Response to the Government White Paper on Reforming the Mental Health Act

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I shall not respond to all the questions, posed in the White Paper, although I have views on many of them.

I shall focus on the following areas.

1. The proposed plan for advanced consent to admission.
2. The proposed alterations to the detention criteria, which are portrayed in the White Paper, but which I shall argue actually broaden their scope.
3. The proposed abolition of the role of the hospital managers in reviewing detention.
4. The proposed replacement of the nearest relative with a nominated person.

Before I offer my views on these issues, I would like to put on record my dismay at the direction of travel of mental health and mental capacity law. Each has become a dense thicket of legalistic complexity. The interface between the Mental Health Act and the MCA like much of this area, has become a lawyer's playground. The powers to detain and subject people to compulsion in the community under the MHA and MCA are set ever wider with each new reform intiative, and their scope extended into domestic settings. The issue is often not whether there is power to detain or treat without consent, because there are often many; it is rather under what legal regime, Mental Health Act, Mental Capacity Act, or common law. This is an unfortunate state of affairs.

An important part of the brief of the Wessely Committee was to bring about a reduction in the use of powers of detention. They have set about this with immense enthusiasm, at various points becoming almost teary eyed about the loss of some golden age of informality. It is important not to forget that any voluntary or informal patient can be prevented from leaving hospital under s 5 of the MHA. For the first two decades of its life, the Mental Health Act Commission was drawing attention to the lack of protections for the 'de facto detained', who were in fact detained and would be prevented from leaving, but who lacked the protections afforded to detained patients

One can foresee, if these provisions are enacted, that one way of reducing detentions under the Mental Health Act would be to shift towards detention under the new Mental Capacity Act Liberty Protection Safeguards. This is made evident in the explanatory text to Chapter 7 of the White Paper on the Interface between the Mental Health Act and the Mental Capacity Act where we are told all we need to know about the LPS - 'The LPS will be a simpler process that involves families more and gives swifter access to assessments, be less burdensome on people, carers, families and local authorities and will allow the NHS, rather than local authorities, to make decisions about their patients.' Glowing testimonials of this kind are giant signposts that professionals are being encouraged to use the LPS as an alternative to detention under the Mental Health Act. The LPS and the Mental Capacity Act offer fewer

safeguards against detention and treatment without consent by comparison with the Mental Health Act. [1]

Advance Consent to informal admission

The almost religious enthusiasm for informal admission has led the Committee and the Government White Paper to the wilder shores of jurisprudential fancy with the frankly bizarre proposal that patients should have the right to give advance consent to informal admission to a mental health hospital and this right should be set out in the Act and the Code of Practice. This takes us through the legal looking glass. Portraying this as a right is somewhat disingenuous. To be an informal patient is to be denied access to the safeguards which apply if one is detained. The White Paper rehearses (p 64) the objections raised in the Wessely review. One of these was that an individual consenting in advance to informal admission may not be aware of the conditions, settings, care and treatment they might experience and therefore the gravity of what they are agreeing to.'

The White Paper goes on to say this (p 64) 'To mitigate these issues the Review suggested a 'get out clause' to prevent a patient from being held to his earlier consent when it is unreasonable to do so. 'This clause', says the White Paper, 'could apply when the person withdraws their consent when they have the capacity to do so.' Or there are reasonable grounds to believe that a person's advance consent was reasonably informed, or if their actions are not compatible with their decision at the time of consent. To be blunt, this has to be kite flying. If a patient is informal and it is necessary to prevent them from leaving hospital they can be prevented from doing so by using s 5 of the Act. Many patients consent to informal admission to avoid compulsory admission. The they decide they want to leave and are subject to s 5. This new category of patient would agree to be admitted informally, and once they are admitted they can be subject to s 5, which would provide a much clearer authority to hold them than any prior Ulysses contract.

Question 18 Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the MHA and the MHA Code of Practice to make clear the availability of this right to individuals? My answer is that I strongly disagree with the principle of a 'right' to sign away one's rights, for all the reasons rehearsed by the Wessely review and reproduced on p 64 of the White Paper. One very basic problem with this suggestion is that patients might actually believe they had effectively signed away their rights.

