

Journal of Mental Health Law

Articles and Comment

Mental Health Inquiries – Views from the Chair

The Draft Mental Incapacity Bill

Is this a revolution? The impact of the Human Rights Act on Mental Health Law

The Consequences of Acting Unlawfully

Placed Amongst Strangers – the Tenth Biennial Report (2001 – 2003) of the
Mental Health Act Commission

Casenotes

Capacity, Treatment and Human Rights

Judicial recognition of the status of the Code of Practice

Re-detention after a tribunal discharge – the last word?

Book Reviews

Mental Health Law Policy and Practice, by Peter Bartlett and Ralph Sandland
(2nd edition)

Decisions and Dilemmas – working with mental health law, by Jill Peay



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Please contact Maureen Cooke: 0191 243 7587

E-mail maureen.cooke@northumbria.ac.uk

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| Contents | Page |
|------------------------------------------------------------------------------------------------------------------------------------------|------|
| Foreword | 5 |
| <i>Articles and Comment</i> | |
| Mental Health Inquiries – Views from the Chair <i>Herschel Prins</i> | 7 |
| The Draft Mental Incapacity Bill <i>Camilla Parker</i> | 16 |
| Is this a revolution? The impact of the Human Rights Act on Mental Health Law <i>Paul Bowen</i> | 27 |
| The Consequences of Acting Unlawfully <i>Kris Gledhill</i> | 35 |
| Placed Amongst Strangers – the Tenth Biennial Report (2001 – 2003) of the Mental Health Act Commission <i>Mat Kinton</i> | 44 |
| <i>Casenotes</i> | |
| Capacity, Treatment and Human Rights <i>Peter Bartlett</i> | 52 |
| Judicial recognition of the status of the Code of Practice <i>Anna Harding</i> | 66 |
| Re-detention after a tribunal discharge – the last word? <i>David Hewitt and Kristina Stern</i> | 75 |
| <i>Book Reviews</i> | |
| Mental Health Law Policy and Practice, by Peter Bartlett and Ralph Sandland (2nd edition) <i>William Bingley</i> | 86 |
| Decisions and Dilemmas – working with mental health law, by Jill Peay <i>John Horne</i> | 91 |

Foreword

Those who have been following the progress of the mental health law reforms in England and Wales may be forgiven for experiencing a sense of déjà-vu during the Queen's Speech last year, as the much anticipated Mental Health Bill was (perhaps not surprisingly) absent from the Government's parliamentary agenda for the second year running. It would seem that ministers are unable to reach agreement on the exact direction of the new Bill. There are also rumblings that the much needed Mental Health Act reforms are not being afforded sufficiently high priority by the Government. John Reid, the Health Secretary, was quick to respond such criticisms in November, confirming the Government's intention to bring forward a revised Bill for pre-legislative scrutiny by Parliamentary Committee "as soon as possible". For the time being however, it remains to be seen when the new reforms will be introduced.

In this issue of the Journal our first article, "Mental Health Inquiries – Views from the Chair", by Professor Herschel Prins will be of interest to those who have chaired or who are interested in the procedures surrounding mental health inquiries. Professor Prins' article solicits views from a number of inquiry chairs and highlights their experiences of chairing mental health inquiries and how they view the problems they encounter. The author hopes that the observations made will reveal a number of matters that are of particular concern to those who chair mental health inquiries, and in particular, those who chair homicide inquiries.

At the end of November, the Joint Committee appointed by both Houses to examine the draft Mental Incapacity Bill published their detailed report. Camilla Parker examines the Draft Mental Incapacity Bill in this issue of the Journal, and highlights the need for greater clarification of a number of the draft Bill's proposals. Our third and fourth articles are taken from papers which were presented at the North of England Mental Health Law Conference in June last year. Paul Bowen's article looks at the impact of the Human Rights Act in the field of Mental Health Law and the way in which the European Convention on Human Rights continues to shape the law in this field. Kris Gledhill's article takes a detailed look at the consequences of acting unlawfully and the various ways legal challenges are being brought within the context of mental health. Both pieces are of significant practical importance for professionals working in the area of mental health.

Finally, Mat Kinton's article considers the Mental Health Act Commission's Tenth Biennial Report "Placed Amongst Strangers" and explains the context surrounding the Report and discusses some of its core themes.

In our case notes section, Peter Bartlett reviews the latest in a number of cases which examine the scope of the Human Rights Act and compulsory treatment under the Mental Health Act

in *R (PS) v G(RMO) and W (SOAD)*[2003]. David Hewitt and Kristina Stern review the current state of the law surrounding the re-detention of patients after tribunal discharge, following the recent House of Lords' judgment in *R v East London and the City Mental Health NHS Trust and another, ex parte von Brandenburg* [2003]. The Court of Appeal judgment in *R (on the application of Colonel Munjaz) v Mersey Care NHS Trust; S v Airedale NHS Trust* [2003], reviewed by Anna Harding, examines the current legal status of the Mental Health Act Code of Practice following this high profile conjoined appeal last year.

In our Book Review section, Professor William Bingley reviews the second edition of Bartlett and Sandland's seminal text, *Mental Health law: Policy and Practice*, published by Oxford University Press, and John Horne reviews 'Decisions and Dilemmas – working with mental health law' written by Jill Peay and published by Hart Publishing.

Our gratitude to the authors for their generous contributions to this issue.

Charlotte Emmett

Editor

Mental Health Inquiries – Views from the Chair

*Herschel Prins**

The data to be presented in this contribution form part of a more detailed account which will appear as a Chapter in a book entitled ‘The Age of the Inquiry’ edited by Nicky Stanley and Jill Manthorpe of Hull University, for Routledge (April 2004). The material is produced here with their kind permission. My brief from the editors was to write about my experiences of chairing mental health inquiries since hardly anything seemed to have been written about how those who chair inquiries and their colleagues viewed the problems they encountered. Although I had chaired three mental health inquiries I considered that my own responses might be seen as somewhat idiosyncratic and partial. I therefore decided to solicit the views of a small number of those who had also chaired such inquiries in the mental health field, including, in the main, homicide inquiries.¹

The three inquiries were all somewhat different. The *first* was into the sudden death of an African-Caribbean offender-patient following seclusion; the *second* was an inquiry into the circumstances in which a detained sex offender-patient had absconded from escorted day leave to a Zoo and theme park. Both these cases attracted a good deal of media publicity and a number of sensitive issues were involved. The *third* was a ‘homicide inquiry’ into the circumstances in which a former patient of the mental health and allied services had killed a vagrant in the centre of Leicester. This inquiry also had some unusual aspects, since several agencies were involved in addition to the mental health service (probation, education, social services and the voluntary sector). One or two of these services considered that we were exceeding our remit in including them in the inquiry. However, for reasons that are contained in our report, we felt we were highly justified in doing so.

* Professor, Midlands Centre for Criminology and Criminal Justice, Loughborough University, Loughborough, Leicestershire, LE11 3TU

1 The three inquiries I chaired were (i) the Committee of Inquiry into Orville Blackwood’s death at Broadmoor Hospital (Prins, H., Backer Holst, T., Francis, E. and Keitch, I., 1993). Report of the Committee of Inquiry into the Death in Broadmoor of Orville Blackwood and a Review of the Deaths of two other Afro-Caribbean Patients: Big, Black and Dangerous?

Special Hospitals Service Authority. (ii) Prins, H., Marshall, A. and Day, K. (1997). Report of the Independent Panel of Inquiry into the Circumstances Surrounding the Absconion of Mr. Holland From the Care of the Horizon NHS Trust on 19 August, 1996. Horizon NHS Trust. (iii) Prins, H., Ashman, M., Steele, G. and Swann, M. (1998). Report of the Independent Panel of Inquiry into the Care and Treatment of Sanjay Kumar Patel, Leicester Health Authority.

Much has been written in recent years about mental health and allied inquiries and most of them have common findings.² As already indicated, little appears to have been written about the view from the 'other side of the table'. Debate has continued about private or public inquiries, their cost, their purpose etc. My questions to the respondents bore these (and allied) considerations in mind.

It is worthwhile noting here that a number of homicide inquiries pre-dated the central government requirement to hold them from 1994 onwards,³ a significant inquiry being that into the homicides committed by Graham Young.⁴ Other important cases were those of Sharon Campbell, who stabbed to death her former social worker Isabel Schwarz,⁵ and Carol Barratt, a young woman who stabbed to death an 11-year-old girl in a shopping mall following detention under Section 2 of the Mental Health Act 1983. A Mental Health Review Tribunal had ruled firmly against discharge but the Responsible Medical Officer (RMO) discharged her following representations by the patient's mother.⁶ Kim Kirkman was a patient with a long history of psychiatric secure hospital care; he killed a neighbour, but committed suicide before he could come to trial. The Inquiry held into his case concluded that there was no way in which Kirkman's homicidal behaviour could have been predicted, but the team did recommend that in future more use might be made by practitioners of actuarial devices and research findings.⁷ Michael Buchanan beat to death a complete stranger (a retired police officer) in an underground car park. Buchanan had a long history of both residential childcare and psychiatric treatment.⁸ Andrew Robinson's and Jason Mitchell's cases were the subject of *public inquiries* and, amongst other matters, both revealed serious deficiencies in risk

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- 2 For discussions of inquiries more generally see G. Drewry and C. Blake (eds) (1999) *Law and the Spirit of Inquiry: Essays in Honour of Sir Louis Blom Cooper*, Kluwer. Clothier, Sir Cecil, Q.C. 'Ruminations on Inquiries', in J. Peay (ed) *Inquiries After Homicide*, Duckworth. On the public versus private debate see: Blom-Cooper, L. Q.C. (1999) 'Public Inquiries in Mental Health (With Particular Reference to the Blackwood Case at Broadmoor and the Patients Complaints of Ashworth Hospital)'. In D. Webb and R. Harris (eds) *Mentally Disordered Offenders: Managing People Nobody Owns*, Routledge. Prins, H. (1999) *Will They Do it Again? Risk Assessment in Criminal Justice and Psychiatry*, Routledge (Chapter 4). More generally see: Prins, H. (1998) 'Inquiries After Homicide in England and Wales', *Medicine, Science and the Law*, 38, 211–220. See also Eldergill, A. (1999) 'Reforming Inquiries Following Homicides', *Journal of Mental Health Law*, 2, 111–136; also Morris, F. (2003) 'Confidentiality and the Sharing of Information', *Journal of Mental Health Law*, 9, 38–50. McGrath, M. and Oyeboode, F. (2002) 'Qualitative Analysis of Recommendations in 79 Inquiries After Homicide Committed by Persons With Mental Illness', *Journal of Mental Health Law*, 8, 262–282. Concerning the lessons to be learned see Petch, E. and Bradley, C. (1997), 'Learning the Lessons From Homicide Inquiries: Adding Insult to Injury', *Journal of Forensic Psychiatry*, 8, 161–184; Reith, M. (1998) *Community Care Tragedies: A Practice Guide to Mental Health Inquiries*, Venture Press. Walshe, K. (2002) *Inquiries: Learning From Failure in the NHS*, Manchester Centre For Health Care Management, University of Manchester.
- 3 Department of Health, NHS Executive (1994) *Guidelines on the Discharge of Mentally Disordered People and their Care in the Community*, HSG/94/27, London.
- 4 Aarvold, Sir Carl, Hill, Sir Dennis and Newton, G. (1973) *Report of the Review of Procedures into the Discharge of Psychiatric Patients Subject to Special Restrictions*, Cmnd 5191, HMSO.
- 5 Spokes, J.C., Pare, M. and Royle, D. (1985) *Report of the Committee of Inquiry into the After-Care of Miss Sharon Campbell*, Cmnd 440, HMSO.
- 6 Unwin, C., Morgan, D.H. and Smith, B.D.M. (1991) *Regional Fact Finding Committee of Inquiry into the Administration, Care, Treatment and Discharge of Carol Barratt*, Trent Regional Health Authority.
- 7 Dick, D., Shuttleworth, B. and Charlton, J. (1991) *Report of the Panel of Inquiry Appointed by the West Midlands Regional Health Authority, South Birmingham Health Authority and the Special Hospitals Services Authority to Investigate the Case of Kim Kirkman*, West Midlands Health Authority.
- 8 Heginbotham, C., Carr, J., Hale, R., Walsh, T. and Warrant, C. (1994) *Report of the Independent Panel of Inquiry Examining the Care of Michael Buchanan*, North-West London Mental Health Trust.

assessment and management.⁹ Finally, the case of Christopher Clunis, probably the best known of all homicide inquiries, has served very much as a pattern to be followed in all the subsequent homicide inquiries mandated by the government instruction of 1994.¹⁰ With a succession of such high profile cases (though minute in relation to the numbers of homicides committed annually overall) and the activities of intruders such as Michael Fagin in Royal Palaces, and Ben Silcock's intrusion into the lion's enclosure at London Zoo, it not altogether surprising that the politicians of the day decided that rather more formal procedures should be established for inquiring into such cases. However, it is also important to add that this need for central government direction was doubtless fuelled by media 'hype'.

It is also of interest to note that governmental preoccupation is with those having a history of involvement with *mental health services*. Although homicides and other serious instances of violence against the person will be the subject of internal inquiries where the perpetrator is known to other services (such as probation or social services), there appears to be no mandate for an *independent external* inquiry in such cases. However, it is also noteworthy that there is nothing to prevent a health authority setting up an independent inquiry into a *non-fatal* case concerning a patient known to the psychiatric services. This occurred in the case of Benjamin Rathbone who pleaded guilty to the attempted murder of a passenger at Loughborough station by pushing him on to the railway track. Mr. Rathbone was subsequently made the subject of a Hospital Order with Restrictions under Sections 37/41 of the Mental Health Act, 1983.¹¹

After much debate a new procedure appears to have now been agreed. In future independent inquiries into homicides are likely to come under the umbrella of a recently established *National Patient Safety Agency*. This agency is intended to serve as a body to collect information about clinical errors by health service staff and is expected to become operational in 2004.¹²

THE RESPONDENTS AND THE RESPONSES

I hope that the foregoing observations will have revealed a number of matters that are of particular concern to those who chair mental health inquiries of one kind or another, but, in particular, homicide inquiries. As stated earlier, I considered that a purely personal view might well be somewhat idiosyncratic. For this reason I addressed a series of questions to 13 respondents, nine of whom replied. No censure is due to the small number who, despite reminders, did not reply, since my two letters of inquiry might not have reached their destinations. To those who did reply (and most at very considerable length) I must express my sincere thanks for the trouble they took.¹³ Almost all of them had undertaken more than one inquiry into mental health or other matters such as childcare. One of my respondents had undertaken four into mental health and two into child abuse. Two had undertaken three and, in addition, one had also been a *member* of mental

9 Blom-Cooper, Sir L. Q.C., Hally, H. and Murphy, E. (1995) *The Falling Shadow: One Patient's Mental Health Care 1978–1993*, Duckworth. Blom-Cooper, Sir L. Q.C., Grounds, A., Guinan, P., Parker, A. and Taylor, M. (1996) *The Case of Jason Mitchell, Report of the Independent Inquiry*, Duckworth.

10 Ritchie, J. Q.C., Dick, D. and Lingham, R. (1994) *Report of the Inquiry into the Care and Treatment of Christopher Clunis*, HMSO.

11 Mackay, R., Badger, G., Damle, A., and Long, R. (2001) *Report of the Independent Inquiry into the Care and Treatment of Benjamin Rathbone*, Leicestershire Health Authority.

12 NHS Federation (2001) *Briefing Note, Issue 49, May*.

13 One of my respondents opted to talk around their answers, so my questions formed the basis of an extended interview during which I made notes of their responses.

health inquiry teams on several other occasions, including internal panels of inquiry. Thus, all of my respondents can be said to be persons of considerable experience and reputation. To the best of my knowledge (professional status was not asked for) all, save one, had legal backgrounds and two were Queen's Counsel. The replies of my respondents have been compressed to present composite answers. This is because of a promise of anonymity and non-attribution.

The questions I put to my respondents are summarised under the following headings. (They are produced in detail in my letter of inquiry – see Appendix).

1. Manner of appointment to chair the inquiry.
2. Extent to which chairman/woman had any 'say' in the selection of team colleagues.
3. Provision of support services.
4. Degree of 'lobbying' by interested parties.
5. Public or private debate.
6. Problems relating to possible conflict of interest between parties.
7. Management of 'hearings'.
8. Access to documentation.
9. Problems in drafting final report.
10. Arrangements for promulgation, publication and dissemination of findings. Feedback from appointing authority and any requests for return to undertake 'follow-up'.

I Manner of appointment to chair the inquiry

For the majority of my respondents the request to chair the inquiry came 'out of the blue'. One respondent had extensive experience of clinical negligence cases; another was already 'known' to the Department of Health; one or two had experience in chairing 'internal' inquiries so their competence was already 'tested'. In one instance, the respondent had agreed to take on the task on the recommendation of a colleague who had been approached first, but was unable to undertake it. The 'out of the blue' approach was usually by an initial telephone call. One of my respondents had chaired two previous homicide inquiries and turned down a request to undertake a third, not wishing to be 'type-cast'. Only rarely did the request seem to come through the recommendation of a body such as the Mental Health Act Commission.¹⁴

2 Extent to which chairman/chairwoman had any 'say' in the appointment of panel colleagues.

In general, chairmen/women did not have any direct 'say' in the appointment of panel colleagues, though in one or two instances names 'were run past' them and if, for any valid reason, they were not deemed suitable their views would have been taken into account. One or two of my respondents thought that chairman/women should be consulted and have a right to veto appointments. In general, chairmen/woman were very satisfied indeed with the contributions made by their fellow panel members.

¹⁴ In my own case, in the Blackwood inquiry, I was not the first choice for chairman; the nominee of the SHSA was not considered by the Central Government Authority to have sufficient independence. Nominations would seem to be somewhat serendipitous, as the answers to Question 1 indicate.

3 Support services

Generally speaking support services were considered to be very good. In one or two instances they were regarded as 'exceptional' and greatly facilitated the work of the inquiry.

4 Degree of lobbying by interested parties

Occasional lobbying did occur. For example, requests to hold the inquiry in public rather than in private. In one or two instances, attempts were made to proffer witnesses of an authority's choosing rather than those identified by the inquiry panel. One respondent considered that there had been less lobbying than they had expected. One's overall impression is that lobbying was not a problem. When it arose, it was dealt with effectively (and judiciously) by the inquiry panel.

5 Public or private inquiries

A small minority of my respondents favoured public inquiries (but did recognize the problems of expensive and more lengthy hearings). One or two favoured them if the matters being investigated raised issues of serious national concern or notoriety. The majority of my respondents favoured inquiries in private, largely on the grounds of them being less intimidating, litigious and better able to deal with sensitive clinical issues. However, a number of them stressed the need for the *findings* of inquiries held in private to be made public. Two respondents thought that there might be a trend for more inquiries to be held in public as a result of the coming into force of the Human Rights Act 1998.¹⁵

6 Problems relating to possible conflicts of interests and the achievement of 'fairness' to all parties

The stresses involved for witnesses in inquiries, whether in private or in public, were noted sympathetically by my respondents. One or two of my respondents noted the problems involved in reconciling relatives' understandable desire to apportion 'blame' and the need to be fair to professional witnesses. There was a reported need to ensure that there was a proper factual basis for any criticisms that might be made. Occasionally, there was a need to 'rein in' a colleague adopting either too hard or too sympathetic an approach to a professional witness. Chairmen and women had to operate a delicate balancing act.

7 Management of hearings

No major problems were identified. Occasionally, witnesses needed to be given a sense of direction to lessen any tendency to ramble or be inconsistent, or to stop the grinding of 'axes'. Emphasis was placed upon the need for the chair of the panel to put all witnesses at their ease and to facilitate the proceedings generally. Some respondents adopted the practice of asking the relevant panel member to begin the questioning of a witness from their own discipline.

¹⁵ This would seem to be the case as is shown by the appeal of Paul and Audrey Edwards to the European Court of Human Rights in respect of the killing of their mentally ill son whilst on remand in prison. (*Edwards v. The United Kingdom*. application No. 46477/99, 14, March 2002). The reference was in respect of the decision not to hold the inquiry into his death in public. Coonan, K. Q.C., Bluglass, R., Halliday, G., Jenkins, M. and Kelly, O. (1998) *Report into the Care and Treatment of Christopher Edwards and Richard Linford*, North-East Essex Health Authority, Essex County Council, H.M. Prison Service and Essex Police.

8 Access to documentation

Several of my respondents would have welcomed clearer central government guidance on the need for compulsory disclosure of documents. Problems had arisen on several occasions when patients or their medical advisers refused access to their medical records. A clearer statement concerning what might constitute public interest 'over-ride' would have been welcomed. In one or two instances problems involved in accessing patients' medical records led to serious delays in the panel's work. This apart, the respondents did not seem to have had difficulty in accessing other medical and allied records. However, comment was made on the poor quality of record-keeping in some cases and an over-abundance of records in others, which took many hours to assimilate and put into comprehensible order!

9 Problems in drafting the final report

There seemed to be a broad consensus of opinion that drafting the final report could present considerable logistical problems. The difficulties of drafting 'by Committee' was alluded to by more than one respondent; it was considered more helpful if the chairman/woman took the initiative in constructing a first draft to be subsequently worked over and amended by the rest of the panel. Occasionally, the sponsoring authority requested changes at the drafting stage. In some cases panels had agreed to these if such changes were considered justified. In others, requests for change were resisted by the panel. One respondent referred to the dangers of individual panel members wishing to ride personal 'hobby-horses' – a tendency which needed to be resisted firmly. An essential requisite seemed to be that parties likely to be criticised should be informed of any potential criticisms in advance and given the opportunity to comment on them. Sometimes, modifications were made if these concerned matters of fact, but matters of opinion would remain unchanged if the panel considered these had been substantiated by their investigators.

10 Promulgation, publication and dissemination of findings. Feedback and requests for follow-up by panel

Respondents identified some problems concerning the 'launch' of their report. For example, insufficient publicity being given to the 'launch'; in some cases the panel members were not invited to attend such events. One is drawn to the conclusion from some of the replies that in a few instances the sponsoring authority did not wish for too much publicity. Hardly ever was there any feedback to panels from sponsoring authorities. Requests to return to see to what extent the panel's recommendations had been acted upon were very rare indeed. Only two of my respondents had been asked to revisit in this way. In one instance the offer was accepted, in the other it was declined on the basis that an independent assessor would be a more appropriate choice. This was acted upon by the sponsoring authority and the panel subsequently informed of the findings. One respondent considered that re-visiting was not appropriate and that the relevant authorities should be trusted to implement any recommendations. Two respondents referred to undue delay in the promulgation of their reports.

Other Observations

Respondents were asked to make any additional observations on matters not covered in my questions. One respondent referred to what could best be described as the serendipitous nature of panel membership. Normally, panel members seemed to work well, but where this might not be the case, serious problems could arise. The need to make proper allowance for the time required for an adequate inquiry was stressed. One or two respondents had reservations as to the impact their reports and recommendations would have on future practice. Another respondent considered that there needed to be some degree of control exercised over the number of inquiries taking place. My attention was also drawn to an omission in my questions to respondents. This concerned the very important question of venue. I had assumed (erroneously as it turned out) that this might be raised under the question of appropriateness of accommodation (Question 3). In most instances, accommodation does not seem to have been a problem. *Venue* is, of course, a rather different matter. In most inquiries it is usual to hold the formal panel hearings in, say, an hotel and arrange for 'site' visits as appropriate. For example, in our inquiry into Orville Blackwood's death, we held most of our 'hearings' at a London hotel. However, we paid several site visits to the unit at which Orville had been detained and also interviewed a number of patients there. We also, at my insistence, visited the local general hospital to which Orville's body had been taken. This was in order to inspect the 'viewing' arrangements for relatives. For various reasons these had been very unsatisfactory and caused Orville's relatives considerable distress. Had we not visited for ourselves, we would not have been able to assess the level of trauma caused to the family. Choice of venue can be a complex matter as, for example, in the on-going Saville inquiry into the events of 'Bloody Sunday' in Northern Ireland. In this instance the issue of whether soldiers/witnesses should travel to the province to give their evidence has proved problematic.

OVERALL IMPRESSIONS

My overall impression from my respondents' answers is that they recognised the inherent tensions involved in balancing the victims' relatives' views and feelings on the one hand, against those of the professionals involved in the case on the other. Most seemed satisfied with the arrangements for support services and accommodation. Lobbying by interested parties did not seem particularly problematic, and possible conflicts of interest seemed capable of resolution. Most respondents favoured inquiries being held in private, but acknowledged the need for public hearings in certain cases where the public interest or notoriety were of paramount importance. They seemed keenly aware of their role in seeing 'fair play' in the conduct of hearings and managing them with an appropriate mixture of informality and 'judicial' restraint. Problems were encountered concerning access to documentation; more specific guidance from central government would have been welcomed on this matter. Drafting the final report was occasionally problematic if sponsoring authorities wished for deletions or amendments. Allowing witnesses to suggest modifications to their factual evidence seemed a helpful device in this respect and panel chairmen and women seemed able to separate this from opinion. It was very rare for panels to be asked to return to the authority to examine to what extent their recommendations had been acted upon; and it was also rare to find the provision of feedback to panels. A final word of caution is necessary concerning the responses I obtained. The sample is a very small one; for this reason it would be unwise to over-generalise any conclusions. Had I chosen to survey a larger number of those who had chaired mental health inquiries the results *might* have been different.

APPENDIX

1 Home Close Road,
Houghton on the Hill,
Leicester.
LE7 9GT.
Tel: 01162 417 675

CONFIDENTIAL

Dear

I am writing to solicit your assistance in the hope that you will feel able to help me. I have been commissioned by Taylor and Francis (Routledge) to contribute a chapter in a book (edited by Nicky Stanley and Jill Manthorpe of Hull University) and provisionally entitled 'The Age of Inquiry'. The remit given me by the Editors is to discuss some of the problems facing the chairmen/women of Inquiries (and, in particular, those into homicides committed by those known to the mental health services and agencies).

Having chaired three somewhat different mental health inquiries myself (Orville Blackwood's death at Broadmoor, Trevor Holland's absconsion from escorted day-leave to Chessington Zoo (Theme Park) and Sanjay Patel's killing of a vagrant in the City of Leicester) I have naturally formed some views about the problems confronting those who chair such investigations. However, I am very aware that my own views could well be somewhat idiosyncratic. For this reason, I am keen to solicit the views of a small number of colleagues who have chaired mental health inquiries. None of my hoped for respondents will be identified individually; I intend, if possible, to present a 'composite' picture of your views. I do not wish to constrain you in any reply you may wish to furnish me with, but comment on the following matters in particular would be very helpful.

1. The manner in which your appointment was made. For example, were you nominated by a particular agency or organisation or did the request come 'out of the blue' so to speak? The manner in which you were 'sounded out' by the body setting up the inquiry would be of interest.
2. Did you have any say in the appointment of your team colleagues, or were you presented with a 'fait accompli'?
3. Were the support services provided adequate (for example, secretarial/administrative help, accommodation)?
4. Were you exposed to any degree of 'lobbying' by interested parties? (For example, in our 'Blackwood' Inquiry, there was some pressure on the part of some of the parties for us to conduct the inquiry in public. There was also an initial reluctance on the part of the National P.O.A. (but not the local membership) to co-operate).
5. Have you any views on whether such inquiries should be in 'public' or 'private'?
6. Is it possible for you to describe any conflict you may have felt personally in attempting to be 'fair' to all parties and to avoid subjecting them to undue stress?

7. Did you experience any difficulties in ‘managing’ the actual hearings? (For example, was it necessary to exercise more than a ‘light’ degree of control over witnesses or, for that matter, your colleagues)?
8. Did you experience any problems in gaining access to relevant documentation (for example patient’s and other records)? Would clearer central government guidance on this matter have been of assistance?
9. Did you experience any major problems in drafting the various stages of the final report? Were there significant pressures placed upon you to modify your version of events, the conclusions you drew from these and your final recommendations?
10. Were you satisfied with the arrangements made for the promulgation, publication and dissemination of your findings? Were you asked to revisit to see if your recommendations had been implemented?

The above questions are, of course, highly selective and you may well have identified from your experiences other areas of concern that I have not indicated. Please feel free to add any additional comments.

Finally, may I thank you in anticipation for any help you may feel able to offer me. I enclose a stamped and addressed envelope for your reply.

With best wishes.

Yours sincerely,

The Draft Mental Incapacity Bill

Camilla Parker*

I. Introduction

'It is widely recognised that, in this area, the law as it now stands is unsystematic and full of glaring gaps'. (Mental Incapacity, Law Commission, 1995)¹

Despite the general agreement with the Law Commission's assessment of the failings of the current system for decision-making on behalf of people who lack the capacity to make decisions for themselves, the steps towards achieving comprehensive reform, as recommended in its report, *Mental Incapacity*, has been a protracted process. *Mental Incapacity* was followed, two years later, by a consultation paper – *Who Decides? Making Decisions on Behalf of Mentally Incapacitated People*² – in which the Government sought views on the Law Commission's recommendations for reform. In October 1999, the Lord Chancellor's Department published *Making Decisions*³, which set out the Government's proposal for reform, 'in the light of the responses to the consultation paper *Who Decides*'.

