

Protection! Protection! Protection! Déjà vu all over again. The Government Response to the Parliamentary Scrutiny Committee

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This article discusses the Government's Response to the Joint Parliamentary Scrutiny Committee Report on the Draft Mental Health Bill², from the bias of someone who served as the specialist legal adviser to the Committee.³ The point of Pre-Parliamentary Scrutiny was explained by the House of Commons Modernisation Committee in 1998 as follows:

'Pre legislative scrutiny provides an opportunity for the house as a whole, for individual back-benchers and for the opposition to have a real input into the form of the actual legislation which subsequently emerges, not least because ministers are likely to be far more receptive to suggestions for change before the Bill is actually published. It opens Parliament up to those outside affected by legislation ... above all it should lead to better legislation and less likelihood of amending legislation'.⁴

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2 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill 2004 Cm 6624 (July 2005)*

3 *I should like to pay tribute to the Commons and Lords and Committee Clerks and Managers who make this system work. Their ability rapidly to come to grips with mental health law and policy, to organise evidence*

sessions, and to manage the effective scrutiny of a complex Bill of more than 300 clauses effectively between October 2004 and late February 2005 impressed me immensely, as did the quality of the Committee and its Chairman. Together with Professor Tom Burns they made the most remarkable team of people I have ever had the pleasure of working with.

4 *HC Modernisation Committee The Legislation Process (1997–1998 session HC 190 para 20)*

***Protection! Protection! Protection! Déjà vu all over again.
The Government Response to the Parliamentary Scrutiny Committee***

Scrutiny gives the key ‘stakeholders’ in draft legislation, to use Government parlance, the opportunity to voice their views on its workability and desirability. On its establishment in the summer of 2004, the Joint Parliamentary Scrutiny Committee on the Draft Mental Health Bill invited written evidence in response to a series of questions, asking whether the Draft Bill:

- Was based on unambiguous principles, which were both appropriate and desirable?
- Used a definition of mental disorder that was appropriate and unambiguous?
- Contained provisions for care and treatment in the community which were adequate and sufficient?
- Set conditions of compulsion which were sufficiently stringent?
- Achieved the right balance between protecting the personal and human rights of mentally ill people on the one hand and concerns for public and personal safety on the other?
- Was adequately integrated with what was then the Mental Capacity Bill? While the Committee was sitting, the European Court of Human Rights delivered judgment in *HL v United Kingdom* Judgment of 5 October 2004, requiring amendments to be tabled to the Mental Capacity Bill.
- Was in full compliance with the Human Rights Act 1998?

Finally the Committee asked those submitting evidence to comment on the human and financial resource implications of the draft Bill, whether the Government had analysed the effects of the Bill adequately, and whether sufficient resources would be available to cover any cost arising from the implementation of the Bill?

The Joint Committee received over 450 written submissions and heard evidence from 124 witnesses including representatives of all the professional groups involved in mental health care, from service users and from carers, and from all the key non-governmental organisations, including MIND, Rethink, Hafal, the King’s Fund, and the Zito Trust, which represents victims and families of victims of mentally disordered offenders, from the Law Society, from the Bar Council, and from the Mental Health Review Tribunal. The evidence was of an extremely high quality, and the Committee was clearly moved by the testimony of service users and carers. The overwhelming weight of evidence was highly critical of the Bill.

In March 2005 the Committee reported, recommending a radical overhaul of the Bill.⁵ Describing the case for reform as cogent, but not overwhelming, the Committee made 107 recommendations. Many of the changes proposed were based on the Scottish legislation, such as that guiding principles should appear on the face of the Bill, that conditions of compulsion should be introduced that the person’s judgment in relation to accepting treatment was significantly impaired, and a condition of likely therapeutic benefit. The Committee accepted the broad definition of mental disorder used in the Bill, but recommended that there be exclusions stating that a person should not be treated as mentally disordered by reason only of addiction to alcohol or drugs. This has been accepted by the Government. However, the Government Response loftily dismissed many of the Committee’s core concerns on the grounds that they ‘miss the point’ of mental health legislation. This article suggests that, far from missing the point, the Scrutiny Committee have identified key flaws in the Draft Bill.

⁵ House of Lords House of Commons Joint Committee Report on the Draft Mental Health Bill, Session 2004–2005 HL Paper 79-1, HC 95-1. Session 2004–2005.