[1] Dr Lucy Series' 'Unintended consequences of taking people with learning disability and or autism out of the Mental Health Act', which may be found on her The Small Places Blog https://thesmallplaces.wordpress.com

Q 2 a We want to change the detention criteria so that detention must provide a therapeutic benefit for patients. Do you agree? As someone who resisted removal of the treatability test and supported therapeutic benefit in the run up to the 2007 Act, I strongly agree. However, I do not consider that this will impose a significant limit on clinical discretion for the following reasons

The treatment criteria - *Appropriate treatment is available and the test of therapeutic benefit.*

The criterion that appropriate treatment must be available before detention can take place was introduced in 2007 to replace what had become known as the 'treatability test' under the MHA 1983 whereby detention for longer than 28 days was only possible for people with psychopathic disorder or mental impairment if the responsible doctor certified that medical treatment for mental disorder was 'likely to alleviate or prevent deterioration in the patient's condition.'

One of the main goals of the Labour Government in 2007 was to bring patients with personality disorders clearly within the scope of powers of detention, and to abolish the treatability test. As Minister of State Rosie Winterton informed the Joint Committee on Human Rights, the Government wanted to 'remove ground for argument about the likely efficacy of treatment which can be used as an argument to prevent detention of people who present a risk to themselves or others.'[2] They were also worried that it might be hard for a doctor to certify that the treatability test was met if the patient was not co-operating with psychological treatment. The Minister told the Public Bill Committee (Cols 121-122) she had been informed that 'lawyers have advised their patients not to engage with treatment because if it can be proved they are not treatable they must be released.' Hence the urgent desire to replace treatability with the test of availability of 'appropriate treatment'.

Before this change was adopted there was much debate at the Committee Stage in the House of Lords, where Lords who were psychiatrists argued that if the treatability test was abolished, it should be replaced by a test that treatment is available which is likely to be of therapeutic benefit. This was to avoid a perceived risk that psychiatrists would be seen as mere custodians rather than therapists and that psychiatric detention would become perceived as preventive detention. There was also the question of compliance with Council of Europe Recommendation No (2004)10 of the Committee of Ministers on the human rights and dignity of people with mental disorder. This stops short of requiring therapeutic benefit, but article 17 provides that it should be a requirement of the lawfulness of psychiatric detention that it has a therapeutic purpose, broadly defined in Article 2 to include 'prevention, diagnosis, control, cure or treatment.'

[2] Rosie Winterton Letter of 11 November 2006 to the Joint Committee on Human Rights.

An amendment tabled by Chris Bryant MP, led to the introduction of a therapeutic purpose test in s 145(4) and brought the Act into compliance with Article 17 of the Council of Europe recommendation by requiring that the appropriate treatment must have a therapeutic purpose.

Medical treatment for mental disorder was initially defined under the Mental Health Act 1983 as 'including nursing, care, habilitation, and rehabilitation under medical supervision. This is an inclusive definition. It is potentially very broad indeed. It includes the matters listed, but that list is capable of extending to other interventions not mentioned such as drug treatment, Electro Convulsive Therapy, or forcible feeding but also other treatments. In 2007 psychological intervention was added to the list, s 145(1) now stating that 'Medical treatment includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care (but see also subs (4) below).

Section 145(4) provides that 'Any reference in this Act to medical treatment, in relation to mental disorder shall be construed as a reference to medical treatment the purpose of which is to alleviate or prevent a worsening of, the disorder, or one or more of its symptoms or manifestations.'

Baroness Royall, speaking for the Government in the Lords debates explained that 'Symptoms', 'is intended to cover the consequences of which patients themselves complain while 'manifestations' more obviously covers the evidence of the disorder as seen by other people.'[3]

Following the 2007 Act reforms, appropriate treatment is currently defined in the Act (s 3(4)):

References to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of his mental disorder and all other circumstances of his case.

Appropriate treatment means treatment which is appropriate. Here are more words conferring discretionary powers on clinicians. And treatment of the manifestations of the disorder, such as treatment of people with paedophilia by libidinal suppressants, comes within treatment for mental disorder.

