Taking Stock[1]

Brenda Hale[2]

Many congratulations to Cardiff Law School and the Approved Mental Health Professionals Association (North West and North Wales) for organising this timely conference. I am looking forward to learning a lot from the galaxy of mental health law practitioners and scholars here today. It is a special pleasure to be back in Manchester, where I spent 18 years of my professional life and first encountered mental health and the law.

We shall be reflecting on the experience of the three recent upheavals in mental health and mental capacity law – the *Mental Capacity Act 2005,* most of which came into force on 1 October 2007, accompanied by a Code of Practice; the *Mental Health Act 2007* amendments to the *Mental Health Act 1983*, most of which came into force on 3 November 2008, accompanied by its two Codes of Practice; and the *Mental Health Act 2007* amendments to the *Mental Capacity Act 2005*, bringing in the so-called deprivation of liberty safeguards or DOLS, on 1 April this year, together with another Code of Practice. That is a huge amount of new law for us all to get to grips with. Things have changed a great deal since I first started teaching Mental Health Law to social workers and psychiatrists in this very City in 1971 – nearly 40 years ago.

There was no such thing as mental health law then. The *Mental Health Act 1959* had only been in force for ten years. The only law books were large practitioners' tomes (Shaw's *Mental Health Services*[3] and Heywood and Massey's *Court of Protection Practice*[4]). For many mental health professionals, including Kathleen Jones, whose *History of the Mental Health Services*[5] (1972, bringing together *Lunacy, Law and Conscience 1744–1845* and *Mental Health and Social Policy 1845–1958*) was the main academic text of the time, "legalism" was a dirty word. The 1959 Act was hailed as the death of mental health law. The Court of Protection might be necessary to look after the property and affairs of people who were rich enough to make it worthwhile but whose families were not smart enough to devise ways of avoiding its attentions. But everything else could be handled by a presumption of informality.

What lawyers might call safeguards, mental health professionals called formalities. The formal procedures were operated largely by the professionals and only used when the patient's resistance made it necessary to do so. The social workers I taught were deeply uncomfortable with the contradictions between their therapeutic role, based for many of them on psychotherapeutic principles of client responsibility and autonomy, and their power to take that autonomy away. The result was a playing down of the importance of legal safeguards. The law said nothing about what treatment might be given to incapacitated or detained patients in hospital because it was assumed that they could be given whatever treatment their doctors thought best for them.

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[1] *This is the text (with added footnotes) of the keynote address delivered by the author at 'Taking Stock: The Mental Health & Mental Capacity reforms: the first year', a conference organised by the Approved Mental Health Professionals Association (North West and North Wales) and Cardiff Law School in Manchester on 9th October 2009.*

[2] *Baroness Hale of Richmond; Justice of the Supreme Court.*

[3] *Now out of print. However, Shaw & Sons Ltd intend to publish in due course its successor 'Gostin on Mental Health Law' (publication date not known).*

[4] *Heywood and Massey: Court of Protection Practice is now in its 13th edition (2009) (Sweet & Maxwell).*

[5] *Published by Routlege & Kegan Paul (1972)*

A parallel system of court orders was provided for mentally disordered offenders. In theory, they could be neatly pigeon holed into the 'bad' – who should be punished in proportion to the seriousness of their crimes – and the 'mad' who could be kept in hospital until they were cured. But in practice, there was a category of restricted patients who could be kept in hospital for as long as the Home Secretary thought that they might be a danger to the public. For those who could not be cured this meant that they might remain in hospital for a very long time.

The lawyers were hardly involved at all. There was virtually no case law about the 1959 Act in the 1960s. (So it is not surprising that the first edition of my little book[6], published in 1976, was able to cover the whole of the law in England and Wales, with a supplement on Scottish law, in around 75,000 words and 236 pages.) The underlying policy assumptions were that the NHS could be trusted to look after the health and local authorities to look after the social care of people with mental disorders and disabilities, in much the same way as they looked after people with physical disorders and disabilities. Warehousing patients in large institutions in the countryside was to be phased out.

It is easy to forget what a radical change the 1959 Act had been from the previous approach of both the law and the pubic services. Much of it we now take for granted: the *United Nations Convention on the Rights of People with Disabilities*, adopted in 2006 and coming into force in 2008 (ratified by the United Kingdom in 2009) uses the conventional language of "mainstreaming".

