

### **(b) Treatability<sup>15</sup>**

According to the Fifth Relevant Condition, it will not be possible to make a person subject to compulsion unless “medical treatment is available which is appropriate in his case”.<sup>16</sup> This is a very

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6 Department of Health, *Draft Mental Health Bill*, September 2004, Cm 6305-I, cl 2(5)

7 *Ibid*, cl 9

8 *Ibid*, cl 9(4)

9 *Ibid*, cl 9(4)(b)

10 See, for example: *Joint Committee on the Draft Mental Health Bill*, *Ibid*, vol I, paras 121 & 122; *Department of Health*, 2005, *Ibid*, Recommendation 20.

11 *Ibid*, cl 9(4)(a)

12 Department of Health, *Improving Mental Health Law: Towards a new Mental Health Act*, September 2004, para 3.15

13 MHA 1983, s 2(2)(b) & 3(2)(c)

14 See, *Joint Committee*, *Ibid*, Vol II, Ev 280 (David Hewitt), para 2.3

15 See, *Joint Committee*, *Ibid*, Vol II, Ev 280 (David Hewitt), para 2.2

16 Department of Health, *Draft Mental Health Bill*, September 2004, Cm 6305-I, cl 9(6)

controversial proposal.<sup>17</sup> Some critics of the Draft Bill claim that it represents a dilution of the current ‘treatability test’.

The treatability test is contained in section 3 of the Mental Health Act 1983. It provides, amongst other things, that a person suffering from psychopathic disorder may be detained only if he is ‘treatable’.<sup>18</sup> Critics say this test is being diluted because it makes it too hard to detain psychopaths.

In fact, and perhaps surprisingly, the Government agrees with this analysis. It says the treatability test,

“[...] has led to uncertainty about whether a patient’s disorder can be treated or not, irrespective of any opinion that they remain a risk to themselves or others. Some patients are not being brought under the Act even when it is appropriate to do so.”<sup>19</sup>

This conclusion is wrong. The Government has misunderstood several important legal judgments and, as a result, exaggerated the strength of the treatability test. Its proposal is a solution to a problem that doesn’t exist.<sup>20</sup>

As used in the Mental Health Act, the term ‘medical treatment’ currently includes, “nursing [...] and care, habilitation and rehabilitation under medical supervision”.<sup>21</sup> This is a very broad definition, which the courts have broadened still further. Now, the treatability test will be satisfied, and a patient will be detainable under the 1983 Act, if hospital treatment will prevent deterioration in his condition, or make him less uncooperative or more insightful;<sup>22</sup> or if it is likely to impact on his symptoms, even if it won’t touch the substantive illness.<sup>23</sup> In *Wheldon*, the High Court said, “It is plain [...] that the concept [of treatability] is a very wide one”;<sup>24</sup> while in *Reid*, the House of Lords said the definition of ‘treatment’ was now so wide that its purpose “may extend from cure to containment”.<sup>25</sup>

There must be very few patients whose condition – or the *symptoms* of whose condition – cannot be alleviated, or whose deterioration cannot be prevented, by some form of clinical intervention. It is difficult, therefore, to see how the treatability test in the 1983 Act is anything other than a dead letter, and surprising, perhaps, that the Government should be willing to risk so much to abolish it.<sup>26</sup>

The desire to make psychopaths detainable, and the mistaken belief that they aren’t already detainable, are at the centre of the Government’s plans for a new Mental Health Act. In fact, some might say that they have distorted those plans. That is unfortunate. But it shouldn’t just colour our view of the Draft Bill; it should also affect the way we think about the *current* Act.

