

# Journal of Mental Health Law

## Articles and Comment

The Mental Health Act 2007 – The Defeat of an Ideal

Community Treatment Orders

Deprivations of Liberty: Mental Health Act or Mental Capacity Act?

Children and Young People and the Mental Health Act 2007

Mental health, community care and human rights in Europe:  
Still an incomplete picture?

Mental Health in the Workplace (2) – Mental Health and Discrimination in Employment

## Casenotes

Human Rights and the Provision of Residential Care under the  
National Assistance Act 1948

The Re-call of Conditionally Discharged Patients – the breadth of the  
Secretary of State's discretion

Protection from what? The nullifying effect of section 139

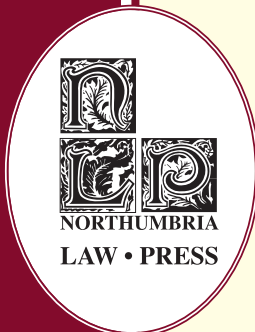
Hello Doli? ... or is it Goodbye?

## Book Reviews

The Nearest Relative Handbook by David Hewitt

Psychiatry and the Law, edited by Warren Brookbanks and Sandy Simpson

Mental Health, Incapacity and the Law in Scotland by Hilary Patrick



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# Journal of Mental Health Law

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### Footnotes and references

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# Foreword

In the Foreword to the May 2007 issue, I said of the perceived 'stand-off' between the House of Lords and the House of Commons in respect of the *Mental Health Bill 2006*, as follows:

*"It seems probable that parliamentary ping-pong between the two chambers will continue during the remainder of the parliamentary session, and the final form of the Bill is far from clear."*

I was wrong. As readers will be well aware, the 'ping-pong' hardly materialised, and on 19th July 2007, the *Mental Health Act 2007* ('the 2007 Act') received the Royal Assent. A process which had started with the appointment of the Expert Committee under Professor Genevra Richardson way back in October 1998<sup>1</sup>, was finally concluded.

The 2007 Act amends the *Mental Health Act 1983* ('MHA 1983'), the *Mental Capacity Act 2005* ('MCA 2005') and the *Domestic Violence, Crime and Victims Act 2004*. It brings in very significant changes to legal provisions within the MHA 1983 for the compulsory detention, supervision and treatment of people suffering from mental disorders. The substantial amendment made to the MCA 2005 is intended to meet the concerns of the European Court of Human Rights in the 'Bournewood' case, *H.L. v U.K.*<sup>2</sup>. For those engaged in the mental health field, be it as lawyers, doctors, nurses, social workers or in some other professional role, or as service users, carers or family members, there is a great deal to take on board before most of these provisions are implemented on the intended date of October 2008<sup>3</sup>. Much of the contents of this issue of the JMHL will hopefully assist readers who need to get to grips with the changes ahead.

Speaking of the Code of Practice to the MHA 1983, Lord Bingham in *Munjaz*<sup>4</sup> said:

*"It is guidance, not instruction... but it is much more than mere advice which an addressee is free to follow or not as it chooses. It is guidance which any hospital should consider with great care, and from which it should depart only if it has cogent reasons for doing so..."*

Increasingly I am viewing the directive on the inside cover of this Journal that "articles should be a maximum of 5000 words", as 'guidance not instruction' and permitting deviation if there are 'cogent reasons for doing so'. I hope readers will agree that the subject-matter of the two opening articles in this issue fully justify the permission given to Rowena Daw and Kris Gledhill to exceed the maximum word-limit.

Rowena Daw was Vice-Chair of the *Mental Health Alliance*, that extraordinary (given the range of bodies who found common cause) grouping of organisations which for so long united to oppose so many of the Government proposals to reform mental health law. As such, she was of course very heavily involved in the ongoing debates. She looks back at the lengthy process and considers some of the end-results in '**The Mental Health Act 2007 – The Defeat of an Ideal**', choosing a title for her article which has echoes of one employed by Jill Peay, a member of the Richardson Committee in the opening article of the February 2000 issue of this Journal ('*Reform of the Mental Health Act 1983: Squandering an Opportunity?*'), an article comparing and contrasting the Expert Committee's Report with the Government's subsequent Green Paper<sup>5</sup>).

Compulsory treatment in the community was on the agenda, and as was clear from the words of the then

1 *The Report of the Expert Committee, 'Review of the Mental Health Act 1983', was published by the Department of Health in November 1999.*  
 2 *HL v United Kingdom (2005) 40 EHRR*  
 3 See the Department of Health website. *Some of the provisions have come into effect already, or will come into effect before October 2008 – see Commencement Orders (Nos. 1, 2 and 3) contained in S.I.s Nos. 2156, 2635 and 2798.*

4 *R (on the appl'n of Munjaz) v Mersey Care National Health Service Trust [2005] UKHL 58*

5 *The Government's Green Paper, 'Reform of the Mental Health Act 1983', was published at the same time as the Richardson Committee's Report – in November 1999.*

relevant Government Minister, not negotiable<sup>6</sup>, from the moment the Expert Committee was appointed. Ten years later provisions for ‘Supervised Community Treatment’ are to come into effect with the ‘damp squib’<sup>7</sup> which is After-care under Supervision being abandoned. Kris Gledhill, a barrister now lecturing in the Law School at the University of Auckland, New Zealand, employs an international perspective when he closely and critically analyses ‘Community Treatment Orders’. He concludes:

*“The legal framework is much less important than resources and good practice: which makes it a real shame that the government made use of smoke and mirrors to create the impression of a problem which was not clearly reflected in the research it relied on and a new solution which merely repackaged what was already there.”*

In a short and succinct article, ‘Deprivations of Liberty: Mental Health Act or Mental Capacity Act?’, Richard Jones, the author of the well-respected and very widely used *Mental Health Act Manual*<sup>8</sup>, considers the amendments made by the 2007 Act to the MHA 1983 (in particular the power to be given to the guardian of a mentally incapacitated person to take the person to where he or she does not want to go, using force if necessary), and states – no doubt somewhat controversially, given the long-established view that guardianship cannot be used to deprive a person of their liberty – that “there would appear to be no legal impediment to prevent guardianship being used to justify the deprivation of a patient’s liberty in a care home in preference to the MCA procedure”. The ‘MCA procedure’ to which he refers is of course the ‘Deprivation of Liberty’ procedure introduced to the MCA 2005 by section 50 of the 2007 Act. As editor of this specialist refereed journal, I am of course delighted to host debates on contentious issues of interest to the readership, and if readers wish to submit a response to this, or indeed any other, article, I would be pleased to be contacted.

In June 2007 the Law School at Northumbria University hosted a seminar ‘Children and Mental Health and Human Rights’. One speaker at the seminar was Camilla Parker. As consultant to the Children’s Commissioner for England, Ms Parker had a particular interest in the rights of young people as the parliamentary debates about the *Mental Health Bill 2006* progressed. The Mental Health Alliance’s representations on behalf of this particular group of service users yielded some success, as her article ‘Children and Young People and the Mental Health Act 2007’ makes clear. Within the article Ms. Parker considers the statutory provision for young people against the background of the *United Nations Convention on the Rights of the Child*, and concludes that despite the additional safeguards secured, there is still cause for concern, particularly for those children under 16 considered to lack competence to make decisions for themselves.

The focus of the next article is community care for those suffering from mental ill-health. Jill Stavert, a lecturer at the Centre for Law, Napier University, asks ‘Mental health, community care and human rights in Europe: Still an incomplete picture?’ Her primary concern is that as care increasingly takes place outside institutions, there is an insufficient acknowledgement at national level of socio-economic rights of those with mental illness despite International and European standards set out in various instruments.

In the May 2006 issue of the Journal we published the first of two articles prepared by Kay Wheat, a Reader in Law at Nottingham Law School, on ‘Mental Health in the Workplace’<sup>9</sup>. I am pleased we are publishing the second article in this issue – ‘Mental Health and Discrimination in Employment’. If a narrow definition of mental health law is adopted, this is clearly not an obvious subject area to be considered within the pages

6 Speech by Mr Paul Boateng, then Parliamentary Under Secretary of State for Health, at first plenary meeting of the Committee on 22 October 1998 – reproduced as Appendix C in the Report of the Expert Committee (November 1999).

7 To adopt the description given to ACUS by Professor Phil Fennell (Cardiff Law School) in his presentation ‘Community Treatment Orders: More than Window-dressing?’ delivered at the Mental Health Law Conference

hosted by Central Law Training in London on 1 October 2007.

8 10th edition and First Supplement (2007), Sweet and Maxwell.

9 ‘Mental Health in the Workplace (1) – ‘Stress’ Claims and Workplace Standards and the European Framework Directive on Health and Safety at Work’, JMHL May 2006 @ pp 53–65.

of this Journal. However I have no doubt the subject-matter is of interest to the readership – hence the acceptance of both articles for publication. It was through no fault of the author that we failed to publish the second article in the issue of May 2007.

In the *Casenotes* section, we first look at the case of *YL v Birmingham City Council and others*<sup>10</sup>. Ralph Sandland (Associate Professor at the School of Law, Nottingham University) casts a critical eye over this significant House of Lords majority decision in ‘**Human Rights and the provision of Residential Care under the National Assistance Act 1948**’. He does not hesitate to point out the worrying implications of the decision for “thousand of care homes and hundreds of thousands of residents in such homes”.

We then move on to consider ‘**The Re-call of Conditionally Discharged patients [and] – the breadth of the Secretary of State’s discretion**’. This issue came before the Court of Appeal in *R (on the application of MM) v Secretary of State for the Home Department and Five Boroughs NHS Trust*<sup>11</sup>. Roger Pezzani (Barrister) discusses the decision, concluding that “whilst this is of course an intensely difficult area, involving the balancing of personal liberty and autonomy against real risks to the public, this judgment’s lack of clear reasoning and failure to make any positive statement of principle beyond the obvious, represents a missed opportunity.”

The case of *Seal v Chief Constable of South Wales Police*<sup>12</sup> was another recent case in which the House of Lords reached a majority decision. David Hewitt, Visiting Fellow to the Law School at Northumbria University, expresses no surprise at the decision in ‘**Protection from what? The nullifying effect of section 139**’, but concludes with a statement of regret that proposals to amend s.139 which had been included within the *Draft Mental Health Bill 2004* did not survive the culling of that document and its replacement with the *Mental Health Bill 2006*.

Our final case review has (with respect to the other authors) the most intriguing title within this issue. Natalie Wortley (Senior Lecturer at the Law School, Northumbria University) asks ‘**Hello Doli? ... or is it Goodbye?**’ The principle of *doli incapax* came in for further judicial examination in the recent case of *Director of Public Prosecutions v P*<sup>13</sup>, a case which should be of considerable interest to anyone concerned with children and young people charged with the commission of criminal offences.

We conclude with three *Book Reviews*. Rob Brown (social work trainer) has written about ‘**The Nearest Relative Handbook**’<sup>14</sup> by David Hewitt; William Brereton (Psychiatrist) has considered a New Zealand book, ‘**Psychiatry and the Law**’<sup>15</sup> edited by Warren Brookbanks and Sandy Simpson; and I have contributed an overdue review of ‘**Mental Health, Incapacity and the Law in Scotland**’<sup>16</sup> by Hilary Patrick.

The next issue is due out in May 2008, and, as always, every effort will be made to adhere to that date. Submissions for publication should be made by 1st February 2008 to allow ample time for completion of the refereeing process. In the meantime, many thanks are due to the contributors to this issue. They have had tight deadlines imposed on them, and I am very grateful to them for their readiness to comply not only conscientiously but also with good humour. One person who has never been publicly thanked in previous Forewords, is Ann Conway, Administrator with Northumbria Law Press. Mrs. Conway does considerable work ‘behind the scenes’ in respect of each issue, and an expression of sincere gratitude to her is long overdue.

## John Horne

Editor

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10 [2007] UKHL 27.

11 [2007] EWCA Civ 687.

12 [2007] UKHL 31.

13 [2007] EWHC 946 (Admin.).

14 Jessica Kingsley (2007).

15 LexisNexis (2007).

16 Tottel Publishing (2006).

# The Mental Health Act 2007 – The Defeat of an Ideal

Rowena Daw<sup>1</sup>

This short account of the history of the reform of the *Mental Health Act* covers the main issues that divided the participants in the process, and the flawed legacy that remains. It gives the background to central provisions of the 2007 Act as they were amended during the parliamentary process and reflects on some problems they raise<sup>2</sup>. It does not consider the amendments to the *Mental Capacity Act 2005* to cover so-called ‘Bournewood’ patients<sup>3</sup>, although some implications of the different regimes will be mentioned.

The *Mental Health Bill 2006* has now reached the statute books. It bears the scars of its tortured history: an ideological warfare conducted between the government and everyone else over a seven year period ending with a torrid passage through Parliament where the outcome was decided, inevitably, by a Labour majority in the House of Commons.

