

The Mental Health Act 2007 – The Defeat of an Ideal

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This short account of the history of the reform of the *Mental Health Act* covers the main issues that divided the participants in the process, and the flawed legacy that remains. It gives the background to central provisions of the 2007 Act as they were amended during the parliamentary process and reflects on some problems they raise². It does not consider the amendments to the *Mental Capacity Act 2005* to cover so-called ‘Bournewood’ patients³, although some implications of the different regimes will be mentioned.

The *Mental Health Bill 2006* has now reached the statute books. It bears the scars of its tortured history: an ideological warfare conducted between the government and everyone else over a seven year period ending with a torrid passage through Parliament where the outcome was decided, inevitably, by a Labour majority in the House of Commons.

In the House of Lords, Conservatives, Liberal Democrats and Crossbenchers under the expert leadership respectively of Earl Howe, Baroness Barker and Lord Williamson had united in their opposition to the core of the Bill. Collectively they commanded formidable expertise⁴. They were informed by the report of the Joint Scrutiny Committee into the 2004 Bill⁵, legislative scrutiny reports from the Joint Committee on Human Rights⁶ and by the research of the Mental Health Alliance⁷ and other stakeholders. To these were added, in the last stages, the Institute of Psychiatry report on the international experience of community treatment orders⁸ and the written and oral evidence presented to the Public Bill Committee

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2 For an excellent account of the detailed provisions of the Act, see Mental Health Act Commission Mental Health Act 2007, Policy Briefing for Commissioners, July 2007 www.mhac.org.uk.

3 Introduced by section 50 Mental Health Act 2007.

4 They included Lord Carlile (Chair of the Scrutiny Committee); Lord Patel (Chairman of Mental Health Act Commission) Baroness Neuberger (Former Chief Executive Kings Fund) Lord Adebawale (Chief Executive of Turning Point) Lord Bragg (President of Mind) Psychiatrists Lord Alderdice and Baroness Murphy, Baroness Meacher (Chair of Mental Health Trust).

5 Joint Scrutiny Committee on Draft Mental Health Bill 2004, Vols I–III.

6 The Joint Committee on Human Rights played a significant role in the process of reform, through its detailed critique of the 2002 Bill and then a series of Scrutiny reports on the 2007 Bill. Joint Committee on Human Rights, Legislative Scrutiny: Mental Health Bill, 22nd Report Session 2001–2; 4th Report Session 2006–7; Legislative Scrutiny: Seventh Progress Report 15th report Session 2006–7.

7 The Mental Health Alliance, finally a coalition of 80 organisations, was a unique alliance of: service users; psychiatrists; social workers; nurses; psychologists; lawyers; voluntary associations; charities; religious organisations; research bodies; and carers’ groups. The Alliance was established in 1999, solely for the purpose of working for improved mental health legislation, following widespread concern about Government proposals for a new Mental Health Act. Some professional organizations suspended their membership in June 2007 because of differences of view over professional roles, although these issues were later resolved. Remaining members continue to work on the Code of Practice.

8 Churchill R et al (2007) International Experiences of using community treatment orders, Institute of Psychiatry.

in the House of Commons⁹. There was an astonishing consensus from all these viewpoints. In a series of amendments the House of Lords savaged the heart out of the Bill, only to have all their amendments reversed by the House of Commons. In the end the House of Lords was overruled. Baroness Barker stated that:

*the Bill is not the step forward for people with mental health problems that we all wanted, it is not the Bill that we needed and it will not be the legislation that we need.*¹⁰

Ultimately, despite the mountain of expertise, it was a mixture of serendipity, intransigence, hasty compromises and the arcane practices of parliament, leavened to an extent by reasoned debate, that produced the text of new law. It was a shambolic way to produce legislation of such importance for people's lives

This was to be the mental health law for a new generation – the first full-scale re-examination of mental health law since 1959. New Labour was riding the crest of the wave. The mental health community saw this as the chance for an enlightened and up to date approach to the care and health of those with mental illness, a chance to put into practice ideas, clinical approaches and values many of which were already common currency in academic and professional circles. Therapeutic care and civil rights were central to this. Medical practice and treatments for mental illness had changed, paternalism and authoritarianism was on the wane, human rights law had developed, disability discrimination law had sprung up, professional roles and attitudes evolved, the National Service Framework for Mental Health was being drawn up, service user groups were alert and articulate. This was the background to the formation of the Expert Committee chaired by Professor Geneva Richardson. Their report¹¹ was a detailed and coherent blue print for new legislation. It proceeded from the central propositions of non-discrimination, patient autonomy, a preference for voluntary treatment over compulsion, and the concepts of a right to care and treatment.

Government, on the other hand, had different priorities. It was driven to legislate by its need to deal with breaches of the European Convention on Human Rights; its wish to give flexibility in delivery of mental health services through compulsory treatment in the community; and its fear of 'loopholes' through which otherwise treatable patients might slip. In its general approach, the government followed a populist agenda fuelled by homicide inquiries into the deaths caused by mental health patients¹². Public concern and media frenzy went hand in hand to demand better public protection against those who were mentally ill and dangerous. Although the government dropped its unpopular policy for dealing with people with "dangerous and severe personality disorder", they remained obsessed with the "problem" of risk and the need to give clinicians every power they might need to contain it. The then Health Minister Rosie Winterton MP stated that "every barrier that is put in the way of getting treatment to people with serious mental health problems puts both patients and public at risk"¹³. This conflates the need for treatment with the need for compulsion, and is the antithesis of Richardson Committee approach under which voluntary treatment should always be the preferred option and compulsion the last resort.¹⁴

Thus the lines of conflict were drawn from the beginning. Through Green Paper, White Paper and the Bills of 2002 and 2004, the Government pursued these agendas, little deflected by the widespread opposition led by the Mental Health Alliance, whose members grew to include almost all stakeholders.

9 These are published on the parliamentary website <http://www.publications.parliament.uk/pa/>

10 Hansard HL 2 July 2007, Col 817.

11 Expert Committee (1999) *Review of the Mental Health Act 1983*, Dept of Health, November 1999.

12 For a detailed account see Rogers & Pilgrim (2001) *Mental Health Policy in Britain*, Palgrave, Ch. 12.

13 Rt. Hon Rosie Winterton MP, Local Govt. Assoc. Conference, Mental Health Bill, 1 March 2007.

14 The MHA 1983 Code of Practice (para 2.7) also refers to compulsion as "the last resort".

Deflection came with a critical report on the 2004 Bill by the Parliamentary Scrutiny Committee chaired by Lord Carlile of Berriew, which began with a statement that the case for reform of the 1983 Act was not overwhelming, but made 127 recommendations which, broadly speaking, supported the approach taken by the Richardson Committee, and the Mental Health Alliance policies.

Meanwhile in Scotland there had been two Reports; the Millan Committee Report considering civil patients, and the Mclean Committee Report on provisions for defendants and offenders. The Millan Committee Report, which broadly agreed with the approach set out in the Richardson Committee Report, had led to Scottish mental health legislation, the *Scottish Mental Health (Care and Treatment) Act 2003*. The Scrutiny Committee was clearly impressed with that legislation which influenced their recommendations.

