



# REFORM OF MENTAL HEALTH LEGISLATION IN THE UK

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Mental health law reform and proposals for reform in the UK have focused around resolving the tension that exists between preserving the patient's autonomy and protecting the patient and others. The key issue is the determination of an individual's 'capacity'. The reform of mental health legislation in Scotland has been guided by human rights principles and similar principles are advocated for Northern Ireland by the Bamford Review in its proposal for a "*single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland*". The reform of mental health legislation in England and Wales has been controversial and "*has caused widespread concern*" since the publication of an initial draft Bill in 2002 aimed at replacing the Mental Health Act 1983. The draft Mental Health Bill was finally "*abandoned*" in March 2006 and the Government introduced a new "shorter streamlined" bill in November 2006, which amends the existing Mental Health Act 1983.

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## SUMMARY OF KEY POINTS

According to the World Health Organisation, the primary aim of mental health legislation is to protect, promote and improve the lives and mental well-being of citizens<sup>1</sup>. The United Nations Principles for the Protection of Persons with Mental Illness are based around human rights promoting community care in the least restrictive environment<sup>2</sup>.

To appreciate the directions that mental health law reform and proposals for reform have taken in the UK it needs to be understood that in mental health “*a tension exists between preserving the patient’s autonomy and protecting the patient and others*”. The key issue is the determination of an individual’s ‘capacity’, “*a balanced human rights approach is one that embraces an expansive definition of capacity, but also contemplates non-consensual intervention when necessary, in order to ensure the appropriate balance of rights, obligations and interests*”<sup>3</sup>.

For Northern Ireland, the Bamford Review has proposed a rights-based approach, as the guiding principle for the reform of mental health legislation, which respects the decisions of all who are assumed to have capacity to make their own decisions. It proposes that there should be a “*single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland...A framework is proposed for interventions in all aspects of the needs of persons who require substitute decision-making, including mental health, physical health, welfare or financial needs*”<sup>4</sup>. The Bamford Review proposes that the principles underpinning the legislation for Northern Ireland should support the dignity of the person including<sup>5</sup>:

- Autonomy – there should be an assumption of capacity;
- Justice – persons with a mental disorder or a learning disability should retain the same rights and entitlements as other members of society;
- Benefit – Interventions via the legislation should achieve benefits, which could not be achieved any other way; and
- Least Harm – Treatment and care must be provided in the “*least invasive manner and in the least restrictive environment compatible with the delivery of safe and effective care*”.

Unlike the previous Mental Health Act (Scotland) 1984, the new Mental Health (Care and Treatment) (Scotland) Act is also based on human rights principles, a set of 10 guiding principles, and anyone who takes action under the Act has to take account of the principles. This “*approach was recommended by the Millan Committee which prepared the groundwork for the Act, and ensures that concepts such as reciprocity, non-discrimination and respect for carers are at the heart of this legislation*”<sup>6</sup>. It has

<sup>1</sup> [http://www.who.int/mental\\_health/policy/resource\\_book\\_MHLeg.pdf](http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf)

<sup>2</sup> Wand T. and Chiarello, M. (2006), *International Journal of Mental Health Nursing* (2006) **15**, 119-127, A conversation: Challenging the relevance and wisdom of separate mental health legislation

<sup>3</sup> Potter, M. (2007), NI Human Rights Commission Review, Issue 5, summer 2007, Mental Health, capacity and non-consensual intervention: A human rights perspective, [www.nihrc.org/dms/data/NIHRC/attachments/dd/files/71/HRC\\_Review\\_5\\_web.pdf](http://www.nihrc.org/dms/data/NIHRC/attachments/dd/files/71/HRC_Review_5_web.pdf)

<sup>4</sup> The Bamford Review of Mental Health and Learning Disability (Northern Ireland), A Comprehensive Legal Framework, Executive Summary, August 2007, page 4

<sup>5</sup> The Bamford Review, A Comprehensive Legal Framework, Executive Summary, August 2007, pg 6-7

<sup>6</sup> Pirnie, L. (2003) Mental Health Act: care and treatment, *The Journal*, Nov. 2003, page 50 [www.journalonline.co.uk/article/1000641.aspx](http://www.journalonline.co.uk/article/1000641.aspx)

been proposed that the “*most controversial reform in the Act is the introduction of a new compulsory treatment order (“CTO”) which will allow care and treatment to be tailored to the personal needs of each patient, whether in hospital or in the community*”<sup>7</sup>.

The Adults with Incapacity (Scotland) Act 2000 provides ways to help safeguard the welfare and finances of people (aged 16 and over) who lack the capacity to take some or all decisions for themselves, because of a mental disorder or inability to communicate. A court can appoint a ‘welfare guardian’ to make decisions for him or her. Welfare guardians can make decisions about where a person lives, as well as about their personal and medical care.

The reform of mental health legislation in England and Wales “*has caused widespread concern*” since the publication of an initial draft Bill in 2002 aimed at replacing the Mental Health Act 1983. After a campaign lasting eight years by mental health charities, including the Mental Health Alliance, and two controversial draft bills in 2002 and 2004, the draft Mental Health Bill was finally “*abandoned*” in March 2006 and the Government introduced a new “shorter streamlined’ bill in November 2006, which amends the existing Mental Health Act 1983<sup>8</sup>. The main purpose of the 2007 Act is to amend the 1983 Act and to introduce “*deprivation of liberty safeguards*” through amending the Mental Capacity Act 2005 and to extend the rights of victims by amending the Domestic Violence, Crime and Victims Act 2004 to introduce new rights for victims of mentally disordered offenders who are not subject to restrictions.

The Mental Health Act 2007 has been used to amend the Mental Capacity Act 2005 in relation to compliant incapacitated patients who are detained. The changes in relation to the Mental Capacity Act 2005 are in response to the 2004 European Court of Human Rights judgment (the “Bournewood judgment”) involving an autistic man who was kept at Bournewood Hospital by doctors against the wishes of his carers.<sup>9</sup>

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<sup>7</sup> Pirnie, L. (2003) Mental Health Act: care and treatment, The Journal, Nov. 2003, page 50  
[www.journalonline.co.uk/article/1000641.aspx](http://www.journalonline.co.uk/article/1000641.aspx)

<sup>8</sup> Glover-Thomas, N. (2007), *Clinical Ethics* 2, 28-31, A new ‘new’ Mental Health Act? Reflections on the proposed amendments to the Mental Health Act 1983

<sup>9</sup>Extracted from:

[www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH\\_078743](http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH_078743)

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## 1. BRIEF OVERVIEW OF INTERNATIONAL PRINCIPLES OF MENTAL HEALTH CARE AND LAW

According to the World Health Organisation, the primary aim of mental health legislation is to protect, promote and improve the lives and mental well-being of citizens<sup>10</sup>. The United Nations Principles for the Protection of Persons with Mental Illness are based around human rights promoting community care in the least restrictive environment. With regard to involuntary admission, the UN Principles state that individuals can only be admitted involuntarily if they have a mental illness diagnosed under internationally accepted medical standards; there is serious likelihood of immediate harm to the person or others, or the person is severely mentally ill and their impaired judgement could cause deterioration in their condition<sup>11</sup>.

It is proposed that Mental Health Law Reform is a “*significant and controversial undertaking*” with separate mental health legislation having the potential to be “*essentially discriminating as it prevents individuals with a mental illness from being recognised as full and equal citizens*”. Both the UN and WHO Principles deal in considerable detail with the protection that should be given to people who require involuntary hospitalisation and this includes the provision for access to representation, advocacy and procedural fairness and an independent review for both detention and certain forms of treatment. It is proposed that by upholding the UN and WHO Principles for a preference for community care, voluntary access to mental health services and involuntary hospitalisation on the grounds of mental incapacity as a last resort it is believed that mental health legislation can maintain protection for users of mental health services<sup>12</sup>.