But things were changing in the 1970s. Larry Gostin, now at Georgetown University in Washington, brought an American civil rights lawyer's eye to our system and found it deeply wanting (MIND, *A Human Condition*, 1975 and 1977[7]). The Butler Committee on Mentally Disordered Offenders (1975) was sceptical about the pigeon holes. The public remained scared of mentally disordered offenders. Mr X, conditionally discharged from Broadmoor for some years, was summarily returned to hospital because of what his estranged wife told his probation officer. He could do nothing at all to challenge the reasons for his detention before a court which could let him out. The European Court of Human Rights held the United Kingdom in breach of its obligations under article 5 of the ECHR (*X v United Kingdom* (1982) 4 EHRR 188, an application made in 1975 and decided in 1981). Human rights were very firmly on the scene.

The result was the *Mental Health Act 1983*. This left the basic structure intact. But it gave a greatly expanded and enhanced role to mental health review tribunals. It also placed some restrictions on the compulsory treatment of detained patients. Perhaps above all, it created the Mental Health Act Commission. Can we pay tribute to the work of the Mental Health Act Commission[8] and regret its passing? I hope that the Care Quality Commission will be able to keep up their good and very necessary work on behalf of detained patients, which could all too easily be obscured by the more everyday concerns of a body which has the whole of health and social care to regulate and worry about.

After the 1983 Act, there was a great deal more law for the professionals to know (so the second edition of my little book, published in 1984, had grown to 346 pages and had to drop its Appendix on Scotland). Academic lawyers, most notably Phil Fennell[9], were now taking an interest and engaging in serious research. But there was still not a lot of case law and only a few practising lawyers were involved.

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[6] *Mental Health Law by Brenda Hoggett (Sweet & Maxwell) – now in its 4th edition (1996): The 5th edition is due to be published in June 2010.*

[7] *Now out of print.*

[8] *See a review of the MHAC's 13th Biennial Report in this issue of the Journal of Mental Health Law.*

[9] *Now Professor of Law, Cardiff Law School, Cardiff University. Author of 'Mental Health: The New Law' (Jordans) (2007), reviewed in the Journal of Mental Health Law May 2008.*

Richard Jones' invaluable *Mental Health Act Manual* did not begin publication until 1985, but has sped to 12 editions[10] in less than quarter of a century.

But soon the legal practitioners did begin to take an interest. I assume that this was because legal aid (technically only assistance by way of representation) had become available before MHRTs. Their enhanced powers over restricted patients meant that heavy weight judges had been drafted in to preside over what became increasingly like ordinary trials. Lawyers began to specialise and the olden days when the tribunal and the mental health professionals knew far more about the law than the lawyers did were left behind. Lawyers also began to bring judicial review proceedings in the High Court. The case law began to develop, though only quite slowly to begin with. So my third edition in 1990 grew only to 369 pages.

By then there was a new concern. Many more people with serious mental disabilities were living in the community and living longer. Their families and carers were very concerned that there seemed to be no legal framework for looking after them. Here again, the assumption was that informality was best. I do not at all question this assumption, but there were no clear principles governing what could be done and no obvious procedures for resolving doubts and difficulties. Behind closed doors, the Family Division of the High Court began granting declarations authorising controversial procedures. In a blaze of publicity in 1989, the House of Lords endorsed this: *Re F (Mental Patient) (Sterilisation)* [1990] 2 AC 1. The Law Society (in the shape of Penny Letts)[11] and the Law Commission (in the shape of Brenda Hoggett, as I then was) began to take an interest in reforming the law.

The nineties and noughties saw a massive expansion in activity on three fronts. The Law Commission produced their *Report on Mental Incapacity* in 1995 (Law Com No 231). The Government consulted and produced draft Bills for pre-legislative scrutiny. Eventually, 10 years after the Law Commission's Report, the *Mental Capacity Act 2005* hit the statute books, doing more or less what the Commission had proposed. It was kind of Paul Bowen to call it "an elegant piece of legislative architecture" (*Blackstone's Guide to the Mental Health Act 2007*[12], 2007, p ix).