No clear timescale was given for the reforms, with *Making Decisions* stating that they could only be taken forward 'when Parliamentary time allows'. However, in June of last year the reform process moved to a significant stage with the publication of the Government's draft Mental Incapacity Bill ('the Draft Bill'). This set out proposals to reform the law:

*'in order to improve and clarify the decision making process for those aged 16 and over who are unable to make decisions for themselves.'*⁴

Thus provisions set out in the Draft Bill are based on the Law Commission's recommendations. However, not all the recommendations included in *Mental Incapacity* have been followed. For example, the Government decided not to take forward the proposals relating to the public law protection of vulnerable people.

* Legal and Policy Consultant

1 Law Com 231, March 1995

2 Cm 3803, Lord Chancellor's Department, December 1997

3 Cm 4465, *Making Decisions – The Government's proposals for making decisions on behalf of mentally*

incapacitated adults – A report issued in the light of responses to the consultation paper Who Decides?, October 1999

4 *Draft Mental Incapacity Bill, Commentary and Explanatory Notes – Making Decisions*, Department for Constitutional Affairs, June 2003, page 6

The Draft Bill was considered by the Joint Committee on the Draft Mental Incapacity Bill (the Joint Committee) which published its report in November 2003⁵. The Joint Committee stressed the enormity of the task it was expected to meet – in just over two months, providing detailed scrutiny of a draft Bill which was ‘*the product of an extensive consultation stretching back to 1989*’. Despite making nearly one hundred recommendations in relation to the Draft Bill, the Joint Committee concluded that there is a clear need for the Bill and supported, ‘*on the whole*’, the principles and general direction of the draft Bill. The recommendations include the need for guiding principles to be set out in the Bill⁶; greater clarity in relation to the scope of powers under the Bill⁷; the grey areas between the draft Bill and the present Mental Health Act 1983 (particularly the ‘Bournewood gap’⁸) to be addressed⁹ and the title of the Bill to be changed to ‘the Mental Capacity Bill’ to reflect more accurately the purpose of the Bill which is to recognise and give effect to the right to make decisions and remove the pejorative associated with incapacity¹⁰.

While acknowledging the amount of work involved in addressing their recommendations, the Joint Committee expressed their hope that the new Bill would soon be brought to Parliament:

‘...we would be extremely disappointed if the Government felt unable to continue to give the Bill priority. Those it is intended to help have waited long enough for the benefits it should bring them’¹¹.

2. Overview of the Proposals

The Draft Bill includes both informal and formal mechanisms for making decisions on behalf of people who lack capacity to make such decisions for themselves:

‘The Bill introduces new decision making mechanisms to allow welfare and healthcare decisions, as well as financial decisions, to be taken on behalf of persons lacking capacity. It begins by setting out a number of key principles and ways in which informal decisions can be lawfully taken on behalf of adults who lack capacity. As these principles are based on existing best practice for the majority of caring decision makers they will bring about no change in how they approach decision making. The Bill then lays out formal decision making powers that can be acquired or granted.’¹²

The main provisions of the Draft Bill cover the following areas:

- (In)capacity
- Best interests
- Informal decision-making: the General Authority
- Formal decision-making mechanisms: the Lasting Power of Attorney, new Court of Protection, Court appointed Deputies and Advance Decisions to Refuse Treatments

The Draft Bill sets out a range of decisions that cannot be made on behalf of others. These include consent to marriage, consent to have sexual relations and a decision on voting at an election for any public office.

5 *House of Lords, House of Commons Joint Committee on the Draft Mental Incapacity Bill, Draft Mental Incapacity Bill, Session 2002–03, HL Paper 189-1, HC 1083-1. This article was submitted prior to the publication of the Joint Committee’s report and therefore does not include a detailed analysis of the report.*

6 *Paragraph 44*

7 *See for example paragraphs 129, 132, 144 and 184*

8 *This is discussed below, see section 3.*

9 *See paragraphs 222, 225 and 227*

10 *Paragraph 365*

11 *Paragraph 23*

12 *Explanatory Note, page 6*

a. (In)capacity

The Draft Bill adopts a ‘functional’ approach to capacity in that an individual’s capacity will be assessed in relation to each decision that needs to be taken. Clause 1 states that a person lacks capacity in relation to a matter if:

‘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’

Thus the Draft Bill has removed the ‘diagnostic threshold’ favoured by the Law Commission, which recommended:

‘a new test of capacity should require that a person’s inability to arrive at a decision should be linked to the existence of a “mental disability”’¹³.

The term ‘mental disability’ was defined as ‘a disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.’¹⁴ The Law Commission considered that using such a diagnostic threshold would provide protection to individuals by ensuring that the test does not include people who make unusual or unwise decisions¹⁵. However, the decision to remove ‘mental disability’ from the definition has been welcomed by the Making Decisions Alliance (MDA) – a consortium of 28 organisations campaigning for the introduction of mental incapacity legislation. The MDA has a number of concerns with this term, including that it ‘would risk stigmatising or prejudicing people who need support with decision-making’¹⁶.

The ‘impairment’ or ‘disturbance’ can be permanent or temporary. Furthermore, individuals are assumed to have the capacity to make their own decisions unless it is established otherwise.

The Draft Bill sets out the test for capacity, stating that individuals will be regarded as unable to make a decision if they are unable:

- to understand the information relevant to the decision,
- to retain the information relevant to the decision
- to use the information relevant to the decision as part of the process of making the decision, or
- to communicate the decision (whether by talking, using sign language or any other means).

Assessment of Capacity

Although the assessment on whether a person has, or lacks capacity, is key to the proposed legislation, the process of assessing capacity is not included in the Draft Bill. This omission is considered to be a major gap by the Mental Health Foundation (MHF) given the potentially far reaching and significant consequences of a finding of ‘incapacity’ – a concern shared by the MDA¹⁷. The MHF acknowledges that it will not be possible to set out detailed provision for the procedures for assessing capacity given that such assessments will be required in relation to a wide

¹³ Paragraph 3.12

¹⁴ Clause 2(2) of the Law Commission’s Mental Incapacity Bill

¹⁵ Paragraph 3.8

¹⁶ Paragraph 4.2 Submission to the Joint Committee on the Draft Mental Incapacity Bill, Making Decisions Alliance www.makingdecisions.org.uk

¹⁷ See 5d, page 26 of the Making Decisions Alliance’s submission. The MHF is a member of the Alliance.

range of personal welfare, health and financial matters and in many cases, where the general authority applies, a formal assessment process will be both impracticable and inappropriate. However, the MHF considers that some legal requirements are necessary, for example the MHF suggests:

‘...the Draft Bill should provide that a particular agency is given the responsibility for ensuring that the assessments of capacity are undertaken appropriately, for example by professionals with the relevant skills and experience.’¹⁸

In considering the assessment of an individual’s capacity to make a particular decision the Joint Committee commented that whoever assesses capacity must be prepared to justify their findings and if this gives rise to a dispute it will be a question for the Court of Protection to decide. The Joint Committee concluded that given the diverse range of situations covered by the proposed statutory framework for decision-making the processes and requirements relating to assessment of capacity would be better dealt with in the Codes of Practice¹⁹.

b. Best Interests

Anything done for, and any decision made on behalf of, a person without capacity under this legislation should be done or made in the ‘best interests’ of that person. The Explanatory Note to the Bill states:

‘The concept of acting in the best interests of a person who lacks capacity already exists in the common law. The Bill will enshrine this principle in statute as the overriding principle that must guide all decisions made on behalf of someone lacking capacity.’²⁰

The Draft Bill sets out a checklist of factors which those making decisions are expected to ‘work their way through when considering what is in the best interests of the person concerned’²¹. The matters to be considered include:

- whether the person is likely to have capacity in relation to the matter in question in the future;
- the need to permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for and any decision affecting him;
- ‘so far as ascertainable’, the person’s past and present wishes and feelings.

If it is practicable and appropriate, the following individuals should be consulted about the person’s past and present wishes and feelings as well as the factors the person would consider if he or she were able to do so:

- anyone named by the person concerned as someone to be consulted on the particular issue
- any person engaged in caring for the person concerned or is interested in the person’s welfare
- any donee of a lasting power of attorney (see below) granted by the person concerned

18 *Draft Mental Incapacity Bill – Memorandum to the Joint Committee from the Mental Health Foundation and the The Foundation for People with Learning Disabilities, paragraph 4.6*

20 *Draft Mental Incapacity Bill, Commentary and Explanatory Notes – Making Decisions, Department for Constitutional Affairs, June 2003, page 7*

21 *ibid*

19 *Joint Committee, paragraphs 244 and 245*

- any deputy appointed by the court (see below)

The Draft Bill states that consideration must also be given to whether the purpose for which any act or decision is needed can be as effectively achieved in a way which is less restrictive of the person's freedom of action.

Best Interests and Advocacy

In determining what is in the best interests of the individual, it is vital that the focus is on the wishes and feelings of the person concerned, not what the consultees think the person concerned should think and feel. This is an area in which it will be crucial for individuals to be supported by advocates so that they can participate 'as fully as possible' in decisions affecting them.

Despite the important role that advocates have the potential to play in the implementation of the mental incapacity legislation (such as assisting those whose capacity is being assessed and supporting the participation of individuals in the decision making process) advocacy is not referred to in the Draft Bill. The MDA has called for the legislation to include a 'right to access to independent advocacy when formal powers are applied for' and a duty on the relevant Secretary of State 'to provide sufficient advocacy services to deliver this'²².

The Joint Committee agreed that independent advocacy services play an essential role in assisting people who lack capacity. However, the Joint Committee felt that it would be inappropriate to recommend that resources be committed to provide a statutory right to advocacy and therefore recommended that provisions of the Bill should empower the relevant Ministers to arrange:

'to such extent as considered necessary to meet all reasonable requirements, for the provision of independent advocacy services to incapacitated adults affected by the Bill's provisions'.²³

c. Informal decision making: the General Authority

Clause 6 provides for the 'general authority'. This is a key provision of the Draft Bill. It permits a person to 'do an act when providing any form of care for another person' where the person providing the care reasonably believes the other person lacks capacity in relation to the matter in question and 'in all the circumstances it is reasonable for the person to do the act'.

The intention of the general authority is to:

*'make lawful many day-to-day decisions that have to be made about the care and welfare of adults who lack capacity without the need for informal powers. It aims to clarify the principle of necessity that currently exists at common law.'*²⁴

The scope of the general authority is far too broad. For example, whereas the Law Commission's Mental Incapacity Bill included specific restrictions on the use of the general authority in relation to medical interventions (such as treatment for mental disorder) there are no similar provisions in the Draft Bill. Furthermore, the general authority permits the use of force and the restriction of a person's liberty of movement (whether the person resists or not) if it is believed that such action is necessary in order to avert a substantial risk of significant harm to the person without capacity. (Similar powers are given to the donee of a LPA.) No further details are provided in the Draft Bill

²² See paragraph 2.8 and also section 5b of the Making Decisions Alliance submission.

²³ Paragraph 302

²⁴ Explanatory Notes, paragraph 33

on how such powers are to be exercised and/or reviewed. This raises the question of compatibility with both the right to liberty (article 5) and the right to private and family life (article 8) of the European Convention of Human Rights.

The MDA points out that no distinction is made between ‘day-to-day’ decisions taken by a parent or carer and more significant decisions such as medical treatment or where a person should live. The MDA recommends that the legislation includes specific restrictions on the scope of the general authority²⁵.

The Law Society raises similar concerns, giving a cautious welcome to a power which offers a practical solution to the day-to-day authority to make decisions, but has ‘insufficient safeguards’²⁶. Furthermore:

‘No other jurisdiction (as far as it is known) has a General Authority as part of their substituted decision-making law. The Law Society would therefore suggest proceeding with caution so as to find a correct balance between efficacy and safeguards. The scope of a general authority in particular needs to be clearly defined on the face of the Bill. This is because it would not be realistic to expect informal carers to have regard to a code of practice.’²⁷

The Joint Committee noted such concerns and stated:

‘We strongly recommend a redrafting of the clauses concerning the general authority in order to clarify that its use is intended to be limited to day-to-day decision-making and emergency situations.’²⁸

d. Formal decision-making powers

The Explanatory Note describes the formal decision-making mechanisms as follows:

‘Most of the day to day care of adults who lack capacity will take place under the general authority with no need for any formal decision-making authority. However, in some circumstances it may be better to have a designated decision maker to act on behalf of the person who lacks capacity. The Bill sets out a number of ways in which formal decision making powers can be acquired or granted. These powers represent an extension to the current ways in which financial decisions can be taken on behalf of others, allowing decisions to be taken on welfare (including healthcare) matters as well.’²⁹

These fall into four broad categories:

- the Lasting Power of Attorney (LPA),
- Court of Protection,
- Court of Protection appointed deputies,
- Advance Decisions to Refuse Treatment.

The Draft Bill requires the Lord Chancellor to prepare ‘a code or codes of practice’ for the guidance of:

- Persons assessing whether a person has capacity in relation to any matter
- Persons acting under the general authority

25 4.5.6 & 4.5.7

26 *Submissions to the Joint Committee on the Draft Incapacity Bill from the Law Society, paragraph 3.1*

27 3.5

28 *Paragraph 119*

29 *page 10*

- Donees of the LPA
- Deputies appointed by the Court

Individuals who are acting in relation to a person who lacks capacity either in a professional capacity or for remuneration must 'have regard to any relevant code of practice'.

i. The Lasting Power of Attorney (LPA)

The Lasting Power of Attorney (LPA) will enable an individual (the donor) to appoint another person (the donee) to act on the donor's behalf if s/he should lose capacity in the future. LPAs can cover personal welfare (including healthcare) and/or property and financial affairs. Both the person who executes the LPA and the donee of the LPA must have reached the age of eighteen. The LPA must be executed in the prescribed form and in accordance with the provisions set out in the Draft Bill³⁰. Clause 4 makes clear that a person acting under the powers of the LPA is under a duty to act in the best interests of the donor.

LPAs clearly offer an important means of enabling individuals to choose who they would want to make welfare and/or financial decisions on their behalf, if they should lose the capacity to make such decisions themselves. Thus these powers have been widely welcomed in principle. However, the provisions as drafted raise a number of concerns.

For example, while Clause 10(4) makes clear that a LPA does not authorise an attorney to give or refuse consent to treatment unless the donor lacks capacity to make such treatment decisions, this does not appear to be the case for other matters. The Explanatory Notes state that a LPA can, in certain circumstances, operate as an 'ordinary' power of attorney when the donor has full mental capacity³¹ but do not explain in what circumstances this will apply.

The Royal College of Psychiatrists points out that the registration of an LPA 'appears to be an "all or nothing" event' with the loss of capacity of the donor of the LPA in one area leading to the registration of the LPA, thus giving the attorney wide powers of decision making³².

ii. A new Court of Protection

The new Court of Protection will have authority for all areas of decision-making for adults who lack capacity, including the power to make declarations in relation to individuals' capacity to make certain decisions. The Court will also be able to appoint deputies to make decisions on both welfare (including healthcare) decisions and financial matters.

Thus the two existing and separate jurisdictions in relation to decision making on behalf of people who lack capacity (the current Court of Protection in relation to financial matters and the High Court's inherent jurisdiction, in relation to other decisions) will be merged. The Explanatory Note states that by creating such a new specialised Court of Protection, with authority over all areas of decision-making for adults who lack capacity it will be possible to build and maintain expertise in matters relating to adults who lack capacity. It will have a supervisory role in relation to all decision-making mechanisms under the legislation:

30 See clauses 8 & 9 and Schedule 1, Part 1

31 Paragraph 42

32 Draft Mental Incapacity Bill – Evidence to the Joint Committee from the Royal College of Psychiatrists www.rcpsych.ac.uk/college/parliament/MIBill.htm

‘The new jurisdiction will be responsible for clarifying all issues covered by the draft Bill. It will be a superior court of record able to establish precedent and it will have the power to remove attorneys and deputies who have acted improperly. It will also be the option of last resort in cases of dispute, for example if there is a disagreement between relevant parties as to the best interests of a person lacking capacity which cannot be resolved in any other way.’³³

Part 2 of the draft Bill sets out the more detailed provision concerning the new Court of Protection, including the practices and procedures before the Court, fees and costs. A new ‘Public Guardian’ will be established. This office will have a range of responsibilities which include establishing and maintaining a register of LPAs and orders appointing deputies and supervising donees of LPAs and deputies appointed by the Court of Protection.

The Draft Bill provides a description of the type of powers that the Court of Protection can make. In relation to personal welfare matters, these include deciding where individuals may live, what contact they may have with specified persons and the giving or refusing consent to the continuation of treatment. However, there is no provision relating to specific forms of treatment despite the statement in *Making Decisions* that certain ‘serious healthcare decisions’, such as the withdrawal of artificial nutrition and hydration from a patient in a permanent vegetative state or similar condition should remain a matter for the court and not be delegated³⁴.

iii. Court of Protection appointed deputies

Where individuals lack capacity in relation to matters concerning their personal welfare and/or property and affairs, the Court of Protection may appoint a person (a ‘deputy’) to make decision on their behalf in relation to such matters. When deciding whether the appointment of a deputy is in the person’s best interest the Court must have regard to (in addition to the general issues under the ‘best interests’ provision discussed above) the following matters:

- A decision by the court is to be preferred to the appointment of a deputy to make a decision, and
- The powers conferred on a deputy should be as limited in scope and duration as possible.

As with the general authority and the LPA, there is a lack of clarity on the scope of the court appointed deputies. For example, it would seem that deputies will have the power to consent to the withdrawal of treatment.

iv. Advance Decisions to Refuse Treatment

Where a person makes a valid advance refusal of treatment this must be upheld if at a later date the person no longer has the capacity to make such decisions. Thus an advance refusal of treatment will have the same effect as if the person had retained the capacity to make such decisions. The Draft Bill provides that it will be a criminal offence for a person ‘with intent to deceive’ to conceal or destroy another person’s advance written advance refusal.

The inclusion of advance directives has been widely welcomed. However many organisations have highlighted the importance of giving legal recognition to the use of advance statements in ensuring that individuals have the opportunity of setting out their preferences on personal welfare issues

33 page 13

34 Paragraph 3.8

such as where they would like to live and how they would like to be cared for and treated, if and when there is a time that they cannot make such decisions for themselves³⁵.

3. The Aftermath of Bournewood: Interrelationship between the Draft Mental Incapacity Bill and Mental Health Legislation

The proposals in the Draft Bill raise a number of questions in relation to the adequacy of the safeguards for people who lack capacity and need treatment for their mental disorder.

Bournewood

The House of Lords' decision in 'Bournewood'³⁶ – that people who lack capacity to consent to their admission for treatment for mental disorder, but do not object, can be admitted into hospital informally i.e. without the need to detain them under the Mental Health Act 1983 (the MHA 1983) raised serious concerns about the lack of safeguards for such individuals. This was described by Lord Steyn, one of the law lords as leaving 'an indefensible gap in our mental health law'. Having referred to the safeguards that are only available to individuals who are detained under the MHA 1983, such as clear procedures for detention, a review of that detention and independent scrutiny of the decision to give treatment without consent, Lord Steyn then stressed the need to provide similar protection to people without capacity who are admitted to hospital informally:

*'Given that such patients are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of the Act of 1983 from a large class of vulnerable mentally incapacitated individuals. Their moral right to be treated with dignity requires nothing less.'*³⁷

The Law Commission's recommendations

The Law Commission had specifically excluded issues relating to detention in hospital and compulsory treatment for mental disorder from its review on mental incapacity:

*'Although many people who lack mental capacity will have some form of mental disorder, few of them will require compulsory treatment in hospital for that disorder. Instead we are addressing in this report the legal problems which result from the fact that mental disorder may affect people's decision making in relation to much wider issues. The law relating to mental incapacity and decision-making must address quite different legal issues and social purposes from the law relating to detention and treatment for mental disorder.'*³⁸

However, the Law Commission considered that the Court of Protection should have powers to order individuals who lacked the capacity to make such decisions to be admitted and detained in hospital and therefore recommended:

'...the court should have the power to order the admission to hospital for assessment or treatment for mental disorder of a person without capacity, if satisfied on the evidence of two doctors that:

35 See the Mental Health Foundations response, paragraphs 3.4 – 3.6 and the Making Decision Alliance's submission 5 a. page 18.

(Also referred to as R v Bournewood Community and Mental Health NHS Trust ex p L)

36 Re L (by his next friend GE) (1998) 1CCLR 391

37 1 CCLR 390 at 408

38 Paragraph 2.2

(1) the grounds for admission specified in sections 2 or 3 respectively of the Mental Health Act 1983 exist, and

(2) it is appropriate, having regard to the “best interests” factors, that the person concerned should be admitted to hospital.’

The Law Commission considered that individuals admitted to hospital under such orders would be in exactly the same position as anyone admitted under the civil procedures of the MHA 1983, save that the right to apply to a Mental Health Review Tribunal would not arise in the first period of detention³⁹.

However, these proposals were not included in *Making Decisions* (although no explanation was given for this decision). Similarly, the Government has decided not to take forward the Law Commission’s recommendations in relation to the treatment for mental disorder for people who lack capacity to make treatment decisions. The Law Commission had recommended that the safeguards set out in the MHA 1983 in relation to the administration of medication or electroconvulsive treatment (ECT)⁴⁰ should apply to all people who lack capacity to consent to such treatment, whether or not they are detained under the Act. Under such proposals individuals incapable of consenting to medication or ECT could only be treated if an independent medical practitioner authorises such treatment.

The Draft Mental Health Bill

The Draft Mental Health Bill, published in June 2002, includes some safeguards (such as the right to apply to the Mental Health Tribunal to be discharged) for those individuals who are informally admitted to hospital for treatment for their mental disorder. The Explanatory Note to the Bill states:

‘Incapacitated patients who do not resist treatment will continue to be treated informally under common law to avoid inappropriate use of compulsion and the stigma associated with it, but the Bill will introduce a range of safeguards to guard against possible inappropriate treatment or detention.’⁴¹

However, these provisions are limited in scope as they only apply to adults without capacity who are receiving treatment for their mental disorder in hospital, whereas the Law Commission’s proposals in relation to treatment for mental disorder would have applied to all individuals who lacked capacity to consent and were receiving such treatment.

Treatment for Mental Disorder and the Draft Bill

The Draft Bill makes no provision for the treatment of mental disorder. Thus it would seem that such treatment, including electroconvulsive treatment (ECT) may be given to individuals who lack capacity to consent under the general authority – without any independent scrutiny or review⁴².

Clause 27 states that there is no authority to give, or consent to a ‘patient’ being given, treatment for mental disorder ‘if the giving of the treatment to the patient is regulated by Part 4 of the

39 Paragraph 8.29

40 Section 58 of the MHA 1983

41 Draft Mental Health Bill, Explanatory Notes, Department of Health 2002, Cm 5538-II, paragraph 187

42 See Robert Robinson, *ECT and the Human Rights Act 1998*, *Journal of Mental Health Law*, July 2003, 66 for a discussion on the practice of administering ECT under common law.

Mental Health Act'. While this makes clear that the powers to authorise treatment under the provisions of this Draft Bill will not apply to individuals detained under the MHA 1983, the Royal College of Psychiatrists questions whether this is also intended to cover all people who require treatments which are regulated under Part 4 of the Act. The College adds:

'...the draft Bill is unclear about treatment for mental disorder in incapable people not resisting treatment and not seeming to need detention. It [clause 27] could be taken to imply that psychiatrists (and social workers and general practitioners, in collaboration with family and carers) should formally detain all incapable people requiring medical drug treatment for mental disorder, regardless of the circumstances. Most incapable people would be at home or in nursing/residential homes. Such a practice would seem inordinately restrictive, inappropriate and excessively bureaucratic.'

Detention and the Use of Force under the Draft Bill

Both the general authority and the LPA permit the use of force to 'secure the doing of an act' which a person resists and the restriction of a person's 'liberty of movement', whether or not the person resists, if it is believed that the action is necessary in order to 'avert a substantial risk of significant harm' to the person without capacity.

The scope of such powers are unclear. Potentially, it would seem that these powers could be used to require a person to be admitted into hospital for treatment for mental disorder. Thus, it is not clear how these powers relate either to the House of Lords' decision in *Bournewood* or the compulsory powers under the MHA 1983. Do these powers override the *Bournewood* judgment that individuals could be informally admitted to hospital for treatment for their mental disorder only if they do not resist, by permitting the informal admission of individuals, whether or not they resist? Presumably this is not the intention of the Draft Bill and in such cases the MHA 1983 should be used, if the criteria are met. However, there is no indication in the Draft Bill or the Explanatory Notes that these provisions may overlap with the MHA and therefore no guidance is given on how professionals are to decide on which legislative procedures are to be followed, in which set of circumstances.

Conclusion

While the general consensus is that legislation to provide a clear and comprehensive framework for decision-making on behalf of people who lack capacity is urgently required, the Draft Bill requires substantial amendments if this is to be achieved. Under the current proposals the decision-making powers lack clarity. In particular the general authority is far too wide and is open to abuse. Furthermore, the relationship between the proposals, the MHA 1983 and the provisions in the Draft Mental Health Bill must be clarified. It is hoped that in addition to addressing these issues, the Government will also consider how the legislation can place a greater focus on enabling individuals to make decisions for themselves, wherever possible, for example by providing a right to advocacy.

Is this a revolution? The impact of the Human Rights Act on Mental Health Law

*Paul Bowen**

In 'Almost a Revolution: Mental Health Law and the Limits of Change', Prof. Paul Applebaum, writing in 1994, describes a period of tumultuous change in the United States during the late 1960s in civil rights and mental health law and which lasted nearly three decades¹. At the end of that period, he concluded, there had been little real and substantial change to mental health law in the United States. This article looks at some of the changes to mental health law that have already been wrought in England & Wales by the Human Rights Act 1998 and briefly considers its potential for creating real and substantial change in the longer term.

Current legislation governing the detention and treatment of those with mental disorder – the Mental Health Act 1983 – is widely recognized as being out of date, based as it is largely upon its predecessor, the Mental Health Act 1959. New legislation is proposed, much of which is highly controversial, demonstrating that while there may be a perception by significant elements in society that change is required, there is by no means unanimity as to the direction in which that change should take. Perhaps less controversially, but no less necessary, Incapacity legislation is also likely soon to be introduced, after many years of urging from the Law Commission, the Courts and interested groups.

On 2 October 2000 the Human Rights Act 1998 (HRA) came into force. The United Kingdom has been a signatory to the European Convention on Human Rights 1950 (the Convention) since its inception – indeed, was the first to ratify the Convention, on 8 March, 1950 – and the Convention has led to significant changes prior to its incorporation through the HRA. Most notable, perhaps, is the seminal case of *X v United Kingdom*² which established that, in order to comply with Article 5(4), a Mental Health Review Tribunal must have power to order a patient's release from hospital, even one who has committed serious criminal offences. This led to a change in the law introduced

* Barrister, Doughty Street Chambers, London

¹ Applebaum P, 'Almost a Revolution: Mental Health Law and the Limits of change', (Oxford University Press) (1994)

² (1981) EHRR 181

by the Mental Health (Amendment) Act 1982 whereby the Tribunal's power of recommendation to the Home Secretary became a power to discharge in the face of objections from that minister.

But that case is also an illustration of the shortcomings of the Convention prior to its incorporation through the HRA, as it was *only* through the introduction of primary legislation that the law could be changed so as to comply with the Convention. The impact of the Convention on domestic law was limited by the constitutional principle of the sovereignty of Parliament. As a matter of international law the executive may bind the state to abide by the terms of international treaties, but the legislature alone can give effect to those terms in domestic law by passing legislation, which it has now done, by introducing the HRA. Accordingly, in the absence of such enacting legislation, individuals could not enforce their Convention rights directly through domestic courts, which were obliged to uphold primary legislation, and could find it unlawful or invalid, notwithstanding any conflict with the United Kingdom's Convention obligations³. Accordingly, although the Courts applied the presumption that Parliament has enacted legislation so as to comply with the United Kingdom's Convention obligations⁴, that presumption had to yield to express statutory wording, even if that violated Convention rights.

The HRA, however, has introduced three fundamental changes to the law. First, it confers upon individuals the right to enforce Convention rights directly through the domestic courts. Section 6 provides 'It is unlawful for a public authority to act in a way which is incompatible with a Convention right'. An aggrieved individual is no longer confined to invoking an analogous common law right (where one existed) or to taking his case to Strasbourg: by section 7 he may directly rely upon the Convention rights contained in the Schedule to the HRA, whether by bringing proceedings against a public authority or by raising it in other proceedings to which he is a party, most notably by way of a defence to civil or criminal proceedings. Second, by section 3 the HRA imposes a strong interpretative obligation upon the Courts to 'read and give effect to' Convention rights in a way which is compatible with the Convention rights. By contrast with the position prior to October 2000, Courts must construe legislation in a Convention compatible manner even where there is no ambiguity; indeed, provided it does not lead to an absurd result. Third, and last, while the principle of Parliamentary sovereignty is preserved in that Courts cannot strike down incompatible legislation, by section 4 HRA they can make a 'declaration of incompatibility' in respect of a provision that cannot be 'read and given effect to' under section 3 in a way that complies with the Convention. While the HRA has its limitations, which are becoming more apparent as time goes by, we do now have a 'a body of theory that can be applied to extend or alter the law in the desired direction', if not as far as some would like.

