

Two Bills; Two Agendas

Genevra Richardson¹

This short article² represents, in substance, a memorandum of evidence submitted to the Joint Scrutiny Committee on the Draft Mental Health Bill.³

A. The Relationship between the Draft Mental Health Bill and the Mental Capacity Bill

The government has published two Bills concerning similar, but not identical, populations and dealing with some similar decisions. The Mental Capacity Bill (MC) concerns those, mainly adults, who lack decision-making capacity, while the Mental Health Bill (MH) covers people, including children, who have a mental disorder of the required severity.⁴ Both Bills deal with decisions relating to care and treatment for mental disorder. So adults:

- who have a mental disorder of sufficient severity to attract MH powers,
- who require care and treatment for mental disorder, and
- who lack decision-making capacity,

could fall under the remit of either Bill.

B. The Present Confused Relationship:

Clause 28, Mental Capacity Bill gives priority to MH powers where these have already been engaged, but offers no indication of how the initial choice is to be made. MC further provides that people acting under the Bill (clause 6), including attorneys and court appointed deputies (clauses 11 and 20), may in certain circumstances restrain the incapable person (P). MC therefore envisages the need to override physical objections on the part of P, suggesting that the Bill's powers are not to be limited to those who appear to comply.

Clause 9, Draft Mental Health Bill sets out the conditions for the use of compulsory powers under that framework. These would cover people with a mental disorder, who require treatment for that disorder in order to protect them from suicide, serious self-harm or serious self-neglect, or in order to protect others. There is no requirement that the person must first lack capacity, but many of those who met these conditions would certainly do so. However, clause 9(5) specifically excludes from MH powers those who can be lawfully treated without the use of those powers, provided

1 Professor of Public Law, Queen Mary, University of London. Chair of the Expert Committee appointed by the Government in September 1998 to advise on mental health law reform, and whose report 'Review of the Mental Health Act 1983' was published in November 1999.

2 An earlier version of this text was presented at the North East Mental Health Law Conference held in November 2004. This article was accepted for publication before (a) the Joint Parliamentary Scrutiny

Committee on the Draft Mental Health Bill reported (23rd March 2005), and (b) the Mental Capacity Bill received the Royal Assent (7th April 2005).

3 Oral evidence was given on 20th October 2004 (ref: HCii); written evidence was printed on 21st January 2005 (ref: DMH 408).

4 Mental Capacity Bill 2004, as introduced in the Commons 24 November 2004, and Draft Mental Health Bill, published by the Department of Health, September 2004, Cm 6305-1.

they pose no serious threat to others. This suggests that in cases where care and treatment for mental disorder can be provided under MC powers, those powers should take priority, provided there is no substantial risk of serious harm to others. This would include a significant number of those cases where the person lacks capacity. Indeed, on a very literal reading of clause 60 of the Draft Mental Health Bill a person who entered MH powers while having capacity would have to be discharged from those powers if he or she subsequently lost that capacity. That clause requires the clinical supervisor to discharge a patient if at any time he or she is not satisfied that all the relevant conditions are met. It could thus impose on the clinical supervisor a continuing duty to keep capacity under review.

Further clause 9 does not cover people who need treatment for mental disorder and who lack capacity, but who present no threat to others and the danger they pose to themselves is insufficiently severe to meet the clause 9 threshold of risk of suicide, serious self-harm or serious self-neglect. Such people would have to be treated under MC, if at all, even if they were non-compliant.

There is therefore a considerable area of ambiguity and possible overlap between the two Bills. This uncertainty matters for patients, carers and mental health professionals and in certain crucial respects cannot be left to resolution through the Codes of Practice; it will require the amendment of both Bills.

Implications for patients. The uncertainty matters for patients because the choice of framework will carry significant implications. In many respects the provisions of MC might be preferable because all decisions would have to be made in P's best interests, the principle of least restriction would apply, a valid advance decision would be respected, a single framework would apply to all decisions P was unable to make for him or herself and there would be less stigma. However, under MC P would enjoy less rigorous safeguards than those which would apply under MH (see below).