In the face of such widespread consensus over how to improve it, the government abandoned the 2004 Bill. Factors in this decision were the costs of the new Tribunal system; government's failure to undertake a Race Equality Impact Assessment on the Bill as required under the *Race Relations Act, 2001* and the Bill's incomprehensible drafting. The Amendment Bill that followed in 2006 jettisoned some popular features of the 2004 Bill (most notably the new process for authorising compulsion through the new Tribunals and statutory care plans) and bolted government's central policies on to the 1983 Act. The holy grail of mental health law fit for a new century had vanished.

The ideological differences between government and lobbyists made this result inevitable. Home Office determination to detain 'dangerous people with personality disorder' coloured every contentious area. Certainly, with the complexity of the issues, agreement over less contentious issues was never going to be easy. However, had the Department of Health and the Home Office taken the stakeholders along with them in meaningful collaboration, some improvement may have been made. There are examples of collaboration on complex issues that have been productive – the work of the Disability Rights Task Force on substantial reform of the *Disability Discrimination Act* and the work on the *Mental Capacity Act* among them. As it was, positions became more entrenched as time went by, and policy making was too politicised. On the side of the stakeholders, policy proposals were developed without an understanding of the real nature of government's objections to them. Frustrated by the lack of dialogue, they remained locked into positions that were never likely to succeed. The government departments also seemed to be lodged in their separate bunkers. The many efforts at consultation were unproductive. It was only in parliament that a genuine dialogue occurred and glimpses of workable compromises could be seen. This was too late. The opportunity to benefit mental health patients, their families and those professionals who care for them was lost.

The remaining parts of this article will examine the issues that dominated the parliamentary process, and will consider their results.

Principles

The Richardson Committee and the Joint Scrutiny Committee both considered it vital for the law to be based on a statutory set of principles that would give greater clarity and certainty to the courts; guide practitioners concerned about how to exercise their powers; and reassure the public, patients and families that the values and principles set out in the Act should permeate how mental health services are provided. The professional organisations and the Black and Minority Ethnic Network were united in emphasising the symbolic importance of statutory principles in directing best practice and in helping to overcome stigma¹⁵.

¹⁵ *Briefing for the Second Reading of the Mental Health Bill in the House of Lords, BME Network, 25th November 2006.*

Although there had been a set of principles for the 2004 Bill, there remained contention over what any such principles might state. The House of Lords sought, as a minimum core, respect for wishes and feelings, participation of patients in decisions, and non-discrimination with the least restrictive alternative applying in all circumstances. However, the government balked at even such a minimalist list, arguing in part that it would be impossible to graft principles onto the 1983 Act, and that:

*principles may not in fact be relevant to every situation or, may conflict with each other or with the specific provisions of the Act. What weight is the decision-maker to give to the different criteria in that case? Is there a potential for him to be challenged because he has, for example, not complied with the patient's wishes?*¹⁶

The result was a messy compromise. The Code shall include a statement of the principles which the Secretary of State thinks should inform decisions under this Act, and the following “matters shall be addressed”:

- (a) Respect for patients' past and present wishes and feelings,
- (b) Minimising restrictions on liberty,
- (c) Involvement of patients in planning, developing and delivering care and treatment appropriate to them,
- (d) Avoidance of unlawful discrimination,
- (e) Effectiveness of treatment,
- (f) Views of carers and other interested parties,
- (g) Patient wellbeing and safety, and
- (h) Public safety¹⁷.

The 2007 Act further requires that the Secretary of State shall also have regard to the desirability of ensuring the efficient use of resources and the equitable distribution of services¹⁸. This was explained as being required for Wales, with its placement outside the principal list of matters to be addressed an acknowledgement that it was not of equal weight to them. In contrast to the House of Lords' core principles, the 2007 Act therefore gives a long list of factors of different levels of importance. Indeed, some of these are very important, and address matters not otherwise dealt with under the legislation. For instance, the references to wishes and feelings and to patient participation are vital given the fact that the patient may be treated without consent, and that the statute does not provide a duty to consult him or her, or, in most situations, take note of any advance directive. It will be interesting to see how the Code will word these principles, and whether, for instance, any of the robust language of the Richardson principles will find their way in to the Code. It is also possible that their usefulness will be further reduced by being expanded. The draft Code of Practice included¹⁹, for instance, transparency and communication. Will any of these extra principles have a lesser weight for not having a status in statute?

Section 10 of the Act also requires professionals to have regard to principles. This is no further than the partial enactment of the House of Lords decision in *Munjaz*²⁰ which stipulates that cogent reasons are

16 *Hansard HL 19 Feb 2007, Col 897 (Lord Hunt of King's Heath).*

17 MHA 1983 s118(2B), as amended by MHA 2007, s8.
18 *ibid.*

19 *The draft Code of Practice was published with the 2006 Bill, but was subsequently revised; an updated Code was*

made available for public consultation on 25 October 2007.

20 *R v. Ashworth Hospital Authority (now Mersey Care National Health Service Trust) (Appellants) ex parte Munjaz (FC) (Respondent) [2005] UKHL 45. This was the view stated by the Minister, Lord Hunt, Hansard HL 6th March 2007, Col 120.*

needed for departing from the Code, but at least its recognition on the face of the statute may give it greater weight in practice. However, the real issue is how the courts will read the new provision. The significance from the point of view of statutory interpretation of having “matters” specified in the Act but the principles set out in the Code (rather than as at present simply in the Code) is not clear, and may present a challenge to an ingenious counsel. Will it be possible to use judicial review to challenge a decision on the ground that it was made without regard to a principle, or will these linguistic niceties preclude such an approach?

The definition of mental disorder

The gateway to the compulsory powers in the 1983 Act is the definition of mental disorder, which is circumscribed by a set of exclusions. The 2007 Act replaces this definition and the four classifications of mental illness, psychopathic disorder, mental impairment and severe mental impairment, with a wider general definition of mental disorder as “any disorder or disability of the mind”, and it changes the exclusions.

Lord Rix and Angela Browning MP led an unsuccessful attempt to exclude people with learning disabilities and developmental disorders such as autism from Part II. The new Act extends compulsory powers to people with developmental disorders and those with learning disabilities in the same way as the unamended Act. This leaves some confusion and overlap with the *Mental Capacity Act*, which (when amended to cover the ‘Bournewood’ patients) will also cover people with learning disabilities who lack capacity; permitting the deprivation of their liberty, including the use of a proportionate degree of force if it is in their best interests. The clinician²¹, instructed by the Code of Practice to consider first the use of the MCA²², will need to decide whether or not to opt for the regime of the MHA which has different safeguards and lacks a specific ‘best interests’ test. It is not clear what factors (other than presumably the degree of restraint) should guide that choice.

The role of exclusions is to make clear what kind of behaviour, beliefs or life style should not be brought within compulsory powers, even if they fall within the definition of mental disorder. Human rights law requires the definition of mental disorder to be very clear in order for exercise of detention powers to be lawful²³. The use of exclusions is a standard feature of most common law jurisdictions in meeting that requirement²⁴ by providing legal certainty; guaranteeing individual autonomy; and ensuring that the powers of detention are used no more than strictly necessary²⁵.