Therapeutic Benefit

The definition of medical treatment is broad indeed, and the therapeutic purposes it may pursue are also broadly set, both in domestic law and the Council of Europe Recommendation. Hence it is hard to see how the proposed therapeutic benefit test

[3] Hansard HL Deb. Vol 693, col 885.

will differ from the old treatability test whereby the treatment the patient will receive must be 'likely to alleviate or prevent a worsening of the disorder or one or more of its symptoms or manifestations.' As a matter of law, it can be argued that specialist nursing care, and anger management in a structured environment is treatment for mental disorder, and is preventing deterioration.[4]

As Richard Jones remarks in his Mental Health Act Manual 'the case law on the treatability test was such that it was difficult to imagine circumstances where a patient would fail it… a similar comment could be made about the appropriate treatment test, given that it will almost always be appropriate to provide nursing or care for the purpose of alleviating or preventing deterioration in the patient's condition or its symptoms or manifestations.[5] The Mental Health Act Code of Practice acknowledges that there 'may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day to day care under clinical supervisions .. in a safe and secure therapeutic environment in a structured regime.'[6]

Given the breadth of the concept of treatment and its permitted purposes, it is highly unlikely that the therapeutic benefit test will prove more effective than the treatability test in limiting the number of detentions under the Act.

Consultation Question 3 We want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health safety or welfare of the person, or the safety of any other person. Do you agree?

For the reasons set out below I agree with the addition of the words substantial and significant as qualifiers of the likelihood of harm but question whether they will make much difference to rates of detention. I strongly disagree with the introduction of the extra ground that there is a substantial risk of significant herm to welfare. This seems to be an unnecessary extension of the grounds of detention.

Substantial Likelihood of Significant harm – the Risk Criterion

The proposals regarding the risk criteria and the criterion of therapeutic benefit are represented in the White Paper (p 26) as a tightening of the detention criteria. This is unlikely to be the case. I will argue that they may actually expand the scope of powers of detention rather than narrow them.

The test is that there is a substantial likelihood of significant harm to the health safety or welfare of the person or the safety of any other person. The criteria appear to be tightened by the need for a 'substantial' likelihood of 'significant' harm, only then to be palpably

[4] *Reid* v *Secretary of State for Scotland* [1999] 2 AC 512.
[5] R.M Jones Mental Health Act Manual , 23rd Edition, p 55.
[6] Mental Health Act Code of Practice para 23.17.

loosened by the introduction of the new criterion that detention can be justified if there is a substantial risk of significant harm to the person's own welfare. Welfare is manifestly broader than health or safety, and such a wide extension of these powers deep into the territory of strong paternalism, more than offsets any potential reduction introduced by the words substantial and significant.

The addition of the words substantial and significant seems to tighten the requirement, but one may further question whether introduction of the word substantial will narrow the application of the criteria significantly. Substantial is one of many words dealing with questions of degree, where judges resist the urge to define, and leave it to the decision-maker to exercise discretion. 'Significant' is another. Despite this there have been two Supreme Court rulings on their meaning in different contexts. In *R* v *Golds* (2016) the Supreme Court held that

> as a matter simply of dictionary definition, "substantial" is capable of meaning either (1) "present rather than illusory or fanciful, thus having some substance" or (2) "important or weighty", as in "a substantial meal" or "a substantial salary". The first meaning could fairly be paraphrased as "having any effect more than the merely trivial", whereas the second meaning cannot. It is also clear that either sense may be used in law making.' [7]

The court held that the meaning varied depending on the statutory context. The use of 'substantial' in a power for used for safeguarding purposes in a professional context obsessed with risk management, suggests that a meaning towards the 'more than trivial' end of the scale (rather than the extremely weighty end) is likely to be adopted by those operating the Act.