But when the Act was passed it was already known to be incomplete. This was the result of the rapidly growing case law, even before the *Human Rights Act 1998* came into force. One product of that, as everyone knows, was the *Bournewood* case (*R v Bournewood Community and Mental Health NHS Trust, ex p L* [1999] AC 458). The Court of Appeal, as everyone knows, held that Richard Jones and I were wrong to think that the 1983 Act authorised informal admission and treatment of people who lacked the capacity to decide for themselves to accept treatment. They had not been referred to the legislative history, or to the policy underlying the 1959 Act, or to the case law on necessity, including *Re F*. The House of Lords rescued the situation in 1998, but many thought that the absence of safeguards to protect people who were informally deprived of their liberty in this way was indeed a gap. The facts did not help, as L would clearly have objected to his admission to hospital had he not been sedated in order to get him there. In 2004, the European Court of Human Rights held, in *HL v United Kingdom* (2004) 40 EHRR 761, that the risk of arbitrary and unjustified deprivation of liberty without access to a tribunal meant that there was a breach of article 5 of the European Convention on Human Rights. Something had to be done. But the Government could not decide what to do before the Mental Capacity Bill was passed,

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[10] *Mental Health Act Manual by Richard Jones (Sweet & Maxwell) (12th edition) (2009). See 'Some Recent Publications' by John Horne in this issue of the Journal of Mental Law.*

[11] *Now an independent Policy Consultant; then Law Society Policy Advisor and Secretary to the Law Society Mental Health and Disability Committee.*

[12] *Blackstone's Guide to the Mental Health Act 2007 by Paul Bowen (Oxford University Press) (2007), reviewed in the Journal of Mental Health May 2008.*

just before Parliament was dissolved in time for the election in May 2005. Countless breaches of article 5 must have taken place up and down the country while the Government pondered the dilemma. I am not aware that anyone has taken action under the *Human Rights Act* as a result, but perhaps someone here will know. Five years after *HL* we now have the answer in the DOLS.

As Paul Bowen[13] comments, these are a "decidedly inelegant" addition to the 2005 Act, nearly doubling it in size. I am not sure that I would call it "the new triumph of legalism" because legalism referred to the involvement of lawyers and magistrates in committal procedures, whereas these procedures are, as he points out "labyrinthine and bureaucratic". I am not sure which is worse.

The Government thinks that there are roughly 500,000 people in England and Wales who have a mental disorder and lack capacity living in institutions (including over 190,000 with severe learning difficulties and about 230,000 older people with dementia). Department of Health analysts concluded that around 10% of these would require additional restrictions for their own protection which might involve deprivation of liberty. For some reason they then predicted that there will be 21,000 assessments in 2009/2010, of which only 25% would lead to authorisation. They also predicted that assessments will rapidly decline to 6,600 in 2015/16 but a similar proportion will result in authorisations. This is because they think that care homes and hospitals will become skilled at avoiding deprivations of liberty. An alternative hypothesis is that they will become skilled at avoiding using these procedures, just as most people managed to avoid troubling the Court of Protection even though they should have done. The Ministry of Justice thinks that only 2.5% of authorisations will result in a Court of Protection hearing. We shall see, but current experience suggests that they have over- rather than under-estimated the numbers. The worry remains that people who are in fact being deprived of their liberty are also being deprived of the safeguards to which they are entitled.

Meanwhile, in another part of the forest, the Government was reviewing the *Mental Health Act*. As always, deeply contradictory forces were at work. On the one hand were the mental health professionals who wanted the law to reflect the realities of modern mental health care, including multi-disciplinary teamwork and treatment in the community. But there was now much a better understanding between the professionals and the lawyers. Jill Peay's study of "Decisions and Dilemmas" (2003)[14] showed that the professionals were much more respectful of their patients' autonomy and conscious of their legal rights than they had been when I was sitting on Mental Health Review Tribunals in the early 1980s. The dilemma as always was how to reconcile that consciousness with their perception of their patients' needs. The lawyers too were beginning to realise that the goal was not always to keep the patient out of hospital at all costs but often how to achieve the care and treatment which the patient really needed. Together they could make common cause. It was that collaboration which produced the 1999 Report of the Expert Committee[15], led by Genevra Richardson. This tried to reflect the realities of modern practice while providing rational and defensible grounds for interfering in autonomy and proper procedural safeguards for doing so.

On the other hand the Government, with a great deal of public support, was increasingly concerned with protecting the public from offenders deemed especially dangerous. This meant detaining them long after the proportionate "tariff" for the crimes they had committed had expired and until they could show that

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[13] *Barrister, Doughty Street Chambers. See n.12.*

[14] *'Decisions and Dilemmas: working with Mental Health Law' by Jill Peay (Hart Publishing) (2003), reviewed in the Journal of Mental Health Law February 2004.*

[15] *The report of the Expert Committee 'Review of the Mental Health Act 1983' was published by the Department of Health in November 1999.*

they were "safe". This concern was first reflected in the "hybrid" orders brought in by the *Crime (Sentences) Act 1997* but we also see it in the indefinite sentence for public protection. The view that a restriction order was no longer an answer must have increased when the first declaration of incompatibility under the *Human Rights Act 1998* held that it was for the hospital to show that the grounds for detention still existed and not for the patient to show that they did not (*R (H) v Mental Health Review Tribunal* [2002] QB 1).

