

# Some thoughts on the proposed Mental Health Act

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Our thoughts on the proposed Mental Health Act are a product of us working together for a considerable period of time and feeling that we have something to offer jointly by bringing together our legal and psychiatric perspectives.

## Main concern with the basis of the proposed Mental Health Act

The main thrust of our thoughts is that we have a fundamental problem with the reform of mental health law as proposed.<sup>1</sup> We are beginning to question whether there is any need for a mental health act at all.<sup>2</sup> In any case, legislation which interferes with the freedoms of others should, we believe, be predicated on the libertarian model as espoused by John Stuart Mill. He stated, in his essay *On Liberty*, that.

“... the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.”

This is a philosophical statement that is echoed in the most famous legal version by Cardozo CJ in *Schloendorff v New York Hospital*<sup>3</sup>:

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault...”

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1 Despite its omission from the Queen’s Speech at the commencement of the Parliamentary Session 2002–3 (The Times 14th November, pp. 42 and 15), a Bill is to be introduced (The Times 15th November, p. 12).

2 This is a line of thought that we intend to pursue further.

3 (1914)105 N.E. 92. The same position is taken by the English courts, see Lord Goff in *Re F* [1990] 2 A.C. 1 at p. 72; Lords, Keith, Goff, Browne-Wilkinson and Mustill in *Airedale NHS Trust v Bland* [1993] A.C. 789 at pp. 864, 857, 882 and 891 respectively; Lord Reid in *W v W* [1972] A.C. 24, at p. 43; and Judge L.J. in *St George’s Healthcare NHS Trust v S* [1999] Fam 26, at pp. 43–50.

Therefore, the first requirement is to determine whether a person is capable of making their own decisions (i.e. is not of “sound mind”). If capable, they make their own decisions, unless an interference is warranted as above. If not capable, decisions must be made on their behalf. Whilst the law has developed since the decision in *Re F*<sup>4</sup> to produce a test for incapacity<sup>5</sup> and to expand the types of factors to be taken into account when declaring the legal position in relation to an incapacitated adult,<sup>6</sup> we firmly hold to the view that there is still a requirement for legislation. The introduction of a Mental Incapacity Act would provide still needed clarity and ensure that decisions can unequivocally be made<sup>7</sup> in all areas<sup>8</sup> when needed.<sup>9</sup> This legislation should come first.<sup>10</sup> Thus, where a person has a mental disorder that impairs their decision-making capacity, the first requirement would be to determine if they were capable of making their own decisions. If not, such decisions would be made under the auspices of a Mental Incapacity Act which would produce decisions in the best interests of the incapacitated adult.<sup>11</sup> If someone is capable of making the decision, that must then be binding and advanced refusals should, where valid, be binding.<sup>12</sup>

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4 [1990] 2 A.C. 1. Subsequently, it has become clear that (a) the courts are looking for there to be a “serious justiciable issue” to trigger the jurisdiction of the High Court to make a declaration; this may be no different from the need to look for a civil wrong to which a defence, such as necessity, was required, as was the analysis by the House of Lords in *Re F*, but it is open to a broader interpretation. In fact, in all the subsequent decisions it is possible to identify a civil wrong; (b) the jurisdiction to issue the declaration is not limited to an assessment of best medical or scientific interests, but best interests “encompasses medical, emotional and all other welfare issues”, per Butler Sloss P. in *Re A* (medical treatment: male sterilisation) [2000] 1 F.C.R. 193, and see *Re F* (adult: court’s jurisdiction) [2000] 3 F.C.R. 30; and (c) it is for the court to determine what is in the incapacitated adult’s best interests on the basis that there can only be one option that is in her/his best interests: *Re S* (Adult Patient: Sterilisation) [2001] Fam 15.

5 See, now, *Re MB* [1997] 2 F.L.R. 426; and see *Re C* [1994] 1 All E.R. 819 and *Re T* [1993] Fam 95.

6 See above, n. 4.

7 So the jurisdiction would not be merely declaratory. Even though the distinction between the declaratory nature of English law and the old Scottish law based on *parens patriae* is minimal (see *Law Hospital NHS Hospital Trust v Lord Advocate* 1996 SLT 848), it could have significant effects not least in requiring cases to be taken to court. Further, see n. 8 below.

8 Subject to the caveat that some decisions are so personal that no one should ever be able to make them on behalf of an incapacitated adult, such as the decision to marry. See, further, Law Commission (1995) *Mental Incapacity* (Report no. 231) at para. 4.29, and the accompanying Draft Mental Incapacity Bill, clause 30.

9 Technically a declaration is only applicable between the parties before the court, though they tend to have wider application in fact. Decisions made under a Mental Incapacity Act would have general applicability. On

declarations, see Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity) [2001] 2 F.L.R. 158.

10 We are not the first to make this sort of proposal, see Price, D.P.T., “Civil Commitment of the Mentally Ill” (1994) 2 *Medical Law Review* 321, but we have propounded it before, see Zigmund, A. and Holland, A.J., “Unethical Mental Health Law: History Repeats Itself” (2000) 3 *Journal of Mental Health Law* 49, and Gunn, M., “Reforms of the Mental Health Act 1983: The relevance of capacity to make decisions” (2000) 3 *Journal of Mental Health Law* 39. For a different perspective, see Robinson, R., “Capacity as the Gateway: an alternative view” (2000) 3 *Journal of Mental Health Law* 44.

