Mental Health Law in England & Wales

A Guide for Mental Health Professionals

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Introduction

Before the compulsory powers contained in the Mental Health Act may be used, a series of criteria must be met. Even if the criteria *are* all met, this will not necessarily result in the powers being invoked because health and social care professionals retain the discretion to take a different approach. Approved mental health professionals (AMHPs), for example, have an obligation under s13(2) (and restated in Forms A2 and A6 in England; HO2 and HO6 in Wales) in respect of applications for admission of a patient to hospital to satisfy themselves *"that detention in hospital is in all the circumstances of the case the most appropriate way of providing the care or medical treatment of which the patient stands in need"*. Doctors completing recommendations for s3 must state in Form A8 (HO8 in Wales) that the necessary treatment cannot be provided unless the patient is detained under s3. Even for admissions under s2, doctors must (in Forms A4 and HO4 respectively) explain why informal admission is not appropriate.

The first criterion to be met is that the patient is suffering from mental disorder. This is important because it is a legal requirement of the Mental Health Act and the powers can only be exercised precisely within a legal framework. However, it also touches upon one of the essential requirements of Article 5 of the European Convention on Human Rights (see Chapter 17 and Appendix 5) which in certain circumstances permits the detention of *"persons of unsound mind"*. We will therefore, in this chapter, consider the meaning of mental disorder and look at some of the key issues associated with this. We will also look at the "appropriate medical treatment" test introduced by the Mental Health Act 2007.

The meaning of mental disorder

Mental disorder is succinctly defined in s1(2) as follows: *"mental disorder" means any disorder or disability of the mind.*

It is nowhere further defined in the Act, but, as will be seen, it is qualified in relation to learning disability. A distinction is clearly intended to be made between "a disorder or disability of the **mind**" and a "disorder or disability of the **brain**". The words "or brain" were included within the draft 2002 Bill definition, but then dropped. At Para. 17, the Explanatory Notes state that "*disorders or disabilities of the brain are not mental disorders unless (and only to the extent that) they give rise to a disability or disorder of the mind as well*". The intention is no doubt to create a demarcation line between the Mental Health Act and the Mental Capacity Act (which includes the words "or brain" in its definition of incapacity in s2), but the distinction may not always be clear-cut.

A non-exhaustive list of possible examples of mental disorder is set out in the Code of Practice for England at Para. 2.5:

- *affective disorders, such as depression and bipolar disorder;*
- *schizophrenia and delusional disorders;*
- *neurotic, stress-related and somatoform disorders, such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders;*
- *organic mental disorders such as dementia and delirium (however caused);*
- *personality and behavioural changes caused by brain injury or damage (however acquired);*
- *personality disorders;*
- *mental and behavioural disorders caused by psychoactive substance use …;*
- *eating disorders, non-organic sleep disorders and non-organic sexual disorders;*
- *learning disabilities;*
- *autistic spectrum disorders (including Asperger's syndrome) …;*
- *behavioural and emotional disorders of children and young people.*

The 2016 Code for Wales no longer includes such a list at all, and there is some logic to this approach. The mere presence of such conditions listed in the Code or included in manuals such as the International Classification of Diseases (ICD 11) or the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) does not establish them as mental disorders for the purposes of the Act. Nor does the non-appearance of a condition in the manuals mean that it cannot legally be considered a mental disorder. As was noted by the court in *DL-H v Devon Partnership NHS Trust v Secretary of State* (2010) (see Appendix 6), "the specific criteria in ICD 11 are labelled as diagnostic criteria for *research*" and the introduction to DSM-V confirms that the "clinical diagnosis of a DSM-V mental disorder is not sufficient to establish the existence for legal purposes of a 'mental disorder'". An example would be dependence on alcohol or drugs, which are included in the manuals as mental disorders but are expressly excluded from the legal definition of mental disorder as discussed below.

The removal of the classifications

The broad definition of mental disorder is accompanied by the removal of the previous classifications. These classifications (mental illness, mental impairment, severe mental impairment and psychopathic disorder) acted to restrict the application of some sections of the Act to certain categories of mental disorder. Although in relation to the treatment to be given to a patient, case law had decided that the classification of the disorder was not decisive, the distinction was important in determining which parts of the Act applied to which disorder for a variety of purposes. For s3, the longer-term admission for treatment required a patient to be placed within one of the four classifications, whereas s2 did not. Now, whether s2 or s3 is under consideration, the first criterion for either is simply whether the patient is suffering from mental disorder.

