

Vulnerability and the law: A practitioner's perspective

An introduction to the new Mental Health Act 2007 and the major differences between the MHA 2007 and MHA 1983

1. It is an obvious point that everyone who comes to the law is vulnerable in some sense, whether suing or being sued, accused of a crime or the victim of a crime. That is why they generally require the assistance of specialised professional services to navigate the system - but with that help in place, someone with capacity is unfettered in their decision - making and has the right to make bad decisions as well as good ones.
2. The decision – making ability of those who are deemed of particular vulnerability by the law, whether by lack of capacity or by reason of poor mental health, is fettered at a most fundamental level: the “right” to live in a place of their choosing, the “right” to take medication or not take medication, to attend hospital for treatment or not to attend.
3. With the advent of a rights - based culture incorporated into the law by the Human Rights Act, there is an apparent shift away from paternalism over vulnerable people to supposed empowerment of their decision – making. I say supposed, because insofar as this paper is a polemic, I question the extent to which that shift operates in reality.
4. The main features of the 2007 Act on which I will focus will come into force on 3 November 2008. The Act is available on the DoH website as is the Code of Practice accompanying the Act. There will be new Rules governing the function of the Mental Health Review Tribunals and those Rules should be published in October.
5. I shall address four main points:
 - (1) What were the limitations of the old Act?
 - (2) Why was a new Act thought necessary?
 - (3) What does the new Act do?
 - (4) Will the new Act safeguard rights?

Limitations of the old Act.

6. An Act dating back to 1983 was regarded as outmoded and outdated. Mental health reform is slow – the first draft Bill proposed a couple of years into the new century.
7. Mental health reform was to address the twin concerns of individual and public safety; the better treatment of people so as to maximise their autonomy and promote greater freedom, the move away from institutionalisation. It was also the case that as greater understanding of conditions such as paedophilia and personality disorder developed and the need to manage people with such disorders was recognised, the mental health legislation in its 1983 form was inadequate.

Why was a new Act thought necessary?

8. It is notable that the Department of Health's Mental Health Bill Regulatory Impact Assessment identified 3 aims of the new legislation.
 - (1) to ensure that patients receive the treatment they need to protect themselves and the public from harm
 - (2) to bring mental health law into line with modern service provision
 - (3) to strengthen patient safeguards, and remedy incompatibilities with Human Rights legislation.
9. The ordering of those aims may give an insight into the priorities driving the legislation. Breaking it down:
 - (1) To ensure patients receive the treatment they need to protect themselves and the public from harm:
10. The aims of the 1983 and 2007 Acts are no different in seeking to ensure that patients receive the treatment they need to protect themselves. The 2007 Act aims to avoid institutionalisation, or a "revolving door patient" culture through a new regime of community treatment orders.
11. However, risk assessment and public safety are key words in mental health. There is always a tension between the rights of the individual to have their illness managed with as little intervention as possible and the rights of the wider public to be protected from someone who, in their illness, may do harm to their family or close friends or even others.
12. Many people with mental health problems – organisations such as Mind and Mental Health Alliance would say the vast majority - live entirely trouble – free lives and are only ever likely to be a danger to themselves through the risk of suicide or, in many cases, because their illness makes them an easy target for unwelcome attention from others in the community. Unfortunately, difference is not always well – tolerated by certain factions in society and those who are identifiably different by reason of their mental health are not excluded from abuse.
13. The second aim
 - (2) to bring mental health law into line with modern service provision

This is generally regarded as long overdue, there having been a move since the 1990s towards community treatment rather than institutionalisation. However, the 2007 Act also recognises the part that satellite mental health services play in keeping people well, for example the potentially key roles of the psychologist or approved social worker are recognised.
14. The third aim
 - (3) to strengthen patient safeguards and remedy incompatibilities with human rights legislation.
15. It is interesting to think why this is the third aim and not the first. Without being too simplistic and to coin a phrase from an article by Camilla Cavendish in The Times (10 September 2008:

www.timesonline.co.uk/tol/comment/camilla_cavendish/article4719399.ece

“Patients’ rights must not trump public safety”

