Reforming mental health law in England and Wales

The government's recent climb down is not a victory: the real battle is about to begin

The UK government's announcement that it has abandoned its eight year attempt to achieve a new Mental Health Act for England and Wales¹ is an apparent victory for patients, professionals, and liberal democracy. Faced with vehement, sustained, and almost unanimous opposition from those with an interest in mental health care, the government has stated that it will instead introduce a shortened and streamlined bill amending the 1983 Mental Health Act. This amending legislation will replace a draft mental health bill that had been described as a "public order bill," which would be "unethical, unworkable, and also ineffective," even in enhancing public safety.^{w1}

The draft bill had succeeded in turn an earlier draft bill,^{w2} a white paper,^{w3} a green paper,^{w4} and an expert scoping report.^{w5} Its most contentious proposals included widening the criteria for compulsory detention and treatment; removing exclusion clauses in the current law that prevent compulsion for people with disorders of substance misuse and sexual deviance; removing the "treatability test" for personality disorder (so that those with dangerous and severe personality disorder could be detained by doctors when not capable of being sentenced by criminal courts); and extending compulsion beyond detention in hospital, thus creating a community treatment order.

The bill was also attacked in relation to the proposed new system for mental health tribunals. These tribunals would not merely have reviewed but would also have made all orders for care and treatment. The greatly increased number of hearings would have made them wholly unworkable given current manpower resources, as well as further diverting participating clinicians away from clinical care. Indeed, it seems to have been internal opposition from the Lord Chancellor's Department—which would have had to administer the new tribunals—that finally killed the bill.

Community treatment order

The intention to achieve a community treatment order, which is retained in the amending bill, has probably become for many clinicians and even some users' and carers' organisations the least controversial of the original proposals. Services have already moved into the community to such an extent that it seems difficult now to continue to argue that compulsory treatment should occur only through detention in hospital. In any event, the courts have already interpreted the notion of treatment in hospital so widely that patients

on long term leave after detention under the current Mental Health Act 1983 may now be required to attend hospital for treatment long after they have ceased to be inpatients in any real sense. Thus, "treatment in hospital" can mean "treatment at hospital" even under present law.² Also, an order for compulsory treatment in hospital can be renewed as long as there is a continuing requirement that the patient attend hospital in this way.³

It is crucial that, under the new legislation, compulsion should continue to be effected not in the community as such but through requiring attendance at hospital for treatment, with the option of a return to inpatient care if the patient refuses. The government does seem to accept that any community treatment order imposed would have to be preceded by an inpatient treatment order.

People with substance misuse disorders who have no other type of mental disorder are excluded from compulsory detention or treatment under current mental health law. The government's previous intention under the draft bill to remove this exclusion, as well as that covering sexual deviance, has now been reversed and this is welcome. Removal of the exclusion clause could have resulted in mental health services being swamped by patients with substance misuse disorders. However, the government's rationale for its earlier intention, that the exclusion clause allowed doctors to avoid admitting patients with dual diagnosis of substance misuse and psychosis, should be heeded. Psychosis should be treated, including compulsorily, even if its cause is substance misuse. Doctors should be wary of substituting moral for clinical judgment, although not admitting such patients sometimes results from lack of adequate inpatient wards.

Clinical discretion

A less debated, but crucial, element in the draft bill had been the removal of clinical discretion in deciding whether to initiate legal compulsion of a patient who satisfied the bill's very broad criteria for such compulsion. Current legislation amounts to "law without enforcement,"⁴ and, in overturning this, the government would have achieved legal control over clinical judgment. However, in terms of properly limiting admission and treatment to medically appropriate

cases, the abandonment of this legal control mechanism will only somewhat soften the effect of the government's continued intention to abolish the treatability test for people with psychopathic disorder and mental impairment.

