

Reforming the Mental Health Act 1983: 'Joined Up Compulsion'

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Introduction

This article discusses the two volume White Paper *Reforming the Mental Health Act* issued by the Government in December 2000. The two volumes are separately titled *The New Legal Framework*¹ and *High Risk Patients*². The foreword to the White Paper appears above the signatures of the Secretary of State for Health, Alan Milburn, and the Home Secretary, Jack Straw. This is heralded as an example of 'joined up government', and indeed one of the themes of the White Paper is the need for closer working between the psychiatric and criminal justice systems. The primary policy goal of the proposals is the management of the risk posed to other people by people with mental disorder, perhaps best exemplified in Volume One of the White Paper which proclaims that 'Concerns of risk will always take precedence, but care and treatment should otherwise reflect the best interests of the patient.'³ This is a clear reflection of the fact that the reforms are taking place against the background of a climate of concern about homicides by mentally disordered patients, whether mentally ill, learning disabled, or personality disordered.⁴

The Government has also had to ensure that their proposals comply with the requirements of the Human Rights Act 1998, and state that new legislation will be 'fully compliant' with the Human Rights Act.⁵ The issue of Convention compliance is an important one. In terms of rights, the traditional concern of mental health legislation has been to protect patients against arbitrary detention (Article 5) and to respect their right to protection against inhuman and degrading treatment (Article 3) or their right to respect for autonomy (Article 8). However, implicit, and sometimes explicit in the new proposals is a broader concept of rights, going beyond the notion of patients' liberty rights to embrace the right of the public to expect that the state will in certain circumstances protect them against threats to their right to life under Article 2. The classic case on this is of course *Osman v United Kingdom* where the European Court of Human Rights held that

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1 *Reforming the Mental Health Act: Part I The New Legal Framework* TSO 2000 Cm 5016-I.

2 *Reforming the Mental Health Act: Part II High Risk Patients* TSO 2000 Cm 5016-II.

3 Cm 5016-I, para. 2.16

4 Taylor, P.J. and Gunn, J., 'Homicides by People with Mental Illness: Myth and Reality' (1999) 174 Br. J. Psychiatry, 9-14,

5 Cm 5016-II para. 1.11

there would be a breach of Article 2 if authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of identified individual or individuals from the criminal acts of a third party, and failed to take action within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.⁶ Clearly the Government has realised that it enjoys a certain margin of appreciation in balancing the rights of the patient not to be detained arbitrarily against the 'rights' of the public to be protected against violent conduct from mentally disordered people, and public protection clearly predominates the proposals.

The Government's primary concern is that too few rather than too many risky people are subject to compulsory intervention, as is evident from the following passage:

The 1983 Act ... fails to address the challenge posed by a minority of people with mental disorder who pose a significant risk to others as a result of their disorder. It has failed properly to protect the public, patients or staff. Severely mentally ill patients have been allowed to lose contact with services once they have been discharged into the community. Such patients have been able to refuse treatment in the community. And it is the community as well as those patients which has paid a heavy price. We also need to move away from the narrow concept of treatability which applies to certain categories of mental disorder in the 1983 Act. New legislation must be clearly framed so as to allow all those who pose a significant risk of serious harm to others as a result of their mental disorder to be detained in a therapeutic environment where they can be offered care and treatment to manage their behaviour.⁷

The Mental Health Act 1983 is described as 'outmoded, based on treatment within hospitals, complex, confusing and lacking in explicit statements of its underlying principles.' There are two primary policy goals behind the White Paper. The first is to introduce more effective compulsory community powers than guardianship or supervised discharge to ensure that patients in the community are subject to an effective undertaking to carry on with medication. The second main goal is to ensure that dangerous severely personality disordered patients can be subject to detention in the mental health system or in some intermediate system of 'third way' therapeutic institutions. In addition there are a number of subsidiary aims, one of which is the abolition of the nearest relative and their replacement by a nominated person with much more limited powers in relation to the patient's care and treatment, shifting the balance away from the rights of families towards the power of the state to intervene compulsorily. Another is the abolition of the review functions of hospital managers, which for the most part will be taken over by a new Mental Health Tribunal. In this article I shall argue that these proposals will bring about a convergence between the psychiatric and criminal justice systems, with adverse consequences for traditional medical values such as confidentiality, and a refocusing away from traditional due process rights of patients towards the rights of the community to be protected from mentally disordered people.

The White Paper Proposals

The White Paper begins by acknowledging that promoting and supporting good mental health services is a key responsibility of Government⁸ and outlining the Government's investment programme. It then proceeds to list the Mental Health National Service Framework Standards which states the legitimate expectations of service users and carers to assessments of their needs,

6 (1998) 29 EHRR 245 at 305.

8 *Ibid.*, Para 1.1.

7 *Cm 5016-I, para. 1.15*

to written care plans, to access the service, and to the benefit of suicide prevention strategies. After statements of the importance of social inclusion and non-discrimination, the Government then states 'the two aims of mental health legislation' in the following terms:

First that those who are seriously ill get appropriate health care to meet their particular needs; and second, that the public is protected from the small minority of people with mental disorder who may pose a risk to their safety.⁹

The fixation on risk management is evident from the fact that a notable absentee from this list is the traditional aim of protecting patients against ill-treatment or arbitrary use of compulsory powers. The ascendancy of risk management is further exemplified in the combination of broader powers to detain and treat compulsorily in the community, and there will be a single pathway to compulsion, a care and treatment order, which will allow either care and treatment under detention in hospital or compulsory care in the community.

Mental Disorder

In order to be subject to the new regime of compulsory powers the patient will have to be suffering from mental disorder which will be broadly defined as 'Any disability or disorder of mind or brain, whether permanent or temporary which results in an impairment or disturbance of mental functioning.'¹⁰ The definition is drawn from the Law Commission Report on Mental Incapacity.