The 2007 Act removes the exclusions for sexual deviance and illegal or disorderly acts from the 1983 Act, but retains a reworded exclusion for ‘dependence’ on alcohol or drugs. This, alongside the broad definition of mental disorder in the revised Act, has two consequences:

21 *A Responsible Clinician appointed under the MHA may not have the status to take such a decision so will presumably prefer the MHA.*

22 *Draft MHA Code of Practice, 2.10d.*

23 *For example HL v United Kingdom (2004) 40 EHRR 761; see JUSTICE, Mental Health Bill, Second Reading Briefing, November 2006.*

24 *For instance, the Irish Mental Health Act 2001 excludes someone who has a personality disorder or “is socially*

deviant or is addicted to drugs or intoxicants”. Mental Health (Care and Treatment) Scotland Act 2003 excludes from the definition of mental disorder “sexual orientation; sexual deviancy; transsexualism; transvestism; dependence on, or use of alcohol or drugs; or behaviour which causes, or is likely to cause harassment, alarm or distress to any other person; or acting as no prudent person would act”. New Zealand excludes a person’s political, religious, or cultural beliefs; sexual preferences; criminal or delinquent behaviour; substance abuse; or intellectual disability.

- First, the Act's definition of mental disorder covers all the diagnoses listed in the WHO International Classification of Diseases (ICD10), some of which even the government acknowledges to be inappropriate for compulsory powers. For instance, the binge drinker and the casual consumer of drugs are brought within the Act, even though the 'dependent' person is excluded²⁶. Furthermore, disorders of sexual preference in ICD10 cover fetishistic behaviour, voyeurism, sado-masochism and transvestism. The Joint Committee on Human Rights stated their concern that a person with Gender Identity Dysphoria or transvestic fetishism, which are recognised aspects of private life under Article 8, might be inappropriately detained on grounds of mental disorder. The explanatory notes to the Bill²⁷ stated that it is intended that certain behaviours (specifically fetishism and paedophilia) be brought within the scope of mental health legislation for the first time.
- Secondly, the definition of mental disorder potentially covers almost any significant deviation from a "normal" condition of the mind, however temporary. It could cover behaviour that, although not listed in ICD10, can be called disordered. (Nothing in the Act confines the definition to the conditions listed in ICD10 or DSM IV, the American diagnostic manual). Whilst the 1983 Act's original definition of mental disorder (and, more specifically, its use of the term 'mental illness'²⁸) clearly excludes, for example, drunkenness, addiction to tobacco, and religious or political fanaticism, the revised definition of mental disorder and the new exclusions do not.

In the diverse and rapidly changing societies of British towns and cities, mental health professionals face the challenge of understanding and interpreting the thoughts and behaviour of people from different cultural, religious or political groups. The potential for misunderstanding is demonstrated in the history of the use of compulsory powers against African–Caribbean people²⁹. Disproportionately high numbers of people from BME backgrounds are still diagnosed with major mental illness and detained in mental hospitals or institutions³⁰. Culturally appropriate and acceptable behaviour has also been wrongly construed as symptoms of abnormality³¹ or aggression. Baroness Murphy suggested that the inappropriate use of mental health powers is a continuing danger:

25 *Informal Oral Hearing on Mental Health Bill*, April 17th 2007.

26 *The Act provides an exception for "dependence" on alcohol or drugs but does not exclude "misuse" of these substances. In both cases this includes a level of intoxication that does not cause lasting harm or dependence. Both misuse and dependence are covered by ICD 10 and are therefore classified as mental disorders.*

27 *Paragraph 37 Explanatory Notes Mental Health Bill 2006.*

28 *Although 'mental illness' is not defined in the 1983 Act, the courts have construed the phrase as "ordinary words of the English language to be construed in the way that ordinary sensible people would construe them" W v L [1974] QB 711.*

29 *Sainsbury Centre for Mental Health (2002) Breaking the Circles of Fear.*

30 *Bhui K, Stansfeld S, Hull S, Priebe S, Mole F and Feder G (2003) Ethnic Variations in pathways to and use of specialist mental health services in the UK: Systematic*

Review. British Journal of Psychiatry, 182, 105–116. Morgan C, Mallett R, Hutchinson G, Bagalkote H, Morgan K, Fearon P, Dazzan P, Boydell J, McKenzie K, Harrison G, Murray R, Jones P, Craig T and Leff J (2005) Pathways to care and ethnicity. I: Sample characteristics and compulsory admission, Report from the AESOP study, British Journal of Psychiatry 186, 281–289.

31 *See, for example, in relation to obsessive compulsive disorder as discussed in NICE Guideline Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder (2005). Supplementary memoranda from the BME Network (DMH 445) Academic Paper By Dr Kwame McKenzie, Senior Lecturer In Psychiatry, Royal Free And University College Medical School Joint Scrutiny Committee on the Mental Health Bill, report, Vol.II.*

In the 1970s, when I first worked in psychiatric hospitals outside the great fringe around London – what we call the Epsom archipelago – the place was full in the back wards of people whom we had enormous difficulty diagnosing with anything.

Society does not know what to do with other social misfits ... those who are persistently addle-headed on drink and drugs ... paedophiles ... religious fanatics who belong to the Moonie loonies and the like... We know that those people are not as we would like them to be; they are not like us; they probably need some help, but how we should help them is rather obscure. No doubt a significant percentage of them suffer, from time to time, with mental disorder which would bring them properly under the scope of the Act, but it is a profound mistake to include all categories of people behaving badly simply because we do not have any other answers ... I regret that I do not find it difficult to envisage the inappropriate use, perhaps well meant, of mental health legislation for non-medical purposes, for social convenience and control – “Get the paedophiles off the streets”. The pressure on services to find solutions to the presently insoluble problems will be massive. Exclusions ensure that practitioners carefully consider the basis for compulsory treatment. If there is an underlying mental health diagnosis, a person is covered by the Act; if there is no diagnosis, it is unhelpful and inappropriate for the mental health services to manage that person³².

All these reasons persuaded the House of Lords to seek to insert into the Act a set of exclusions relating to disorders of sexual preference (with the exception of paedophilia) or gender identity; the commission, or likely commission, of illegal or disorderly acts; and cultural, religious or political beliefs³³.

The government argued variously (and contrary to evidence from Victoria, New South Wales and New Zealand) that exclusions would be “arbitrary obstacles to the use of compulsion”³⁴ and could give rise to legal challenges, or that they were unnecessary and potentially counter-productive (in that excluding certain conditions from the definition might imply that, but for the exclusion, they would be mental disorders within the meaning of the Act)³⁵.

Government finally agreed to add to the principles “respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006)”:

This would be a declaratory statement about what mental health legislation should be in our society, now and that society should treat with decency and dignity people whose behaviour is different and, sometimes, difficult and challenging.³⁶

Baroness Barker, perhaps with detained terrorists in mind, regretted that the amendment did not expressly cover belief as well as religion: “we already have people detained under mental health legislation, at least in part because of their beliefs”³⁷. Given that freedom of belief is included with freedom of religion in Article 9 of the *European Convention on Human Rights*³⁸, there is not quite the lack of protection that she feared. The initial draft Code of Practice stated that:

32 *Hansard* HL 8 Jan 2007, Col 77.

33 *Supported by the Joint Committee on Human Rights Legislative Scrutiny: Seventh Progress Report 5. Para 1.5.*

34 *Hansard* HL 8 Jan 2007, Col 86 (Baroness Royall).

35 *See Lord Hunt (Hansard* HL 2 July 2007, Col 812 *et seq*) and Baroness Royall (*op cit* n.30, Col 84 *et seq*).

36 *Hansard* HL 2 July 2007, Col 816 (Baroness Barker).

37 *ibid*.

