

Is it time for yet another Mental Health Act?

Royal College of Psychiatrists Annual Conference, Birmingham

Lady Hale President of The Supreme Court

24 June 2018

I first started teaching Mental Health Law in 1970 with the advent of generic social work. This was only 10 years after the Mental Health Act 1959 had come into force. The legal focus was still on hospital admission rather than community care. But the radical new principle was that people should be admitted to hospital for the care and treatment of their mental disorders in just the same way that people with physical disorders were admitted – with no special formalities prescribed by law or judicial safeguards. Informal admission was the name of the game. And most of us thought it was a very good thing too.

But last year the Prime Minister set up the Independent Review of the Mental Health Act, chaired by Professor Sir Simon Wessely, with survivor Steven Gilbert, my former colleague Sir Mark Hedley, and Rabbi the Baroness Neuberger as Vice-Chairs. She did so because of concern at the rising rates of detention under the Act, at the disproportionate number of people of black and minority ethnicities who are detained, and ‘stake-holder concerns’ that some processes under the Act were out of step with a modern mental health system.¹

¹ <https://www.gov.uk/government/publications/mental-health-act-independent-review/terms-of-reference-independent-review-of-the-mental-health-act-1983>

The figures are remarkable. Over the last 10 years, detentions in England have risen by 47%, from 43,000 in 2005/6 to 63,500 in 2015/16. The Review² suggests that this is because more people are being detained rather than because the same people are being detained more often. There is no one cause for this but several possible contributors: that people are not receiving the care in the community they need to prevent them reaching crisis; that reducing the number of beds tempts people to resort to compulsory powers in order to get a patient into hospital; increasing risk aversion amongst professionals worried about the repercussions if they fail to take protective action; broadening the scope of detention under the 2007 amendments; and confusion about the overlap with the Mental Capacity Act.

Some of these are not new. For as long as I can remember, there have been complaints that people cannot get the care they need in the community. There have also been fears that compulsion is used to get a bed when beds are scarce. But others may be newer and the law may have a lot to do with them. It is interesting that, just as the Government and the Review are expressing their concern at the rising use of compulsion in mental health care, the current and future Presidents of the Family Division have been speaking of a crisis in the child care system, with a similar huge increase in the use of compulsion over the past ten years. The Care Crisis Review, set up by the Family Rights Group and funded by the Nuffield Foundation, has just published its report.³ As with mental health care, the causes are complex and the local variation incomprehensible. But the causes are very similar. Work to support families to cope with their many problems is being marginalised by risk assessment and monitoring. Practitioners are increasingly risk averse, partly as a result of media coverage of tragic child deaths and a culture of

² *The independent review of the Mental Health Act, Interim report*, 1 May 2018, para 7.1.

³ *Care Crisis Review: options for change* (2018) London: Family Rights Group.

'blame, shame and fear'. My profession may well have contributed to that sense of blame, shame and fear. And we have probably done the same in the mental health care system, even if we didn't mean to. A case like *Rabone v Pennine Care NHS Foundation Trust*,⁴ where the hospital was held liable for the death of an informal patient who killed herself while on weekend leave of absence, is bound to make practitioners less inclined to use informal care.

Apart from that, there are more specific legal factors. The revised grounds for detention introduced by the 2007 Act did broaden its legal scope. All that is required for long term detention under section 3 is that the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital, that it is necessary for his own health or safety or for the protection of other people that he receive such treatment, and that it cannot be provided unless he is detained. All the old gradations between the serious and less serious forms of mental disorder have gone. The Care Quality Commission has recently concluded that 'legislative change alone may not have had a major or immediate effect' on detention rates,⁵ but that does not mean that they have had no effect.

Then there is the Supreme Court decision known as *Cheshire West*.⁶ The question was whether the living arrangements made for three severely mentally disabled people deprived them of their liberty within the meaning of article 5 of the European Convention on Human Rights. We held that the 'acid test' was whether they were under the continuous supervision and control of their carers and not free to leave. It did not matter that they were living lives which were normal for

⁴ [2012] UKSC 2, [2012] 2 AC 72.