11 Best interests as a concept has presented some problems, e.g. to Lord Mustill in *Airedale NHS Trust v Bland* [1993] A.C. 789, at p. 897 where he thought that *Bland* had no interests. In Scotland, the approach has been to avoid use of the concept of best interests and, instead, to provide a set of general principles to assist in decision-making on behalf of an incapacitated adult, see *Adults with Incapacity* (Scotland) Act 2000, s. 1.

12 Of course, establishing validity and applicability is never easy but assuming those requirements are present, such advance refusals should apply to all forms of treatment including treatments for mental disorder. It is for reason of the practical problems and some concern that its presence might make passage of any Mental Incapacity Bill through Parliament difficult (which are the reasons for not codifying the *Bland* rules and for not introducing statutory rules on research and people with incapacity) that the Government, in its consultation process, has not decided whether to have advanced refusals within any future Mental Incapacity Act, see Lord Chancellor’s Department, *Making Decisions: The Government’s proposals for making decisions on behalf of mentally incapacitated adults* (1999, Cm 4465), at paras. 13–20.

A Mental Health Act would exist only to cover those circumstances where the person presented a danger to others and so interference could be justified on that basis, notwithstanding the person's capacity to make decisions or even their refusal to accept treatment. Once detained, the logic would suggest that treatment could only be provided for the reason that permitted the initial detention, so any treatment falling outside that justification would have to be authorised either with a capable person's consent or through the Mental Incapacity Act for an incapable person. So, treatments to reduce the risks presented to others would be the only treatments for mental disorder that would be permissible.<sup>13</sup> The Mental Health Act would not permit interference where it was for the interests of the person affected. Therefore, we would fundamentally restructure the legislation package. For the draft Mental Health Bill this would mean no ability to admit, detain and treat any person on the basis of their own health and safety. Thus, any future Mental Health Act would be considerably narrower in scope than at present or as proposed. Most decisions affecting people not capable of decision-making would fall within a Mental Incapacity Act, subject to the possibility (as with people capable of decision-making) of that procedure being overridden by use a Mental Health Act.<sup>14</sup> Whilst we recognise that the draft Mental Health Bill does, to some extent, endeavour to take capacity and autonomy more seriously,<sup>15</sup> we feel that it does not go far enough.

### Dangerous and severe personality disorder

What would this say for the proposals for dangerous and severe personality disorder? Provided there was evidence to establish that there is such a diagnosable condition and that the consequences of it in terms of harm to others could be predicted, there is no reason why such proposals should not be introduced subject to the requirement that there be serious attempts to ameliorate the condition and to avoid incarceration wherever possible. However, the significant problems are

13 Currently, the treatments may not effectively be even limited to treatment for the mental disorder because of the extended meaning provided for section 63 in *B v Croydon H.A.* [1995] Fam 133. Hoffmann L.J., at p. 138, interpreted s. 63 to extend to treatment that was "ancillary to the core treatment" (authors' underlining) and the latter being the treatment that warranted compulsory admission to hospital under the Mental Health Act). He went on later on the same page to expand upon when treatment might be ancillary. Bartlett, P. and Sandland, R., *Mental Health Law: Policy and Practice* (2000), at pp. 220–227, make the interesting point that, where a patient's life is at risk, the extended definition of s. 63 more readily is applied. Probably, the law now, rather, is that there must be a sufficient connection to warrant the application of section 63. Such a sufficient connection was to be found in *B v Croydon H.A.* and in *Tameside and Glossop Acute Services Trust v CH* [1996] 1 F.L.R. 762 (though this case can alternatively be viewed as a bad decision), but not in *Re C* (adult: refusal of medical treatment) [1994] 1 All E.R. 819 nor in *Re JT* (Adult: Refusal of Medical Treatment) [1998] 1 F.L.R. 48. Support for this approach is to be found in *St. George's Healthcare N.H.S. Trust v S* [1999] Fam. 26 where Judge L.J., at p. 52, stated that "Section 63 may apply to the treatment of any condition which is integral to the mental disorder" (authors' underlining). Whilst Judge L.J. purported to be following *B v Croydon H.A.*, it seems more likely that this has

limited its extent in a manner that will receive approval and be followed in the future. Further Judge L.J. in that case thought that there would not have been a sufficient connection for s. 63 to apply.

14 Implicit here is the proposition that, where a capable person (because of their risk to others) would be detained under a Mental Health Act, so also should an incapable person, even if the Mental Incapacity Act might apply. Thus the legislation would be more readily compatible with the non-discrimination principle most clearly propounded by the Richardson Committee (Expert Committee, *Review of the Mental Health Act 1983* (Department of Health, 1999) available at [www.doh.gov.uk/mhar.report.htm](http://www.doh.gov.uk/mhar.report.htm); and see the February 2000 issue of the *Journal of Mental Health Law*).