To appreciate the directions that mental health law reform and proposals for reform have taken in the UK it needs to be understood that in mental health “*a tension exists between preserving the patient’s autonomy and protecting the patient and others*”. The key issue is the determination of an individual’s ‘capacity’, “*a balanced human rights approach is one that embraces an expansive definition of capacity, but also contemplates non-consensual intervention when necessary, in order to ensure the appropriate balance of rights, obligations and interests*”<sup>13</sup>.

As is discussed later in the paper, a balanced approach is advocated by the Bamford Review. The Review proposes that there should be a “*single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland...A framework is proposed for interventions in all aspects of the needs of persons who require substitute decision-making, including mental health, physical health, welfare or financial needs*”<sup>14</sup>.

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<sup>10</sup> [http://www.who.int/mental\\_health/policy/resource\\_book\\_MHLeg.pdf](http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf)

<sup>11</sup> Wand T. and Chiarello, M. (2006), *International Journal of Mental Health Nursing* (2006) **15**, 119-127, A conversation: Challenging the relevance and wisdom of separate mental health legislation

<sup>12</sup> Wand T. and Chiarello, M. (2006), *International Journal of Mental Health Nursing* (2006) **15**, 119-127, A conversation: Challenging the relevance and wisdom of separate mental health legislation

<sup>13</sup> Potter, M. (2007), NI Human Rights Commission Review, Issue 5, summer 2007, Mental Health, capacity and non-consensual intervention: A human rights perspective, [www.nihrc.org/dms/data/NIHRC/attachments/dd/files/71/HRC\\_Review\\_5\\_web.pdf](http://www.nihrc.org/dms/data/NIHRC/attachments/dd/files/71/HRC_Review_5_web.pdf)

<sup>14</sup> The Bamford Review of Mental Health and Learning Disability (Northern Ireland), A Comprehensive Legal Framework, Executive Summary, August 2007, page 4

*considered necessary for reforming existing legislation, applying a principles-based approach*<sup>15</sup>.

Central to a person's human rights is 'autonomy', which is the right to make decisions about one's life. Under law autonomy is related to 'capacity' and the law presumes that people with mental illnesses and learning disabilities are mentally capable unless it is medically established otherwise and if 'incapacity' is found "*the law eclipses the rights of the individual to a significant extent*"<sup>16</sup>.

## **2. PROPOSED MENTAL HEALTH LEGISLATION FOR NORTHERN IRELAND - THE BAMFORD REVIEW PROPOSALS FOR A COMPREHENSIVE LEGISLATIVE FRAMEWORK**

### **2.1 CURRENT SITUATION**

Currently the law in Northern Ireland permits non-consensual intervention where a person has a prescribed mental disorder of a nature or degree warranting his detention in hospital for medical treatment, and where a failure to detain exposes him or others to a "*substantial likelihood of serious physical harm*". Once detained, that person can be treated involuntarily, subject to a number of safeguards. Unlike the situation in England and Wales, Northern Ireland law does not allow intervention where a person is diagnosed with a severe personality disorder and not a mental illness<sup>17</sup>.

### **2.2 THE NEED FOR CHANGE**

The Bamford Review (the Review) highlighted that since the introduction of the Mental Health (Northern Ireland) Order 1986 new opinion has been expressed reflecting human rights obligations; there have been changes in scientific knowledge; changes in views on health, illness, safety and risk; changes in mental health law elsewhere; and that legislation should reflect the views of users of mental health and learning disability services and their carers<sup>18</sup>.

The work of the Review coincided with preparatory work by the Office of Law Reform<sup>19</sup> to introduce new capacity legislation into Northern Ireland. The Review believes that this has provided "*a unique opportunity to consider the overall purpose of legislation, the guiding principles underpinning legislative reform and an opportunity to develop a comprehensive approach to protecting and respecting the dignity of people with mental health problems*"<sup>20</sup> and that the reform of Mental Health

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<sup>15</sup> The Bamford Review, A Comprehensive Legal Framework, Executive Summary, August 2007, page 1

<sup>16</sup> Potter, M. (2007), NI Human Rights Commission Review, Issue 5, summer 2007, Mental Health, capacity and non-consensual intervention: A human rights perspective, [www.nihrc.org/dms/data/NIHRC/attachments/dd/files/71/HRC\\_Review\\_5\\_web.pdf](http://www.nihrc.org/dms/data/NIHRC/attachments/dd/files/71/HRC_Review_5_web.pdf)

<sup>17</sup> Potter, M. (2007), NI Human Rights Commission Review, Issue 5, summer 2007, Mental Health, capacity and non-consensual intervention: A human rights perspective,

<sup>18</sup> The Bamford Review of Mental Health and Learning Disability (Northern Ireland), A Comprehensive Legal Framework, Executive Summary, August 2007, page 2

<sup>19</sup> Now the Civil Law Reform Division of the Department of Finance and Personnel

<sup>20</sup> The Bamford Review, A Comprehensive Legal Framework, Executive Summary, August 2007, page 3

Legislation should be included as one of the strategic priorities for the first phase of implementation of the Review<sup>21</sup>.

### **2.3. THE NEED FOR PRINCIPLES FOR LEGISLATION**

The Review has proposed a rights-based approach, as advocated by the UN and described in the Introduction above, as the guiding principle for the reform of mental health legislation, which respects the decisions of all who are assumed to have capacity to make their own decisions:

*“Grounds for interfering with a person’s autonomy should be based primarily on impaired decision-making capacity...A principled, human rights-based approach moves from public protection as the priority towards safeguarding the rights and dignity of people with mental disorder and ensuring their access to appropriate care and treatment. It will be necessary in some situations to balance these individual rights with the rights of others who may be placed at risk through the individual’s behaviour”<sup>22</sup>.*

The Review proposes that the 1986 Order is not based on this approach as it allows the individual’s autonomy to be over-ridden in the interests of his own or other’s safety, with the powers focusing on compulsory assessment based on a relatively narrow definition of risk, rather than ensuring appropriate treatment<sup>23</sup>.

### **2.4 RECOMMENDATIONS FOR REFORM OF LEGISLATION – A COMPREHENSIVE FRAMEWORK FOR SUBSTITUTE DECISION-MAKING**

#### **2.4.1. OVERARCHING RECOMMENDATIONS**

The Review proposes that there should be a “single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland...A framework is proposed for interventions in all aspects of the needs of persons who require substitute decision-making, including mental health, physical health, welfare or financial needs”<sup>24</sup>. The Review notes that its proposals are “not an attempt at legislative drafting but a description and an explanation of what is considered necessary for reforming existing legislation, applying a principles-based approach”<sup>25</sup>.

Such a principles-based approach was taken by Scotland in the Mental Health (Care and Treatment) (Scotland) Act 2003, which is discussed in section 3 of this paper. The Act for Scotland is based on a set of ten guiding principles, and anyone who takes action under the Act has to take account of the principles. This “*approach was recommended by the Millan Committee which prepared the groundwork for the Act,*

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<sup>21</sup> The Bamford Review, Reform and Modernisation of Mental Health and Learning Disability Services, Strategic Priorities for the First Phase of Review Implementation, August 2007, page 23

<sup>22</sup> The Bamford Review, A Comprehensive Legal Framework, Executive Summary, August 2007, page 3

<sup>23</sup> The Bamford Review, A Comprehensive Legal Framework, Executive Summary, August 2007, page 3

<sup>24</sup> The Bamford Review of Mental Health and Learning Disability (Northern Ireland), A Comprehensive Legal Framework, Executive Summary, August 2007, page 4

<sup>25</sup> The Bamford Review, A Comprehensive Legal Framework, Executive Summary, August 2007, page 1

and ensures that concepts such as reciprocity, non-discrimination and respect for carers are at the heart of this legislation”<sup>26</sup>.