In order to understand the Government's repeated rejection of criticism of its reform proposals, it is important to appreciate the importance of the public safety agenda as a driver of Government policy and to outline the key features of the reform process before turning to the Scrutiny Committee Report and the Government response.

The Process of Reform

This effectively began in 1998 with the famous pep talk from the then Health Minister Paul Boateng to Professor Genevra Richardson's Expert Committee that, whilst they were at liberty to consider 'root and branch reform', they should remember the Government's key imperative, to 'make clear that non-compliance with agreed treatment plans is not an option.' The Richardson Committee recommended a system that employed a broad definition of mental disorder, but narrower accompanying criteria for compulsion, that dispensed with the statutory review function of hospital managers, which removed the rights of the nearest relative, that provided for a single pathway to compulsion regardless of whether compulsion was to be in hospital or in the community, and that placed the Mental Health Tribunal at the centre of the system of safeguards, authorising compulsion, hearing applications for review of compulsion, and approving the compulsory treatment plan. Under their proposals, after 28 days compulsory assessment, a tribunal would authorise compulsory treatment either in hospital or in the community. The Committee sidestepped the issue of how compulsory powers in the community would be enforced. Clear undertakings had already been given by Minister Boateng at the committee launch, that compulsory treatment in the community did not mean forcibly injecting people on their kitchen tables. The Committee did not say anything about enforcement in the event of non-compliance with medication in the community.

The Richardson Committee was concerned that the broad concept of mental disorder might lead to a potential 'net widening' effect. Because of this, and their concern to produce a non-discriminatory and principled framework for intervention in the absence of consent, the Committee recommended the introduction of strict accompanying conditions of compulsion, including a capacity test.⁶ Under their proposals anyone who lacked capacity could be subject to compulsion if necessary for their own health, or safety, or for the protection of others. Anyone retaining capacity could be subject to compulsion only if there was a substantial risk of serious harm to the health or safety of the patient or to the safety of others. The Committee also proposed a further condition of compulsion that there must be positive clinical measures, which were likely to prevent deterioration or secure an improvement in the patient's condition. Without this, they said, healthcare professionals might be forced 'to engage in activities they would regard as inappropriate and possibly unethical.'⁷

Richardson attached great importance to the inclusion of principles on the face of the Act which in their view would be educative and would provide a guide as to how provisions should be interpreted. The Committee recommended that some principles should be spelt out on the face of the legislation, whilst others should be reflected in the Code of Practice.⁸ They regarded the principle of non-discrimination on grounds of mental health as central to the provision of

6 *Report of the Expert Committee, Review of the Mental Health Act 1983 DoH 1999, para 5.96.*

7 *Ibid., para 5.99.*

8 *Report of the Expert Committee, Review of the Mental Health Act 1983 DoH 1999, paras 2.14 – 2.25.*

treatment and care to those suffering from mental disorder. However, they also recognized that it would not be appropriate to express the principle within the legislation itself. Instead they endorsed the approach of giving considerable emphasis in the Code of Practice to the principle that wherever possible the principles governing mental health care should be the same as those which govern physical health.

The Committee also recommended that the legislation should state one of its main purposes as being recognizing and enhancing patient autonomy. They then went on to list ten principles, noting at the outset that they did not intend them to be susceptible of specific enforcement on the part of individuals. The principles advocated included the least restrictive alternative, that necessary care, treatment and support be provided both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account of the safety of other patients, carers and staff. The other principles recommended included that there should be a preference for informal and consensual care, reciprocity, participation, equality, respect for diversity, recognition of carers, provision of information, and effective communication.

As is well known to readers of this journal, the Government selected the features of the report that pleased them, and rejected those that conflicted with the public safety agenda⁹. They rejected the idea of having any principles on the face of the legislation, in favour of aims to be fleshed out by principles in a 'less binding' Code of Practice. They accepted the broad definition of mental disorder, but rejected the more limiting conditions of compulsion. Most important, they accepted the central role for the Mental Health Tribunal in imposing compulsion. The Government built on the Richardson Committee's rationale that because the central safeguard was a judicial body, other safeguards could be watered down or dispensed with, such as the right of objection to compulsion vested in nearest relatives, and the statutory second opinion system in relation to treatment without consent.