Because for the purposes of the Act psychopathic disorder no longer exists, the particular qualifications attaching to the condition disappear likewise. So, for s3, there is no requirement that treatment is likely to alleviate or prevent a deterioration of the condition (this was replaced by the appropriate medical treatment test considered below). Further, for all purposes it is unnecessary to establish that the disorder is "persistent" or "resulting in abnormally aggressive or seriously irresponsible conduct" on the part of the patient. All that is required is "mental disorder". This can only mean that more people (particularly those with personality disorders) are eligible

to be considered for use of the compulsory powers under the Act than before the amendments introduced by the Mental Health Act 2007.

The exclusions

There was a good deal of debate around the proposed removal of the exclusions from mental disorder as the 2007 Bill was passing through Parliament. Section 1 of the unamended Act precluded promiscuity or other immoral conduct, sexual deviancy, or dependence on alcohol or drugs from being considered as mental disorders for the purpose of using the compulsory powers. The House of Lords pressed for the addition of further exclusions, whereas the Government wanted the removal of all of them. In the end only the exclusion relating to dependence on alcohol or drugs was retained. While this means that it is not possible to use the Act's compulsory powers on the basis of drug or alcohol dependence alone, as the Code of Practice points out at E Para. 2.11:

> *Alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. If the relevant criteria are met, it is therefore possible (for example) to detain people who are suffering from mental disorder, even though they are also dependent on alcohol or drugs. This is true even if the mental disorder in question results from the person's alcohol or drug dependence.*

(The Code for Wales at 2.6 gives similar guidance.) So, a related or consequential mental disorder would not rule out use of the compulsory powers.

The removal of the exclusions relating to promiscuity, other immoral conduct and sexual deviancy is controversial. The Explanatory Notes state at E Para. 24:

> *Clinically, neither promiscuity nor "other immoral conduct" by itself is regarded as a mental disorder, so the deletion of that exclusion makes no practical difference. Similarly, sexual orientation (homo-, hetero- and bi-sexuality) alone is not regarded as a mental disorder. However, there are disorders of sexual preference which are recognised clinically as mental disorders. Some of these disorders might be considered "sexual deviance" in the terms of the current exclusion (for example paraphilias like fetishism or paedophilia). On that basis, the amendment would bring such disorders within the scope of the 1983 Act.*

Clearly the intention is that paedophilia, for example (so long as the other criteria are met), should be capable of being regarded as a mental disorder for the purposes of using the compulsory powers of the Act. If paedophilia could be considered a symptom of a personality disorder, it would not have been excluded from consideration in any event under the unamended Act. The question is whether without being such a symptom, the removal of sexual deviancy as an exclusion makes it easier to argue that such conditions constitute mental disorders eligible for consideration for use of the compulsory powers. Of course, all other criteria would have to be met (e.g. as to risk), but an argument can be anticipated that rather than being true mental disorders, they are behaviours "deviating from society's norms" and therefore fall foul of the *Winterwerp* criteria for what constitutes lawful detention on the basis of unsoundness of mind (see Appendix 6).

Learning disability

Although the definition of mental disorder has been simplified and broadened (so as to include some conditions not previously considered eligible for use of the Act's powers), there is one area in which the complexity of the unamended Act has been retained, namely learning disability. This is defined in s1(4) as: *"a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning".*

As such it would clearly fall within the s1(2) definition of mental disorder. However, as a result of an amendment introduced during the Bill's passage, words familiar from the unamended Act were reintroduced (drawn from the old definition of mental impairment). The effect of s1(2A) is that for all but the short-term sections (2, 4, 5, 135, 136), learning disability will not constitute a mental disorder unless "associated with abnormally aggressive or seriously irresponsible conduct" on the part of the patient. It follows that, for example, neither s3 nor s7 can be invoked without this qualification being met. Given the generally restrictive but not entirely consistent interpretation often placed in particular on the phrase "seriously irresponsible conduct" by the courts (see *Re F (Mental Health Act: Guardianship* (2001) in Appendix 6), there will be some cases where guardianship will not be a possible avenue for a patient because of this requirement. The intention is probably that such patients should be managed for preference under the Mental Capacity Act. The Deprivation of Liberty Safeguards (DoLS) procedure does not require learning disability to be qualified in this way in order to constitute a mental disorder. Whether it is to the advantage of a learning disabled person to be managed under DoLS rather than the Mental Health Act is a moot point among health and social care professionals.