17 Department of Health, 2005, *Ibid*, Recommendation 74

18 MHA 1983, s 3(2)(b)

19 Department of Health, *Draft Mental Health Bill: Explanatory Notes, June 2004*, Cm 6305-II, para C9.10. See also, Department of Health and Home Office, *Reforming the Mental Health Act – Part I: The new legal framework, December 2000*, Cm 5016-I, paras 1.15 & 3.5; Department of Health, *Draft Mental Health Bill: Explanatory Notes, June 2002*, Cm 5538-II, para 2.11

20 David Hewitt, *Treatability Tests*, *Solicitors Journal*, 146 (37), 4 October 2002, pp 886 & 887

21 MHA 1983, s 145

22 *R v Canons Park Mental Health Review Tribunal*, ex parte A [1994] All ER 659, CA, per Roch LJ

23 *R v Secretary of State for Scotland*, 1998 SC 49, 2 Div

24 *R (Wheldon) v Rampton Hospital Authority* [2001] EWHC 134 (Admin), per Elias J at para 14

25 *Reid v Secretary of State for Scotland* [1999] 1 All ER 481

26 In fact, it would seem that the Government has an even wider conception of treatability. In its response to the Joint Committee, it said that compulsion need not be limited to those cases where treatment will improve a patient’s condition or prevent it deteriorating. See, Department of Health, *Ibid*, Recommendations 21 & 22. This raises the possibility that it will be lawful to confine and compulsorily treat a mental health patient for the sole purpose of making his/her condition worse.

### 3. Non-resident Patients

Under the Draft Mental Health Bill, a person to whom compulsion is applied when he is not in hospital will be a ‘non-resident patient’.<sup>27</sup> The Government has been disingenuous about its motive for making this change.<sup>28</sup>

#### (a) Motive

Most recently, the Government claimed that non-resident patients were the embodiment of the principle of the ‘least restrictive alternative’. This principle is best summarised in the Mental Health Act 1983 Code of Practice, which states that anyone who is subject to the Act should,

“be given any necessary treatment or care in the least controlled and segregated facilities compatible with ensuring their own health or safety or the safety of other people.”<sup>29</sup>

This is the spirit the Government wishes to invoke now. In a paper published alongside the Draft Bill, it said:

“The intention of allowing patients to be under formal powers in the community is to provide greater flexibility to practitioners so that the principle of least restriction can be put into effect.”<sup>30</sup>

However, five years ago the Government said something rather different. In its White Paper it said,

“At the moment clinicians have to wait until patients in the community become ill enough to need admission to hospital before compulsory treatment can be given. This prevents early intervention to reduce risk to both patients *and the public*”.<sup>31</sup>

Far from reflecting the ‘principle of least restriction’, it seems that community compulsion – in other words, the ‘non-resident patient’ scheme – is necessary to *protect the public*. Here, and not perhaps for the first time, the Government might be accused of trying to appeal to two different, even antipathetic, constituencies.

The Government may have been disingenuous about its plans, but is it possible that community compulsion is already a reality; that many people outside hospital are ‘non-resident patients’ in all but name?

#### (b) Leave

It is necessary to consider the case of *DR*.<sup>32</sup> In that case, a patient’s detention under section 3 of the Mental Health Act 1983 was renewed for a further 6 months even though she was on unlimited leave of absence. The only relevant requirement was that she return to hospital for the ward round every Monday and OT every Friday. The High Court said it was lawful to renew the patient’s

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27 The Joint Committee has criticised these proposals and recommended that more rigorous conditions be introduced for community compulsion. See, Joint Committee, *Ibid*, Vol I, paras 187–199. In response, the Government has said it does not propose to make any such changes. See, Department of Health, 2005, *Ibid*, Recommendation 33.

28 See, Joint Committee, *Ibid*, Vol II, Ev 280 (David Hewitt), para 2.6

29 MHA 1983 Code of Practice, para 1.1

30 Department of Health, *Improving Mental Health Law: Towards a new Mental Health Act, September 2004*, para 3.35. See also, Department of Health, 2005, *Ibid*, Recommendation 33

31 Department of Health and Home Office, *Reforming the Mental Health Act – Part I: The new legal framework, December 2000*, Cm 5016-I, para 2.14; *emphasis added*

32 *R (DR) v Mersey Care NHS Trust, Administrative Court (Wilson J)*, 7 August 2002, CO/1232/2002

detention in those circumstances, because treatment in hospital – the OT and the ward round – formed a “significant component” of the plan for her.<sup>33</sup>

This decision has been seen as re-introducing the ‘long leash’ that doctors had been asked to abjure since the case of *Hallstrom*,<sup>34</sup> and it has been confirmed, and possibly even extended, by the recent High Court decision in the case of *CS*.<sup>35</sup>

It has always been clear that, as a matter of general law, a patient may have her leave revoked, and she may be recalled to hospital, at any time by her Responsible Medical Officer (‘RMO’).<sup>36</sup> Provided she is given the relevant notice in writing, it isn’t necessary for the RMO to have a good reason for revocation and recall, or for the RMO to have any reason at all.