In 2000, the Government issued a two volume White Paper, *Part 1 The New Legal Framework, and Part 2 High Risk Patients*¹⁰, following which the Department of Health and the Home Office together produced the Draft Mental Health Bill 2002, lauding their own efforts as an example of 'joined-up government'.¹¹ The crucial factor in any understanding of the process of mental health law reform, and the reason for the repeated rejection of criticism of the Draft Bills is that the Home Office has been the dominant partner, and the Department of Health has tended to fall in line with a public safety agenda.

Although issued after policy was formed, the evidence base for Government policy on mental health law reform consists mainly of the findings of the *National Confidential Inquiry into Homicides by Mentally Disordered People* which reported in 2001. The Inquiry, due to report again in 2006, found that around one third of all perpetrators of homicide in England and Wales had a diagnosis of mental disorder based on life history. It must be remembered that this is mental disorder in the general sense and includes alcohol dependence, drug dependence and personality disorder, which were by far the most common diagnoses in this group. Fifteen percent had

9 The Government's initial response was: 'Reform of the Mental Health Act 1983 – Proposals for Consultation'. Cm 4480 (November 1999)

10 *Reforming the Mental Health Act, Part 1 The New Legal Framework, and Part 2 High Risk Patients, Cm*

5016-1 and 2, 2000.

11 P. Fennell, 'Joined Up Compulsion: The White Paper on Reform of the Mental Health Act 1983' *Journal of Mental Health Law* June 2001, pp5–20.

symptoms of mental illness at the time of the offence, and five per cent of all perpetrators had a diagnosis of schizophrenia. Nine per cent had a diagnosis of personality disorder. Alcohol and drugs were more likely to contribute to the offence in people convicted of homicide who were not mentally ill, and alcohol is a factor in 50% of all homicides.

A longitudinal survey of mental illness in people who kill strangers published in 2004 concluded that whilst stranger homicides increased between 1967 and 1997, the increase was not the result of homicides by mentally ill people and therefore the “care in the community” policy. Stranger homicides are more likely to be related to alcohol or drug misuse by young men, and alcohol was a factor in 56% of stranger homicides.¹²

The homicide statistics for 2002 show that in each year the number of people convicted of homicide where the court felt that the defendant’s mental disorder was a sufficient to have diminished their responsibility for the offence was 24.¹³ The number of homicides by people driving under the influence of alcohol or drugs is roughly equivalent to the number of people killed by people with mental illness. It is estimated that at least 50% of homicides are committed by people under the influence of alcohol, and each year alcohol plays a role in over 40,000 deaths, including 500 of young people.¹⁴ It is interesting to compare the Government’s response to the risk data about mental ill-health in its Mental Health Bills with its response to the risk from alcohol in the Licensing Act 2003, which allows 24 hour a day, seven days a week sale of alcohol.

A finding of the *Confidential Inquiry* which has influenced policy greatly was also that 9% of perpetrators (55 people) of homicide had been in contact with mental health services in the year before the offence. The policy implications derived from these findings by the Government was that these homicides might have been prevented by broadening the conditions of compulsion to allow more people with personality disorder and alcohol or drug problems to be subject to compulsory powers, restricting clinicians’ discretion to discharge from compulsion in high risk cases, and ensuring that long term compulsory care in the community would be possible.

The basic premise of the reform proposals is that the system of supervision of restricted offender patients in the community, run by the Home Office Mental Health Unit, works well in terms of public safety, that there are few problems with the offender provisions in Part III of the 1983 Act, and all the problems are with the non-offender provisions in Part II. Home Office restrictions on clinicians’ power to discharge are imposed on offender patients where necessary to protect the public from serious harm from offenders. If that system could effectively be replicated for non-offender patients, public safety would more effectively be secured. The Mental Health Bills 2002 and 2004 were designed to do just that, to introduce a concept of restricted non-offender patients, supervised by the tribunal, not the Home Office, whose discharge could only be ordered by the Mental Health Tribunal, not by clinicians. Moreover, they sought to ensure that these ‘high risk’ non-offender patients would enjoy more limited rights than those who did not pose a risk to others. Hence any statement of legislative principle should be flexible enough to be dis-applied to high risk patients. These are the non-negotiable bottom lines of policy. They are driven by the Home Office public safety agenda.