As to the meaning of 'significant', and the distinction between substantial and significant, there is also Supreme Court authority, *AM (Zimbabwe)* v *Secretary of State for the Home Department*. Lord Wilson delivering a single judgment on behalf of the Court, said this:

> Like the skin of a chameleon, the adjective takes a different colour so as to suit a different context. Here the general context is inhuman treatment; and the particular context is that the alternative to "a significant reduction in life expectancy" is "a serious, rapid and irreversible decline in ... health resulting in intense suffering". From these contexts the adjective takes its colour. The word "significant" often means something less than the word "substantial". In context, however, it must in my view mean substantial.[8]

Hence each of these qualifiers to the risk required to justify detention involve questions of fact and degree which are context dependent and fall to be interpreted

[7] [2016] UKSC 61 para 27.
[8] [2020] UKSC 17, para 32

on the individual facts of the case. Rather than limit the scope of the powers they create potential for litigation over the meaning of these words.

We have had two Supreme Court rulings on the meaning of these terms. One in the context of a case on diminished responsibility and the other in the context of a Human Rights Act claim. If this reform proceeds, it is unlikely to significantly narrow the detention criteria. In fact it may widen them. It will probably also generate significant case law on the scope of these words, where the courts will say it is a matter for the decision-maker taking into account the statutory context. Familiar arguments will be rehearsed. Those contending for definitions of significant and substantial which would expand the scope of the powers will argue that this is a safeguarding statute (necessary for health safety or welfare) which should be interpreted so as to give effect to that purpose of the statute, whilst their opponents will contend that as a statute which interferes with individual rights, the scope of the powers in the Act should be construed narrowly.

The Proposed abolition of the right to apply to the hospital managers for discharge
Consultation Question 7 Do you agree or disagree with the proposal to remove the role of the managers hearing in reviewing a patient's case for discharge from detention or a CTO. Strongly disagree, and consider that in human rights terms this is non negotiable.

In order for a psychiatric detention to be lawful under Article 5(1) of the European Convention on Human Rights, the so-called *Winterwerp* criteria must be met. There must

(a) be objective medical evidence of a true mental disorder which must be of a kind or degree warranting confinement
(b) that medical evidence must be placed before a competent authority (a court, or in our case in England and Wales, the hospital managers).
(c) The detaining authority must keep under review whether the criteria for detention continue to be met, and discharge the patient if they are not.

Under the MHA 1983, the hospital managers are the detaining authority. They must keep under review whether the criteria for detention continue to be met. They must discharge if they are not met. The corollary is that the patient must have the right to ask the managers to exercise that power. The tribunal is not the detaining authority, and cannot be so. Cases before the tribunal involve the managers as detaining authority as one party and the patient as another. The managers' power of discharge is the necessary price of our having an administrative, hospital managers-based system, whereby the admission documents are received and their adequacy scrutinized by officers appointed by the managers, and decisions to renew detention are dealt with by an independent panel of appointees. In human rights terms, the power of the hospital managers to discharge, and the right of the service user to ask them to exercise it, are non-negotiables.

The Nominated Person Proposals Balance between the State and the Family

The nearest relative concept is to be removed from the Act and the powers of the nearest relative vested in a nominated person. This is not being consulted on. It should be. The only consultation question here is **Question 13 Do you agree or disagree with the proposed additional powers of the nominated person. I do strongly agree with the proposed additional powers for the nominated person.**

However, I strongly believe that at the time of considering detention it is wrong for the AMHP (the person applying for detention) should have the power to appointing the Interim Nominated Person (who is supposed to advocate for the person) if there is none in place already and, as is often likely to be the case, the patient is deemed to lack capacity to appoint someone. I explain this further below

It is important to recognize the role of family carers in looking after people with severe learning disabilities and severe mental disorder. In the majority of cases, it is their support which keeps people out of hospital or other institutional care. The 1959 Mental Health Act set the balance between the power of the state to take a person into psychiatric detention, and the rights of the family to look after their loved one at home. Hence the family is allowed to take responsibility for the care of the person and obtain their discharge, provided they are not likely to act in a manner dangerous to self or to others. The nearest relative's powers and rights include the following.

1. To apply for the person's detention in hospital if they cannot be looked after in the community
2. To be consulted when an Approved Mental Health Professional applies for compulsory detention
3. To object to detention for treatment. Such an objection which blocks detention, provided it is reasonable.
4. To direct discharge of a patient who is not dangerous to self or to others.
5. Apply to the Mental Health Tribunal if discharge is barred by the psychiatrist certifying that the patient if discharged would be likely to act in a manner dangerous to self or others;
6. Be informed if the patient is discharged from detention.