In Scottish cases, the Scotland Act 1999 goes further, enabling Courts (including the Privy Council, as the highest Court of Appeal) to strike down legislation of the Scottish Parliament when it is incompatible with Convention rights.

We are now more than three years on from the coming into force of the HRA. Mental Health has proved to be one of the most fruitful areas of challenge under the Act. At the time of writing there have been 10 declarations of incompatibility, three of which have related to the MHA, and one of which has led to the only remedial legislation yet to be introduced under section 10 of the Act.⁵

3 see, e.g., *R v Home Secretary, ex p Brind* [1991] A.C. 696, per Lord Bridge at 747

4 see, e.g., *Lonrho Plc* [1990] 2 AC 154, per Lord Bridge at 208

5 *The Mental Health Act 1983 (Remedial) Order 2001*

The following provisions have been declared incompatible: the reverse burden of proof under section 72/ 73 (see *R (H) v Mental Health Review Tribunal*⁶); sections 26 and 29 MHA (nearest relative provisions) (*R (M) v Health Secretary*⁷); and section 74 MHA (absence of any power in the Tribunal to release a transferred post-tariff discretionary lifer: *R (D) v Home Secretary*⁸). Others are likely to follow.

But declarations of incompatibility are only a very small part of the process of change. There has been a great deal of activity in the Courts, particularly in applications for judicial review, some of which has led to enhanced protection for those with mental disorders, and much which has not. I am going to focus on five areas in this paper:

- Detention and discharge
- Compulsory treatment
- Seclusion
- Other conditions of detention
- Protection of confidential information.

Detention & discharge

The clearest developments have been in relation to Article 5, with some significant enhancements to the existing procedural safeguards provided by the Mental Health Review Tribunal.

The reverse burden of proof has been declared incompatible with Article 5 and reversed by remedial legislation (*R (H) v Mental Health Review Tribunal*⁹), subsequently affirmed by the ECHR in *Hutchison Reid v United Kingdom* 20 February 2003.

Undue delay by the Home Office in granting leave of absence to a patient who has been conditionally discharged by a Tribunal, but deferred, may violate Article 5 (*R (RA) v Home Secretary*¹⁰).

A series of cases brought in relation to delay in the arrangement of MHRT's have led to findings of violations of the 'speediness' requirement of Article 5(4), although the level of damages paid out has been fairly low (*KB and others v MHRT*¹¹).

The Court of Appeal has affirmed the power of the Tribunal to discharge a patient from high secure accommodation via 'stages', by ordering their discharge on condition of residence either in another hospital or in hostel accommodation with suitable levels of security, provided those conditions do not amount to a 'deprivation of liberty': see *R (SSHD) v MHRT, PH interested party*¹². The Home Secretary argued that the Tribunal's decision amounted to an order for transfer, rather than discharge, which it had no power to make. Not so, said the Court of Appeal; the fact that the conditions were imposed so as to *increase* the patient's freedom, by allowing his release from a high secure hospital, was a key factor in their finding that the order would not result in PH continuing to be 'detained' and was, therefore, lawful.

6 [2002] QB 1

7 [2003] EWHC 1094 Admin

8 [2003] 1 WLR 1315

9 [2002] QB 1

10 [2002] EWHC 1618 (Admin)

11 [2003] EWHC 193 (Admin)

12 [2002] EWCA Civ 1868

However, a number of challenges in relation to the procedural protections of Article 5 have failed. The dual role of the medical member as both witness and judge, although clarified (*ex p. Hannaway*), has nevertheless been found not to be incompatible with Article 5 (*R (S) v MHRT*¹³).

The vexed question remains of who is bound by the decision of a Mental Health Review Tribunal. A series of cases has now considered two linked questions: first, are doctors and social workers bound by a Tribunal's decision to discharge so that they cannot lawfully detain a patient if they disagree with the Tribunal's decision¹⁴; and, second, are other statutory agencies (in particular section 117 Health & Social Service Authorities) bound by a decision to discharge so that they act unlawfully if they fail to provide the services necessary to implement a patient's discharge¹⁵. The House of Lords has now confirmed that the answers to each, in turn, are (a) yes, if there has been a relevant change in circumstances¹⁶; and (b) no, there is no positive duty under the Convention to provide accommodation or treatment that will enable a detained patient to be discharged into the community¹⁷.

The Tribunal remains powerless to order a restricted patient to be *transferred* from one hospital to another, either as a necessary precursor to discharge¹⁸ or to ensure the patient is close to his family¹⁹.

Both the Privy Council in the Scottish case of *Anderson, Doherty & Reid v Scottish Ministers*²⁰, and the ECHR in *Hutchison Reid v UK*²¹, have confirmed that it is not a violation of Article 5 to detain a mentally disordered individual on the grounds of dangerousness, even if they are considered to be 'untreatable'. A person may be detained under Article 5(1)(e) where they suffer from a qualifying mental disorder even if there is no treatment available for that disorder:

'Such confinement may be necessary not only where a person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons (Hutchison Reid v United Kingdom, ibid, §51; Witold Litwa v. Poland, (2000) 33 EHRR 53, § 60).

It is likely, then, that the proposals in the Mental Health Bill 2002 for removing the 'treatability' requirement for psychopathic patients will survive the HRA.

Although a case preceding the coming into force of the HRA, the *Bournewood* case nevertheless represents a failure by the Courts through the existing law to safeguard vulnerable mentally disabled patients. In *R (L) v Bournewood Community Mental Health NHS Trust*²², the House of Lords overturned the Court of Appeal in finding that so-called 'Bournewood patients', i.e. who lack capacity but do not object to their detention or treatment, do not need to be formally detained under the MHA, notwithstanding that they are therefore left with inadequate legal protections. In May 2003 the ECHR conducted a final hearing of the case brought on behalf of Mr. L under Article 5, and judgment is awaited.

13 [2002] EWHC 2522

14 see *Von Brandenburg* [2002] QB 235 and *R (H) v Ashworth* [2002] EWCA Civ 923

15 *R (K) v Camden & Islington HA* [2002] QB 198 and *R (H) v Home Secretary* [2003] 3 QB 320

16 *Von Brandenburg* [2003] 3 WLR 1265

17 *R (H) v Home Secretary* [2003] 3 WLR 1278

18 *R (SSHD) v MHRT, (MW & FO intervening)* [2001] ACD 62

19 *R (H) v MHRT* [2002] EWHC 1128 (Admin)

20 [2002] 3 WLR 1460

21 *Application 50272/99*, *Times Law Reports* 26th February 2003

22 [1999] AC 458

Treatment

As to compulsory treatment, there have been a number of significant cases. In *R (Wilkinson) v Broadmoor*²³ the Court of Appeal accepted that a combination of Articles 2, 3, 6 & 8 entitled a patient to a determination by a court of the lawfulness of compulsory treatment *in advance* of the treatment being given. Moreover, because domestic law created no statutory right to such a hearing, the Administrative Court on judicial review was required to reach its own views on the *merits*, where the treating doctor was required to prove to a high standard that the treatment was medically necessary. In doing so, it would be necessary for the Court to hear live evidence with cross-examination.

Wilkinson was followed by the case of *R (Wooder) v Dr. Feggetter*²⁴, in which the Court of Appeal ruled that, given the fundamental rights engaged by a decision to compulsorily treat an individual (notably Articles 3 & 8), a SOAD is required to give reasons for his decision for endorsing an RMO's treatment plan under section 58.

A subsequent decision of the CA, *N v DR M*, has watered down the impact of those judgments, particularly *Wilkinson*, by expressing the view that it will rarely, if ever, be necessary to hear live evidence on a challenge to a treatment decision, and that such a right cannot be derived from Article 6 ECHR. However, the Court did emphasise the high standard of proof required to demonstrate medical necessity.

Most recently the Court of Appeal in *R (B) v Ashworth HA*²⁵, in a perhaps surprising decision, held that a patient may only be compulsorily treated under the MHA Part IV in respect of the mental disorder from which he is classified as suffering. Although not explicitly reasoned as a human rights decision, the case imposes some limitations upon the circumstances in which treatment may be imposed without consent (although it is not clear, in practice, how significant those limitations will prove to be, given that the Court of Appeal confirmed that where necessary the common law could be invoked to provide treatment for disorders that the patient was not classified as suffering from). Nevertheless, it is likely that in respect of many patients, particularly those in Special Hospitals, there will be an increase in applications to reclassify brought by the hospital before Tribunals. The House of Lords has recently given leave to Ashworth HA to appeal this judgement.

I have only mentioned those aspects of the case law that have led to an increase in *procedural* protection against arbitrary or mistaken treatment. Of potentially greater significance is the proposition, advanced in *Wilkinson*, and accepted (in part) by one of the judges (Simon Brown LJ), that a detained patient who retains *capacity* to refuse treatment should remain entitled to refuse treatment even if he is detained under the MHA, as the right of autonomy of self-determination is one protected by Articles 3, or 8, or 6. This right of autonomy or self-determination has since been explicitly recognized as a component of Article 8 by the ECHR in *Pretty v UK*²⁶, albeit in a slightly different context, and is likely to form the basis of future challenges to compulsory treatment and detention of patients who, despite the existence of a mental disorder, retain the capacity to make decisions about their future and who would rather suffer the effects of their illness than the effects of their treatment.

23 [2002] 1 WLR 419

24 [2002] 3 WLR 591

25 [2003] EWCA Civ 547

26 [2002] 2 FLR 45

It is difficult to predict which way the Courts will go on this issue. A recent decision of the Scottish Court of Session, *Petition of WM for Judicial Review*, Court of Session, 11 July 2002, rejected the argument; on the other hand, in *Starson v Swayze*²⁷, the Ontario Court of Appeal affirmed the right of the competent individual to refuse treatment, which was upheld on appeal to the Canadian Supreme Court. In the United States the Supreme Court has never directly addressed the issue, but relevant decisions of the federal courts (including the Supreme Court) have tended to adopt a conservative, treatment-driven approach, although state courts have been more proactive in protecting the rights of the competent to refuse treatment²⁸. The issue is squarely raised in an application brought by Mr. Wilkinson to the European Court of Human Rights, *Wilkinson v United Kingdom*, but the case has yet to reach the admissibility stage.

The failure to provide suitable treatment to those suffering from mental disorder is also capable of giving rise to violations of Convention rights. Complex issues are raised by the transfer between prison and hospital of convicted prisoners who are suffering from mental illness. A recent challenge was brought by a transferred life sentence prisoner, detained under sections 47 & 49, to his return to prison under section 50 on the grounds that he remained so mentally ill that to return him to prison would constitute inhuman and degrading treatment, contrary to Article 3²⁹. He also claimed that he remained of 'unsound mind' within the meaning of Article 5(1)(e) and thus his detention anywhere other than in a 'hospital, clinic or other appropriate institution' was unlawful. The prisoner was diagnosed as suffering from paranoid schizophrenia which was controlled by medication. However, on two previous occasions his condition had relapsed while in prison and an independent psychiatrist gave evidence that it was almost inevitable that his condition would deteriorate once again if returned to prison. The Administrative Court, while accepting in principle that the detention of a mentally ill individual in prison might violate both Articles 3 and 5, rejected the challenge on the basis that the Secretary of State was entitled to rely upon the patient's doctor's opinion that suitable treatment was available for the patient in prison. The Court's role was limited to one of review of that decision; it was not required to determine for itself whether, on the facts, the patient would receive appropriate treatment while in prison.

Seclusion

As to the use of *seclusion*, in two cases decided in 2002 the Administrative Court reached rather disappointing conclusions as to the effect of the Convention rights on the practice of seclusion, finding that to seclude the patient in circumstances where the Code of Practice was not complied with did not give rise to a breach of either Articles 3, 5 or 8 (*R (Col. Munjaz) v Ashworth HA*³⁰; *S v Airedale NHS Trust*³¹). The Court of Appeal considered the cases in a conjoined appeal on 16th July 2003 and overturned the two earlier High Court rulings³². The appeal court held that seclusion that did not comply with the Code of Practice was in breach of Articles 3 & 8. The Convention requirement of 'legality' was only met through adherence to the Code of Practice. The Court went on to say that the Code should not be departed with as a matter of policy and should be observed

27 (2001) 201 DLR (4th) 123

28 Applebaum P, 'Almost a Revolution: Mental Health Law and the Limits of Change', 1994, pp. 131-132)

29 *R (R) v. Shetty and Home Secretary* [2003] EWHC 3022 (Admin); see also *R (Morley) v Nottinghamshire Healthcare NHS Trust* (2003) 1 All ER 784

30 [2002] EWHC 1521 Admin

31 (2003) Lloyd's Rep Med 21

32 *R (on the application of Munjaz) v Mersey Care NHS Trust*; *R (on the application of S) v Airedale NHS Trust* [2003] EWCA Civ 1036

by all hospitals unless they have good reason for departing from it in relation to an individual patient or groups of patients with well-defined characteristics. The House of Lords has recently granted Mersey Care NHS Trust leave to appeal.

Other conditions of detention

As to other *conditions of detention*, there has yet to be a successful challenge under either Articles 3 or 8 to the conditions of detention in any of the detaining hospitals. Challenges have failed to the policy of a Special hospital not to issue condoms (*R (RH) v A Hospital Authority*, 30 October 2001), a refusal to permit a patient to dress as a woman (*E v Ashworth*³³), the introduction of random telephone monitoring in special hospitals (*R (N) v Ashworth*³⁴), and the restriction on visits by children to patients in special hospitals (*R (L) v Secretary of State for Health*³⁵). However, this is an area that is likely to see an increase in challenges as litigators become more sophisticated in the means employed to mount such challenges, so as to adduce greater evidence as to the prevailing standards in other hospitals and in other countries, and as judges become more comfortable with making decisions of a kind that previously fell outside their remit altogether.

Confidential information

The Admin Court has recently affirmed the ECHR decision in *JT v UK*³⁶ to the effect that the disclosure of confidential medical information to the nearest relative, in circumstances where the patient objects, violates Article 8 (*R(M) v Health Secretary*³⁷). A declaration of incompatibility has now been made in relation to sections 26 and 29.

Where next?

The law is in a state of flux, and it is difficult to predict where it will end. However, it is likely that more is yet to be said by the Courts (both here and in Strasbourg) on the following issues:

- Powers and procedures of the Mental Health Review Tribunal. I expect challenges to the standard of proof in Tribunal proceedings: the current civil standard may be too low; the use of hearsay evidence will be more tightly regulated; the qualifications of those giving evidence in support of a patient's continuing detention will be more anxiously scrutinized.
- Whether Article 5 and/ or 8 requires the tribunal to have power to transfer patients to lower security, or grant leave of absence, as a necessary precursor to discharge.
- Whether decisions of the Tribunal to discharge are binding on subsequent clinicians (including those in the community) in the absence of compelling reasons.
- Whether positive obligations may be derived from Article 5(1) upon public authorities to provide both in-patient and after-care treatment which will enable patients to be discharged.
- Bournewood: whether compliant incapacitated adults are to be given greater safeguards against arbitrary and mistaken detention or treatment.
- Whether the right of autonomy entitles a competent patient to refuse treatment other than in circumstances where he is a threat to others.

33 [2001] EWHC 1089 Admin

34 [2001] HRLR 46

35 (2000) 58 BMLR 101

36 [2000] 1 FLR 909

37 [2003] EWHC 1094 Admin

Conclusion

In conclusion, however, I consider it unlikely that the HRA will lead to a 'revolution' in mental health law, for three reasons. First, the constitutional doctrine of the separation of powers obliges the judiciary to allow a certain discretionary area of judgment to our elected representatives and those upon whom Parliament confers statutory powers. That principle remains largely unaffected by the HRA, particularly in cases involving the allocation of scarce public resources, although the width of that discretion has undoubtedly narrowed. Second, the search for solutions that comply with Convention rights involves a balancing exercise between individual rights and the interests of the wider community (see *Sheffield and Horsham v UK*³⁸):

'In determining whether or not a positive obligation exists, regard must be had to the fair balance that has to be struck between the general interests of the community and the interests of the individual, the search for which balance is inherent in the whole of the Convention'.

Any shifts in that balance are likely to be incremental rather than seismic. Third, the HRA cannot always provide an effective remedy where domestic law fails to meet up to the standards of the Convention. Where the failure is a result of an incompatible provision of primary legislation, the Courts' power under section 4 HRA is limited to making a declaration of incompatibility which does not bind the Government to take steps to remedy the incompatibility. Moreover, where the lack of adequate protection stems from a gap in the law the Court is powerless to intervene: a declaration of incompatibility may only be made in respect of a specific provision of primary legislation³⁹ and no challenge may be brought to a failure of the Executive to introduce or lay before Parliament a proposal for legislation or to make any primary legislation: HRA 1998, section 6(6). The sovereignty of Parliament to legislate is unaffected.

Although the Human Rights Act has proved to be an effective means of highlighting the potential for human rights violations involved in the detention and treatment of the mentally disordered, substantial reform is likely to occur only by democratic means through Parliament. We must continue to wait for a new Mental Health Act and a new Incapacity Act.

38 (1998) 27 EHRR 163, at 191, para 52

39 *Re. S (Minors) (Care Order: Implementation of Care Plan)* [2002] 2 AC 291, §§85–86 per Lord Nicholls

The Consequences of Acting Unlawfully

*Kris Gledhill**

The Mental Health Act 1983 provides for detention and also for treatment which would otherwise be an assault. As such, it allows for interference with the fundamental rights to liberty and to self-determination. Particularly as it does so in the context of a branch of medicine which is often highly subjective, it is hardly surprising that litigation is occasionally resorted to by those affected who wish to challenge the legality of what is occurring to them.

The framework for this litigation has developed, spurred on in particular by the growth of public law and human rights law. As a result, mental health professionals have to be familiar not just with the court-machinery which is central to the Mental Health Act 1983 (which provides for the Mental Health Review Tribunal to determine the legality of the ongoing detention of a patient, and refers the issue of the displacement of a nearest relative to the county court) but also with the courts which deal with questions of public law (in particular the Administrative Court) and the civil litigation courts.

Public Law

The last quarter of the Twentieth Century saw a significant growth of public law, with an increased jurisdiction assumed by the High Court to intervene in the decisions of inferior courts and decision-makers by way of the process of judicial review. Mental health law was caught in this trend; for example, decisions of Mental Health Review Tribunals¹ but also decisions of mental health professionals to “section” or renew the detention of a patient² were subject to challenge by way of judicial review.

Mental health law has been at the forefront of the further invigoration of public law in the era since the Human Rights Act 1998 was ushered in on 2 October 2000. The first declaration of incompatibility to stand was made in relation to the powers of a Tribunal under ss72 and 73 of the

* *Barrister specialising in public law, particularly mental health and prison law; editor of Mental Health Law Reports and Prison Law Reports; regular lecturer on mental health and prison law.*

1 *Encouragement was given to use judicial review rather*

than the statutory method of special case stated under s78(8) of the Mental Health Act 1983: see Bone v MHRT [1985] 3 All ER 330.

2 *R v Hallstrom ex p W (No 2), R v Gardner ex p L [1986] QB 1090.*

1983 Act³ and two further declarations have so far been made⁴. In addition, the first action taken by a Minister to amend a primary statute by way of delegated legislation in the form of a Human Rights Act Remedial Order was also a mental health matter.⁵

Judicial Review Since the Human Rights Act 1998

The further growth of challenges to the legality of decisions made in a mental health law context can be traced to three major developments arising from the Human Rights Act 1998. The first is the development of the test for intervention by way of judicial review. Traditionally, a judicial review would only succeed if there were significant procedural defects in the decision-making process or the decision was irrational (the so-called *Wednesbury* unreasonableness test⁶); however, the courts now have to be more willing to examine the merits of a decision which interferes with fundamental rights guaranteed under the European Convention, by reviewing not just whether a decision maker exercised a rational judgment but also whether a proportionate balancing decision was reached⁷.

The second development is linked and is the extended scope of fact-finding (and hence evidence in the course of hearings) in judicial review proceedings. The case which made plain that this was necessary in order to comply with the requirements of Article 6 of the European Convention, the right to a fair trial in relation to civil rights, was *R (Wilkinson) v Broadmoor and Others*⁸. In essence, the ruling here was that where fundamental rights are involved, the courts do not simply review the rationality of a decision but make their own judgment, including determining as between competing medical opinions as to whether a particular form of treatment would breach Articles 2, 3 and 8 of the Convention (which would require the doctors to attend and be cross-examined). This was necessary to provide compliance with the right to a fair trial under Article 6.

The case of *Wilkinson* was an interlocutory appeal on a point of practice, namely whether it was necessary for doctors to attend to give evidence. It has been applied in practice in the case of *R (N) v A Hospital and Others*⁹. In this case, a High Court judge made the determination on contested evidence of whether a particular course of treatment should be allowed in light of the patient's rights under Article 3 and Article 8, which turned on issues of the correct diagnosis of the patient's condition and whether forced depot medication was in a patient's best interests. Although in upholding the decision the Court of Appeal¹⁰ noted that live evidence would not always be essential, the jurisdiction of the court to make the contested decision is clear.

The same fact-finding jurisdiction has been used in another mental health law context, namely the issue of whether a nearest relative had objected to an application being made to admit a patient

3 *R (H) v London North and East Region Mental Health Review Tribunal* [2002] QB 1, [2001] Mental Health Law Reports 48

4 The regime for the release of life sentence prisoners transferred to hospital under ss47 and 49 of the 1983 Act (*R (D) v Secretary of State for the Home Department* [2003] Mental Health Law Reports 193 – see now s295 Criminal Justice Act 2003) and the absence of a provision to allow a patient to change his or her nearest relative under s29 of the Act (*R (M) v Secretary of State for Health* [2003] Mental Health Law Reports 348

5 *The Mental Health Act 1983 (Remedial) Order 2001*, SI 2001 No 3712

6 *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223

7 *R (Daly) v Secretary of State for the Home Department* [2001] 2 AC 532

8 [2002] 1 WLR 419, [2001] Mental Health Law Reports 224

9 [2003] Mental Health Law Reports 138

10 [2003] 1 WLR 562, [2003] Mental Health Law Reports 157

under s3 of the 1983 Act¹¹ and it has also been used in different contexts, such as whether a search warrant was lawfully executed¹².

The third development has been the growth of challenges by one public law body to the decisions of another public law body, particularly challenges to decisions of Mental Health Review Tribunals by hospitals and after-care authorities. This is a consequence of the need to accord appropriate weight to the fact that a Tribunal is a judicial body which, to comply with Article 5(4) of the Convention, has to have the power to order the release of an unlawfully detained psychiatric patient. The issue of lawfulness here includes the question of whether the merits of the need to detain are made out.

Prior to the Human Rights Act 1998, if the mental health professionals believed that a decision to discharge a patient was wrong, they were able to arrange for the patient to be re-sectioned if they felt that the criteria were met¹³. Indeed the duty to make an application if it were thought appropriate, under s13 of the 1983 Act, could be said to require such an application. However, the situation has had to be revisited pursuant to the duty imposed on the courts under s3 of the 1998 Act to strive to interpret legislation so that it is compatible with Convention rights, which has required that previous authorities be revisited despite the common law's adherence to the doctrine of precedent. The new position is that a Tribunal decision is to be respected and allowed to stand unless it can be shown that there was information of which the Tribunal was not aware which puts a significantly different complexion on the case (such as the patient reneging on an undertaking to take medication or a deterioration in the patient's condition)¹⁴.

As a result of these developments, the Administrative Court's case load in relation to challenges to the lawfulness of decisions in the mental health context has seen a significant growth.¹⁵

Habeas Corpus

One of the other consequences of the growth of judicial review has been a diminution in the use of the remedy of Habeas Corpus, the remedy whereby a challenge to the jurisdiction to detain can be brought in front of the High Court. It was the remedy used in the leading case of *Re S-C*¹⁶, which involved a challenge to the right of the hospital to detain someone when the application was fundamentally flawed because the nearest relative objected. However, in *B v Barking, Havering and Brentwood Community Healthcare NHS Trust*¹⁷, which involved an allegation that the renewal of detention was fundamentally flawed, a differently constituted Court of Appeal suggested that judicial review should be the remedy sought. It is certainly possible to have judicial review cases heard speedily¹⁸ and the right to seek bail in the course of judicial review proceedings allows a detainee to be released in a short time-scale if the merits are clear.

11 *R (PG) v LB Ealing and Others* [2002] *Mental Health Law Reports* 140

12 *R (H) v Commissioners of Inland Revenue* [2002] *Police Law Reports* 350

13 *R v Managers of South Western Hospital ex p M* [1993] *QB* 683

14 *R v East London and The City Mental Health Trust ex p von Brandenburg* [2003] *UKHL* 58

15 A very simplistic approach is to look at the volume of cases in the *Mental Health Law Reports*: the 2002 and 2003 volumes are double the size of the 1999 volume.

16 [1996] *QB* 599

17 [1999] *1 FLR* 106

18 *The Administrative Court has a separate form, the N463, whereby an applicant for judicial review can seek an urgent hearing, and interim relief*

One of the controversial areas of the law of Habeas Corpus is the power of the High Court to review the sufficiency of evidence on the basis of which a person is detained¹⁹. In *R v Board of Control ex p Ruddy*²⁰, the High Court granted a writ of Habeas Corpus to secure the release of a person detained under the Mental Deficiency Act 1913 on the basis that the stipendiary magistrate who made the order did not have sufficient evidence that the patient had been “found neglected”, as required before a committal order could be made under the statute. A similar conclusion has recently been reached in *R (Kenneally) v Snaresbrook Crown Court*²¹, in which the release of a patient was ordered on the basis that the Crown Court judge had erred in finding that he had the jurisdiction to make a hospital order under s51 of the 1983 Act²², which requires that it be “impracticable or inappropriate to bring the detainee before the court”. The factual circumstances were that the patient was in the cells of the court, and it was his counsel’s request that s51 be invoked: however, the High Court held that the statutory language had to be construed restrictively, requiring a level of disablement such that it was inappropriate for the patient to be brought to court, and the judge had misdirected himself as to the law in using the power. There had been a parallel application for Habeas Corpus in case the time limit rules applicable to judicial review had caused a problem²³, though this was adjourned when permission to bring the judicial review proceedings was granted with a time extension of just under 4 years²⁴.

Both *Ruddy* and *Kenneally* involved what might be seen as procedural prerequisites for detention which were separate from the central medical question of whether the detainee suffered from a mental disorder of the necessary nature or degree. However, there is nothing in principle to prevent the jurisdiction of the High Court from being exercised in this regard. The Court has demonstrated that it is willing to review whether the prerequisites of the jurisdiction to detain are made out, and is willing to enter into the arena of medical disputes. Consequently, the existence of an “unsound mind” of the necessary nature or degree, established by adequate evidence²⁵ is a matter fit for judicial determination.

Those detained under the civil provisions of s3 of the 1983 Act are the subject of a public law decision which is open to challenge in the High Court; the right to apply to a Mental Health Review Tribunal is not an alternative remedy (it being a principle of judicial review that other avenues of appeal are exhausted first) because the Tribunal considers not the lawfulness of the original detention but the position of the patient at the date it meets. There is the practical fact that it might be possible to have a Tribunal consider the case more quickly than the High Court, which will have to allow time for the relevant medical evidence to be compiled and for the case to be listed.

19 See Sharpe, *The Law of Habeas Corpus*, 2nd Ed (OUP 1989) pp79–85; it is a jurisdiction clearly accepted in extradition cases

20 [1956] 2 QB 109

21 [2002] QB 1169, [2001] *Mental Health Law Reports* 53

22 s51(5) and (6) provide that if a transfer direction has been made in respect of a remand prisoner, it is impracticable or inappropriate to bring the detainee to court, and there is evidence from 2 doctors that the transferred prisoner is suffering from mental illness or severe mental impairment making detention in hospital for medical treatment appropriate, the court may make

a hospital order without convicting him if it is proper to do so; a restriction order may also be imposed.

23 Judicial review proceedings have to be commenced promptly and in any event within 3 months of the decision challenged: see CPR 54.5. However, the Court may extend the time limit if there is good reason for delay

24 See the note to the report of the case in [2002] *Mental Health Law Reports* 53

25 In other words, the criteria for deprivation of liberty under Art 5(1)(e) of the European Convention as interpreted in *Winterwerp v Netherlands* (1979) 2 EHRR 387, which is reflected in ss3 and 37 of the 1983 Act

In relation to those detained under a s37 hospital order by the Magistrates Court, there is a right of appeal to the Crown Court in the first instance, which has jurisdiction to examine the merits of the making of an order; the ruling of the Crown Court on appeal can be taken to the High Court. In relation to those detained under s37 by the Crown Court following a trial on indictment, the appeal route is to the Court of Appeal rather than by way of judicial review²⁶: the fact that there is a prospect of appeal on the merits supports the contention that the High Court, when it has jurisdiction by way of judicial review, should be willing to examine whether there is proper evidence that a person is of “unsound mind” so as to require detention.