12 Shaw et al. ‘Mental illness in people who kill strangers: longitudinal study and national clinical survey’ [2004] 328 BMJ, 734–737 (27 March)

13 Criminal Statistics, <http://www.homeoffice.gov.uk/rds/pdfs2/cs2002vol2pt6.xls>

14 <http://www.ncl.ac.uk/nmp/teaching/disorders/substance/alcrelate.html>

The consultation on the 2002 Bill elicited over 2,000 responses, and the result was a resounding thumbs-down from stakeholders. Such was the opposition that psychiatrists, service users, and mental health charities banded together to form the Mental Health Alliance specifically to resist the Bill. The Department of Health and the Home Office rejected the evidence of the key stakeholders in their document *Improving Mental Health Law: Towards a New Mental Health Act*¹⁵ which accompanied the Draft Mental Health Bill 2004, introduced in substantially in the same form as the much criticised 2002 version. The 2004 Draft did not include the 2002 procedures for admission of compliant incapacitated (Bournewood) patients, because the Government apparently did not anticipate that it would lose the case of *HL v United Kingdom*.¹⁶

The most important general question of principle facing the Scrutiny Committee was the balance struck between the personal freedoms and human rights of mentally disordered people and pursuit of the public safety agenda.

Did the Bill achieve the right balance between protecting the personal and human rights of mentally ill people on the one hand and concerns for public and personal safety on the other?

One of the main areas of contention between the Scrutiny Committee and the Government was the extent to which the public safety agenda has come to dominate mental health law reform and whether this dominance would be to the detriment of mental health services. Shortly stated, the Scrutiny Committee concluded that the balance was wrong, and the Government reasserted its position. The Government rebuke the Committee for having ‘missed the point’ that it is really ‘a patient and public safety’ agenda. This criticism is inaccurate, as the inclusion of ‘personal safety’ in the Committee’s question shows. It is also less than frank. Whilst the Government talk about the need to guard against the risk of self harm, official policy documents consistently major on the Confidential Inquiry statistics from 2001 on homicides by mentally disordered people, and the self-harm statistics are rarely spelt out.

This is borne out in the two Departments’ response to the Scrutiny Committee. They acknowledge that ‘media coverage of homicides leads to a distorted view of the risk that is posed by mentally disordered people, the great majority of whom will never be a risk to anyone.’ ‘But’, they continue, ‘the fact remains that there are significant numbers of homicides by mentally disordered people each year – some of which are preventable’, turning again for support to the 2001 report of the National Confidential Inquiry on homicides¹⁷ and asserting that ‘society has a reasonable expectation that the law will provide protection, as far as possible, from patients with a serious mental disorder who present a risk of harm to others’.¹⁸

The vast majority of written and oral evidence was highly critical of the balance struck by the Bill, giving rise to speculation as to how the Government would respond if the Scrutiny Committee’s Report reflected that weight of evidence. The Government Response seeks to appeal, over the

15 Department of Health and Home Office, *Improving Mental Health Law: Towards a New Mental Health Act*, 2004.

16 E.Ct.H.R Judgment of 5 October 2004.

17 *Safety First: Five year report of the National Confidential Inquiry into Suicide and Homicide by*

People with Mental Illness 2001 <http://www.national-confidential-inquiry.ac.uk>.

18 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005*, para 14.

heads of those service users, carers, and professionals who did give evidence to the Committee (often of a powerful and harrowing kind), to the Banquo's ghost of the views of the general public:

'The Committee, while recognising that public protection is a relevant issue, does not in our view recognise the significance of this. The great majority of the evidence came from stakeholders who represent health and social care professionals and service users, and relatively little from those with responsibility for protecting the public or from the general public themselves – the majority of whom do not share the Committee's belief that the Bill is inappropriately concerned with public safety'¹⁹

So, with one mighty leap, the Committee's views can be disregarded. In appealing to 'the general public and those responsible for protecting them', the Government is calling for support from a particular sector of 'public opinion' which it has already acknowledged may be influenced by the very media distortions they have earlier described as misleading. The key question for the Government Departments was to assert homicide prevention as the core goal of mental health legislation, with all other considerations in a secondary position.