Particular care will need to be taken by AMHPs and doctors in this area as, for some inexplicable reason, the forms for applications and medical recommendations under s3 do not make this behavioural requirement explicit.

The Code of Practice (E Para. 2.17; W Para. 2.13) differentiates autistic spectrum conditions from learning disability so that the condition for use of the longer-term compulsory powers could be met (albeit rarely) without any other coexisting form of mental disorder and without the association with abnormally aggressive or seriously irresponsible behaviour.

The availability of appropriate medical treatment

The UK Government was adamant that the "treatability" test contained in the unamended Act was to be removed. It was seen as one of the reasons relied on not to admit certain patients whom the Government did not wish to see excluded. This was one of the principal battlegrounds during the Bill's passage and although the Government had its way, a last-minute amendment was introduced upon which opinion is divided. Does the definition of "appropriate medical treatment" effectively introduce a new more widely applicable treatability test, or is the definition so imprecise that virtually all patients will meet it should the health and social care professionals wish to use the compulsory powers in any given case?

The requirement that appropriate medical treatment is available for the patient applies to all patients suffering from mental disorder, whether at the time of initially considering s3 or of its renewal. In addition, it is a requirement for placing a patient on a community treatment order under s17A (and extending it), and for Tribunals considering whether to discharge a patient. It even extends to the exercise by second opinion appointed doctors (SOADs) of their certification responsibilities, where the "alleviation" test is replaced with an "appropriateness" test.

An application for admission for treatment is now possible if three grounds are met for the patient:

(a) *he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and*

(b) *…*

(c) *it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and*

(d) *appropriate medical treatment is available for him.*

The meaning of the availability of appropriate medical treatment

Section 3(4) states as follows:

> *In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to 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.*

"Appropriate medical treatment" is not further defined in the Act, and at first sight the s3(4) definition is not particularly helpful to health and social care professionals in deciding whether this fundamental criterion for admission for treatment is met. The first part of the definition simply repeats itself and the concluding phrase confines itself to directing the professionals to consider anything which may be relevant, the broad ambit of which is stated in the Code of Practice (E Para. 23.12; W Para. 23.13). On one view, the lack of elaboration in the definition will merely serve to underline the professionals' discretion whether to proceed with admission. On the other hand, the broad nature of the phrase might be seen to encompass so much that not to admit would amount to a bold decision. In *MD v Nottinghamshire Healthcare NHS Trust* (2010) (see Appendix 6), the judge stated that "appropriateness is an important additional criterion for detention; it is not surplus verbiage". However, he did not elaborate further and the Code merely refers back to the statutory definitions (E Para. 23.9; W (in different terms) Para. 23.11).

If "appropriate medical treatment" is not particularly helpfully defined, and the word "appropriate" simply confirms the existence of professional discretion whether to use the compulsory powers, what about "medical treatment"? Section 145(4) states:

> *Any reference in this Act to medical treatment in relation to mental disorder shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.*

In addition s145(1) states:

> *"Medical treatment" includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.*

The following points should be noted in relation to these definitions:

1. The courts have tended to adopt a broad view of what medical treatment comprises. In *Reid v Secretary of State for Scotland* (1999) (see Appendix 6), it was stated that it was broad enough to include treatment the purpose of which ranged from "cure to containment". The inclusion of "psychological intervention" is spelled out in s145(1) but would have fallen within this broad view in any event.
2. The s145(4) definition does not require medical treatment to alleviate or prevent a deterioration of the disorder, but merely one or more of its symptoms or manifestations. In *Reid*, however, the same judge stated that "medical treatment" included treatment "designed to alleviate or prevent a deterioration of the mental disorder or the symptoms of the mental disorder"; so, as Bowen (2007, 3.55) has pointed out, s145(4) simply makes this requirement specific. The inclusion of "manifestations", however, does broaden the scope of the definition still further.
3. The s145(4) definition does not require that (as in the unamended Act) the medical treatment is "likely" to produce an effect, merely that that is its "purpose": "Purpose is not the same as likelihood" (Codes E Para. 23.4; W Para. 23.3). This would seem to imply a lowering of the threshold (but see *Reid* above). The Government was anxious that patients should not be denied admission under the compulsory powers merely because,

> for example, they were unlikely to cooperate with treatment offered, thus rendering it ineffective. As the Code for England states at Para. 23.19 and the Code for Wales at Para. 23.14: "An indication of unwillingness to co-operate with treatment generally, or with a specific aspect of treatment, does not make such treatment inappropriate." See also W Para. 4.17.