In the House of Lords, Conservatives, Liberal Democrats and Crossbenchers under the expert leadership respectively of Earl Howe, Baroness Barker and Lord Williamson had united in their opposition to the core of the Bill. Collectively they commanded formidable expertise<sup>4</sup>. They were informed by the report of the Joint Scrutiny Committee into the 2004 Bill<sup>5</sup>, legislative scrutiny reports from the Joint Committee on Human Rights<sup>6</sup> and by the research of the Mental Health Alliance<sup>7</sup> and other stakeholders. To these were added, in the last stages, the Institute of Psychiatry report on the international experience of community treatment orders<sup>8</sup> and the written and oral evidence presented to the Public Bill Committee

- 
- 1 Vice-chair, Mental Health Alliance. Rowena Daw was a legal adviser to the opposition throughout the Mental Health Bill debates in Parliament. She worked on the Bill at Mind and later as consultant at the Royal College of Psychiatrists during most of the period covered by this article, but the views expressed are personal to her. The author is grateful to Mat Kinton (Senior Policy Analyst, Mental Health Act Commission) for his editorial assistance.
  - 2 For an excellent account of the detailed provisions of the Act, see Mental Health Act Commission Mental Health Act 2007, Policy Briefing for Commissioners, July 2007 [www.mhac.org.uk](http://www.mhac.org.uk).
  - 3 Introduced by section 50 Mental Health Act 2007.
  - 4 They included Lord Carlile (Chair of the Scrutiny Committee); Lord Patel (Chairman of Mental Health Act Commission) Baroness Neuberger (Former Chief Executive Kings Fund) Lord Adebawale (Chief Executive of Turning Point) Lord Bragg (President of Mind) Psychiatrists Lord Alderdice and Baroness Murphy, Baroness Meacher (Chair of Mental Health Trust).
  - 5 Joint Scrutiny Committee on Draft Mental Health Bill 2004, Vols I–III.
  - 6 The Joint Committee on Human Rights played a significant role in the process of reform, through its detailed critique of the 2002 Bill and then a series of Scrutiny reports on the 2007 Bill. Joint Committee on Human Rights, Legislative Scrutiny: Mental Health Bill, 22nd Report Session 2001–2; 4th Report Session 2006–7; Legislative Scrutiny: Seventh Progress Report 15th report Session 2006–7.
  - 7 The Mental Health Alliance, finally a coalition of 80 organisations, was a unique alliance of: service users; psychiatrists; social workers; nurses; psychologists; lawyers; voluntary associations; charities; religious organisations; research bodies; and carers’ groups. The Alliance was established in 1999, solely for the purpose of working for improved mental health legislation, following widespread concern about Government proposals for a new Mental Health Act. Some professional organizations suspended their membership in June 2007 because of differences of view over professional roles, although these issues were later resolved. Remaining members continue to work on the Code of Practice.
  - 8 Churchill R et al (2007) International Experiences of using community treatment orders, Institute of Psychiatry.



in the House of Commons<sup>9</sup>. There was an astonishing consensus from all these viewpoints. In a series of amendments the House of Lords savaged the heart out of the Bill, only to have all their amendments reversed by the House of Commons. In the end the House of Lords was overruled. Baroness Barker stated that:

*the Bill is not the step forward for people with mental health problems that we all wanted, it is not the Bill that we needed and it will not be the legislation that we need.*<sup>10</sup>

Ultimately, despite the mountain of expertise, it was a mixture of serendipity, intransigence, hasty compromises and the arcane practices of parliament, leavened to an extent by reasoned debate, that produced the text of new law. It was a shambolic way to produce legislation of such importance for people's lives

This was to be the mental health law for a new generation – the first full-scale re-examination of mental health law since 1959. New Labour was riding the crest of the wave. The mental health community saw this as the chance for an enlightened and up to date approach to the care and health of those with mental illness, a chance to put into practice ideas, clinical approaches and values many of which were already common currency in academic and professional circles. Therapeutic care and civil rights were central to this. Medical practice and treatments for mental illness had changed, paternalism and authoritarianism was on the wane, human rights law had developed, disability discrimination law had sprung up, professional roles and attitudes evolved, the National Service Framework for Mental Health was being drawn up, service user groups were alert and articulate. This was the background to the formation of the Expert Committee chaired by Professor Geneva Richardson. Their report<sup>11</sup> was a detailed and coherent blue print for new legislation. It proceeded from the central propositions of non-discrimination, patient autonomy, a preference for voluntary treatment over compulsion, and the concepts of a right to care and treatment.

Government, on the other hand, had different priorities. It was driven to legislate by its need to deal with breaches of the European Convention on Human Rights; its wish to give flexibility in delivery of mental health services through compulsory treatment in the community; and its fear of 'loopholes' through which otherwise treatable patients might slip. In its general approach, the government followed a populist agenda fuelled by homicide inquiries into the deaths caused by mental health patients<sup>12</sup>. Public concern and media frenzy went hand in hand to demand better public protection against those who were mentally ill and dangerous. Although the government dropped its unpopular policy for dealing with people with "dangerous and severe personality disorder", they remained obsessed with the "problem" of risk and the need to give clinicians every power they might need to contain it. The then Health Minister Rosie Winterton MP stated that "every barrier that is put in the way of getting treatment to people with serious mental health problems puts both patients and public at risk"<sup>13</sup>. This conflates the need for treatment with the need for compulsion, and is the antithesis of Richardson Committee approach under which voluntary treatment should always be the preferred option and compulsion the last resort.<sup>14</sup>

Thus the lines of conflict were drawn from the beginning. Through Green Paper, White Paper and the Bills of 2002 and 2004, the Government pursued these agendas, little deflected by the widespread opposition led by the Mental Health Alliance, whose members grew to include almost all stakeholders.

9 These are published on the parliamentary website <http://www.publications.parliament.uk/pa/>

10 Hansard HL 2 July 2007, Col 817.

11 Expert Committee (1999) *Review of the Mental Health Act 1983*, Dept of Health, November 1999.

12 For a detailed account see Rogers & Pilgrim (2001) *Mental Health Policy in Britain*, Palgrave, Ch. 12.

13 Rt. Hon Rosie Winterton MP, Local Govt. Assoc. Conference, Mental Health Bill, 1 March 2007.

14 The MHA 1983 Code of Practice (para 2.7) also refers to compulsion as "the last resort".



Deflection came with a critical report on the 2004 Bill by the Parliamentary Scrutiny Committee chaired by Lord Carlile of Berriew, which began with a statement that the case for reform of the 1983 Act was not overwhelming, but made 127 recommendations which, broadly speaking, supported the approach taken by the Richardson Committee, and the Mental Health Alliance policies.

Meanwhile in Scotland there had been two Reports; the Millan Committee Report considering civil patients, and the Mclean Committee Report on provisions for defendants and offenders. The Millan Committee Report, which broadly agreed with the approach set out in the Richardson Committee Report, had led to Scottish mental health legislation, the *Scottish Mental Health (Care and Treatment) Act 2003*. The Scrutiny Committee was clearly impressed with that legislation which influenced their recommendations.

In the face of such widespread consensus over how to improve it, the government abandoned the 2004 Bill. Factors in this decision were the costs of the new Tribunal system; government's failure to undertake a Race Equality Impact Assessment on the Bill as required under the *Race Relations Act, 2001* and the Bill's incomprehensible drafting. The Amendment Bill that followed in 2006 jettisoned some popular features of the 2004 Bill (most notably the new process for authorising compulsion through the new Tribunals and statutory care plans) and bolted government's central policies on to the 1983 Act. The holy grail of mental health law fit for a new century had vanished.

The ideological differences between government and lobbyists made this result inevitable. Home Office determination to detain 'dangerous people with personality disorder' coloured every contentious area. Certainly, with the complexity of the issues, agreement over less contentious issues was never going to be easy. However, had the Department of Health and the Home Office taken the stakeholders along with them in meaningful collaboration, some improvement may have been made. There are examples of collaboration on complex issues that have been productive – the work of the Disability Rights Task Force on substantial reform of the *Disability Discrimination Act* and the work on the *Mental Capacity Act* among them. As it was, positions became more entrenched as time went by, and policy making was too politicised. On the side of the stakeholders, policy proposals were developed without an understanding of the real nature of government's objections to them. Frustrated by the lack of dialogue, they remained locked into positions that were never likely to succeed. The government departments also seemed to be lodged in their separate bunkers. The many efforts at consultation were unproductive. It was only in parliament that a genuine dialogue occurred and glimpses of workable compromises could be seen. This was too late. The opportunity to benefit mental health patients, their families and those professionals who care for them was lost.

The remaining parts of this article will examine the issues that dominated the parliamentary process, and will consider their results.

## **Principles**

The Richardson Committee and the Joint Scrutiny Committee both considered it vital for the law to be based on a statutory set of principles that would give greater clarity and certainty to the courts; guide practitioners concerned about how to exercise their powers; and reassure the public, patients and families that the values and principles set out in the Act should permeate how mental health services are provided. The professional organisations and the Black and Minority Ethnic Network were united in emphasising the symbolic importance of statutory principles in directing best practice and in helping to overcome stigma<sup>15</sup>.

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<sup>15</sup> *Briefing for the Second Reading of the Mental Health Bill in the House of Lords, BME Network, 25th November 2006.*

Although there had been a set of principles for the 2004 Bill, there remained contention over what any such principles might state. The House of Lords sought, as a minimum core, respect for wishes and feelings, participation of patients in decisions, and non-discrimination with the least restrictive alternative applying in all circumstances. However, the government balked at even such a minimalist list, arguing in part that it would be impossible to graft principles onto the 1983 Act, and that:

*principles may not in fact be relevant to every situation or, may conflict with each other or with the specific provisions of the Act. What weight is the decision-maker to give to the different criteria in that case? Is there a potential for him to be challenged because he has, for example, not complied with the patient's wishes?*<sup>16</sup>

The result was a messy compromise. The Code shall include a statement of the principles which the Secretary of State thinks should inform decisions under this Act, and the following “matters shall be addressed”:

- (a) Respect for patients' past and present wishes and feelings,
- (b) Minimising restrictions on liberty,
- (c) Involvement of patients in planning, developing and delivering care and treatment appropriate to them,
- (d) Avoidance of unlawful discrimination,
- (e) Effectiveness of treatment,
- (f) Views of carers and other interested parties,
- (g) Patient wellbeing and safety, and
- (h) Public safety<sup>17</sup>.

The 2007 Act further requires that the Secretary of State shall also have regard to the desirability of ensuring the efficient use of resources and the equitable distribution of services<sup>18</sup>. This was explained as being required for Wales, with its placement outside the principal list of matters to be addressed an acknowledgement that it was not of equal weight to them. In contrast to the House of Lords' core principles, the 2007 Act therefore gives a long list of factors of different levels of importance. Indeed, some of these are very important, and address matters not otherwise dealt with under the legislation. For instance, the references to wishes and feelings and to patient participation are vital given the fact that the patient may be treated without consent, and that the statute does not provide a duty to consult him or her, or, in most situations, take note of any advance directive. It will be interesting to see how the Code will word these principles, and whether, for instance, any of the robust language of the Richardson principles will find their way in to the Code. It is also possible that their usefulness will be further reduced by being expanded. The draft Code of Practice included<sup>19</sup>, for instance, transparency and communication. Will any of these extra principles have a lesser weight for not having a status in statute?

Section 10 of the Act also requires professionals to have regard to principles. This is no further than the partial enactment of the House of Lords decision in *Munjaz*<sup>20</sup> which stipulates that cogent reasons are

16 *Hansard HL 19 Feb 2007, Col 897 (Lord Hunt of King's Heath).*

17 MHA 1983 s118(2B), as amended by MHA 2007, s8.  
18 *ibid.*

19 *The draft Code of Practice was published with the 2006 Bill, but was subsequently revised; an updated Code was*

*made available for public consultation on 25 October 2007.*

20 *R v. Ashworth Hospital Authority (now Mersey Care National Health Service Trust) (Appellants) ex parte Munjaz (FC) (Respondent) [2005] UKHL 45. This was the view stated by the Minister, Lord Hunt, Hansard HL 6th March 2007, Col 120.*

needed for departing from the Code, but at least its recognition on the face of the statute may give it greater weight in practice. However, the real issue is how the courts will read the new provision. The significance from the point of view of statutory interpretation of having “matters” specified in the Act but the principles set out in the Code (rather than as at present simply in the Code) is not clear, and may present a challenge to an ingenious counsel. Will it be possible to use judicial review to challenge a decision on the ground that it was made without regard to a principle, or will these linguistic niceties preclude such an approach?

### The definition of mental disorder

The gateway to the compulsory powers in the 1983 Act is the definition of mental disorder, which is circumscribed by a set of exclusions. The 2007 Act replaces this definition and the four classifications of mental illness, psychopathic disorder, mental impairment and severe mental impairment, with a wider general definition of mental disorder as “any disorder or disability of the mind”, and it changes the exclusions.

Lord Rix and Angela Browning MP led an unsuccessful attempt to exclude people with learning disabilities and developmental disorders such as autism from Part II. The new Act extends compulsory powers to people with developmental disorders and those with learning disabilities in the same way as the unamended Act. This leaves some confusion and overlap with the *Mental Capacity Act*, which (when amended to cover the ‘Bournewood’ patients) will also cover people with learning disabilities who lack capacity; permitting the deprivation of their liberty, including the use of a proportionate degree of force if it is in their best interests. The clinician<sup>21</sup>, instructed by the Code of Practice to consider first the use of the MCA<sup>22</sup>, will need to decide whether or not to opt for the regime of the MHA which has different safeguards and lacks a specific ‘best interests’ test. It is not clear what factors (other than presumably the degree of restraint) should guide that choice.

The role of exclusions is to make clear what kind of behaviour, beliefs or life style should not be brought within compulsory powers, even if they fall within the definition of mental disorder. Human rights law requires the definition of mental disorder to be very clear in order for exercise of detention powers to be lawful<sup>23</sup>. The use of exclusions is a standard feature of most common law jurisdictions in meeting that requirement<sup>24</sup> by providing legal certainty; guaranteeing individual autonomy; and ensuring that the powers of detention are used no more than strictly necessary<sup>25</sup>.