38 *In order for Article 9 to apply a belief must ‘attain a certain level of cogency, seriousness, cohesion and importance’ Campbell and Chaush v United Kingdom 25 February 1982, Series A, No.48, 4 EHRR 293, para 36. However, the Court has adopted a very broad approach as to what constitutes a religion or belief, from main stream religions to belief systems such as Druidism: Chappl v United Kingdom 14 July 1897, (1987)53 DR 93. The protection of the freedom of thought, conscience and religion under Article 9(1) is absolute.*

*disordered beliefs are sometimes symptoms of clinically recognised mental disorders, but in the absence of such a disorder no-one may be considered to be mentally disordered solely because of their political or cultural beliefs, values or opinions*³⁹.

There are few but telling examples of case law in jurisdictions with similar exclusions that demonstrate their role in protecting patients from inappropriate use of compulsory powers because of their beliefs⁴⁰.

Capacity

The debate over the place of capacity in a future mental health law was launched by the Richardson Committee but was given impetus by the passing of the *Mental Capacity Act* in 2005. The Committee founded its approach on patient autonomy. While acknowledging that exceptions might be made for a person who was dangerous to others or suicidal, they recommended that compulsory powers should be largely confined to those who lack capacity to make their own decisions

The most committed proponents of a law based on capacity were an unexpected trio of the Royal College of Psychiatrists, the British Psychological Society and Mind. They pointed to the persistence of discrimination against people with mental health problems and its blight on peoples' lives⁴¹. They highlighted the link between stigma and poor health, patient choice and the better health outcomes which NICE Guidelines⁴² and NHS policies⁴³ proclaim. In their view, fairness to service users and patients demanded that the issue of forcing treatment on mentally capable patients be addressed.

The Mental Health Alliance proposed adopting the "significantly impaired decision making" test from the *Scottish Mental Health (Care and Treatment) Act 2005*⁴⁴. This sets a lower threshold than a "capacity" test, and one more capable of taking into account emotional as well as cognitive factors⁴⁵. This found favour with the Joint Scrutiny Committee and later the House of Lords.

However, the Mental Health Act Commission raised questions over how a capacity test might work in practice⁴⁶, and government resisted calls for any sort of capacity threshold for the use of most compulsory powers. They insisted that impaired decision-making was neither well understood, nor a reliable test, and that it would be hard to administer. These arguments lacked weight, in that the *Mental Capacity Act* (MCA) requires all professionals to become proficient in determining capacity; impaired decision-making

39 *Draft MHA Code of Practice, para 1B.5*

40 For instance the series of reported cases of the Victorian Mental Health Review Board on religious belief: [2001] VMHRB 2 (19 February 2001); 04-057 [2003] VMHRB 2 (27 October 2003); 98-232 [1998] VMHRB 5 (9 April 1998); HL [1997] VMHRB 17 (1 September 1997); RM [1996] VMHRB 3 (7 August 1996).

41 The Department of Health's study of public attitudes to people with mental illness found that "levels of fear and intolerance of people with mental illness have tended to increase since 1993" and that "attitudes ...have become less positive between 2000 and 2003". The Social Exclusion Report 2004 found stigma to be the biggest problem people with mental health problems face as a group.

42 See, for example, the NICE Guideline on treatment for bipolar disorder.

43 "Involving individuals in an effective partnership with healthcare professionals, with all decision-making being shared, improves outcomes". Dept of Health (2006) *Our health, our care, our say: a new direction for community services*.

44 The notion of "significantly impaired decision-making" is explained in detail in the Scottish Executive's Document: Code of Practice Code of Practice for the Mental Health (Care and Treatment) (Scotland) act 2003, Volume 1; 31. March 2004; Chapter 1, paras 33–38.

45 See paper "Impaired decision making" at www.mentalhealthalliance.org.uk

46 See, for example, Heginbotham C and Kinton M (2007) 'Developing a capacity test for compulsion in mental health law' JMHL 15; 72–84 .

is a feature of other laws⁴⁷, and research evidence shows the reliability of capacity tests⁴⁸. Nevertheless, the proponents of the test did not make a consistent case either.

The debate in both Houses of Parliament on this issue was impassioned and sustained, with advocates for a capacity threshold from all political parties. The government refusal to negotiate for a test was framed as a concern not to stand in the way of treating a suicidal patient, but the underlying fear was how it would apply to patients with personality disorder, and the underlying assumption the government's extraordinary paternalistic position (in the context of a debate over the appropriate scope of mental health compulsion) that "every restriction was a patient not treated"⁴⁹:

*if it cannot be shown that a patient's judgment is impaired, they cannot be detained – regardless of how much the patient needs treatment and however much they, and others, are at risk without it.*⁵⁰

The impassioned response by Earl Howe summed up the differences between the positions of government and those calling for a threshold of impaired decision-making:

*A test of impaired decision-making would do more to bring mental health services into the modern world than just about any other change. As it is we are, in a real sense, back in the world of Enoch Powell and 1959. Patient empowerment and respect for the wishes of the patient are acknowledged features of good clinical practice in all other areas of healthcare – but not, it seems, in mental health. ... Finding a way through this issue would have been the way to show that we wanted to banish the stigma and discrimination associated with mental illness. To have acknowledged in law that there is a place for the wishes and feelings of patients who are capable of making their own choices would have been a profoundly far-sighted and beneficial change*⁵¹.

As the English Bill was in Parliament, the Bamford Committee recommended capacity-based legislation in their report on reforming the mental health law in Northern Ireland, so that the treatment of people who lack capacity for both physical and mental illness should proceed under the same principles⁵². The Joint Committee on Human Rights has argued that there is a rational and objective justification, in relation to decisions about treatment, for treating differently a person suffering from a condition which seriously impairs his or her mental capacity to choose whether to accept treatment, from someone whose mental capacity for decision-making is not so seriously impaired⁵³. The principle of autonomy is also included in General Medical Council principles⁵⁴; standards of the World Psychiatric Association⁵⁵ and

47 The principle has been recommended for Northern Ireland and is a criterion for admission in other jurisdictions, for instance, in Ireland, New South Wales, North Carolina, Israel, Saskatchewan.

48 A recent study found that a significant minority of detained patients, particularly those who had been detained on a previous occasion retained their capacity (Cairns et al (2005) Prevalence and predictors of mental incapacity in psychiatric in-patients *British Journal of Psychiatry* 187, 379–85). The authors also found that a capacity test worked with a high level of reliability (Cairns et al (2005) Reliability of mental capacity assessments in psychiatric in-patients *British Journal of Psychiatry* 187, 371–8).

49 Op cit n.13.

50 Op cit n.13.

51 Hansard HL 2 July 2007, Col 826.

52 The Bamford Review of Mental Health and Learning

Disability (Northern Ireland) "A Comprehensive Legislative Framework" Consultation Report, March 2007.

53 Joint Committee on Human Rights, 25th Report. Para 20.

54 "The requirement that a person's decision-making ability must be significantly impaired before they can be detained and treated without their consent is consistent with the guidance the GMC issues to doctors, in which we make clear that doctors are expected to respect the wishes of patients who have capacity to make their own decision ... These are fundamental principles of good medical practice which we would expect to see applied to decisions involving patients with mental disorders in the same way as those suffering from physical conditions". Public Bill Committee on Mental Health Bill, Evidence 43.