Mental health law versus criminal law

The treatability test is designed, particularly in relation to antisocial personality disorder, to draw a clear distinction between the role of the mental health services and that of the criminal justice system. The proper role of the former is to treat patients so as to provide them with some therapeutic benefit, albeit sometimes properly in conjunction with reduction of risk to the public. However, public protection as such should be the responsibility of the criminal justice system. The treatability test—which does not apply to people with mental illness or severe mental impairment—protects both untreatable psychopaths from preventive detention without conviction and psychiatrists from being used as substitute agents of social control.⁵⁻⁹

Notably, the General Medical Council's evidence to the Joint Parliamentary Scrutiny Committee—which deemed the draft bill to be deeply flawed—asserted that the definition of treatment itself in the bill went far beyond what it would term medical treatment, with the effect of further facilitating detention for public protection under mental health legislation. However, the courts had already adopted a similar approach in their interpretation of the current Mental Health Act in determining that treatment can include anything administered under the authority of the Responsible Medical Officer.¹⁰

The legal amendments now being proposed will still remove the treatability test from the act. Any patient coming within the broad category of mental disorder (which replaces the four current categories of mental disorder of mental illness, psychopathic disorder, mental impairment, and severe mental impairment) will be eligible for compulsory detention or treatment under the amended act so long as treatment is merely "available." This further softening of the need for any therapeutic benefit is very likely to blur further the distinction between the responsibilities of health services and the criminal justice system, particularly in relation to those with personality disorder and mental impairment.

A survey conducted for the Department of Health has shown deep opposition from psychiatrists to being used to effect preventive detention of people who cannot benefit from treatment.¹¹ And this almost certainly explains the government's additional proposal to substitute a Clinical Supervisor, who could be a psychologist or any other mental health professional, for the Responsible Medical Officer currently recognised, and required, under the Mental Health Act.

Yet the Criminal Justice Act 2003 already allows for dangerous offenders (often those with mental disorder) to be given an indeterminate sentence for public protection, even if their offences would not otherwise justify such indeterminate detention. This is likely to lessen the pressure to use doctors to justify non-therapeutic preventive detention of those with personality disorder under amended mental health legislation. However, under the 2003 Act, psychiatrists

are required to give evidence about risk to the sentencing court in relation to a person's mental disorder, irrespective of the treatability of that disorder. This poses similar ethical dilemmas concerning the use of psychiatry solely for public protection, as well as for punishment of offenders, rather than for treatment.

The government's climb down on reform of mental health legislation is, almost certainly, merely a prelude to climbing up by another route. The devil will certainly still be in the amending bill's clause detail, including in relation to the legal protection offered to patients who lack the capacity to decide about admission,^{10 11} and more broadly towards compliance with the Human Rights Act 1998. Crucially, amendment should include introducing guiding principles into the act,¹² including those of autonomy¹³ and reciprocal rights,¹² in order to enhance consistent and ethical operation of the legislation. Unsurprisingly, this is resisted by the government.

Professionals working in mental health care, including general practitioners, should be vigilant in scrutinising the detail of the proposed amending legislation. Sadly, we remain nowhere near achieving the ethical reform enacted within Scottish mental health law, which now bases compulsion on patients' impaired decision making ability, and not primarily on risk to others, thus bringing mental health law closer to common general medical law.¹³ There is a grave danger of being lulled into a false sense of security through having apparently won the seven year phoney war. The real parliamentary battle is about to begin.

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Competing interests: The author is chairman of the law sub-committee of the Royal College of Psychiatrists and an elected member of the executive of the forensic faculty of the college. He is also a member of the Forensic Medicine Committee of the BMA and of the Mental Health and Disability Committee of the Law Society. He co-chaired a thinktank sponsored by the Department of Health (DoH) on mental health law reform at a very early stage of the government's reform process, conducted DoH funded empirical research related directly to law reform, and was also an occasional adviser to the DoH after publication of the green paper on the reforms.

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- 3 B v Barking, Havering & Brentwood Community Mental Health NHS Trust [1999] 1 FLR 106
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- 9 Coid J, Maden T. Should psychiatrists protect the public? *BMJ* 2003;326:406-7.
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- 11 HL v United Kingdom (2004) 40 EHRR 761, §§98
- 12 Eastman N. Mental health law: civil liberties and the principle of reciprocity. *BMJ* 1994;308:43-5.
- 13 Mental Health (Care and Treatment) (Scotland) Act 2003.