

Treatment and care under mental health law

In this article, **Lucy Scott-Moncrieff**, partner at Scott-Moncrieff, Harbour and Sinclair, examines the practical difficulties inherent in the proposals to reform current mental health law. Lucy Scott-Moncrieff also discusses the implications of the European Court of Human Rights (ECtHR) decision in *HL v UK* Application 45508/99 ('the Bournewood case'), and indicates where there may be potential breaches of the European Convention on Human Rights ('the convention').

At present, decisions about the care and treatment of people with mental disorders are made either under common law or under the provisions of the Mental Health Act (MHA) 1983. Under common law, if a person with a mental disorder has the capacity to make decisions about his/her care and treatment, s/he generally has the right to do so. If s/he lacks the capacity to make these decisions (or some of them), then they can be made by others, in his/her best interests, under the doctrine of necessity. There are no statutory safeguards to regulate or monitor the use of common law powers, but a body of case-law has been developed over the years that provides guidelines for those making decisions on behalf of people who lack capacity. Furthermore, the inherent jurisdiction of the court allows particularly serious or contentious decisions to be referred for judicial approval.

The MHA allows care and treatment decisions to be made on behalf of people with mental disorders – whether or not they have capacity – where they refuse to accept some types of care and treatment voluntarily. The compulsory treatment powers are only available while the person with mental disorder continues to be liable to be detained in hospital. The use of powers under the MHA has to comply with the convention, in particular article 5 (right to liberty) and article 8 (right to a private and family life).

Proposed new legislation

The government is seeking to introduce two new pieces of legislation – the Mental Capacity Bill (MCB) which is, broadly speaking, intended to deal with the decisions that are currently made under common law, and the draft Mental Health Bill (MHB) which is intended to reform the provisions of the MHA. Much concern has been expressed that the provisions of the MHB will increase greatly the scope of compulsory powers, to include many people who currently are entitled to autonomy,

However, the government has insisted that this is not its intention.

The Mental Capacity Bill

The MCB sets out a framework in which decisions can be made on behalf of people who lack capacity. It is underpinned by principles that should ensure that decisions are only made in relation to matters where the person genuinely lacks capacity. The MCB should ensure that people who have capacity to make certain decisions, but lack capacity to make others, will be encouraged and supported to make decisions when they can. People who have capacity will be able to make advance directives to refuse treatment at times when they lack capacity, and appoint attorneys to make decisions on their behalf if they subsequently lose capacity. NHS Trusts and social services authorities will have to set up procedures to allow disputes on what is in the best interests of a person who lacks capacity to be resolved, with the Court of Protection as the final arbiter. The Court of Protection will also be able to appoint deputies to make decisions on behalf of a person who lacks capacity.

Although the MCB generally appears benign and useful, there is at least one unacceptable provision. Clause 5 protects a person from criminal or civil liability if s/he does an act in connection with the care or treatment of a person who lacks capacity, providing s/he reasonably believes that it will be in that person's best interests for the act to be done. Clause 6 confirms that using restraint (including using or threatening to use force to make the incapacitated person do something that s/he does not want to do, and restricting his/her liberty of movement, whether or not s/he resists) would be a protected act under cl5, so long as it is necessary and proportionate. The explanatory notes (para 35) to the MCB make it clear that restraint could include sedation. This suggests that the MCB will make it lawful for a person who lacks capacity to be taken to a hospital,

and given (for instance) depot medication, even though s/he resists.

Clause 28 of the MCB says that medical treatment for mental disorder cannot be authorised under the bill if, at the time that it is proposed to treat the patient, his/her treatment is regulated by MHA Part 4. However, the provisions of cls5 and 6 may make it less likely that the MHA will be used to treat certain people, and more so that their treatment will be given under the MCB, which lacks the safeguards provided for in the MHA – in particular the rights to appeal to a Mental Health Review Tribunal (MHRT), and have a second opinion. The use of compulsory powers under the MHA is discretionary. If a psychiatrist can provide treatment other than by sectioning somebody under the MHA, s/he may feel very inclined to use such alternative powers, particularly as s/he could suggest that the use of the MCB would be in the patient's best interests: if a patient has to be compulsorily treated under the MHA s/he must be admitted to hospital, at least initially, whereas a person compulsorily treated under the MCB does not. The MCB, therefore, appears to contemplate a situation where non-compliant people who lack capacity can be compelled to accept treatment that could only be provided to non-compliant people with capacity under the MHA. This may give rise to challenges under articles 8 and 14 (prohibition of discrimination). (See example 1.)