The 2007 Act removes the exclusions for sexual deviance and illegal or disorderly acts from the 1983 Act, but retains a reworded exclusion for ‘dependence’ on alcohol or drugs. This, alongside the broad definition of mental disorder in the revised Act, has two consequences:

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21 *A Responsible Clinician appointed under the MHA may not have the status to take such a decision so will presumably prefer the MHA.*

22 *Draft MHA Code of Practice, 2.10d.*

23 *For example HL v United Kingdom (2004) 40 EHRR 761; see JUSTICE, Mental Health Bill, Second Reading Briefing, November 2006.*

24 *For instance, the Irish Mental Health Act 2001 excludes someone who has a personality disorder or “is socially*

*deviant or is addicted to drugs or intoxicants”. Mental Health (Care and Treatment) Scotland Act 2003 excludes from the definition of mental disorder “sexual orientation; sexual deviancy; transsexualism; transvestism; dependence on, or use of alcohol or drugs; or behaviour which causes, or is likely to cause harassment, alarm or distress to any other person; or acting as no prudent person would act”. New Zealand excludes a person’s political, religious, or cultural beliefs; sexual preferences; criminal or delinquent behaviour; substance abuse; or intellectual disability.*

- First, the Act's definition of mental disorder covers all the diagnoses listed in the WHO International Classification of Diseases (ICD10), some of which even the government acknowledges to be inappropriate for compulsory powers. For instance, the binge drinker and the casual consumer of drugs are brought within the Act, even though the 'dependent' person is excluded<sup>26</sup>. Furthermore, disorders of sexual preference in ICD10 cover fetishistic behaviour, voyeurism, sado-masochism and transvestism. The Joint Committee on Human Rights stated their concern that a person with Gender Identity Dysphoria or transvestic fetishism, which are recognised aspects of private life under Article 8, might be inappropriately detained on grounds of mental disorder. The explanatory notes to the Bill<sup>27</sup> stated that it is intended that certain behaviours (specifically fetishism and paedophilia) be brought within the scope of mental health legislation for the first time.
- Secondly, the definition of mental disorder potentially covers almost any significant deviation from a "normal" condition of the mind, however temporary. It could cover behaviour that, although not listed in ICD10, can be called disordered. (Nothing in the Act confines the definition to the conditions listed in ICD10 or DSM IV, the American diagnostic manual). Whilst the 1983 Act's original definition of mental disorder (and, more specifically, its use of the term 'mental illness'<sup>28</sup>) clearly excludes, for example, drunkenness, addiction to tobacco, and religious or political fanaticism, the revised definition of mental disorder and the new exclusions do not.

In the diverse and rapidly changing societies of British towns and cities, mental health professionals face the challenge of understanding and interpreting the thoughts and behaviour of people from different cultural, religious or political groups. The potential for misunderstanding is demonstrated in the history of the use of compulsory powers against African-Caribbean people<sup>29</sup>. Disproportionately high numbers of people from BME backgrounds are still diagnosed with major mental illness and detained in mental hospitals or institutions<sup>30</sup>. Culturally appropriate and acceptable behaviour has also been wrongly construed as symptoms of abnormality<sup>31</sup> or aggression. Baroness Murphy suggested that the inappropriate use of mental health powers is a continuing danger:

25 *Informal Oral Hearing on Mental Health Bill*, April 17th 2007.

26 *The Act provides an exception for "dependence" on alcohol or drugs but does not exclude "misuse" of these substances. In both cases this includes a level of intoxication that does not cause lasting harm or dependence. Both misuse and dependence are covered by ICD 10 and are therefore classified as mental disorders.*

27 *Paragraph 37 Explanatory Notes Mental Health Bill 2006.*

28 *Although 'mental illness' is not defined in the 1983 Act, the courts have construed the phrase as "ordinary words of the English language to be construed in the way that ordinary sensible people would construe them" W v L [1974] QB 711.*

29 *Sainsbury Centre for Mental Health (2002) Breaking the Circles of Fear.*

30 *Bhui K, Stansfeld S, Hull S, Priebe S, Mole F and Feder G (2003) Ethnic Variations in pathways to and use of specialist mental health services in the UK: Systematic*

*Review. British Journal of Psychiatry, 182, 105-116. Morgan C, Mallett R, Hutchinson G, Bagalkote H, Morgan K, Fearon P, Dazzan P, Boydell J, McKenzie K, Harrison G, Murray R, Jones P, Craig T and Leff J (2005) Pathways to care and ethnicity. I: Sample characteristics and compulsory admission, Report from the AESOP study, British Journal of Psychiatry 186, 281-289.*

31 *See, for example, in relation to obsessive compulsive disorder as discussed in NICE Guideline Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder (2005). Supplementary memoranda from the BME Network (DMH 445) Academic Paper By Dr Kwame McKenzie, Senior Lecturer In Psychiatry, Royal Free And University College Medical School Joint Scrutiny Committee on the Mental Health Bill, report, Vol.II.*

*In the 1970s, when I first worked in psychiatric hospitals outside the great fringe around London – what we call the Epsom archipelago – the place was full in the back wards of people whom we had enormous difficulty diagnosing with anything.*

*Society does not know what to do with other social misfits ... those who are persistently addle-headed on drink and drugs ... paedophiles ... religious fanatics who belong to the Moonie loonies and the like... We know that those people are not as we would like them to be; they are not like us; they probably need some help, but how we should help them is rather obscure. No doubt a significant percentage of them suffer, from time to time, with mental disorder which would bring them properly under the scope of the Act, but it is a profound mistake to include all categories of people behaving badly simply because we do not have any other answers ... I regret that I do not find it difficult to envisage the inappropriate use, perhaps well meant, of mental health legislation for non-medical purposes, for social convenience and control – “Get the paedophiles off the streets”. The pressure on services to find solutions to the presently insoluble problems will be massive. Exclusions ensure that practitioners carefully consider the basis for compulsory treatment. If there is an underlying mental health diagnosis, a person is covered by the Act; if there is no diagnosis, it is unhelpful and inappropriate for the mental health services to manage that person<sup>32</sup>.*

All these reasons persuaded the House of Lords to seek to insert into the Act a set of exclusions relating to disorders of sexual preference (with the exception of paedophilia) or gender identity; the commission, or likely commission, of illegal or disorderly acts; and cultural, religious or political beliefs<sup>33</sup>.

The government argued variously (and contrary to evidence from Victoria, New South Wales and New Zealand) that exclusions would be “arbitrary obstacles to the use of compulsion”<sup>34</sup> and could give rise to legal challenges, or that they were unnecessary and potentially counter-productive (in that excluding certain conditions from the definition might imply that, but for the exclusion, they would be mental disorders within the meaning of the Act)<sup>35</sup>.

Government finally agreed to add to the principles “respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006)”:

*This would be a declaratory statement about what mental health legislation should be in our society, now and that society should treat with decency and dignity people whose behaviour is different and, sometimes, difficult and challenging.<sup>36</sup>*

Baroness Barker, perhaps with detained terrorists in mind, regretted that the amendment did not expressly cover belief as well as religion: “we already have people detained under mental health legislation, at least in part because of their beliefs”<sup>37</sup>. Given that freedom of belief is included with freedom of religion in Article 9 of the *European Convention on Human Rights*<sup>38</sup>, there is not quite the lack of protection that she feared. The initial draft Code of Practice stated that:

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32 *Hansard* HL 8 Jan 2007, Col 77.

33 *Supported by the Joint Committee on Human Rights Legislative Scrutiny: Seventh Progress Report 5. Para 1.5.*

34 *Hansard* HL 8 Jan 2007, Col 86 (Baroness Royall).

35 *See Lord Hunt (Hansard* HL 2 July 2007, Col 812 *et seq*) and Baroness Royall (*op cit* n.30, Col 84 *et seq*).

36 *Hansard* HL 2 July 2007, Col 816 (Baroness Barker).

37 *ibid*.

38 *In order for Article 9 to apply a belief must ‘attain a certain level of cogency, seriousness, cohesion and importance’ Campbell and Chaush v United Kingdom 25 February 1982, Series A, No.48, 4 EHRR 293, para 36. However, the Court has adopted a very broad approach as to what constitutes a religion or belief, from main stream religions to belief systems such as Druidism: Chappl v United Kingdom 14 July 1897, (1987)53 DR 93. The protection of the freedom of thought, conscience and religion under Article 9(1) is absolute.*

*disordered beliefs are sometimes symptoms of clinically recognised mental disorders, but in the absence of such a disorder no-one may be considered to be mentally disordered solely because of their political or cultural beliefs, values or opinions*<sup>39</sup>.

There are few but telling examples of case law in jurisdictions with similar exclusions that demonstrate their role in protecting patients from inappropriate use of compulsory powers because of their beliefs<sup>40</sup>.

## Capacity

The debate over the place of capacity in a future mental health law was launched by the Richardson Committee but was given impetus by the passing of the *Mental Capacity Act* in 2005. The Committee founded its approach on patient autonomy. While acknowledging that exceptions might be made for a person who was dangerous to others or suicidal, they recommended that compulsory powers should be largely confined to those who lack capacity to make their own decisions

The most committed proponents of a law based on capacity were an unexpected trio of the Royal College of Psychiatrists, the British Psychological Society and Mind. They pointed to the persistence of discrimination against people with mental health problems and its blight on peoples' lives<sup>41</sup>. They highlighted the link between stigma and poor health, patient choice and the better health outcomes which NICE Guidelines<sup>42</sup> and NHS policies<sup>43</sup> proclaim. In their view, fairness to service users and patients demanded that the issue of forcing treatment on mentally capable patients be addressed.

The Mental Health Alliance proposed adopting the "significantly impaired decision making" test from the *Scottish Mental Health (Care and Treatment) Act 2005*<sup>44</sup>. This sets a lower threshold than a "capacity" test, and one more capable of taking into account emotional as well as cognitive factors<sup>45</sup>. This found favour with the Joint Scrutiny Committee and later the House of Lords.

However, the Mental Health Act Commission raised questions over how a capacity test might work in practice<sup>46</sup>, and government resisted calls for any sort of capacity threshold for the use of most compulsory powers. They insisted that impaired decision-making was neither well understood, nor a reliable test, and that it would be hard to administer. These arguments lacked weight, in that the *Mental Capacity Act* (MCA) requires all professionals to become proficient in determining capacity; impaired decision-making

39 *Draft MHA Code of Practice, para 1B.5*

40 For instance the series of reported cases of the Victorian Mental Health Review Board on religious belief: [2001] VMHRB 2 (19 February 2001); 04-057 [2003] VMHRB 2 (27 October 2003); 98-232 [1998] VMHRB 5 (9 April 1998); HL [1997] VMHRB 17 (1 September 1997); RM [1996] VMHRB 3 (7 August 1996).

41 The Department of Health's study of public attitudes to people with mental illness found that "levels of fear and intolerance of people with mental illness have tended to increase since 1993" and that "attitudes ...have become less positive between 2000 and 2003". The Social Exclusion Report 2004 found stigma to be the biggest problem people with mental health problems face as a group.

42 See, for example, the NICE Guideline on treatment for bipolar disorder.

43 "Involving individuals in an effective partnership with healthcare professionals, with all decision-making being shared, improves outcomes". Dept of Health (2006) *Our health, our care, our say: a new direction for community services*.

44 The notion of "significantly impaired decision-making" is explained in detail in the Scottish Executive's Document: Code of Practice Code of Practice for the Mental Health (Care and Treatment) (Scotland) act 2003, Volume 1; 31. March 2004; Chapter 1, paras 33–38.

45 See paper "Impaired decision making" at [www.mentalhealthalliance.org.uk](http://www.mentalhealthalliance.org.uk)

46 See, for example, Heginbotham C and Kinton M (2007) 'Developing a capacity test for compulsion in mental health law' JMHL 15; 72–84 .



is a feature of other laws<sup>47</sup>, and research evidence shows the reliability of capacity tests<sup>48</sup>. Nevertheless, the proponents of the test did not make a consistent case either.

The debate in both Houses of Parliament on this issue was impassioned and sustained, with advocates for a capacity threshold from all political parties. The government refusal to negotiate for a test was framed as a concern not to stand in the way of treating a suicidal patient, but the underlying fear was how it would apply to patients with personality disorder, and the underlying assumption the government's extraordinary paternalistic position (in the context of a debate over the appropriate scope of mental health compulsion) that "every restriction was a patient not treated"<sup>49</sup>:

*if it cannot be shown that a patient's judgment is impaired, they cannot be detained – regardless of how much the patient needs treatment and however much they, and others, are at risk without it.*<sup>50</sup>

The impassioned response by Earl Howe summed up the differences between the positions of government and those calling for a threshold of impaired decision-making:

*A test of impaired decision-making would do more to bring mental health services into the modern world than just about any other change. As it is we are, in a real sense, back in the world of Enoch Powell and 1959. Patient empowerment and respect for the wishes of the patient are acknowledged features of good clinical practice in all other areas of healthcare – but not, it seems, in mental health. ... Finding a way through this issue would have been the way to show that we wanted to banish the stigma and discrimination associated with mental illness. To have acknowledged in law that there is a place for the wishes and feelings of patients who are capable of making their own choices would have been a profoundly far-sighted and beneficial change*<sup>51</sup>.

As the English Bill was in Parliament, the Bamford Committee recommended capacity-based legislation in their report on reforming the mental health law in Northern Ireland, so that the treatment of people who lack capacity for both physical and mental illness should proceed under the same principles<sup>52</sup>. The Joint Committee on Human Rights has argued that there is a rational and objective justification, in relation to decisions about treatment, for treating differently a person suffering from a condition which seriously impairs his or her mental capacity to choose whether to accept treatment, from someone whose mental capacity for decision-making is not so seriously impaired<sup>53</sup>. The principle of autonomy is also included in General Medical Council principles<sup>54</sup>; standards of the World Psychiatric Association<sup>55</sup> and

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47 The principle has been recommended for Northern Ireland and is a criterion for admission in other jurisdictions, for instance, in Ireland, New South Wales, North Carolina, Israel, Saskatchewan.