The Bamford Review proposes that the principles underpinning the legislation for Northern Ireland should support the dignity of the person including<sup>27</sup>:

- Autonomy – there should be an assumption of capacity and provision of care and treatment should be on a “*partnership and consensual basis*” as much as possible, extending to decisions made legally in advance by a person for such times as when he loses capacity;
- Justice – persons with a mental disorder or a learning disability should retain the same rights and entitlements as other members of society and the legislation should not discriminate on grounds of age, gender, sexual orientation, ethnicity, disability, social class, culture or religion. Any loss of rights by compulsion to treatment or detention should be matched by an obligation to provide adequate treatment and care. Individuals should have the right to representation to challenge due process and the specific rights of children should be protected;
- Benefit – Interventions via the legislation should achieve benefits, which could not be achieved any other way, including reduction of risk of harming themselves or others. However, in providing public and individual protection to the community, legislation must not discriminate “*unjustifiably against persons who suffer from a mental health problem or learning disability*”; and
- Least Harm – Treatment and care must be provided in the “*least invasive manner and in the least restrictive environment compatible with the delivery of safe and effective care*”.

#### 2.4.2. SPECIFIC RECOMMENDATIONS REGARDING MENTAL CAPACITY

The Review proposes that certain provisions of the Mental Capacity Act 2005<sup>28</sup> should be introduced with “*minimal amendment*” including, for example<sup>29</sup>:

- The definition of decision-making capacity and persons with impaired decision-making capacity<sup>30</sup>;
- Any decision or action taken must be in the person’s best interests and have regard for the least restrictive option;
- Legal protection for everyday acts in respect of a person’s care or treatment;
- Lasting power of attorney to extend to welfare, including healthcare;
- Recognition of advance decisions regarding treatment;
- Safeguards in relation to involvement of such persons in research;

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<sup>26</sup> Pirnie, L. (2003) Mental Health Act: care and treatment, The Journal, Nov. 2003, page 50 [www.journalonline.co.uk/article/1000641.aspx](http://www.journalonline.co.uk/article/1000641.aspx)

<sup>27</sup> The Bamford Review, A Comprehensive Legal Framework, Executive Summary, August 2007, pg 6-7

<sup>28</sup> The Mental Capacity Act 2005 provides a comprehensive framework for decision making on behalf of adults aged 16 and over who lack capacity to make decisions on their own behalf. The Act applies to England and Wales.

<sup>29</sup> The Bamford Review, A Comprehensive Legal Framework, Executive Summary, August 2007, pg 7-8

<sup>30</sup> Definition used in the Mental Capacity Act 2005 “*A person lacks capacity if in relation to a matter at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary*”



- Other issues, including independent advocates, codes of practice, the new offence of ill-treatment or neglect, appointment of a Public Guardian; and ratification of the Convention on the International Protection of Adults.

#### 2.4.3 OTHER SPECIFIC RECOMMENDATIONS

The Review recommends that the single legislative framework also includes:

- Compulsory admission to an approved facility for assessment;
- Compulsory detention in hospital for treatment;
- Supervised intervention in the community;
- Development of the role and functions of:
  - The Mental Health Commission<sup>31</sup>;
  - The Mental Health Tribunal;
  - Professional boundaries, including creation of the Approved Clinician and the Responsible Clinician;
  - Carers (and recognition of their rights); and
  - The introduction of the nominated person as a replacement for the “nearest relative”; and
- Ratification of the Convention on the Rights of Persons with Disabilities.

#### 2.5. DELIVERING THE BAMFORD VISION – THE NI EXECUTIVE’S DRAFT RESPONSE TO THE BAMFORD REVIEW

The NI Government, which includes the NI Departments and the Departments with responsibility for reserved matters, “*accepts the central thrust of the Bamford recommendations which seek to create an overarching statement of human rights principles governing substantially amended mental health legislation and new mental capacity legislation*”<sup>32</sup>. It accepts that the Review has established an “*intrinsic link between mental health and mental capacity legislation*”, and considers that the proposals are best delivered in two pieces of legislation, one for changes to or replacement of the 1986 Order and the other for new capacity legislation, as a single piece of legislation would be very complex and difficult to interpret<sup>33</sup>.

The NI Government proposes the following timescale<sup>34</sup>:

- By 2011 new mental health legislation to come into operation - it is considered that such a major reform of mental health law will take up to three years to complete and subsequent to enactment, work will begin to bring forward capacity legislation;
- By 2014 new mental capacity legislation to come into operation.

These timescales will put Northern Ireland many years behind Scotland with regard new mental health legislation. As will be discussed in the next section of this paper Scotland has had similar legislation passed 2003 and 2000 respectively.

The NI Government proposes that the issue of a statutory right to advocacy will be considered as part of the legislative framework that is being developed, and separately, subject to the RPA consultation, a statutory duty of public involvement

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<sup>31</sup> Which will transfer to the Regulation and Improvement Authority

<sup>32</sup> Delivering the Bamford Vision, The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability, Draft for consideration by NI Executive, Chapter 7, page 26

<sup>33</sup> Delivering the Bamford Vision, Chapter 7, page 26

<sup>34</sup> Delivering the Bamford Vision, The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability, Draft for consideration by NI Executive, Chapter 7, page 27

and consultation will be placed on the new Regional Health and Social Care Board, the Health and Social Care Trusts and other agencies of DHSSPS<sup>35</sup>.

The NI Board for Mental Health and Learning Disability has recently voiced concern over the proposal in the NI Executive's draft response to the Bamford Review for two pieces of legislation and the fact that no mention is made of the "*single legislative framework recommended by Bamford*". The Board believes that the Executive's approach "*will lead to a dismantling of the overall coherence of the proposals specified in the Bamford Review*"<sup>36</sup>.

### **3. MENTAL HEALTH LEGISLATION IN SCOTLAND**

#### **3.1. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003**

##### 3.1.1 OVERVIEW

The impetus for the Mental Health (Care and Treatment) (Scotland) Act 2003, which came into effect in April 2005, came mainly from a change in psychiatric practice with the move towards care in the community. The Act applies to people with a 'mental disorder', which is defined as<sup>37</sup> "*any mental illness, personality disorder or learning disability however caused or manifested*"<sup>38</sup>.

The issues dealt with by the Act can be grouped under four main headings<sup>39</sup>:

- *Principles, roles and responsibilities* – how the Act defines the nature, duties and powers of the organisations and individuals involved in mental health law and how they should give effect to the principles of the Act - these human rights-based principles are seen by many as the major strength behind the legislation;
- *Compulsory powers* – how the Act sets out the circumstances in which a person with mental disorder may receive treatment and/or be detained on a compulsory basis, and the procedures which have to be followed;
- *People with mental disorder within the criminal justice system*; and
- *Rights and safeguards* – the additional rights and safeguards the Act gives to a person with mental disorder.

In section 2.5 above, it was noted how the Northern Ireland Executive had accepted that the Bamford Review has established an "*intrinsic link between mental health and mental capacity legislation*". The Scottish legislation has established such a link in that people who may lack capacity and have an incapacity certificate under the Adults with Incapacity (Scotland) Act (see section 3.2) can also be covered under this

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<sup>35</sup> Delivering the Bamford Vision, Chapter 7, page 26

<sup>36</sup> Board for Mental Health and Learning Disability Comments on Executive's Draft Response to the Review of Mental Health and Learning Disability, 22 May 2008

<sup>37</sup> Thomson, L.D.G. (2005), *Psychiatric Bulletin* (2005), 29, 381-384, The Mental Health (Care and Treatment) (Scotland) Act 2003: civil legislation

<sup>38</sup> A person is not considered to have a mental disorder by reason only of sexual orientation, sexual deviancy, transsexualism or transvestism; dependence on or use of alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; or acting as no prudent person would.

<sup>39</sup> Extracted from Mental Health (Care and Treatment) (Scotland) Act 2003, NHS Education for Scotland, Education for Frontline Staff, [www.nes.scot.nhs.uk/mha/](http://www.nes.scot.nhs.uk/mha/)

new Act where there is a mental illness requiring treatment in either a hospital or in the community<sup>40</sup>.