This represents a reversal of the 20th Century trend in mental health legislation towards developing legal sub-categories of mental disorder, and attaching different admission criteria to each. At the end of the 19th Century there was separate legislation dealing with lunatics and with idiots and imbeciles. The Idiots Acts were replaced by the Mental Deficiency Act 1913, which introduced the concept of mental deficiency, with several subcategories of 'mental defective' including moral imbeciles. Until the Mental Health Act 1959 these separate statutory frameworks continued to operate, subject to the overarching jurisdiction of the Board of Control, the successor body of the 19th Century Lunacy Commissioners. The 1959 Act brought all mental disorder under one framework. It allowed compulsory admission for up to 28 days based on the presence of mental disorder generally defined. Detention under the long-term power to detain for treatment had to be based on the presence of one of four statutory subcategories of mental disorder. The so-called 'major disorders' were 'mental illness' (undefined) and 'severe subnormality'. The minor disorders were 'subnormality' and 'psychopathic disorder', and here there was a rudimentary treatability test, as well as an upper age limit on detention unless the patient was dangerous.¹¹

The Mental Health Act 1983 abolished the age limit and relied solely on a treatability test for the 'minor disorders', now psychopathic disorder and mental impairment. The drawback of the treatability test from the Government's point of view is that it confers clinical discretion on psychiatrists, which means that doctors may refuse to detain those whom they consider untreatable. Adoption of the new broad definition of mental disorder is almost equivalent to using the catch all 'any other disorder or disability of mind' which appears at the end of the generic definition in s. 1 of the current Act. The Government is frank about its intentions:

It is intended to ensure that the presence, or absence, of any one particular clinical condition does not limit the discretion of clinicians to consider whether a patient with mental disorder

⁹ Cm 5016-I, para. 1.13.

¹¹ Mental Health Act 1983, s 26.

¹⁰ Cm 5016-I, para. 3.3.

should be treated under compulsory powers. ... This means that no particular clinical diagnosis will have the effect of limiting the way that the powers are used ... It will also help to ensure that people who require care and treatment under mental health legislation are not excluded because of too narrow a definition of mental disorder.¹²

In addition to broadening the definition of mental disorder, it seems that the Government intends to abandon the limiting clause in s. 1(3) of the 1983 Act, which states that no-one shall be treated as suffering from mental disorder by reason only of sexual deviancy or addiction to alcohol or drugs. This reflected the desire to ensure that homosexuals were not subject to detention under mental health legislation, and the idea that there was little point in compelling addicts to accept treatment which they did not want. The effect of this has been that a person cannot be detained unless there is some accompanying mental disorder, such as Korsakoff's syndrome, in the case of alcoholism.

There is nothing in Article 5(1)(e), which authorises detention on grounds of unsoundness of mind, to inhibit such a broad definition. The well-known *Winterwerp* formula requires only that the unsoundness of mind must be a true mental disorder established by objective medical expertise, and that it must be of a nature or degree warranting confinement. Article 5(1)(e) of the European Convention on Human Rights allows detention on grounds of alcoholism or addiction to drugs, but the European Court of Human Rights was emphatic in *Winterwerp* that detention on grounds of unsoundness of mind under Article 5(1)(e) did not authorise detention on grounds of mere deviance from society's norms.¹³

The broadening of the definition of mental disorder on its own will have the effect of narrowing the mesh of the net of compulsory powers, more people will be liable to detention, and more people to compulsory medication in the community. Before turning to the question of treatability, it is important to examine the new framework of compulsory assessment and treatment, 'the single pathway' to compulsion.

The Single Pathway

There will be a single pathway to compulsory care and treatment. What this means is that the same decision-making procedures will apply to compulsory treatment in hospital or in the community. Instead of separate procedures for detention (hospital based) and, supervised discharge (which requires a previous period of detention) and guardianship (local authority social services based) there will be one single pathway to either form of compulsion. This is based initially on powers very similar to the current s. 2 admission for assessment under the 1983 Act. The patient will be able to be subjected to compulsory assessment for up to 28 days on the authority of two doctors and a social worker or other 'mental health professional with specific training in the application of the new legislation.'¹⁴ The major difference in personnel will be that the Government appears to be contemplating using community psychiatric nurses as applicants as well as the current Approved Social Workers. The current system is based on the fact that the application comes from an ASW who is specially trained in this work, who is employed independently of the hospital authorities, and who exercises individual statutory discretion as to whether it is necessary to make an application. The addition of 'another mental health professional' as a potential applicant is intended to involve community psychiatric nurses (CPNs). CPNs have traditionally worked under the direction of psychiatrists. ASWs currently undergo 60 days

12 Cm 5016-1, paras. 3.3 – 3.5.

14 Cm 5016-1, para. 3.14.

13 *Winterwerp v the Netherlands* (1979) 2 EHRR 387.

of specialist training to receive their warrant, and similar training will be needed for CPNs. The principle of independent checks and balances and the notion that admission is as much a social as a medical matter are both greatly diluted by these proposals.

The criteria for compulsory assessment are that: (a) the patient must be suffering from mental disorder that is sufficiently serious to warrant further assessment or urgent treatment by the specialist mental health services; and (b) without such intervention the patient is likely to be at significant risk of serious harm, including deterioration in health, or pose significant risk of serious harm to other people. The specialist mental health service is defined as care and treatment for mental disorder provided under the management of a clinical supervisor.¹⁵ In contrast to the responsible medical officer under the 1983 Act, a clinical supervisor need not be a psychiatrist, he or she could be a clinical psychologist¹⁶, and this may be more likely where the patient has a personality disorder or a learning disability. Currently the criteria for admission for assessment under s. 2 are that that person has mental disorder, in the general sense, of a nature or degree warranting assessment, and that the patient's detention for assessment is warranted in the interests of their health or safety or for the protection of others. The proposed new test will be that the mental disorder warrants assessment or urgent treatment by the specialist psychiatric service, in other words bad enough to see a consultant psychiatrist or clinical psychologist. Under the new criteria, the risk will have to be significant. This may be thought, and intended, to be a dilution of the 'substantial risk of serious harm' which appears in the supervised discharge criteria in ss 25A-H of the 1983 Act. But neither term refers to statistical probabilities. 'Substantial' means having substance, and significant means having 'significance'. How much substance or significance they have to have is a matter for the decision-maker, and presumably also for the Code of Practice to be issued to accompany the Act.