48 A recent study found that a significant minority of detained patients, particularly those who had been detained on a previous occasion retained their capacity (Cairns et al (2005) Prevalence and predictors of mental incapacity in psychiatric in-patients *British Journal of Psychiatry* 187, 379–85). The authors also found that a capacity test worked with a high level of reliability (Cairns et al (2005) Reliability of mental capacity assessments in psychiatric in-patients *British Journal of Psychiatry* 187, 371–8).

49 Op cit n.13.

50 Op cit n.13.

51 Hansard HL 2 July 2007, Col 826.

52 The Bamford Review of Mental Health and Learning

Disability (Northern Ireland) "A Comprehensive Legislative Framework" Consultation Report, March 2007.

53 Joint Committee on Human Rights, 25th Report. Para 20.

54 "The requirement that a person's decision-making ability must be significantly impaired before they can be detained and treated without their consent is consistent with the guidance the GMC issues to doctors, in which we make clear that doctors are expected to respect the wishes of patients who have capacity to make their own decision ... These are fundamental principles of good medical practice which we would expect to see applied to decisions involving patients with mental disorders in the same way as those suffering from physical conditions". Public Bill Committee on Mental Health Bill, Evidence 43.

55 The World Psychiatric Association approved at the General Assembly, August 25, 1996. No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her.



the World Health Organisation<sup>56</sup>; and above all in Recommendation (2004)10 of the Committee of Ministers of the Council of Europe concerning the protection of the human rights and dignity of persons with mental disorder<sup>57</sup>. This Recommendation represents a consensus within the Council of Europe that is in advance of Convention jurisprudence and its application in domestic courts. The latter have upheld treatment without consent on mentally capable patients on the basis of “medical necessity” rather than capacity<sup>58</sup>.

## Treatability

The treatability test was the single key issue in the Bill for civil libertarians, the Royal College of Psychiatrists and some individual psychiatrists<sup>59</sup> – and its abolition, the crossing of the Rubicon from a health measure to one of preventive detention. Lord Carlile explained that

*there is a principle here ... as a matter of medical and legal ethics and of professional ethics ... no professional person should be required to provide a service to someone whose requirements do not come within their professional ethical code of practice. Under the Bill as it stands, doctors and other clinicians – or from all clinicians are qualified medical practitioners – are being asked to provide medical treatment in circumstances in which such treatment is simply inappropriate.*

*If it is the Government's view that it is appropriate to introduce legislation which requires people to be locked away from society because they are perceived to be dangerous but could not benefit therapeutically, then I am sure that this House will consider any such proposed legislation on its merits. It may achieve a fair passage and it may not. At least it would be honest, ethical legislation in which the Government would set out their objective and we...would then consider such legislation<sup>60</sup>.*

The existing ‘treatability test’ is a weak test, applied to certain patients at certain times, which sets a threshold only that a patient is likely to respond to a very broad range of interventions. Nevertheless, government argued that it was used to exclude from services people whose personality disorder is deemed to be ‘untreatable’. Their opponents held that this was no longer the case, given the more widespread availability of psychological treatments for personality disorder (whose prominence is likely to increase under the new Act, since psychologists would become responsible clinicians in charge of treatment). Training and the development of services will help to deliver a new generation of practitioners who are versed in the new approaches to treatment. Professor Appleby, the National Director of Mental Health has recently acknowledged the improvements for people with a personality disorder<sup>61</sup>.

The Bill replaced the treatability test with a loosely worded test of “appropriate treatment” which is “available” to the patient<sup>62</sup>. These terms significantly broaden the scope of the law. If treatment must be simply “available” to a person, the test will be satisfied whether or not s/he agrees to be treated or is willing or able to engage with or benefit from treatment. The Minister stated that the requirement that treatment

56 WHO Mental Health Care Law: Ten Basic Principles WHO/MNH/MND/96.9. These include the right to self determination covering the need for consent to medical treatment.

57 The UK government has reserved the right – alone out of 45 member states – not to comply with the recommendation.

58 Forced treatment is capable of reaching the threshold of severity required for Article 3, in which case the hospital authorities must ‘convincingly show’ before a Court a

‘therapeutic necessity’ for such treatment R (Wilkinson) v Broadmoor SHA [2002] 1 WLR 419, R (N) v Dr M [2003] 1 WLR 562.

59 Professor Eastman. Evidence to the Public Bill Committee, Memorandum 62.

60 Hansard HL 19 Feb 2007, Col 925.

61 National Personality Disorder Conference, 18th January 2007.

62 Professor Eastman. Evidence to the Public Bill Committee, Memorandum 62.

must be “appropriate in [the patient’s] case, taking into account the nature and degree of the mental disorder from which he is suffering and all other circumstances of his case” was much more than the treatability test currently requires, as the medical treatment must be appropriate to the patient “as an individual”<sup>63</sup>, but others fear that “all the circumstances of the case” will permit issues of public protection to override therapeutic benefit.

With government facing a torrent of criticism in parliament, a compromise amendment was passed to require that the “purpose” of medical treatment must be to “alleviate the mental disorder or one or more of its symptoms or manifestations”. Chris Bryant, Member of Parliament for Rhondda, who moved the amendment, was clear that “purpose” was a robust test. It avoided the concept of “likelihood” implied in the current legislation, and stated in previous amendments proposed by the opposition, which was deemed too high a threshold and inappropriately based upon prediction. Nevertheless, a treatment could not have the necessary purpose unless the clinician could show that there was some likelihood it would succeed, and this should be evidence-based rather than subjective.

For behaviour to be a “manifestation” of a disorder, it must be the direct result of it. The term has the same meaning as the clinical term “signs”<sup>64</sup>. It follows that a person with a mental disorder may not be detained because of their violent behaviour if it arises from other sources than the disorder itself, however difficult that distinction may be in practice. How the test will be applied (perhaps especially to people with learning difficulties) remains to be seen. However, the existing treatability test has been interpreted to allow that the required treatment for restricted patients may be no more than containment within a therapeutic environment under the supervision of health professionals, with only minimal benefit to the patient<sup>65</sup>. If this is extended to all patients the new legislative wording will make little difference to practice.

### Community treatment orders (CTOs)<sup>66</sup>

The introduction of community treatment orders is the most substantial change to the regime for compulsory treatment under the 1983 Act and it remains a controversial innovation. Significantly, it was opposed entirely by Mind<sup>67</sup> and by all service user groups .

Critics claim that, by removing the limiting pressure of bed spaces, CTOs will inevitably lead to more patients being subject to compulsory powers, will increase the use of or reliance upon medication in the

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63 *Hansard* HC 19 June 2007, Col 1284 (Rt Hon Rosie Winterton MP).

64 *ibid.*, Col 1280 (Chris Bryant MP). The Mental Health Alliance argued for “signs” rather than “manifestations” as a term that like “symptoms” had a clear clinical meaning, the former being that which the patient reports, the latter that which the clinician elicits by observation. However they were reassured that the intention of “manifestation” was to have the same meaning in lay language. The Minister stated that “there will be no difference between the word “signs” and “manifestations”. It is ultimately simply a matter of people being able to understand what it means” *Hansard* HL 2 July 2007 Col 834 (Baroness Royall).

65 A person could be detained if hospital treatment would prevent a deterioration in his condition, make him more co-operative and insightful, or if detention was likely to impact on his symptoms, even if it would not touch the substantive illness. *R v Cannons Park MHRT* [1995] QB

60 *In Reid v Secretary of State for Scotland* [1999] 2AC 512 the House of Lords stated that the definition of treatment may in some circumstances extend ‘from cure to containment’. The case concerned a restricted psychopathic patient whose anger management was improved by the supervision he received in the structured setting of a state hospital.

66 For further consideration of CTOs see ‘Community Treatment Orders’ by Kris Gledhill in this issue of the *Journal of Mental Health Law*. Also see ‘Does compulsory or supervised community treatment reduce ‘revolving door’ care? Legislation is inconsistent with recent evidence.’ by Kisely and Campbell, *British Journal of Psychiatry* (2007) 191 pp 373–374. This review of recent studies in Australia argues that CTOs do not reduce revolving door care.

67 Submission to the Joint Committee on the Draft Mental Health Bill:2004, Report Vol II.

treatment of illness (given that the power is designed to impose medication compliance); and will disproportionately impact on people from Black and minority ethnic backgrounds. They fear that the community services are not sufficiently well resourced or well developed to ensure the delivery of safe and effective care<sup>68</sup>. Government, for its part, favours CTOs for a range of reasons – that they are more flexible; more consistent with community-based modern service delivery; less traumatic for patients than long hospital stays; and, above all, that they will address the problem of revolving door patients. After the outcry surrounding the 2004 Bill, the government decided to limit CTOs to any person who has been placed on a treatment order (if only for a short time) as a civil or a Part III patient.

The Mental Health Alliance criticised the Department of Health for proceeding to legislate having neither analysed the different models of community treatment in force in other jurisdictions nor assessed overseas experience of such models. Although the Department of Health did commission research from the Institute of Psychiatry, it did so too late to influence the policy making process. The Institute's report<sup>69</sup>, which was released the day after the Bill had completed its process through the House of Lords, is the most comprehensive review that has yet been undertaken of the existing international research literature on CTOs relating to civil patients over 52 jurisdictions in Australia, New Zealand, Canada, USA, Scotland and Israel. It reviewed 72 studies from six countries and concluded that there is no robust evidence that CTOs cause either reduction or increase in a range of outcomes, including hospital admissions; hospital bed days; compliance with treatment; violence; symptoms; offences resulting in arrest; social functioning; quality of life, care or satisfaction; and perceived coercion.

The 2007 Act provides that a person may be discharged from hospital on a CTO with the agreement of the responsible clinician and the approved mental health professional that the conditions are met. As the British Association of Social Workers pointed out, there is a lack of external oversight in this procedure. They will be close colleagues in the same clinical team, with no requirement to bring in a professional from outside the team as is the case with admissions to hospital<sup>70</sup>.

The conditions are very broad. If the patient has a mental disorder which makes it “appropriate for him to receive medical treatment” the responsible clinician must decide whether it is “necessary for his health or safety or for the protection of others that he should receive such treatment”, the treatment can be provided without his continuing to be detained in hospital and “it is necessary that the responsible clinician should be able to exercise the power to recall the patient to hospital”<sup>71</sup>.

The House of Lords argued for limits to be placed on CTOs. As Lord Patel expressed it:

*If Parliament drafts the law too widely, the danger is that CTOs will be applied too widely. They could even become part of the normal discharge process for detained patients generally, as a kind of safety net for risk-averse mental health service staff and managers. If this happens, Parliament will not have produced a measure that enables a less restrictive alternative for the effective management of this small group of patients, but instead will have increased massively the legal coercion of psychiatric patients generally.*<sup>72</sup>

68 The British Association of Social Workers commented (Second Reading Briefing House of Lords Mental Health Bill 2006) that “in most places there are now too few in-patient beds, and that there is pressure to reduce the numbers still further in order to cut costs, resulting in patients being discharged prematurely in order to free beds for others who are even more acutely ill. In this context, there is a high likelihood that CTOs will be used to expedite discharges in circumstances where the patient has not yet fully recovered and where they have not yet

regained sufficient insight to be able to co-operate voluntarily with community services, and where they do not have a history of non-co-operation resulting in relapse”.

69 Op.Cit. n. 8.

70 British Association of Social Workers, Second Reading Briefing, Mental Health Bill, November 2006.

71 MHA 1983 s17A (5)(b)(c)(d) as amended by MHA 2007, s32.

72 Hansard HL 2 July 2007, Col 844.

Another fear was that patients would remain on CTOs indefinitely. Given the broad criteria, Tribunals would find it difficult to justify the discharge a patient if the responsible clinician and approved mental health professional decided otherwise. The patient's right to apply to the Tribunal to challenge a CTO, or its renewal, would be of little value.

The Government's stated goal was identified to Parliament by Lord Warner as:

*the continuing number of revolving door patients...who leave hospital, disengage from mental health services, do not continue with their treatment, [until] their health deteriorates and they end up compulsorily detained in hospital. We may have differences in view about the numbers involved, but that is the cycle we are trying to deal with.*<sup>73</sup>

Their argument for community treatment orders also focused on cases where a person poses a serious risk to others. This was in part as a result of the work of forensic psychiatrists such as Professor Tony Maden<sup>74</sup>.

The House of Lords amendments, which would have limited the scope of CTOs to such "revolving door" patients, were ultimately overturned. However Lord Hunt emphasised that the clinician must be "satisfied of the patient's previous history of non engagement and non-compliance that made it unsafe to treat the patient in the community voluntarily"<sup>75</sup>. In a small acknowledgement of the issue, the government agreed to an amendment that would amplify why it was necessary for a clinician to have a power of recall. The Act now provides that:

*in determining whether the criterion in subsection (5) (d) above is met, the responsible clinician shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).*<sup>76</sup>

The Minister stated that:

*this has the effect that the responsible clinician must consider the risk of the patient's condition deteriorating in the community when deciding whether it is necessary for him to be able to exercise the power to recall the patient to hospital. This means that, in order to place a patient on supervised community treatment, the responsible clinician will need to be able to show that he has properly considered and, if appropriate, assessed the risk of deterioration—otherwise, his decision could be open to challenge in the courts.*<sup>77</sup>

The failure to get any significant changes to the thresholds for CTOs leave the anxieties expressed above undiminished. It should be noted that if one takes account of all the eligibility criteria for a person being placed on a CTO, including the definition of mental disorder that is the initial gateway, then the powers provided in this Act, are in excess of those provided in the mental health laws in Scotland, Ireland, Australia, New Zealand, and in those parts of Canada and USA with community treatment regimes<sup>78</sup>.