What the *DR* and *CS* cases suggest is that by the careful use of section 17, a person who remains ‘liable to be detained’ in hospital may be maintained in the community indefinitely and hauled back into hospital if she acts inappropriately. There would appear to be no difference between that patient’s situation and the situation of a ‘non-resident patient’ under the Draft Mental Health Bill.

#### 4. The Code of Practice

Like the present Mental Health Act, the next one will have a Code of Practice.<sup>37</sup> However, on the face of it, the next Code will be less binding than the present one.

It would seem from the Draft Mental Health Bill that hospitals and practitioners will only need to “have regard” to the new Code.<sup>38</sup> The fear is that this would strip the Code of Practice of its essential force.

Whilst that may be a legitimate concern, it is questionable whether the new proposals diminish the Code of Practice at all. In the *Munjaz* case, the House of Lords held that the Code of Practice on the 1983 Act was guidance, and not binding, and that professionals and providers might lawfully depart from it if they had “cogent reason” to do so. (The Court of Appeal had earlier held that departures from the Code would be lawful where there was “good reason” for them.)<sup>39</sup>

#### 5. An Approved Mental Health Professional

The Approved Mental Health Professional is the replacement for the Approved Social Worker (‘ASW’), and the ASW role is to be abolished. The Government’s proposals in this regard are perhaps the most perplexing in the whole Draft Bill.

33 David Hewitt, *There is no magic in a bed*, *Journal of Mental Health Law*, August 2003, pp 87–101

34 *R v Hallstrom and another, ex parte W*; *R v Gardner and another, ex parte L* [1986] 2 All ER 306

35 *R (CS) v Mental Health Review Tribunal* [2004] EWHC 2958 (Admin). See further within this issue of the *JMHL* for a review of this case.

36 MHA 1983, s 17(4)

37 Department of Health, *Draft Mental Health Bill*, September 2004, Cm 6305-I, cl 1

38 *Ibid*, cl 1(2) & (5)

39 *R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58; *R (Munjaz) v Mersey Care NHS Trust*; *R (S) v Airedale NHS Trust* [2003] EWCA Civ 1036. (Detailed papers on each of these cases may be found at [www.hempsons.co.uk](http://www.hempsons.co.uk)) David Hewitt, *A room of one’s own – seclusion is at last lawful*, *The Times*, 26 November 2002; David Hewitt, *A secluded view*, *New Law Journal*, 153 (7090), 25 July 2003, p 1133; David Hewitt, *The seclusion of psychiatric patients: trusts’ position clarified*, *Health Care Risk Report*, 10(1), November 2003, pp 17 & 18

**(a) Motive**

The Government has given six main reasons for introducing a new Mental Health Act.<sup>40</sup> Two of them concern the ASW, and looked at from that perspective, they appear to lack logic.

*(i) Up-dating principles*

In 1999, the Government said it wanted to “bring up to date the principles and processes established by the 1959 and 1983 Mental Health Acts”.<sup>41</sup>

One of the key principles of the current Act was the balancing of the ‘medical model’ of mental illness with the ‘social model’. Because he was seen as an arch proponent of the social model, the ASW was given significant powers. However, the Draft Bill abolishes the ASW role.

In future, it is the Approved Mental Health Professional who will make an application for compulsion, and he won’t have to be a social worker. He might be a community psychiatric nurse or an occupational therapist, and he might even be employed by the NHS trust that is to be responsible for subjecting a patient to compulsion.<sup>42</sup>

Where does that leave the ‘social model’ of mental illness? More generally, how far can a Government go with legislation before the principles it hopes to up-date it actually destroys?

*(ii) Inadequate knowledge*

The Government has said that the way the current Mental Health Act is applied varies widely between different parts of the country, and that this has something to do with a lack of knowledge amongst mental health professionals. Though they are “mostly people with professional training in clinical and social care,” the Government says, “few have specialist training in or understanding of the law”.<sup>43</sup> However, this suggestion raises more questions than it answers.