The Purpose of Mental Health Legislation

The Committee said that 'The primary purpose of mental health legislation must be to improve mental health services and safeguards for patients and to reduce the stigma of mental disorder.'²⁰ The Government's Response was dismissive: 'The Bill is not about service provision, it is about bringing people under compulsion.'²¹

The Bill is about service provision in the sense that the Committee heard evidence from many authoritative quarters that the workforce requirements of the new legislation would divert clinician time from patient care into servicing the regulatory apparatus, and this at a time of considerable shortages of clinical staff, particularly in Wales. The Committee expressed 'major concerns about the resources needed to implement the Bill', stating their 'lack [of] confidence in the Government's models and assumptions of funding and staff necessary to make the new provisions work.' They asserted that 'without adequate staff and funding, the new tribunal will fail to improve patient safeguards, and mental health could remain the Cinderella Service of the NHS.'²² This is a major concern. A regulatory apparatus which is staffed by clinicians, and which is resource intensive, will inevitably have an impact on services, in that more clinicians will be needed to meet demands for treatment.

Law performs a number of roles in relation to psychiatry. It authorises detention and compulsory treatment. It defines, with greater or lesser precision what treatment for mental disorder may include. It provides clinical authority to treat without consent. In order for these interferences to be legitimate, they must not only be authorised by law, that law must also provide safeguards to prevent their arbitrary use.

19 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005, para. 13.*

20 *House of Lords House of Commons Joint Committee Report on the Draft Mental Health Bill, Session 2004–2005 HL Paper 79-1, HC 95-1. Session 2004–2005, Summary, p 5.*

21 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005, para. 10.*

22 *House of Lords House of Commons Joint Committee Report on the Draft Mental Health Bill, Session 2004–2005 HL Paper 79-1, HC 95-1. Session 2004–2005, Summary p 6.*

The Educational Function of Law

Law also performs an educational or ideological role, and its tone and language is capable of promoting positive or negative images of mental disorder and mentally disordered people. The tone of the Mental Health Bill reflects a perception of people who suffer from mental ill health as potential threats to society, and this was remarked on by witnesses before the Committee. This is best illustrated by comparing the style of the Mental Capacity Act 2005 with that of the Mental Health Bill 2004. Both allow treatment to be given without consent to people who suffer from mental disorder, the MCA on grounds of incapacity and best interests, the MHA on grounds of risk and necessity. The Mental Capacity Act includes statutory principles to which decision-makers must have regard, including the least restrictive alternative, the presumption of capacity, and that people shall not be treated as incapable merely because they make an unwise decision. These are based on common law, and reflect principles proposed by Richardson. The tone of the Mental Capacity Act is inclusive, with provisions requiring that decisions about best interests shall not be based merely on age, appearance, condition or aspect of behaviour which might lead someone to make unjustified assumptions about what might be in their best interests.²³ The inclusion of these principles implemented a recommendation of the Scrutiny Committee on the Mental Capacity Bill.

The language of the Mental Health Bill strikes a different note. It is the language of risk management rather than social inclusion. It reflects the Government's assertion that 'The Bill is not about service provision, it is about bringing people under compulsion.'²⁴ Some members of the Scrutiny Committee on the Mental Health Bill had served on the Committee for the Mental Capacity Bill and were struck by the contrast in style. In contrast to section 1 of the Mental Capacity Act 2005, Clause 1 of the Mental Health Bill 2004 is less concerned with principles than it is with how they might be departed from for certain groups. It provides for the production of the Code of Practice which will establish general principles based on aims stated in clause 1(3) that (a) patients are involved in the making of decisions, (b) decisions are made fairly and openly, and (c) the interference to patients in providing medical treatment to them during the treatment are kept to the minimum necessary to protect their health or safety or other persons. Clause 1(4) then states that the Code may provide that one or more of the general principles is not to apply in circumstances where its application would be inappropriate or impracticable, and in relation to decisions or persons specified in the Code. These statements of principle are non-contentious. If a decision is not made fairly, or a decision is made to impose compulsion without adequately informing the patient, it will be susceptible to judicial review. Similarly, application of a power which affects a Convention right in breach of the principle of minimal interference or proportionality would be susceptible to judicial review. So it would be pointless to seek to dis-apply them.