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73 Hansard HL 17 Jan 2007, Col 702.

74 *Review of Homicides by Patients with Severe Mental Illness*. Tony Maden, Professor of Forensic Psychiatry, Imperial College London 15th March 2006.

75 Hansard HL 17 Jan 2007, Col 709.

76 MHA 1983 s17A (6) as amended by MHA 2007, s32.

77 Hansard HL 2 July 2007, Col 848 (Lord Hunt).

78 *Mental Health (Care and Treatment) Scotland Act 2003*;

*Irish Mental Health Act 2001*; *Mental Health (Northern Ireland) Order 1986*; *NSW Mental Health Act 1990* ; *Victorian Mental Health Act 1986*; *Queensland Mental Health Act 2000*; *ACT Mental Health (Care and Treatment) Act 1986*; *New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992*; *Ontario Mental Health Act*; *Saskatchewan Mental Health Services Act*; *Alberta Mental Health Act*, *New York Kendra's Law*; *North Carolina Mental Health Act*, *Florida Mental Health Act*.

The CTO regime in USA is particularly narrow. In most US jurisdictions the use of compulsory powers has been greatly restricted on civil rights grounds and is confined to people with a mental illness who are at imminent danger to themselves or others<sup>79</sup>. In many cases there is no enforcement mechanism<sup>80</sup>, and so they are comparable in many respects to supervised discharge rather than to CTO.

Several other features of the CTO regime are worth noting. There is no requirement in the Act to discuss the making of an order with the patient or with the nearest relative, even though their participation is essential. The conditions placed upon the patient may be varied by the responsible clinician only with the agreement of the approved mental health professional. The Bill originally specified the types of conditions that could be placed on the orders, which included specifying a place of residence and rules about the patient's conduct. In response to the Joint Committee on Human Rights' concerns that these conditions were unduly intrusive and could breach Article 8 rights to private and family life and home,<sup>81</sup> the government amended the Bill, removing all references specifying the permissible subject of orders, but limiting them to measures necessary to ensure a patient receives medical treatment; to prevent risk of harm to the patient's health or safety; or to protect others<sup>82</sup>.

A patient has no right to challenge a condition placed on a CTO and, even on an application for discharge, the Tribunal has no power to vary conditions. An amendment to provide for a right of appeal against the conditions was defeated, with the government maintaining that conditions that were not agreed by patients would not be appropriate. However the experience in the Australian state of Victoria for instance, where a condition of residence is permitted, is that such appeals are not rare<sup>83</sup>.

The Royal College of Psychiatrists<sup>84</sup> and the Chair of the Mental Health Act Commission<sup>85</sup> were alarmed by provisions for the involvement of a second opinion approved doctor (SOAD) embedded in the almost incomprehensible Part IVA of the 2007 Act. The treatment of any CTO patient (including those who consent to treatment) will, after a month, have to be authorised by a second opinion appointed doctor (SOAD). The SOAD is empowered to authorise such treatment as may be imposed should the patient be recalled to hospital, and, extraordinarily, also to authorise treatment that would be imposed should a consenting patient withdraw consent or lose capacity. This changes an essential component of the SOAD role which, as the current Code of Practice stipulates<sup>86</sup>, is to examine the patient and make a judgment in the light of the patient's changed circumstances. As Lord Patel, Chairman of the Mental Health Act Commission, made clear:

*it anticipates that a SOAD, whose role should be to safeguard against unnecessary or unsafe compulsory treatment, will authorise the forced application of medication in circumstances that he or she cannot foresee at some unpredictable point in the future. A patient who has developed dangerous and possibly irreversible side-effects might have them worsened by the further imposition of medication on the*

79 This results from the *Lessard v Schmidt* (1972) decision which stipulated "extreme likelihood that if the person is not confined he will do immediate harm to himself or others". See generally *Diesfeld & Freckelton Involuntary detention and therapeutic jurisprudence: international perspectives on civil commitment*. (2003).

80 The Virginia Code Title 37.2.

81 Joint Committee on Human Rights Session 2006–7, 4th Report p. 20–22.

82 MHA 1983 s17B(2) as amended by MHA 2007 s.32

83 Understood from recent discussions between the author and John Lesser, President, Mental Health Review Board, Victoria. The Victorian Mental Health Act permits conditions to be placed only on residence.

84 Royal College of Psychiatrists Evidence to the Public Committee House of Commons MH10.

85 Lord Patel of Bradford Hansard HL 26 February 2007 Col 1450.

86 MHA 1983 Code of Practice, para 16.21.

*authority of the SOAD. A patient with a heart condition might be killed by the imposition of medication authorised in good faith by the SOAD.*<sup>87</sup>

The fact that a SOAD who certifies that a community patient consents to treatment will also certify what treatments can be imposed on the patient if he or she withdraws consent and is recalled to hospital, underlines the coercive nature of the CTO regime and surely breaches the principle underlying true consent that “permission given under any unfair or undue pressure is not ‘consent’”<sup>88</sup>.

The differences between the SOADs’ role for detained and community patients is not based on clinical considerations or patients’ welfare, but a technical problem of the difficulty in ensuring that a SOAD can be called quickly enough (within 72 hours) if a community patient is recalled to hospital. Other solutions could have been found to this problem, including the use of emergency powers under section 62.

### Roles of clinicians

The 2007 Act provides for the role of the responsible medical officer to be replaced with that of the responsible clinician, to be defined in regulations. It is anticipated that chartered psychologists, nurses, social workers and occupational psychologists will be included. They will need to satisfy specified competencies. Stakeholders have welcomed this workforce reform.

The government accepted the opposition argument that Section 20 of the 1983 Act needed amending. It was anomalous for a patient to have his/her detention renewed on the recommendation of one clinician, when it required two opinions for the original order. From a clinical point of view, it is likely to require a higher level of expertise to diagnose an illness once the person’s condition has stabilised than when he or she is in a state of mental crisis and the disordered state of mind is only too evident. From an ethical point of view, a person’s liberty should not be denied on the basis of one opinion.

In the case of the renewal of detention, the amended Act will require that a person who has been “professionally concerned with the patient’s medical treatment; but who belongs to a profession other than that to which the responsible clinician belongs”, must state “in writing that he agrees that the conditions are satisfied” before a section can be renewed<sup>89</sup>. This does not expressly require the patient to be examined by the second professional, and in that respect it is a weaker safeguard than that to be provided for patients deprived of liberty under the amended Mental Capacity Act<sup>90</sup>. Given that the two clinicians will come from the same team, and that the status of the clinician giving the second opinion is not specified, it also fails to provide the robust safeguard the opposition amendments had sought.

It is not clear that the new arrangements satisfy the requirements of Article 5 of the European Convention. Under the 2007 Act, the initial s.3 detention for six months is still based on the opinions of two medical practitioners. Thereafter (where the responsible clinician is not a doctor), all periods of detention can be authorised by non-medical practitioners. This potentially removes from the process the “objective medical expertise of a kind or degree warranting compulsory confinement” (the test from *Winterwerp v the Netherlands*), which is required for a valid detention under ECHR Article 5. The Joint Committee on Human Rights have cited ECHR jurisprudence to the effect only a person with medical

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87 He also warned that the MHAC would be likely to advise SOADs to be extremely cautious indeed when considering whether or not to authorise treatments to be given in unforeseeable situations at some unidentified point in the future: *Hansard HL 26 Feb 2007, Col 1450*.

88 MHA 1983 Code of Practice, para 15.13.

89 MHA 1983 s.20(5A) as amended by MHA 2007, s9(4).

90 Schedule 7 MHA 2007 (referring to the ‘Bournewood’ authorisation procedures) requires the person to be examined by a medical practitioner to ascertain whether s/he has a mental disorder.



training could satisfy the *Winterwerp* test for deprivation of liberty<sup>91</sup>. The government disagreed; and in their view the competencies which the responsible clinician needs to meet would be sufficiently robust to satisfy the *Winterwerp* test. The Joint Committee countered this by pointing to the lack of examination planned for those seeking to satisfy the competencies, and reiterating that in their view only a doctor or clinical psychologist could be sure to have the requisite training to satisfy the test<sup>92</sup>. The legal landscape is now rather uneven. Two medical opinions are required for an initial civil detention under the MHA; two opinions (one medical) for Bournemouth deprivation of liberty; two professional opinions for a person being placed on a CTO or for a CTO renewal; but in the case of a renewal of civil detention under the MHA only one medical opinion is needed. This is clearly an issue that the courts will be called upon to resolve. Meanwhile, cautious authorities might be advised to include a medical practitioner in renewals.

### The overlapping regimes of MCA and MHA

That the *Mental Capacity Act* (MCA) and the *Mental Health Act* (MHA) provide overlapping regimes for adults with a mental disorder is well known. Many incapacitous patients would be detained under the MHA but for their compliance with their care. The acts are however based on different principles – patient empowerment and best interests govern the MCA, whilst risk and paternalism govern the MHA. Patients receive different standards of care and protection if they are treated under one statute rather than the other. For instance, MCA patients who receive ECT do not qualify for a second opinion, nor if they need to be detained under the deprivation of liberty regime will they receive free care. On the other hand, advance directives will be respected and their appointed representatives will have a role in their care and treatment. Their legal redress is through the Court of Protection, which is not free, rather than through the Mental Health Tribunal, which is. Clinicians are expected to consider carefully which regime to use, but may not have a formal legal status under both acts.

Attempts in Parliament for amendments to bring greater consistency to the two schemes were unsuccessful. The inconsistencies may give rise to human rights challenges<sup>93</sup>. Moreover this still leaves the fact that professionals are faced with two legal structures which could be used for patients who lack capacity. Except in case of patients who present a high level of risk to others, it may not be clear what factors should determine the choice.

### Some welcome reforms

The *Mental Health Act 2007* has made many other significant changes to the 1983 Act. Patients will be able to apply to the county court to displace their nearest relative, including on the new grounds that s/he is “not a suitable person to act”<sup>94</sup>. There were persistent attempts for a better solution – either to substitute a nominated person for the nearest relative, as under the 2004 Bill, or a more user friendly means for the patient to displace a nearest relative who had been appointed. The Mental Health Alliance also called it “harsh and unreasonable” to expect a patient to risk causing dissension in their family by seeking a different nearest relative when s/he was in a most vulnerable<sup>95</sup> state. The government saw all

91 *Varbanov v Bulgaria* Judgment of 5 October 2000.

92 Joint Committee on Human Rights, *Legislative scrutiny: Seventh progress Report, Session 2006-7 15th Report* p.6–9.

93 *ibid.* The issue of charging and the need for a procedure prior to the imposition of compulsion were the two issues

that concerned the Joint Committee. Others could include the differences in treatment safeguards.

94 MHA 1983 s29(3)(e) as amended by MHA 2007 s23(5)(b).

95 M H Alliance Memorandum, Joint Committee on Human Rights, 4th Report Session 2006–7, p.76.



alternative proposals as unworkable. However they did concede that a person could be “unsuitable” to act for reasons other than abusiveness. The Minister explained that:

*concerns have been expressed about whether the provision would cover situations where patients have no real relationship with their nearest relative. Although it is important that the courts look at each case on its merits we intend the idea of unsuitability to cover situations where there is no effective relationship between the patient and their nearest relative or where that relationship has broken down irretrievably.*<sup>96</sup>

JUSTICE was also concerned about the converse situation in which the word ‘unsuitable’ might be used by the local authority to justify removal of a nearest relative:

*we note that nearest relatives frequently have a tense relationship with those detaining and treating patients, and we have serious concerns that applications may be made to remove a nearest relative on the basis of suitability, when, in essence, the detaining/treating authority is making the application on the basis that they are ‘difficult customers’.*<sup>97</sup>

The courts and Code of Practice will be relied upon for guidance with this issue.

The right to advocacy, although not directly enforceable, is a huge gain for patients if the resources that have been promised are made available<sup>98</sup>. There are significant gains for children and young people. Age appropriate facilities will in time be required for all patients under 18 years<sup>99</sup>. The capacious refusal of 16- and 17-year-olds to hospital admission will not be overridden by parental authority<sup>100</sup>, a second opinion appointed doctor will need to agree for ECT to be administered to any detained patient under 18-years-old<sup>101</sup>, and there will be an annual referral to the Mental Health Review Tribunal for patients under 18 years old who do not request a hearing<sup>102</sup>. There will be no ECT in the face of capacious refusal of any patient, other than in an emergency, and emergency ECT will only be permitted if immediately necessary to save life or immediately necessary to prevent a serious deterioration in his condition<sup>103</sup>.

## Lost opportunities

There is no doubt that the 2007 Bill was improved in its course through Parliament. The extremes of the government’s zeal that nothing should stand in the way of clinical discretion were tempered and patient safeguards were improved. Nevertheless, it remains simply an amending Bill and, as such, a valuable opportunity lost. No government is likely to re-enter the minefield of mental health law reform in a hurry. Progressive reforms including, above all, the recognition of statutory care plans and advance directives, and a right to assessment of mental health needs, were all in the Richardson Committee framework and were all supported with enthusiasm in Parliament, but were all dismissed summarily by the government.

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96 Hansard HC 18 June 2007, Col 1099 (Rt Hon R Winterton MP).