If professionals know too little about the existing Mental Health Act, why is a new Mental Health Act required? Wouldn’t the answer be to provide more and better training on the existing Act? The one group of professionals that does receive specialist training in mental health law is ASWs, yet, as has been noted, the Draft Bill would abolish their role.

The Government is deeply confused about its motives for abolishing the ASW. However, it is also necessary to ask whether the Approved Mental Health Professional, or something very like him, is already a feature of psychiatric practice, more than two years before the Draft Bill is scheduled to become law.

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40 David Hewitt, *Windmills, not giants*, *Solicitors Journal*, 148 (42), 5 November 2004, pp 1271 & 1272

September 2004, Cm 6305-I, cl 15(1), 16(3), 19(2) & 22(1)

41 Department of Health, *Reform of the Mental Health Act 1983: Proposals for Consultation*, November 1999, Cm 4480, para 1.3. (Slightly more information may now be found in Department of Health, 2005, *Ibid*, Recommendation 102.)

43 Department of Health, *Reform of the Mental Health Act 1983: Proposals for Consultation*, November 1999, Cm 4480, para 2.8. See also, Department of Health, *Reforming the Mental Health Act – Part I: The new legal framework*, December 2000, Cm 5016-I, paras 1.14 & 2.6

42 Department of Health, *Draft Mental Health Bill*,

## (b) Proposals

As has been indicated, it won't be necessary for an Approved Mental Health Professional to be a social worker.<sup>44</sup> If, in a particular case, he should turn out to be a community psychiatric nurse or an occupational therapist, there are two principal fears.

The first fear is that in that case, not only the two recommendations but also the compulsion application itself would be provided by someone whose primary allegiance was to the 'medical model' of mental health, and that as a result, the 'social model' would be ignored.

The Government has tried to address this fear. It has said, "The competence required of an AMHP will be broadly similar to that required of an ASW currently".<sup>45</sup> However, a nurse is not a social worker, and their perspectives, training and experience differ very widely. Therefore, the loss of the social model must remain a legitimate fear.

The second fear is about a loss of independence.<sup>46</sup> At the moment, the ASW is not only the sole exemplar of the 'social model'; he is also wholly independent and cannot, for example, be compelled to make an admission application.

If it will be possible in future for a compulsion application to be made by an employee of the body that is to do the compelling, the fear is that he will be more biddable than an ASW would have been and that a crucial element of independence will have been lost. That, again, is a legitimate fear. However, given what the law allows even now, is the feared position really so far away?

Here, it is necessary to consider partnership working, which perhaps reaches its culmination in the Care Trust. In most if not all of the mental health partnerships and care trusts that have been created so far great pains have been taken to keep local authority mental health functions outside the formal structure of the partnership or trust. However, the simple truth is that this is more than the law requires.

Partnership arrangements between local authorities and NHS bodies have been possible since the year 2000, when section 31 of the Health Act 1999 came into force. Under the relevant regulations, a social services authority may give nearly all of its "health related functions" (as they are defined in Schedule 1 of the Local Authority Social Services Act 1970) to the partnership, and thereby delegate the performance of those functions to its NHS partner.<sup>47</sup> (In fact, the only "health related functions" a local authority can't give away are the appointment of ASWs and its powers of entry and inspection).

This means that where there is a mental health partnership or care trust, a whole swathe of local authority mental health functions could pass to a NHS trust. They include: directing an ASW to consider making an admission application;<sup>48</sup> receiving a patient into guardianship;<sup>49</sup> and providing after-care once a patient has left hospital.<sup>50</sup>

If the relevant agreement so provides, all of these local authority functions will be performed by a NHS body, and the staff that perform them, including any ASWs, will be answerable to that NHS body.

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44 Department of Health, *Draft Mental Health Bill: Explanatory Notes*, June 2004, Cm 6305-II, para 36

45 *Ibid*

46 *The Joint Committee did not share this fear. See, Joint Committee, Ibid*, Vol I, para 445

47 *The NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 2000 No 617)*, regs 4 & 6

48 MHA 1983, s 13(4)

49 *Ibid*, ss 7 & 8

50 *Ibid*, s 117

This could be seen as a positive thing. Under these arrangements the ‘social model’ of mental health is not left on the periphery; it is moved to the very centre of the detention process and allowed to compete on equal terms with the ‘medical model’. However, there is another way of seeing it.