⁵ Care Quality Commission, *Mental Health Act. The rise in the use of the MHA to detain people in England*, 2018.

⁶ *Cheshire West and Chester Council v P; S v Surrey County Council* [2014] UKSC 19, [2014] AC 896.

people with their degree of disability if their lives were not normal for people who did not share those disabilities. They should not be treated differently because they were disabled. This meant that legal safeguards were required for many more mentally disabled people than had previously been thought to be the case, echoing the result of the *Bournemouth* case in relation to informal hospital admissions.

Hence it is not surprising that, among other things, the Review wants to ‘rescue’ informal admission and no doubt other informal care arrangements. But both *Bournemouth* and *Cheshire West* were the result of the obligations in international law which the United Kingdom has undertaken under the European Convention on Human Rights, now part of United Kingdom domestic law as a result of the Human Rights Act 1998. And the values underpinning the Convention are respect for human freedom, human dignity and the essential equality of all human beings – ‘born free and equal in dignity and rights’, as the Universal Declaration on Human Rights put it as long ago as 1948. And these are the very values which led to the Wessely Review and are espoused by the College in its evidence to the Review.⁷ The Review’s terms of reference declare that ‘the government is committed to delivering parity of esteem between mental and physical health. We want to ensure that people with mental health problems receive the treatment and support they need when they need it, are treated with dignity, and their liberty and autonomy is respected as far as possible’.

Article 5 of the European Convention provides that ‘Everyone has the right to liberty and security of person’. This means several things. First, no-one can be deprived of their liberty except in the circumstances listed in article 5.1. These include ‘the lawful detention of persons of

⁷ *Review of the Mental Health Act 1983, The Royal College of Psychiatrists’ submission of evidence*, February 2018, p 5.

unsound mind' (article 5.1.e). This means a 'true mental disorder', established by 'objective medical expertise', and 'of a kind or degree warranting compulsory confinement'.⁸ Second, in order to be lawful, there must be safeguards sufficient to ensure that this is indeed the case and the detention is not arbitrary. The European Court of Human Rights decided, in the *Bournemouth* case,⁹ that this was not the case for informal admission to hospital of people who lacked the capacity to agree to it, where there were no procedural rules, no grounds, no statement of purpose, no limits of time or treatment, and no requirement of continuing clinical assessment. Thirdly, anyone who is deprived of his liberty by detention has to be 'entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful' (article 5.4).

HL was a profoundly mentally disabled and autistic man in his forties, who became agitated at his day centre, was sedated and taken to A & E where a psychiatrist assessed him as needing hospital care, so he was admitted informally, because by then he was compliant. But he was sedated, both to get him to hospital and to keep him there. He would have been sectioned had he tried to leave. His carers were at first not allowed to see him in case he wanted to leave with them. The hospital would not release him back into their care until it thought that he was ready. Two members of the House of Lords and the Grand Chamber of the European Court of Human Rights held that he had been deprived of his liberty.

But hospitals are not the only places where people may be deprived of their liberty. In *Cheshire West*, a man with Down's syndrome and cerebral palsy who needed 24 hour care and help with all the activities of everyday life lived in a large house with two other residents. The staff helped

⁸ *Winterwerp v The Netherlands* (1979-80) 2 EHRR 387.

⁹ *HL v United Kingdom* (2005) 40 EHRR 761.

him to live as normal a life as possible, but he was not allowed to go anywhere or do anything without them. The linked *Surrey County Council* case concerned two sisters with severe learning disabilities who had been removed from home as children because of abuse. One lived in a small group home and one lived with a foster mother in an ordinary house. Neither was allowed out on her own. Neither had shown any wish to leave but if they had done so they would not have been allowed to go. All were deprived of their liberty and there had to be some safeguards to protect them.