97 JUSTICE, Second Reading Briefing, House of Lords, November 2006.

98 Independent Mental Health Advocates will be available for all patients liable to be detained whether under Part II or Part III of the Act, being placed under guardianship or on a CTO, if discussing section 57 type treatments, for minors under 18 years of age and in discussing section 58A type treatments.

99 The managers of the hospital must ensure that the patient’s environment in the hospital is suitable having regard to his/her age (subject to his/her needs). The

managers shall consult a person who appears to them to have knowledge or experience of cases involving patients under 18 years old. Section 140 has been amended (duty on health authority to inform social services of arrangements) for the provision of accommodation for patients who have not attained the age of 18 years.

100 MHA 1983 s131(2) as amended by MHA 2007 s43.

101 MHA 1983 s58A as amended by MHA 2007 s27.

102 MHA 1983 s68(6) as amended by MHA 2007 s37.

103 MHA 1983 s58A as amended by MHA 2007 s27.

In addition, a whole raft of amendments<sup>104</sup> which were designed to make good defects or gaps in the 1983 Act were rejected without seriously considering their merits, on the grounds that there was no intention to undertake a wider revision of the 1983 Act. This underlined the unsatisfactory nature of the reform process.

There remain significant unresolved issues that may give rise to expensive human rights cases; there are difficulties in harmonising the two parallel statutes; and, above all, there is the uncertainty as to the operation of community treatment orders. Predictions as to the use of community treatment orders vary greatly<sup>105</sup> and the impact of new clinical roles on rates of detention is unknowable. It is unlikely that the Code of Practice can rescue these difficulties.

Indubitably the *Mental Health Act 2007* has broadened the scope of compulsory powers in hospital and in the community and is likely to lead to a greater use of compulsion in the treatment of mental illness. In the context of the 'blame' culture, where every tragedy caused by a patient can potentially be attributed to a psychiatrist's misjudgement, psychiatrists often feel required to recommend the detention of patients, perhaps against their better judgement or the best interests of the patient. Apart from the considerable disquiet this arouses from the point of view of patient's welfare, there is a fear that this will impose strains on a system where new and successful services are already struggling to survive, and that it will take away resources from voluntary patients – both in terms of bed space and professionals' time in dealing with the procedural requirements of the Act.

Ultimately it will depend upon clinical practice whether the words of Earl Howe are borne out:

*In this, as in other ways, the whole approach of the Bill views mentally ill people as patients who need compulsory treatment for their own good, whether they like it or not. Compulsion is, of course, necessary for many patients. But we need to remember – I do not think that some doctors always do – that it should always be a last resort. The Government say that every limitation on the ability of doctors to detain patients against their will has the effect of preventing those patients receiving the treatment that they need. To put the matter in those terms, however, presupposes that compulsion is the only means by which effective treatment can be delivered. Of course, it is not: good treatment is available without compulsion, and the fear of some of us is that the wider the gateway to compulsion and the easier the law makes it to get people through it, the less likely it is that those who need help will come forward to ask for it. Never let us forget the anguish, trauma and humiliation involved in subjecting a patient to compulsion –and never let us forget, as the RCN has emphasised, that compulsion should never be seen as a substitute for good healthcare.*<sup>106</sup>

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104 For example, providing for a right to move hospital; a duty of a Trust to act on a request for transfer to hospital from prison; the right to order a mental health report for an accused person remanded on bail.

106 Hansard HL 2 July 2007, Col 826.

105 The Department of Health assumed that in the first year, 2% of detained s3 patients in England and Wales may be discharged to a CTO. However, if the experience of Scotland is replicated – where in the first six months 23% of all hospital-based orders were varied, upon patient discharge, to a CTO – this is a significant underestimate. Lawton-Smith S (2005) *A Question of Numbers*. London: King's Fund. The current King's Fund estimate is between 7,800–13,000 CTOs in 10–15 years time (Briefing for Second Reading Mental Health Bill, Kings Fund 2006).

# Community Treatment Orders

*Kris Gledhill*<sup>1</sup>

A community treatment order is now a well-established feature of various common law jurisdictions in North America and Australasia, and in other countries. Its introduction into England and Wales was a central part of the government's drawn out reform of the Mental Health Act 1983<sup>2</sup>, and it attracted heated debate as part of the Parliamentary process<sup>3</sup>, both in the exchanges between Parliamentarians and the evidence and briefings filed by interested parties. A CTO provision was introduced with a speedier gestation period in Scotland. But there is no single form of "community treatment order"; and there may also be different policy objectives. What is usually central is the desire to provide a regime for patients who are assessed as being able to function in the community so long as they accept medication but who may disengage from treatment and relapse to the extent that they require in-patient treatment: the description "revolving door" is often attached to such patients and was during the course of the debates<sup>4</sup>.

The first question to be explored is whether what emerged in the Mental Health Act 2007 is much different from what already exists in relation to such patients: if it is and it allows community treatment which was previously not available, the further question is whether that is a good thing in light of the experience of other jurisdictions that have CTO regimes. If it is not, there are two further questions: firstly, why has something called a CTO been introduced if it does not amount to a change of substance; and secondly, is it a missed opportunity in light of the information from other jurisdictions – in other words, would a substantive change provide benefits which England and Wales is now missing?

## A. The New English Law: What Difference Will it Make?

### (i) The Current Law

Until the relevant portions of the Mental Health Act 2007 are brought into effect<sup>5</sup>, the existing provisions in the Mental Health Act 1983 will govern. The courts have interpreted the language of the 1983 Act to allow a patient to live in the community but be subject to compulsory treatment (albeit that if force has to be used, that can occur only in a hospital setting). The extent of the shift towards treatment

<sup>1</sup> *Barrister; Lecturer, Law School, University of Auckland; Editor of the Mental Health Law Reports.*

<sup>2</sup> *There was an expert committee which reported in November 1999, a Green Paper in November 1999, a White Paper in December 2000, a Draft Bill in 2002 and a further Draft Bill of 2004, both of which proposed a replacement Mental Health Act and finally a Bill introduced in 2006 to modify the 1983 Act but in a number of significant respects, which became the Mental Health Act 2007.*

<sup>3</sup> *Although there was no real opposition to the introduction*

*of something to be called a CTO, there was a significant difference of views on some of the details of the scheme. Some of this is discussed below.*

<sup>4</sup> *At the risk breaching the obvious requirement that patients should be treated on an individual basis, the use of the "revolving door" motif is accepted as a way of describing a feature which is common to some patients.*

<sup>5</sup> *The changes are apparently due to come into force around October 2008: see the Regulatory Impact Assessment of June 2007, Department of Health.*

with a community basis is made plain by figures as to the number of available beds: a Joint Committee of both Houses of Parliament<sup>6</sup> on mental health law reform noted that there were 154,000 psychiatric beds in 1954, but only 33,000 by 2005.

The civil provisions of the Mental Health Act 1983 authorise detention for assessment and treatment, under sections 2 and 3 respectively; both provide for a patient to be “admitted to hospital and detained there”. However, the power to detain does not mean that there has always to be detention. The Act sometimes uses the phrase “liable to be detained”: perhaps most importantly, powers relating to the imposition of treatment (in Part IV of the Act) arise in relation to those who are “liable to be detained”<sup>7</sup>.

At first sight, the phrase “liable to be detained” is explicable by the existence of the power to grant leave of absence under section 17: however, the power to grant leave of absence applies to a person who is “liable to be detained” and so the granting of leave of absence cannot produce that status<sup>8</sup>. The important point for present purposes is that the treating clinician may allow the patient to be in the community whilst still liable to detention and treatment under the Act. Indeed, the government position is that the granting of leave can be part of the treatment programme: the Code of Practice issued under s118 of the 1983 Act<sup>9</sup> states in paragraph 20.1 that it can be an important part of the treatment plan.

Given that the aim of detention for treatment under the Act must usually be the rehabilitation of the patient and hence their return to liberty, which may entail an element of testing in the community or reintegration, it is sensible to have leave as part of a care plan. Whether leave is treatment is a different question, but one which is important to resolve because in assessing whether liability to detention remains appropriate and necessary (to use the example of a s3 treatment order and its substantive criteria), it has to be for the purposes of treatment. So what amounts to treatment is central to whether liability to detention should remain in place.

The starting point is the language of the statute, under which “medical treatment” is widely defined<sup>10</sup> as including (and so not being limited to) “nursing, and ... care, habilitation and rehabilitation under medical supervision”. The use of leave as a part of the testing of progress is easily categorised as rehabilitation. But what if leave becomes long-term, such that the patient may no longer have a bed assigned? Both sections 2 and 3, plus the provisions for the renewal of the section 3 order in section 20, have as a pre-requisite that the patient’s condition is such that detention in a hospital is required: so the breadth of the definition of what amounts to treatment seems to be qualified by the context that the patient’s condition must be such as to require it on in-patient basis. Extended leave to allow the patient to reside in the community is difficult to square with the need for in-patient treatment to justify the continuation of the section. But there are no specific limits on leave, which can be granted indefinitely<sup>11</sup>, and there is the wide definition of what is treatment.

How this tension has been resolved can be traced through a number of cases, the net effect of which is a judicial endorsement of the view that extended leave is part of a treatment programme and only a very limited amount of in-patient treatment is required, which need not involve any bed being provided at the

6 *Joint Committee on the Mental Health Bill, Session 2004–5, HL Paper 79, HC 95; see ch 5, paras 183ff.*

7 *Though not if that liability arises from various short-term powers; and also not if the patient is a restricted patient granted a conditional discharge. See s56.*

8 *There is also the point that the patient can remain in custody during the leave period, under s17(3), which is*

*not consistent with being other than detained. It is beyond the scope of this article to provide (or determine whether there is) a satisfactory explanation for the statutory language.*

9 *As guidance in relation to the operation of the Act.*

10 *Section 145.*

11 *Section 17(2).*

hospital. The starting point is *R v Hallstrom ex p W*, *R v Gardner ex p L*<sup>12</sup>, in which it was noted that the law did not permit the patient to be detained in order to be released on leave with the status of “liable to detention” and hence subject to treatment even though the patient is in the community: some form of in-patient treatment remains necessary. The next case is *R v Barking, Havering and Brentwood Community Healthcare NHS Trust ex p B*<sup>13</sup>, where a section 3 patient’s detention was renewed at a time when she was allowed to be at home between Thursday and Monday inclusive and to be away from the hospital during the days when she slept in the hospital. She was subject to ongoing monitoring to determine whether she was using illicit drugs. The renewal was challenged on the basis that there was insufficient in-patient treatment: the test for renewal<sup>14</sup> is that medical treatment in hospital “cannot be provided unless he continues to be detained”. The Court of Appeal, in rejecting the challenge, held that the phrase “continues to be detained” should be construed to mean “continues to be liable to be detained” and that the treatment as a whole – including returning from leave and being monitored for drug use – was sufficient to meet the test. It was important, noted the Court, to assess whether or not the treatment plan as a whole required an element of in-patient treatment to ensure its success. If this were the case, then the test for liability to detention would be made out even if the patient spent a considerable part of the time on leave<sup>15</sup>.

More recently, in *R (DR) v Mersey Care NHS Trust*<sup>16</sup> the issue for the Administrative Court was whether it was proper to renew the detention of a patient who lived outside hospital and who returned only for occupational therapy one day a week and to attend the ward round on a different day for monitoring and review by the clinical team. The liability to detention was the only way in which DR would take her prescribed medication, without which there would be a rapid deterioration. The judge held that the renewal was valid, and went further than had the Court of Appeal in the *Barking* case. Wilson J commented that the latter case had involved in-patient treatment, and so it was natural that there would be reference to in-patient treatment: he felt that the requirement was only for there to be treatment at a hospital<sup>17</sup>. On the facts, the judge found that the requirements to attend hospital on two separate days meant that a significant component of treatment plan was provided in hospital and so it was permissible to renew the section and hence subject the patient to treatment without her consent. He also noted that leave of absence may be part of the treatment regime<sup>18</sup>.

Finally, in *R (CS) v MHRT*<sup>19</sup>, the facts before the Tribunal related to a patient on leave with a requirement that she attend ward rounds every four weeks. She had a history of not complying with medication for her diagnosed condition, schizophrenia, leading to a deterioration of her state and

12 [1986] 1 QB 1090.

13 [1999] 1 FLR 106.

14 Section 20(4)(a) and (c).

15 Thorpe LJ described the patient as retaining a “home base” in the hospital despite spending significantly more time away from hospital, and the structure and discipline of having to return to hospital for monitoring to ensure that prescribed medication was taken and illicit drugs were avoided were essential parts of the rehabilitation programme. As it happened, the facts of the case demonstrated that this was so: before the appeal hearing, the patient had moved to permanent leave, ie without any time in hospital to provide the structure, and had relapsed.

16 [2002] Mental Health Law Reports 386.

17 At para 29 he confessed that the “distinction between treatment at hospital and treatment in hospital is too subtle for me” and noted that “When I eat at a restaurant, I eat in a restaurant.” The argument against this as a statement of principle is that the purpose of the civil sections is to secure “admission” to hospital for assessment or treatment, which connotes treatment as an in-patient rather than treatment at a hospital as an out-patient. The analogy should perhaps have been between a restaurant in a hotel which is available to residents only and one which, although at a hotel, is open also to non-residents.

18 At para 30 the judge stated “There is no doubt ... that the proposed leave of absence for the claimant is properly regarded as part of her treatment plan.” He relied expressly on the Code of Practice.