### 3.1.2 THE PRINCIPLES, ROLES AND RESPONSIBILITIES OF THE ACT

Unlike the previous Mental Health Act (Scotland) 1984, the new Act for Scotland is based on a set of 10 guiding principles, and anyone who takes action under the Act has to take account of the principles. This *“approach was recommended by the Millan Committee which prepared the groundwork for the Act, and ensures that concepts such as reciprocity, non-discrimination and respect for carers are at the heart of this legislation”*<sup>41</sup>. The Principles are<sup>42</sup>:

1. Non-discrimination against a person with mental disorder;
2. Equality – all powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic or social origin;
3. Respect for diversity – care, treatment and support should be received regardless of a patient’s abilities, background and characteristics;
4. Reciprocity – in terms of service provision for those subject to the Act;
5. Informal Care – care should be provided as far as possible without the use of compulsory powers;
6. Participation of the patient in the processes of assessment, care, treatment and support as far as possible;
7. Respect for carers – including consideration of their views and needs;
8. Least restrictive alternative – care, treatment and support should be provided in the least invasive manner and in the least restrictive manner possible;
9. Benefit – intervention under the Act should achieve benefit for the service user that cannot be achieved in another way aside from the intervention; and
10. The welfare of any child with mental disorder should be paramount.

The Act makes provision for two organisations: the Mental Welfare Commission for Scotland and the Mental Health Tribunal for Scotland. The latter replaces a sheriff who, sitting alone, decided applications for detention under the 1984 Act. The new Mental Health Tribunal acts as a judicial body, authorising compulsory treatment orders (CTOs) and dealing with appeals against and reviews of CTOs, short-term detention, compulsion orders and other mental health disposals affecting mentally disordered offenders. It will have three members<sup>43</sup>:

- A legally qualified chairperson;
- A medical member (normally a current or retired consultant psychiatrist) and;
- A member with professional or personal experience of mental health services.

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<sup>40</sup> Mental Health (Care and Treatment) (Scotland) Act 2003, NHS Education for Scotland, Education for Frontline Staff, [www.nes.scot.nhs.uk/mha/principles\\_questions.htm](http://www.nes.scot.nhs.uk/mha/principles_questions.htm)

<sup>41</sup> Pirnie, L. (2003) Mental Health Act: care and treatment, The Journal, Nov. 2003, page 50 [www.journalonline.co.uk/article/1000641.aspx](http://www.journalonline.co.uk/article/1000641.aspx)

<sup>42</sup> Information extracted from Mental Health (Care and Treatment) (Scotland) Act 2003, NHS Education for Scotland, Education for Frontline Staff, [www.nes.scot.nhs.uk/mha/principles2.htm](http://www.nes.scot.nhs.uk/mha/principles2.htm) and from Thomson, L.D.G. (2005), *Psychiatric Bulletin* (2005), 29, 381-384, The Mental Health (Care and Treatment) (Scotland) Act 2003: civil legislation

<sup>43</sup> Pirnie, L. (2003) Mental Health Act: care and treatment, The Journal, Nov. 2003, page 50 [www.journalonline.co.uk/article/1000641.aspx](http://www.journalonline.co.uk/article/1000641.aspx)

The Act provides for a Code of Practice and also places duties on, and grants certain powers, to NHS Boards and local authorities<sup>44</sup> in relation to people with mental disorder; on hospital managers in relation to a person who is subject to compulsory measures; and on Scottish Ministers. It creates and defines a number of professional roles including approved medical practitioners, designated medical practitioners and Mental Health Officers<sup>45</sup>.

### 3.1.3 THE COMPULSORY POWERS OF THE ACT

The new Act reforms and modernises the legal framework for compulsory detention and treatment and sets out criteria that must be met before compulsion can be authorised, as well as the detailed procedures, which must be followed. The Act specifies the following forms of compulsion:

- Emergency detention (72 hours);
- Short-term detention (28 days, but may be extended);
- Compulsory treatment orders (six months – this may be extended);
- Other powers in relation to entry, removal and detention.

Fuller details on all these forms of compulsion can be found at Mental Health (Care and Treatment) Scotland Act 2003, NHS Education for Scotland, Education for Frontline Staff<sup>46</sup>.

It has been proposed that the “*most controversial reform in the Act is the introduction of a new compulsory treatment order (“CTO”) which will allow care and treatment to be tailored to the personal needs of each patient, whether in hospital or in the community*”. Under the 1984 Act, ‘leave of absence’ allowed psychiatrists to discharge compelled patients from hospital for weeks or months if satisfied they were well enough, however the patient was not formally discharged from hospital and could have been compelled to return to hospital if their mental health deteriorated. The difference under the new Act is that it “*will be possible for the Tribunal to authorise a CTO that is entirely based outside a hospital setting – a community based compulsory treatment order*”<sup>47</sup>.

### 3.1.4. THE ACT WITH RESPECT TO PEOPLE WITH MENTAL DISORDER WITHIN THE CRIMINAL JUSTICE SYSTEM

The Act reforms the law relating to people with mental disorder who enter the criminal justice system. It amends the Criminal Procedure (Scotland) Act 1995 to give courts new options on how they deal with people with mental disorder. It provides new orders as follows<sup>48</sup>:

- An Assessment Order;
- A Treatment Order;
- An Interim Compulsion Order; and
- A Compulsion Order.

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<sup>44</sup> to promote the wellbeing and social development of all persons in their area who have, or have had, a mental disorder

<sup>45</sup> Information extracted from Mental Health (Care and Treatment) (Scotland) Act 2003, NHS Education for Scotland, Education for Frontline Staff, [www.nes.scot.nhs.uk/mha/principles3.htm](http://www.nes.scot.nhs.uk/mha/principles3.htm)

<sup>46</sup> [www.nes.scot.nhs.uk/mha/compulsory2.htm](http://www.nes.scot.nhs.uk/mha/compulsory2.htm); [www.nes.scot.nhs.uk/mha/compulsory3.htm](http://www.nes.scot.nhs.uk/mha/compulsory3.htm); [www.nes.scot.nhs.uk/mha/compulsory4.htm](http://www.nes.scot.nhs.uk/mha/compulsory4.htm); and [www.nes.scot.nhs.uk/mha/compulsory5.htm](http://www.nes.scot.nhs.uk/mha/compulsory5.htm)

<sup>47</sup> Pirnie, L. (2003) Mental Health Act: care and treatment, The Journal, Nov. 2003, page 50 [www.journalonline.co.uk/article/1000641.aspx](http://www.journalonline.co.uk/article/1000641.aspx)

<sup>48</sup> Information extracted from Mental Health (Care and Treatment) (Scotland) Act 2003, NHS Education for Scotland, Education for Frontline Staff, [www.nes.scot.nhs.uk/mha/principles3.htm](http://www.nes.scot.nhs.uk/mha/principles3.htm)

A court may still make a Hospital Direction and a Restriction Order (in combination with a Compulsion Order). The Act retains Scottish Ministers' powers to transfer a prisoner to hospital for treatment of a mental disorder and introduces the Transfer for Treatment Direction.

### 3.1.5. THE ACT WITH RESPECT TO SAFEGUARDS AND RIGHTS OF REVIEW AND APPEAL

The new Act provides additional rights and increased safeguards, including the following, which support the underlying Principle of increased patient participation<sup>49</sup>:

- The right to independent advocacy services has been enshrined in the Act and it is intended that advocacy will allow people to make informed choices about, and to remain in control of, their own healthcare;
- The creation of the new role of 'named person'. The named person is nominated by the patient (and can be revoked), acts independently of the patient, but should provide support and represent the patient's interests. The role can be assumed by the patient's primary carer or nearest relative if no nomination is made or the nominee refuses the role;
- The Act legislates for advance statements, which describe an individual's preferences for treatment of a mental disorder in the event that his or her ability to make decisions about treatment becomes significantly impaired. There is the possibility that the patient's wishes can be overruled by the Responsible Medical Officer provided reasons are given to the patient, the named person, any welfare attorney, any guardian and the Mental Welfare Commission.