Implications for carers and health professionals. The uncertainty also matters for carers and for health professionals who need to know with as much clarity as possible which framework to apply. It is possible that they too might have a preference for MC powers because those powers would involve less bureaucracy and would place all decisions under the same framework, an issue of particular importance in relation to medical care and treatment. To some extent the required clarity might be achieved through Codes of Practice but some of the issues reach beyond the proper scope of a Code.

C. Safeguards and *Bournewood*⁵

While it might be possible to accommodate most of the above issues by selective redrafting of both Bills and the production of carefully co-ordinated Codes of Practice, this would not deal with the central issue of safeguards. MC provides far less rigorous safeguards to the patient, in relation to both treatment and the deprivation of liberty, than does MH. It is hard to justify this distinction in anything other than pragmatic terms and it is now evident that no pragmatic justification for the absence in MC of adequate safeguards in relation to the deprivation of liberty will suffice. The *HL* decision of the ECtHR⁶ is quite clear that the common law regime under which individuals who lack the capacity to consent are currently deprived of their liberty in hospital fails to comply with

5 *R v Bournewood Community and Mental Health NHS Trust, ex p L* [1999] AC458

6 *HL v United Kingdom* ECtHR decision 5 October 2004.

the requirements of either article 5.1 or article 5.4. The detention in hospital under the authority of the common law is itself unlawful, since there are no formal admission procedures, no clarity over the purpose of admission and insufficient safeguards to protect against arbitrary detention, as required by article 5.1. Also there is no access to a court to determine the legality of the detention under article 5.4. Although this note is primarily concerned with those people who are deprived of their liberty within hospital, the reasoning of the court in *HL* could apply equally in respect of those detained in non-hospital institutions.

While the ECtHR's judgement in *HL* presents immediate practical problems for all those concerned with the provision of care and treatment for people who lack capacity, particularly when that care involves the imposition of significant restrictions on the liberty of the incapable person. This note does not attempt to offer any answers to those immediate problems. Rather it considers how the two current Bills might be amended to provide possible long-term solutions.

D. *HL* and both Bills.

In broad terms the provisions of MH are designed to comply with the requirements of article 5. The same is not true of MC. Significantly perhaps the explanatory notes accompanying MC make no mention of article 5 in their section *Compatibility with ECHR*.⁷

Article 5.1: MC has been drafted with no appreciation of the implications of the fact that the people resident in hospital under its provisions might be detained in the terms of the ECHR. As a consequence no provision has been made for the formal recognition of detention, its recording, its justification and its review. While the substantive provisions of the Bill are such as to render detention under its powers potentially lawful under 5.1, there are insufficient procedural safeguards. And, according to the court in *HL*, lawfulness under 5.1 requires 'the existence in domestic law of adequate legal protections and "fair and proper procedures"'(para115).

Article 5.4: The breach of article 5.4 is perhaps even more evident. In *HL* the Court refused to accept that either proceedings for judicial review or habeas corpus, or the ability to seek declaratory relief from the High Court could satisfy the requirements of article 5.4. Neither the developments in judicial review following the Human Rights Act⁸ nor the present extension of the role of the Court of Protection under the MC Bill itself would be sufficient to fill the gap. In theory the role of the Court of Protection could be amended to do so, but it is not the obvious body for the task since its expertise lies in the assessment of decision-making capacity and in the determination of the best interests of people lacking capacity, not in reviewing detention, imposing compulsory treatment or approving care plans.

Quite clearly steps have to be taken to bring the new provisions into compliance with article 5 and, against the uncertainties outlined above, those steps must involve redrafting the primary legislation. There is no single obvious solution but two distinct and, to some extent, polar options present themselves. Each has both advantages and disadvantages but it is possible that a combination of their strengths might eventually be achieved. As a first step the two options are described below.

⁷ Explanatory Notes accompanying the Bill as introduced in the Commons 24 November 2004.

⁸ In this regard it is interesting to note the decision of the Court of Appeal in *R (MH) v Secretary of State for Health* [2004] EWCA Civ 1690.