Although the decisions of the court all predate the amendments introduced by the 2007 Act, there is no reason to suppose that the amended definitions would be construed differently in any future challenge. So the bar of what is required to meet the "appropriate medical treatment" test is set low. The Code for England states at Para. 23.8 that:

> *The appropriate medical treatment test must be applied to ensure that no one is detained (or remains detained) for treatment, or is on a CTO, unless medical treatment for their mental disorder is both appropriate and available.*

And the Code for Wales at Para. 23.8 that:

> *The purpose of the "appropriate medical treatment test" is to ensure that no one is detained (or remains detained) for treatment, unless they are actually to be offered medical treatment for their mental disorder.*

And both Codes (E Para. 23.4; W Para. 23.3) make the point that:

> *Purpose is not the same as likelihood. Medical treatment must be for the purpose of alleviating or preventing a worsening of mental disorder even if it cannot be shown, in advance, that a particular effect is likely to be achieved.*

So given the broad interpretation of "medical treatment", even though:

> *Simply detaining someone – even in a hospital – does not constitute medical treatment [E Para. 23.18].*

very little more than this is required either in terms of specific treatment or its therapeutic "purpose". So we have a situation where:

> *There may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day to day care under the clinical supervision of an approved clinician [W Para. 23.9] in a safe and secure therapeutic environment with a structured regime [E Para. 23.17].*

That the threshold is low was confirmed by subsequent court decisions. In *MD v Nottinghamshire Healthcare NHS Trust* (2010) (see Appendix 6), the court found that in respect of a personality disordered patient:

1. Detention without reduction of risk did not constitute mere containment.
2. Merely benefitting from the ward "milieu" meant that appropriate medical treatment was available.
3. The argument that a theoretical capacity to engage with psychological therapy did not equate to a practical ability to benefit from treatment was "untenable".

In *DL-H v Devon Partnership NHS Trust et al.* (2010) (see above), the court confirmed that the s145(4) definition of medical treatment was broad enough to include attempts by nursing staff

to encourage the patient to engage. Recognising that this ran the risk of patients being contained for public safety rather than detained for treatment, the court suggested that Tribunals avert the danger by investigating behind assertions, generalisations and standard phrases and asking: What treatment could be provided? What benefit might it have for the patient? Is the benefit related to the patient's mental disorder? Is the patient truly resistant to engagement? When this case returned to the Upper Tribunal in 2013, the court denied that these questions reintroduced a treatability test.

What is "availability"?

Appropriate medical treatment, whatever it comprises, is not by itself sufficient. Such treatment must also be "available". There is no indication in the Act as to how this word is to be construed in this context. Is treatment for a patient living in Bath but only available in, say, Oxford or Wrexham "available"? Is treatment for a patient available locally but only in the private sector at a price the health authority is not prepared to fund "available"? Is treatment, such as cognitive behavioural therapy (CBT), which because of demands on the service can only be commenced three months after compulsory admission, "available"?

In WH v Llanarth Court (Partnerships in Care) (2015), the court found that, at least as far as location is concerned, appropriate treatment only relates to the treatment available at the hospital where the patient is actually detained, not to some theoretical alternative elsewhere.

The Code of Practice for England states at Para. 23.14:

> *Medical treatment must actually be available to the patient. It is not sufficient that appropriate treatment could theoretically be provided* [but note the comment in the MD case above].