During the 28 day period no treatment without the consent of the patient, other than urgent treatment, can take place before a written care plan has been produced.¹⁷ This is the equivalent under the existing Act of the provision that Part IV, which authorises treatment without consent, does not apply until the second medical opinion has been furnished to convert an emergency 72 hour admission into an admission for assessment under s. 2.¹⁸ There will be a requirement to prepare a written care plan within three days unless there are exceptional circumstances making this impractical.¹⁹ The treatment plan 'may in the initial stages be quite simple', but once there has been a full assessment it will have to set out in detail what is to be provided, in line with the Care Programme Approach, which means that there must be a key worker, a risk assessment, a needs assessment, a written care plan, and regular review.²⁰ There can be no compulsion beyond 28 days unless the Mental Health Tribunal (MHT) makes a compulsory care and treatment order or makes a further order for assessment, and patients have a 'fast track right of appeal' to the MHT during the first 28 days.

Care and Treatment Orders

One of the main changes proposed is in the role of the Mental Health Review Tribunal. Currently it reviews the need for continued detention, decisions to detain being made by mental health professionals, hospital managers and the courts. The new tribunal will be a Mental Health Tribunal (MHT), which will be the body which makes the decision to impose the care and treatment order

¹⁵ *Ibid.*, p. 62

¹⁶ *Ibid.*, p. 58.

¹⁷ *Ibid.*, para. 3.38.

¹⁸ *Mental Health Act 1983*, s. 56.

¹⁹ *Cm 5016-I*, para. 3.17.

²⁰ *Ibid.*, para. 3.19.

which will be for a maximum period of six months in the first instance, renewable by the MHT for a further six months and thereafter at yearly intervals. Despite the disappearance of the word 'Review' from its title the MHT will have review functions. The patient has a 'fast track' right to apply to the MHT against detention for assessment and has the 'right to request that the tribunal reviews any order for compulsory care and treatment lasting longer than three months.'²¹ If this means that the patient will be entitled to apply for a tribunal after three months, on current delay rates, the hearing will be happening within very few weeks of the next hearing to renew the order. And there will be problems of independence. Will the MHT panel which hears the review be differently constituted to the MHT which imposed the care and treatment order?

The MHT will consist of a legally qualified chair and two other members with experience of mental health services. One of the members will be a person with 'a clinical background' and the other will usually have a background in community or voluntary sector service provision.²² When the clinical supervisor applies to the Tribunal for authority to continue the compulsory care and treatment beyond 28 days patient arrangements will be made for the patient to be seen by an independent doctor drawn from a panel of experts appointed by the Commission for Mental Health to give expert evidence to the tribunal. This task will have to be carried out by a doctor, but the expert panel will have a broad membership. The doctors will be drawn from a variety of backgrounds, general, old age, learning disability, child and forensic, and also from clinical psychology. The expert panel will also include people with experience in ethnic minority issues, social care, learning disability nursing, mental health nursing and, tellingly, the probation service.²³ The medical members of the panel will perform the role currently undertaken by medical members of tribunals, but they will be expert witnesses, no longer tribunal members. They will also take over the role undertaken by second opinion appointed doctors (SOADs) under Part IV of the 1983 Act. Moreover, they will have the function of visiting all patients who are assessed as long term incapable and in need of treatment from the specialist service.

At a 28 day review the MHT will have the option of discharging the patient, of authorising a further 28 days assessment, or of making a care and treatment order.²⁴ The criteria for the tribunal to make a care and treatment order will be: (a) a diagnosis of mental disorder of a nature or degree to warrant specialist treatment; and (b) that specialist treatment must be necessary in the best interests of the patient and/or because without care and treatment there is a significant risk of harm to other people; and (c) a plan of care and treatment is available to address the mental disorder.

A number of features of these criteria deserve comment. First of all this is a break with the approach of the 1959 and 1983 Act that detention under long term powers should require a more specific 'diagnosis'. The same broad concept of mental disorder applies to admission for assessment and to the longer term care and treatment order. Secondly the 'necessary in the interests of the patient's own health or safety' criterion is to be replaced by 'necessary in the best interests of the patient', and the 'or necessary for the protection of other persons' criterion by 'because without care and treatment there is a significant risk of harm to other people.'

The best interests criterion is presumably an attempt to introduce common law concepts into the Mental Health Act. The Green and White Papers have apparently rejected the idea of employing a test based on capacity, although at the time of writing there are suggestions that the Government may be considering introducing a test based on impaired judgment due to mental disorder.

21 *Ibid*, para. 3.61.

23 *Ibid.*, paras. 3.45-3.47..

22 *Ibid.*, para. 3.44

24 *Ibid.*, para. 3.42.