### 3.1.6 ISSUES AND OPINION SURROUNDING IMPLEMENTATION OF THE ACT

An implementation report prepared for the Scottish Executive and published in March 2004 concluded that "*for the statutory agencies, their partners and other interested parties to combine to implement the provisions and objectives of the new Act, will require urgent and continued attention on the planning and, most importantly, the delivery of comprehensive mental health services*". It was proposed that a minimum range of provision would be required as the foundation on which to build the new services and approaches called for in the new legislation including<sup>50</sup>:

- A range of crisis and responsive services available throughout the 24 hour period;
- Multi-agency and multidisciplinary community mental services, including the voluntary sector, for the range of care groups, including people with a learning disability;
- Access to a range of appropriate inpatient facilities through local and regional planning and managed care networks e.g. young people, mentally disordered offenders, mothers with perinatal illness and their babies;
- A range of therapies including psychosocial interventions, structured daytime activities and employment, and support for recovery;
- A local consensus on the way forward for workforce planning and development including independent advocacy; and
- Training in the specific requirements of the Act and arrangements for administration.

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<sup>49</sup> Thomson, L.D.G. (2005), *Psychiatric Bulletin* (2005), 29, 381-384, The Mental Health (Care and Treatment) (Scotland) Act 2003: civil legislation

<sup>50</sup> Information extracted from: Grant (OBE), Dr S., National Mental Health Services Assessment, Towards implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, Final Report, March 2004, Executive Summary, page 3

With regard to service provision, The National Schizophrenia Fellowship (Scotland), (NSF Scotland), expressed concern that the implementation of the Act as hoped for will be hampered by “*services being unable to rise to the challenge*”, including insufficient resources for services<sup>51</sup>. Despite those concerns it welcomed the first fundamental change to Scottish Mental Health law in over 40 years and noted that many aspects of the Act have been welcomed by a diverse range of organisations, in addition to NSF (Scotland), including<sup>52</sup>:

- Inclusion of a set of Principles, implicit in which is the commitment to ensuring that “*compulsion will truly be used as a last resort*”;
- An individual right to advocacy;
- New rights to involvement and information for carers;
- The right of a service user, when well, to nominate a ‘named person’ and the removal of consent by the ‘nearest relative’ to detention under the Act;
- The right to service users to make an Advance Statement;
- Introduction of the new Tribunal to replace the Sheriff Court System; and
- The right to appeal against being held in conditions of excessive security.

Mr. Geoff Huggins, Head of Mental Health Division, Healthcare Policy and Strategy Directorate (Scottish Executive), reported at a recent conference<sup>53</sup>, “*on the whole the implementation of the Mental Health Act has been effective and is delivering an appropriate framework for care and treatment...more work needs to be done to raise awareness of, and reference to, the principles on a regular basis...professionals may need additional guidance on how to apply the principles*”.

Other issues regarding implementation considered by the conference<sup>54</sup> (and independently by other groups as cited in the bullet points below) included:

- The benefits of the new Tribunal process appeared to have exceeded the problems that some have encountered. The process is now deemed as being more patient-centred and empowering and there is a better rate of attendance at Tribunal hearings. SAMH, “*Scotland’s leading mental health charity*”<sup>55</sup> reported that the new Mental Health Tribunal was widely welcomed and seen as a major improvement on the previous Act, however Tribunal experiences had been mixed, with some having positive experiences and others reporting lack of adequate notice of hearings and excessive formality in proceedings<sup>56</sup>.
- With regard to advance statements, it was felt that such statements held professionals more accountable if they were to override the patient’s views and that the Mental Welfare Commission’s role of investigation into such overrides was considered reassuring for patients. The need to provide

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<sup>51</sup> NSF (Scotland) and the New Mental Health Act, [www.nsfscot.org.uk/what\\_we\\_do/mental\\_health\\_act.html](http://www.nsfscot.org.uk/what_we_do/mental_health_act.html)

<sup>52</sup> NSF (Scotland) and the New Mental Health Act, [www.nsfscot.org.uk/what\\_we\\_do/mental\\_health\\_act.html?topic\\_id=28](http://www.nsfscot.org.uk/what_we_do/mental_health_act.html?topic_id=28)

<sup>53</sup> Press Release, The Fife Rights Forum, Citizens Advice and Rights Fife, NHS Fife and the Scottish Legal Aid Board, Mental Health Act 2003 reclaimed by service users and professionals at unique event in Dunfermline, 21 February 2008, [www.slab.org.uk/news/2008/21\\_2\\_2008.htm](http://www.slab.org.uk/news/2008/21_2_2008.htm)

<sup>54</sup> [www.slab.org.uk/news/2008/21\\_2\\_2008.htm](http://www.slab.org.uk/news/2008/21_2_2008.htm)

<sup>55</sup> [www.SAMH.org.uk](http://www.SAMH.org.uk)

<sup>56</sup> SAMH Policy and Information Briefing May 2006, The Mental Health (Care and Treatment) (Scotland) Act 2003 – Views on Implementation

arrangements to accommodate people with learning disabilities in the preparation of such statements was emphasised. NSF Scotland expressed concern that there is no right of appeal to a Tribunal if an Advance Statement is over-ridden<sup>57</sup>;

- The ‘named person’ system was well regarded but could be difficult in practice with respect to lack of understanding among both professionals and ‘named persons’. NSF Scotland noted that the ‘named person’ has no right to assist the service user prior to proceedings being commenced under the Act<sup>58</sup> and SAMH noted that it understands there have been difficulties implementing the ‘named person’ provisions, often due to unfamiliarity with the Acts provisions on named persons<sup>59</sup>.
- Community-based compulsory treatment orders (CCTOs) – in order to enhance the success of CCTOs it was suggested that more consideration needs to be given to “*quality of life issues and community support services as well as recognising individual patient needs and improving co-operation between members of the multi-disciplinary team, carers and patients*”. NSF Scotland expressed concern that the introduction of CCTOs does not restrict their use to the prevention of relapse and deterioration<sup>60</sup>.

It has been proposed that although the Principles of the Act maintain that interventions should involve the minimum restriction of the patient, the Act “*paradoxically introduced a number of new restrictions on patients*”, and does not fulfil the Principle of minimum restriction, as follows<sup>61</sup>:

- Supporters of the Act propose that the 28-day short term detention order with compulsory treatment is *less restrictive* than a 72 hour (emergency) detention period with no compulsory treatment as the latter gives no right of appeal;
- Previously it was common practice to grant ‘time off the ward’. Formal suspension of detention is now required before patients leave hospital grounds;
- The Act introduced the Mental Health Tribunal for Scotland, which hears all applications for six-month detentions. “*These formal and often adversarial hearings occur irrespective of patients’ objections and can be an ordeal for many patients*”; and
- “*Administrative demands on services have increased significantly, diverting clinical resources from the majority of (informal) patients*”.

With regard to Advocacy, most Advocate organisations have reported a “*steady increase in referrals...Most of these are in relation to tribunal hearings...The practice around referral is improving and people are being referred at an earlier stage...Referrals in relation to the Act tend to be long term – with preparatory work on e.g. advance statements etc. to applications for the Tribunal right through to*

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<sup>57</sup> NSF (Scotland) and the New Mental Health Act, [www.nsfscot.org.uk/what-we-do/mental\\_health\\_act.html?topic\\_id=28](http://www.nsfscot.org.uk/what-we-do/mental_health_act.html?topic_id=28)

<sup>58</sup> [www.nsfscot.org.uk/what\\_we\\_do/mental\\_health\\_act.html?topic\\_id=28](http://www.nsfscot.org.uk/what_we_do/mental_health_act.html?topic_id=28)

<sup>59</sup> SAMH Policy and Information Briefing May 2006, The Mental Health (Care and Treatment) (Scotland) Act 2003 – Views on Implementation

<sup>60</sup> NSF (Scotland) and the New Mental Health Act, [www.nsfscot.org.uk/what-we-do/mental\\_health\\_act.html?topic\\_id=28](http://www.nsfscot.org.uk/what-we-do/mental_health_act.html?topic_id=28)

<sup>61</sup> Bennett, D.M. and Mitchell, K.M. (2007), *The Psychiatric Bulletin*, 31 (5), 194, Is the Mental Health (Care and Treatment) (Scotland) Act 2003 the least restrictive option?