The draft Mental Health Bill

As if this inconsistency were not enough, the government has now published the draft MHB, to replace the MHA. The most significant changes from the MHA are that:

- people with mental disorder (whether with or without capacity) will be compelled to accept medication, and other treatment, while living in the community (cls9 and 16). (This may fail the convention's test of proportionality.);

- clinicians will no longer have any discretion about whether or not to make an individual subject to compulsory powers (cls16 and 38); if the person meets the relevant criteria, s/he has to be made subject to compulsory powers. Also, tribunals will no longer enjoy an overriding discretion to discharge patients (cls45 and 56). If the relevant conditions apply, the tribunal cannot discharge;

- in some cases, even when a person has the capacity to agree to accept treatment and does so, his/her doctor will have no option but to make him/her subject to compulsory powers. Again, this provision will, almost certainly, fail the test of proportionality. If the MHB had the same principles in support of autonomy as the MCB

Example 1

Ms A has schizophrenia. She was previously detained for treatment under the MHA 1983, and was prescribed injectable anti-psychotic medication, which made her feel much better. She agreed to go on taking the medication when she went home, and as a result of this her doctor discharged her. Some months later she decided, as she was feeling so well, that she no longer needed to take her medication. She was cajoled and chivvied into the injection clinic, and when she protested and said that she did not want to have an injection, the doctor told her that if she did not accept it quietly, he would have to call in some nurses to restrain her while he injected her. He said that he had the legal authority to do this under the MCB.

(which it does not), they would be breached by this requirement; (See example 2.)

■ where a person is made subject to compulsory powers, it seems likely that his/her consent to treatment need no longer even be sought (cl199).

The major limitation on the use of compulsory powers under the MHB comes with the definition of medical treatment: 'treatment for mental disorder provided under the supervision of an approved clinician'. The explanatory notes confirm that approved clinicians will be senior specialists such as consultant psychiatrists and consultant psychologists. It is clear, therefore, that if the medical treatment is not being given under the supervision of an approved clinician, then the MHB's powers cannot be used.

The implications of the reforms

If one tries to work out how things will work if the MHB and MCB are passed in their current form, there are a mind-boggling array of variables to be considered before deciding how to proceed, concerning the issues of consent, capacity, compliance, dangerousness, advance directives, the views of carers, attorneys or deputies and the availability of alternatives. Some of these are matters that have to be considered under the current mental health system, but the loss of flexibility in the new proposals means that there will often be only one legally correct authority for the use of compulsory powers, with serious legal and financial consequences if a mistake is made. (See example 3.)

Some practitioners who have been looking at the provisions of the two bills have already come to the conclusion that the relationship between them is so complex that, in many cases, it would be practically impossible to work out when one or the other should be used. But just as we were starting to get to grips with the intricacies of the relationship between the two bills, the ECtHR's decision in *HL v UK* Application 45508/99 arrived, and blew the whole debate sky high.

HL v UK: the facts

HL is a profoundly disabled autistic man. In 1998 he was living with foster carers in

the community, and attending a day centre regularly. One day, he became very distressed and agitated at the centre and was taken by staff to his catchment area psychiatric hospital. HL did not resist or protest (he is mute) and his psychiatrist therefore decided that he did not need to be detained under the MHA, but could be treated as an informal patient under MHA Part 7. HL was eventually allowed to return home, after habeas corpus proceedings persuaded the hospital to section him and a tribunal subsequently discharged him. Through his carers, he sought compensation for the time that he spent in hospital before he was sectioned, on the basis that he had been unlawfully detained. He eventually failed in the House of Lords, and took his case to the ECtHR. The decision was handed down in October 2004, by which time both the MCB and the draft MHB had been published. Clearly, the government had expected to win in the ECtHR, as the provisions of neither bill anticipated the outcome.

The ECtHR's decision

The ECtHR decided that HL had been detained, and that, therefore, he was entitled to safeguards under article 5 of the convention. The court said that the common law safeguards of judicial review and habeas corpus were inadequate to provide proper regulation and supervision of such detention. It also held that whether or not a person who lacked capacity could be defined as being detained would depend on the facts of the individual case. Some people who lacked capacity and were being cared for in hospital would not be detained, whereas others being looked after in residential accommodation, or even in their own homes, could be living in circumstances that amounted to detention.

Mental health law after *HL v UK***Current law**

The decision in *HL* throws both current and proposed mental health law legislation into complete disarray. Dealing first with the current law: it will be necessary to review the position of all people who lack capacity, and are currently receiving treatment for mental disorder in hospital as informal patients under MHA Part 7. Probably the most legitimate way to do this will be to section all of these people, and then refer their cases to the MHRT, so that it can decide whether the particular circumstances of the individual patient amount to detention.