16. The reason for this view is not because there is any great likelihood that the vast majority of mentally ill persons will commit violent crime – statistics from Mind and the Mental Health Alliance show this patently not to be the case – but it is because of heightened awareness of the failures of the mental health system following the Jonathan Zito case. Jonathan Zito was killed by Christopher Clunis at a London tube station in 1992. The Zito Trust has worked tirelessly for inquiries to be held into situations where mentally ill people kill after discharge and it is right that the assessment of risk that such people pose is something that should be subject to scrutiny. Any failures in care that may contribute to such crimes should be identified and addressed. However, it should not be given disproportionate weight in determining how the rest of the non – violent mentally ill population should be treated by the law.
17. The ordering of aims by the DoH’s regulatory impact paper favours public safety over patient’s rights. When looking at what the new Act does, it is interesting to keep in mind the extent to which that prioritisation is reflected in the legislation.

What does the new Act do?

18. In summary, the new Act:

Redefines mental disorder and mental impairment

Removes, in particular, the exclusion of sexual deviancy so as to allow the detention of paedophiles under the Act

Incorporates a new test for detention of the “appropriate treatment” test in replace of the “treatability” test

Extends the definition of medical treatment

Brings in continued supervision in the community

Extends professional responsibilities

19. Comparison of the new Act with the old Act (Please note so as to avoid accusations of plagiarism: some of the following material has been taken from training provided by the Ministry of Justice to MHRT panel members).

1983 Act	2007 Act
Definition of mental disorder	
<p>The 1983 Act defined mental disorder by reference to 4 categories:</p> <ul style="list-style-type: none"> ➤ Mental illness ➤ Arrested or incomplete development of mind ➤ Psychopathic disorder 	<p>The 2007 Act has just one definition: a single definition of “mental disorder”.</p> <p>No further definition provided, but the explanatory notes to the Act refer to “clinically recognised” mental disorder.</p> <p>Thus: classification/labelling of the disorder is not important, as long as it is a clinically</p>

<p>➤ Any other disorder or disability of mind</p> <p>For many of the purposes of the Act, a diagnosis of “mental disorder” was not sufficient and one of the four categories had to be met</p>	<p>recognised disorder.</p> <p>This amendment reflects the ECHR ruling in Winterwerp –v- Netherlands (1979) 2 EHRR 387 which requires a “true mental disorder” to be established on the basis of “objective expertise” before detention can be considered.</p> <p>Includes (quite apart from mental illnesses such as schizophrenia, bipolar disorder, depression etc):</p> <ul style="list-style-type: none"> ➤ Organic mental disorders such as dementia ➤ Personality and behavioural changes due to brain injury ➤ Personality and behavioural changes due to psychoactive substance misuse ➤ Non – organic disorders: eating disorders, sleep disorders, sexual disorders ➤ Autistic spectrum disorders and other learning disabilities <p>Generally thought to be a widening of the category of persons who may be at risk of detention under the Act.</p>
<p>Learning disability</p>	
<p>Defined as:</p> <p>“mental impairment” means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and “mentally impaired” shall be construed accordingly</p>	<p>The definition is identical, save that it is referred to as “learning disability” rather than “mental impairment”.</p> <p>The caveat that detention cannot be used unless the learning disability is associated with abnormally aggressive or seriously irresponsible conduct remains.</p> <p>That means (and it appears still means) that detention cannot be used until an actual instance of abnormal aggression or irresponsible conduct has occurred.</p> <p>However: the operation of section 2A and 2B of the new Act mean that someone with a learning disability can be detained for an assessment.</p> <p>But what would be the point of such an assessment? One might assess the propensity</p>