*representation at the Tribunal hearing*". Independent Advocacy organisations reported the following concerns<sup>62</sup>:

- Independent advocates are rarely reaching people in care homes;
- Potential for unmet need with regard to children and young people;
- Difficult to raise awareness of advocacy among voluntary patients and those in the community;
- It may be as long as two or three months before an advocacy worker is assigned due to consistently having to prioritise tribunal and other urgent work;
- Most organisations have only one or two key paid workers, with a small number of volunteers;
- Low uptake on advance statements as service users often do not want to think about being unwell again or the fact that it may be over-ridden; and
- Confusion over the role of the 'named person' and that of the advocate.

Prior to the Act coming into effect SAMH raised concerns that the new right to advocacy would not be meaningful if there was insufficient advocacy provision to meet demand and SAMH proposed that anecdotal evidence indicates "*advocacy services are being skewed in favour of people subject to compulsory powers under the Act at the expense of people receiving services on a voluntary basis*"<sup>63</sup>.

### **3.2. THE ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000**

The Adults with Incapacity (Scotland) Act provides ways to help safeguard the welfare and finances of people (aged 16 and over) who lack the capacity to take some or all decisions for themselves, because of a mental disorder or inability to communicate. A court can appoint a 'welfare guardian' to make decisions for him or her. Welfare guardians can make decisions about where a person lives, as well as about their personal and medical care. The law gives the Mental Welfare Commission for Scotland a role in ensuring that welfare guardianship works in a person's best interests<sup>64</sup>.

The Act provides various methods of intervening on behalf of an adult and when deciding whether to intervene a welfare guardian must apply the Principles of the Act<sup>65</sup>:

- The intervention must be necessary and must benefit the adult and it should be considered if it is possible to intervene without the Act;
- The intervention must be the minimum necessary to achieve the purpose;
- The adult's past and present wishes and feelings must be taken into account, and every possible means of communicating with the adult must be tried;
- The views of the adult's nearest relative and primary carer, and of any other person with powers to intervene in the adult's affairs or personal welfare, must be taken into account as far as it is reasonable and practicable to do so; and
- The adult must be encouraged to use any skills he or she has.

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<sup>62</sup> Proceedings of three seminars on Advocacy held by Mental Health Division, Healthcare Policy and Strategy Directorate, Scottish Executive (September 2006)

<sup>63</sup> SAMH Policy and Information Briefing May 2006, The Mental Health (Care and Treatment) (Scotland) Act 2003 – Views on Implementation

<sup>64</sup> Mental Welfare Commission for Scotland, Our role in the Adults with Incapacity (Scotland) Act 2000, [www.mwscot.org.uk](http://www.mwscot.org.uk)

<sup>65</sup> Extracted from Adults with Incapacity – Part 1 – Principles and Operation, [www.scotland.gov.uk/Topics/Justice/Civil/awi/legislation/part1/](http://www.scotland.gov.uk/Topics/Justice/Civil/awi/legislation/part1/)



With respect to healthcare and treatment, other than in an emergency or where there is a proxy decision-maker, where an adult lacks capacity, a certificate of incapacity must be issued in order to provide care or treatment. The Act introduced a new form of proxy decision-making, and clarified the legal basis upon which doctors make decisions about the medical treatment of incapacitated adults. The Act made provision for safeguarding the welfare of incapacitated adults, and managing their property and financial affairs. *“Doctors may become involved in assessing a person’s capacity to make decisions about these matters but it is Part 5 of the Act which regulates medical treatment and research, that has the biggest impact on medical practice”*<sup>66</sup>.

Problems arose following the implementation of Part 6 of the Act as it was not clear whether a significant intervention (such as a change of residence) for an adult who lacks capacity should always require the authority of a guardianship or intervention order. Disagreement exists amongst legal experts as to the appropriateness of seeking a Part 6 Order in every case. This has caused problems, for example, when moving an incapable adult from hospital to a care home or from his/her own home to a care home without an order under the Act. Problems have included beds being blocked by people remaining in hospital while their Part 6 applications are processed. The Mental Welfare Commission for Scotland proposed that the *“drafting of local authorities’ duties under Part 6 may support the selective approach. It could be argued that the Act does not envisage the use of an order for every significant intervention”*<sup>67</sup>.

A number of changes were made recently to this Act by the Adult Support and Protection (Scotland) Act 2007. The Regulations to support the implementation of a number of those changes, provide for new, and amendments to existing, forms and certificates in relation to:

- Applications for intervention and guardianship orders;
- Renewal of guardianship orders;
- Recall of guardianship orders;
- Registration of powers of attorney;
- Revocation of powers of attorney; and
- Applications under new Part 3.

## **4. MENTAL HEALTH LEGISLATION IN ENGLAND**

### **4.1 THE MENTAL HEALTH ACT 2007**

#### **4.1.2 INTRODUCTION AND HISTORY OF THE REFORM**

The reform of mental health legislation in England and Wales *“has caused widespread concern”* since the publication of an initial draft Bill in 2002 aimed at replacing the Mental Health Act 1983. *“Initial recommendations from an expert committee for progressive and ethical reform mutated into a draft bill uniting all interested organisations in opposition”*<sup>68</sup>. This opposition included the formation of

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<sup>66</sup> BMA, Medical treatment for adults with incapacity: guidance on ethical and medico-legal issues in Scotland, June 2002, [www.bma.org.uk/ap.nsf/Content/AdultsincapacitySC](http://www.bma.org.uk/ap.nsf/Content/AdultsincapacitySC)

<sup>67</sup> Patrick, H. Honorary Fellow, School of Law, Edinburgh University, Mental Health Commission for Scotland, Authorising significant interventions for adults who lack capacity (August 2004)

<sup>68</sup> Darjee, R. and Crichton, J. (2004), *BMJ* **329**, 634-635, Editorial, New Mental Health Legislation

the Mental Health Alliance (the Alliance) consisting of 32 core and 41 associate members, including user groups, psychiatrists, social workers, nurses, psychologists, lawyers, voluntary associations, research bodies and carers' associations<sup>69</sup>.

Superficially it seemed that the initial draft bill and the Scottish legislation looked similar, however opposition groups to the bill noted that the Scottish legislation had many good qualities lacking in the draft bill including, the inclusion of capacity; ethically sound principles; no over-emphasis on risk; no compulsory treatment in prison; genuinely responsive consultation with government; and incapacity legislation already in place. It was noted that in Scotland the legislation adhered to "*recommendations from the expert committee and the process had not been hijacked by a government department more concerned with locking up dangerous offenders than with the care of people with mental health problems*"<sup>70</sup>.

A second draft bill was published in 2004 to address concerns raised, however, the Alliance, although noting some positive aspects of the 2004 bill<sup>71</sup> noted that the bill did nothing to address the problem of discrimination against people experiencing mental health through its failure to address the issue of capacity. The Alliance was "*particularly disturbed by the over-emphasis in the Draft Bill on protection of the public from 'dangerous' people and the disastrous impact this will have on the vast majority of mental health patients who pose no danger to anyone*"<sup>72</sup>.

After a campaign lasting eight years by mental health charities, including the Mental Health Alliance, and two controversial draft bills in 2002 and 2004, the draft Mental Health Bill was finally "*abandoned*" in March 2006 and the Government introduced a new "shorter streamlined" bill in November 2006, which amends the existing Mental Health Act 1983<sup>73</sup>.