At common law doctors have a power and a duty to give incapacitated patients treatment which is necessary in their best interests. At common law the gatekeeper concept is incapacity and best interests refers to the doctor's duty once there has been a finding of incapacity. It is the doctor's duty to consider a wider range of interests than the purely medical, including social interests. The doctor must then balance the certain and the possible gains against the certain and the possible losses, and only if the account is in significant credit should the treatment be viewed as being in the patient's best interests.²⁵ In *Re SL* the Court of Appeal held that 'the doctor ought not to make any decision about a patient that did not fall within the broad spectrum of the *Bolam*²⁶ test. This might give the doctor more than one option since there may well be more than one acceptable medical opinion. But then the doctor has to move on to consider the best interests of the patient, and this involves choosing the best option.²⁷

It seems that there will be a statutory definition of best interests which will be at variance with the common law concept, and the White Paper sets out a number of considerations to be taken into account in deciding whether continuing care and treatment is in a patient's best interests. These include:

The nature and degree of the disorder – what and how severe the symptoms are, how the disorder is likely to develop and what interventions are appropriate. The clinical team should take account of any information that is available about how the patient has responded to treatment in the past, whether they have complied with care and treatment and what are the risks of not treating them. This will include consideration of how the mental disorder may affect the patient's capacity to make decisions about treatment. Second the team should take account of the patient's expressed wishes and preferences supported, where appropriate, by an advocate. They also need to consider whether overriding the patient's wishes may make it more difficult to deliver effective care and treatment.²⁸

Despite all this statutory guidance the fact remains that a concept which has not traditionally been used as a gatekeeper concept is being pressed into service as such by the White Paper, and it is difficult to see how this is an improvement on 'necessary in the interests of the patient's health.' Patients challenging care and treatment orders will be able to argue that the treatment plan is not in their best interests, and patients or representatives of patients who are not detained but who will be subject to the new procedures for patients with long term incapacity will have the right to seek a review of the care and treatment plan if there are concerns about the content or whether it is being delivered in the patient's best interests²⁹ This will bring the tribunal for the first time into deliberations about the nature and quality of treatment offered to patients subject to compulsion. Hitherto their jurisdiction has been to decide whether or not to discharge patients.

The treatability test, although widely interpreted to include treatment of the symptoms and sequelae of mental disorder, and to include anger management in a structured environment, has been seen by the Government as a major 'fault line' in the legislation.³⁰ The White Paper applies different criteria of 'treatability' depending on whether compulsion is in the patient's best interests or because there is a significant risk of harm to other people. In cases where the use of compulsory

25 *Re A (Mental Patient: Sterilisation)* (1999) 53 B.M.L.R. 66 at 77).

26 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 582.

27 *Re SL (Adult Patient)(Medical Treatment* [2000] 2 FCR 452..

28 Cm 5016-l, para. 3.24 - 3.25.

29 Cm 5016-l, para. 6.11.

30 *B v Croydon District Health Authority* [1995] 1 All ER 683; *Reid v Secretary of State for Scotland* [1999] 1 All ER 481.

powers arises in the person's own best interests, the treatment plan must be anticipated to be of direct therapeutic benefit to the individual. Therapeutic benefit will cover 'improvement in the symptoms of mental disorder or slowing down deterioration and the management of behaviours arising from the disorder. This would include only behaviours which lead to significant adverse consequences for the patient such as suicide or serious self-harm, or serious deterioration in physical health.' (emphasis added).³¹ In cases where the compulsory powers are sought primarily because of the risk the patient poses to others, the plan must be considered necessary directly to treat the underlying disorder or to manage behaviours arising from the disorder. In such a case the care plan must include the provision of interventions that are specifically designed to ameliorate the behaviours that cause them to be a risk.³² Care and treatment for mental disorder will not be defined in new legislation. Instead, each plan of treatment must indicate what symptoms or behaviours arising from mental disorder it is intended to address, thus ensuring that 'the Tribunal considers any issues regarding the limits of care and treatment for mental disorder.'³³

The purpose of this refined approach to treatability is to make it clear that people with personality disorders may be detained even if the only treatment available is addressed at the behaviour which causes them to be a risk to others rather than at the 'core disorder.' The net effect of these changes will be to make it clear that a much larger number of people will be liable to compulsion under mental health legislation, and the procedural changes contained in the White Paper are also aimed at ensuring the primacy of risk management. Transparency, uniformity and ownership of psychiatric decision-making are key themes in the White Paper. Discretionary powers to detain will be broadened through a widening of the definition of mental disorder, and the relevant trust will be required, when called upon to do so by the nominated person, the patient's General Practitioner (GP), the police or other criminal justice agencies to send mental health professionals to carry out an assessment of the need for compulsion. Under the current legislation an ASW who is called upon by the nearest relative to carry out an assessment must give reasons in writing when he or she does not make an application for admission³⁴, so it is likely that the mental health professionals will be required to give written reasons to GPs, police or other criminal justice agencies for not using those powers. This prompts the question whether those reasons, if inadequate, could be used to found a damages action based on Article 2 and the *Osman* principle brought by the family of a victim of a homicide by a mentally disordered person. In such a case, if the police or probation ask for an assessment and those carrying out the assessment decline to use compulsory powers, they give their reasons. If there was a risk to an identified individual or individuals, and the authorities failed to take action within the scope of their powers, which judged reasonably might have been expected to avoid the risk, the authorities would be liable under the *Osman* principle. This will inevitably lead to an expansion in defensive medicine and defensive practice from other professionals involved in the assessment process.

A further major change is the abolition of the statutory role of nearest relative and its replacement with the nominated person. Currently the nearest relative can ask for an assessment of the need for compulsory admission, can apply for compulsory admission, and has the right, where practicable to be consulted about an admission for treatment for up to six months. If the nearest relative objects, no application for admission for treatment may proceed, subject to displacement by the county court if the objection is unreasonable. This right of veto is not available in relation to

31 Cm 5016-l, para. 3.21.

32 Cm 5016-l, para. 3.18.

33 Cm 5016-l, para. 3.20.

34 Mental Health Act 1983, s 13(4).

admission for assessment under s 2. The nearest relative is also entitled to ask for the discharge of a patient detained under the non-offender provisions of the 1983 Act, and the patient must be discharged unless it is certified by the responsible medical officer (RMO) that the patient is dangerous to self or to others. The nearest relative can appeal to the Mental Health Review Tribunal against refusal of discharge, and is also entitled to notice of any tribunal application for discharge made by the patient, a provision which was challenged in *JT v United Kingdom*³⁵. Here the patient objected to her mother being her nearest relative, given that she was living with the man who had allegedly abused her. This was held to be a breach of Article 8 of the Convention, in that the patient did not have any say in who could exercise the functions of nearest relative. The Government's response to this is that role of nearest relative and the powers attached will be removed by the new legislation to be replaced by nominated person who will be nominated by the mental health professional applying for compulsory powers, and the nominated person will have the right to be consulted over the exercise of compulsory powers, and will have the right to apply to the tribunal for review of the use of compulsory powers, but will have no power of veto or discharge.³⁶