The Code at E Para. 23.12 (W Para. 3.13) refers to the location of treatment as being part of "all the other circumstances of the patient's case". At Para. 23.10 the Code for England states:

> *The appropriate medical treatment test requires a judgement about whether an appropriate treatment or package of treatment for mental disorder is available for the individual in question. It is not consistent with the least "restrictive option and maximising independence" and "purpose and effectiveness guiding principles" to detain someone for treatment that is not actually available* ***or may not become available until some future point in time*** *[emphasis added].*

And at E Paras 23.13, 23.21:

> *Medical treatment must always be an appropriate response to the patient's condition and situation and indeed wherever possible should be the most appropriate treatment available. It may be that a single medical treatment does not address every aspect of a patient's mental disorder …*

[but]

> *… those making the judgement must satisfy themselves that appropriate medical treatment is available for the time being, given the patient's condition and circumstances as they are currently understood.*

The Code for Wales at Para 23.16 gives guidance in similar vein. Faced with this guidance, health and social care professionals can be forgiven for concluding that "appropriate" means what they say it means. To put it another way, they have a very broad discretion to decide whether any particular form of medical treatment (itself a very broad concept) is "available" in any given case.

Conclusion

It is reasonable to suggest that the broad definition of mental disorder, the removal of most of the exclusions, the abolition of the classifications of mental disorder, and the replacement of the treatability requirement with a therapeutic purpose test constitute a collective lowering of the threshold for use of compulsory powers; and that this makes those powers more widely available for use, even though the risk and other criteria must be met and health and social care professionals retain their discretion not to use the Act. One might expect this to be reflected in the statistics published since the Mental Health Act 2007 changes came into effect; and indeed these show a rise every year in the use of the compulsory powers. Between 2005–06 and 2015–16 (the last year for which reliable statistics are available) use of the compulsory powers increased by 40 per cent. Since 2016, NHS Digital statistics have been incomplete but still show a year-on-year increase (for example, 50,893 detentions in 2019/20 rising to 53,239 in 2020/21). There are other factors in play – not least the lack of available beds for patients not detained under the Act, a reduction in the availability of community resources and the combined effect of the decision of the Supreme Court in *Cheshire West*, which lowered the threshold for what constitutes deprivation of liberty so requiring an authorisation, and the decision in *A PCT v LDV et al*. (2013) (see Appendix 6) which raised the level of understanding required for a patient to be capable of being admitted informally. However, the ease with which the availability of the appropriate medical treatment test can be met is likely to have contributed to this increase.

One might query whether it is necessary to continue to consider some 12 years on the changes introduced by the 2007 Act rather than simply explaining the Act as it currently stands. The truth is that the Government set up the recent Mental Health Act Review because of concerns, inter alia, at the increasing use of the compulsory powers since the 2007 Act amendments were introduced, at whether safeguards available to patients were sufficient and at the possibility that detention might be being used to detain rather than treat: all problems anticipated and argued over in the period leading up to the 2007 Act. The review, which reported in December 2018, made 154 recommendations and had a particular focus on the need to strengthen detention criteria concerning treatment and risk: treatment should be available which would benefit the patient and not just serve public protection, and the risk thresholds raised to that of a substantial likelihood of significant harm to the health or welfare of the person or the safety of any other person – recommendations at least in part prompted by the introduction of the availability of the appropriate treatment test. The draft Mental Health Bill published in June 2022 does propose amendments to the detention criteria:

The phrase "serious harm" is added to the risk criteria: "*serious harm may be caused to the health or safety of the patient or of another person*"'

A new focus on imminence and likelihood of a risk arising is added: "*the nature, degree and likelihood of the harm, and how soon it would occur.*"

Whether these proposals would materially raise the bar for detention remains to be seen.

Key points

1. Mental disorder means any disorder or disability of the mind.
2. Disorders or disabilities of the brain are excluded unless leading to a disorder or disability of the mind.
3. Health and social care professionals retain the discretion not to use the compulsory powers even when the criteria are met.
4. When considering longer-term compulsion, consider whether the learning disability is associated with abnormally aggressive or seriously irresponsible conduct.

5. Drug or alcohol dependence alone is insufficient for use of the compulsory powers.
6. Whether paedophilia is a true mental disorder is uncertain.
7. For s3 detention and for CTOs appropriate medical treatment must be available.
8. Case law confirms that medical treatment is to be very broadly defined and construed.
9. The "treatability" test is replaced with a "therapeutic purpose" test.
10. It is sufficient for the "therapeutic purpose" test merely to relate to a symptom or manifestation of the mental disorder.