There is nothing in the new partnership possibilities that would allow a NHS trust to *order* an ASW to make an admission application, so that element of independence is preserved. However, where there is formal partnership working there is at least the possibility that all other functions of an ASW, and all other mental health functions of a local authority, will be under the direct control of a NHS trust.

Ultimately, of course, the social services authority will be still be liable for the way someone else performs the health-related functions it has given them. However, the new arrangements mean much more than ASWs occasionally being managed by health professionals.

Even now, long before the Draft Bill becomes a reality, the context in which a detention application is to be judged could be an avowedly medical one, and the entire statutory process – from assessment to aftercare – could be performed by practitioners whose primary fealty is owed to the NHS body that will do the detaining.

One of the other functions a social services authority can give to a partnership is the function of being a patient’s Nearest Relative under the 1983 Act.<sup>51</sup> This means that a NHS trust that is “the managers” of a hospital for the purposes of the Act could also find that it is the Nearest Relative of a patient whom it is detaining or, where it has assumed such responsibilities, of a patient of whom it is also the Guardian. Though undoubtedly intriguing, these are also troubling possibilities.

## **6. Incapable patients**

It is necessary to consider the case of *MH*.<sup>52</sup> This case concerned a young woman who was detained under section 2 of the Mental Health Act 1983. Because an application had been made to displace her mother as the ‘nearest relative’, the patient’s detention continued long after the usual 28-day period had come to an end.

The Court of Appeal held that where a section 2 patient is ‘incapable’ of making an application to a Mental Health Review Tribunal, there should be a system to ensure that her case comes before a tribunal. And it said that because the current Mental Health Act doesn’t provide such a system, it is incompatible with the ‘right to liberty’ in Article 5 of the European Convention on Human Rights.

There are at least two ways of interpreting this decision. The first interpretation says that incapable patients who are detained must have the same Mental Health Act rights as capable patients. This is the more restrictive interpretation. However, it still has some quite significant implications. It means, for example: that the current Act will have to be amended, in order to give incapable section 2 patients something like an automatic right of appeal; that section 3 patients who are

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<sup>51</sup> MHA 1983, s 29(1)

<sup>52</sup> *R (MH) v The Secretary of State for the Department of Health* [2004] EWCA Civ 1690. (A detailed paper on this case may be found at [www.hempsons.co.uk](http://www.hempsons.co.uk)). This

*paper was last revised on 16th October 2005, shortly before the House of Lords judgment in the case of MH ((2005) UKHL 60). Notwithstanding the decision of the House of Lords, the writer submits that his reasoning within this section of this paper remains sound.*



incapable will probably have to be given the same right; and that the Draft Mental Health Bill will also have to be amended, to the same effect.<sup>53</sup>

It may be that it is also contrary to the Human Rights Convention for *any* mental health laws to be applied differentially. In other words, incapable patients might have to have *all* the same Mental Health Act rights as capable patients. This wouldn't be limited to tribunal rights; it would apply to every aspect of compulsory treatment for mental disorder.

This idea is worthy of being explored in more detail: it might contradict recent trends and also compromise what was seen as the best hope of all those who opposed the current Draft Bill.

Drawing on the report of the Expert Committee under Professor Richardson,<sup>54</sup> and taking encouragement from the *obiter* comments of Lord Justice Simon Brown in the case of *Wilkinson*,<sup>55</sup> many have argued that capable patients should have the right to refuse medical treatment for mental disorder, even if they are subject to detention. However, that isn't a right they have claimed for incapable patients.

The *MH* judgment suggests that it's all or nothing: that incapable patients must have the *same* rights as capable patients if they are subject to detention.

The Government dismissed Professor Richardson's proposals for a capacity-based system of compulsion, and its Green Paper, White Paper and first Draft Bill didn't admit capacity as an issue at all.<sup>56 57</sup>

The current Draft Mental Health Bill offers some small concessions: it gives capable patients the right to refuse ECT,<sup>58</sup> and to refuse to be transferred to another hospital.<sup>59</sup> It doesn't give similar rights to incapable patients, so maybe it too is called into question by the *MH* decision.