15 For example, there is a commitment that the Code of Practice should set out general principles to further patients' autonomy, however, "the draft Bill does not spell out the central role of these considerations, and would not impose a statutory obligation on decision-makers to give effect to them: breach of the Code would not seem to make a decision or action unlawful...." (The House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill* (25th Report of the Session 2001–02; HL Paper 181; HC 1294), at para. 21). And so the matter should not be left to a Code (para. 22).

whether it is indeed diagnosable with sufficient accuracy and, more tellingly, whether the requisite level of harm can be predicted in an individual case.<sup>16</sup> In particular because of weakness in the latter, it is not likely to reach the level of certainty necessary for interference with freedoms on the basis of anticipated harm and so incarceration must be based upon the commission of harm to others and it being a response to that actual harm and its future prevention.<sup>17</sup> What the draft Bill contains is the facility to be able to detain people where they need treatment, but that treatment does not involve relieving their disorder. This is clarified by the more extended definition of “medical treatment”, which now explicitly covers “education, and training in work, social and independent living skills.”<sup>18</sup> Further, there is no equivalent of the treatability requirement that appears in the 1983 Act. Thus, “the effect of [the relevant conditions] taken together with the broad definitions of ‘mental disorder’ and ‘medical treatment’ ... would be to permit the compulsory detention and care of people for the protection of others when the people detained have never been charged with any criminal offence and nothing can be done to alleviate the mental disorder from which they are suffering. This raises human rights issues, flowing mainly from the breadth of the circumstances in which a patient could be subjected to compulsory, non-consensual, treatment.”<sup>19</sup> This more eloquently puts our point. Whilst the proposal is compliant with the European Convention on Human Rights even though the detained patient may not be truly treatable,<sup>20</sup> this is an example where ECHR compliance does not produce a good or proper result.<sup>21</sup>

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16 This latter point is also strongly made by the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at paras. 43–47.

17 See also the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 35.

18 *Draft Mental Health Bill*, clause 2(5). This may be regarded as a clarification rather than an extension of the meaning of “habilitation” which appears also in the definition of medical treatment in the *Mental Health Act 1983*, s. 145.

19 *The House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 37.

20 *A v Scottish Ministers* [2001] S.L.T. 1331. The view of the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181;

HC 1294), at para. 34, is that there are signs, which really are not very clear at all, that a treatability requirement will be introduced by the European Court. That is a proposition with which we would agree, but, like the Committee, find it hard to make the case a convincing one on the basis of the existing jurisprudence. The other approach is to argue that in some cases the failure to treat might involve a breach of Article 3 as there is inhuman or degrading treatment or punishment. Owing to the high threshold before breach is established, this will not be an easy argument, but, using *Kudla v Poland* (2000) application no. 302190/96, the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 35, makes the case.

21 Further, the judgments are relatively old and “it would in our view be a mistake to restrict attention to judgments delivered as long ago as 1979 and 1985:” *The House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 34.

## The Bournemouth gap

A further consequence of our approach is that there is no need for Part 5, i.e. the proposals for dealing with the so-called *Bournemouth* gap.<sup>22</sup> If a person is not capable of making a decision to be a voluntary patient, such a decision should be made under a Mental Incapacity Act. Admission would be possible, but only if it were in the best interests of the incapacitated adult. As there would be measures for protection from exploitation and abuse within a Mental Incapacity Act, no need for Part 5 arises. It is perhaps only in the proposed Bill because a Mental Incapacity Act is not currently in the Parliamentary timetable. The Government accepts the need to introduce one when Parliamentary time allows.<sup>23</sup> On some of the particular points made in Part 5, one interesting comparison is with the approach that the Government proposes to take with regard to children. The two appear to be inconsistent when the differences between the two groups do not support such a markedly different approach. It is the opinion of the House of Lords and House of Commons Joint Committee on Human Rights, that children are inadequately protected by the draft Mental Health Bill and that a preferable approach would be to apply the system in Part 5 also to children.<sup>24</sup> What Part 5 of the draft Mental Health Bill provides is (a) a statement of those cases where informal treatment is not available, that is where an incapable patient either would resist treatment or “is at substantial risk of committing suicide or causing serious harm to other persons;”<sup>25</sup> And (b) provisions whereby the status of a “qualifying patient” is created.<sup>26</sup>

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22 *The House of Lords in R v Bournemouth Community and Mental Health N.H.S. Trust, ex parte L* [1999] 1 A.C. 458 decided that an informal patient, under the Mental Health Act 1983, s.131, is someone who is incapable and compliant. Section 131 permits their admission to hospital notwithstanding that they are not capable of decision-making (those patients going into hospital after consenting are voluntary rather than informal admissions). The gap that this leaves is obvious. There is no protection for informal patients as, if they are not competent to decide whether to enter hospital, they are not in a position to exercise the normal protections (leaving hospital, saying no to treatment, and seeking legal advice). However, neither are there any agencies designated with oversight of their condition (the remit of the Mental Health Act Commission to informal patients has never been introduced as the Mental Health Act 1983, s. 121(4) has never been implemented). Whilst it is entirely possible that the vast majority of such patients will be properly cared for, because the staff will act properly and appropriately, there is no mechanism to ensure that the compliant, incapacitated patient's interests are properly preserved and protected.

