113 Chancery Lane
London WC2A 1PL
Tel 020 7320 5858
Fax 020 7320 9551
www.lawsociety.org.uk

Parliamentary Brief

The Law Society

Mental Health Bill

Second Reading House of Lords

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The Law Society believes that the proposals contained in the Mental Health Bill are deeply flawed. It is crucial that mental health law which governs the use of coercive powers overriding individual autonomy, is sufficiently precise and clearly defined. This helps protect patients from unjustified interference in their human rights. We are concerned that the Bill introduces concepts which lack sufficient legal precision and rely too much on professional discretion. Our key concerns are set out below.

The new definition of mental disorder

The Bill introduces a single broad definition of mental disorder ("any disorder or disability of the mind") for all detentions in hospital and removes the specific exclusions from the Mental Health Act 1983 (1983 Act) which provide that no person can be detained because of his/her sexual orientation, immoral conduct or deviance.

The Law Society is not opposed in principle to a single broad definition of mental disorder but only if delineated by clear exclusions. The purpose of a legal definition of mental disorder is to define as far as practicable the group of people to whom mental health legislation may apply. However, the Bill leaves to professional discretion whether disorders of sexual preference or social conduct could be construed as the sole basis of mental disorder and thus compulsion under the 1983 Act. We believe that the Bill should retain a modified version of the current exclusions, or at the very least include a set of statutory principles on its face to guide professional decision makers.

The appropriate treatment test

The Government proposes to remove the treatability test from the 1983 Act and introduce a provision that any treatment will have to be 'clinically appropriate' for the patient and 'available' to him/her.

Our main concern with the availability of treatment as a basis for compulsory intervention is that it could be misused to exclude patients inappropriately from medical treatment on the basis of scarcity of mental health resources. This would hamper the government's chief intention – to ensure that people with a personality disorder cannot be turned away from services.

The phrase 'appropriate treatment' is further explained in clause 4(3) as being "appropriate in his case, taking into account the nature and degree of the mental disorder from which he is suffering and all other circumstances of the case". We believe that this definition is too vague and lacks sufficient certainty. The Bill must – in line with human rights case law - clearly define appropriate treatment as being treatment which is in the patient's best interests and of medical necessity.

Medical treatment

The Bill widens the definition of medical treatment in the 1983 Act to include "psychological intervention and specialist mental health habilitation, rehabilitation and care". We are concerned that this definition is too wide and removes the requirement under the 1983 Act for compulsory treatment to be given under a doctor's supervision. Unless it is clearly stated that 'specialist mental health intervention' includes some level of supervision by a psychiatrist, then this provision is likely to fall short of human rights requirements for objective medical expertise when a patient is receiving non consensual medical treatment for a mental disorder.

Nearest Relative

Under the 1983 Act the Nearest Relative has extensive powers including the power to block admission and discharge a patient. The appointment of the Nearest Relative is determined by a hierarchical list and the patient has little say in this - even if they dislike the person or have an abusive relationship with them. The Bill addresses this by adding the patient to the list of those who can apply to displace the Nearest Relative and it also inserts a new ground to the reasons for displacement: that the person is "not suitable" to act in this role.

We believe that the concept of 'suitability' is too restrictive and fails to pay sufficient regard to the patient's wishes. It would not for example cover antipathy between the patient and his/her Nearest Relative – the Code of Practice even states that a Nearest Relative cannot even be rendered unsuitable on the basis that another person is more suitable. We believe that these provisions must be interpreted in accordance with a patient's Article 8 ECHR rights so as to take account of his/her wishes and health and well-being.[1] We believe that the displacement criteria should simply be that the patient does not want a person to be their Nearest Relative and it would then be for the Court to decide who to appoint in their place.

Community Treatment Orders

The Bill proposes a new community treatment order (CTO) for patients who have been discharged from detention, with a power to require compliance with a treatment regime and powers of recall where there are concerns about the patient.

Powers to treat patients under compulsion in the community are already available through leave of absence under section 17 of the 1983 Act, which as a result of case law allows a patient to be maintained in the community indefinitely and recalled back to hospital where there are concerns. It is difficult to understand why clinicians would choose a CTO, when section 17 leave is far less bureaucratic and would have a similar effect. We therefore question the need for new legislation.

We are deeply concerned by the proposal that a patient on a CTO can be recalled, forcibly treated and returned to the community within 72 hours. This is both ethically dubious and would undermine therapeutic relationships in the community. It is even more concerning that this

[1] R (E) v Bristol City Council [2005]

decision could be taken by a responsible clinician who is not a doctor, which again is likely to contravene human rights requirements.

Also, the conditions that can be attached to a CTO are extremely wide and could include "a condition that the patient abstains from a particular conduct". This raises the alarming possibility of psychiatric ASBOs.

The Mental Health Review Tribunal (MHRT)

While we welcome the new order making powers to reduce the time limits for automatic referrals to the MHRT, the Bill does not go far enough. Case law has established that hospital managers have a duty to ensure that patients who lack capacity have their cases referred to the Secretary of State, who may then refer the matter to the MHRT for a hearing.[2] However in practice this rarely happens[3] which clearly suggests that managers are not complying with their legal obligations.

We believe that the MHRT should be given the power to direct a restricted patient's leave of absence and transfer to another hospital offering conditions of lower security. The MHRT already has the power to discharge a restricted patient and therefore it should also be able to order transfer and leave of absence, which are a necessary precondition to the patient being discharged.

Bournewood

The Bill inserts a new legal framework into the Mental Capacity Act 2005 to allow people who lack capacity to be detained 'in their best interests'. The changes are a response to the 'Bournewood judgement', which concerned an autistic man who lacked capacity and was detained in hospital under the common law – without legal safeguards. The Bill will allow people who lack capacity to be detained in a hospital or care home for up to a year – with a right of appeal to the Court of Protection.

However the government proposals extend much further than the Bournewood case where the patient was compliant with his treatment and will also allow patients to be detained who are non compliant with their treatment. This is likely to lead to confusion because there will be a significant number of patients who could be detained under the Mental Capacity Act or the Mental Health Act.

Furthermore, patients detained under the Bournewood regime will have far fewer safeguards than patients detained under the Mental Health Act: for example they will not receive free aftercare services; there is no right for a second medical opinion for any medical treatment provided while the person is detained; and relatives will not be able to discharge a patient. In addition, an emergency detention without safeguards can last up to 7 days, rather than 72 hours as under the Mental Health Act.

It is difficult to see what the objective justification would be for treating Bournewood patients less favourably when they are clearly more vulnerable than those who have the capacity to protest against their detention or treatment, and to instruct lawyers to protect their interests. It is therefore crucial that these vulnerable patients are provided with effective and robust safeguards.

For further information please contact:

John Ludlow, Head of Parliamentary Unit.
Tel: 020 7320 5858 Email: john.ludlow@lawsociety.org.uk

[2] R (MH) v Secretary of State [2005]
[3] In the last 12 months since the ruling there have been only 16 referrals in total