There might be a second, more far-reaching interpretation of the *MH* judgment. It may be that there is no justification for giving incapable patients fewer rights of *any kind* – and not just fewer *Mental Health Act* rights – than are enjoyed by capable patients. In other words, maybe incapable patients – even incapable patients who are detained in hospital – cannot be treated any differently just because they *are* incapable. This is where the *Bournewood* case comes in.

In the *HL* case,<sup>60</sup> the European Court of Human Rights ruled that it was unlawful, and that it would breach the right to liberty in Article 5 of the European Convention on Human Rights, to admit an incapable patient to hospital under the common law doctrine of 'necessity' if what was to be done to him there would amount to a deprivation of his liberty. And it interpreted

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53 David Hewitt, *Incapacity and the right to liberty*, *New Law Journal*, 155 (7158), 7 January 2005, pp 26 & 27

54 Department of Health, *Review of the Mental Health Act 1983: Report of the Expert Committee*, November 1999, paras 5.96 & 5.97

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

56 See, for example, Department of Health, *Reform of the Mental Health Act 1983: Proposals for Consultation*, November 1999, Cm 4480, chap 5, para 6

57 However, the Joint Committee suggested that one of the conditions for compulsion should be that, by reason of

mental disorder, a patient's ability to make decisions about the provision of medical treatment is "significantly impaired". See, Joint Committee, *Ibid*, Vol I, para 156. The Government has dismissed this suggestion. See, Department of Health, 2005, *Ibid*, Recommendation 26.

58 Department of Health, *Draft Mental Health Bill*, September 2004, Cm 6305-1, cl 178 & 179

59 *Ibid*, cl 75–79

60 *HL v United Kingdom*, Application no 45508/99, decision of 5 October 2004. (A detailed paper on this case may be found at [www.hempsons.co.uk](http://www.hempsons.co.uk))

‘deprivation of liberty’ in such a way that most forms of confinement, treatment and control would be caught by its decision.<sup>61</sup>

As a result of this case, a new framework will have to be devised by which incapable patients can be ‘detained’ in a way that complies with Article 5.<sup>62</sup> Even the Government has conceded as much.<sup>63</sup>

At the very least, this framework will have to cover all incapable patients who need *Bournewood*-style detention. But not all incapable patients admitted to hospital under ‘necessity’ meet the criteria for detention under the Mental Health Act. For example, some of them are incapable because of an *acquired* brain injury; they aren’t in a state of arrested or incomplete development of mind, and they don’t, therefore, come within the statutory definition of ‘mental impairment’ or ‘severe mental impairment’.<sup>64</sup>

So, if *they* are to be detainable the new framework will have to have a much broader conception of ‘mental disorder’ – or of the sorts of conditions that justify detention – than the current Act. Effectively – and to persist with the current classifications – it would be necessary to provide that a person might be detained if he suffered from mental illness, mental impairment, severe mental impairment or psychopathic disorder, *or if he was incapable in some material way*.

That, in itself would be a significant step. But might the law now require even more than that? Does the *MH* case mean that it isn’t possible to use ‘incapacity’ as a substantive ground for confinement? Does it mean that incapable patients can only be confined if they meet the criteria that capable patients must meet in order to be confined?

That would not present an insuperable obstacle in the case of a patient whose incapacity amounted to ‘mental impairment’ or ‘severe mental impairment’ under the 1983 Act, or where an incapable patient was also suffering from ‘mental illness’ or ‘psychopathic disorder’. Other cases, however, might prove more problematic.

If it were not possible to use ‘incapacity’ as a substantive ground for confinement but it were still necessary to devise a system for the confinement of the incapable, another way to do it would be to adopt a very broad definition of ‘mental disorder’; a definition that was so broad that it covered everyone from people with schizophrenia to those with acquired brain injury, and, more importantly, from psychopaths to the learning disabled or dementia-impaired. The Draft Bill already contains a definition of mental disorder that is very broad – that is, perhaps, broad enough for this purpose. Hitherto, however, critics of the Bill have attacked this definition, and they’ve done so specifically because of its broadness. It is conceivable that they may now find themselves having to change tack.