19 [2004] Mental Health Law Reports 355.

readmission to hospital. At the ward rounds, there was discussion of her progress, whether changes in medication were required, and what was described as motivational interviewing to assist in her move to out-patient treatment; she received anti-psychotic medication by injection in hospital because she did not wish to receive it at home and had sessions with the ward psychologist. The Tribunal upheld the section on the basis that her poor insight and history of non-compliance with medication and disengagement with services meant that she would probably refuse medication and deteriorate rapidly if taken off section, so the nature of the illness justified detention.

Five weeks later, her care was transferred to a community psychiatrist and the section was lifted approximately 6 weeks after that. A challenge to the Tribunal decision failed on the basis that there was a significant element of treatment at hospital as part of a transition towards discharge, which was designed to break the historical cycle of relapse and readmission. Although Pitchford J rejected a submission that “the mere existence of the hospital and its capacity to be treated by the patient as a refuge and stability is part of the treatment of the patient at that hospital”, he noted that the treating psychiatrist was planning a staged discharge designed to break the cycle of admission, serious relapse and readmission. He concluded:

“46. ... It may be that in the closing stages of the treatment in hospital her grasp on the claimant was gossamer thin, but to view that grasp as insignificant is, in my view, to misunderstand the evidence. ...”

So extended leave of absence is legally acceptable as part of the process of treatment, allowing patients to be treated at hospital even if they are not in-patients: at the outer limits, liability to detention is liability to be recalled from leave so long as there remains a process of moving the patient towards the community (which may be extended).

Once released from liability to detention under section 3 of the Act, a patient has a right to aftercare under s117 of the Act: this is phrased as a duty on the relevant social service and health authorities to provide aftercare<sup>20</sup>. Onto this is grafted the Care Programme Approach process, based in Department of Health guidance to health and social services, which is designed to ensure that there is easy access to care, and provides for a level of intensity in care planning which is suitable for the needs of the patient and so designed to ensure there is ongoing service provision but also monitoring and persuasion where there is limited co-operation<sup>21</sup>.

In addition, there is the power to make the patient subject to an order for aftercare under supervision, under ss25A of the 1983 Act, introduced by the Mental Health (Patients in the Community) Act 1995 as from 1 April 1996. This was designed for patients who do not exercise their right to aftercare services because they do not accept its need (or may be insufficiently organised to co-operate fully). The patient must be 16 or over and liable to detention under section 3 of the 1983 Act when the order is made<sup>22</sup>; it must be determined (but only in the loose sense that the opinion must be formed by the treating

20 There are also general duties as to comprehensive health service and community care provision in various other statutes. The duty also expressly applies to those who have been detained under ss37, 45A, 47 or 48.

21 At the same time as the Mental Health Bill 2006 was passing through its early Parliamentary stages, there was an ongoing consultation on proposals for a modification of the CPA, which was introduced in 1990 and was last revised in 1999: see *Reviewing the Care Programme Approach 2006: a consultation document*, Department of

Health, November 2006. The consultation process ended in February 2007. It does not seem to feature in the Parliamentary debates on the CTO.

22 And so be mentally disordered; this is an express pre-condition to a supervision application – s25A(4)(a). A patient who has been detained under a s.37 hospital order is treated as if detained under s3 for this purpose. See s40(4) of the 1983 Act read with sch.1 part 1, particularly paras 1,2 and 8A.



psychiatrist) that the failure to accept aftercare services would lead to a “substantial risk of serious harm to the health or safety of the patient or the safety of other persons or of the patient being seriously exploited” and the use of the order is “likely to help to secure that he receives the aftercare services”<sup>23</sup>. A risk which is more than remote of the patient relapsing so that the degree of their illness necessitates in-patient treatment would meet the test<sup>24</sup>.

The patient on an aftercare under supervision order may be required to reside at a particular place (such as a hostel or similar setting), to attend for treatment, occupation, education or training (and be taken and conveyed there), and to grant access to medical and social care professionals<sup>25</sup>. The statute sets out a process for the making of an application, and its review<sup>26</sup>: these arrangements, which include a consultation process, are comparable to what is required by the CPA process<sup>27</sup>. A failure by the patient to co-operate means that there should be consideration of whether to assess him or her for a return to liability to detention through the making of a further order for detention<sup>28</sup>. Naturally, this may also apply if the patient co-operates fully but deteriorates.

So the 1983 Act provides for a regime of liability to detention whilst residing in the community on leave (from which recall is a simple matter of a written order of revocation if that is felt “necessary ... in the interests of the patient’s health or safety or for the protection of other persons”<sup>29</sup>), and for ongoing monitoring on release from liability to detention. There is no power to require acceptance of treatment in a community setting: but a patient on s17 leave can be recalled, and in relation to a person receiving aftercare under supervision there is persuasion and the threat of a review which might lead to detention<sup>30</sup>.

## (ii) The New Regime

The Mental Health Act 2007 introduces a Community Treatment Order regime by the addition of ss17A–G to the 1983 Act<sup>31</sup>. At the same time, the aftercare under supervision regime is removed<sup>32</sup>. In addition, s17 is amended by requiring that consideration be given to the use of a CTO instead of using leave which is longer than 7 days<sup>33</sup>. The essential components of the CTO regime are:

- (a) *Preconditions, Criteria and Effect*: A CTO can only be put in place in relation to a patient who is liable to be detained under an application for admission for treatment<sup>34</sup>: it cannot be imposed

23 s25A(4)(b) and (c).

24 See Jones, *Mental Health Act Manual*, (Sweet and Maxwell) 10th ed, para 1–291.

25 s25D; these are similar to the provisions applicable under a guardianship application (see s8 of the Act), with the addition of the power to convey the patient to the place of treatment etc. It is similar to guardianship, but led by health services rather than social services (though the development of partnership trusts in relation to mental health matters meant that there was supposed to be integration between health and social services).

26 Ss25B and E. There are also provisions relating to the renewal of the order, and its ending – ss25G and H; the patient may appeal to the Mental Health Review Tribunal – ss66 and 72(4A).

27 Given the target group, it is almost inevitable that those subject to aftercare under supervision would be subject to more intensive levels of the CPA process; there is an obvious need in all cases to ensure that the relevant services in the community are in place.

28 s25E(2) and (4).

29 s17(4).

30 The initial research suggested that the powers of s25Aff were of assistance where used: see the articles cited by Jones at para 1-329 of the *Mental Health Act Manual*, 10th ed.

31 By s32(2) of the 2007 Act.

32 By s36 of the 2007 Act, which also provides for the right to apply to a Mental Health Review Tribunal by a CTO patient.

33 Section 33 of the 2007 Act, adding s17(2A) and (2B) to the 1983 Act.

34 See ss17A(1) and (2); s40(4) provides that a hospital order under s37 has the effect of an application for admission for treatment, subject to amendments in Schedule 1 to the 1983 Act: the Schedule as amended provides for the application of the CTO regime to a hospital order patient, but not to a patient whose hospital order was combined with a restriction order.



without a period of in-patient treatment (and so mirrors aftercare under supervision in this regard), and is therefore not available in relation to voluntary in-patients or voluntary patients who seem to be disengaging but have not yet reached the stage when their condition justifies in-patient treatment<sup>35</sup>.

The criteria for the use of a CTO are that there be a mental disorder requiring treatment for the protection of the patient or others (and that appropriate treatment be available<sup>36</sup>), but that “such treatment can be provided without his continuing to be *detained* in a hospital” though with the additional point that it is necessary that the power of recall to hospital be available<sup>37</sup>. In assessing whether the latter test is met, the “responsible clinician”<sup>38</sup> must consider the risk of deterioration in the absence of detention in hospital<sup>39</sup>.

The making of a CTO means that the patient is discharged from hospital but is made liable to recall<sup>40</sup>; in addition, conditions can be imposed, provided they are “necessary or appropriate” to ensure that the patient receives treatment or to prevent risk to the patient or protect others<sup>41</sup>.

One of the conditions will invariably be that the patient accept treatment: but there is no way to enforce any condition, ie compulsion will not be available<sup>42</sup>. At the Committee Stage in the House of Commons, the Minister of State said<sup>43</sup>:

*“The way that a community treatment order would work is as follows. The individual would need to accept the conditions on which the CTO was being given and be given a written copy of those. The conditions would have to be agreed by an approved mental health professional, because if an individual did not accept the conditions of the CTO, it would not work so there would be no point giving it in the first place. This is not about saying, “This is what you are going to do”, with the person sitting there saying, “I don’t accept any of that”, because a CTO will not be given if the individual does not accept the conditions.”*

35 At the Second Reading in the House of Commons, the Secretary of State for Health, Ms Hewitt, noting that the proposals envisaged CTOs being available in more limited situations than in Scotland or than had been proposed under the 2004 Draft Bill, stated “under the Bill, supervised community treatment will not be available to a patient who is already being treated in the community or who is a voluntary in-patient”. This was said to be a change which responded to objections made plain in the process of consultation relating to the 2004 proposals. See Hansard 16 April 2007, Vol 459 at col 57. As noted below in the article (part B (ii) (b)), a patient whose condition is liable to relapse may be detained prior to relapse on the basis of the nature of the illness.

36 A new requirement in relation to detention for treatment (inserted into s3 of the 1983 Act by s4(2) of the 2007 Act); but, note, not a pre-requisite for the use of guardianship.

37 Section 17A(5).

38 The replacement for the Responsible Medical Officer, the change in terminology necessitated by the extension of the lead clinical role to those who are not medically qualified: see s9(10) of the 2007 Act; see also paras 47 and 48 of the Explanatory Notes to the 2007 Act, which notes that approved clinicians may be from various professions,

namely medical, nursing, psychology, occupational therapy and social work.

39 Section 17A(6).

40 Section 17A(1). Section 17D(1) is express that the application for admission for treatment does not cease to have effect, but s17D(2) provides that the authority to detain under s6 is suspended and so the patient is not liable to detention at that time. There are detailed provisions relating to the duration and renewal of the order; it can be discharged under s23 (by the RC, hospital managers or nearest relative, the latter being subject to a barring certificate by the RC) or through an application to the Mental Health Review Tribunal.

41 Section 17B(2). The conditions can be modified or suspended: ss17B(4) and (5).

42 See Part 4A, which is inserted into the 1983 Act to deal with treatment in the community. Its effect is summarised in the Explanatory Notes issued with the 2007 Act: ‘129. ... Community patients aged 16 or over with capacity to consent to treatment can only be treated in the community if they do consent to their treatment.’ There are also equivalent provisions for children who are competent; but different rules apply to those without capacity.

43 Rosie Winterton MP, 10 May 2007, Hansard Public Bill Committee Session 2006–7 Cols 305–358 at col 334.

So the requirement that the treatment be possible without detention – the substantive test – means that the criteria for a CTO are fairly strict: the RC must form a view that the patient will accept treatment in the community. In turn, this means that the CTO is as much dependent on the co-operation of the patient as is aftercare under supervision if the key component for successful maintenance in the community is medication.

- (b) *Putting a CTO in Place*: there is no application process; instead an order for a CTO may be made by the RC. Before making such an order, there must be consultation with, and agreement by, an Approved Mental Health Professional<sup>44</sup>. The process may appear more streamlined than the requirements in relation to aftercare under supervision, but since this all takes place in the context of the CPA and the need for adequate community-based services to be in place, this is hardly a difference which is fundamental<sup>45</sup>. There may be an assumption that the RC will be the same, whereas aftercare under supervision may well have set a requirement for extensive consultation on the basis of an assumption that there would be a different Responsible Medical Officer in the community: the process is, naturally, much easier if there is in fact only one clinician involved. It should be noted that since the government wishes CTOs to be considered instead of leave lasting more than 7 days, and the process of ordering s17 leave is simpler still than the CTO process, the bureaucratic burden of operating the new regime may be greater overall if patients currently on s17 leave are moved to CTOs.
- (c) *Recall*: although breach of a condition is a relevant factor in determining whether to recall<sup>46</sup>, it does not automatically lead to recall. The criteria for recall are that the patient “requires medical treatment in hospital for his mental disorder” and a failure to recall would present “a risk of harm to the health or safety of the patient or to other persons”<sup>47</sup>. This may be met even if there is no breach of condition<sup>48</sup>. It is also stated in section 17E(2) that “the responsible clinician may also recall a community patient to hospital if the patient fails to comply with a condition...”<sup>49</sup>.

The important point is that there is a power of recall, not a duty. Since its effect is that, at least if accompanied by a revocation of the CTO under s17F, the patient returns to the status of a patient under section 3 of the Act, the recall power can be used properly only if the patient meets the test under that section. Again, to quote the Minister of State in Committee<sup>50</sup>:

*“I should also say... that if an individual did not stick to the conditions, it would not automatically mean that they would be recalled to hospital. It is up to the clinician to decide whether it is appropriate – whether it is because the person has become a risk to themselves or others – for them, at that point, to be recalled to hospital.”*

44 Section 17A(4). The AMHP is the replacement for the Approved Social Worker, reflecting the fact that professionals from other roles may now perform this other role: see ss18–21 of and Schedule 2 to the 2007 Act, which sets out the various amendments to the 1983 Act. Paragraph 64 of the Explanatory Notes to the 2007 Act notes that “a wider group of professionals, such as nurses, occupational therapists and chartered psychologists will be able to carry out the ASW’s functions as long as individuals have the right skills, experience and training, and are approved by an LSSA to do so.” It is also suggested that, whilst they may be NHS employees, their skills and training will ensure that they bring an “independent social perspective”.

45 And if the application process relating to aftercare under supervision was the problem, that could have been amended.

46 Section 17B(6).

47 Section 17E(1).

48 And s17B(7) is clear about this. See also s17E(4) which allows a recall even if the patient is in hospital at the time, as a voluntary patient.