55 The World Psychiatric Association approved at the General Assembly, August 25, 1996. No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her.

the World Health Organisation⁵⁶; and above all in Recommendation (2004)10 of the Committee of Ministers of the Council of Europe concerning the protection of the human rights and dignity of persons with mental disorder⁵⁷. This Recommendation represents a consensus within the Council of Europe that is in advance of Convention jurisprudence and its application in domestic courts. The latter have upheld treatment without consent on mentally capable patients on the basis of “medical necessity” rather than capacity⁵⁸.

Treatability

The treatability test was the single key issue in the Bill for civil libertarians, the Royal College of Psychiatrists and some individual psychiatrists⁵⁹ – and its abolition, the crossing of the Rubicon from a health measure to one of preventive detention. Lord Carlile explained that

there is a principle here ... as a matter of medical and legal ethics and of professional ethics ... no professional person should be required to provide a service to someone whose requirements do not come within their professional ethical code of practice. Under the Bill as it stands, doctors and other clinicians – or from all clinicians are qualified medical practitioners – are being asked to provide medical treatment in circumstances in which such treatment is simply inappropriate.

If it is the Government's view that it is appropriate to introduce legislation which requires people to be locked away from society because they are perceived to be dangerous but could not benefit therapeutically, then I am sure that this House will consider any such proposed legislation on its merits. It may achieve a fair passage and it may not. At least it would be honest, ethical legislation in which the Government would set out their objective and we...would then consider such legislation⁶⁰.

The existing ‘treatability test’ is a weak test, applied to certain patients at certain times, which sets a threshold only that a patient is likely to respond to a very broad range of interventions. Nevertheless, government argued that it was used to exclude from services people whose personality disorder is deemed to be ‘untreatable’. Their opponents held that this was no longer the case, given the more widespread availability of psychological treatments for personality disorder (whose prominence is likely to increase under the new Act, since psychologists would become responsible clinicians in charge of treatment). Training and the development of services will help to deliver a new generation of practitioners who are versed in the new approaches to treatment. Professor Appleby, the National Director of Mental Health has recently acknowledged the improvements for people with a personality disorder⁶¹.

The Bill replaced the treatability test with a loosely worded test of “appropriate treatment” which is “available” to the patient⁶². These terms significantly broaden the scope of the law. If treatment must be simply “available” to a person, the test will be satisfied whether or not s/he agrees to be treated or is willing or able to engage with or benefit from treatment. The Minister stated that the requirement that treatment

56 WHO Mental Health Care Law: Ten Basic Principles WHO/MNH/MND/96.9. These include the right to self determination covering the need for consent to medical treatment.

57 The UK government has reserved the right – alone out of 45 member states – not to comply with the recommendation.

58 Forced treatment is capable of reaching the threshold of severity required for Article 3, in which case the hospital authorities must ‘convincingly show’ before a Court a

‘therapeutic necessity’ for such treatment R (Wilkinson) v Broadmoor SHA [2002] 1 WLR 419, R (N) v Dr M [2003] 1 WLR 562.

59 Professor Eastman. Evidence to the Public Bill Committee, Memorandum 62.

60 Hansard HL 19 Feb 2007, Col 925.

61 National Personality Disorder Conference, 18th January 2007.

62 Professor Eastman. Evidence to the Public Bill Committee, Memorandum 62.

must be “appropriate in [the patient’s] case, taking into account the nature and degree of the mental disorder from which he is suffering and all other circumstances of his case” was much more than the treatability test currently requires, as the medical treatment must be appropriate to the patient “as an individual”⁶³, but others fear that “all the circumstances of the case” will permit issues of public protection to override therapeutic benefit.

With government facing a torrent of criticism in parliament, a compromise amendment was passed to require that the “purpose” of medical treatment must be to “alleviate the mental disorder or one or more of its symptoms or manifestations”. Chris Bryant, Member of Parliament for Rhondda, who moved the amendment, was clear that “purpose” was a robust test. It avoided the concept of “likelihood” implied in the current legislation, and stated in previous amendments proposed by the opposition, which was deemed too high a threshold and inappropriately based upon prediction. Nevertheless, a treatment could not have the necessary purpose unless the clinician could show that there was some likelihood it would succeed, and this should be evidence-based rather than subjective.

For behaviour to be a “manifestation” of a disorder, it must be the direct result of it. The term has the same meaning as the clinical term “signs”⁶⁴. It follows that a person with a mental disorder may not be detained because of their violent behaviour if it arises from other sources than the disorder itself, however difficult that distinction may be in practice. How the test will be applied (perhaps especially to people with learning difficulties) remains to be seen. However, the existing treatability test has been interpreted to allow that the required treatment for restricted patients may be no more than containment within a therapeutic environment under the supervision of health professionals, with only minimal benefit to the patient⁶⁵. If this is extended to all patients the new legislative wording will make little difference to practice.

Community treatment orders (CTOs)⁶⁶

The introduction of community treatment orders is the most substantial change to the regime for compulsory treatment under the 1983 Act and it remains a controversial innovation. Significantly, it was opposed entirely by Mind⁶⁷ and by all service user groups .

Critics claim that, by removing the limiting pressure of bed spaces, CTOs will inevitably lead to more patients being subject to compulsory powers, will increase the use of or reliance upon medication in the

63 *Hansard HC 19 June 2007, Col 1284 (Rt Hon Rosie Winterton MP).*

64 *ibid.*, Col 1280 (Chris Bryant MP). *The Mental Health Alliance argued for “signs” rather than “manifestations” as a term that like “symptoms” had a clear clinical meaning, the former being that which the patient reports, the latter that which the clinician elicits by observation. However they were reassured that the intention of “manifestation” was to have the same meaning in lay language. The Minister stated that “there will be no difference between the word “signs” and “manifestations”. It is ultimately simply a matter of people being able to understand what it means” Hansard HL 2 July 2007 Col 834 (Baroness Royall).*

65 *A person could be detained if hospital treatment would prevent a deterioration in his condition, make him more co-operative and insightful, or if detention was likely to impact on his symptoms, even if it would not touch the substantive illness. R v Cannons Park MHRT [1995] QB*

60 *In Reid v Secretary of State for Scotland [1999] 2AC 512 the House of Lords stated that the definition of treatment may in some circumstances extend ‘from cure to containment’. The case concerned a restricted psychopathic patient whose anger management was improved by the supervision he received in the structured setting of a state hospital.*

66 *For further consideration of CTOs see ‘Community Treatment Orders’ by Kris Gledhill in this issue of the Journal of Mental Health Law. Also see ‘Does compulsory or supervised community treatment reduce ‘revolving door’ care? Legislation is inconsistent with recent evidence.’ by Kisely and Campbell, British Journal of Psychiatry (2007) 191 pp 373–374. This review of recent studies in Australia argues that CTOs do not reduce revolving door care.*

67 *Submission to the Joint Committee on the Draft Mental Health Bill:2004, Report Vol II.*

treatment of illness (given that the power is designed to impose medication compliance); and will disproportionately impact on people from Black and minority ethnic backgrounds. They fear that the community services are not sufficiently well resourced or well developed to ensure the delivery of safe and effective care⁶⁸. Government, for its part, favours CTOs for a range of reasons – that they are more flexible; more consistent with community-based modern service delivery; less traumatic for patients than long hospital stays; and, above all, that they will address the problem of revolving door patients. After the outcry surrounding the 2004 Bill, the government decided to limit CTOs to any person who has been placed on a treatment order (if only for a short time) as a civil or a Part III patient.