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61 David Hewitt, *Effective, Unqualified Control*, *New Law Journal*, 154 (7149), 22 October 2004, pp 1553 & 1554

62 See, Joint Committee, *Ibid*, Vol I, paras 179 & 180; *Ibid*, Vol II, Ev 281 (David Hewitt), paras 4.1 & 4.2; *Ibid*, Vol III, Ev 843 (W A Leason)

63 Department of Health, *Advice on the decision of the European Court of Human Rights in the case of HL v UK (the “Bournewood” case)*, 10 December 2004, paras 30 & 31. See also: Department of Health,

*Bournewood consultation: The approach to be taken in response to the judgment of the European Court of Human Rights in the “Bournewood” case*, March 2005, para 1.2; Department of Health, 2005, *Ibid*, Recommendation 29. The Joint Committee reported that on 22 February 2005, the Government tabled amendments to the Mental Capacity Bill that it said would have the desired effect. See, Joint Committee, *Ibid*, para 181 and n. 211.

64 MHA 1983, s 1(2)

It is dangerous to extrapolate too far from a single High Court judgment, even one as intriguing and apparently fertile as *MH*. However, if this is where the law is leading – if, because of *Bournewood* and because of *MH*, it is necessary to have a far wider definition of ‘mental disorder’ – it is clear that the current position is not far removed from the one proposed in the Draft Mental Health Bill.

In any case, it may be that we are entering an odd, looking-glass world; a world where those who have so far seen a capacity-based model of compulsion as the epitome of everything good and a broad definition of ‘mental disorder’ as the epitome of everything bad suddenly find themselves arguing for the reverse.

## 7. Conclusion

In summary, then:

- (a) Although the Relevant Conditions are controversial, the most extreme of them simply restate the current position: patients who aren’t a danger to others have to pose a *serious* risk to themselves if they’re to be detained and almost every patient passes the ‘treatability test’.
- (b) With regard to ‘non-resident’ patients, the Government wants it both ways: it says it wishes merely to up-date the principle of the ‘least restrictive alternative’, so patients should be in the community unless they really *need* to be in hospital; but it also says that community treatment increases the risk to the public.
- (c) Because of the *DR* case, we already have ‘non-resident’ patients, who can be made to reside in hospital at the drop of a hat.
- (d) As for the Code of Practice, it’s not as strong as many believe, so even the weak Code envisaged by the Draft Bill won’t, in truth, be any weaker.
- (e) The reasons given for killing off the ASW don’t stack up. In any case, an ASW embedded in a mental health partnership or care trust might be an Approved Mental Health Professional in all but name.
- (f) And finally, the need to improve the lot of ‘*Bournewood* patients’ might rule out a capacity-based model of compulsion, and it might also usher in a much wider definition of ‘mental disorder’ than is contained in the 1983 Act.

This doesn’t, of course, mean that we already have *everything* in the Draft Bill. However, the leap to there from here may not be as great as some – most – have assumed.

That’s not to say that criticism should be withheld: even if a surprising proportion of the Draft Bill is, on closer inspection, quite familiar, there’s still a lot of it that should give cause for concern. But that concern should not be confined to the Draft Bill.

If there’s no ‘treatability test’ worthy of the name, it is because the courts have reasoned it out of existence. If leave patients can be kept on a long leash, that is because the High Court said it was OK. And if the Code of Practice is weak, that is because the House of Lords said it did not need to be any stronger. But the courts could only do this because the Mental Health Act allowed them to. And if the ASW is nothing more than the Approved Mental Health Professional in different shoes, that is because Parliament wanted it that way.

In making its current proposals, the Government has held up an inconvenient mirror, one in which our current mental health laws are rather alarmingly reflected. And the shapes that form in that inconvenient mirror force us to confront a worrying possibility.<sup>65</sup> It may be that what we would like to see – what we have until now *tried* to see – as flaws in the Draft Bill are actually something quite different: maybe they're really hard, durable, unyielding seams deep within the Mental Health Act we already have.

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<sup>65</sup> David Hewitt, *Windmills, not giants*, *Solicitors Journal*, 148 (42), 5 November 2004, pp 1271 & 1272