23 Indeed the signs from the Lord Chancellor's Department through its Mental Incapacity Consultative Forum (of which Gunn is a member) are that this is a serious commitment, but any Bill will not be before Parliament before the 2003–04 Parliamentary session at the very

earliest, see LCD Press Statement, “Government Proposals to Codify Law on Mental Incapacity” 16th December 2002.

24 *The House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 80.* The Committee is of the view that the proposed approach in relation to children under 16 “leaves them under-protected compared to adults, and may lead to violations of their rights under the ECHR and under Article 25 of the [Convention on the Rights of the Child]” as “[d]ecision-making for these child patients would be left to parents or guardians and the professionals, without the need for independent scrutiny or review of treatment decisions.” However, that accords with the current system for decisions in other areas, and so the question is whether the fact that it is mental health problems that are involved is a sufficient reason to vary the system. If the Mental Incapacity Act takes priority, then there is no need to separate out this issue within a Mental Health Act, but it may be the case that more protections for children under 16 need to be considered for all types of decisions, whether involving mental health care or not.

25 Clause 121(1) - (3). Where a patient has at any time indicated that they would not want the treatment, it is to be presumed that they would resist that treatment: clause 121(4).

26 Clause 122.

A qualifying patient is someone who satisfies certain criteria<sup>27</sup> and for whom a clinical supervisor is appointed.<sup>28</sup> The relevant criteria are:

- (a) the patient is 16 or more
- (b) the patient is suffering from mental disorder
- (c) that mental disorder is of such a nature or degree as to warrant the provisions of medical treatment to the patient
- (d) it is necessary for the patient to be resident at a hospital for the treatment and that requirement is likely to continue for at least 28 days
- (e) the patient is incapable of consenting to the treatment and that condition is likely to continue for at least 28 days
- (f) the treatment can lawfully be provided without the need for Part 2.

Putting the proposals together means that the treatment will be administered in accordance with the common law.<sup>29</sup> Quite clearly, this is, therefore, in the wrong piece of legislation. What Part 5 does endeavour to do is to provide some safeguards for such patients. Before examining them, it is worth recognising that one of the weaknesses with the current proposed Mental Incapacity Act is the reliance on the general authority to act reasonably in relation to an incapacitated adult without the need for special procedures (except in certain specified cases). The ultimate protection is the ability to have disputes resolved by a judicial forum, but disputes only arise where there are two parties at odds. This may not occur when it is the carer or a professional, etc making decisions about an incapacitated adult. It is possible that the safeguards in the draft Mental Health Bill might be worthy of introduction to the general authority so as to preserve it as an essential element of any Mental Incapacity Act. Under the draft Bill, it will be the responsibility of social services (having been notified by the hospital) to “notify the patient of the help available from mental health advocates,” “to appoint a person to act as the patient’s nominated person” and “to notify the nominated person of the help so available.”<sup>30</sup> The nominated person will have a key role as they should be involved in treatment decisions and, if it appears to him or her that the patient would not have consented to the treatment, the clinical supervisor is to be informed and the treatment is not to go ahead “except in a case of urgency.”<sup>31</sup> Why urgency should be a sufficient reason to override what is a form of advance refusal is mysterious. There may be criteria to be introduced here, though we would have thought that an advanced refusal should take priority since the English courts do not recognise any state interests as being sufficient to override the decision of a competent adult.<sup>32</sup> However, this Part operates on a more paternalistic basis, but even then simply a case of urgency would not be sufficient warrant to interfere with the patient’s wishes. What might be sufficient, if a paternalistic approach is accepted, might be a treatment that is life-saving or preventing a serious deterioration in their condition. Any treatment will need to fall within the care plan that must be drafted by the clinical supervisor within 28 days of his or her appointment.<sup>33</sup>

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27 Clause 125.

28 Clause 123.

29 See above, n. 4.

30 Clause 127(2)

31 Clause 128.

32 See *Secretary of State for the Home Department v Robb* [1955] 1 All E.R. 677, and *Re T (Adult: Refusal of Treatment)* [1993] Fam. 95. The apparently contrary decision in *Re S (Adult: Refusal of Treatment)* [1993] Fam. 123 was properly overruled in *Re MB (Medical Treatment)* [1997] 2 F.L.R. 426.

33 Clause 129(2).

The clinical supervisor is obliged to consult the patient and the nominated person, if practicable.<sup>34</sup> That care plan must then be approved by a medical adviser.<sup>35</sup> The care plan must be reviewed every 12 months.<sup>36</sup> Finally, the patient and his/her nominated person has a right of application to the Mental Health Tribunal to seek their discharge, despite not being detained.<sup>37</sup> The tribunal will discharge the patient if “satisfied that [they are] being unlawfully detained at the hospital.”<sup>38</sup> We would agree with the following overall assessment of the House of Lords and House of Commons Joint Committee on Human Rights, although the Committee is concerned that the system does not apply to non-resident patients or patients in residential homes. The latter is clearly impossible to justify, since the only difference is type of venue,<sup>39</sup> the former is hard to justify, especially when account is taken of the fact that, under the Mental Incapacity Act it is the decision and its effect that matters not where someone happens to be. If the regime is to exist at all, it should apply to all compliant, incapable patients.<sup>40</sup>

“We welcome the clear structure for decision-making which the draft Bill would introduce in relation to the treatment of ... informal patients. We also welcome the element of independent review by medical adviser and MHT, and the ability of the nominated person to trigger those mechanisms. We consider that these steps constitute major protections for the human rights of patients who are unable to consent to treatment but do not require compulsory treatment.”<sup>41</sup>

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34 Clause 129(5). “Consult” does not provide the consultees with a power of veto.