This is a major transfer of power from the family to the state, and a departure from the principle that the family is entitled to take care of their loved one's health needs, but the state may override that if the person is dangerous to self or to others. Nearest relatives have successfully challenged applications for admission, where the wrong relative has been consulted, and have successfully applied to tribunals for the patient's discharge on grounds that they were not dangerous.³⁷ To allow the very person whose actions might be challenged to nominate the nominated person, and to take away the family's express powers and replace them with a consultation duty, when added to all the other reforms, represents an almost complete dismantling of the delicate system of checks devised to reflect the balance of perspectives between the state, health and social care professionals and the family. The proposals for a legal framework for the care and treatment of non-offender patients will broaden considerably the scope of compulsion under mental health legislation, and will undoubtedly lead to a significant increase in the numbers of patients who are subject to compulsory powers. Before looking at the safeguards for patients, it is important to see the proposals in the context of the second volume of the White Paper, entitled *High Risk Patients*.

High Risk Patients

High Risk Patients sets the new legal framework for detaining non-offender patients in the context of the changes to the criminal justice system. The Volume begins with a statement that the majority of patients who are detained are detained in their own best interests and defines high risk as covering 'a smaller group characterised primarily by the risk which they pose to others. It includes both those detained under civil powers and offenders who have been given a mental health disposal and a restriction order.'³⁸ Although the Government acknowledges that no society can ever be totally free of the risk of serious harm. 'where there are deficiencies in the provision of specialist services, as in the case of DPSD, the public rightly expects the Government to take action, and the clear aim of the proposals is to remedy 'weaknesses in the law' which stand in the way of detention of dangerous people with severe personality disorders.'³⁹

35 *European Commission on Human Rights Decision as to Admissibility Application 26494/95 26 February 1997, (1997) EHRR CD 81.*

36 *Cm 5016-I, paras. 5.5 – 5.9.*

37 *Re S-C (Mental Patient: Habeas Corpus) [1996] 1 All ER 532.*

38 *Cm 5016-II, para. 1.3.*

39 *Ibid., para. 1.8.*

The proposals for high risk patients need to be understood in the context of what the Government calls 'the full package' of criminal justice reforms. These include the requirement that sex offenders register with the police on leaving prison under the Sex Offenders Act 1997, sex offender orders under the Crime and Disorder Act 1998, and automatic life sentences for a second serious violent or sexual offence under the Crime Sentences Act 1997. The Home Office has also introduced an Early Warning System' to alert the Home Office to the imminent release of potentially dangerous violent or sexual offenders and enable the risk management arrangements for those offenders to be monitored. Further measures are being developed to strengthen the effectiveness of child protection law, and to put police and probation service risk management strategies on a statutory basis to improve standards. Measures are also being taken to prevent sex or violent offenders against children from working with them on release, and to introduce electronic tagging as condition of licence.

High Risk Offender Patients

As for mentally disordered offenders, the new broad definition of mental disorder will apply, and the current range of remand powers for assessment and for treatment under ss. 35 and 36, and the interim hospital order under s. 38 will be replaced by a single power of remand for assessment or treatment based on a single medical recommendation. However, a second medical recommendation will be required before compulsory treatment can be given. The remand may be to detention in hospital or on bail, and will be available to both magistrates and higher courts. Remand will be for an initial period of 28 days renewable by Court for up to a year.

There are three provisions in English law for protective sentencing, life imprisonment, protective sentencing under sections 1(2)(b) and 2(2)(b) (longer than normal) of the Criminal Justice Act 1991, and the new procedures for mandatory minimum sentences in the Crime (Sentences) Act 1997, whereby conviction of a second serious violent or sexual offence attracts a mandatory life sentence. These comparatively recent developments are intended to bring about wider use of indeterminate sentencing in the penal system, although the Government is clearly disappointed that these powers are not being used as extensively as they had hoped. They are also concerned about the numbers of prisoners with personality disorders who are coming to the end of determinate sentences and will be entitled to release regardless of risk.

Where an offender is suffering from mental disorder in the new broad sense, it will be open to any criminal court to impose a care and treatment order which will last for six months before requiring to be continued by the Mental Health Tribunal. Where a mentally disordered offender poses a significant risk of serious harm to others or because of the nature of the offence or previous convictions, the court may impose a care and treatment order with restrictions. This will be applicable only where the care and treatment order is based on detention in hospital. The major disadvantage of hospital and restriction orders from the Government's point of view is that a patient may be entitled to discharge by a Mental Health Review Tribunal if no longer mentally disordered before he or she has served a period of detention proportionate to the gravity of the offence. The Government seeks to rectify this by extending the availability of the hospital and limitation direction, which currently applies only to offenders with psychopathic disorder, to all offenders suffering from mental disorder in the new broad sense. This will enable the court to have the option of combining criminal justice tariff with an order for care and treatment under the mental health legislation. Patients will be able to be transferred from prison as under current

legislation, but on expiry of their sentence, continued care and treatment will have to be authorised by the MHT.