Other Public Law Cases

In addition to the jurisdiction of the High Court in judicial review and habeas corpus cases, mental health practitioners should also be aware of other courts which may take decisions. In particular, the Family Division of the High Court has jurisdiction to make declarations as to the lawfulness or otherwise of treatment plans²⁷. It should also be noted that inquests are potentially of much greater significance in instances where there are deaths arising from inadequate care and treatment. Although the rules relating to inquests do not generally allow findings of neglect²⁸, the obligations which arise under Article 2 of the European Convention to investigate deaths which have occurred when a person is in the custody of the State mean that it is permissible to return a finding of systemic neglect (as opposed to neglect by an individual) when to do so will allow compliance with this procedural duty under Article 2 and reduce the risks of repetition of a death in similar circumstances: *R (Middleton) v HM Coroner*²⁹.

Private Law – Potential Tort Actions and Damages

Mental health law challenges to the lawfulness of a particular decision may also involve challenges framed in private law. The usual remedy available in such circumstances is a claim for damages, although injunctions to prevent or occasionally compel certain steps may be involved. (An injunction can be granted in judicial review proceedings, which can also include a claim for damages. Proceedings may be transferred from the Administrative Court to the Queen’s Bench Division of the High Court once the public law element of the claim has been determined³⁰.)

26 *The High Court’s jurisdiction by way of judicial review is excluded by s29 of the Supreme Court Act 1981*

27 *As a recent example of this, see In re W [2002] Mental Health Law Reports 411, in which it was declared that a psychopathically disordered prisoner was competent to refuse treatment in relation to various self-inflicted wounds which he was trying to make septic as part of a campaign to be transferred from prison to hospital.*

28 *R v HM Coroner for North Humberside and Scunthorpe ex p Jamieson [1995] QB 1*

29 *[2003] QB 581, [2002] Prison Law Reports 100.*

30 *See CPR 54.3(2), which indicates that a claim for judicial review may involve a claim for damages, though not as the only remedy; see also s31(4) of the Supreme Court Act 1981. CPR 54.20 provides that the Administrative Court may direct the transfer of a case. Note, however, that a transfer will not always occur and the judge may make an immediate assessment of any damages.*

1. False Imprisonment

False imprisonment is, in essence, detention without lawful authority. The House of Lords has confirmed that this is a tort of strict liability in the case of *R v Governor of Brockhill Prison ex p Evans (No 2)*³¹. The facts of this case are fairly stark. The prisoner was detained on the basis of an honest sentence calculation which was correct in law until the law was changed in *ex p Evans (No 1)*³², when the cases on which the governor had relied were effectively overruled. Because the legal theory is that the courts determine what the law has always been, in that they do not change the law just from the date of the judgment, the detention became unlawful, albeit retrospectively, and so damages were awarded at a level of £5000 for 59 additional days.

It follows that an action in false imprisonment is a possible consequence of detention in hospital without the cover of lawful authority. In mental health cases, lawful authority is provided by either the Mental Health Act 1983 or common law, so it is necessary to check whether the many requirements of the statute or common law have been complied with. There is scope for argument as to various of the specific requirements, but it should be noted that:

(i) s6 of the Act provides that a “duly completed” application is authority to convey to hospital within a set time and, on admission, is “sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions of this Act”. Clearly, it is important that the application is duly completed, though there is an additional safeguard for hospitals in that s6(3) provides that an application which “appears to be duly made and to be founded on the necessary medical recommendations may be acted upon without further proof of the signature or qualification of the person by whom the application or any such medical recommendation is made or given or of any matter of fact or opinion stated in it”. There may be scope for argument about whether an apparently duly completed form which is not in fact duly completed amounts to detention “in accordance with a procedure prescribed by law” as required by Article 5 of the European Convention³³. The High Court is able to look behind the apparent due completion and grant habeas corpus if the form is inaccurate³⁴.

(ii) An admission order made under the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 provides authority to convey to the hospital designated by the Home Secretary and to detain. (See also the place of safety powers of the Crown Court under Schedule 1 to the 1991 Act.) A failure to designate the appropriate hospital within the time scale set by the Act, namely 2 months, arguably takes away the jurisdiction to detain.

(iii) See also police powers under s135/136 of the 1983 Act, which have various procedural requirements which ought to be construed strictly as the right to liberty is involved.

31 [2001] 2 AC 19

32 [1997] QB 443

33 In *R(A) v Harrow Crown Court* [2003] Mental Health Law Reports 393, the High Court held that a hospital order which was *ultra vires* (and should have been an admission order) was valid until set aside – as an order of a superior court: *R v Cain* [1985] AC 46.

Further, as a substantially fair procedure had been followed before the erroneous order of similar effect was made, there was no breach of Art 5. However, the judge drew a distinction (at para 24) between the case of a court-ordered detention and an administrative act.

34 *Re S-C*

(iv) The common law allows detention in a situation of necessity of a person of unsound mind who is a danger to himself and others; necessity requires a manifest danger to the patient or others: see *Black v Forsey*³⁵.

In addition to the procedural requirements, there is the question of the substantive merits of the detention – ie, is the mental disorder such as to justify detention. The discussion above of the cases of *Rutty* and *Kenneally* applies in relation to the question of damages as well: the public law remedy which may result in an order for the release of the patient can be followed by a private law remedy in the form of damages.

The lawful authority to detain must be continuing. At this point, the issue of the merits becomes more important (though there are procedures to be followed, in particular compliance with s20 of the 1983 Act in relation to compulsory but non-restricted patients). For example, in *R v Riverside Mental Health Trust ex p Huzzey*³⁶, an error made by the managers in considering whether to uphold a barring order made under s25 of the Act following an application to discharge by a nearest relative (in that they considered the s3 test rather than the additional dangerousness criterion in s25) rendered false the detention between that time and the patient's release some 12 weeks later on the direction of a Tribunal, which in turn led a jury to award him £24000 in compensatory damages and £2000 in aggravated damages³⁷.

The issue of the merits of detention is usually dealt with by the Mental Health Review Tribunal, and two issues frequently arise. First: if the Tribunal orders discharge and the patient is soon re-sectioned, is that lawful? As explained above, the answer is basically not unless there has been a change in circumstances³⁸.

The second issue is what happens when a Tribunal orders a deferred discharge but conditions are not met, leading to the continued detention of the patient. As it stands, if the impasse is because a professional judgment stands in the way, there is little that can be done in domestic law to force the discharge through: so, when a community responsible medical officer refused to take a patient, the courts did not intervene³⁹; equally, when a social worker would not approve a hostel, the courts did not intervene with what was held to be a rational judgment⁴⁰. There has been a development in the law in that, in relation to the deferred conditional discharge of a restricted patient, the Tribunal is able to retain supervisory powers over the meeting of conditions and may modify them if it

35 1987 SLT 681. Note also there is a general common law power to detain to prevent a breach of the peace, and a now-statutory power to use reasonable force to prevent crime (s3 Criminal Law Act 1967); and necessity allows emergency medical treatment of incapable patients. The situation of patients covered by the case of *R v Bournewood Community and Mental Health NHS Trust ex p L* [1999] 1 AC 458 should also be considered; the decision of the European Court of Human Rights on this situation is awaited.

36 (1998) 43 BMLR 167

37 see Jones, *Mental Health Act Manual*, 8th Ed, 1–293

38 This change in practice also has implications for the quality of reasons required by a Tribunal because those involved in the fresh process of sectioning the patient may not know what evidence was given to the Tribunal and why it discharged the patient: hence, the previous

view that the reasons of a Tribunal could be limited as they were given to an “informed audience” which know the evidence presented and the arguments made is no longer adequate. See *R (H) v Ashworth Hospital* [2003] 1 WLR 127, [2002] *Mental Health Law Reports* 314.

39 *R (K) v Camden and Islington Health Authority* [2002] QB 198, [2001] *Mental Health Law Reports* 24

40 *R (W) v Doncaster City Council* [2003] EWHC 193 (Admin): the judge granted permission to appeal, and one of the issues raised is whether a breach of the Convention deprives the detention of its lawfulness for the purposes of the tort of false imprisonment and, if so, whether it is the detaining hospital or the after-care authorities who are liable. The appeal is due to be heard in March 2004.

is not possible to persuade those involved to put the conditions into effect, though arguments remain as to whether this amounts to compliance with Article 5(4) of the Convention, the need for a Court to be able to order release if the merits of detention is not made out⁴¹. The European Court has held that the absence of powers to ensure that a deferred conditional discharge is put into effect without unreasonable delay amounts to a breach of the Convention⁴².

The issue of damages in this context is made plain by the fact that Article 5(5) of the Convention requires a right to compensation for those detained in breach of Article 5 of the Convention⁴³.

One final point to mention here is the effect of s139 of the Mental Health Act 1983, which in essence provides a defence for actions purportedly done under the Act in the absence of bad faith or the lack of reasonable care, except in relation to actions against the Secretary of State or a health authority or trust: the fact that this imposes a fault requirement for actions brought by those who are or are alleged to be mentally disordered in what is otherwise a strict liability tort may raise arguments under Article 14 (prohibition on discrimination). Although the more restrictive provisions of the predecessor of s139 was upheld in *Ashingdane v UK*⁴⁴, this was on the basis that there was not an improper breach of the right of access to a Court guaranteed by Article 6 of the Convention and it does not appear to be have been argued that there was a breach of Article 14.

2. Assault

The cases of *Wilkinson* and *N* make it plain that detention under the Mental Health Act 1983 does not necessarily authorise the imposition of such treatment as the Responsible Medical Officer indicates should be administered. There are some statutory procedural hurdles to overcome in certain situations (including use of medication for more than 3 months): see ss56ff of the Act. However, even if the statutory pre-requisites have been met, including approval from the Second Opinion Appointed Doctor, the matter may be litigated if there is a proper argument that the proposed treatment is not authorised by the statute or is not in the best interests of the patient. It has always to be remembered that the fact that there is authority to treat against the wishes of the patient does not mean that it will necessarily follow: see, for example, para 16.11 of the Code of Practice issued under s118 of the 1983 Act.

Typically this sort of dispute will be based on arguments that the patient has been misdiagnosed, or that the nature or degree of the illness does not require a course of treatment as invasive as that proposed. The role of the Court is to ensure that Articles 3 and 8, and perhaps Article 2 in some circumstances, are respected: (i) Article 3 requires that treatment is convincingly shown to be a medical necessity; (ii) Article 8 requires that the treatment be a proportionate response⁴⁵.

The other issue which may arise in relation to treatment is whether a particular treatment is medical treatment for the purposes of the Act: in this regard, it should be noted that “medical treatment” is widely defined in s145 of the Act and that “treatment for mental disorder” can

41 *R (IH) v Home Secretary* [2003] QB 320, [2002] Mental Health Law Reports 87. This decision was upheld by the House of Lords ([2003] UKHL 59), which unfortunately declined to grapple with the important question of whether the community psychiatrist is a public authority and so bound by the Human Rights Act 1998 to act in a way which does not breach Article 5.

42 *Johnson v UK* (1999) 27 EHRR 296

43 This includes the failure to have a speedy review, as required by Article 5(4): see below.

44 (1979) 2 EHRR 387

45 See *Herczegfalvy v Austria* (1993) 15 EHRR 437 as applied in *Wilkinson and N*.

include treatment ancillary to the core treatment or designed to relieve the symptoms of disorder⁴⁶.

These issues can be litigated by way of judicial review or claims for assault and/or breach of the Human Rights Act 1998, all with interim injunctions likely to be sought.

3. Breach of Human Rights Act 1998

The Human Rights Act makes it unlawful for public authorities (a concept which is co-extensive with bodies amenable to judicial review) to breach Convention rights unless required to do so by a primary statutory provision: s6 Human Rights Act 1998. Section 7 of the Act allows action to be taken, and the remedies may include damages if such an award is necessary to afford just satisfaction to the Claimant. The case law in relation to this is currently being developed: as an example, see *R (KB and Others) v Mental Health Review Tribunal and Secretary of State*⁴⁷, in which damages were ordered for the majority of a number of claimants whose rights to a speedy Tribunal decision as guaranteed by Article 5(4) of the Convention had been breached (including some whose detention was upheld). This is a useful adjunct to claims phrased in false imprisonment (and may be the only claim if the courts decide that a detention which is unlawful in Convention terms but otherwise lawful in domestic law does not give rise to a claim in false imprisonment). Claims phrased in assault can also usually be supplemented by a claim for a breach of Articles 3 or 8, and claims for breach of Article 8 may be used in many areas⁴⁸.

4. Negligence and Other Torts

As a matter of presenting the complete picture, it should be noted that the law of professional negligence applies to the relationship between doctor and patient (and other professionals), and if damage is caused by a negligent failure in treatment, damages can be awarded. However, note that there is no duty of care arising directly from s117 of the Act if the doctor-patient relationship had not been formed⁴⁹. It is also possible that other torts will be made out on the particular facts: note, in particular, that torts such as misfeasance in a public office are developing. The mental health sphere is also one which involves information protected by confidentiality, and the Article 8 right to protection of privacy: a failure to maintain confidentiality may be actionable by way of the tort of breach of confidence⁵⁰.

46 See also the relevant case law, particularly *Reid v Secretary of State for Scotland* [1999] 2 AC 512; for example, in *B v Croydon Health Authority* [1995] Fam 133, tube feeding was authorised for someone who suffered from a personality disorder which caused her to self-harm.

47 [2003] *Mental Health Law Reports* 1 (for the argument on liability) and 28 (for the argument as to damages)

48 In *Wainwright v Home Office* [2003] 3 WLR 1137, the House of Lords held that it was not proper to use

the Convention to modify the common law and create a tort of breach of privacy: but it was noted that any gaps in protection offered by existing remedies in areas covered by Art 8 are now met by the claims available under the Human Rights Act 1998.

49 *Clunis v Camden and Islington Health Authority* [1998] QB 978

50 See as an example *Cornelius v De Taranto* [2000] *Mental Health Law Reports* 145 and, on appeal, [2001] *Mental Health Law Reports* 217. See also *Fenella Morris*, *JMHL*, July 2003.

Placed Amongst Strangers – the Tenth Biennial Report (2001–2003) of the Mental Health Act Commission

*Mat Kinton**

The Mental Health Act Commission's Tenth Biennial Report was laid before Parliament and published in December 2003. The report covers two years' activity – financial years 2001 to 2003 – monitoring the operation of the Mental Health Act 1983 as it relates to the detention and treatment of patients. In twenty chapters it deals with a range of issues pertinent to the care of mental health patients subject to compulsory treatment.

I will not attempt here to list systematically the points made by our report. Readers of this journal are likely already to have thumbed a copy of the report itself, or accessed it on the Commission website¹, and, if not, I hope that this article will encourage them to do so. Instead, I will seek to explain in more general terms the context and themes of the report, and what we would wish to see as its desired outcome.

The context of the report

Everybody with a concern in mental health services, particularly in relation to patients who may be compelled to accept treatment, has a general sense of the purpose of the Mental Health Act Commission. The legal remit of the Commission is stated in the Mental Health Act 1983, which requires the body to 'monitor the exercise of the powers and discharge of duties conferred or imposed' by that Act in respect of the detention of patients for psychiatric care and treatment². Mental health professionals who encounter visiting Commissioners will know that such 'monitoring' focuses primarily on meeting in private with such patients, as required by statute, and

* Senior Policy Analyst, Mental Health Act Commission 2 Mental Health Act 1983, s 120(1)

¹ www.mhac.trent.nhs.uk

includes the examination of documents and other evidence of practice in the use of the Act to detain and treat patients, culminating in a report to the hospital managers on the Commission's findings. The Commission's own gloss on this activity is that it is in the business of 'safeguarding the interests of detained patients'³. This is certainly the most apparent use of such a body, and one that can indeed be traced back to Government intentions when the Commission's establishment was suggested in the early 1980s⁴.

There is, however, an obverse aspect to the Commission's role as the defender of detained patients' interests. The Commission forms part of a framework of checks and balances that helps to legitimise what is otherwise a rather extended use of State power: the civil detention of mentally disordered people⁵. It is one of the means by which the State meets its obligation 'to know enough about its patient...to provide effective protection' to that patient⁶ (others are the Code of Practice, which provides guidance on the use of the powers that are monitored by the Commission, and the Mental Health Review Tribunal, whose remit is rather more sharply focussed on the legitimacy of continuing to subject individual patients to the general powers of the Act). Without these elements of patient protection, such healthcare interventions of the State could fail requirements of the European Convention on Human Rights (ECHR).

This Tenth Biennial Report may not be the last ever produced by the Commission in its current establishment – the eventual repeal of the 1983 Act upon which its existence depends is almost certainly too far away to expect a change in monitoring arrangements within the next two years – but it has been written under the assumption that we are upon the brink of potentially radical change in arrangements for monitoring the use of mental health legislation. In particular, Government has announced that it intends, upon the eventual repeal of the 1983 Act, to put such monitoring into the hands of the soon to be established Commission for Healthcare Audit and Inspection (CHAI). The Mental Health Act Commission is sympathetic to the need for such rationalisation of health service bodies, provided that the core statutory function and duties towards patients subject to care under the State's compulsion, including and especially visiting practices, are not lost in such arrangements. The proposals for the next Mental Health Act would create a conceptual shift in the role of the Tribunal, so that instead of functioning simply as an appeal body concerned with review and exit from compulsion, it will provide authority for compulsion. With this aspect of patient protection changed, some equivalent of the Mental Health Act Commission's monitoring function by a suitably independent and properly focussed body may be not only an ethical requirement for protecting vulnerable patients, but also necessary for the legitimacy of civil detention itself.

3 *Mental Health Act Commission, mission statement adopted in 1999. This statement has been criticised by some legal commentators (see, in particular Richard Jones (2003) Mental Health Act Manual, Eighth Edition, London: Sweet & Maxwell, page 467) as insufficiently precise in relation to the Commission's legal remit, but the Commission remains unapologetic in its focus.*

4 *Department of Health and Social Security, Home Office, Welsh Office, Lord Chancellor's Department (1981) Reform of Mental Health Legislation Cmnd 8405. London: HMSO, November 1981, para 34.*

5 *The Commission's remit does, of course, also extend to the use of the 1983 Act in a criminal justice context, whose legitimacy less obviously relies on any system of external safeguards. However, detention under the criminal justice powers of the 1983 Act takes place in hospital rather than prison, and is justified as treatment rather than punishment, so any clear distinction between civil and criminal justice use of the Act's powers is questionable.*

6 *R (on the application of Colonel Munjaz) v Mersey Care NHS Trust & Another; S v Airedale NHS Trust [2003] EWCA Civ 1036 at para 58.*

The core themes of the report: 'Placed amongst strangers'

We have taken as the title of the Tenth Biennial Report the words of John Perceval, who was committed to an asylum in the 1830s, and detained for a period of 18 months. Notwithstanding the emphasis on 'modernisation' in mental health services and developments in psychiatry in the last 170 years, it is remarkable how relevant Perceval's concerns are to detention under current mental health legislation⁷. The following passage from Perceval is an edited version of that which prefaces the report:

Instead of my understanding being addressed... I was... placed amongst strangers, without introduction, explanation or exhortation. Instead of great scrupulousness being observed in depriving me of my liberty or privilege, and of the exercise of so much choice and judgment as might be conceded to me with safety – on the just ground, that for the safety of society my most valuable rights were already taken away – on every occasion ... the assumed premise immediately acted upon was that ... my few remaining privileges to be infringed upon for the convenience of others. Yet I was in a state of mind not likely to acknowledge even the justice of my confinement...and jealous of any further invasion of my natural and social rights; but this was a matter that never entered into their consideration⁸.

In many ways the core themes of the Tenth Biennial Report are encapsulated in that statement. Noting the disempowerment of being forcibly removed into the company of others that is common to all detained psychiatric patients, Perceval complains that he is not involved in any decisions about his care and treatment, and uses the language of rights to set out his objections. However much we may think that healthcare for the mentally disordered has 'moved on' from Perceval's time, his words still describe the task of real 'modernisation' that has yet to be achieved.

The human rights challenge to mental health service provision.

The Commission's Ninth Biennial Report of 2001 was primarily addressed to mental health service providers and sought to contribute to a standards framework for the care and treatment of patients under the Act. We are pleased that many service providers continue to use the recommendations of that report in their own organisational risk assessments. Although about a third of the recommendations of the Tenth Biennial Report are similarly relevant to service providers, the report as a whole seeks to speak directly to Government and two-thirds of its recommendations are directly addressed to the Secretary of State for Health and his department. There are a number of reasons for this shift of emphasis, not least of which is the fact that, although the Commission's Biennial Reports have a wide readership for which they serve a number of purposes, they are in the first instance reports to Government, required by law to be set before Parliament by the Secretary of State⁹, and this report's publication falls within the parliamentary session during which it is likely the Government will introduce the latest draft of the Mental Health Bill.

7 This is not the only example of a historical precedent to contemporary concerns highlighted by the report. The report highlights a Lunacy Commission 'tribunal' hearing of a patient's appeal against detention in 1838 which, over two days and ending on a majority vote, debated and rejected the 'preventive' detention of a patient who, in today's legal terminology, would be classed as having a psychopathic disorder (see MHAC (2003) Tenth Biennial Report, p 83).

8 Perceval J (1840) *A Narrative of the Treatment*

*Experienced by a Gentleman, During a State of Mental Derangement; Designed to Explain the Causes and the Nature of Insanity, and to Expose the Injudicious Conduct Pursued Towards Many Unfortunate Sufferers Under That Calamity. A fuller version of this quotation, taken from Peterson D [ed] (1982) *A Mad People's History of Madness*, University of Pittsburgh 1982 p96-10, is at page 22 of the Commission's Tenth Biennial Report.*

9 Section 121(10) *Mental Health Act 1983*

The Commission takes the view that fostering a truly human rights based culture in the provision of mental health services involving compulsion will require positive action led by Government. The Human Rights Act 1998 has created a duty on all public authorities to operate their powers according to the principles and specific articles of the European Convention of Human Rights (ECHR)¹⁰. As a number of other bodies have already reported, including Parliament's own Joint Committee on Human Rights (which took evidence from the Mental Health Act Commission), insofar as this requires public authorities to be pro-active in their development of services that promote human rights principles, the 1998 Act has only partially been implemented, and, without intervention, the high-water mark of its effect in this respect may have been passed¹¹.

The Commission notes that the thrust of Government policy appears to be that health and social authorities should become more locally accountable, and that this implies a lessening of prescriptive guidance from central government. We agree with the aim of encouraging nursing, psychology and other professional leadership, and the fostering of grassroots pioneers in local services, to revitalise the notion of human rights as positive entitlements that are considered on a day-to-day level in service development. But, particularly in relation to the restriction of fundamental human rights as a health or safety measure on the authority of the State, the Commission views any divestiture of *responsibility* by Government as inappropriate, both in legal terms and in a wider ethical sense. For practitioners to attain the confidence to move beyond a defensive approach to human rights they must have the support of adequate and authoritative guidance on legal and practice issues. The Commission believes it to be the task of Government, in addition to ensuring that the legal framework provides the certainty and transparency required to meet ECHR principles, to provide such guidance.

During the writing of the Commission's report, these issues were tested by the Court of Appeal. The cases of *R (on the application of Colonel Munjaz) v Mersey Care NHS Trust & Another* and *S v Airedale NHS Trust*¹² underlined the State's general responsibility for the treatment of those whom it has deprived of their liberty, as mentioned above. The *Munjaz* judgment was based upon the determination that the State is under a requirement to know enough about those it detains to afford them protection, and that the law allowing such detention must have transparency and predictability in its results, so as to avoid arbitrary use of powers and the disproportionate infringement of human rights. Where the law is insufficiently clear (as in the case of seclusion powers, which are nowhere mentioned explicitly in the 1983 Act), the judgment ruled that guidance such as that provided by the Government in its Code of Practice must be read as providing the necessary clarity for such powers¹³, and that the State, having provided guidance on the use of its powers to persons acting under its authority, must afford that guidance a status consistent with its purpose¹⁴. The immediate effect of this ruling was to raise the legal profile of the Code of Practice, in that practices that are not consistent with its guidance may fail ECHR requirements and be unlawful on such grounds. Practitioners are now required to follow the Code of Practice guidance

10 '... so far as it is possible to do so...' (section 3 Human Rights Act 1998)

11 Joint Committee on Human Rights (2003) *The Case for a Human Rights Commission: Sixth Report of Session 2002–03, Volume 1. HL Paper 67-I, HC 489-I*. London, The Stationery Office, March 2003. Pages 6-7. See also Audit Commission (2003) *Human Rights: improving public service delivery*, London: Audit Commission, October 2003; British

Institute for Human Rights (2002) *Something for Everyone: The impact of the Human Rights Act and the need for a Human Rights Commission*, London: British Institute for Human Rights.

12 [2003] EWCA Civ 1036. The case is reviewed by Anna Harding in this issue of the JMHL.

13 *Munjaz* paras 65, 74

14 *Munjaz*, paras 60, 71–6

unless they have good reasons not to do so based upon the clinical need of the patient concerned¹⁵. In the longer term, the ruling has perhaps set a precedent regarding governmental responsibilities that will be seen as a landmark human rights case.

Creating and maintaining a human rights focus in developing psychiatric services

There remains much to do to bring about a psychiatric service that fully respects human rights values. Patients are still compelled to reside on wards that are acknowledged by those responsible for them to be substandard, frightening and even dangerous. The majority of patients who are compelled to reside on such wards are subject to such compulsion for reasons of their own health or safety. It seems possible that the courts will, at some point, accept a human rights-based challenge to the lawfulness of such a detention on the grounds that the services provided under compulsion have neither addressed nor provided for the health or safety of the patient concerned.

The Commission understands and welcomes the apparent intention of Government to make mental health care 'a little less institutional and a little more diverse' through the provision of smaller inpatient units with closer links to the community¹⁶. It is easy to see how such a service could solve some of the most obvious problems inherent in acute inpatient care as presently organised. There are, however, particular and perhaps obvious risks inherent in having physically decentralised structures of smaller inpatient units operating powers of compulsion on behalf of the State. One such risk is the spreading of available medical and other expertise too thinly, so that no inpatient units could realistically have immediate access to a doctor when emergencies arise. Where patients are detained for their own safety, this may raise a similar ethical and potential legal dilemma to that faced by mental health professionals whose admission wards fall below acceptable standards under the current system. Under the proposals for future legislation, the increased demands on medical staff posed by the Tribunal system may exacerbate these difficulties at a time when 'legalism' and 'clinicalism' are likely to come increasingly into conflict.

A less obvious risk of decentralised structures, and indeed the potential converse of positive attempts to make the provision of mental health services 'patient-centred', is what a "less institutional" framework could mean for the practice of compulsion. The danger of emphasising the need for less formal structures of care is that these may disguise or detract from underlying realities of coercion. Throughout its existence, the Commission has expressed its concern over patients who, under current mental health legislation, are "*de facto*" detained in hospitals with none of the protections of the law, including Commission oversight and monitoring. We have similar concerns that, under envisaged structures of mental health care, and in the absence of sufficient central guidance and monitoring, laudable aims of less formality with greater immediacy of response and availability of appropriate care could lead, in practice, to the casual and unregulated application of powers of coercion. We believe that this would increase the dangers to patients, not only of arbitrary and unfair interference with their rights, but of dangerous or potentially abusive practice¹⁷.

15 In a departmental briefing post-Munjaz, the Department of Health stated "Although the declaration ... was limited to those parts of the Code that covered seclusion, the Department takes the view that the Court's analysis of the legal status of the Code is applicable to all aspects of it." Also see MHAC Guidance Note 1/04 'The status of the Code of Practice following the Munjaz judgment' available from the Commission and its web-site.

16 Professor Louis Appleby (National Director for Mental Health) giving evidence to the David Bennett inquiry [2003]. Inquiry transcript II.6-650.

17 The position of prisoners under present legislation is a telling example of the dangers of a 'casual' approach to compulsion. See Kinton, M (2002) Should we allow compulsory mental health treatment in prisons? in *Journal of Mental Health Law*, No 8, December 2002. University of Northumbria: Northumbria Law Press

A human rights culture in the coercion of psychiatric patients

The Commission acknowledges that a culture of human rights cannot be imposed upon services from above, but that Government nevertheless has an essential role in establishing the boundaries within which services work. By establishing such ground-rules, and by doing so with a particular regard to human rights issues, Government can at least partially fulfil its obligation to ensure that powers used in its name are implemented in accordance with principles of the European Convention.

Clearly, one consequence of this argument is the Commission's view that the next Mental Health Act needs to be clearer in its aims and thresholds for compulsion than was evident from the draft Bill published in 2002. The Commission argues for the next draft of future mental health law to express principles of use explicitly on the face of primary legislation. We continue to press for more clarity about specific powers and duties provided by the law. We would like, for example, to see statutory regulation of complex areas of patient management (including seclusion and restraint). We call for the judiciary's recent reading of the status of a Mental Health Act Code of Practice¹⁸ to be protected through primary legislation.