The MHRT will have to take into account:

- the nature of the care being provided;
- the extent of the individual's disorder;

Example 2

Mr X has schizophrenia, and when he is ill he can behave dangerously, as he believes that people want to attack him and he therefore attacks other people in what he perceives to be self-defence. He has received hospital treatment for this, he has full insight and he is fully compliant with his medication which keeps him well, so that he is able to live a normal life. He has been accepting treatment voluntarily for years. Under the provisions of the MHB his doctor would have no choice but to section him if he considers that Mr X would still be at substantial risk of causing serious harm to others if he did not take his medication.

- the extent to which s/he has capacity;
- the extent to which s/he consents to his/her care and treatment; and
- the availability of alternatives that would allow the person to be treated without detention.

In regard to the last point, the views of relatives and potential carers, and/or the extent to which lack of funds limits the availability of alternatives to detention will, probably, become issues to be litigated.

However, the provisions of the MHA will not be sufficient to deal with the problem. There is likely to be a significant number of people who are detained according to the *HL v UK* definition, who could not be made subject to the provisions of the MHA, either because they are not being cared for in a place registered to take detained patients, or because they do not need medical treatment for mental disorder as defined in the MHA. These people will also need article 5 safeguards, and the government will have to come up with a satisfactory solution, in very short order, to avoid the risk of having to deal with many claims alleging unlawful detention.

Proposed reforms

We also have to look ahead to consider what effect *HL* will have on the proposed provisions in the MCB and MHB. One of the very interesting things about the decision is that it relates only to detention, and not to medical treatment for mental disorder. The MHB only allows compulsory powers to be used if the person concerned needs medical treatment for mental disorder (ie, treatment under the supervision of an approved clinician). As many of the people who will be affected by *HL* are not 'in need of medical treatment for mental disorder' as defined in the MHB, the government may be tempted to try and deal with the implications of the judgment by amending the MCB rather than the MHB. At the moment (and despite a comment to the contrary in para 122 of the judgment) the MCB is clearly not intended to authorise detention. If the MCB is to be amended to take account of *HL*, it will be essential for some kind of system to be set up to decide whether or not an individual person is being detained, and, if so, whether or not it is necessary. Although, in theory, the

Example 3

Mr B is a physically frail older man living in a nursing home. He is starting to suffer from dementia, and he has written an advanced directive to say that if he loses capacity he does not want to have any form of life-saving treatment. He does start to lose capacity, and he also starts to become depressed and rather withdrawn. His GP prescribes anti-depressants, in his best interests, under the MCB, and these seem to work. However in a conversation with Mr B's son and daughter the GP comments that if Mr B did not take the anti-depressants he would probably become more and more withdrawn until he would be refusing to eat or drink. Mr B's daughter points out that this appears to be covered by Mr B's advanced directive, which she insists should be respected. Mr B's son, on the other hand, refuses to accept that his father ever contemplated such a scenario. The GP is worried and consults his insurers, who say that he needs to be very careful not to ignore the advanced directive if there is a possibility that it is valid. He then speaks to a consultant psycho-geriatrician, who listens to what he says and gives the view that the GP is probably being overly pessimistic, and that Mr B will not come to serious harm if he stops taking the anti-depressants, because the staff at the nursing home will be able to coax him to eat and drink. The GP is reassured by this conversation, feeling that the psycho-geriatrician's view means that he can go on prescribing the anti-depressants under the MCB, as the anti-depressants are not a life-saving treatment and therefore not included in Mr B's advanced directive. The daughter is unhappy about this, and pursues the matter through the dispute procedure up to the Court of Protection, which concludes that the advanced directive was valid and that therefore the anti-depressants could not be given under the MCB. The GP then has to arrange for Mr B to be admitted to the local psychiatric hospital so that anti-depressants can be prescribed to him under the compulsory powers of the MHB. Once his care plan has been agreed by the MHRT he is discharged back to the nursing home as a non-resident patient.

revamped Court of Protection would be able to deal with these issues, the government's regulatory impact assessment (published with the bill) assumed that the court would only deal with about 200 cases a year. There are probably going to be thousands of cases to be dealt with following *HL*. It would be absurdly expensive and unnecessary to expand the Court of Protection's remit to enable it to deal with many decisions that are likely to be uncomplicated, uncontroversial and uncontested. It seems more likely that the government will set up a Mental Capacity Tribunal to deal with these issues. However, such a system would take months, or even years, to create: a legislative framework would have to be designed, and then many people would have to be recruited and trained to carry out its necessary functions.