The proposals for mentally disordered offenders show some small but significant changes to the current framework. These are broadening the definition of mental disorder which will form the basis of a hospital disposal, simplifying the remand powers for treatment and assessment, extending the hospital and limitation direction to all mentally disordered patients, and to comply with the Strasbourg decision in *James Kay v United Kingdom*⁴⁰ the introduction of express statutory criteria for recall of restricted patients to hospital. Unless it is an emergency the authorities must satisfy themselves that the patient continues to suffer from a mental disorder within the meaning of the new legislation and is failing to co-operate with care plan, and/or his continued presence in community poses risk of serious harm to others and/or the care and treatment needed cannot safely be provided in the community. The most significant changes are in the provision made for the involvement of criminal justice agencies in mental health care decisions, a development which is largely fuelled by the Government's desire to manage the problem of Dangerous People with Severe Personality Disorder.

High Risk Non-Offender Patients

The primary focus of the *High Risk Patients* proposals is on Dangerous People with Severe Personality Disorder (DPSPD patients). Having put forward two options, one involving the use of existing prison and health service institutions, the other involving the development of new specialist 'third way institutions'⁴¹, the Government has not taken a final decision on how services will best be provided long-term. However, it will 'bring forward the legislative changes required' whichever option is chosen, and there will be a 'new framework for the detention of DPSPD in a therapeutic environment for as long as they pose a risk to others as a result of mental disorder.'⁴²

The new powers 'will apply to individuals in civil proceedings as well as those sentenced for an offence', that is, it will not be necessary to be convicted of an offence to be subject to detention. However, the Government assures us that in practice, the nature of the assessment process (12 weeks long) means that it is highly unlikely that any individual without a long track record of increasingly serious offending will be affected by these new powers.⁴³ Although the Government is worried about this group, they offer only a working definition. The person must show significant disorder of personality and present a significant risk of causing serious physical or psychological harm from which the victim would find it difficult or impossible to recover e.g. homicide, rape, or arson. The risk presented must appear to be functionally linked to his personality disorder. The Government intends to 'refine the definition during the pilot period as we develop a clearer picture of the nature and characteristics of this group.'⁴⁴ The 'treatability' requirement in the current legislation is described as 'unhelpful' as it has neither met the needs of patients nor helped to give the public the protection it needs. The new 'civil admission' procedures will in the Government's view provide the unambiguous authority to detain individuals who would fall within the DPSPD group where appropriate interventions are offered to tackle the individual's high risk behaviour. In all cases treatment will be delivered in an appropriate therapeutic environment.

40 *James Kay v United Kingdom* (1998) 40 BMLR 20

42 Cm 5016-II, para. 2.12.

41 Home Office and Department of Health, *Managing Dangerous People with a Severe Personality Disorder* July 1999.

43 *Ibid.*, 2.13

44 *Ibid.*, para. 2.18

The important aspect of the new civil procedures is that they enable pressure to be exerted by criminal justice agencies on mental health professionals to assist in managing risk. We have already seen how police and criminal justice agencies will be able to request a mental health assessment and will be entitled to reasons if compulsory powers are not used. The Sex Offenders Act 1997 puts a duty on the police to monitor those offenders who are on the sex offender register, and MARPs have been set up to meet these requirements. The White Paper reports that 'Many panels have subsequently extended their remit to respond to the risks posed by other potentially dangerous offenders in their communities and a range of other agencies are now involved in local arrangements, led by police and probation services.'⁴⁵ The Criminal Justice and Court Services Act 2000 places a statutory duty on police and probation services to establish arrangements for the assessment and management of risks posed by relevant sexual or violent offenders in the community and to monitor those arrangements. The duty extends to patients who have been detained on a hospital order as well as those sentenced to imprisonment, so that information will have to be shared with police when violent or sex offenders are discharged from hospital.

If compulsory powers to assess non-offender patients are used at the request of criminal justice agencies, they, and other agencies involved in formal risk management arrangements in the community (i.e. Multi-Agency Risk Panels (MARPs)) will be able to provide evidence before the tribunal, independent of the assessment of the clinical team. This may include evidence of previous criminal behaviour. Tribunal will have a duty to consider such evidence in making its decision. When a tribunal orders supervision in the community, this may include involvement of MARPs.⁴⁶

The White Paper also indicates the Government's intention to introduce a 'new statutory duty covering the disclosure of patient information between health and social services and other agencies for example housing and criminal justice agencies where it is justified, for example in the public interest.' The new duty is intended to 'support these new risk management arrangements led by the criminal justice system.'⁴⁷

The purpose of these provisions is to bridge the information barriers between health and social services with their emphasis on individualistic health and social care values such as confidentiality, and the police, whose primary task is risk management. This necessarily entails the incorporation of the police into what previously were health and social care decisions. The right of privacy under Article 8 of the European Convention allows for exceptions to the confidentiality of medical records if it is in accordance with law and necessary in a democratic society for the prevention of crime, for health, or for the protection of the rights of others. Given the breadth of these exceptions, it is unlikely that the new statutory duty of disclosure would fall foul of Article 8, provided that those making decisions to share information without the consent of the subject observe the requirement to restrict this to a need to know basis, and to bear in mind the principle of proportionality, that the method chosen to achieve the protection of the public interest does not go beyond what is strictly necessary for that purpose. The provisions on information sharing are a classic example of risk management values justifying exceptions to the medical principle of confidentiality. It also shows a desire to limit clinical discretion by imposing a duty to share information, and it also opens up the possibility of a *Tarasoff* type action for breach of that statutory duty, if a person suffers damage as a result.⁴⁸

45 *Ibid.*, paras. 5.4 - 5.6.

46 *Ibid.*, paras. 3.22-3.23.

47 *Ibid.*, para. 5.7.

48 *Tarasoff v Regents of the University of California* (1976) 551 P.2d 334 (Cal.Sup. Ct.).