The battle between these two points of view continued for nearly a decade until the *Mental Health Act 2007*. After the expert report, there was a green paper, a white paper, three draft bills, pre-legislative scrutiny in Parliament, human rights audits by the Joint Committee on Human Rights, and eventually a decision to make only those amendments to the 1983 Act which were thought most necessary. It is not entirely clear that either side has prevailed.

Two examples will have to do. We now have a completely open-ended diagnostic criterion for compulsion – any mental disorder – which removes any connection between the capacity of the patient to make decisions for himself and the power of the state to authorise his detention. But we also have a requirement that appropriate treatment actually be available for the patient before his liberty is taken away[16]. We also have community treatment orders – so confusingly called SCT in the Codes of Practice – but considerable limitations on the circumstances in which treatment can be imposed upon a community patient.

So now the mental health law community has to grapple with two pieces of legislation, three Codes of Practice, and a multitude of case law both in the UK and in Strasbourg. Oh, and with different Codes and Regulations in England and Wales. Enormous care has been taken to keep the mental health and mental capacity regimes separate. But why? Some might think that the principles underlying the mental capacity regime were all one needed and the procedures in the mental health regime might be suitably adapted. But that is probably too radical a thought. No wonder all the books are getting fatter.

But I continue to ask myself, what is all this law for? Is it to enable people with mental disorders to obtain the care and treatment most suitable to their needs? Or is it to protect the rest of us from our fear of the harm that a small minority of them may do? Or is it to keep them away from hospitals and doctors and protect them from being treated differently from other people? I think that I might summarise the guiding and unifying principles like this:

(1) People with mental disorders and disabilities should be enabled to receive the treatment and care which they need.

(2) This applies to all people, without discrimination on grounds such as sex, racial or ethnic origin, sexual orientation, religion, membership of a particular social group, or the nature of their disorder or disability.

(3) Enabling does not mean enforcing. Everyone should be assumed to have the ability to decide for themselves whether to accept the treatment or care that others think they need. A person's right to choose what may be done with his body or his mind should only be taken away if he lacks the capacity to make the decision for himself.

(4) Any restriction on this right should be kept to a minimum. If it is taken away in important respects, for example by depriving him of liberty or obliging him to accept treatment which he

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[16] *Other than in the case of short-term detentions (ss.5(4), 5(2), 135, 136), detentions for assessment (ss.4, 2) and remands by the criminal courts for reports (s.35).*

does not want, there should be effective safeguards against abuse, regular reviews and the opportunity to challenge the decision before an independent tribunal.

(5) There must always be the appropriate care and treatment in return. The guiding principle in deciding what to do should be the best interests of the patient, but his own personality, wishes, feelings and values are an important part in deciding what will be best for him.

(6) Underlying and overriding all of these principles is respect for the dignity and humanity of all people, however disabled or disordered in body or in mind or both.

These are undoubtedly the values underlying the *Mental Capacity Act 2005* and translated into law. They are less obviously the values underlying or reflected in the *Mental Health Act 2007*. The amended section 118 of the *Mental Health Act 1983* requires the Code of Practice to say something similar, but reading the Code always suggests a sting in the tail:

> "1.2 Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder by maximising the safety and wellbeing of patients, promoting their recovery *and protecting other people from harm*."

I think it improves with the next:

> "1.3 People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose upon the patient's liberty, *having regard to the purpose for which the restrictions are imposed*."

The next is better still:

> "1.4 People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient . . . They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance)."

As is the next:

> "1.5 Patients must be given the opportunity to be involved, as far as practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible ... Carers and families should also be involved."

But what about the last?

> "1.6 People taking decisions under the Act must seek to use the resources available to them and to patients *in the most effective, efficient and equitable way,* to meet the needs of patients *and to achieve the purpose for which the decision was taken*."

Which is more efficient? To invoke the DOLS where an elderly patient is in fact being prevented from leaving the ward, to find ways of caring for her which avoid this risk, or to find ways of avoiding invoking the DOLs? As we learn more about the new laws and how they are working in the course of today, perhaps we could think about my radical suggestion!