35 Clause 130. The medical adviser will be a member of the Expert Panel and must examine the patient, satisfy him/herself that the consultation took place and discuss the treatment specified in the plan with the clinical supervisor before approving the plan, if at all: clause 130.

36 Clause 133.

37 Clause 136.

38 Clause 136(2).

39 The House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 81.

40 See also the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 81.

41 The House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill*, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 78.

## Compliance with the European Convention on Human Rights

Compliance with the European Convention on Human Rights is a laudable objective for the Mental Health Act, and is required by the Human Rights Act 1998. It produces some important and welcome changes, such as the need to involve an independent organisation, the Mental Health Tribunal, prior to longer term admission,<sup>42</sup> the provision of a right of appeal to a Mental Health Appeal Tribunal on a point of law, and the burden of proof lying on those alleging the need for detention rather than on the patient.<sup>43</sup> Further, the legislation underlines the need for the continued presence of the criteria that warranted original detention and to require release when the patient's condition gets better.<sup>44</sup> But, the power of professionals other than the Tribunal to discharge a patient (and in particular the patient's clinical supervisor<sup>45</sup>) appears to have been removed, and so there may be a longer delay than is necessary before someone is indeed discharged, which would be contrary to the ECHR. In any case, compliance with the ECHR should never be regarded as sufficient. The Convention does not cover all human rights issues and is time-framed, despite the commitment to its dynamic interpretation, by its ratification in the 1950s. Thus, simply because a proposal is Convention compliant does not necessarily mean that it is right. It is Convention compliant to detain a person as a "person of unsound mind"<sup>46</sup> without treating them, as the requirements of Article 5(1)(e) of the Convention do not demand treatment.<sup>47</sup> It is entirely possible that the detention of an untreatable person of unsound mind could eventually be held to fall outside the Convention. Because of the European Court's commitment to a dynamic interpretation of the Convention, no interpretation is set in stone. The logic of the detention would, we submit, rely upon the person detained being treatable. Further, it might

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42 See also the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill (25th Report of Session 2001–02; HL Paper 181, HC 1294)*, which states, at para. 23, that "[t]he new arrangements have the potential to address concerns [that MHRTs do not adequately protect patients from arbitrary detention under Art 5, ECHR], and so are of great significance in the drive to safeguard patients' rights." The Committee thinks that the availability of independent experts from the Expert Panel will contribute to such safeguards (para. 24). But the Committee does have a concern about independence because the qualifications of members are to be dealt with by regulations rather than the primary legislation (para. 26). One significant concern is that the success of the new system relies on the ability to appoint sufficient people of sufficient quality and "there might not be enough available people" (para. 25). On the other hand, the Royal College of Psychiatrists has deep concerns about the Tribunals because (i) medically resourcing both the Tribunals and the Expert Panel for an increased numbers of hearings will be problematic; (ii) a deep concern that there will be a consequential lengthening of the period before a hearing, which will eventually contravene the ECHR; (iii) doctors will not always be on Tribunals and so the work of the Tribunal may be poor (especially with regard to analysing care plans and whether psychologists can adequately review cases for review of on-going detention as opposed to psychiatrists, as well as the overall decision-making in relation to detention and continued detention),

especially if also the medical member of the Expert Panel does not have to be present at the hearing (Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: Response to the draft Mental Health Bill and consultation document – Points on which consultation is not requested* (2002).

43 *R (on the application of H) v Mental Health Review Tribunal North and East London Region (Secretary of State for Health intervening)* [2002] Q.B. 1 which resulted in a change to the Mental Health Act introduced by the Mental Health Act 1983 (Remedial) Order 2001 (S.I. 2001 No. 3712) passed under the Human Rights Act 1998 provisions on amending legislation incompatible with the European Convention on Human Rights. See also the House of Lords and House of Commons Joint Committee on Human Rights, *Draft Mental Health Bill, (25th Report of Session 2001–02; HL Paper 181; HC 1294)*, at para. 59.

44 *Johnson v United Kingdom* (1997) 27 E.H.R.R. 196, and see *Winterwerp v Netherlands* (1979) 2 E.H.R.R. 387 and *Luberti v Italy* (1984) 6 E.H.R.R. 440.

45 Under the Mental Health Act 1983, s. 23, the patient's responsible medical officer, amongst others, has the power to order discharge, and frequently does.

46 There is no definition of this phrase and, therefore, the wide definitional approach adopted in the proposed Mental Health Act is Convention compliant as it does rely upon the availability of medical evidence.