In most cases where a relative or partner is caring for someone, they will be the nearest relative. Service users may challenge a nearest relative who is unsuitable. In the discussions leading to the 2007 Act the Government resisted all calls to allow service users to allow greater choice for service users as to who should be their nearest relative on the grounds that it would undercut their risk management agenda – a patient might, for example, choose someone who they believe is likely to resist the use of compulsory powers.[9]

[9] Victoria Yeates, Ambivalence, Contradiction, and Symbiosis. Carers and Mental Health service Users Rights [2007] *Law and Policy 435-459 at pp 442-443*

A service user can apply to the court to displace an unsuitable nearest relative, and under the regulations a nearest relative can pass on the role to someone else.

It should be noted at this point that removal of the nearest relative has been a reform which has been near the top of the internally maintained Department of Health shopping list since the late 1970s. restriction of the nearest relative's rights was rejected in 1982, as the Conservative Government felt it was at odds with its avowed support of family values. Nearest relatives are sometimes seen as an irritant, and the trope of 'the stroppy nearest relative' is familiar. The stroppy carers are often those who bring test cases establishing important precedents, such as Mr and Mrs E in the *Bournewood* litigation and Mark Neary in his landmark case against Hillingdon London Borough. Most of the applications for habeas corpus in relation to mental health have involved failure to consult the nearest relative, or failure to uphold the nearest relative's objection.

A further attack on the nearest relative was survived when the Mental Health Act 2007 kept the concept. This time it looks as though the long game has paid off. The package of rights and powers currently vested in nearest relatives will be transferred to the nominated person.

The Wessely Committee MHA Review (p 83), said this

'The patient can choose their own nominated person, either prior to detention, at the point of assessment for detention, or whilst detained through a new nomination process.

It is quite unlikely that patients will have had the foresight to nominate someone to act in this role. It is also quite unlikely that they will be deemed capable of nominating someone. The Wessely Committee here acknowledge that some kind of fall back is necessary. The logical position here would be to adopt the nearest relative as a fallback. But Wessely reject that. 'Don't worry' they then say, we know the very person to nominate an interim nominated person, it's the Approved Mental Health Professional (AMHP). Hence at the very point when a person might want their nearest relative to advocate against detention, they will have an interim nominated person nominated by the person who is applying for detention. Again, don't worry say Wessely, the AMHPs will 'be working to guidance to identify the friend or relative most suitable to fulfil the role.' Moreover, all this will supposedly be going on during an assessment for compulsory admission. This is all repeated in the White Paper (p 49)

This will cut away rights of family carers, for example the parent who might want to raise a legitimate objection to the detention under s 3 of their adult child with a learning disability in an assessment and treatment unit. Family carers are often seen as stroppy because they spend their lives fighting for the rights of their loved one, often fighting to keep them out of institutions. This reform shifts the balance away from this floor of rights for relatives who are carers, but it also creates a whole further set of issues such as the level of capacity needed to nominate a nominated person, and is an AMHP bound by an objection by a nominated person where the service user has appointed them in advance? To adopt the phrase of the Review, this massively 'shifts the dial' away from recognition of the rights of family carers to advocate for their loved one towards consolidating the power of the state and mental health professionals. Although the powers remain the same. At the very point where the service

user might need them most, the role will be given to an Interim Nominated Person nominated by the officer applying for detention. This reform risks cutting the legal ground out from under the feet of people who currently are nearest relatives and who are providing significant amounts of daily care. It represents a move towards a Mental Capacity Act style of representation, an approach which as Lucy Series has argued, on the Governments own projected figures, is expected to lead to a miniscule number of challenges reaching the Court of Protection and has not proved effective in protecting the right to challenge detention. [10]

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[10] See Dr Lucy Series' excellent legal analysis of this issue 'Unintended consequences of taking people with learning disability and or autism out of the Mental Health Act', which may be found on her The Small Places Blog https://thesmallplaces.wordpress.com