Principles on the Face of the Bill

One of the Committee recommendations the Government apparently accepted, was that principles should appear on the face of the Bill. I say 'apparently' because, whilst the Government Press Release states that 'The guiding principles will appear on the face of the Bill'²⁵, what the Response actually says is this:

23 *Mental Capacity Act 2005*, s 4(1).

2005, para. 10.

24 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624*

25 *Next Steps for Mental Health Bill*, 13 July 2005 2005/0244.

The Government accepts that principles ought to be set out on the face of the Bill, provided that they can be drafted in a way that allows for due protection of an individual's rights and autonomy, while also facilitating practitioners and others to take decisions that are necessary to minimize harm.²⁶

It may be that the Government has found that the principles cannot be drafted in order to allow sufficient flexibility to meet these potentially competing goals. Given that a key component of the public safety agenda is avoiding the possibility that rights or principles might get in the way of the public protection agenda, it is quite likely that the Government will not put principles on the face of the Bill, but will leave them to the Code. Of course, a lot depends on what the principles are.

The Scrutiny Committee recommended the principles to be found in section 1 of Mental Health (Care and Treatment) (Scotland) Act 2003 which requires anyone discharging functions under the Act to have regard a number of matters designed to promote patient participation and non-discrimination. The decision-maker must have regard to the past and present wishes of the patient, the views of the patient's named person, any carer, any guardian or welfare attorney for the purposes of the Adults with Incapacity Act. Decision-makers do not have to have regard to the views of carers, named persons, guardians or attorneys in so far as it is unreasonable or impracticable to do so.

Decision-makers must also have regard to the importance of the patient participating as fully as possible in the discharge of the function, the importance of providing adequate information to enable the patient to participate in decision-making, and the range of options available in the patient's case. They must have regard to the importance of providing the maximum benefit to the patient, and the need to ensure that, unless it can be shown that it is justified in the circumstances, the patient is not treated in a way that is less favourable than the way in which a person who is not a patient might be treated in a comparable situation. Finally, the decision-maker must have regard to the patient's abilities, background and characteristics, including age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background, and membership of any ethnic group.

When the person has had regard to all these matters they must discharge the relevant function in the manner that appears to involve the minimum restriction on the freedom of the patient that is necessary in the circumstances. Where people are subject to compulsion or have been detained, the decision maker must have regard to the need to provide appropriate services and continuing care for the patient. Where anyone, including Government ministers, is discharging functions under the Act, they must do so in a manner that encourages equal opportunities and in particular the observation of equal opportunity requirements.²⁷

The Scottish Act requires decision-makers to 'have regard' to these principles. Having regard means that they should be considered, but that there is freedom to depart from them. In *R(Munjaz) v Ashworth Hospital Authority* Lord Hope of Craighead said that Guidance under the Mental Health Act Code of Practice was 'less than a direction, but more than something which those to whom it is addressed "must have regard to"'. Having regard to a principle was felt by Lord Hope to be less of an obligation than the duty to follow the Code's provisions which applies where a Convention right is engaged, unless there are cogent reasons not to.²⁸

26 Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005, response to recommendation 4.

27 Mental Health (Care and Treatment) (Scotland) Act 2003, s 3.

28 [2005] UKHL 58.

The Government has sought to employ a ‘belt and braces’ approach to the subjugation of principles to risk management, by relegating principles to the Code, and providing for their disapplication. This pre-occupation with ensuring sufficient flexibility to ensure that principles will not be susceptible of general application risks losing sight of what a principle is: a guide to action across the board. As Lucy Scott Moncrieff so brilliantly summed it up in her evidence to the Committee, a principle which can be departed from is a ‘nice idea’, not a principle. The principle of proportionality applies across the board. There is no need to dis-apply it in order to justify detaining someone whose level of risk to self or others requires detention, because detention would be a proportionate response.