47 *Winterwerp v Netherlands* (1979) 2 E.H.R.R. 387.



eventually be decided that the failure to treat someone detained in hospital might fall foul of the prevention of inhuman or degrading treatment or punishment in Article 3<sup>48</sup> or of the prevention on improper interferences with privacy under Article 8. It is Convention compliant not to have a detailed definition of “person of unsound mind”, but does that warrant not attempting to provide definitions where available and exclusions where possible? Any comparison with the width of the DSM or ICD and the exclusions under the Mental Health Act 1983, s. 1(3) will demonstrate the risks associated with losing the exclusions, and we consider this further below.

### Definition of mental disorder and conditions for detention

One of the relevant conditions for compulsory admission to hospital is the presence of a mental disorder.<sup>49</sup> This is very widely defined in the proposed Act in clause 2:

“‘Mental disorder’ means any disability or disorder of mind or brain which results in an impairment or disturbance of mental functioning...”

Further, there is no equivalent to the Mental Health Act 1983, section 1(3), which excludes some things from being a mental disorder.<sup>50</sup> The argument for the change is<sup>51</sup> that some clinicians have mistakenly assumed that it means that someone who is dual diagnosed as an alcoholic and with mental illness or someone whose alcoholism has caused mental illness does not have a mental disorder. This interpretation of the current s. 1(3) is plain wrong and it is completely unsustainable. The better solution, therefore, is either to educate or guide the practitioners better or to clarify the provision. The approach of removing the exclusions is not justified for the reason given. What is proposed is extraordinarily wide, but it is the view of the Government that its application is limited by the need for the other relevant conditions to be present<sup>52</sup> and the need for the professionals to develop a care plan. The relevant conditions are stated at clause 6 as being the following.

“(3) The second condition is that that mental disorder is of such a nature or degree<sup>53</sup> as to warrant the provision of medical treatment to him.”<sup>54</sup>

48 A line into this possible development is provided by the decision of the European Court in *Aerts v Belgium* (2000) 29 E.H.R.R. 50 whereby detaining someone in a completely inappropriate environment may be a breach of Article 3. However, it is some way from there to the argument that detention of the mentally disordered without the provision of treatment is a breach of Article 3, especially when the Court has given precedence to compliance with current medical thinking (*Herczegfalvy v Austria* (1992) 15 E.H.R.R. 437 in relation to consideration of Article 8), and a significant proportion of the medical profession would support the detention of persons with serious personality disorder who were not treatable but who might be aided in being present in an ordered or environment or whose potential for violence might be curbed by such detention. Article 8 is less likely to provide the need for treatment as the prevention of crime and the protection of the interests of others being served by such detention would permit such interferences with privacy under Article 8(2) assuming that the failure to provide treatment could be regarded as *prima facie* an interference with privacy.

49 Draft Mental Health Act, cl. 6(2).

50 So no one can be diagnosed under the Act as having any form of mental disorder “by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.”

51 Department of Health, *Mental Health Bill: Consultation Document* (2002, Cm 5538-III), at paras. 3.18 – 3.19.

52 Department of Health, *Mental Health Bill: Consultation Document* (2002, Cm 5538-III), at para. 3.21.

53 As this is the same phrase as currently appears in the Mental Health Act 1983, s. 3(2)(a), the same interpretation will apply as was given by Poplewell J. in *R v Mental Health Review Tribunal for the South Thames Region, ex parte Smith* [1997] C.O.D. 148 where he recognised that the phrase is disjunctive and that nature and degree each have their own different meaning and so, whilst often detention will be based upon the presence of both, only one condition need be satisfied.

54 Sadly, legislation still is structured in the male only gender, though applying to people of either.

- (4) The third condition is –
- (a) in the case of a patient who is at substantial risk of causing serious harm to other persons, that it is necessary for the protection of those persons that medical treatment be provided to him, and
  - (b) in any other case, that –
    - (i) it is necessary for the health or safety of the patient or the protection of others persons that medical treatment be provided to him, and
    - (ii) that treatment cannot be provided to him unless he is subject to the provisions of this Act.
- (5) The fourth condition is that appropriate medical treatment is available in the patient’s case.”

The question, therefore, is whether the draft Bill will have much wider application through a different approach to the definition of mental disorder.<sup>55</sup> The Government does not expect it to be “used as a means of social control, nor to detain anyone simply because their sexual preferences diverge from the norms of society, nor to detain anyone who does not have a mental disorder.”<sup>56</sup> However, concerns have been expressed that it could be applied to people who should not be regarded as potential subjects for mental health legislation. Any swift review of the international classifications of mental disorder will reveal that a number of conditions appear in either or both of the American Psychiatric Association’s Diagnostic Statistical Manual or the World Health Organisation’s International Classification of Diseases and Disorders that cannot credibly be argued to be a mental disorder at all or that could warrant compulsory admission to hospital. Under the criminal law, it is the case that any internal cause of an inability to know what one is doing or to know that it is legally wrong raises the defence of insanity,<sup>57</sup> such that a person attacking another when suffering an epileptic fit is claiming that defence when saying that they did not know what they were doing,<sup>58</sup> similarly a person with diabetes who has not taken their insulin.<sup>59</sup> “The prospect of a Mental Health Act being used to authorise compulsory treatment of people suffering from diabetes or epilepsy is unattractive.”<sup>60</sup> It is much worse than that! Further, could the new approach lead, as has been suggested, presumably more credibly by Zigmond,<sup>61</sup> to people with multiple sclerosis or Parkinson’s disease or mild anxiety being compulsorily detained under the draft Bill?