The Mental Health Alliance criticised the Department of Health for proceeding to legislate having neither analysed the different models of community treatment in force in other jurisdictions nor assessed overseas experience of such models. Although the Department of Health did commission research from the Institute of Psychiatry, it did so too late to influence the policy making process. The Institute's report⁶⁹, which was released the day after the Bill had completed its process through the House of Lords, is the most comprehensive review that has yet been undertaken of the existing international research literature on CTOs relating to civil patients over 52 jurisdictions in Australia, New Zealand, Canada, USA, Scotland and Israel. It reviewed 72 studies from six countries and concluded that there is no robust evidence that CTOs cause either reduction or increase in a range of outcomes, including hospital admissions; hospital bed days; compliance with treatment; violence; symptoms; offences resulting in arrest; social functioning; quality of life, care or satisfaction; and perceived coercion.

The 2007 Act provides that a person may be discharged from hospital on a CTO with the agreement of the responsible clinician and the approved mental health professional that the conditions are met. As the British Association of Social Workers pointed out, there is a lack of external oversight in this procedure. They will be close colleagues in the same clinical team, with no requirement to bring in a professional from outside the team as is the case with admissions to hospital⁷⁰.

The conditions are very broad. If the patient has a mental disorder which makes it "appropriate for him to receive medical treatment" the responsible clinician must decide whether it is "necessary for his health or safety or for the protection of others that he should receive such treatment", the treatment can be provided without his continuing to be detained in hospital and "it is necessary that the responsible clinician should be able to exercise the power to recall the patient to hospital"⁷¹.

The House of Lords argued for limits to be placed on CTOs. As Lord Patel expressed it:

*If Parliament drafts the law too widely, the danger is that CTOs will be applied too widely. They could even become part of the normal discharge process for detained patients generally, as a kind of safety net for risk-averse mental health service staff and managers. If this happens, Parliament will not have produced a measure that enables a less restrictive alternative for the effective management of this small group of patients, but instead will have increased massively the legal coercion of psychiatric patients generally.*⁷²

68 The British Association of Social Workers commented (Second Reading Briefing House of Lords Mental Health Bill 2006) that "in most places there are now too few in-patient beds, and that there is pressure to reduce the numbers still further in order to cut costs, resulting in patients being discharged prematurely in order to free beds for others who are even more acutely ill. In this context, there is a high likelihood that CTOs will be used to expedite discharges in circumstances where the patient has not yet fully recovered and where they have not yet

regained sufficient insight to be able to co-operate voluntarily with community services, and where they do not have a history of non-co-operation resulting in relapse".

69 Op.Cit. n. 8.

70 British Association of Social Workers, Second Reading Briefing, Mental Health Bill, November 2006.

71 MHA 1983 s17A (5)(b)(c)(d) as amended by MHA 2007, s32.

72 Hansard HL 2 July 2007, Col 844.

Another fear was that patients would remain on CTOs indefinitely. Given the broad criteria, Tribunals would find it difficult to justify the discharge a patient if the responsible clinician and approved mental health professional decided otherwise. The patient's right to apply to the Tribunal to challenge a CTO, or its renewal, would be of little value.

The Government's stated goal was identified to Parliament by Lord Warner as:

*the continuing number of revolving door patients...who leave hospital, disengage from mental health services, do not continue with their treatment, [until] their health deteriorates and they end up compulsorily detained in hospital. We may have differences in view about the numbers involved, but that is the cycle we are trying to deal with.*⁷³

Their argument for community treatment orders also focused on cases where a person poses a serious risk to others. This was in part as a result of the work of forensic psychiatrists such as Professor Tony Maden⁷⁴.

The House of Lords amendments, which would have limited the scope of CTOs to such "revolving door" patients, were ultimately overturned. However Lord Hunt emphasised that the clinician must be "satisfied of the patient's previous history of non engagement and non-compliance that made it unsafe to treat the patient in the community voluntarily"⁷⁵. In a small acknowledgement of the issue, the government agreed to an amendment that would amplify why it was necessary for a clinician to have a power of recall. The Act now provides that:

*in determining whether the criterion in subsection (5) (d) above is met, the responsible clinician shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).*⁷⁶

The Minister stated that:

*this has the effect that the responsible clinician must consider the risk of the patient's condition deteriorating in the community when deciding whether it is necessary for him to be able to exercise the power to recall the patient to hospital. This means that, in order to place a patient on supervised community treatment, the responsible clinician will need to be able to show that he has properly considered and, if appropriate, assessed the risk of deterioration—otherwise, his decision could be open to challenge in the courts.*⁷⁷

The failure to get any significant changes to the thresholds for CTOs leave the anxieties expressed above undiminished. It should be noted that if one takes account of all the eligibility criteria for a person being placed on a CTO, including the definition of mental disorder that is the initial gateway, then the powers provided in this Act, are in excess of those provided in the mental health laws in Scotland, Ireland, Australia, New Zealand, and in those parts of Canada and USA with community treatment regimes⁷⁸.

73 Hansard HL 17 Jan 2007, Col 702.

74 *Review of Homicides by Patients with Severe Mental Illness*. Tony Maden, Professor of Forensic Psychiatry, Imperial College London 15th March 2006.

75 Hansard HL 17 Jan 2007, Col 709.

76 MHA 1983 s17A (6) as amended by MHA 2007, s32.

77 Hansard HL 2 July 2007, Col 848 (Lord Hunt).

78 *Mental Health (Care and Treatment) Scotland Act 2003*;

Irish Mental Health Act 2001; *Mental Health (Northern Ireland) Order 1986*; *NSW Mental Health Act 1990* ; *Victorian Mental Health Act 1986*; *Queensland Mental Health Act 2000*; *ACT Mental Health (Care and Treatment) Act 1986*; *New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992*; *Ontario Mental Health Act*; *Saskatchewan Mental Health Services Act*; *Alberta Mental Health Act*, *New York Kendra's Law*; *North Carolina Mental Health Act*, *Florida Mental Health Act*.

The CTO regime in USA is particularly narrow. In most US jurisdictions the use of compulsory powers has been greatly restricted on civil rights grounds and is confined to people with a mental illness who are at imminent danger to themselves or others⁷⁹. In many cases there is no enforcement mechanism⁸⁰, and so they are comparable in many respects to supervised discharge rather than to CTO.

Several other features of the CTO regime are worth noting. There is no requirement in the Act to discuss the making of an order with the patient or with the nearest relative, even though their participation is essential. The conditions placed upon the patient may be varied by the responsible clinician only with the agreement of the approved mental health professional. The Bill originally specified the types of conditions that could be placed on the orders, which included specifying a place of residence and rules about the patient's conduct. In response to the Joint Committee on Human Rights' concerns that these conditions were unduly intrusive and could breach Article 8 rights to private and family life and home,⁸¹ the government amended the Bill, removing all references specifying the permissible subject of orders, but limiting them to measures necessary to ensure a patient receives medical treatment; to prevent risk of harm to the patient's health or safety; or to protect others⁸².

A patient has no right to challenge a condition placed on a CTO and, even on an application for discharge, the Tribunal has no power to vary conditions. An amendment to provide for a right of appeal against the conditions was defeated, with the government maintaining that conditions that were not agreed by patients would not be appropriate. However the experience in the Australian state of Victoria for instance, where a condition of residence is permitted, is that such appeals are not rare⁸³.