However, while we have one set of human rights obligations which aim to prevent people from being deprived of their liberty without adequate safeguards, we have another set of human rights obligations which could mean that they cannot be deprived of their liberty at all. The UK has ratified the United Nations Convention on the Rights of Persons with Disabilities, without any reservation aimed at preserving the current law in both the Mental Health Act and the Mental Capacity Act. Unlike the European Convention, however, the rights contained in the UN Convention have not been turned into directly enforceable rights in UK law. Indeed, in some respects they are irreconcilable with UK law.

The purpose of the UN Convention is ‘to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity’ (article 1). The definition of ‘persons with disabilities’ includes ‘those who have long term physical mental intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’ (article 1). This clearly covers many people with long term mental disorders or disabilities. States Parties have an obligation to recognise ‘that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law’ (article 5.1) and to ‘prohibit all discrimination on the basis of disability’

(article 5.2). This was the reason for saying, in *Cheshire West*, that mentally disabled people should be compared with people without disabilities, not with other people like them.

Article 14.1 of the CRPD says this:

‘States parties shall ensure that persons with disabilities, on an equal basis with others:

Enjoy the right to liberty and security of person;

Are not deprived of their liberty, unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.’

According to the UN High Commissioner for Human Rights,¹⁰ this marked a radical departure from the previous United Nations’ approach, which had accepted that mental disorder or disability was a lawful ground for detention. Under the UN Convention, deprivation of liberty based on the existence of any disability, including a mental or intellectual disability, is forbidden. Not only that. Proposals to limit this prohibition to detention ‘solely’ on the ground of disability were rejected during the drafting of the Convention. So the prohibition applies whenever mental or intellectual disability is part of the grounds, along with other elements, such as dangerousness or the need for care and treatment. This does not mean that people can never be detained for these purposes, but ‘the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis’ (para 49).

¹⁰ *Thematic Study by the Office of the High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities*, A/HRC/10/48, 26 January 2009.

In September 2015, the UN Committee on the Rights of Persons with Disabilities published its guidelines on article 14.¹¹ This emphasises that there are no exceptions to the absolute prohibition of detention on the basis of impairment (para 6). Involuntary commitment of people with disabilities to mental health institutions on health care grounds is prohibited (para 10), as is deprivation of liberty on the basis of perceived dangerousness, alleged need for care or treatment or any other reasons (para 13). People thought dangerous to others should be dealt with under the criminal justice system (para 14). Not only that, detention based on declarations of unfitness to stand trial or incapacity to be found criminally responsible are also contrary to article 14 (para 16).

Thus it is not surprising that the Committee's *Concluding observations Committee on the initial report from the United Kingdom of Great Britain and Northern Ireland*, published in October 2017,¹² recommended that the UK repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment (para 35). The Government has yet to respond, but somehow I don't think that it will agree.

So we are between a rock and a hard place. Neither the Law Commission, in their review of the Deprivation of Liberty safeguards in the Mental Capacity Act,¹³ nor the government in its

¹¹ *Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, The right to liberty and security of persons with disabilities*. Available at <https://www.ohchr.org/EN/HRBodies/CRPD/Pages/GC.aspx>.

¹² CRPD/C/GBR/CO/1.

¹³ *Mental Capacity and Deprivation of Liberty*, Law Com No 372, 2017.

response,¹⁴ has suggested that we do not continue to use the definition of deprivation of liberty adopted by the European Court – or that the interpretation in *Cheshire West* was wrong. A great many people are in fact being deprived of their liberty. The European Convention recognises this and says that there must be safeguards to protect them against arbitrariness. The UN Convention, on the other hand, says that people must not be detained at all on the basis of their impairment, whether mental or physical.