Even if doctors might view these as a mental disorder within the proposed definition, it is hard to see on what basis all the other conditions would be satisfied. But the warning is worthy of recognition and rather than rely upon the appropriate use of the Act by clinicians and the work

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55 *Under the Mental Health Act 1983, a broad concept of mental disorder only applies to admission to section 2 and the emergency sections, and greater certainty of diagnosis is required for admission under section 3 or the imposition of a hospital order under section 37.*

56 *Department of Health, Mental Health Bill: Consultation Document (2002, Cm 5538-III), at para. 3.22.*

57 *M’Naghten’s case (1843) 10 Cl. & Fin. 200; Bratty v Attorney General for Northern Ireland [1963] A.C. 386; R v Sullivan [1984] A.C. 156.*

58 *R v Sullivan [1984] A.C. 156.*

59 *R v Hennessy [1989] 2 All E.R. 9. The sleepwalker also raises the defence of insanity because the cause of not knowing what they are doing is an internal cause: R v Burgess [1991] 2 Q.B. 92.*

60 *The House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 29.*

61 *The Times November 14th 2002, at p. 15.*

and its effect on general practice of Mental Health Tribunals, would it not be better to prevent the problem by improved definitions? The difficulty is with the lesson that derives from the passage of the Mental Health Act 1983. In that Act only three of the four specific conditions of mental disorder are defined.<sup>62</sup> Attempts to define “mental illness” were considered,<sup>63</sup> but no generally acceptable definition was discovered.<sup>64</sup> Therefore, the condition with which the vast majority of compulsorily detained patients are diagnosed is not defined in the Act. The only legal definition is that to be found in a decision on the Mental Health Act 1959, where Lawton L.J. stated that the words “mental illness” are “ordinary words of the English language. They have no particular medical significance. They have no particular legal significance.... [O]rdinary words of the English language should be construed in the way that ordinary sensible people would construe them.... In my judgment [an ordinary sensible person] would have said, ‘Well, the fellow is obviously mentally ill.’”<sup>65</sup> Despite Lawton L.J.’s requirement that there would have to be a medical basis for the view reached, it was memorably and derogatorily termed “the-man-must-be-mad” test.<sup>66</sup> The lesson seems to be that the concept could not be defined before the 1983 Act, and it has not created any major problems, so the task is not worth pursuing now. Some support is derived from the E.C.H.R. jurisprudence as there the courts have shied away from attempting to define what is a “person of unsound mind.”

One particular consequence flowing from the changes represents a very significant change in policy. Under the 1983 Act strenuous efforts were made to exclude people with learning disability from the potential for compulsory admission to hospital. The introduction of the concepts of mental impairment and severe mental impairment had the unfortunate consequence that not only could few people with learning disability be admitted compulsorily to hospital (which received general approval at the time) but also they could not be received into guardianship, which is a major reason for the poor take up of guardianship.<sup>67</sup> The consequence of the change in policy is that many more people with learning disability will potentially fall within the purview of the draft Mental Health Act than of the 1983 Act. This is a further argument for a Mental Incapacity Act to be the primary piece of legislation as some people now falling within the purview of the Act (which includes not only residential orders in hospitals but also non-residential orders for people living in the community<sup>68</sup>) will be incapable of making decisions for themselves. However, the draft Bill leaves us with, effectively, undefined concepts or, rather, broadly defined concepts when some attempts could have been made to provide exclusions and examples of inclusion. Heavy reliance will, therefore, be placed on the propriety of clinicians’ actions and the quality of their education and continuing professional development.

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62 In s.1(2), definitions are provided for mental impairment, severe mental impairment and psychopathic disorder.

63 D.H.S.S., *A Review of the Mental Health Act 1959* (1976), building upon a recommendation in the Report of the Committee on Mentally Abnormal Offenders (1975, Cmnd. 6244; the Butler Report).

64 D.H.S.S., *The Review of the Mental Health Act 1959* (1978, Cmnd. 7320; the White Paper).

65 *W v L* [1974] Q.B. 711, at p. 719. As it happens this

was obiter dictum, but has nevertheless moved into the accepted interpretation of the legislation.

66 Hoggett, B., *Mental Health Law* (4th ed., 1996), at p. 32.

67 Gunn, M., “Mental Health Act Guardianship: where now?” [1986] J.S.W.L. 144.

68 We have chosen not directly to address issues arising from the possibility of compulsory community provision, though the general themes are directly applicable.