The Royal College of Psychiatrists⁸⁴ and the Chair of the Mental Health Act Commission⁸⁵ were alarmed by provisions for the involvement of a second opinion approved doctor (SOAD) embedded in the almost incomprehensible Part IVA of the 2007 Act. The treatment of any CTO patient (including those who consent to treatment) will, after a month, have to be authorised by a second opinion appointed doctor (SOAD). The SOAD is empowered to authorise such treatment as may be imposed should the patient be recalled to hospital, and, extraordinarily, also to authorise treatment that would be imposed should a consenting patient withdraw consent or lose capacity. This changes an essential component of the SOAD role which, as the current Code of Practice stipulates⁸⁶, is to examine the patient and make a judgment in the light of the patient's changed circumstances. As Lord Patel, Chairman of the Mental Health Act Commission, made clear:

it anticipates that a SOAD, whose role should be to safeguard against unnecessary or unsafe compulsory treatment, will authorise the forced application of medication in circumstances that he or she cannot foresee at some unpredictable point in the future. A patient who has developed dangerous and possibly irreversible side-effects might have them worsened by the further imposition of medication on the

79 This results from the *Lessard v Schmidt* (1972) decision which stipulated "extreme likelihood that if the person is not confined he will do immediate harm to himself or others". See generally *Diesfeld & Freckleton Involuntary detention and therapeutic jurisprudence: international perspectives on civil commitment*. (2003).

80 The Virginia Code Title 37.2.

81 Joint Committee on Human Rights Session 2006–7, 4th Report p. 20–22.

82 MHA 1983 s17B(2) as amended by MHA 2007 s.32

83 Understood from recent discussions between the author and John Lesser, President, Mental Health Review Board, Victoria. The Victorian Mental Health Act permits conditions to be placed only on residence.

84 Royal College of Psychiatrists Evidence to the Public Committee House of Commons MH10.

85 Lord Patel of Bradford Hansard HL 26 February 2007 Col 1450.

86 MHA 1983 Code of Practice, para 16.21.

*authority of the SOAD. A patient with a heart condition might be killed by the imposition of medication authorised in good faith by the SOAD.*⁸⁷

The fact that a SOAD who certifies that a community patient consents to treatment will also certify what treatments can be imposed on the patient if he or she withdraws consent and is recalled to hospital, underlines the coercive nature of the CTO regime and surely breaches the principle underlying true consent that “permission given under any unfair or undue pressure is not ‘consent’”⁸⁸.

The differences between the SOADs’ role for detained and community patients is not based on clinical considerations or patients’ welfare, but a technical problem of the difficulty in ensuring that a SOAD can be called quickly enough (within 72 hours) if a community patient is recalled to hospital. Other solutions could have been found to this problem, including the use of emergency powers under section 62.

Roles of clinicians

The 2007 Act provides for the role of the responsible medical officer to be replaced with that of the responsible clinician, to be defined in regulations. It is anticipated that chartered psychologists, nurses, social workers and occupational psychologists will be included. They will need to satisfy specified competencies. Stakeholders have welcomed this workforce reform.

The government accepted the opposition argument that Section 20 of the 1983 Act needed amending. It was anomalous for a patient to have his/her detention renewed on the recommendation of one clinician, when it required two opinions for the original order. From a clinical point of view, it is likely to require a higher level of expertise to diagnose an illness once the person’s condition has stabilised than when he or she is in a state of mental crisis and the disordered state of mind is only too evident. From an ethical point of view, a person’s liberty should not be denied on the basis of one opinion.

In the case of the renewal of detention, the amended Act will require that a person who has been “professionally concerned with the patient’s medical treatment; but who belongs to a profession other than that to which the responsible clinician belongs”, must state “in writing that he agrees that the conditions are satisfied” before a section can be renewed⁸⁹. This does not expressly require the patient to be examined by the second professional, and in that respect it is a weaker safeguard than that to be provided for patients deprived of liberty under the amended Mental Capacity Act⁹⁰. Given that the two clinicians will come from the same team, and that the status of the clinician giving the second opinion is not specified, it also fails to provide the robust safeguard the opposition amendments had sought.

It is not clear that the new arrangements satisfy the requirements of Article 5 of the European Convention. Under the 2007 Act, the initial s.3 detention for six months is still based on the opinions of two medical practitioners. Thereafter (where the responsible clinician is not a doctor), all periods of detention can be authorised by non-medical practitioners. This potentially removes from the process the “objective medical expertise of a kind or degree warranting compulsory confinement” (the test from *Winterwerp v the Netherlands*), which is required for a valid detention under ECHR Article 5. The Joint Committee on Human Rights have cited ECHR jurisprudence to the effect only a person with medical

87 He also warned that the MHAC would be likely to advise SOADs to be extremely cautious indeed when considering whether or not to authorise treatments to be given in unforeseeable situations at some unidentified point in the future: *Hansard HL 26 Feb 2007, Col 1450*.

88 MHA 1983 Code of Practice, para 15.13.

89 MHA 1983 s.20(5A) as amended by MHA 2007, s9(4).

90 Schedule 7 MHA 2007 (referring to the ‘Bournewood’ authorisation procedures) requires the person to be examined by a medical practitioner to ascertain whether s/he has a mental disorder.

training could satisfy the *Winterwerp* test for deprivation of liberty⁹¹. The government disagreed; and in their view the competencies which the responsible clinician needs to meet would be sufficiently robust to satisfy the *Winterwerp* test. The Joint Committee countered this by pointing to the lack of examination planned for those seeking to satisfy the competencies, and reiterating that in their view only a doctor or clinical psychologist could be sure to have the requisite training to satisfy the test⁹². The legal landscape is now rather uneven. Two medical opinions are required for an initial civil detention under the MHA; two opinions (one medical) for Bournemouth deprivation of liberty; two professional opinions for a person being placed on a CTO or for a CTO renewal; but in the case of a renewal of civil detention under the MHA only one medical opinion is needed. This is clearly an issue that the courts will be called upon to resolve. Meanwhile, cautious authorities might be advised to include a medical practitioner in renewals.

The overlapping regimes of MCA and MHA

That the *Mental Capacity Act* (MCA) and the *Mental Health Act* (MHA) provide overlapping regimes for adults with a mental disorder is well known. Many incapacitous patients would be detained under the MHA but for their compliance with their care. The acts are however based on different principles – patient empowerment and best interests govern the MCA, whilst risk and paternalism govern the MHA. Patients receive different standards of care and protection if they are treated under one statute rather than the other. For instance, MCA patients who receive ECT do not qualify for a second opinion, nor if they need to be detained under the deprivation of liberty regime will they receive free care. On the other hand, advance directives will be respected and their appointed representatives will have a role in their care and treatment. Their legal redress is through the Court of Protection, which is not free, rather than through the Mental Health Tribunal, which is. Clinicians are expected to consider carefully which regime to use, but may not have a formal legal status under both acts.

Attempts in Parliament for amendments to bring greater consistency to the two schemes were unsuccessful. The inconsistencies may give rise to human rights challenges⁹³. Moreover this still leaves the fact that professionals are faced with two legal structures which could be used for patients who lack capacity. Except in case of patients who present a high level of risk to others, it may not be clear what factors should determine the choice.