Is there any way in which we could make our law consistent with the UN Convention? The Mental Health Act contains two justifications for non-consensual interventions – the protection of other people, and the interests of the health or safety of the person concerned. In the 1970s,¹⁵ we debated whether there was any justification for compulsory admission and treatment of people with mental disorders and disabilities other than the risk of harm to others; and then in the 1990s,¹⁶ we debated whether the lack of capacity to decide for oneself was the best justification for non-consensual interventions. But in both debates it was taken for granted that the underlying criterion was the existence of a mental disorder or mental disability. The question was what *extra* justification was required beyond the existence of a disorder of the appropriate nature or degree.

But what if we were to turn the question round and ask ourselves in what circumstances would the protection of other persons or the interests of that person’s health or safety be a good reason

¹⁴ <https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2018-03-14/HCWS542>.

¹⁵ Largely prompted by Larry Gostin’s two volume critique, *A Human Condition*, MIND, 1975 and 1977.

¹⁶ See the Richardson report, *Report of the Expert Committee: Review of the Mental Health Act 1983*, Department of Health, 1999.

for compulsory intervention, not only by way of detention, but also by way of treatment, if there were *no* requirement that the person be suffering from a mental disorder? In other words, take away the reference to something which will quite often fall within the UN Convention's definition of disability?

The answer is obvious. We do not believe in the preventive detention of people who have not been proved to have offended against the criminal law: witness the problems faced by the government when they tried to introduce a form of preventive detention for suspected terrorists.¹⁷ And the criminal law has stringent safeguards: the presumption of innocence, the rules of evidence, the burden and standard of proof, and the right to trial by jury for serious offences. Nor do we believe in the compulsory detention and treatment of people with physical disorders and disabilities: we believe in their right to decide for themselves what shall be done with their own bodies, their right to be given enough information to enable them to make a real choice,¹⁸ and their right to refuse even the most beneficial treatment and care.

So does the fact that a person is suffering from a recognised mental disorder of a nature or degree which makes it appropriate for him to receive treatment for that disorder in a hospital make all the difference? I have never been sure that it does: especially now that the criterion is so loose. On the other hand, the fact that a person lacks the capacity to make the decision for himself should surely make a difference. Is it not inhumane to deny to a person the care and treatment he needs because he is unable to decide whether or not to have it?

¹⁷ In Part 4 of the Anti-terrorism, Crime and Security Act 2001; see the 'Belmarsh case', *A v Secretary of State for the Home Department* [2004] UKHL 56, [2005] 2 AC 68.

¹⁸ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430.

The Mental Capacity Act says that a person lacks capacity ‘if at the material time he is unable to make a decision for himself . . . because of an impairment of, or a disturbance in the functioning of, the mind or brain’ (s 2(1)). It then goes on to explain that a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision, (b) to retain that information (I would say that this means for long enough to make the decision), (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or other means) (s 3(1)).

There is nothing in that definition which requires a person to be suffering from a recognised mental disorder or disability (ICD or DSM). The reference to ‘an impairment of, or a disturbance in the functioning of, the mind or brain’ does not equate with the UN Convention definition of disability. And in any event, would it make much difference if we were to take out this so-called diagnostic threshold altogether? Does it serve any useful purpose? Surely we would want to have some means of substitute decision-making for anyone who was unable to make the decision in question for themselves, for whatever reason?

So could the substitute decision-making provided for in the Mental Capacity Act be made compatible with the UN Convention? Many of the people for whom it is invoked will in fact be persons with disabilities for the purpose of the Convention but it is their lack of capacity rather than their disability as such which justifies the non-consensual intervention. You or I, if we were temporarily incapacitated by an accident or a stroke, would be in the same position. Thus, can we say that the Mental Capacity Act does not discriminate against persons with disabilities as such? Nor is it an attack on their autonomy, or mental or bodily integrity, because by definition the person concerned is not autonomous, at least in this respect at this time.