The Commission's report centres, of course, on our findings in relation to the exercise of the current law. Trends of use in the Act over the last twenty years are examined, and areas of current law are identified as insufficiently clear, requiring action or guidance from Government. We note for example that the use of section 3 has increased rapidly over the last ten years at the 'expense' of section 2, and that there appears to have been a rise in the use of emergency admissions during the last four years, following a long period in which the use of section 4 fell steadily. We also note the rise in second opinions to some 9,000 per annum, of which 3% (five patients per week) result in a significant change to the care plan under consideration.

We particularly call upon Government to address outstanding incompatibilities that have been declared between the Mental Health Act 1983 and the Human Rights Act 1998, and not to leave these to the uncertainties of a future legislative programme. We applaud Government initiatives in addressing inequalities in service provision to Black and minority ethnic patients, women and children, but urge continued effort in respect of these and other specific groups of patients who are additionally vulnerable in psychiatric services. We urge Government to allow flexibility in the implementation of its current and future Security Directions in relation to high secure care, and suggest that, in not doing so at present, Government is at risk of legal challenge based upon clear precedents in case law¹⁹.

¹⁸ see *Munjaz*

¹⁹ *In part, such a reading of case law is suggested by the Munjaz judgment's finding that Ashworth Hospital's seclusion policy was unlawful in its blanket departures from the Code of Practice irrespective of individual patient circumstances. In R (on the applications of 'P' and 'Q' and QB) v Secretary of State for the Home Department and another [2001] EWCA Civ 1151, the*

Court of Appeal required 'blanket' policies on matters that engage human rights issues to be flexible enough, through allowing exceptions to general rules, so as to ensure proportionality and compliance with ECHR requirements. See also Audit Commission (2003) Human Rights: improving public service delivery, London: Audit Commission, October 2003, p16.

Psychiatric services and the 'choice' agenda of Government reform

The current emphasis by Government on patient choice and participation in care has inherent dangers for those patients who are subject to compulsory care and treatment under mental health legislation. Patients who are denied choice in whether to engage with services – or when to disengage with them – are disadvantaged as 'consumers' of health care in any system where there is a contest for restricted resources. It is arguable that such disadvantages are already evident in mental health services' 'Cinderella' reputation, and by the historic under-funding of some acute psychiatric inpatient wards, where a high percentage of patients are detained under the Mental Health Act 1983. Government has, however, given a commitment to improve the patient environment on these acute wards, and shows a willingness to intervene in promoting better standards of care and treatment.

The potential disadvantages to psychiatric patients of the choice agenda may therefore be avoided with the correct safeguards and checks appropriate to public services. Furthermore, a renewed emphasis on patient choice and involvement in decision-making could provide the impetus for the cultural change required in the treatment of psychiatric patients that I touched upon above when discussing the core themes of the report and its title, *Placed amongst strangers*. Real choice for patients, whether they are detained or not, must be based upon their genuine involvement in drawing up their care plans and in making decision about their treatment options. Even within a context of compulsion, and even with patients whose mental capacity to make decisions is impeded by their illness, there is usually some scope for patients to exercise preferences if they are provided with appropriate opportunity and information.

We devote a chapter of the Tenth Biennial Report to outlining the concept of values-based practice as a means by which patients can be involved in treatment planning even within the context of compulsion²⁰. We are pleased that values-based practice has the support of Government and is being promoted by the National Institute for Mental Health in England (NIMHE). This should build upon existing policy structures: patient-involvement in care planning is, of course, already a key expectation of the Care Programme Approach (CPA), which was established over a decade ago and updated in 2000²¹. But despite many examples of good practice, CPA has still not yet been adopted properly and effectively across all mental health services. Commissioners too often report that they meet with detained patients who appear to have had little involvement in, and have scant understanding of, the details of their care plan, and certainly have not been provided with a written copy of it.

The choice agenda should also fuel ongoing work aimed at providing appropriate and responsive services that are culturally competent, sensitive to diversity of personal need and capable of providing effective treatment. No values-based practice can be indifferent to diversity issues, and the Commission is proud of its role bringing these into the foreground in mental health services policy²².

20 See Mental Health Act Commission (2003) *Tenth Biennial Report*, Chapter 5

21 Department of Health (2000) *Effective Care Co-ordination: Modernising the Care Programme Approach*. London, Stationery Office.

22 see NIMHE (2003) *Engaging and Changing: Developing effective policy for the care and treatment of Black and minority ethnic detained patients*. Centre for

Ethnicity & Health, University of Central Lancashire; Mental Health Act Commission; NIMHE. London: Department of Health. This report flowed from the MHAC second 'national visit' of 1999. At the time of writing, consultation is underway on Government proposals in Department of Health (2003) *Delivering Race Equality: A Framework for Action*. Mental Health Services Consultation Document. London: Department of Health, October 2003.

In promoting patient involvement in care planning, Government (and the Commission or its successor body) will have the law on its side. The courts' reading of existing statutory powers of compulsion in mental health care in the light of ECHR principles has strengthened the legal necessity of taking patient's views into account in decision-making²³. The added legal weight given to the Code of Practice's guidance by the judgment in *Munjaz* reinforces the need of practitioners to have a proper regard to patients' views and mental capacity when providing treatment and care under the 1983 Act, and to keep appropriate records of determinations of a patient's mental capacity and discussions regarding consent to treatment in the patient's notes²⁴. In September 2003, just as our report went to press, the judgment in the case of *R (on the application of PS) v Dr. G and Dr. W* determined that even where statutory powers provided by the 1983 Act allow for the imposition of care and treatment against a patient's capacitated refusal, such imposition must be necessary according to the common-law tests of whether it is in the best interests of the patient if it is not to infringe human rights established under the European Convention²⁵. To demonstrate the necessity of their actions, professionals must take into account and give proper weight to the patient's views on treatment, defined to encompass nursing care and rehabilitation under medical supervision²⁶, including any alternatives to proposed interventions. Decisions taken by professionals will have to be increasingly sensitive to patients' views, and to patients' mental capacity when stating such views²⁷.

Such legal changes alone may provide a lever for changes in practice, if only through the adoption of minimum standards of consultation and recording as a form of defensive medico-legal practice. However, if services are encouraged to look beyond such a reactive approach, there are much broader opportunities for the establishment of a truly human rights based mental health service in the dying days of the 1983 Act.

23 e.g. *R (on the application of PS) v Dr. G and Dr. W* [2003] EWHC 2335 (Admin).

24 See *Mental Health Act Code of Practice*, Chapters 15 and 16.

25 See footnote 23 above. Also see (1) a review of the case by Peter Bartlett in this issue of the *JMHL*, and (2) MHAC Guidance Note 2/04 'Guidance for RMOs on PS' available from the Commission and its website.

26 see *Mental Health Act 1983*, section 145

27 The Commission does not, however, argue that capacitated refusals of consent should necessarily override future powers of compulsion. Chapter 4 of our report suggests that further thinking and agreement is needed over the different ways of understanding capacity in particular contexts and for particular purposes before mental incapacity should play a role different to that under the current *Mental Health Act* and its *Code of Practice*.

Casenotes

Capacity, Treatment and Human Rights

*Peter Bartlett**

**R (on the application of PS) v. G (RMO) and W (SOAD) [2003] EWHC 2335 (Admin).
Administrative Court (10th October 2003) Mr. Justice Silber.**

This is the most recent in a series of cases regarding the scope of the Human Rights Act and compulsory treatment under the Mental Health Act 1983. In particular, this case concerns the right of a competent patient detained under section 37 of the Mental Health Act 1983 (MHA) to refuse anti-psychotic medication, and the scope of articles 3, 8 and 14 of the ECHR.

The Facts

The applicant, PS, was detained under section 37 of the MHA in 1995, following conviction of manslaughter on the grounds of diminished responsibility. It would appear that the homicide occurred during a psychotic episode. He was conditionally discharged in April 1998, and re-admitted in December 1999. He was again conditionally discharged in January 2002, but recalled the following month. Both the readmissions were occasioned by apparent psychotic episodes. All of these psychotic episodes abated without resort to medication. With the consent of PS, Quetiapine, an anti-psychotic medication, was administered from September to November 2002. In the view of the then RMO, G, this trial was a success, and faced with PS's competent refusal to consent to further administration of the drug, he pursued the processes for compulsory treatment under the MHA. W, a SOAD, provided the required second opinion, but before treatment could recommence, PS obtained an injunction precluding treatment until his rights under the Human Rights Act 1998 could be determined.

Behind this legal question lay a factual question of diagnosis. PS had been given a variety of diagnoses during his time in the psychiatric system. Schizophrenia was first suggested in 2001, but by the time of the court application, it had become the consensus view of the treating physicians. PS's expert, however, instead diagnosed schizophreniform disorder, a condition with substantially similar symptoms to schizophrenia, but where the duration of the symptoms was instead less than six months. It was argued for PS that if the psychotic episodes he experienced were viewed discretely, schizophreniform disorder was a credible diagnosis. If they were instead viewed as

* Senior Lecturer, School of Law, University of Nottingham; Co-author 'Mental Health Law Policy and Practice', Oxford Publishing Press (2nd edition, 2003).

manifestations of an ongoing disorder, schizophrenia was more likely. The distinction in diagnosis was important, as the manifestations of schizophreniform disorder would be likely to abate of their own accord, while schizophrenia was appropriately treated with medication such as that proposed in this case.

The Decision

The Factual Question of Diagnosis

Following the procedure established in *R (Wilkinson) v. RMO Broadmoor and MHAC SOAD*¹, Silber J heard oral evidence on the question of diagnosis. In considering that evidence, he made it clear that he was guided by the decision in *R (N) v. Dr M*², that the role of the court remained essentially one of review [para 5, quoting *N* at para 39], and that the court should ‘pay a very particular regard to the views held by those specifically charged with a patient’s care’ [para 82, quoting *N* at para 39].

Consistent with this orientation, the factual question of the appropriate diagnosis was determined primarily by findings of credibility of the various witnesses. The treatment team and those doctors who testified in their support were found to be credible, while the views of the patient’s expert were given less weight. The only other factor considered by the Court in its determination of diagnosis was the most recent review tribunal decision, which had, consistent with the treatment team, held that PS would not improve without medication. The Court also accepted this view, and held that the appropriate diagnosis was schizophrenia.

Article 3: The Right to be Free from Inhuman or Degrading Treatment

The Court applied a two-pronged test to determine an article 3 violation:

[W]here medical treatment is administered on a patient against his or her will, Article 3 will only be contravened if:–

- the proposed treatment on the patient reaches the minimum level of severity of ill-treatment, taking into account all the circumstances, including the positive and adverse mental and physical consequences of the treatment, the nature and context of the treatment, the manner and method of its execution, its duration and if relevant, the sex, age and health of the patient (“the Minimum Level of Severity Sub-Issue”) and
- the medical or therapeutic necessity for the treatment has not been convincingly shown to exist (“the Convincing Medical or Therapeutic Evidence Sub-Issue”).’ [para 107]

The standard of proof to be met was the criminal standard of beyond reasonable doubt. [para 106]

The Court held that neither aspect of the test had been met. Regarding the first branch of the test, the Court noted that the medication proposed had already been used for a three-month trial period on PS, without any suggestion that the result met the minimum level of severity to engage Article 3. That medication had been given with PS’s consent, and the withdrawal of that consent was relevant to but not determinative of the determination of the severity issue. The primary adverse effects of the proposed medication, tiredness and weight gain, could be easily controlled. While adverse effects would be more extensive if the medication were administered by depot medication rather than by mouth, the indications were that if the non-voluntary administration

1 [2001] EWCA Civ 1545

2 [2002] EWCA Civ 1789

were authorised by the Court, PS would in fact consent to the oral administration.

PS also relied on the judgment of Simon Brown LJ in *Wilkinson*, which on his counsel's reading appeared sceptical of the consistency of overriding competent treatment refusals with article 3. Silber J instead held that those remarks were confined to their facts, rather than purporting to impose a uniform prohibition on mandatory psychiatric treatment of competent and refusing patients. He instead preferred the approach of Hale LJ (as she then was) in *Wilkinson* to the effect that precluding treatment without consent of persons with capacity would have the undesirable result of driving up the standard of capacity, and that the preferred approach was to maintain a lower standard of capacity but to allow occasional treatment of those with capacity. Hale LJ did not say what threshold would be required to treat a competent patient without consent, but did hold that a requirement that the treatment be necessary to protect the patient or others was more stringent than necessary.

On this basis, the treatment was not sufficiently invasive to meet the minimum level of severity to engage article 3.

Further, PS had failed to demonstrate that the proposed treatment failed to meet the convincing medical or therapeutic evidence threshold. The Court considered two approaches to this question, without expressing a preference between them. In one, the question of therapeutic threshold was considered as a single 'simple' question: had the proposed treatment been convincingly shown to be necessary? In the other, regard would be had to seven more specific questions:

- (a) how certain is it that the patient does suffer from a treatable mental disorder;
- (b) how serious a disorder is it;
- (c) how serious a risk is presented to others;
- (d) how likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition;
- (e) how much alleviation is there likely to be;
- (f) how likely is it that the treatment would have adverse consequences to the patient;
- (g) how severe may these adverse consequences be? [para 121]

A disagreement in medical opinion as to the necessity of treatment was relevant, but not determinative of the question of best interests or medical necessity. Relying on Hale LJ's decision in *Wilkinson*, Silber J held that it was not necessary to show dangerousness to self or others in order to override the views of a competent and refusing patient, although such refusal was an important factor to be considered.

On the facts as the Court found them, it was clear that PS was suffering from schizophrenia, a treatable mental disorder. While this disorder would not put others at risk while PS was in the medium secure unit, if relapse occurred in the community 'the risk of injury might well be great but nobody can be sure about it'. [125] When under stress, he behaved 'bizarrely and unpredictably, thereby making him a potentially dangerous individual to himself and to others, particularly to those known to him'. [125] On the questions relating to alleviation, the Court held that Quetiapine was an appropriate treatment for schizophrenia. On the evidence of the treating physicians, there was a 'good chance' that the medication would prevent relapse or deterioration in PS's condition. [126] It would also contribute to the suppression of PS's residual persecutory

ideas, making him more accessible to therapy and thus potentially more insightful into his condition. As to adverse consequences, the treatment might be expected to cause weight loss and drowsiness, the latter reducing over time. If administered by injection, there would also be risks of sedation and neurological effects, but some of these could be controlled by additional medication, and in any event, PS would likely choose to take the medication orally rather than by injection, if the treatment were ordered by the Court.

Whether the matter were considered according to the seven sub-issues above, or as one single question, the proposed treatment met the therapeutic necessity threshold. PS's claim therefore failed on this issue as well.

Article 8: The Right to Private Life

As with article 3, there was a level of severity which treatment must attain to engage article 8. This level of severity was not as high as under article 3, and would often be reached when a competent patient was treated without consent. The Court assumed without deciding that this threshold had been met in this case.

Such intrusions would nonetheless be justified under article 8(2) if 'necessary in a democratic society ... for the protection of health' and 'in accordance with law'. Such interventions would be considered necessary, if they corresponded to a pressing social need, if they were proportionate to the legitimate aim pursued, and if the reasons presented by the national government were relevant and sufficient. In this case, the proposed medication would be likely to lead to the rehabilitation and release of PS, rather than his continued incarceration. It would improve his mental health, and protect against relapse. It was therefore necessary within the terms of article 8(2).

Silber J also held that the treatment was in accordance with law, as it complied with the test of best interests laid down in cases such as *Re F (Mental Patient: Sterilisation)*³, and *Re S (Adult Patient's Best Interests)*⁴. This was determined by a two stage process: was the proposed treatment consistent with a reasonably competent body of medical opinion; and was it the best option available? The proposed treatment in PS's case clearly met the first criterion. The second criterion was to be determined by consideration of the efficacy of the proposed treatment, the availability of alternative treatments, and the necessity of the treatment's administration. In this case, the treatment was likely to alleviate PS's condition, and there was further no less invasive form of treatment that could be given. The matter of necessity in this best interests context was to be considered according to the following factors: (a) the patient's resistance to treatment; (b) the degree to which the treatment would alleviate or prevent a deterioration of the patient's condition; (c) the risk the patient presents to himself; (d) the risk he presents to others; (e) the consequences if treatment were not given; and (f) any adverse effects of the treatment. In this case, if the treatment were authorised by the Court PS would likely consent to its administration other than by depot, and the treatment would alleviate his condition. He further presented a risk to himself and others if in the community, under stress, and untreated. If untreated, he would be unlikely to be discharged, and if discharged, would be unable to cope in the community. The adverse effects of the medication would be minimal. [145]

The proposed treatment met the test of proportionality: it had considerable benefits, with minimal adverse consequences.

The proposed treatment was therefore not in violation of article 8.

3 [1990] 2 AC 1

4 [2000] 2 FLR 389

The Article 14 Issue: Freedom from discriminatory application of Convention rights

The question of discrimination was considered according to the following four questions, drawn from *Wandsworth LBC v Michalak*⁵:

- (a) Do the facts fall within the ambit of one or more of the substantive Convention provisions?
- (b) If so, was there different treatment as respects that right between the complainant and other persons put forward for comparison (the 'chosen comparatives')?
- (c) Were the chosen comparatives in an analogous situation to the complainant's situation?
- (d) If so, did the difference in treatment have an objective and reasonable justification? Did it pursue a legitimate aim and did the differential treatment bear a reasonable relationship of proportionality to the aim sought to be achieved?

The comparative chosen by PS in this case was drawn from the case of *Re W*⁶, a case involving a prisoner with a mental disorder who was not within the scope of the Mental Health Act as his psychopathy was held to be non-treatable. It was held in that case that he could refuse treatment to wounds caused by self-harm, even though his decisions were considered irrational or indeed manipulative, as it was thought that he was using these refusals in an attempt to force his transfer to a hospital.

Silber J held that the comparative was not in an analogous situation to PS. Unlike PS, W was not treatable, and therefore outside the remit of the Mental Health Act. The fact that PS could be treated for his condition, but W could not be, justified a totally different approach to the issue of administering treatment. The requirements of (c) and (d) above were not met, therefore.

Conclusion

As a result, the proposed treatment of PS would not violate his Convention rights.

Discussion

The Findings of Fact

The approach of Silber J to the findings of fact in this case reflect tensions in prior case law both in the application of the Human Rights Act to compulsory treatment, and in medical law more generally.

The underlying position of Silber J is that while the court in this case had to determine for itself the disputed facts, 'it must not be overlooked that the court's role is essentially one of review' [5]. On this point, His Lordship relies on *R (N) v. Dr M*, which in turn purports to rely on *Wilkinson*.

In *Wilkinson*, the Court of Appeal was impressed by the argument that a claim regarding unjustified treatment could be brought by way of judicial review or battery. If the case were brought through standard civil law channels, a full assessment of the evidence would be necessary. The Court held that when rights under the Human Rights Act were at issue, the form of the action ought not be relevant to the level of judicial scrutiny of facts. [*Wilkinson* at 24, 51, 62] Where as here there is no prior judicial forum that considers the matter, Simon Brown J expressly found that the failure of the court to reach its own, independent view of disputed factual questions would constitute a breach of article 6 of the Convention [at 35].

5 [2003] 1 WLR 617

6 [2002] MHLR 411

R (N) does not exactly dissent from those views, but after reciting them it does add a paragraph stating that ‘*Wilkinson* should not be regarded as a charter for routine applications to the court for oral evidence in human rights cases generally’ and, in the passage cited by Silber J, that the court’s role is essentially one of review. [39] The two aspects of these comments are not the same, and it is not clear how they are meant to be read within the context of *Wilkinson*. Insofar as the point is that there will be many cases where relevant facts will not be disputed, and thus where resort to cross-examination will not be necessary, it is unobjectionable. Rights under the Human Rights Act regarding enforced treatment are further unusual in a mental health context, as (unlike, for example, psychiatric confinement) there is no tribunal review or other judicial process prior proceedings before the Administrative Court. Insofar as the point of the comments is that cross-examination on judicial review should not be viewed as *carte blanche* for a second kick at the factual cat after an oral hearing elsewhere, it is also reasonable enough. Insofar however as the comments suggest a different standard of scrutiny as regards disputed facts that have not been judicially determined elsewhere, it is difficult to see that they are consistent with *Wilkinson*.

This set of issues is relevant in *PS* because of the court’s approach to the finding of facts. Certainly, the Court allowed oral evidence based on the affidavits of the medical experts; indeed, almost half of the judgment is devoted to recitations of the factual evidence. The Court’s articulation of the findings of fact, however, resemble traditional judicial review, rather than the substantive assessment required by *Wilkinson*: they are based on findings of witness credibility, rather than engagement with the substantive content of the witnesses’ testimony. [81–95] A variety of criticisms might fairly be levelled at this approach.

The Court identifies deference to the views of the treating physicians as its starting point. [82, 84] In this, the Court is following the approach of R (N): ‘Courts are likely to pay very particular regard to the views held by those specifically charged with the patient’s care.’ [38] In human rights terms, this is at best a peculiar starting point. It suggests that the factual basis of whether a basic human right has been violated will be determined by privileging the views of the alleged violator of the right. This cannot be a general principle of human rights law: we would not similarly defer to the views of alleged torturers in determining an article 3 violation. Can treating physicians be meaningfully distinguished from other alleged violators of rights, such as would warrant the deference proposed by the courts? Certainly, we may reasonably hope and expect that physicians are motivated by benevolence, but good faith does not guarantee compliance with the Human Rights Act. Few if any treating physicians, one hopes, are intentionally dishonest in their court testimony. The same must however apply to other witnesses, and the patient’s expert witness in particular. If the integrity attaching to respected professionals is the justification for deference, it should equally apply to expert witnesses testifying on behalf of the patient.

The RMO may have the benefit of an ongoing role regarding the patient, and this is identified as relevant to the respect accorded to his or her testimony both in *PS* [84] and in R (N) [38]. It will not always be the case that such an ongoing relationship exists, however. Particularly when an individual is civilly admitted under Part II of the MHA, periods spent in hospital may be short, and patient-doctor relationships transient. There may also be implicit in the court’s reasoning a romanticisation of the relationship between patient and doctor. Gone are the days, if they ever existed, of low patient-doctor ratios and frequent and extensive patient-doctor consultations. Determination of credibility by judicial fact-finders should not be naïve on these points.

It is perhaps in any event unfortunate to base the deference to the views of treating physicians on the relationship between patient and doctor, since the fact that the matter has ended up in court suggests that this relationship has broken down. In this context, deference to the views of the treating physicians places the patient at a considerable disadvantage. To be realistic, his or her medical expert will generally be funded through the legal aid scheme, and will therefore have become acquainted with the patient's situation only recently. Indeed, the evidence of the patients' experts in both *PS* [88] and *R (N)* [38] was criticised on precisely that basis. It is however difficult to see that the patient can acquire expert evidence other than on this basis. Deference to the evidence of treating physicians makes it almost impossible for the patient to challenge the factual context presented by those physicians. The treating physicians are not necessarily emotionally detached professionals in these situations. These are human rights claims, in which the treating physicians are respondent parties. It is difficult to see that approaching factual assessments as a matter of judicial review, with deference to the initial fact-finder and evidential practices that marginalise the evidence offered on behalf of the patient offers a level playing field.

The focus of the Court on the credibility of the various witnesses means that the Court does not engage with the factual situation it is asked to decide. Credibility may be understood in various ways. Certainly, there was no suggestion by anyone in the case that the medical witnesses were acting dishonestly or in bad faith. There was further no suggestion that they had been remiss in their recording of facts in the patient record; indeed, *PS* relied on aspects of that record to make his case. In these senses, the treating physicians and those testifying on their behalf were agreed to be credible. Such credibility does not necessarily imply agreement with their conclusions, however.

PS made quite specific factual submissions. It was clear that *PS* had suffered from psychotic symptoms in 1995 and 2002. A further apparent episode in 1999 was more difficult to analyse. It occurred in December 1999. *PS*, who had become a fundamentalist Christian, believed that the end of the world would occur at the end of that month, and that there would be major disasters caused by computer failure at that time as well. Counsel for *PS* submitted that these were consistent with fears of many non-psychotic people as 1 January 2000 approached. He further submitted that the 1995 episode had been caused by an adverse reaction to Paroxetine, an anti-depressant medication that had been prescribed for *PS*. All the episodes in question resolved themselves without medication. In the submission of *PS*'s counsel, *PS* suffered from an episodic disorder that could be triggered by stress.

The recitation of the facts in the judgment discloses much in the clinical records compiled by the treating physicians to support this view. A few examples will give a flavour of the ambiguities. The treating physician, *B*, in whom the Court placed such high regard, acknowledged in a report to the MHRT in 1999 that the 1995 psychotic symptoms were consistent with an adverse effect of Paroxetine. [36] For considerable periods of *PS*'s incarceration, the medical record notes that there was no evidence of mental disorder. While the file notes evidence of 'unreliability' – specifically an allegation that he was not truthful with *B* regarding his relationship with a parishioner in his church – there is no evidence of psychosis identified in the factual summary of the case notes from 1995 to 1999. The concern at that time instead appears to have been a concern that *PS* had a 'fragile personality' which might in conditions of stress result in a relapse of a depressive disorder, and a lack of insight of *PS* into his condition. At Christmas, 1999, Dr Boyd, another of the doctors whose evidence was given considerable respect by the Court, diagnosed 'underlying schizophreniform illness', [41] the diagnosis later provided by *PS*'s expert and rejected by the Court. The diagnosis of

schizophrenia was not made until 2001, and then not by Dr Boyd, but by another consultant. Until speaking with that consultant at that time, she had been expecting to support PS's application for a conditional discharge. After speaking with the consultant, she favoured continued detention and treatment instead. The nature of that conversation, and the specific reasons for her change of view, are never made clear in the factual findings.

By the time of the court hearing, all of these doctors had moved to a diagnosis of schizophrenia. This case note obviously cannot assess credibility of the evidence: the writer was not present at the hearing. At the same time, given the changes and development in the views of the witnesses to whom the court accords credibility, determination of the factual issues by stating that those witnesses are credible is not convincing. They would presumably also have been credible when they held their previous views. Had PS ended up in his expert witness's hospital, would the court have found that expert's testimony more credible? The specific questions and issues raised by PS remain largely unanswered. Their answer lies in the court engaging with the facts as they appear in the medical record and the testimony, not in blanket findings of witness credibility.

The Article 3 Issue

Neither English nor Convention jurisprudence is in a settled state on the question of the rights of competent patients who refuse psychiatric treatment. The Convention was concluded in 1950, and came into effect three years later. There can be little doubt that that the rights of psychiatric patients were not at the forefront of the minds of its drafters. Indeed, the lumping together in article 5 of 'persons of unsound mind' with 'alcoholics', 'drug addicts' and 'vagrants' serves as a salient reminder how attitudes to persons with psychiatric conditions have changed in the last half century. It was more than a quarter of a century before the first case concerning mental disability reached the Strasbourg court. From the mid-1990s there has been a considerable increase in the Court's caseload relating to mental disorder, but its jurisprudence remains in its relative infancy.

The Strasbourg court has never squarely addressed the scope of the phrase 'inhuman or degrading treatment' regarding the enforced psychiatric treatment of competent patients who refuse that treatment. There is a brief decision of the European Commission of Human Rights, from the days in which that body vetted cases prior to a hearing of the full court, in which the question was raised and dismissed summarily: *Grare v France*⁷. In that case, the treatment resulted in nervous shakes, blurred vision and attention deficit, but in the view of the Commission nonetheless did not reach the standard of gravity which would trigger article 3. The persuasive effect of this case is somewhat limited: it is more than a decade old; it is not a decision of the Court; and there is no significant analysis. The views of the Strasbourg court are thus a matter of speculation, based on analogy from cases where the psychiatric patient lacked consent capacity (eg., *Herczegfalvy v Austria*⁸) or cases where allegedly inhuman or degrading treatment occurred outside a psychiatric context.

Silber J applies a number of these cases to arrive at his two-pronged test for an article 3 violation, that the allegedly offensive treatment must reach a minimum level of severity and that there must be no convincing medical necessity for the treatment. While the factors cited by His Lordship including medical necessity will no doubt be relevant to the determination of whether a treatment violates article 3, the placement of medical necessity as a separate branch to assess an article 3 violation is inconsistent with the Convention jurisprudence. As noted by Silber J, the severity test

7 (1993) 15 EHRR CD 100

8 (1992) 50 EHRR 437

already includes a variety of contextual factors, such as duration of the alleged violative action, its physical or mental effects, and the age, health and sex of the alleged victim. This is how it is determined whether acts are 'inhuman' or 'degrading': see, eg., *Keenan v UK*⁹. *Keenan* notes that the severity test is determined according to all the facts of a case, and there is no reason that medical circumstances cannot be considered as part of this package. The placement of medical necessity as a second hurdle is however inconsistent with Convention jurisprudence, as it suggests that there is a defence available to the state when actions meet a level of severity to engage article 3. This is not the case: the jurisprudence is clear that article 3 admits of no derogation: see, eg., *Aksoy v Turkey*¹⁰. Silber J himself considers such a unified approach briefly at paragraph 130, holding that applying such an approach would still not result in a finding of an article 3 violation in this case. That is the stronger line of reasoning.