The Mental Health Tribunal

The Department of Constitutional Affairs will take responsibility for the Mental Health Tribunal, adding a third Government department to the process of joined-up Government. The additional need for tribunal hearings under the new legislation which would require a hearing to authorise compulsion and each time it is renewed, together with the need to ratify treatment plans, will dramatically increase the workload of the tribunal over that currently undertaken by the Mental Health Review Tribunal. The Committee received a memorandum of evidence from the Tribunal Chairs for England and Wales and the Liaison Judge, Judge Sycamore, stating with one voice that they felt the proposed new role for the tribunal would be hugely resource-intensive and disproportionate to its aims, as well as being cumbersome to the point of being unworkable.²⁹ The proposals for the new tribunal will transform it from a review body hearing applications for discharge from patients, to more of a mental health court, imposing compulsory treatment or detention and ratifying treatment plans. This change of ethos of the tribunal should not be underestimated. Nor should the likely numbers of cases to be processed by tribunals.

General opinion is in favour of increasing safeguards. There seems to be broad consensus that a judicial process is the best form of safeguard, although as is persuasively argued by Victoria Yeates in this issue³⁰, it is an inadequate replacement for substantive rights such as the nearest relative’s right to object to compulsory admission. Placing the tribunal at the centre of the system of safeguards poses the greatest threat to the workability of the new legislation because of the workforce implications, and as we have seen this was a major issue before the Scrutiny Committee. It was feared that the tribunal would be placed under such pressure of work that it would become like judicial certification under the Lunacy Acts; that the functions of the MHT would soon come to be carried out largely by their legal presidents, that the Tribunal would in effect become what one official dubbed a ‘unibunal’ for many purposes, and that its effectiveness in scrutinizing the need for compulsion would be compromised.

Widening the scope of compulsion

One of the central concerns of stakeholders was the potential net-widening effect of the new criteria and powers, and the numbers who might be subject to compulsion in the community. Since the

²⁹ Professor Jeremy Cooper, Mrs Caroline Kirby, Judge Philip Sycamore, Mr John Wright, *Submission to the Joint Committee on the Mental Health Bill DMH (memo) 200, para 5.*

³⁰ ‘Death of the Nearest Relative?’, Victoria Yeates – pp123–137 of this issue of the JMHL.

Committee reported, the King's Fund has published its estimate of the numbers likely to be subject to community based treatment orders, concluding that the use of non-residential orders in England and Wales is likely to build over a period of 10–15 years to a figure of 15–25 per 100,000 population, that is around 8,000 people. The research estimates that the build up to that figure would be gradual, but that health services should plan over time for several thousand people in the community under orders, rather than the figure of less than 2,000 estimated by the Department of Health.³¹

Conditions of Compulsion

In the limited space available, I shall concentrate on one of the two additional conditions of compulsion proposed by the Scrutiny Committee and rejected by the Government. Both are modelled on the Mental Health (Care and Treatment) (Scotland) Act 2003. The first requires that the person's judgment *in relation to the decision to accept treatment* must be significantly impaired. The second is that there be treatment available which is of therapeutic benefit. The Richardson Committee recommended that capacity play a part in the conditions of compulsion, to the extent that a higher threshold of risk to self or others would be required to impose compulsion on a capable person. Richardson also recommended a similar test to that of therapeutic benefit. The Government has rejected both recommendations. They have done the same with the Scrutiny Committee recommendations.

The Departments were concerned that the significantly impaired judgment criterion would mean that there might be capable people who would escape compulsion even though they posed a substantial risk to others. The Millan Committee learned from this experience of Richardson and proposed the intermediate concept of 'significantly impaired judgement'³², which was adopted. The Scottish Code of Practice emphasises that it is a separate concept to incapacity, even though similar factors are taken into account, including consideration of 'the extent to which the person's mental disorder might affect adversely their ability to believe, understand and retain information concerning their care and treatment, to make decisions based on that information, and to communicate those decisions to others.' The question whether judgment is significantly impaired bears a similar relationship to incapacity in the civil field, as that between diminished responsibility and McNaghten insanity in the criminal field. A person's judgment might be significantly impaired if they lacked insight into the fact that they had a mental illness, or where their ability to use information and weigh it in the balance to make a decision was impaired by a depressive illness.

The Government has rejected this proposal, reiterating its opinion that 'it is possible that people who are at very great risk to themselves or to others would nonetheless retain the ability to make unimpaired decisions about treatment.'³³ Dawson, in his excellent comparative survey of community treatment orders, suggests that the decision-making of people with less severe personality disorders would probably not be sufficiently impaired to meet the test, and that 'This is one principled way to exclude most persons with a personality disorder from cover by an involuntary patient regime.'³⁴

31 S. Lawton Smith, *A Question of Numbers: The potential impact of community based treatment orders in England and Wales*, Kings Fund Working Paper (September 2005), p 7

32 *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984*. Scottish Executive January 2001

33 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005*, response to recommendation 26, p 16.