If the government did decide to go down this path, and also persisted with the MHB in its present form, a point would be reached where there would be three separate jurisdictions dealing with the compulsory care and treatment of people with mental disorders, ie, the Mental Health Tribunal, the Mental Capacity Tribunal

and the Court of Protection. Decisions on the authorisation of care and treatment would, therefore, have to consider:

- whether or not a person had capacity;
- whether or not a person was consenting;
- whether or not a person's capacitous consent had to be overridden;
- whether or not a person lacking capacity had made a valid advance directive;
- whether or not a person lacking capacity had carers, an attorney or a deputy and, if so, whether or not they disagreed with the proposed treatment;
- whether or not it was intended to give the treatment in circumstances that amounted to detention;
- whether or not it was necessary to give the treatment in circumstances which amounted to detention;
- whether or not the proposed treatment amounted to 'treatment for mental disorder' within the meaning of the MHB; and
- whether or not alternative treatment could be given that would not amount to 'treatment for mental disorder' as defined in the MHB. (See example 4.)

Of course these matters would not only have to be considered at the time that the original decision was made, but would also have to be kept under continuous review. The appropriate authority would vary according to fluctuations in a person's capacity, the extent of his/her compliance, the extent to which s/he needed to be detained and the extent to which the necessary treatment amounted to medical treatment for mental disorder.

Possible solutions

The MHB could be re-worked so that all safeguards relating to detention, or to the compulsory provision of medical treatment for mental disorder, would be made by a unified Mental Health and Capacity Tribunal. It would be able to consider any potential variations in capacity, consent and treatment and would be able to authorise a holistic package of care and treatment, taking into account the principles of autonomy, proportionality (which would include seeking the least restrictive alternative) and best interests.

Another possibility would be for the government to work with existing legislation. If, for instance, it required all establishments that care for people with mental disorder to register under the Care Standards Act (CSA) 2000 as independent hospitals authorised to take detained patients, a number of consequences would follow. In the case of people with learning difficulties or dementia, if their care involved regular restraint or an element of detention, they could be sectioned without any disruption being caused, with the result that their care

Example 4

Mrs W has dementia, lacks capacity and lives in a nursing home (not an independent hospital under the CSA). She is compliant and quiet, her family visit every day and take her out, and she has lots of visitors. She has quite complex psychiatric needs because she also suffers from depression, and her care is supervised by a consultant psychiatrist – a specialist in old-age psychiatry.

Although she is compliant and quiet, she couldn't go out on her own because she has no sense of personal danger and could easily wander into the traffic. She therefore meets the condition under the MHB that she would be at substantial risk of causing serious harm to others if she does not receive treatment, and so her psychiatrist has to section her. As she is completely compliant and does not need to be detained she will be made subject to compulsory powers as a non-resident patient.

If she became non-compliant, and tried to leave, she would then meet the conditions for detention in *HL*, but her approved clinician could not simply make her a resident patient, because the nursing home would not qualify to meet the definition of 'hospital' in MHB s2(3). It will be necessary for her detention to be authorised under separate provisions (not yet defined) under the MCB. If her supervising clinician wanted to make her a resident patient using his powers under the MHB, he would have to remove her from the nursing home and place her in a different establishment.

would be supervised by a psychiatric specialist, second opinions would have to be obtained before certain treatments could be given, and the patient or his/her relatives would be able to apply to the MHRT, which could find that other, less restrictive, provisions should be made.

In the case of patients with other types of mental disorder, the ready availability of community placements authorised to take detained patients should allow them to move more quickly from a psychiatric unit back into the community, because they would continue to be subject to compulsory powers in the community. They would be entitled to apply to the MHRT to be discharged from the use of compulsory powers, and when they were well enough to live independently, the compulsory powers would lapse, automatically, within 12 months. This provision would give the government the compulsory community treatment that it wants, so long as it was prepared to accept that compulsory community treatment is not appropriate for people who are well enough to live independently.

These changes would be expensive, as more specialist staff would have to be employed and the NHS would have to pick up the tab for the cost of the care. However, the changes would not necessarily be as expensive as the system proposed by the MHB, and there is a good argument for saying that people who need to be detained or need to be compelled to accept treatment should receive specialist NHS care.

And, who knows? Maybe this would kick-start the improvements in the care of vulnerable elderly people that is so woefully overdue.