The problem is that article 12.2 of the Convention provides that ‘States Parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life’. In General Comment No 1, *Article 12: Equal recognition before the law* (April 2014), the Committee drew a clear distinction between legal capacity and mental capacity (para 13):

‘Legal capacity is the ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency). Mental capacity refers to the decision-making skills of a person, which naturally vary from one person to another . . .’

But it went on to state that

‘Under article 12 of the Convention, perceived or actual deficits in mental capacity must not be used as justifications for denying legal capacity.’

Indeed it declared the ‘functional approach’, on which our own MCA is based, flawed for two reasons:

‘(a) it is discriminatorily applied to people with disabilities, and (b) it presumes to be able to accurately assess the inner workings of the human mind . . .’

Article 12.4 rather confusingly says this:

‘States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and

undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.'

This rather looks as if the Convention does contemplate the taking of decisions on behalf of people who are unable to take them for themselves, subject to appropriate safeguards. But the Committee has made it quite clear that this is not so. 'The human rights based model of disability implies a shift from the substitute decision-making paradigm to one that is based on supported decision-making' (para 3). Article 12.3 imposes a duty to provide such support (para 16). Article 12.4 is all about safeguards from abuse and undue influence. If it is not possible to ascertain a person's views, the 'best interpretation of will and preferences' must replace the 'best interests' determinations (para 21).

So it is not surprising that the Committee has recommended that the UK 'abolish all forms of substitute decision making concerning all spheres and areas of life by reviewing and adopting new legislation in accordance with the Convention to initiate new policies in both mental capacity and mental health laws'. It wants us to 'step up efforts to foster research, data and good practices in the area of, and speed up development of, supported decision-making regimes' (para 31).

There is, of course, nothing wrong with encouraging and developing supported decision-making regimes, but is it sensible to think that they can provide the whole answer?

It follows from all of this that there is a real need for the Wessely Review. It has already identified many points of detail on which the law and practice could be improved: the involvement of family and carers; enhanced respect for advance statements of wishes as to what

treatment to have or not to have; greater safeguards for compulsory treatment during the first three months in hospital, with the possibility of an appeal to the tribunal against compulsory treatment decisions; whether the tribunal should be the sole channel for review, rather than the current confusing distribution between tribunals and judicial review; strengthening the principle of least restrictive practice when it comes to seclusion and restraint; improving the ward environment and atmosphere; clarifying decision-making roles in relation to children and young people; speeding up transfers from prison and considering the distribution of decision-making powers in relation to restricted patients; and much else as well.

For the time being the Review has ruled out synthesising the Mental Health and Mental Capacity Acts, but will consider this in the longer run. You will gather that I am hugely attracted by this idea. It seems to me to come closest to reconciling our conflicting international human rights obligations. It is predicated on respect for human dignity and autonomy and individual values and preferences. It does not discriminate between the treatment and care of physical and mental disorders. It covers all kinds of decision-making.

But I am sure that you would say that the Mental Capacity Act model of capacity does not sit well with mental illnesses. The Act stresses that a person does not lack capacity simply because he makes an unwise choice (section 1(4)). The key is in the third requirement in the test: the ability to use or weigh the relevant information in order to arrive at a decision. Can this be elaborated so as to cater for those patients who are genuinely unable to make a real choice because they are in the grip of some compulsion or delusion? That might well be possible but would it be enough? Is there a way of capturing the severely depressed suicide risk within this concept? And no doubt there are other problematic cases. But it seems to me to be work which is well worth doing – there is a good deal which has already been done.

But to come back to the beginning. Is it really possible to ‘rescue’ informal admission? The concept marked such a change from the attitudes and practices of the past when it was first introduced. And it works for people who do have the capacity to agree to go into hospital for whatever reason. But it is hard to see how it can be rescued for people who lack that capacity. The answer might be instead to make sure that the processes designed to ensure that decisions are taken in their best interests (rather than those of other people) are as simple, as clear, and as streamlined as possible. I wish the Wessely Review every success in their endeavours and, yes, it is time for yet another Mental Health Act.