The Court's view on medical necessity appears to flow from a comment in *Herczegfalvy*, the interpretation of which is relevant both to whether medical necessity is a separate branch in the determination of article 3 violations, and to the question of whether enforced psychiatric treatment of competent patients violates a unified threshold of severity test:

'The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognisable rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit no derogation.'

The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a method which is a therapeutic necessity cannot be regarded as inhuman or degrading.' [*Herczegfalvy* at 82, quoted in *PS* at 98]

At paragraph 99, Silber J appears to raise the second paragraph of this quote to a general principle regarding psychiatric treatment and article 3, re-quoting the sentence but deleting the phrase 'in such cases'. Even if Silber J is right to raise this to a general principle about psychiatric treatment, it does not suggest the need to establish it as a second and separate hurdle to the severity test. It merely suggests, as discussed above, that medical circumstances form a part of the determination of severity.

More difficult is whether the sentence can be raised to a general principle, as Silber J would seem to suggest. The question turns on the interpretation of the phrase 'in such cases'. The first sentence in the first paragraph of the above quotation would appear to refer to people confined in psychiatric facilities generally. If that is the reference, the Court's view is plausible. The second sentence refers to 'those who are entirely incapable of deciding for themselves'. If that is what is meant by 'such cases', the reference is to individuals lacking capacity, and raising the second paragraph to a general principle so as to include patients with capacity begs precisely the question raised in the *PS* case.

Further guidance on the interpretation of the Convention article may perhaps be gained from the 2000 summary report of the Committee for the Prevention of Torture and Inhuman or Degrading

9 (2001) 30 EHRR 38

10 (1996) 23 EHRR 553 at para. 62

Treatment or Punishment (CPT), in a passage cited by Simon Brown LJ in *Wilkinson* but not referred to by Silber J in *PS*:

‘Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.’¹¹

This passage stops just short of saying that the overriding of a competent refusal of consent can never be justified. It would however appear to require ‘clearly and strictly defined exceptional circumstances’ for such an override, suggesting a level of specificity not obviously contained in either the relevant sections of the Mental Health Act or in the facts and reasoning of the *PS* case.

At the same time, the administrative context of the above passage must be acknowledged. The CPT is given the authority under a the Council of Europe treaty to conduct site visits to prevent article 3 violations, but it is not the European Court of Human Rights. How far the Court will adopt the CPT’s approach on this question as yet remains a matter of conjecture. Certainly, the Court is hesitant to allow the imposition of force on those in institutions:

‘In any event, the Court reiterates that, in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3.’ [Selmouni v France¹²]

This approach is most obvious in cases involving alleged violence or punishment of those in institutions. It is less obvious how the Court would apply it in a case of treatment refusal. Indeed, a separate line of comments makes it clear that in order to violate article 3, the force must go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment. [*Kudla v Poland* (2000)¹³] That in turn raises the obvious and unanswered question of whether enforced psychiatric treatment of competent patients is ‘legitimate’.

English law is similarly uncertain in its reading of article 3 rights in a psychiatric context. *PS* is the first case squarely to raise the question in the context of a competent and refusing patient. As the judgment of Silber J suggests, the most important precedent is *Wilkinson*, and His Lordship’s reading of the decision of Hale LJ (as she then was) in that case is uncontroversial. Hale LJ’s concern in *Wilkinson* is that a finding that treatment cannot be enforced on a competent and refusing psychiatric patient would create pressure to raise the threshold of capacity in treatment matters generally. She therefore holds that while capacity may be becoming more relevant in psychiatric practice, it was *not* the case that treatment could only be imposed on a competent and refusing patient for the protection of others or for their own safety. This is, in essence, the decision of Silber LJ in *PS*: each case is to be determined on its facts, and in *PS* the facts did not give rise to a violation. The practical difficulty with this is that it tells us what the test is not (dangerousness), rather than what the test is. On the latter point, Hale LJ’s judgment is silent.

11 *Committee for the Prevention of Torture, (2000) Report, Strasbourg: Council of Europe para 41. See also Wilkinson at para 28.*

12 (1999) 29 EHRR 403, at para 99

13 *appl. 3021/96, para 92*

The reading by Silber J of Simon Brown LJ's decision in *Wilkinson* is more controversial. Simon Brown LJ held:

'If in truth this appellant has the capacity to refuse consent to the treatment proposed here, it is difficult to suppose that he should nevertheless be forcibly subjected to it. True, Dr Horne appears to regard it as his only hope of eventual return to the community. That said, however, its impact on the appellant's rights above all to autonomy and bodily inviolability is immense and its prospective benefits (not least given his extreme opposition) appear decidedly speculative.' [30]

Silber J reduces this to a case-sensitive comment, [116] differentiating the facts of *Wilkinson* from *PS* on the basis of more significant adverse effects of treatment, the differences in the potential benefits of treatment, and the differing levels of restraint which would be required to conduct the treatment. This is not entirely convincing. The passage from *Wilkinson* follows shortly after Simon Brown LJ cites the view of the CPT, quoted above, as providing 'some indication of modern thinking on this sensitive subject'. [29] This suggests a difference from *Hale LJ* which is not based simply on the facts of the case. Further, the factual distinction with *PS* is not necessarily as obvious as Silber LJ suggests. Certainly, the adverse effects in *Wilkinson* appear more significant, but other differences are not as obvious. Anti-psychotic drugs are powerful. The previous use of Quetiapine had, as intended, altered *PS*'s personality, religious beliefs and behaviour. These raise fundamental questions of autonomy, analogous to those in *Wilkinson*. The fact that without medication, odds were thought to be better than even that *PS* would relapse still suggests a better chance at recovery without medication than was the case for *Wilkinson*.

The approach of Silber J, in the end, is that capacity is a relevant but not determinative factor in deciding whether treatment reaches the level of severity to engage article 3. Based on his reasoning, if he were to adopt a univocal test as proposed above, he would in addition consider the seriousness of the disorder, the potential adverse effects of the drug, the likely degree of invasiveness of the administration of the drug, the degree and likelihood of beneficial results of the drug, and the likely results if the treatment were not performed. The difficulty with this approach is that capacity disappears into the mix: there is no indication as to how the various factors play off against each other, to provide meaningful guidance in subsequent cases as to whether an article 3 violation has occurred. We still have no articulated test of when article 3 will be violated when patients have capacity, relative to when they do not. Meaningful guidance from the courts on this point is necessary, if practitioners are not inadvertently to fall afoul of the Human Rights Act.

Article 8: The Right to Private Life

The Court's reasoning regarding article 8 is reasonably brief. For purposes of the judgment, it assumed without deciding that the treatment in question would be sufficiently severe to constitute an interference with private life, and focussed instead on justifications for such an interference. This required consideration of three issues: was the interference necessary in a democratic society for the protection of health; was the interference prescribed by law; and was the interference proportionate to the legitimate aim it sought to achieve?

Regarding the first of these, the Court held that the interference would be necessary if it corresponded to a 'pressing social need'. In this, the Court viewed that the balance to be struck was between the protection of the individual right to private life and the community right as

acknowledged in the justification of necessity for protection of health. [133] The Court's articulation of this balance seems convincing, but its application to the facts is more problematic, as it cites benefits to the individual in its justification of curtailing the individual's rights: rehabilitation rather than incarceration, the suppression of PS's persecutory ideas, the gaining of insight, and the protection against future relapse. Only the last of these is an obviously *social* benefit, and that only if the relapse were to occur while PS was in the community. The rest, and perhaps even the prevention of relapse, are primarily benefits to PS, which he presumably had chosen to discount in his competent treatment refusal. There may well be a pressing social need to treat such patients, but it is not articulated here.

It is not initially obvious why Silber J turns to the common law of medical best interests in his assessment of whether the treatment of PS was 'according to law'. PS was to be treated under the terms of the Mental Health Act, not the common law. The decision as to whether the treatment was according to law should have been made with reference to the statutory provisions and, after *Munjaz v Mersey Care NHS Trust*¹⁴, to the Code of Practice.

It is at best doubtful whether the substance of that law is sufficiently clear for the purposes of article 8(2). It is not sufficient that the actions in question are within the scope of a validly-enacted statute. To be 'according to law', the law must be sufficiently clear that citizens can foresee its consequences for him. When the law provides discretion on a public authority, it must indicate the scope of the discretion. [*Herczegfalvy* para 89] The Mental Health Act provides merely a process for overriding the refusal of competent patients to consent to treatment. Whether that process is sufficient may be doubtful; there is no mechanism short of judicial review to challenge the decision of the RMO and SOAD, for example. In any event, neither the Act nor the Code of Practice provide any substantive standards: see Mental Health Act, ss. 57, 58, 63; COP para. 15.25. The following comment from *Herczegfalvy*, relating to whether a system by which patient mail was censored, also an article 8 issue, was 'according to law', seem at least at first blush to be apposite:

'These vaguely worded provisions do not specify the scope or conditions of exercise of the discretionary power which was at the origin of the measures complained of. But such specifications appear all the more necessary in the field of detention in psychiatric institutions in that the persons concerned are frequently at the mercy of the medical authorities, so that their correspondence is their only contact with the outside world.' [91]

The complete absence of substantive criteria in the Mental Health Act and Code of Practice at the very least offer cause for pause.

It is, perhaps, for these reasons that Silber J turns to the common law and the doctrine of necessity and best interests. This is the first time a court has expressly adopted this approach in its reading of sections 63 and 58 of the Mental Health Act. While it is a doctrine that His Lordship views as satisfying the Convention tests, practitioners will find it a mixed blessing. As His Lordship notes, the best interests approach can have the effect of limiting medical discretion. It requires doctors not merely to offer a treatment drawn from the range of treatments within the realm of appropriate professional practice, but also to assess which of the possible treatments is best for the individual patient. This secondary assessment is to be based on a wide array of factors, some medical and some not. As a matter of process, the courts have been clear that such questions of best interests are justiciable: see eg In *Re TF (An Adult: Residence)*¹⁵. The approach on such applications is based

14 [2003] EWCA Civ 1036

15 [2000] 1 MHLR 120

on the civil burden of proof, rather than the deference shown to doctors in judicial review. The application of best interests to the Mental Health Act therefore provides a new and more lenient judicial forum for patients to challenge treatment decisions.

The difficulty with this approach in the current case is that it does not solve the specific problem of providing guidance as to when *competent* patients should be treated without their consent, the core of the article 8 right alleged to be violated in this case. The doctrine of medical necessity is developed in the context of patients who lack capacity. By applying it to PS's case, the Court is treating PS as if he lacked capacity. No guidance is provided as to whether or how the fact that PS has capacity effects determination of his best interests. For that reason, it is difficult to see that it provides the level of direction necessary to make the treatment of competent patients 'in accordance with the law'.

The Article 14 Issue

Article 14 is meant to ensure that Convention-related rights are provided equally to all citizens, without unjustified discrimination. While an article 14 application must refer to a situation within the ambit of another Convention right, it is not the case that the other situation must on its face infringe that other right. To use the Court's example, if a state provided a system of courts in excess of its article 6 obligations, it would still be in breach of article 14 if the courts were available to some litigants but not others, without appropriate justification: '*Belgian Linguistic*' Case (No. 2)¹⁶. To apply this logic to the PS case, Silber J held that whether treatment absent consent of the competent patient violated articles 3 and 8 was a question of fact, to be determined in individual cases. It seems uncontroversial from the case that this would be sufficient to bring that situation within the ambit of the Convention, for purposes of article 14.

Article 14 does not preclude all discrimination. It refers in particular to an illustrative list of categories such as sex, race, and language. Disability is not on the list, but has now been held to be a similar analogous ground: *R (Pretty) v DPP*¹⁷. The sting of an article 14 argument involves identifying groups of people according to a precluded distinction but treated differently. It is then for the party wishing to justify the different treatment to show justification, that is, that the different treatment pursued a legitimate aim and was proportionate in its pursuit of that aim.

Counsel for PS cited *Re W*¹⁸, arguing that people with mental disabilities who were not confined under the Act were an analogous group to PS, but were treated differently because they had the right to consent to treatment. *W* involved a prisoner with psychopathic disorder who refused treatment for self-inflicted wounds. His mental disorder was not treatable, however, and he was therefore detained as a regular prisoner, not under the Mental Health Act. There was therefore no power to override his refusal of consent, irrational or manipulative though it may have been, and his refusal of treatment was honoured.

The Court's response was, once again, brief, holding that *W* was not similarly situated to PS, since PS met the criterion of treatability. 'Indeed, the fact that PS can be treated for his condition while *W* cannot be treated justifies a totally different approach on the issue of administering treatment in PS's case from that adopted in *W*'s case.' [154] Further, any difference in treatment was justified.

16 (1968) 1 EHRR 252 at para. 9

18 [2002] MHLR 411

17 [2002] 1 All ER 1 (HL) at para 105

The question is not as simple as this finding of the Court suggests, since W's wounds were treatable, and indeed it was for that treatment that the advice of the Court was sought. Treatability per se is therefore not a convincing distinction. It is tempting to argue that the treatment of the physical injuries W caused to himself is treatment of a physical disorder. As such, there would be no distinction: PS, like W, had the right to refuse treatment other than treatment for mental disorder: *Re C (Adult: Refusal of Medical Treatment)*¹⁹. The efficacy of such a claim would presumably depend on whether W's self-injury was related to his mental disorder. If it was, and one can certainly imagine patients where such would be the case, then based on the logic in cases such as *B v Croydon HA*²⁰ the treatments for the wounds would constitute treatment for mental disorder. This would suggest a much closer parallel with the PS case than the Court acknowledges. Other comparison groups may also be of interest here. Competent voluntary patients, for example, may refuse treatment for mental disorder even if their condition is treatable.

If a group were acknowledged to be analogously situated, that would still leave the question of justification. Certainly, there may well be a serious argument to be had on this point, and its articulation is beyond the scope of this casenote. The justification would need to focus on the question of the role of confinement in the determination of treatment rights, since competent informal in-patients can refuse psychiatric medication. A justification based solely on the general benefits of providing people with treatment for mental disorder would not suffice, as it would not address the discriminatory aspect of the enforced treatment.

Conclusion

It will come as no surprise to those following mental health law that the PS case does not solve the issues relating to the enforced psychiatric treatment of persons offering competent treatment refusal. The debate remains in its infancy in England, offered little guidance from a Strasbourg court that similarly has not addressed the core issue. If PS is correct in its application of *Wilkinson*, we know that a capable refusal is relevant to possible violations of article 3 in particular, and we know that the standard for intervention over the patient's objection is something less than the protection of the patient or others from serious harm (dangerousness). If we know what the standard is not, we sadly do not know what the standard is. Rather, the refusal disappears into an indeterminate mix of other facts, offering little guidance to clinicians and little protection to patients.

My thanks to John Horne and Oliver Lewis for providing comments on a draft of this article. All errors, of course, remain my responsibility.

¹⁹ [1994] 1 WLR 290

²⁰ [1995] 1 All ER 683 (CA)

Judicial recognition of the status of the Code of Practice

Anna Harding*

R (on the application of Colonel Munjaz) v Mersey Care NHS Trust;

S v Airedale NHS Trust

Interested Parties: 1) Secretary of State for Health; 2) Mind

[2003] EWCA Civ 1036

Court of Appeal (16th July 2003) Lord Phillips MR, Hale LJ, and Latham LJ

This is the Court of Appeal decision in two cases which raised questions about the status of the Mental Health Act Code of Practice¹. Although both cases concerned the use of seclusion, the judgment is likely to have a significant impact on any matter covered by the Code². At first instance Stanley Burnton J and Sullivan J had each held that the Code was merely guidance to which Trusts should have regard but from which they could depart. Such departure would only be unlawful if it was *Wednesbury*³ unreasonable.

Seclusion and the Code of Practice⁴

The Code of Practice defines seclusion as:

'The supervised confinement in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.'

The Code goes on to expressly state that:

'Seclusion should be used:

- as a last resort;
- for the shortest possible time

Seclusion should not be used:

- as a punishment or threat;
- as part of a treatment programme;
- because of shortage of staff
- where there is any risk of suicide or self harm.'

* Barrister; Legal Unit of Mind (London), an interested party in both cases under review.

1 Mental Health Act 1983 Code of Practice. The Stationery Office (1999)

2 Following the Court's decision, the Department of Health issued a Briefing in which they stated their view that the Court's analysis of the legal status of the Code

is applicable to 'all aspects' of it (i.e. not just 'seclusion').

3 *Associated Provisional Picture Houses Ltd. v Wednesbury Corp.* [1948] 1 KB 223

4 Seclusion is dealt with in Chapter 19 of the Code of Practice

Hospitals are required by the Code to have clear written guidelines on the use of seclusion. A nurse must be within sight and sound of the seclusion room at all times. A documented report must be made at least every 15 minutes. The need to continue seclusion should be reviewed every 2 hours by 2 nurses, one of whom was not involved in the decision to seclude, and every 4 hours by a doctor. A multi-disciplinary review must take place whenever seclusion continues for a period of 8 hours continuously or 12 hours intermittently in any period of 48 hours.

Facts and History

Colonel Munjaz

Colonel Munjaz was a patient in Ashworth hospital. He was regularly nursed in seclusion. Ashworth issued a seclusion policy in 1999, which departed from the Code in a number of respects. In particular, it reduced the number of medical reviews from 4 hourly to twice daily on the second and third days and once daily thereafter. Prior to the first instance hearings in these proceedings, Colonel Munjaz had brought Judicial Review proceedings heard by Jackson J. He decided that departure from the Code would only be lawful if it was justified by a good reason arising from the particular circumstances at Ashworth. The Ashworth policy signified too great a departure from the Code and it was declared to be unlawful⁵.

Ashworth therefore reviewed its policy and produced a new one in 2002. This provided for medical reviews twice daily from days 2 to 7 but after that only provided for 3 per week and a weekly multi-disciplinary review. It is Colonel Munjaz's challenge to the lawfulness of the new policy which is addressed in these proceedings. Sullivan J dismissed the claim saying the mere fact that the policy departed from the Code did not mean that there was a risk of patients' rights under the ECHR being infringed. Read as a whole the policy contained adequate safeguards. The Code of Practice was said to be no more than guidance to which the hospital was obliged to have regard as a material consideration⁶.

Mr S

Mr S was admitted to hospital under section 2 of the Mental Health Act on 11th July 2002. He was aggressive and hostile to staff. He had a history of offending behaviour, he absconded repeatedly and had also attacked another patient. By 18th July his RMO had decided that S required secure accommodation and made efforts to find such a place. In the meantime, due to S's threatening and intimidating behaviour, the decision was made to put him in seclusion. This happened on 21st July. From 28th July S was allowed out of seclusion during the day. On 2nd August S agreed to be transferred to a secure unit in London, where he was treated without the use of seclusion.

S challenged the lawfulness of his seclusion. Dr Grounds, instructed on behalf of the hospital, had accepted that seclusion should normally be used for the shortest possible time to contain acutely disturbed and violent behaviour and that its use in this case was not a normal or ideal use of seclusion. However, it was argued that it was necessary and justifiable as there did not appear to be an effective and safe alternative at the time. Dr Eastman, instructed on behalf of S, had thought

⁵ *R v Ashworth Special Hospital Trust, ex parte Munjaz* [2000] MHLR 183

⁶ *R (Munjaz) v Ashworth Hospital Authority* [2002] EWHC Admin 1521

that the initial decision to seclude had been reasonable but did not think it was necessary to continue the seclusion for so long. Other options such as locking the ward or 1:1 nursing should have been considered.

Stanley Burnton J dismissed the claim and said that in the absence of a secure bed seclusion had been the only way of managing the patient. The exercise of the power to seclude was not made unlawful by reason of it being necessitated by the lack of an available place on a secure ward⁷.

The Appeals

Colonel Munjaz and Mr S appealed these decisions.

The appeal in Munjaz concentrated mainly on whether Ashworth's policy of departing from the Code was unlawful given the risk that seclusion would breach Article 3 (right not to be subject to inhuman or degrading treatment). It was argued that the State had a positive obligation to guard against the risk of a breach of Article 3, and adherence to the Code was one such safeguard.

The appeal in S concentrated on whether the seclusion was in breach of his rights under Article 5 (right not to be unlawfully detained). It was argued that a detained patient had a 'residual liberty' that was taken away by the use of seclusion. Seclusion would be unlawful if it was not justified under Article 5.

Mind intervened to argue that seclusion, and other matters dealt with by the Code, interfered with patients' Article 8 rights (right to respect for private and family life) and would only be lawful if it was justified. Any such interference must be in accordance with law, and the Code provided that legal framework.

Legal Framework

Hale LJ, on behalf of the Court, sought to analyse the questions raised by the use of seclusion under three categories:

1. Domestic private law

Source of the power to seclude

An application under the Mental Health Act is sufficient authority for the hospital managers to detain the patient in hospital (s6(2)). It was common ground that the power to seclude a patient was implied from the power to detain as a necessary ingredient flowing from a power of detention for treatment.⁸

In addition, the Court held that seclusion was capable of being 'medical treatment', authorised under section 63 of the Mental Health Act. Although s63 does not allow the RMO to impose whatever treatment he wishes the broad definition of medical treatment in s145, and the authorities suggesting that it includes various forms of ancillary treatment⁹, meant that seclusion was capable of being categorised as medical treatment¹⁰.

The Court noted that the common law doctrine of necessity might also justify the use of seclusion.

7 *S v Airedale NHS Trust* [2002] EWHC Admin 1780

8 *see R v Broadmoor Special Hospital Authority ex p S, H and D, unreported, 5 February 1998.*

9 *e.g. Reid v Secretary of State for Scotland* [1999] 2 AC 512 and *B v Croydon Health Authority* [1995] Fam 133

10 *Hale LJ, Judgment paras 41–45*

This was said to have two aspects: i) the general power to take such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm; and ii) where the patient lacks capacity, the power to provide whatever treatment or care is necessary in his own best interests¹¹.

Criteria for lawful seclusion

The Court went on to consider in what circumstances seclusion would be lawful in domestic private law. The fact that there existed a power to seclude would not make every use of that power lawful. The criterion was said to be one of reasonable necessity judged against the purpose for which the restraint is employed. “Hence, a detained patient may be kept in the hospital with no more force than is reasonably necessary in the circumstances to achieve this. Any patient may be restrained from doing harm to others with no more force than is reasonably necessary in the circumstances. An incapacitated patient may be given such treatment as is reasonably necessary in his own best interests.”¹²

Hale LJ went on to consider whether the same concept of reasonable necessity applied to treatment given under s63. She noted that the fact that the treatment may be given without consent did not absolve the doctor, or those carrying out his instructions, from their ordinary duties of care towards the patient. In *R (Wilkinson) v Broadmoor Special Hospital Authority*¹³ the Court of Appeal had held that the forcible administration of medical treatment to a protesting patient would contravene Article 3 ECHR unless it was convincingly shown to be a medical necessity. Accordingly, the Court did not find that the criteria for the lawful use of seclusion would be different if the justification were treatment rather than control¹⁴.

Remedies in private law

Confining a patient to a particular room or part of the hospital would not amount to the tort of false imprisonment where a patient had been lawfully detained in the hospital itself. But that did not exclude the possibility of invoking other tortious causes of action if other torts had been committed against him. There might be a claim in negligence if there was a breach of a duty of care which resulted in physical or psychiatric harm.

The use of restraint or the administration of treatment without lawful justification would give rise to a claim for assault and/or battery and would be actionable without proof of harm. There would be no lawful justification for acts which involved excessive force or which were unlawful in public law terms. However, it was accepted that these torts may be difficult to prove. Courts would be slow to criticise decisions of people involved in emergency situations. Section 139 further qualifies the right of detained patients to sue individuals acting under the Mental Health Act – even where actions were not lawfully justified.

In summary, the use of seclusion might involve the commission of a tort for which remedies may be available. However, these remedies would not be triggered by the use of seclusion in itself, nor even every use of seclusion about which legitimate complaint might be made, and certainly not every use of seclusion which did not comply with the Code of Practice¹⁵.

11 *Hale LJ, Judgment para 46*

12 *Hale LJ, Judgment para 47*

13 [2002] 1WLR 419

14 *Hale LJ, Judgment para 48*

15 *Hale LJ, Judgment paras 49–52*

2. European Convention on Human Rights

Article 3

'No-one shall be subjected to torture or inhuman or degrading treatment.'

Treatment must reach a minimum level of severity before this Article will be found to have been breached. The assessment of this minimum is relative, depending on the circumstances of the case. More might be required of the authorities in relation to people who are particularly vulnerable.

It was argued on behalf of the Appellants that the State had obligations not only to refrain from such treatment but also to positively protect the health of people deprived of their liberty. Given that seclusion risked breaching Article 3 the state should take steps to prevent that happening. The Code of Practice was said to be one of those steps and the state should therefore give it some teeth.

By the time of the appeal it was accepted that the treatment of these patients did not reach the minimum threshold level of severity to amount to a breach of Article 3. However, the Court found that there was no doubt that seclusion would be capable of amounting to inhuman and degrading treatment. It was noted that there were important differences between prisoners and compulsory patients. Whereas the detention of criminals was an end in itself, the detention of patients was a means to an end: the assessment and treatment of their mental disorder. Conditions of detention which defeated rather than promoted that end were much more likely to amount to inhuman or degrading treatment.

The Court accepted that it should afford a status and weight to the Code of Practice which was consistent with the State's obligation to avoid ill-treatment of patients detained by or on its authority¹⁶.

Article 8

'1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society ...'

The concept of 'private life' includes the physical and psychological integrity of a person and the right to develop relationships. The concept of personal autonomy has been held to be an important principle underlying the interpretation of the Convention.

On behalf of Mind it was submitted that seclusion was always an interference with Article 8 rights. It involved denial of association with others as well as close and intrusive surveillance. Such interference must therefore be in accordance with law. This required domestic legal justification (see under 'domestic private law' above), but more importantly it required the character of transparency and predictability required by the Convention concept of legality. This was supplied by the Code of Practice.

The Court accepted that seclusion infringed Article 8 unless it could be justified under Article 8(2). The justifications under domestic law were noted to be very broad and, therefore, the Code of Practice had an important role to play in securing that the justification for the interference had the necessary degree of predictability and transparency to comply with Article 8(2)¹⁷.

¹⁶ Hale LJ, *Judgment paras 53–60*

¹⁷ Hale LJ, *Judgment paras 61–65*

Article 5

‘1. Everyone has the right to liberty and security of person. No-one shall be deprived of their liberty save in the following cases and with a procedure prescribed by law ...

(e) the lawful detention of ...persons of unsound mind

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.’

The argument here was that confinement in a ‘prison within a prison’ should amount to deprivation of liberty for the purpose of Article 5. Such detention would therefore require justification on the grounds of the mental disorder and also a ‘speedy review’.

The Court held that the detention itself had to be justified and challengeable in accordance with Article 5. This would be breached if a person was detained in an institution which was inappropriate to meet the purpose of the detention. But provided that the institution was within the appropriate category there would be no breach of Article 5. The conditions of detention were controlled by Articles 3 and 8. Just as the tort of false imprisonment was concerned with all or nothing situations, so was Article 5¹⁸.

3. Public law and the status of the Code of Practice

Section 118 Mental Health Act provides:

- ‘(1) The Secretary of State shall prepare, and from time to time revise, a code of practice—
- (a) for the guidance of registered medical practitioners, managers and staff of hospitals, independent hospitals and care homes and approved social workers in relation to the admission of patients to hospitals and registered establishments under this Act and to guardianship and after-care under supervision under this Act; and
 - (b) for the guidance of registered medical practitioners and members of other professions in relation to the medical treatment of patients suffering from medical disorder.’

If the guidance on seclusion did not fall within either of these subsections it would be non-statutory guidance; a material consideration but no more.

The court held that seclusion was covered by s118(1)(a) and (b). ‘Admission’ did not end at the hospital door but continued until discharge. The court had already discussed the issue of whether seclusion was capable of being medical treatment and held that it was.

Having made this finding the Court went on to consider the weight that should be given to the Code. It was noted that there was no express statutory obligation to comply with it.

Under Section 7 of the Local Authority Social Services Act 1970 social services have an obligation to act under the general guidance of the Secretary of State. This had been held in the case of *Rixon*¹⁹ to mean that they could only depart from such guidance with good reason.

The Court said that there was a considerable difference between the approach adopted by the first instance judges in the present cases and the *Rixon* approach. Hale LJ stated:

18 *Hale LJ, Judgment paras 66–70*

19 *R v LB Islington ex parte Rixon [1998] 1CCLR 119.*

*“It would fly in the face of the original purposes of the Code if hospitals or professionals were in fact free not to follow it without good reason... In relation to those matters where a patient’s human rights are or may be engaged, the arguments for according the Code a greater status are compelling. Where there is a risk that agents of the state will treat its patients in a way which contravenes Article 3, the state should take steps to avoid this through the publication of a Code of Practice which its agents are obliged to follow unless they have good reason to depart from it. Where there is an interference with the rights protected by Article 8, the requirement of legality is met through adherence to a Code of Practice again unless there is good reason to depart from it. The same will apply where the Code deals with the deprivation of liberty within the meaning of Article 5”.*²⁰

The Court went on to say that the Code should be observed by all hospitals unless they have a good reason for departing from it in relation to an individual patient or groups of patients who share particular well-defined characteristics. However, hospitals cannot depart from the Code as a matter of policy.