34 John Dawson, *Community Treatment Orders: International Comparisons*, May 2005, Law Foundation New Zealand, p 100.

From the point of view of the public safety agenda, this would be seen as a major flaw. Yet from the point of view of non-discriminatory mental health law, and bearing in mind the purpose of the concept of significantly impaired judgement, it would bring mental health legislation regarding treatment without consent more closely into line with the common law.

Conclusion

The uncertainty as to whether a mental health bill will be introduced in this Parliamentary session continues. The Scrutiny Committee said that on balance the Government had made out the case for the new legislation. The Bill's goals in relation to compulsory treatment can currently be achieved under section 17 extended leave. If the fact that long term community compulsion is being achieved by the fiction of extended leave from detention troubles the national conscience, this could be remedied by amending legislation. The infringements identified in *JT v United Kingdom*³⁵ could be rectified by remedial order under the Human Rights Act 1998. Legislation to introduce protective care, or whatever the Government's preferred option is, to bridge the 'Bournewood Gap' must also take account of the ruling in *Storck v Germany*³⁶. The implications of having two statutory regimes for treatment without consent, the Mental Health Act and the Mental Capacity Act, need to be carefully thought through.

The current system whereby initial detention for assessment is authorised by properly trained professionals, and is subject to review by the MHRT, is compliant with the Convention. It would be better to inject sufficient human and financial resources into the MHRT, to enable it effectively to discharge the positive obligation under Article 5(4) of the Convention, than to take the leap in the dark to a new Mental Health Tribunal with vastly increased functions. Since other safeguards would be dismantled on the justification that the tribunal will provide more effective safeguards, it is important for us to be confident that the MHT will measure up to that onerous requirement. The Bill would move the system from one based on checks and balances between professional and family power towards one where faith would be placed almost entirely on a judicial body, supplemented by advocates with strictly limited powers and role. In stark terms, the Government has twice failed to secure the assent of the key stakeholders to what is effectively the 2002 Draft Bill. They might have been better advised to attempt a more modest amending measure, but much effort and prestige has been invested, and the departments seem determined to press ahead.

Future historians, and future generations of service users and their families will judge whatever legislation we produce at the beginning of this 21st century. They will find an impressive and moving body of evidence in the report of the Scrutiny Committee. Speaking personally, it was one of the great privileges of my life to witness that evidence, and see the Committee's reaction to it. Of course it is a question of judgment whether a mental health statute achieves a fair balance between a number of different functions, authorising treatment without consent and detention, providing rights to challenge compulsion, and promoting positive and inclusive rather than negative and stigmatising images of mental illness and mentally ill people.³⁷ The Scrutiny Committee felt that the Draft Mental Health Bill 2004 failed the test of holding these aspects of policy in a fair balance. The Government has rejected that view and reasserted its position.

35 [2000] 1 F.L.R.909

36 E.Ct.HR Judgement 16th June 2005

37 P. Fennell, 'Convention Compliance, Public Safety, and the Social Inclusion of Mentally Disordered People' [2005] 32 JLS 90-110.

A programme of mental health law reform which is content to allow the combating of stigma to be left to policy documents, and which is apparently oblivious to the powerful ideological force of law for good or ill, cannot fairly be described, as the Government seeks to do, as 'modern' or 'improved' mental health legislation.

The distinguished international commentator Professor John Dawson recently described Scotland's new legislation as 'state of the art' community treatment order legislation.³⁸ The Scrutiny Committee seemed to agree with this. The Government does not. Time will tell. One of the purposes of Pre-Parliamentary Scrutiny is to increase the chance of better, more workable legislation emerging, legislation which is sensitive to the position of those who will operate it and who will be subject to it. The Government's somewhat grudging approach to the Scrutiny Committee recommendations reflects its commitment and determination to pursue the public safety agenda above all others, and this is to be regretted. If things go wrong there will be no shortage of people in a position to say 'We told you so.'

38 *John Dawson, Community Treatment Orders: International Comparisons May 2005, Law Foundation New Zealand, p 98.*