Safeguards

The current system of safeguards for patients rights is based on local review of the need for detention by hospital managers, formal review of detention by the Mental Health Review Tribunal and the supervisory role of the Mental Health Act Commission which visits and interviews detained patients, reviews the handling of their complaints, and oversees the system of statutory second opinions under Part IV of the 1983 Act. The White Paper affords a central role to the new Mental Health Tribunal, and abolishes the review function of the hospital managers. The Mental Health Act Commission will be replaced by a Commission for Mental Health, which will consist of representatives of users, carers and the key professional bodies. Its remit is described as being 'similar to that of the existing Mental Health Act Commission but without its current responsibilities for visiting':

Instead there will be a fresh emphasis on monitoring the implementation of the safeguards which ensure that compulsory powers are properly used. It will have significant new responsibilities for collecting and analysing information, and overseeing standards of professional advocacy and training for practitioners with key roles under the new legislation. It will also have an important role in overseeing the arrangements for the care of patients with long-term incapacity under the new legislation.⁴⁹

Issues of quality and consistency of services will be matters for the Commission for Health Improvement or the National Care Standards Commission. The role of the Commission in relation to complaints will be taken on by the new specialist Patient Advocacy Liaison Service (PALS). The Commission will have a particular remit to advise the Secretary of State as to whether the powers in the Act are being used in a manner consistent with the principles, set out in Chapter 2 of the White Paper, which 'will be set out in a way that provides a clear context for decisions about when and how the new powers should be used.'⁵⁰ The principles are that the new legislation will be compatible with the Human Rights Act 1998, that decision-making will be conducted openly and fairly, with respect for patients individual characteristics such as age, gender, ethnicity and religion, that formal powers will not be used as an alternative to securing the agreement of people whose disabilities result in communication difficulties, that mentally disordered people will be treated in such a way as to promote to the greatest degree their self-determination and personal responsibility, that care and treatment will involve the least degree of restriction consistent with ensuring that the objectives of the treatment plan are met, and that formal powers should only be used with good cause and when alternatives have been considered.⁵¹ None of these principles is new. They are all currently stated in the Mental Health Act Code of Practice.⁵² It is not clear from the White Paper whether these will be specified in the legislation itself or in a new Code of Practice.

There will continue to be a statutory system of second opinions based largely on the existing system, but provided by doctors and others appointed by the Commission for Mental Health to give expert evidence to the MHT. 'The function of the second opinion doctor will be to consider whether the treatment is consistent with acceptable practice in the treatment of patients with mental disorder.'⁵³ The major difference will be that psychosurgery, which cannot currently be administered unless the patient is capable of consenting and has consented, will be able to be given

49 Cm 5016-1, para. 7.8.

50 *Ibid.*, para. 2.8.

51 *Ibid.*, paras. 2.7 – 2.12.

52 Department of Health and the Welsh Office, *Mental Health Act Code of Practice (1999)*, para. 1.1.

53 Cm 5016-1, para. 5.25.

if approved by the High Court.⁵⁴ There will be guidance in the new Code of Practice on the administration of polypharmacy, and of drugs in excess of British National Formulary upper dose recommendations, and the tribunal, in considering the treatment plan, will consider how and to what extent the treatment plan takes account of any guidance in the code.⁵⁵

The new Mental Health Tribunal will be the most important of the institutions providing safeguards. It will authorise compulsory care and treatment, and it will review the continued need for such compulsion. When a patient is admitted for assessment, his or her clinical supervisor will in an appropriate case, make a recommendation to the MHT for a care and treatment order. The MHT will then decide, on the basis of the evidence, whether the conditions for continuing care and treatment under compulsion are met. In making its decision the MHT is required to consider the proposed care and treatment plan and the report from the panel medical expert and any evidence put by the patient or his or her representative.⁵⁶

It seems that the Government will reverse the notorious negative burden of proof in that the MHT will have to be satisfied that the criteria for compulsory care and treatment are met before initiating or renewing an order. However, there is some lack of clarity as to whether the MHT will have a power or a duty to make an order if so satisfied. Paragraph 3.43 says that 'If the MHT considers that the criteria are met and the care and treatment plan is appropriate it *will* make a care and treatment order.' Paragraph 3.49 says that 'If the tribunal is satisfied that the conditions for compulsory care and treatment are satisfied, it will have *the power* to approve a care and treatment order. If conditions are not met, the patient will be discharged.' Finally, Paragraph 3.50 states that the Tribunal will be '*required* to make a care and treatment order if care and treatment plan proposed by patient's clinical supervisor meets the criteria set out in the legislation, and is appropriate in all the circumstances. Legislation will include provision for the situation where care and treatment order is warranted but treatment plan is inappropriate.' Where the patient is not liable to detention following a court order (i.e. is a non-offender patient) he or she will have the right, to request that the MHT review any order for compulsory care and treatment lasting longer than three months. 'The purpose of the review will be to determine whether the current arrangements under compulsory powers are *appropriate*.'⁵⁷ Leaving aside the question of whether there will be a power or a duty to make an order when the criteria are satisfied, this will involve the tribunal in a whole new range of questions concerning the appropriateness of treatment, and will significantly increase the duration of tribunal hearings.

The MHT's powers will include the power to make 'flexible orders.' The care and treatment order will include a treatment plan, and the tribunal will be required to consider the appropriate location for treatment, and whether care under detention is necessary. It will have the power to specify duration up to the statutory maximum. Where the patient is not detained the treatment plan will specify which aspects of the care plan are compulsory, and the consequences of non-compliance. Where the patient subject to a care and treatment order outside hospital those responsible are required to ensure that services provided in a manner enabling the patient to comply. Patients will not be charged for service specified in the order as something they must comply with.⁵⁸ If the patient is detained, the plan will specify whether he or she may be granted leave or discharged by the clinical supervisor, or whether these powers will be reserved to the MHT.⁵⁹

54 *Ibid.*, para. 5.19.

55 *Ibid.*, para. 5.23.

56 *Ibid.*, para. 3.48.

57 *Ibid.*, para. 3.61.

58 *Ibid.*, paras 3.56-3.58.

59 *Ibid.*, para. 3.51.