Some welcome reforms

The *Mental Health Act 2007* has made many other significant changes to the 1983 Act. Patients will be able to apply to the county court to displace their nearest relative, including on the new grounds that s/he is “not a suitable person to act”⁹⁴. There were persistent attempts for a better solution – either to substitute a nominated person for the nearest relative, as under the 2004 Bill, or a more user friendly means for the patient to displace a nearest relative who had been appointed. The Mental Health Alliance also called it “harsh and unreasonable” to expect a patient to risk causing dissension in their family by seeking a different nearest relative when s/he was in a most vulnerable⁹⁵ state. The government saw all

91 *Varbanov v Bulgaria Judgment of 5 October 2000.*

92 *Joint Committee on Human Rights, Legislative scrutiny: Seventh progress Report, Session 2006-7 15th Report* p.6–9.

93 *ibid.* The issue of charging and the need for a procedure prior to the imposition of compulsion were the two issues

that concerned the Joint Committee. Others could include the differences in treatment safeguards.

94 MHA 1983 s29(3)(e) as amended by MHA 2007 s23(5)(b).

95 M H Alliance Memorandum, Joint Committee on Human Rights, 4th Report Session 2006–7, p.76.

alternative proposals as unworkable. However they did concede that a person could be “unsuitable” to act for reasons other than abusiveness. The Minister explained that:

*concerns have been expressed about whether the provision would cover situations where patients have no real relationship with their nearest relative. Although it is important that the courts look at each case on its merits we intend the idea of unsuitability to cover situations where there is no effective relationship between the patient and their nearest relative or where that relationship has broken down irretrievably.*⁹⁶

JUSTICE was also concerned about the converse situation in which the word ‘unsuitable’ might be used by the local authority to justify removal of a nearest relative:

*we note that nearest relatives frequently have a tense relationship with those detaining and treating patients, and we have serious concerns that applications may be made to remove a nearest relative on the basis of suitability, when, in essence, the detaining/treating authority is making the application on the basis that they are ‘difficult customers’.*⁹⁷

The courts and Code of Practice will be relied upon for guidance with this issue.

The right to advocacy, although not directly enforceable, is a huge gain for patients if the resources that have been promised are made available⁹⁸. There are significant gains for children and young people. Age appropriate facilities will in time be required for all patients under 18 years⁹⁹. The capacious refusal of 16- and 17-year-olds to hospital admission will not be overridden by parental authority¹⁰⁰, a second opinion appointed doctor will need to agree for ECT to be administered to any detained patient under 18-years-old¹⁰¹, and there will be an annual referral to the Mental Health Review Tribunal for patients under 18 years old who do not request a hearing¹⁰². There will be no ECT in the face of capacious refusal of any patient, other than in an emergency, and emergency ECT will only be permitted if immediately necessary to save life or immediately necessary to prevent a serious deterioration in his condition¹⁰³.

Lost opportunities

There is no doubt that the 2007 Bill was improved in its course through Parliament. The extremes of the government’s zeal that nothing should stand in the way of clinical discretion were tempered and patient safeguards were improved. Nevertheless, it remains simply an amending Bill and, as such, a valuable opportunity lost. No government is likely to re-enter the minefield of mental health law reform in a hurry. Progressive reforms including, above all, the recognition of statutory care plans and advance directives, and a right to assessment of mental health needs, were all in the Richardson Committee framework and were all supported with enthusiasm in Parliament, but were all dismissed summarily by the government.

96 Hansard HC 18 June 2007, Col 1099 (Rt Hon R Winterton MP).

97 JUSTICE, Second Reading Briefing, House of Lords, November 2006.

98 Independent Mental Health Advocates will be available for all patients liable to be detained whether under Part II or Part III of the Act, being placed under guardianship or on a CTO, if discussing section 57 type treatments, for minors under 18 years of age and in discussing section 58A type treatments.

99 The managers of the hospital must ensure that the patient’s environment in the hospital is suitable having regard to his/her age (subject to his/her needs). The

managers shall consult a person who appears to them to have knowledge or experience of cases involving patients under 18 years old. Section 140 has been amended (duty on health authority to inform social services of arrangements) for the provision of accommodation for patients who have not attained the age of 18 years.

100 MHA 1983 s131(2) as amended by MHA 2007 s43.

101 MHA 1983 s58A as amended by MHA 2007 s27.

102 MHA 1983 s68(6) as amended by MHA 2007 s37.

103 MHA 1983 s58A as amended by MHA 2007 s27.

In addition, a whole raft of amendments¹⁰⁴ which were designed to make good defects or gaps in the 1983 Act were rejected without seriously considering their merits, on the grounds that there was no intention to undertake a wider revision of the 1983 Act. This underlined the unsatisfactory nature of the reform process.

There remain significant unresolved issues that may give rise to expensive human rights cases; there are difficulties in harmonising the two parallel statutes; and, above all, there is the uncertainty as to the operation of community treatment orders. Predictions as to the use of community treatment orders vary greatly¹⁰⁵ and the impact of new clinical roles on rates of detention is unknowable. It is unlikely that the Code of Practice can rescue these difficulties.

Indubitably the *Mental Health Act 2007* has broadened the scope of compulsory powers in hospital and in the community and is likely to lead to a greater use of compulsion in the treatment of mental illness. In the context of the 'blame' culture, where every tragedy caused by a patient can potentially be attributed to a psychiatrist's misjudgement, psychiatrists often feel required to recommend the detention of patients, perhaps against their better judgement or the best interests of the patient. Apart from the considerable disquiet this arouses from the point of view of patient's welfare, there is a fear that this will impose strains on a system where new and successful services are already struggling to survive, and that it will take away resources from voluntary patients – both in terms of bed space and professionals' time in dealing with the procedural requirements of the Act.

Ultimately it will depend upon clinical practice whether the words of Earl Howe are borne out:

*In this, as in other ways, the whole approach of the Bill views mentally ill people as patients who need compulsory treatment for their own good, whether they like it or not. Compulsion is, of course, necessary for many patients. But we need to remember – I do not think that some doctors always do – that it should always be a last resort. The Government say that every limitation on the ability of doctors to detain patients against their will has the effect of preventing those patients receiving the treatment that they need. To put the matter in those terms, however, presupposes that compulsion is the only means by which effective treatment can be delivered. Of course, it is not: good treatment is available without compulsion, and the fear of some of us is that the wider the gateway to compulsion and the easier the law makes it to get people through it, the less likely it is that those who need help will come forward to ask for it. Never let us forget the anguish, trauma and humiliation involved in subjecting a patient to compulsion –and never let us forget, as the RCN has emphasised, that compulsion should never be seen as a substitute for good healthcare.*¹⁰⁶

104 For example, providing for a right to move hospital; a duty of a Trust to act on a request for transfer to hospital from prison; the right to order a mental health report for an accused person remanded on bail.

106 Hansard HL 2 July 2007, Col 826.

105 The Department of Health assumed that in the first year, 2% of detained s3 patients in England and Wales may be discharged to a CTO. However, if the experience of Scotland is replicated – where in the first six months 23% of all hospital-based orders were varied, upon patient discharge, to a CTO – this is a significant underestimate. Lawton-Smith S (2005) *A Question of Numbers*. London: King's Fund. The current King's Fund estimate is between 7,800–13,000 CTOs in 10–15 years time (Briefing for Second Reading Mental Health Bill, Kings Fund 2006).