The Court considered potential remedies and said that the usual public law remedies would be available if the Code was unlawfully breached. If something was unlawful in public law terms then there could be no defence of lawful excuse for tortious acts and tortious remedies would be available. Finally, if a decision resulted in a breach of an individual’s human rights then the remedies available under the Human Rights Act 1998 would be available.²¹

Ashworth’s policy was declared to be unlawful because the wholesale departure from the Code could not be justified. The seclusion of S, after the point at which it was necessary and proportionate within the meaning of the Code, was also unlawful.

Comment

There are two main aspects of this case which deserve particular attention. First, the case highlights (or, more accurately, fails to highlight) some of the problems regarding the concept of ‘medical treatment’. The Court was of the view that seclusion could be medical treatment and this is a decision that is likely to be controversial.

Secondly, the case clearly elevates and clarifies the status of the Code of Practice. It confirms that patients have the right to challenge practice which is in unlawful breach of the Code. This is a significant and welcome step towards the promotion of the interests of all mental health service users.

I. Medical Treatment

Probably the most controversial aspect of this judgment is the finding that seclusion can be ‘medical treatment’. Although there was some evidence to suggest that some uses of seclusion might be of direct benefit to some patients²², the apparent logic for characterising seclusion as medical treatment was that it protects the patient from the adverse consequences of harming another person. It is difficult to tell whether there are any limits to the concept of treatment in the field of psychiatry where the treatment is of some perceived benefit to anybody at all. It is almost impossible to judge where those limits will lie. This is of massive significance as the Government

²⁰ Hale LJ, judgment para 74

²² Hale LJ, Judgment para 43

²¹ Judgment para 77

seems likely to continue to pursue the power to use mental health legislation to detain people who are dangerous, and so undermine still further the purpose of hospitalisation.

The view of most people is likely to be that medical treatment must be in the therapeutic interests of the patient. Seclusion itself is a controversial practice, and in these appeals evidence was adduced to show the potential harm that such periods of control and isolation might cause – particularly to a person who was already distressed²³. Nonetheless, it was accepted that there might be occasions when such intervention could be justified in the patient’s own interests. There are almost certainly a significant number of people who would not agree with this view, particularly amongst those who use mental health services. The case highlights the fact that the line between what is in the patient’s interests and what is in the interests of other people can be a difficult one to draw. As Hale LJ stated:

“.....seclusion aimed at addressing the risks to others presented by the behaviour of a patient in the manic phase of a bipolar affective disorder when the behaviour is itself the result of that disorder is treatment ‘for’ the disorder in the same way that force-feeding the anorexic patient was treatment for her disorder²⁴. While her behaviour was purely self destructive, the consequences of allowing Mr S to persist in behaviour which was damaging to others would also have been damaging to him.”²⁵

The implication is that preventing actions that may be damaging to a patient will automatically be of benefit. What is not clear is how the ‘benefit’ to the patient is to be assessed. An outsider’s view of benefit is not the same thing as a patient’s best interests. Allowing someone to act in a violent manner might result in injury to themselves, or it might result in feelings of guilt at a later stage, but the same could be said of anyone who acts violently – regardless of whether they are diagnosed with any mental disorder. The Mental Health Act is concerned with treating people *for* mental disorder and this is very different from the power to treat people *with* such a disorder. There must be evidence of a disorder before seclusion can be medical treatment, and surely there must also be a connection between the disorder and the violent conduct? If so, the seclusion of people who happen to have a mental disorder and are in hospital, but whose violence is unrelated to that disorder, would not be medical treatment and would have to be justified in some other way.

Hospital staff should not assume that the presence of mental disorder and violence mean that seclusion will be justified on the basis of it being medical treatment for the disorder. The identification of the causes of violence may be very difficult but will be important in order for the patient to effectively challenge their treatment, and for the hospital to defend it. The question should be addressed if only for the reason that a failure to do so suggests that any violence committed by a person with mental health problems is as a result of those problems. A failure to consider the question assumes that there is a necessary link between the health and violence of the patient. This is unjustified. Any promotion of the view that there is a connection between mental ill-health and violence causes damage by way of stigma and prejudice to anyone who experiences mental distress. If patients can challenge their seclusion hospitals are going to have to be able to explain why they reached the decision to use it. Common assumptions about mental health and violence should not be sufficient.

23 *Hale LJ Judgment paras 10–13*

24 *In B v Croydon Health Authority [1995] Fam 133* where the Court of Appeal held that treatment addressing symptoms of a disorder, or ancillary

treatment for the symptoms of the disorder, was capable of falling within the definition of ‘medical treatment’ under s145 MHA

25 *Hale LJ, Judgment para 44*

2. Status of the Code

More positively, it is worth emphasising the significance of this decision for people who use mental health services. There can be no doubt that the rights of patients are strengthened considerably by the possibility of bringing legal action when the Code is breached. The Code of Practice identifies a benchmark that patients can now begin to rely on when looking to identify and enforce standards of care. It should be easily accessible so that people know what to expect.

The Code is an important tool for the staff who apply the Mental Health Act. It helps staff awareness of their responsibilities, especially when undertaking some of the more difficult aspects of mental health care. There is no doubt that many mental health practitioners are uncomfortable with some of the things they are asked to do. A requirement to comply with the Code will give staff the basis from which to challenge bad practices. Such an opportunity encourages change from within thereby providing a very significant step towards improving standards.

Compliance with the Code and any positive changes to practice are relatively measurable and so should be welcomed by hospital and social services' managers. The judgment does not mean that compliance with the Code is necessarily enough to prevent practices being unlawful but the judgment does give a message that patients' rights will be taken seriously and provides an avenue for those patients to enforce them.

Since this article was written, the House of Lords has given Mersey Care NHS Trust leave to appeal.
Editor

Re-detention after a tribunal discharge – the last word?

David Hewitt* and Kristina Stern**

R v East London and the City Mental Health NHS Trust and another, ex parte von Brandenburg (aka Hanley) [2003] UKHL 58¹

House of Lords (13 November 2003). Lord Bingham; Lord Steyn; Lord Hobhouse of Woodborough; Lord Scott of Foscote; Lord Rodger of Earlsferry

A psychiatric patient who has been recently discharged from detention may be lawfully re-detained where the relevant ASW forms the reasonable and bona fide opinion that he or she has information not known to the tribunal that puts a significantly different complexion on the case.

INTRODUCTION

It is possible that the House of Lords has cleared up one of the most contentious questions in mental health law: in what circumstances may a patient who has been discharged by a Mental Health Review Tribunal ('MHRT') be re-detained under the 1983 Mental Health Act? If they have reached a definitive decision, Their Lordships also may have revived, at least in part, a ten-year old piece of reasoning.²

THE FACTS

This case concerned a male patient who was admitted to St Clement's Hospital in London on 15 March 2000. The Respondent NHS trust ('the Trust') was "the managers" of that hospital for the purposes of the Mental Health Act 1983 ('MHA 1983').³ Initially, the patient was held under MHA 1983, section 4, but later that day he was detained under section 2. The Approved Social Worker ('ASW') who applied for his admission under section was the Second Respondent to these proceedings.

The patient's detention under MHA 1983, section 2 was to expire at midnight on 11 April 2000.⁴ As was his right, the patient made a MHRT application on 22 March 2000, and the hearing took place on 31 March 2000.

Despite opposition from his Responsible Medical Officer ('RMO'), who gave both written and oral evidence, from a staff grade psychiatrist, and from the ASW, the MHRT decided to discharge

* Solicitor; partner in Hempsons. Mr Hewitt represented the NHS trust that was an interested party in *R (IH) v Secretary of State for Health and Secretary of State for the Home Department* [see below for citation]

** Barrister, practising from chambers at 39 Essex Street, London. Dr Stern represented the respondent hospital trust in this case. She also represented the respondent hospital trust at first instance in *H v Ashworth*, and the NHS trust that was an interested party in *R (IH) v Secretary of State for Health and Secretary of State for*

the Home Department [see below for citations]

1 (2003) 3 WLR 1265. See also: David Hewitt, A 'significantly different complexion' to re-detention, *New Law Journal*, vol 153, no 7109, 19 December 2003, pp 1914-1915

2 *R v Managers of South Western Hospital, ex parte M* [1993] QB 683, per Laws J

3 MHA 1983, s 145

4 *Ibid.*, s 2(4)

the patient. However, in order that accommodation could be found for him in the community and a care plan be drawn up, the MHRT deferred discharge until 7 April 2000.⁵

In fact, the patient did not leave hospital. On 6 April 2000, the day before his deferred discharge was to become effective, he was detained under MHA 1983, section 3 on the basis of an application by his ASW supported by recommendations from his RMO and a second doctor (who had also provided a recommendation for his detention under section 2).

Because of the form these proceedings took, the court never investigated the Trust's primary case, which was that there had in fact been a change of circumstances between the time of the MHRT hearing, on 31 March 2000, and the patient's re-detention under section 3 on 6 April 2000. The Trust argued that, according to the evidence of the RMO and ASW, and of the clinical notes, the patient's condition had deteriorated over the relevant period. However, neither of the doctors who completed recommendations for his admission under MHA 1983, section 3 had specifically referred to the earlier MHRT decision or this deterioration in their medical recommendations, and the ASW had made no such reference in his application for admission under section 3.

THE PROCEEDINGS

The patient sought judicial review of the decision by the ASW to apply for his admission under MHA 1983, section 3 and of the Trust's decision to accept that application. As Lord Bingham was to state in the House of Lords,⁶ the "broad thrust" of the patient's claim was that the application and admission of 6 April 2000 were unlawful because there had been no relevant change of circumstances since the MHRT granted him a deferred discharge. The patient argued that, as a matter of law, it was incumbent upon those responsible for admission to establish that such a change of circumstances had taken place. The Respondents argued that a change of circumstances was not necessary in order for a patient to be re-detained, but that there had, in any event, been such a change on the facts of this case. (As set out above, the latter point was not considered by the Administrative Court or the Court of Appeal.)

(a) The Administrative Court

In the Administrative Court, Burton J. found that a change of circumstances was not a necessary requirement for the lawful re-detention of a patient who had been recently discharged by a MHRT.⁷ The Judge followed *Ex parte M*, in which Laws J. said:

*"[T]here is no sense in which those concerned in a section 3 application are at any stage bound by an earlier tribunal decision. The doctors, social worker, and managers must, under the statute, exercise their independent judgment, whether or not there is an extant tribunal decision relating to the patient."*⁸

However, Burton J. found that there was a range of public and private law constraints that operated in these circumstances, and that would provide protection for a patient in the position of Count von Brandenburg.

5 *Ibid.*, s 72 (1) and (3)

6 [2003] UKHL 58, para 4

7 *QBD, Burton J, 23 May 2000; (2000) 3 CCL Rep*

189; *The Independent*, October 2, 2000

8 *R v Managers of South Western Hospital, ex parte M* [1993] QB 683, at p 696

(b) The Court of Appeal

The Court of Appeal also found for the Respondents – the Trust and the ASW – but its reasoning was more specific than that of Burton J. in relation to how the public law constraints would operate⁹.

Although the decision of the Court of Appeal was unanimous, the judgments of Lord Phillips MR and Buxton LJ on the one hand and Sedley LJ on the other were quite distinct. It is necessary to consider them in some detail, for they were also at the heart of the decision in the House of Lords.

(i) *The speeches of Lord Phillips MR and Buxton LJ*

In a speech with which Buxton LJ. concurred, the Master of the Rolls rejected any formal requirement for a change of circumstances.¹⁰ However, he found that the professionals concerned were not free simply to ignore or over-rule a MHRT discharge.

The Master of the Rolls drew a distinction between two types of case. Where “a sensible period” had elapsed following discharge, he found that it was neither sensible nor necessary to require a change of circumstances. This was because the application for re-admission was likely to have been triggered by the patient’s behaviour in the community, a matter that would almost certainly constitute a change of circumstances. Therefore, he held that:

“[t]o require the professionals involved to investigate and attempt a comparison between the two sets of circumstances in order to decide whether or not there has been a relevant change of circumstances would not be helpful or even meaningful.”¹¹

However, according to the Master of the Rolls, a “very different position” would obtain where the re-admission application was made “within days” of the MHRT discharge. This would be especially so if, because the patient had remained in hospital, his “environmental circumstances” had not changed:

“In such a situation there is likely to have been [...] a difference of view between the patient’s [RMO] and the tribunal as to whether or not the criteria justifying detention were established. [...] [W]here such a conflict exists, it is the opinion of the tribunal that is to prevail.”¹²

In such a case, the Master of the Rolls found the ASW who made a fresh admission application could not be properly satisfied (as MHA 1983, section 13 required him/her to be satisfied) that “an application ought to be made”, unless he or she was aware of circumstances not known to the MHRT which invalidated its decision. Absent such circumstances, the Master of the Rolls said, the ASW’s admission application would be vulnerable to challenge.

Therefore, it will be seen that, when deciding how best to test the lawfulness of re-detention following a MHRT discharge, the Master of the Rolls (and Buxton LJ.) relied heavily upon a temporal distinction. However, it was not clear whether the Master of the Rolls sought to constrain the scope for doctors to recommend admission, or whether he wished to confine his comments to the position of the ASW applying for admission. Moreover, there was no clear indication of how the Master of the Rolls anticipated his temporal distinction to apply in practice – for example, would the critical point be reached after a day, a week, or a month?

9 [2001] EWCA Civ 239; [2001] 3 WLR 588. See also: David Hewitt, *Detention of a recently-discharged psychiatric patient, JMHL, February 2002, edition no 6, pp 50–58*

Manual, Sweet & Maxwell, eighth edition, 2003, para 1-048

11 [2001] EWCA Civ 239, para 30

12 *Ibid.*, para 31

10 See discussion in Richard Jones, *Mental Health Act*

(ii) *The speech of Sedley LJ*

For Sedley LJ, the case had taken “a peculiar and in some ways unsatisfactory shape”.¹³ The patient had succeeded in part, in that the Court of Appeal had not followed the broad statement of principle set out by Laws J. in *Ex parte M*;¹⁴ ultimately, however, he had failed in his challenge because the Court had declined to adopt the ‘change of circumstances’ test for which he had contended. Instead, “in the space between the two”,¹⁵ the Court of Appeal had interposed the set of private law and public law controls¹⁶ laid out by Burton J. and endorsed by the Master of the Rolls.¹⁷ Lord Justice Sedley endorsed this approach, but he went on to consider the precise requirements for a lawful readmission decision following a MHRT discharge:

- (aa) Where readmission came “hard on the heels of” a MHRT discharge, Sedley LJ. implied that, *de facto*, it would be necessary to show a change of circumstances. Any such necessity would be imposed by the twin public law requirements that decisions be made in good faith and that they have proper regard to the relevant facts.¹⁸
- (bb) Not only a recent MHRT decision, but also, often, one that was “not so recent” would have to be taken into account as a relevant fact.¹⁹
- (cc) The failure by those involved in the process of admission – by implication, both the doctors and the ASW – to take a recent or “not-so-recent” MHRT decision into account would “vitiating a subsequent decision to seek admission”,²⁰ even where they were unaware of that earlier decision.
- (dd) It would be unlawful for either an ASW or a recommending doctor to take steps towards a patient’s admission under MHA 1983, “if [s/he] believes that a mental health review tribunal will thereupon order the patient’s discharge”.²¹

Sedley LJ concluded by articulating the relevant principle as follows:

“[A] recent [MHRT] decision to discharge a patient, if the circumstances have not appreciably changed, must be accorded very great weight if the second decision is not to be perceived as an illicit over-ruling of the first. Put another way, there will have to be a convincing reason, in such a case, for re-admission. ... [Those concerned in a section 3 application] must have due regard to [the MHRT decision] for what it is: the ruling of a body with duties and powers analogous to those of a court, taken at an ascertainable date on ascertainable evidence.”²²

He said this was “particularly so” if the United Kingdom was to respect its obligations under the European Convention on Human Rights (‘ECHR’) (although he didn’t articulate precisely why this was so), but he found that “neither the Act nor the Convention inhibits the detention by a proper decision-making process of those who, although recently discharged, have deteriorated or whose mental well-being otherwise requires admission. The second decision must be approached with an open mind, but it is not necessarily going to be written on a clean slate.”²³

13 *Ibid.*, para 38

14 *See note 10*

15 [2001] EWCA Civ 239, para 38

16 Which might perhaps be called the ‘within days’ test

17 [2001] EWCA Civ 239, paras 31 and 32

18 *Ibid.*, para 39

19 *Ibid.*, para 41

20 *Ibid.*

21 *Ibid.*, para 40

22 *Ibid.*, paras 40 and 42

23 *Ibid.*, para 41

THEIR LORDSHIPS' JUDGMENT

In the House of Lords, the only substantive speech was delivered by Lord Bingham. He said that, though it was “narrow”, the question at issue in this case was one of “practical importance”.²⁴

First, Lord Bingham set out four over-riding principles.

(a) Over-riding principles

Lord Bingham noted that:

*“The common law respects and protects the personal freedom of the individual, which may not be curtailed save for a reason and in circumstances sanctioned by the law of the land.”*²⁵

This principle, he said, is “reflected in, but does not depend on” Article 5(1) of the ECHR. In fact, it may also be found in the Magna Carta of 1215, which states, in part:

*“No freeman shall be taken or imprisoned or disseised or exiled or in any way destroyed, nor will we go upon him nor send upon him, except by the lawful judgment of his peers or by the law of the land.”*²⁶

However, in his second overriding principle, Lord Bingham noted that in some circumstances the right to personal freedom might lawfully be limited on the basis of the health or safety of the patient or for the protection of others.²⁷ This was recognised by Article 5(1)(e) of the ECHR, which states:

“(1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

[...]

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.”

This, His Lordship said, was the underpinning for, *inter alia*, MHA 1983, sections 2, 3 and 4.

Third, a detained person had the right to take proceedings to test the lawfulness of his detention, as set out in Article 5(4) of the ECHR and provided for in the MHA 1983 by section 72(1)(which gave the MHRT a carefully conscribed power of discharge).

Fourth, the rule of law required that the decisions of legally constituted courts and tribunals should be respected. As the domestic courts had already held that the MHRT was a ‘court’ to which the law of contempt would apply,²⁸ it necessarily followed that “no one may knowingly act in a way which has the object of nullifying or setting at nought the decision of such a tribunal”.²⁹ Thus, those making applications for admission must give proper effect to tribunal decisions for what they decide. An application for admission could not be based upon mere disagreement.³⁰

Having completed his statement of over-riding principles, Lord Bingham turned to several important considerations.

24 [2003] UKHL 58, para 6

25 *Ibid.*

26 17 John, ch 39

27 [2003] UKHL 58, para 6

28 *Pickering v Liverpool Daily Post & Echo Newspapers plc* [1991] 2 AC 370 [1991] 2 WLR 513

29 [2003] UKHL 58

30 *Ibid.*

(b) Important considerations

Lord Bingham said that the exercise of clinical judgment – whether as to diagnosis or treatment (or, implicit in this, as to risk) – is rarely capable of scientific verification, so that “[t]here will often be room for a *bona fide* difference of professional opinion”.³¹ He noted the following words of the European Court of Human Rights in *Johnson v United Kingdom*:

*“It must also be observed that in the field of mental illness the assessment as to whether the disappearance of the symptoms of the illness is confirmation of complete recovery is not an exact science.”*³²

Further, Lord Bingham noted that where someone is suffering from mental disorder his/her condition might not be static. Thus:

*“It does not follow that a tribunal decision, however sound when made, will remain so. Other things being equal, the longer the period since the decision was made, the greater the chance that the patient’s mental condition may have altered, whether for better or worse.”*³³

Moreover, by reason of the statutory language at MHA 1983, section 72(1) – namely, that its focus must be on the mental disorder or mental illness (if any) from which the patient is “then” suffering – the MHRT must consider the patient’s condition at the time of the hearing (and cannot consider the validity of the initial decision to detain).³⁴ When determining this issue, and in considering matters such as health, safety and public protection, the MHRT “cannot ignore the foreseeable future consequences of discharge”. However, it:

*“[...] is not called upon to make an assessment which will remain accurate indefinitely or for any given period of time.”*³⁵

Lord Bingham said that, *ex hypothesi*, the cases that the MHRT was required to consider would be those of patients whom their doctors believed should continue to be detained. If it were otherwise, the doctors would themselves have ordered discharge (assuming that, like Count Von Brandenburg, the patients were not subject to restrictions). Therefore, a MHRT decision to discharge a patient from detention would probably imply that the opinion of the patient’s RMO had not been accepted. This might give a conscientious doctor room for pause, and s/he might wish to consider whether to revise his/her opinion. However, s/he “cannot be obliged to suppress or alter it”. This was because:

*“His [sic] professional duty to his patient, and his wider duty to the public, require him to form, and if called upon express, the best professional judgment he can, whether or not that coincides with the judgment of the tribunal.”*³⁶

This finding is, of course, central to the issue determined in the appeal. Lord Bingham found that a conscientious doctor, properly directing her/himself, is entitled to maintain his/her clinical opinion in the face of disagreement from the MHRT, and is entitled to complete a medical recommendation for admission based upon that opinion. This maintains the principle of clinical freedom, and relies upon a fundamental acceptance that doctors expressing clinical opinions

31 *Ibid.*, para 9

32 (1997) 27 EHRR 296, para 61

33 [2003] UKHL 58, para 9

34 MHA 1983, s 72(1)(a)(i) and (b)(i); *In re Waldron* [1986] QB 824, at p 846

35 [2003] UKHL 58, para 9

36 *Ibid.*

cannot be constrained from uttering those opinions, even where a Court has reached a different conclusion on the facts of the particular case.

The practical significance of this finding is that, in any consideration of the lawfulness of a readmission following an MHRT decision to discharge, then, absent bad faith or some other error of law, it shifts focus away from the doctors and towards the ASW.

The last of Lord Bingham's important considerations arose out of MHA 1983, section 13(1) and (2), which he said must be taken into account. They state:

“(1) It shall be the duty of an approved social worker to make an application for admission to hospital or a guardianship application in respect of a patient within the area of the local social services authority by which that officer is appointed in any case where he is satisfied that such an application ought to be made and is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him.

“(2) Before making an application for the admission of a patient to hospital an approved social worker shall interview the patient in a suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.”

This led Lord Bingham to conclude:

“It is plainly of importance that the ASW is subject to a statutory duty to apply for the admission of a patient where he is satisfied that such an application ought to be made and is of the opinion specified.”³⁷

(c) Lord Bingham's conclusion

Although he put it differently himself, Lord Bingham's conclusion was that the appeal should fail. He reached this conclusion without relying in any way upon the ECHR.³⁸

In resolving the central question in the appeal, Lord Bingham set out the following test:

“[A]n ASW may not lawfully apply for the admission of a patient whose discharge has been ordered by the decision of a mental health review tribunal of which the ASW is aware unless the ASW has formed the reasonable and bona fide opinion that he has information not known to the tribunal which puts a significantly different complexion on the case as compared with that which was before the tribunal.”³⁹

In his judgment there was no broad obligation upon the ASW to make enquiries as to the existence of an earlier MHRT decision. Unless there were exceptional circumstances or the facts were already well known to him/her, an ASW would simply be obliged to enquire into the patient's background and medical history, and to consult those doctors who had pertinent information to give. This obligation was implicit in MHA 1983, section 13. If, by these means, the ASW learned of an earlier MHRT decision, s/he would no doubt wish to know the reasons for it. However, if s/he did not become so aware, s/he could not be subject to a more wide-reaching duty of enquiry. Thus, Lord Bingham rejected Sedley LJ's conclusion that an admission decision could be invalid even where those responsible were not aware of the earlier MHRT decision.⁴⁰

³⁷ *Ibid.*

³⁸ *Ibid.*, para 10

³⁹ *Ibid.*

⁴⁰ *Ibid.*, para 11

Lord Bingham set out three hypothetical examples in which the ASW – or the nearest relative – might lawfully apply for a patient’s re-admission under MHA 1983:⁴¹

- (a) The issue before the MHRT was whether the patient would harm himself if he were discharged. According to the evidence it heard, the MHRT discounted that possibility and discharged the patient. However, after the hearing, the ASW learns that the patient had previously made a determined attempt on his own life. This information was not known to the ASW or the doctors, or, therefore, to the MHRT.
- (b) The MHRT was persuaded by the patient’s assurance that he would continue to take his prescribed medication, and decided to discharge him where it would not have done so if that assurance had not been given. The patient subsequently refuses to take his medication (or indicates that he will refuse in future).
- (c) After a MHRT hearing, the patient’s mental condition “significantly deteriorates, so as to present a degree of risk or require treatment or supervision not evident at the hearing”. (This was essentially the position encountered by the professionals in *R (H) v Oxfordshire Mental Healthcare NHS Trust*,⁴² in which, having applied the Court of Appeal’s test in *Von Brandenburg*, Sullivan J held the patient’s re-detention to be lawful.⁴³)

On the issue of the reasons that must be given to a patient, Lord Bingham felt it was necessary to distinguish between the obligations of the relevant professionals. First, he dealt with the doctors:

*“Whilst it will doubtless be helpful if a medical recommendation identifies any new information on which it is based, a recommending doctor is not in my opinion required to do more than express his or best professional opinion.”*⁴⁴

However, because the decision of a MHRT should be respected, the duty imposed upon the ASW would be more onerous, if only slightly so:

*“[A] patient should be informed why an earlier tribunal decision is not thought to govern his case if an application for admission is made by an ASW inconsistent in effect with the earlier decision.”*⁴⁵

Nevertheless, even this duty would be a limited one, and the ASW could not be required to make a disclosure that would be harmful to the patient or others. (This might be so, for example, where the decision to re-detain was based on information obtained from a relative of the patient or from a doctor with whom s/he has “a continuing and trusting relationship”.⁴⁶) Therefore, “it may be necessary for the ASW to give reasons in very general terms”.⁴⁷ In setting out the limits of the obligations imposed, respectively, upon doctors and upon social workers, Their Lordships’ judgment remedies one of the uncertainties arising from the Court of Appeal judgment that was identified by Stern and Hewitt.⁴⁸

Lord Bingham said that the Court of Appeal might have allowed the patient’s appeal. Although he hadn’t managed to establish the ‘change of circumstances’ test, he had modified the “somewhat

41 *Ibid.*, para 10

42 [2002] EWHC Admin 465

43 See discussion in Richard Jones, *op cit.*, para 1-049

44 [2003] UKHL 58, para 12. This view finds an echo in Kristina Stern and David Hewitt, *Re-admission under the Mental Health Act following discharge by a*

Mental Health Review Tribunal, JMHL, July 2002, edition no 7, pp 169–178

45 [2003] UKHL 58, para 12

46 *Ibid.*

47 *Ibid.*

48 Kristina Stern and David Hewitt, *op cit.*, p 174

inflexible rule that had been applied” at first instance (which had been borrowed from Laws J in *Ex parte M*⁴⁹). However, Lord Bingham added that the patient “has gained little by his appeal to the House”.⁵⁰

Finally, Lord Bingham noted that neither the Administrative Court nor the Court of Appeal had been able to consider the facts of this case, and to resolve certain disputes between the parties. However, Their Lordships had seen certain untested witness statements, which, according to Lord Bingham, suggested that the decision to re-detain this patient would have fallen within the test set out here, and *would* therefore have been lawful.

DISCUSSION

(1) Practical lessons

The decision of the House of Lords in *Von Brandenburg* certainly gives practitioners more clarity. It is probably now true to say that where a patient has been discharged by a MHRT, his/her subsequent re-detention is lawful where:

- (a) the ASW has information not known to the MHRT which puts a significantly different complexion on the case as compared with that which was before the MHRT; and
the ASW informs the patient in broad terms of this conclusion (subject of course to the overriding duty on the ASW not to make any potentially harmful disclosure);

or

- (b) having fulfilled the MHA 1983, section 13(2) duty, the ASW is unaware of the tribunal discharge.

There is no requirement that either the recommending doctors’ or the hospital managers’ decisions be scrutinised to identify any similar analysis.

It follows that it is now more important than ever that ASWs and RMOs attend MHRT hearings, and that they stay for the decision and reasons, so that they know what information was – and, perhaps more importantly, what information can be said not to have been – known to the tribunal. It is equally important that tribunals do not delay in providing full written reasons for their decisions. Ideally, although this is not required by the relevant rules,⁵¹ they should provide such information before any discharge takes effect. In this way, everyone concerned in a MHRT decision may be helped to understand the factors that have, and have not, been taken into account.

(2) Changing tests

In holding as they did, Their Lordships considerably refined the tests set out by the Master of the Rolls and Sedley LJ. in the Court of Appeal.

In future, what will matter is whether the information that is thought to militate in favour of re-detention was known to the tribunal; and if it wasn’t known, whether it puts a significantly different complexion on the case.

⁴⁹ See note 8

⁵⁰ [2003] UKHL 58, para 13

⁵¹ MHRT Rules 1983, rr 24(1) and 33(d)

Information that puts a significantly different complexion on the case may relate to events that occurred *before*, or to a state of affairs in being *at the time of*, the MHRT hearing. If it is to justify re-detention, and if that re-detention is to be lawful, the sole requirements are that the information was not known to the tribunal and that it justifies admission. This is a necessarily practical test, which is likely to be resolved by recourse to clinical opinion. However, ultimately, it will be for the ASW, and not the recommending doctors, to be satisfied that the test is made out.