### **Replacement of the Mental Health Act Commission**

The introduction of a form of inspectorate by the Mental Health Act 1983, the Mental Health Act Commission, was an important contribution to ensuring that the legislation was used appropriately. However, the Commission tended to be confused as to its remit, often wandering away from it into areas that were the remit of other organisations and that often at the expense of its primary remit which was to “visit and interview” patients and to “require the production of and inspect any records relating to the treatment of any person who is or has been a patient.”<sup>69</sup> This remit would ensure that there was some inspection function in relation to compliance with the Act in relation to detained patients and a facility for patients to raise concerns about the way in which they were being treated. Separating this from functions such as examining the environment was always difficult and, despite what has been said, contentious in the sense that some would argue that it did fall within the Commission’s remit. Thus, the introduction of a new health care inspectorate, which will not only have the remit to provide “scrutiny of the proper application of the new Mental Health Act,”<sup>70</sup> but also have the remit to provide “a single point of access on quality issues for service users, service providers and the Government,”<sup>71</sup> is to be welcomed as providing what is indeed likely to be a more influential and effective body. Its success will depend upon those appointed to be inspectors and will require a range of skills, not always available in one individual, to ensure that the width of the remit can properly be delivered.<sup>72</sup> Intriguingly, the Inspectorate will have the power to refer an individual’s case to a Mental Health Tribunal on a point of law. This has interesting potential since inspections sometimes do reveal difficult areas of law that demand resolution for the individual concerned and sometimes that has significant general effect. This ability is a sound proposal and is likely to assist in providing the Inspectorate with the teeth that it needs to ensure that it delivers.<sup>73</sup>

### **Limited reform of the Mental Health Act 1983, section 139**

Sadly, there is no clear proposal to abolish what is currently the Mental Health Act 1983, s. 139. As currently structured this has two elements to it (a) restrictions on the freedom to instigate litigation and (b) defences available to individual members of staff acting or purporting to act under the 1983 Act. The former is unsustainable as an improper restriction on freedom of access to the court. There is no reliable evidence that detained patients endeavour to sue inappropriately more often than anyone else. Indeed, it has been said that “mental health patients are a particularly vulnerable group.... Compared with most other people, they are less likely to be able to action to protect their own rights.”<sup>74</sup> Although not made in the context of s. 139, this suggests that there is no good reason for additional hurdles to be placed in the way of seeking to resolve issues by way

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69 *Mental Health Act 1983, s. 121(5).*

70 *This will include: collecting information; investigating and visiting for cause and certain related responsibilities and powers: Department of Health, Mental Health Bill: Consultation Document (2002, Cm 5538-III), at para. 3.4.*

71 *Department of Health, Mental Health Bill: Consultation Document (2002, Cm 5538-III), at para. 3.2. The scrutiny function will be exercised by a special division of the inspectorate.*

72 *See also the House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill, (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 89.*

73 *Lack of teeth was a criticism of the Mental Health Act Commission though the Commission often contributed to its weakness by sending mixed messages about practices.*

74 *The House of Lords and House of Commons Joint Committee on Human Rights, Draft Mental Health Bill (25th Report of Session 2001–02; HL Paper 181; HC 1294), at para. 5.*

of legal action. In any case, those who, by their actions, have proved themselves to be vexatious litigants can have their freedom to instigate further litigation limited. This operates not on any generalised assumptions about a class of people but on the particular activities of an individual. Whilst a challenge to this part of the section was unsuccessful in *Ashingdane v U.K.*<sup>75</sup>, it is submitted that the restriction is indeed a breach of Article 6 as an improper restriction on the right of access to a court. The Government understands “that [abolition] would make many staff feel vulnerable even when exercising their legal duties responsibly”. Therefore, it proposes that the onus of proof should be reversed, such that “the person complained against will have a defence of good faith and reasonable care.”<sup>76</sup> One difficulty here is that there appears to be a conflation between the right of access to the courts and whether to continue an obstacle to it and the existence of a special defence when sued. The Government appears to be addressing the right of access to a court and so the burden of proof switches to the defendant in pre-hearing proceedings. This does not make sense. Clarity on this is required, and there is no provision in the draft Bill. What is required is a separation, as explained above. In this way the debate can be focussed on whether to have both a limitation on litigation and a special defence. We argue against the former. As regards the latter, there is a better argument for it, which is, in part, presented by the Government in the extracts above. However, no other professionals have any such special defences. Surely, the preferable approach is that acting in compliance with the Act is a defence to any action as indeed would be an honest and reasonable mistake about the powers available under the Act. There is no need for any special provision.

### Sharing information

The need to share information is a common theme of many homicide inquiry reports. Whether the changes proposed through the draft Mental Health Bill are necessary is open to serious doubt. This is because the law on confidentiality is subject to exceptions which would apply where those caring for another who presents a risk to others need to share relevant and important information.

### Final comment: a plea on drafting

One final plea would be for the drafting of the legislation to be reconsidered. It is accepted that drafting legislation is an extraordinarily difficult task. However, this proposed legislation is very difficult to follow. This is a particular problem for legislation such as Mental Health Acts as the size of their non-legal readership and user group vastly outweighs their legal readership and user group. It is difficult to imagine patients, doctors, nurses, carers, etc making much headway through its tangled web.<sup>77</sup>

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75 (1984) 7 E.H.R.R. 528.

76 Department of Health, *Mental Health Bill: Consultation Document* (2002, Cm 5538-III), at para. 3.16.

77 See also Royal College of Psychiatrists, *Reform of the Mental Health Act 1983: Response to the draft Mental Health Bill and consultation document* (2002).