#### 4.1.3 THE MENTAL HEALTH ACT 2007

The main purpose of the 2007 Act is to amend the 1983 Act and to introduce "*deprivation of liberty safeguards*" through amending the Mental Capacity Act 2005 (see section 4.2 for details); and to extend the rights of victims by amending the Domestic Violence, Crime and Victims Act 2004 to introduce new rights for victims of mentally disordered offenders who are not subject to restrictions.

The following are the main changes to the 1983 Act by the 2007 Act as directly extracted from the *Department of Health, Mental Health Act 2007 - overview*<sup>74</sup>:

- **Definition of mental disorder:** it changes the way the 1983 Act defines mental disorder, so that a single definition applies throughout the Act, and abolishes references to categories of disorder. These amendments complement the changes to the criteria for detention.
- **Criteria for detention:** it introduces a new "appropriate medical treatment" test which will apply to all the longer-term powers of detention. As a result, it

<sup>69</sup> [www.mentalhealthalliance.org.uk](http://www.mentalhealthalliance.org.uk)

<sup>70</sup> Darjee, R. and Crichton, J. (2004), *BMJ* **329**, 634-635, Editorial, New Mental Health Legislation

<sup>71</sup> Including the provision of advocates, role of Mental Health Tribunal, Single assessment procedure for civil patients, the ability to appoint a 'nominated person', improvements to treatment safeguards and special provisions for children and young people

<sup>72</sup> [www.mentalhealthalliance.org.uk/policy/documents/01Introduction.pdf](http://www.mentalhealthalliance.org.uk/policy/documents/01Introduction.pdf)

<sup>73</sup> Glover-Thomas, N. (2007), *Clinical Ethics* **2**, 28-31, A new 'new' Mental Health Act? Reflections on the proposed amendments to the Mental Health Act 1983

<sup>74</sup> [www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH\\_078743](http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH_078743)

will not be possible for patients to be compulsorily detained or their detention continued unless medical treatment which is appropriate to the patient's mental disorder and all other circumstances of the case is available to that patient. At the same time, the so-called "treatability test" will be abolished.

- **Professional roles:** it is broadening the group of practitioners who can take on the functions currently performed by the approved social worker and responsible medical officer.
- **Nearest relative:** it gives to patients the right to make an application to displace their nearest relative and enables county courts to displace a nearest relative where there are reasonable grounds for doing so. The provisions for determining the nearest relative will be amended to include civil partners amongst the list of relatives.
- **Supervised community treatment (SCT):** it introduces SCT for patients following a period of detention in hospital. It is expected that this will allow a small number of patients with a mental disorder to live in the community whilst subject to certain conditions under the 1983 Act as amended, to ensure they continue with the medical treatment that they need. Currently some patients leave hospital and do not continue with their treatment, their health deteriorates and they require detention again – the so-called "revolving door".
- **Mental Health Review Tribunal (MHRT):** it introduces an order-making power to reduce the time before a case has to be referred to the MHRT by the hospital managers. It also introduces a single Tribunal for England, the one in Wales remaining in operation.
- **Age-appropriate services:** it requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs).
- **Advocacy:** it places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates.
- **Electro-convulsive therapy:** it introduces new safeguards for patients.

#### 4.1.4 ISSUES AND OPINION SURROUNDING IMPLEMENTATION OF THE ACT

The charity *Mind* believes that the Act is a "*significant improvement on what the Government originally planned*" and although "*far from perfect*" the Act now contains the following positive attributes (as extracted from *Mind's* campaign)<sup>75</sup>:

- "*principles to which professionals should adhere when using the Act, including respect for diversity and user involvement;*
- "*a clause that ensures that compulsory treatment can only be used if its purpose is to alleviate or prevent a worsening of a mental health problem or its symptoms or manifestations;*
- "*tighter controls on what conditions can be placed on someone who is compulsorily treated in the community;*

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<sup>75</sup> [www.mind.org.uk/News+policy+and+campaigns/Campaigns/MHA2007.htm](http://www.mind.org.uk/News+policy+and+campaigns/Campaigns/MHA2007.htm)

- *a right to an independent mental health advocate for anyone subject to the Act;*
- *measures to prevent children and young people being accommodated on adult wards;*
- *a clause to ensure 16 and 17 year olds' refusal of treatment cannot be overridden by their parents;*
- *a safeguard allowing people held in police cells for assessment to be moved to a more appropriate place of safety as soon as one is made available;*
- *new safeguards for patients receiving electroconvulsive therapy;*
- *a strengthening of the provisions in the Act's Code of Practice which means that professionals who do not follow it could face legal challenge”.*

There are still many criticisms of the new Act. The following are some of the concerns cited in literature, often concerned with a lack of ethical principles, in the Act.

*Supervised Community Treatment Orders (SCT or CTO)*<sup>76</sup> – Some doctors and mental health campaigners believe that to compel patients discharged from hospital to continue taking their treatment is “*discriminatory, authoritarian and unnecessary*”. However, the mental health charity *Sane*, believes that “*one in three of the homicides and serious assaults committed by people with mental illness could be prevented*” by such measures. It is noted that there is concern internationally about so called “*revolving-door patients*” who do well in hospital but stop taking their medication after discharge<sup>77</sup>. Under the SCT a patient would be compelled to continue their treatment after discharge on threat of being readmitted to hospital. It has been proposed by a US study,

*“it would take 85 CTOs to prevent one readmission and 238 to prevent one arrest. It is hard to imagine another group of people where so many people have their liberty curtailed to avoid a single hospitalization or to prevent one arrest...there is no clear evidence to support the view that CTOs are either effective or cost effective”*<sup>78</sup>.

*Appropriate Treatment* - The Act introduces a new ‘appropriate treatment test’, which will apply to all longer-term powers of detention, irrespective of diagnosis. This fundamental revision of the 1983 Act removes the previous ‘treatability test’ as it was known which was used to ensure that only those who could benefit from treatment could be detained under the 1983 Act, i.e. the result was that some patients were labelled as ‘untreatable’ and denied treatment within the Act<sup>79</sup>. Concern has been expressed at the lack of emphasis on ‘therapeutic benefit’, a principle seen as

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<sup>76</sup> Laurance, J. *The Independent*, 9<sup>th</sup> January 2007, The Big Question: Will the new mental health Bill make Britain a safer place?

<sup>77</sup> CTOs are used in New Zealand, Australia and 38 states in the US

<sup>78</sup> Laurance, J. *The Independent*, 9<sup>th</sup> January 2007, The Big Question: Will the new mental health Bill make Britain a safer place?

<sup>79</sup> Glover-Thomas, N. (2007), *Clinical Ethics* 2, 28-31, A new ‘new’ Mental Health Act? Reflections on the proposed amendments to the Mental Health Act 1983

fundamental good practice in key international mental health policies<sup>80</sup> and that ‘appropriate’ treatment “*is ambiguous with no necessary connection with ‘therapeutic’*”<sup>81</sup>.

*Principle of Safety* – The ‘protection of others’ in the Act is “*not qualified by a phrase containing the word serious*”. A criterion for the application of an “*involuntary treatment order states that protection of the patient should be on the basis of serious self-harm or serious neglect of his health or safety*”. It is proposed that this implies a difference in threshold for compulsion and an “*acceptable level of risk to the patient’s own health or safety, which must be serious, as against the non-serious risk to others... [which] is likely to reinforce common and stigmatizing stereotypes that associate mental illness and violence*”<sup>82</sup>.