	to violence or irresponsible conduct, but could only do something about it once that behaviour has manifested itself.
Exclusions from the Act	
<p>The 1983 Act excluded sexual deviancy and dependence on drugs and alcohol as follows:</p> <p>Subsection 3: “nothing in subsection (2) above [the definitions of mental disorder] shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder, or from an form of mental disorder described in this section, by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs”</p>	<p>2007 Act: for subsection 3, substitute:</p> <p>(3) “Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of subsection (2) above”</p> <p>Sexual deviancy is now covered by the 2007 Act so paedophiles can be now be included.</p> <p>“Promiscuity/ Immoral conduct” is now no longer excluded: addiction to pornography/ sex addiction would be covered by the Act.</p> <p>It will be interesting to see what limits are placed on these categories and whether they are imposed by clinicians or the law.</p> <p>For example, the criminal law would not generally intervene in the sexual proclivities¹ of adult consenting parties – but the 2007 Act could.</p>
Tests for detention: treatability vs appropriate treatment	
<p>Detention under the 1983 Act (for all but s.2 and the emergency powers) is justified if “it is likely that treatment in hospital will alleviate or prevent a deterioration of the patient’s condition”.</p> <p>Therefore, if treatment could not alleviate or prevent a deterioration of the patient’s condition (such as with personality disorder) then there could be no detention.</p>	<p>Under the 2007 Act, the notion of treatability has been replaced by the availability of appropriate treatment.</p> <p>In order for detention (e.g. under section 3), “appropriate medical treatment” must be “available”</p> <p>“Appropriate medical treatment” is defined as “medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case”.</p> <p>The purpose of the medical treatment is defined i.e. “medical treatment ... shall be construed as a reference to medical treatment the purpose of which is to alleviate or prevent</p>

¹ Laskey -v- UK (1997) 24 EHRR 39 (in the domestic law, this case was known as R -v- Brown (Operation Spanner) where consenting adults engaging in sado – masochistic acts in private were prosecuted for causing grievous bodily harm): the criminal law should not intervene in consensual sexual practices, save where such acts could be construed as failing to show respect for choice and autonomy (e.g. where someone initially consenting withdraws their consent).

	<p>a worsening of, the disorder or one or more of its symptoms or manifestations”.</p> <p>The appropriateness of treatment is not measured by its efficacy i.e. it doesn't mean that it has to actually alleviate the condition or prevent a deterioration, it simply has to have that purpose.</p>
<p>Definition of medical treatment</p>	
<p>Section 145 (1) defines medical treatment as including nursing, care habilitation and rehabilitation under medical supervision</p>	<p>Section 7 of the 2007 Act extends the definition of “medical treatment” to include “nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care”</p> <p>The treatment need no longer be under medical supervision.</p> <p>A further restriction on what is medical treatment, apart from it having to be geared towards the disorder, it that it has to be actually not theoretically available.</p> <p>This requirement is provided for in the explanatory notes to the Act, not by the Act itself, so there is some doubt as to how this will be interpreted.</p> <p>The aim of this test, however was to ensure that detention will be clinically appropriate i.e. that there will be treatment available, rather than the detention simply being a holding situation without the offer of medical treatment. There should not be detention for detention's sake.</p> <p>The sorts of factors that may be relevant to the appropriateness of treatment are:</p> <p>Whether treatment can be provided in an age appropriate setting;</p> <p>Whether particular needs presented by gender, culture and ethnicity can be met;</p> <p>The sorts of factors that do not make treatment inappropriate:</p> <p>Appropriate treatment may not be limited to forms of medication;</p> <p>The patient's unwillingness to comply does not make the treatment inappropriate</p> <p>Difficulties with treatment (e.g. side effects)</p>