(3) A ghost at the feast

There was a ghost at this particular feast. It lurked unheralded over the proceedings, and has now disappeared without a trace – or *almost* without trace.

Readers may remember, if only for its dramatic facts or breathless title, the case of *H v Ashworth*,⁵² in which the High Court imposed and then removed a stay on a patient's discharge, which had been granted by an exasperated tribunal on five minutes' notice. Eventually, the Court of Appeal rejected the first instance finding that *von Brandenburg* would not apply – and a patient might be re-sectioned without more – if the relevant professionals believed on substantial grounds that the MHRT had erred in law. The Court also explained how its own test in *von Brandenburg* should be applied. Dyson LJ. said:

*"[...] when considering whether to re-section a patient who has only recently been discharged by a tribunal, the question that the professionals must ask themselves is whether the sole or principal ground on which they rely is one which in substance has been rejected by the tribunal. If it is, then, in my view, they should not re-section. In deciding whether the grounds on which they rely are ones which have been very recently rejected by the tribunal, they should not be too zealous in seeking to find new circumstances."*⁵³

This test closely resembles the one established by Their Lordships in *von Brandenburg*, and both parties relied heavily upon it in their submissions in that case.

(4) Changed circumstances?

It is ironic, perhaps, that, some 10 years and two significant cases later, the test advanced by Laws J. in *Ex parte M*⁵⁴ has for practical purposes been revived insofar as it concerns the obligations of the recommending doctors (but not, of course, the ASW). Laws J. said:

"[MHA 1983,] section 13 imposes a duty on an approved social worker to make a section 3 application in the circumstances which that section specifies; the duty is not abrogated, or qualified, in a case where there has been a recent tribunal decision directing discharge; if it were to be abrogated or qualified, section 13 would say so. That being the case, the hospital managers must be obliged to consider on its merits an application made by the approved social worker in pursuance of his or her duty, and the existence of a recent tribunal decision can no more fetter this obligation than it can the social worker's own express duty under section 13."

52 *R v Ashworth Health Authority and others, ex parte H : R v (1) Mental Health Review Tribunal for West Midlands and North West Region (2) London Borough of Hammersmith and Fulham (3) Ealing, Hounslow and Hammersmith Health Authority, ex parte Ashworth Hospital Authority* [2002] EWCA Civ 923.

See also: David Hewitt, *Challenging MHRT decisions*, *Solicitors Journal*, vol 146 no 14, 12 April 2002, pp 338-9

53 [2002] EWCA Civ 923, para 59

54 See note 8

CONCLUSION

The House of Lords gave judgment in *von Brandenburg* on the same day it gave judgment in the case of *R (on the application of IH) v Secretary of State for the Home Department*⁵⁵. There was a certain symmetry to that. When the Court of Appeal gave judgment in *von Brandenburg* it also gave judgment in *R (on the application of K) v Camden and Islington Health Authority*⁵⁶. In both *IH* and *K* the applicant had sought judicial review of a failure to satisfy the conditions of a deferred conditional discharge. In both cases this was because of refusals by community psychiatrists to provide supervision and/or treatment in the community.

In *IH* and *von Brandenburg* the House of Lords was faced with mirror images of the same question: to what extent should the professional judgment of psychiatrists be constrained by the conclusions of a MHRT? In answering that question, Their Lordships focused resolutely upon the true extent of the tribunal's jurisdiction: in each case, the question for a MHRT is whether, on the facts at the time of the hearing, a patient's continuing detention is justified. The tribunal may not determine what treatment should be provided in the community or when re-admission can properly take place, nor can it in any way constrain the clinical judgment of doctors who might recommend admission in future. To the extent that MHRT decisions may be seen effectively to constrain re-admission, their relevance is to the question of the *appropriateness* of an application.

In this way, Their Lordships may have reconciled the role of professionals with that of the MHRT, at least for the time being.

⁵⁵ [2003] UKHL 59

⁵⁶ [2001] EWCA Civ 240

Book Reviews

Mental Health Law Policy and Practice, by Peter Bartlett and Ralph Sandland (2nd edition)

Published by Oxford University Press (2003) £26.99

The publication of the second edition of *Mental Health Law Policy and Practice* marks a significant milestone in the development of mental health legal literature whilst at the same time exemplifying the challenge faced by all those interested in the subject: how do you keep up with the sheer volume of legal activity in this particular area? Fortunately the authors of this authoritative and demanding text do so admirably and the second edition ensures that it will remain pre-eminent.

The first edition published four years ago was 447 pages long: the second has 776 pages. The text of the second edition was sent to the publishers in April 2003 and yet as the authors acknowledge and detail in their preface, there has been an avalanche of important cases and other developments since then: *R v Drew* [2003] UKHL 25; *Munjaz v Mersey Care NHS Trust, S v Airedale NHS Trust and others* [2002] EWCA Civ 1036; *JD v East Berkshire Community NHS Trust* [2003] EWCH Civ 1151 and the draft *Mental Incapacity Bill* to name but a few and that was only between April and August when the preface was written. Since then there have been more developments including cases of the importance of *R v East London and the City Mental Health NHS Trust and another, ex parte von Brandenburg (aka Hanley)* [2003] UKHL 58.

The volume of legal activity in the field of mental health has of course, in part been fuelled by the Human Rights Act 1998, which came into force after the publication of the first edition. A cursory inspection of the NHS Litigation Authority website¹ and its details of the human rights decisions impacting on different aspects of healthcare illustrates very clearly how much more activity there has been in mental health as compared with any other form of healthcare. The other challenge for all authors of seminal texts in this field over the past four years has been what might be termed the eternal imminence of any law making Parliamentary activity in relation to the draft Mental Health Bill of June 2002. The temptation to hang about just a bit longer to see if anything substantive happened must have been fairly great but as the authors rightly conclude there were compelling reasons to “to publish a second edition without further delay”: not least of which is that when the time comes to assess the next edition of the Mental Health Bill, commentators and interested parties will have the advantage of this book and its fundamental quality which is not “to provide snappy answers to snappy questions” but to realise that “simple answers to questions of social regulation” just do not exist. A truth borne out by the five years it has taken so far to think about how to change the Mental Health Act 1983.

¹ www.nhs.uk/docs/HRA

The structure of the second edition remains the same as that of the first: chapter one seeks to conceptualise mental health law, the second addresses problems of definition and the third provides an overview of the contemporary mental health system. Underlying the discussion in these chapters and indeed throughout the book is the authors' belief, restated in this edition that it is almost immoral to "divorce the study of mental health law from the social situation of the people most directly involved." They recognise that at its root, mental health law is about power and the compulsion and forcible treatment of people, the exercise of which appears to be focussed disproportionately on particular groups not least the poor. Their skill is not to suggest that such realities render invalid the mental health therapeutic enterprise but that for its own good we must never stop asking about them. When the Minister of State for Health announcing the establishment of the expert committee to review the Mental Health Act in 1998, said "Non-compliance can no longer be an option when appropriate care in appropriate settings is in place. I have made it clear to the field that this is not negotiable" he was adopting what many would see as an extreme position in relation to the three fundamental questions about compulsory treatment posited by the authors:

- Is the expectation of unswerving adherence to treatment in a professional context perceived by the patient as alienating, reasonable;
- Can the enforcement of treatment be justified if psychiatry is rightly perceived as not being an exact science; and
- Should the patient's view be subordinated to a medical vision of their condition?

The answer to all three is not simple or straightforward and not only should mental health lawyers be appropriately armed at least to recognise their validity and be able to address them but also mental health professionals (many of whom ask themselves and others these questions all the time) and especially, at this time of current or imminent policy, service organisation and legal reform, those with responsibility for devising and making such changes.

The authors, having set the scene then, in the next three chapters follow, as it were, the progress of an individual through the compulsory mental health system: admission to hospital, the process of civil confinement, mental disorder and criminal justice, treatment in hospital and leaving hospital. On the way they tarry over many a juicy issue and amongst these is their discussion in the first of these chapters, of the draft Mental Health Bill published for consultation in 2002.

At page 181 they consider the current debate about the place of capacity in any proposed criteria for compulsion. Whilst reasonably convinced that capacity is a workable gatekeeper for treatment (they refer to the experience of the Province of Ontario, which in 1986 introduced a system where treatment could not be imposed on a competent patient without consent) they are far less convinced about its application to psychiatric confinement. Their argument is complex and detailed and culminates with perhaps the most difficult question that requires an answer: how far would individuals need to understand their psychiatric condition and in particular their dangerousness to themselves or others in order to have capacity to make decisions about confinement? Their concerns about the capacity test lead them to suggest that "if such understandings are required, much of the practical advantage of the capacity standard over the dangerousness one disappears", for, as they argue "all the difficulties of assessment return, and the social control ramifications continue, merely under the guise of a neutral capacity test." Whilst I am not certain that the authors' suggestion that the proponents of the capacity test have not

considered these issues at length is entirely fair, they are absolutely right to lay down this marker. In their discussion of the draft Bill, Bartlett and Sandland focus on the key issues: the definition of mental disorder; the proposed criteria for compulsion; the lack of discretion in implementation and dangerousness. Given the Bill's possible metamorphosis into something slightly different next time round, it was probably sensible not to explore at any length its other aspects but it would be interesting to know what they think about proposals such as those about informal carers rights, the adequacy of the safeguards for informal treatment of patients not capable of consenting, the acquisition of a "right" to a mental health advocate for those subject to compulsion and the near demise of any substantive "lay" involvement in the operation of the Act.

At this time of change there is a temptation to focus on the contemporary and to fail to recognise that not only is "mental health law as old as law itself" but that the questions it seeks to address fundamentally never change and in the main are not susceptible to some final and satisfactory solution. At a more prosaic level whatever happens about the draft Mental Health Bill, the earliest any new Act will be implemented seems to be 2006 and therefore we have at least two more years of the 1983 Act and probably more.

At the core of this book and especially in its middle chapters lies the Mental Health Act and the authors, building on the secure base of the first edition, have comprehensively accommodated the mass of legal activity and especially litigation about the Mental Health Act over the last four years. Their discussion at the outset of the book of the impact of the Human Rights Act is salutary: whilst the Act has clearly had an impact and acknowledging that it is still early days, it is not yet clear if, amongst other things, it is effecting a fundamental cultural change in the judiciary. *R v Broadmoor and MHA Second Opinion Approved Doctor, ex p. Wilkinson* [2002] 1 WLR 419(CA) and *Von Brandenburg* indicate that perhaps it may be, even though the influence of human rights may actually be expressed in the development of common law principles.

The challenge of the Human Rights Act and ingraining it in the mindset of public authorities and those, whose professional responsibilities include acting compatibly with the Act, is possibly a more demanding and immediate task. In a recent report, the Audit Commission² conclude that "three years on, the impact of the Act is in danger of stalling and the initial flurry of activity surrounding its introduction has waned." Rather depressingly the health service comes out amongst the poorest performing public authorities with the level of human rights training remaining unchanged since the previous Audit Commission review in 2002. Whatever the actual level of awareness of the implications of the Human Rights Act amongst those charged with the implementation of the Mental Health Act, in this book there is a discussion of human rights cases that is not only comprehensive but which places them in the broader legal, policy and operational context that is essential if the human rights discourse and its potential to contribute to binding and cementing a diverse society – what Francesca Klug calls "values for a godless age"³ – is to be fully realised in mental health.

Once the journey through the labyrinth of compulsory admission, treatment and discharge is completed, the authors focus their attention on the care and control of mentally disordered people in the community. Premised on the understanding that "community care" comprises two discrete systems: service provision and control and supervision, they have developed their thinking since

2 page 3. Audit Commission (2003) *Human Rights: Improving Public Service Delivery*

3 Klug F. (2003) *Values for a Godless Age*. Penguin.

the first edition and crystallize the essential “paradox that traverses all policy and practice in this area.” In particular they argue that the different if not contradictory definitions of ‘community’ implicit in each is significant. Service provision incorporates notions of social inclusion and sees no difference between the interests of mentally disordered persons and those of the broader community. Control and supervision involves concepts of social exclusion, the perception that the interests of the broader community are in opposition to those of mentally disordered people and that as a consequence the rights of mentally disordered people may be overridden in the public interest. In many ways it is in this arena where some of the more radical proposals for reform of the Mental Health Act are to be found and essential to any competent assessment of such proposals, is a clear and coherent exposition of the relevant law and in particular the legal basis for the provision of services. This is a notoriously complex area of law and a personal acid test is the clarity and coherence with which this topic is addressed; especially the extent to which law is related to policy and practice. Bartlett and Sandland are not the only people who write about this topic but the way in which they expound the rather uneasy relationship between the provision of services and the law and interweave into their discussion the, at times, rather mirage like notion of community control is a delight and left one reader at least with considerably greater understanding. In terms of the future this is one of the more important chapters in the book.

The penultimate topic addressed by *Mental Health Law Policy and Practice* is mental incapacity. In doing so they face two challenges. The topic cannot, they argue, “be omitted because it is in part codified by Part VII of the Mental Health Act and it so heavily overlaps... with the lives of the people with mental health problems; yet at the same time, it also concerns people who are not mentally ill in the conventional sense.” The other difficulty is that the second edition preceded the publication in June 2003 of the draft Mental Incapacity Bill. The impact of the latter is minimised by the fact that the Law Commission’s draft Incapacity Bill that is discussed is so similar to the Government’s proposals. The former requires an explanation of how incapacity fits with mental health law “as understood in the rest of the book”: not difficult of course especially as, amongst other things, the first involvement of the law in mental health, Edward 1st’s 1324 statute giving the King jurisdiction over the persons and property of idiots was essentially about mental capacity and property. The subject gets two chapters and whilst the authors’ fascination with mental healthlaw as a whole is very apparent from the vigour of the discussion maintained throughout, it may not be entirely fanciful to suspect that mental incapacity holds a special interest. The first chapter deals with broad issues and basic concepts and deftly interweaves legal, ethical and clinical aspects of mental capacity in a way that is helpful and enlightening for anyone but especially the relative newcomer. Subsequently the authors consider some specific contexts of mental incapacity including the courts response to the “guardianship gap” and in particular the implications of *In Re TF (An Adult: Residence) [2000] 1 MHLR 120* and what the authors describe as its “expansive” approach to its jurisdiction in this area which looks to them to be remarkably like the re-introduction of the doctrine of *parens patriae* for incapacitated people and personal decision taking. Their subsequent, and on the whole approving, critique of the Law Commission’s proposals to reform the law relating to mental incapacity is helpful, obviously relevant to any consideration of the draft *Mental Incapacity Bill* and underlines the importance of ensuring that whatever emerges dovetails with not only the Mental Health Act but also any future Mental Health Bill.

Mental Health Law Policy and Practice started life because there was a textbook gap for students taking the mental health law module at Nottingham University. Whilst it is primarily but not

exclusively designed for lawyers, it is appropriate that it ends with an exploration of the role of the law in securing people's rights and the contribution that legal advocates can make to that end. The law is without doubt extraordinarily important in ensuring that people with mental health problems are dealt with in a consistent and humane way. The wide variations, regional and otherwise in the application of the Mental Health Act suggest that the degree of control that it can provide has its limitations. Whatever contribution the law can make, it has to be accompanied by other things: amongst which are appropriate services, high professional standards and the development of a coherent ethical approach to the use of compulsion. The Mental Health Act Commission's welcome discussion in its 10th Biennial Report⁴ of the values that should prevail in mental health services, and particularly in those that involve the compulsion of patients marks perhaps the start of a more widespread and long overdue debate about this.

With the second edition the authors have ensured that *Mental Health Law Policy and Practice* remains essential reading for not only those who wish to contribute to that debate but also anyone who wants to understand modern mental health care and in whatever way contribute to its improvement.

William Bingley

Professor of Mental Health Law and Ethics, University of Central Lancashire

⁴ page 55. *Mental Health Act Commission's Tenth Biennial Report 2001–2003*, The Stationery Office. Also see the commentary on the Report by Mat Kinton in this issue of the JMHL.

Decisions and Dilemmas – Working with Mental Health Law, by Jill Peay

Published by Hart Publishing (2003) £22.50

In her foreword, Lady Justice Hale (as she then was) describes this book as “fascinating” and “a stimulating read”. This reviewer unreservedly agrees.

Its publication is also very timely. Not only is this (as all readers of this Journal will be all too aware) a time of “ferment in mental health law” (to quote from the book’s back cover), but also the surge of caselaw activity in the area which has occurred since the coming into effect of the *Human Rights Act 1998*, shows no sign of abating. Consider the attention recently given by the courts to Part IV of the *Mental Health Act 1983*, as witnessed in cases such as *Wilkinson*¹, *N*² and *PS*³ – a level of scrutiny which, incidentally, clearly has by no means yet run its course. Those cases well illustrate the range of issues which must now be addressed by those responsible for determining whether or not treatment is to be imposed on a non-consenting detained patient. No longer is it acceptable for Responsible Medical Officers (RMOs) and Second Opinion Appointed Doctors (SOADs) to simply (not that it was ever ‘simple’) apply the statutory provisions set out in particular in sections 63 and 58, but now they must also consider a myriad of other matters in deciding whether or not a proposed treatment is ‘medically necessary’ and ‘in best interests’. Dyson L.J.⁴ and Silber J.⁵ have sought to assist with their lists of relevant lines of enquiry, and in so doing they have highlighted not only the complexity of the issues to be considered but also the standard of decision-making now (rightly) expected. As its title suggests, this book is about how key players such as RMOs and SOADs, make such decisions, many of which are of course of the utmost gravity for those affected.

The informative explanatory preface is essential reading. Like all good prefaces it tells the reader both the context in which the book has been written and what to expect in the following 177 pages of main text (three appendices, a bibliography and an index add a further 40 pages – more on them later). Perhaps more unusually, but rather charmingly, it also contains the author’s own assessment of the outcome of her efforts: thus rather disparagingly she describes the book as “odd” (“For many it will fall between two stools, having neither the methodological rigour of a research report nor the analytical rigour of a scholarly legal text”) and a “smorgasbord” (Concise Oxford Dictionary definition: “Buffet meal with variety of dishes”). By her own high standards, she may be right, but neither criticism (if indeed they can be truly be described as such) in any way detract from what is really, to adopt the BBC Radio 4 accolade, a ‘[very] good read’.

Although not specifically delineated as such, the book is really in two parts. The first part describes and analyses research carried out in 1998/9 by the author, a reader in law at the London School of Economics, and Professor Nigel Eastman, a forensic psychiatrist at St. George’s Hospital Medical School, London. The second part considers the research study firstly alongside other relevant research and literature, and secondly in the context of ongoing legal and policy developments.

Dr. Peay and Professor Eastman are both well-known and respected commentators on, and

1 *R (on the application of Wilkinson) v Broadmoor Special Hospital Authority and others* [2001] EWCA Civ 1545

2 *R (on the application of N) v Dr. M and others* [2002] EWCA Civ 1789

3 *R (on the application of PS) v Dr. G and others* [2003] EWHC 2335 (Admin) – reviewed by Peter Bartlett in this issue of the JMHL.

4 See the case of *N* (footnote 2 above)

5 See the case of *PS* (footnote 3 above)

contributors to, the development of mental health law⁶. The research which forms the backbone to the book was funded by the Department of Health and formed part of the Department's programme of research investigating the operation of the 1983 Act. The Department's stated intention was to acquire a better understanding of how the Act works in practice, an aim surely assisted by this research. The author succinctly summarises the research study as follows:

"Taking part in the original study were psychiatrists approved under section 12(2) of the 1983 Act as having 'special experience in the diagnosis or treatment of mental disorder', approved social workers (ASWs) and a second group of psychiatrists who also held the formal position of second opinion appointed doctor (SOADs). In total, 106 such practitioners participated. Each was required to make decisions alone and as a member of a professional pair, with psychiatrists being paired with approved social workers or with other psychiatrists, namely, the second opinion appointed doctors.

The individual and paired decisions required of them related to three commonplace scenarios. First, the decision to admit a patient to hospital under compulsion; second, the decision to discharge a detained patient from hospital; and finally, the decision to give medical treatment to a patient on a compulsory basis. Three hypothetical but entirely fictitious cases were devised which addressed these scenarios. In making the decisions, both alone and in their professional pairs, practitioners had access to extensive case materials and video evidence; their decisions were also subject to interrogation and deconstruction as part of the research exercise.

In studying decision-making in this way, the focus of the research was not so much on establishing what decisions the practitioners reached, but on how those decisions were reached. Given that there were very divergent outcomes, what were the justifications and reasoning processes adopted? Thus, the book strives to identify the range of strategies employed by real-life practitioners to resolve these three cases, and in so doing explores the ethical, legal and clinical conflicts posed by 'everyday' dilemmas in mental health practice."

Both the quality and quantity of the information provided to the participants about Robert Draper ('A case for Admission?' – chapter 1), Clive Wright ('A case for Discharge?' – chapter 2), and Hazel Robinson ('A case for Treatment?' – chapter 3) make the scenarios very realistic, and it is no surprise that the participants appear to have thrown themselves fully into the roles required of them, an essential pre-requisite for the research to be meaningful. In total 52 psychiatrists, 14 SOADs (all psychiatrists of consultant status) and 40 ASWs took part. Given the fact that participation inevitably meant a not inconsiderable demand on the time of busy professionals, this is an impressive number, and is no doubt indicative of professional respect for the researchers, a desire to learn ("some were tortured souls whose own doubts about their facility with the Act led them to participate in the hope that they might learn something"), a commitment to contribute in a small way to the process of legal change (the initial 'invitation' letter made it clear the importance of the study for law reform) and/or an 'against-the-odds' hope of securing the 'mystery' incentive prize (subsequently revealed to be a weekend for two in a Heritage hotel).

The three opening chapters of the book are absorbing. The author's hope that she might "recapture the sense of anxiety, excitement, curiosity and discovery experienced by those participating in the research" has, in the judgment of this reviewer, been realised. The excruciatingly difficult dilemmas facing the decision-makers are well exposed⁷. To summarise within this review the outcome of the research, and in particular the author's painstaking and conscientious analysis of it, would be a

6 For example they jointly edited 'Law without enforcement' (Hart Publishing) (1999), an impressive collection of essays about the effectiveness of mental health law, reviewed in JMHL (Feb 1999).

7 The questionable objectivity of assessment of this by the reviewer needs to be acknowledged – he well recalls his own agonising as an inexperienced but 'authorised' social worker attempting to apply the provisions of the Mental Health Act 1959.

disservice to her and her publishers, and no such summary will be attempted. Suffice it to say, issues such as knowledge (or rather lack of knowledge) of the law, the pros and cons of duo-disciplinary decision-making, the significance of one discipline being the statutorily-defined ‘lead’ decision-maker in certain scenarios (e.g. the ASW as the admission-applicant; the R.M.O. as the section-‘renewer’), ‘decision-shyness’ amongst some professionals, the clinical knee-jerk (but often legally inappropriate) ‘best interests’ response, the ‘forceful personality’ problem, and of course the diversity of approaches taken and the inevitable inconsistencies of decisions reached, all receive careful and thoughtful attention.

Before proceeding to make some reference to the remainder of the book, the following extract from appendix 2 (‘Methodology’) needs to be highlighted:

“Finally, many of those taking part commented on the usefulness of the exercises for training. Indeed, the sessions were regarded as much more instructive [the reviewer’s emphasis] than the single profession didactic training these professionals had experienced. Their inter-disciplinary nature, together with the exposure to the other party’s thinking process, was highlighted as an aid to understanding the working perspectives of the respective professions. Moreover, whilst many of the participants were clearly nervous about the exercise, they also said that they had ‘enjoyed’ the necessarily challenging and sometimes apparently persecutory questioning. The benefit seemed to derive from having to articulate and justify their own reasoning processes in a way they had not previously been called upon to do.”

Throughout England and Wales there are numerous induction and refresher training courses for s.12 doctors and ASWs⁸ (with the Mental Health Act Commission holding in-house sessions for their SOADs). As one who is regularly involved in the provision of such training, this reviewer urges that when devising regulations and guidelines for the essential training which will be required on the introduction of new legislation, the powers-that-be take note of this perceptive and highly important observation. Research has shown the limitations of current training⁹. Realistic case-study scenarios, such as those used in the author’s research, with an insistence that course participants come from each of the relevant disciplines (which from the proposals contained in the *Draft Mental Health Bill 2002*, will also include appropriately qualified nurses), would surely have a greater prospect of effectiveness than the closeted ‘one-discipline-at-a-time’ approach adopted so commonly at the present time¹⁰.

The second ‘part’ of the book is as thought-provoking as would be expected from an academic who has devoted so much of her career to a consideration of mental health law generally, and decision-making specifically¹¹. Chapters 4 and 5, and the concluding chapter 6, do not disappoint. In chapter 4 the importance of research is highlighted, as is the fact that when the Department decided in the

8 The contrast (in terms of hours, content and assessment) set out in the requirements both for induction training (and subsequent approval) and for refresher training for these two groups, is great. See Guidance HSG (96)3 ‘Approval of doctors under section 12 Mental Health Act 1983’ (NHS Executive – 1996), and the requirements published in 2001 by the former Central Council of Education & Training in Social Work, ‘Assuring Quality for Mental Health Social Work: Requirements for the training of Approved Social Workers...’ and ‘Maintaining and developing the competence of Approved Social Workers...’. Dr. Martin Humphreys highlighted this contrast in an article ‘Psychiatrists’ Knowledge of Mental Health Legislation’ *JMHL* (October 1999) pp 150–153.

9 For example, see ‘Legal Knowledge of Mental Health Professionals: Report of a National Survey’, Peay, Roberts and Eastman, *JMHL* (June 2001) pp 44–55.

10 For an interesting and timely critique of training of s.12 doctors, see ‘Training for approval under section 12(2) of the Mental Health Act 1983’ Brown and Humphreys *Advances in Psychiatric Treatment* (2003) vol. 9 pp 38–44.

11 The earliest work by the author in this area is revealed by the bibliography of the book to be her unpublished PhD thesis, ‘A study of Individual Approaches to Decision-making under the Mental Health Act 1959’, submitted in 1980.

late 1990s to embark on the (ever-lengthening) road to reform, they faced a dearth of knowledge about the application of the 1983 Act. The chapter then proceeds to an informative exploration of such research as there has been, with the author drawing on work carried out in North America and the Nordic countries to assist her in her task. The chapter concludes with a consideration of the contribution made by the research study (“in short, it provided insights into professionals’ reasoning processes in a quasi-legal decision-making setting”), and a separate brief realistic assessment of the relevance of the research to the actual law reform proposed (with reference to provisions within the *Draft Bill*).

‘Legal and Policy Context’ is the title of chapter 5, and what follows is a look at legal and policy developments since the 1983 Act and a placing of them into a practical context. It is an unashamedly (and overtly acknowledged) biased account, readers being reminded at the outset of the chapter of the author’s membership of the expert advisory group (the ‘Richardson Committee’) established by the Government in 1998 to advise on mental health law reform. It is familiar territory to anyone who has been following the reform saga of the last five years, but the presentation is thoughtful and original and many readers will be in sympathy with the author’s provocative and heartfelt critique.

In the final scholarly chapter, the author, with reference to the research study and the issues arising from multi-disciplinary decision-making, considers conflicts associated with the pursuit of legal certainty and consistency, the difficulties of working in chaotic and complex situations, and the extent to which research can influence law reform, before concluding with comments about the effectiveness and acceptability of the reforms proposed in the *Draft Bill*. She is right to end by restating a central lesson of the research:

“Application of the law is fundamentally an interpretative exercise. It involves the construction of choices and bearing the consequences of the choices made. Given all that has been said here about uncertainty and complexity, it is wise to end on a cautionary note. Legislators should remain vigilant of the law of unintended consequences, for as Heginbotham and Elson¹² have argued, the translation of public policy into practice or law does not always follow the original intentions of those who formulated the proposals.”

Helpful and interesting appendices complete the book. Appendix 1 contains relevant selected sections of the 1983 Act, appendix 2 is a fascinating account of the methodology employed, and appendix 3 (on which this reviewer admits to not lingering) is full of the statistical evidence emerging from the research. The concluding 10 page bibliography bears witness to the enormous industry which lies behind this book, and will serve as an invaluable reference source for all students of mental health law.

In summary, this book deserves to be read and considered by all who care about, and debate, the direction of mental health law, not least of course by those faced with the responsibility of devising the appropriate, ethical and practical legislation of the future. The ‘smorgasbord’ presentation invites ‘dipping’, and all those charged with the responsibility of resolving dilemmas and reaching decisions, could well benefit from reading the very accessible chapters 1,2 and 3. These chapters should be obligatory reading for all those engaged in training such professionals.

John Horne, Senior Lecturer, School of Law, Northumbria University

12 ‘Public Policy via Law: Practitioner’s Sword and Politician’s Shield’ Heginbotham and Elson, pp 59-74 in ‘Law without Enforcement’ ed. by Eastman and Peay (Hart Publishing) (1999)