*Mental Health Review Tribunal* – The legislation aims to increase the speed and frequency by which the MHRT system is involved in an individual’s mental health service experience. A main concern is that the tribunal system may not have a sufficient workforce or resources to accommodate the increasing demands on the system<sup>83</sup>. The focus in the legislation on the risk to others is “*the granting of powers, in civil cases, to mental health tribunals to reserve themselves the decision to grant leave to or discharge a patient*”. It is proposed that this is a form of ‘restriction order’ now to be generally applied and is such as that used in the forensic arena. It is believed that this means “*that the clinical supervisor’s decision that it is appropriate for the patient to now be treated informally can be overridden by the tribunal*”<sup>84</sup>.

Overall, the legislation has been summarised as indicating “*an ethical shift away from rights focused approaches to more consequentialist thinking...politically legitimate, but from an ethical point of view any shift away from rights focused thinking would only be desirable if there were overwhelming benefits to society*”. Examples quoted to support this ethical shift are the introduction of community orders, the broad definition of mental disorder and the detention of people with severe personality disorder as they “*favour public safety over individual rights*”<sup>85</sup>.

## **4.2 THE MENTAL CAPACITY ACT 2005**

### **4.2.1 OVERVIEW**

The Mental Capacity Act 2005 provides a framework for decision-making on behalf of adults aged 16 and over who lack capacity to make decisions on their own behalf, including decisions about medical treatment and major decisions about someone’s property and affairs and where the person lives, as well as everyday decisions about

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<sup>80</sup> Including World Health World Health Report on Mental Health (2001) and United Nations Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care 1991

<sup>81</sup> Thornicroft, G. and Szmukler, G. (2005), *Psychiatric Bulletin*, **29**, 244-247, The Draft Mental Health Bill in England: without principles

<sup>82</sup> Thornicroft, G. and Szmukler, G. (2005), *Psychiatric Bulletin*, **29**, 244-247, The Draft Mental Health Bill in England: without principles

<sup>83</sup> Glover-Thomas, N. (2007), *Clinical Ethics* **2**, 28-31, A new ‘new’ Mental Health Act? Reflections on the proposed amendments to the Mental Health Act 1983

<sup>84</sup> Thornicroft, G. and Szmukler, G. (2005), *Psychiatric Bulletin*, **29**, 244-247, The Draft Mental Health Bill in England: without principles

<sup>85</sup> Lepping, P. (2007), *Philosophy, Ethics and Humanities in Medicine*, **2**, 5, Ethical analysis of the new proposed mental health legislation in England and Wales

personal care. It generally places pre-existing common law provisions on a statutory footing, however new features include the ability to nominate substitute decision-makers under a Lasting Power of Attorney, the development of a new Court of Protection with extended powers, and specific provisions for enrolling incapacitated adults in certain forms of research. The Act applies to England and Wales, with Scotland having its own legislation as described above (the Adults with Incapacity (Scotland) Act 2000), and “*the approach in Northern Ireland is currently governed by common law*”<sup>86</sup>. The Act was implemented over two stages in 2007, with the new Independent Mental Capacity Advocate service becoming operational in April 2007.

For the purposes of the Act, a person lacks capacity if, “*at the time the decision needs to be made he or she is unable to make or communicate the decision because of an ‘impairment of, or a disturbance in the functioning of the mind or brain’*”. The assessment of capacity is ‘task-specific’ as it focuses on the “*specific decision that needs to be made at the specific time the decision is required*”. Therefore, it does not matter if the incapacity is temporary or capacity fluctuates and if the person retains the capacity to make other decisions<sup>87</sup>.

#### 4.2.2 PRINCIPLES OF THE ACT

The Act sets out five key principles that must govern all decisions made and actions taken under its powers<sup>88</sup>:

1. *A presumption of capacity* – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
2. *Individuals being supported to make their own decisions* – a person must be given all practicable help before anyone treats them as not being able to make their own decisions;
3. *Unwise decisions* – an individual should not be treated as lacking capacity just because they make what might be seen as an unwise decision;
4. *Best interests* – an act done or a decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests; and
5. *Least restrictive option* – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

#### 4.2.3 ASSESSING CAPACITY

The Act sets out a single ‘decision-specific’ test for assessing whether a person lacks capacity to take a particular decision at a particular time. A person is regarded as being incapable of making the decision at the time if he or she fails<sup>89</sup>:

- To understand the information relevant to the decision;
- To retain information relevant to the decision;
- To use or weigh the information; or
- To communicate the decision (by any means).

The British Medical Association notes that “*the reality of clinical practice is likely to be slightly more complex...and clearly difficult judgments will still need to be made, particularly where there is fluctuating capacity*”. Section 5 of the Act deals with health

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<sup>86</sup> BMA, The Mental Capacity Act 2005 – Guidance for Health Professionals, March 2007, [www.bma.org.uk/ap.nsf/Content/mencapact05](http://www.bma.org.uk/ap.nsf/Content/mencapact05)

<sup>87</sup> BMA, The Mental Capacity Act 2005 – Guidance for Health Professionals, March 2007, [www.bma.org.uk/ap.nsf/Content/mencapact05](http://www.bma.org.uk/ap.nsf/Content/mencapact05)

<sup>88</sup> Extracted from: Cowan, J. (2007), *Clinical Governance: An International Journal*, **12**(1), 64-70, Are we prepared for the Mental Capacity Act

<sup>89</sup> Extracted from: BMA, The Mental Capacity act 2005 – Guidance for Health Professionals, March 2007, [www.bma.org.uk/ap.nsf/Content/mencapact05](http://www.bma.org.uk/ap.nsf/Content/mencapact05)

interventions, “*health professionals will enjoy protection from liability – where the decision maker has a reasonable belief both that the individual lack capacity, and that the action or decision is in his or her best interests...it is applicable not only to an episode of treatment itself, but also to those necessary ancillary procedures such as conveying a person to hospital*”<sup>90</sup>.

#### 4.2.4 BEST INTEREST AND USE OF RESTRAINT

The Act provides a checklist of factors that decision makers must work through in deciding what is in a person’s best interests. A person can put his/her wishes and feelings into a written statement and carers and families gain a right to be consulted. Section 6 of the Act defines restraint and it is only permitted if the person using it believes it is necessary to prevent harm to the incapacitated person, and if the restraint used is proportionate to the likelihood and seriousness of the harm<sup>91</sup>.

#### 4.2.5 ADVANCE DECISIONS

The Act enables people to plan ahead for a time when they lose capacity, “*advance decisions are not yet widespread in medical care, but are undoubtedly encountered more frequently. This is a complex legal area in which treating clinicians must become acquainted with the provisions of the Act to allow them to respect and adhere to unambiguous decisions that their patients have made*”<sup>92</sup>.

#### 4.2.6 RECENT AMENDMENTS TO THE ACT

The Mental Health Act 2007 has been used to amend the Mental Capacity Act 2005 in relation to compliant incapacitated patients who are detained. The principles of supporting a person to make a decision when possible, and acting at all times in the person’s best interests and in the least restrictive manner, will apply to all decision-making in operating the procedures. The changes in relation to the Mental Capacity Act 2005 are in response to the 2004 European Court of Human Rights judgment (HL v UK (Application No.45508/99)) (the “Bournewood judgment”) involving an autistic man who was kept at Bournewood Hospital by doctors against the wishes of his carers. The European Court of Human Rights found that admission to and retention in hospital of HL under the common law of necessity amounted to a breach of Article 5(1) of the European Convention on Human Rights (deprivation of liberty) and of Article 5(4) (right to have lawfulness of detention reviewed by a court)<sup>93</sup>.

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<sup>90</sup> [www.bma.org.uk/ap.nsf/Content/mencapact05](http://www.bma.org.uk/ap.nsf/Content/mencapact05)

<sup>91</sup> Cowan, J. (2007), *Clinical Governance: An International Journal*, **12**(1), 64-70, Are we prepared for the Mental Capacity Act

<sup>92</sup> Cowan, J. (2007), *Clinical Governance: An International Journal*, **12**(1), 64-70, Are we prepared for the Mental Capacity Act

<sup>93</sup> Extracted from:

[www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH\\_078743](http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH_078743)