	<p>do not mean that the treatment is inappropriate if it meets the purpose of alleviating or preventing a worsening of mental disorder;</p> <p>Appropriate does not mean optimum or gold standard.</p> <p>These provisions are generally regarded as a widening of the detention provisions, so that more people with a wider variety of disorders can be made subject to the provisions of the Act and undergo treatment (again, widely construed).</p> <p>The balance to this provided by the 2007 is to place a greater emphasis on supervision in the community, with the advent of community treatment orders.</p>
Community treatment	
<p>Under 1983 Act, leave of absence is provided by section 17 and aftercare under supervision is provided by section 25.</p> <p>RMO can grant leave of absence to any patient who is liable to be detained in hospital, subject to any conditions considered necessary in the interest of the patient or the protections of other persons.</p> <p>Leave of absence can be long term and the section providing for liability to be detained can be renewed while the patient is on leave.</p> <p>There is a power of recall and the patient is liable to compulsory treatment powers.</p> <p>The purpose of the aftercare provisions is to ensure the provision of necessary aftercare services to patients once they leave hospital, in particular for patients who still require support and treatment but are no longer unwell enough to justify their detention in hospital.</p>	<p>Supervised community treatment</p> <p>Aftercare under supervision (section 25) is repealed.</p> <p>Instead, the answer to the “revolving door patient” is the creation of the “community patient”.</p> <p>The aim is to avoid long term leave from hospital, although it doesn’t necessarily prevent it: an RMO cannot release a patient on leave for more than 7 days without first considering a supervised community treatment order.</p> <p>The purpose of the section is to enable people’s care to be managed in the community and recognises that not all people needing treatment for their mental disorder need to be in hospital.</p>
Extending professional responsibilities	
Typically the RMO would be the psychiatrist in charge of overall care.	<p>Approved clinicians and responsible clinicians.</p> <p>The RMO (responsible medical officer) is being replaced with a responsible clinician</p> <p>All medical recommendations will be made</p>

	<p>by registered medical practitioners.</p> <p>The advent of other forms of treatment as appropriate treatment (e.g. psychological intervention; nursing support and care) means that the responsible clinician need not be a psychiatrist.</p>
Fundamental principles and the Code of Practice	
	<p>2007 Act provides that the Code of Practice which accompanies the Act should include a statement of the principles which should inform decision – making under the Act.</p> <p>These are:</p> <p>Respect for patient’s past and present wishes and feelings;</p> <p>Respect for diversity</p> <p>Minimising restrictions on liberty</p> <p>Involvement of patients in planning, developing and delivering care and treatment appropriate to them</p> <p>Avoidance of unlawful discrimination</p> <p>Effectiveness of treatment</p> <p>Views of carers and other interested parties</p> <p>Patient wellbeing and safety</p> <p>(last but not least) Public safety</p>

Will the new Act safeguard rights?

20. There are specific safeguards that are welcome. Specific provisions cover consent to treatment (section 27), the requirement to consult with two other persons concerned with the patient’s treatment before administering treatments identified by regulation, i.e. electroconvulsive therapy (section 27(6), the provision of advocacy services in the form of independent mental health advocates (section 30) and the provision of an independent doctor to give a second opinion in circumstances where treatment is envisaged in the absence of the patient’s consent (“second opinion appointed doctors SOADs).
21. The concern, however, is that the new Act covers more people and, unless properly resourced and implemented, will help them less. More people will become subject to the provisions of the Mental Health legislation in circumstances where previously they would not have done and although the move to community treatment is generally welcomed, the fear is that services will not in fact be made available to those who need them.

22. The fear is that there will be significant over – use of community treatment orders and it gives too much power to clinicians both to define mental disorder and to retain power of recall over people who previously would have had to have been discharged from their section.
23. The suspicion is that the psychiatric services see CTOs as a way of keeping patients on a long leash (and thus liable to be detained) in circumstances where under the 1983 Act their liberty would not have been fettered at all.
24. The “balance of power” between individual rights and public safety is thus yet to be determined.

MARY RUCK

Byrom Street Chambers

17 September 2008