In each case involving a care and treatment order, the patient will be seen by a member of the expert panel prior to the hearing. The Government envisages that there will not necessarily be a hearing to approve a care and treatment order. A hearing will be required where the patient requests or there is a difference of opinion between clinical supervisor and expert panellist. Otherwise the tribunal will review the case on the papers which must include the expert panellist's opinion.⁶⁰ A further important development is the introduction of rights for victims and their families to make representations to the MHT against an offender patient returning to the area of the index offence.

The Tribunal and the Commission for Mental Health will also play a key role in providing safeguards for people with long-term incapacity, filling the so-called 'Bournewood Gap' identified by Lord Steyn in *R v Bournewood Community and Mental Health NHS Trust ex parte L*.⁶¹ The new legislation will place a duty on clinical supervisors to carry out an assessment and obtain an independent second opinion from an expert panellist, where patients with long term incapacity are assessed as needing long-term care and treatment for serious mental disorder from specialist mental health services in their best interests. This will apply to patients admitted to hospital or residential care home, but not to those living at home.⁶² The clinical supervisor will be required to arrange a full assessment and develop a care plan on the basis of the care programme approach and the Care Plan Guidance in Wales. This must cover all aspects of care and treatment including steps to restrict patients' freedom such as locking of doors or routine sedatives. All interventions must be in patient's best interests. The clinical supervisor must arrange for doctor from Tribunal Panel to examine the patient. The doctor from the panel will discuss the proposed care and treatment plan with supervisor and may suggest changes.

In drawing up the treatment plan the clinical supervisor must consult the patient's close relatives and carers, and consult the social care representative who nominates a person to represent the patient. The clinical supervisor must notify the Commission for Mental Health that a plan is being drawn up and, unless there are exceptional circumstances, finalise it within 28 days. The supervisor must then place on record with the care and treatment plan a note that in his or her opinion the care and treatment plan is in the patient's best interests. The supervisor must also certify that the patient is not actively resisting treatment and does not pose a significant risk of serious harm to other people, otherwise it will be necessary to seek compulsory powers. The patient or his or her representative will be able to apply to the MHT either to challenge detention or to seek review of the care and treatment plan, for example on the grounds that it is not in the patient's best interests. MHT will commission new report from a member of its medical panel, and will also consider evidence from the clinical team, and, if appropriate, from carers and close relatives. The clinical supervisor will be required to take account of changes suggested by the MHT and if necessary submit a revised care plan to the MHT for formal approval. However the expectation is that any dispute would be resolved informally through discussion with the clinical team without recourse to the tribunal.⁶³ The Government has chosen to provide this form of safeguard in preference to an Incapacity Act, whereby care managers or health care attorneys could be appointed by a new locally based Court of Protection. The danger is that the Mental Health Tribunal will be overwhelmed by a vast increase in its case load. Between 1986 and 1998 the number of tribunal

60 *Ibid.*, para. 3.63.

61 [1998] 3 All ER 289. See further P. Fennell, 'Doctor Knows Best? Therapeutic detention under Common Law, the Mental Health Act, and the European

Convention' (1998) 6 *Med Law Rev* 322-353.

62 Cm 5016-I, para. 6.5.

63 *Ibid.*, paras 6.7 - 6.13.

hearings held annually increased from 2972 to 9,057.⁶⁴ The new proposals are likely to lead to an even more dramatic increase in case load, even with the provisions for paper review rather than personal hearings, and will undoubtedly lead to longer hearings, since the tribunal will be looking not only at the need for compulsion, but also at the nature and quality of the treatment plan.

Conclusion

The proposals in the White Paper involve a radical change in the legal framework of compulsory mental health care. They place a premium on risk management with significant consequences for the psychiatric system, and the relations between psychiatrists, psychologists and the state. The Government appears to be just as worried about psychiatrists who will not co-operate in its risk management project as it is about uncooperative patients. A prime aim of the proposals is to introduce uniformity and accountability of psychiatric decision-making and to encourage the use of compulsory powers. It does this by broadening the discretionary powers to impose compulsory treatment and by removing any provisions which give clinicians discretion not to impose treatment under compulsion. It is for this reason that the Government is keen to avoid use of concepts like incapacity which are open to subjective judgment. The proposals will alter the relationship between psychiatrists and their patients in subtle and sometimes not so subtle ways, imposing duties to disclose information where a patient is thought to pose a risk of harm to others. They will also alter the balance between the rights of the family and the power of the state in relation to psychiatric compulsion by replacing nearest relatives with nominated persons with more limited powers.

The White Paper will also bring about a convergence, bordering on merger between the psychiatric system and the penal system and the legal status of prisoner and patient. With increasing use of life sentences, prisoners and patients will be subject to indeterminate detention and on release to indefinite supervision and liability to recall. Prisoners who are subject to determinate sentences may be referred by criminal justice agencies for assessment and possible detention under civil powers on expiry of their sentence if they pose a continued risk and are suffering from mental disorder in the new broad sense. Police, probation and other criminal justice personnel are to be given a role in clinical decision-making.⁶⁵ The Government's statement of its determination to challenge the distorted image of mental disorder and to combat the social exclusion that can result from it' is undoubtedly sincere. However, it must be said that the injection of criminal justice values, practices and personnel into psychiatric decision-making calls into question whether the new legal framework will help or hinder health and social services in meeting Standard One of the National Service Framework for Mental Health, when they seek to 'combat discrimination against individuals and groups with mental health problems and promote their social inclusion.'⁶⁶

64 *Mental Health Review Tribunals for England and Wales Annual Report 1997-8*, Department of Health 2000, p. 51.

65 This argument is more fully developed in P. Fennell and V. Yeates, *To Serve Which Master? Criminal Justice*

Policy, Community Care and the Mentally Disordered Offender in A Buchanan, *Community Care of the Mentally Disordered Offender* (2001) Oxford University Press, Chapter 13.

66 Cm 5016-I, para. 1.12.