E. The Extension of the Mental Health Bill.

On the assumption that the admission and discharge procedures in MH will comply with article 5, one option would be to extend the ambit of MH to cover all those who lack capacity and need treatment for mental disorder in hospital. This could be done by amending clause 9 to restrict the scope of clause 9(5), and by extending the conditions to include those with mental disorder who need medical treatment in hospital in the interests of their own health and/or safety and who lack the capacity to make the necessary decisions themselves. This would include both compliant and non-compliant patients and, because of the breadth of the definition of medical treatment (clause 2(7)), could include those who simply require secure accommodation in the interests of their own safety. Further, in order to remove any residual borderline issues, it might be necessary to restrict the use of restraint under MC, so that restraint amounting to the deprivation of liberty could only be used in situations of emergency.

Advantages:

- Such an extension of MH would ensure compliance with article 5.
- It would also clarify the relationship between MH and MC.

Disadvantages:

- The application of full MH requirements to all patients lacking capacity and requiring treatment in hospital would have unrealistic resource implications. In part this could be dealt with by reintroducing provisions similar to those included in Part 5 of the 2002 Draft Mental Health Bill.⁹ These could be adjusted to enable them to relate specifically to the amended clause 9 conditions and to provide sufficient procedural formality within the process of admission to ensure compliance with article 5.1
- Patients without capacity who would now move from MC to MH would be at a disadvantage unless MH was also amended to reflect the provisions in MC in relation to best interests, the least restrictive principle and advance decisions.
- The relevance of the MC framework would be greatly reduced for a significant proportion of those for whom it was specifically designed: those lacking capacity who require medical treatment for mental disorder (very broadly defined, clause 2(7)) in conditions amounting to detention under the ECHR.

F. The Introduction of Enhanced Safeguards in the Mental Capacity Bill.

The procedure for admission to detention could be tightened up in MC and access to a tribunal to review the legality of that detention could be introduced. The MC framework might then become the preferred option for the provision of treatment and care for mental disorder in hospital in cases where the individual lacked capacity.

Advantages:

- It would achieve compliance with article 5 for all people detained in hospital who lack capacity, whatever the nature of the treatment they were receiving.

9 2002 Department of Health, Cm 5538-1

- It could reduce the need to use MH powers with all their resource and stigma implications.
- It would enable the provision of treatment for both mental and physical disorder under the same provisions.
- It would extend the remit of capacity legislation designed in accordance with the principles of non-discrimination and respect for patient autonomy.

Disadvantages:

- It would be very difficult to achieve at this late stage in the progress of the MC Bill, but it could be effected through consequential amendments to the MC Act made subsequently in the MH Bill.
- There may be a concern that the article 5.1 safeguards included in MC would be too resource intensive if they simply replicated those in MH and included the early automatic involvement of the tribunal. However, admission procedures could be devised which were essentially administrative with a right of appeal to a tribunal, and yet were compliant with article 5.1
- There might be fears that the provision of article 5.4 safeguards in MC would lead to the creation of a second tribunal. This could be avoided by the creation of a single body to operate under both MC and MH.
- If MC were to become the primary framework for the provision of treatment in hospital in cases of incapacity, then attention would need to be paid to the safeguards relating to treatment provided within that framework: the inclusion of regular reviews of care and treatment plans, for example, and access to advocacy services.
- An extension in the coverage of MC would not solve all the borderline issues unless a matching restriction in coverage were to be expressly introduced in MH. Thus MH might be expressly restricted to, for example, the core population of those who, whether capable or incapable, present a substantial risk of serious harm to others and possibly those who, despite being capable, present a similar risk to themselves.
- There would remain a need to provide for the transfer of an individual from MC to MH if he or she remained a sufficient risk after regaining capacity.

The preceding paragraphs do not provide a comprehensive answer to the difficulties raised by the interface between the two Bills, nor to the issues presented by *HL*. The solution which is eventually chosen will have to reflect government priorities. However, it is possible to argue from the above that the weight of advantage lies with an extension of the Mental Capacity Bill and a corresponding restriction in the scope of the Mental Health Bill.