49 There is also a process for revoking the CTO, which requires the written approval of an AMHP: see ss17F and G.

50 See note 43 above.

This in turn ought to mean that the only difference between a CTO and the supervised discharge provisions in terms of returning the patient to hospital is that the latter requires a formal resectioning process before the patient is returned to detention, ie a formal assessment with medical and social work support in favour of detention: but this is consistent with the requirements of ethical good practice, which discourages unilateral decision-making, and should not pose a difficulty if the CPA process is working properly in relation to the patient<sup>51</sup>. Equally importantly, if the recall is to a mental health unit which is operating at full capacity, the need to find a bed for a recalled patient will be of as much significance as filling out the relevant form.

So, the CTO does not represent a major change from the existing powers to make creative use of s17 leave (which will remain but be discouraged in relation to leave of more than 7 days) and the aftercare under supervision powers (which will disappear). It is a shuffling around of the deck of powers rather than the addition of new ones.

## B. The Route Taken to the New Position and the Policy Position

If this is right and there is no real change, one question which arises is why did the government make it such a priority to introduce something which it could describe as a new form of order requiring treatment in the community? Assuming a rational explanation exists, one possibility is that there was simply a momentum towards reform involving the introduction of a CTO, and that in the process of compromise that was involved in the formulation of the policy, no-one took the opportunity to stand back and realise that there was in fact no significant reform. At the less charitable end of the same continuum, the explanation is that there was too great a political momentum towards asserting that there was major change even though the reality was one of semantics.

### (i) The Momentum Towards a CTO Regime

It is certainly the case that the introduction of some form of CTO has featured throughout the extended reform process.

#### (a) The Expert Committee and the Initial Proposals

The Expert Committee<sup>52</sup> proposed a new structure to compulsory orders, requiring authorisation by a Tribunal for anything beyond short-term assessment and more restrictive grounds for the use of compulsion, particularly for those with capacity<sup>53</sup>. But it would be possible for the treatment order to be on an in-patient or community treatment basis, with conditions set out in the order (referring to the obligations of both the patient and the care team). Non-compliance by the patient together with

51 Note that if the RC is not a doctor and acts alone in a situation which is not an emergency, there is an obvious ground for a challenge raising Article 5 of the European Convention and the Winterwerp criteria (see *Winterwerp v Netherlands* (1979–80) 2 EHRR 387) requiring “objective medical expertise” before detention can be “lawful” for the purposes of Article 5(1)(e).

52 The Report of the Expert Committee headed by Professor Geneva Richardson, “Review of the Mental Health Act 1983”; Department of Health, November 1999.

53 The cumulative criteria for compulsion (see para 5.95 of the Report) were to be (i) “... mental disorder ... of such seriousness that the patient requires care and treatment

under the supervision of specialist mental health services”; (ii) the treatment be the least restrictive option; (iii) it be in the patient’s best interests; (iv) (a) for those without capacity, the treatment be necessary for the patient’s health or safety or to protect the patient from serious exploitation, or to protect others from serious harm; and (b) for those with capacity (which the Committee believed would largely be those with personality disorders – see para 5.100), there be a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons if s/he remains untreated, together with the availability of positive clinical measures likely to prevent a deterioration or secure an improvement in the patient’s mental condition.

deterioration in health would lead to detention. As to the location of treatment, the Committee indicated that force could only be used to administer medication in a hospital “until safe and adequately staffed non-hospital settings are available”<sup>54</sup>. The Committee did express the view that a community order would not be appropriate in the absence of “a history of failure to accept the proposed care and treatment” to demonstrate the necessity of an order<sup>55</sup>.

The Green Paper issued by the Government following the Expert Committee Report accepted the recommendation relating to the new Tribunal and the power to make CTOs<sup>56</sup>, as did a White Paper issued after consultation on the Green Paper<sup>57</sup>. The Government eventually produced a Draft Bill in 2002<sup>58</sup>, which was designed to replace the Mental Health Act 1983. Its structure for the use of compulsion in the civil context was that an examination would be carried out when requested<sup>59</sup>, which could lead to an assessment section being imposed, on an in-patient or out-patient basis<sup>60</sup>. The main function of the assessment process was the formulation of a care plan on the basis of which an application would be made to the Mental Health Tribunal for a treatment order<sup>61</sup>: this could be as a resident or non-resident patient.

(b) The 2004 Draft Bill

There was a similar structure proposed in the further Draft Bill of 2004<sup>62</sup>, which was subject to pre-legislative scrutiny by a Committee of both Houses of Parliament<sup>63</sup>. The latter examined the issue of CTOs in some depth<sup>64</sup>, having set the context as the move towards treatment in the community. The Mental Health Act Commission gave evidence that of the 13,500 patients detained under the Mental Health Act 1983 at any one time, a relatively significant proportion were in the community under the leave of absence powers of s17 of the Act. The Commission also noted that the proposals in the Draft Bill for non-resident patients (who could be required to attend at specified places, reside, be available for assessment and not engage in specified conduct) was closely approximate to the use of detention and leave and so the effect was to consolidate and clarify the existing legal regime.

Other evidence to the Joint Committee made it clear that there were significantly different views as to the principle behind and efficacy of CTOs. Its conclusion<sup>65</sup> was that the framework suggested in the Draft Bill was too wide: “non-residential compulsion could be applied to a far wider population than is appropriate, and in circumstances which could be unacceptable”. Amendments were therefore recommended to provide a more focussed power: CTOs would normally require previous hospitalisation (albeit only for assessment) and evidence of responsiveness to and co-operation with treatment; and there would be limitations, namely the only permissible conditions would be residence and treatment, force would be permissible only in hospital settings, and there would be time limits, with a maximum of three years on an order in any five.

54 Ch 1, Introduction, paras 21–22; more details are set out at paras 5.105ff.

55 Para 5.104.

56 *Reform of the Mental Health Act 1983: Proposals for Consultation*, November 1999, Cm 4480; see in particular ch 6, paras 10ff.

57 *Reforming the Mental Health Act, December 2000*, Cm 5016 (which was in two parts, one setting out *The New Legal Framework and the other dealing with High Risk Patients*); see in particular ch 3 of Part I.

58 June 2002, Cm 5538.

59 Clause 9ff.

60 Clause 17ff.

61 Under cl 30ff; see in particular cl 38.

62 Cm 6305; see in particular cl 38ff.

63 *Joint Committee on the Mental Health Bill, Session 2004–5*, HL Paper 79, HC 95.

64 Ch 5, paras 183ff. The figures for bed numbers quoted are reported at para 184.

65 Para 197.

The Joint Committee also expressed concern that the CTO regime would be used to manage limited in-patient resources (by discharging people because of bed shortages), and so emphasised the importance of having a significant increase in resources, to be achieved by imposing a duty on health and local authorities to provide adequate care.

(c) Scotland

The Draft Bill of 2004 went no further. In the meantime, the Scottish Parliament had instituted a process of reform of its own legislation. An expert report led to a Bill and then an Act which passed in 2003. The Millan Committee<sup>66</sup> had a number of proposals for reform. One was that the criteria for long-term compulsion involve not only a mental disorder of a nature or degree making treatment appropriate and that it be necessary for the health or safety of the patient or the protection of others (which should be expressed as a significant risk of harm to the health, safety or welfare of the patient, or a significant risk of harm to others), but also that the patient suffer from impaired judgment to the extent that compulsory treatment was appropriate and that the treatment be likely to provide a therapeutic benefit (in alleviating or preventing a deterioration of the patient's condition or symptoms). It further suggested that if the criteria for compulsion were made out, the location of treatment should be either on an in-patient or community basis, depending on what was the least restrictive alternative (but with the proviso that there could be no forced medication in the community, and a Code of Practice should specify treatments that should only be given on an in-patient basis). The Committee also recommended that the decision as to this be made by a Mental Health Tribunal, which would have to sanction compulsion on the basis of a care plan.

The Mental Health (Care and Treatment) (Scotland) Act 2003<sup>67</sup> largely adopted the recommendations of the Millan Committee. The structure it provides is for administratively imposed emergency and short-term detention, but any longer term compulsion must be on the basis of a Compulsory Treatment Order made by the Mental Health Tribunal for Scotland<sup>68</sup>. It provides for community treatment. The criteria for compulsion are set out in s64(5):

- “(a) that the patient has a mental disorder;
- (b) that medical treatment which would be likely to—
  - (i) prevent the mental disorder worsening; or
  - (ii) alleviate any of the symptoms, or effects, of the disorder, is available for the patient;
- (c) that if the patient were not provided with such medical treatment there would be a significant risk—
  - (i) to the health, safety or welfare of the patient; or
  - (ii) to the safety of any other person;
- (d) that because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired;
- (e) that the making of a compulsory treatment order in respect of the patient is necessary; and
- (f) where the Tribunal does not consider it necessary for the patient to be detained in hospital, such other conditions as may be specified in regulations.”

66 *New Directions: Report on the Review of the Mental Health Act (Scotland) 1984, January 2001, SE/2001/56; see in particular ch 5, Compulsory Treatment, which deals with the criteria for the use of compulsion, and ch 6,*

*Compulsory Interventions, which deals with the range of interventions.*

67 *In effect from 5 October 2005.*

68 *Under ss57 ff of the Act.*

The measures that may be specified in a Compulsory Treatment Order are set out in s66 of the Act: they include treatment, detention or attendance for treatment or to receive community care services, residence (and also having to seek permission to change address, or to inform the official coordinating the treatment plan of a change of address), and allowing visits by doctors or community care service providers. So the Tribunal has a clear option to determine that anyone who is in need of ongoing treatment can be made the subject of a non-resident order, which seems to have become known as the Community Based Compulsory Treatment Order<sup>69</sup>.

## (ii) The Mental Health Act 2007: The Policy Objectives

### (a) The Bill in the House of Lords

The Mental Health Bill 2006 was introduced into the House of Lords. It was no longer intended as a replacement for the 1983 Act, but rather contained amendments to various key sections. The introduction of the CTO remained central. On the Second Reading, the then Minister of State, Lord Warner, outlined the proposals in the following terms<sup>70</sup>:

*“Supervised community treatment is probably the key change in the Bill ... It is important not just from a patient and public safety angle but because clinical practice itself has changed. At present, most patients treated under the Mental Health Act are detained in hospital. That reflects the fact that, in 1983, most acute mental health services were provided in hospital. However the world has moved on and we now have a wide range of community-based mental health services....”*

These, he noted, were suitable for the needs of some patients, as was the practice in various other countries. The group to be targeted were patients who...

*“... stop taking their medication or treatment once they leave hospital, and so relapse and end up being readmitted. This detrimental cycle is often referred to as the revolving door. Patients on supervised community treatment will benefit from a structure designed to promote safe community living. This will reduce the risk of relapse and re-detention...”*

But there would be the power of recall in case of deterioration, which would be the only situation in which treatment could be forced. As for numbers<sup>71</sup>, he gave the government estimate as rising “to the order of 3,000 to 4,000 per year over a five-year period”<sup>72</sup>.

69 Also involved in a process of reform which overlapped with the English process was the Irish Parliament. It passed a new Act, the Mental Health Act 2001, but did not find it necessary to include community treatment orders to supplement the powers of admission and leave of absence on conditions under ss14 and 26 of the Act.

70 28 November 2006, Hansard Vol 687 Cols 656ff.

71 Col 730.

72 See also the initial Regulatory Impact Assessment (Department of Health, November 2006). It stated that the procedures for managing patients in the community (which it described as guardianship and supervised aftercare: it did not mention the use of leave) “19. ... are limited in terms of providing an effective way for clinicians to treat a patient in the community both in terms of ensuring compliance with treatment and acting quickly when problems occur...” The introduction of the CTO would have three benefits (see para 49), namely it would

“enhance patient and public safety” by enabling swift recall if patient’s mental health “deteriorated to the point that they pose a risk to themselves or others”, provided the community treatment in lieu of detention, minimizing the disruption to patients’ lives and allowing early intervention for ‘revolving door’ patients, and supported the modern community-based provision of mental health services; and there were no real risks (para 50) as the criteria for the use of a CTO and the safeguards in place would prevent the “unjustified extension of the use of compulsion”. An alternative option of encouraging the use of supervised aftercare could not provide the benefits (see para 117) and so there remained the risk that it would not be used; nor would that address the administrative burden of supervised discharge (and the RIA did not contain any suggestions for making the administrative burden less cumbersome). It calculated the cost implications on the basis of 10% of people placed on a s3 detention order would be placed on a CTO.



The House of Lords amended the government's proposals<sup>73</sup> by adding a requirement that the patient have significantly impaired ability to make decisions about treatment by virtue of his or her mental disorder<sup>74</sup>, limiting the CTO to the protection of others, and requiring that the patient had a previous history of refusing treatment leading to relapse which was remedied on further compulsory treatment<sup>75</sup>.

(b) Action in the House of Commons

The government's response to the Lords' action (and some other changes they made) was made plain outside Parliament. The lead Minister on the Bill in the House of Commons, Rosie Winterton MP<sup>76</sup>, on 1 March 2007 noted the need for intervention because of risks posed:

*"6. These risks are real. Every year over 1,300 people in contact with mental health services take their own lives. Every year mental health patients commit around 50 homicides. Often these are preceded by a reluctance to take treatment that would have kept them well. This number is higher than of homicides (46) by shooting last year."*<sup>77</sup>

The changes introduced by the Lords were roundly criticised as producing the risk "either that patients have to stay longer in hospital, or be discharged without proper supervision. The result again may be that they become a danger to themselves and others". She indicated that they had to be overturned.

And overturned they duly were in the Public Bill Committee<sup>78</sup>. Ms Winterton set out government policy in more detail<sup>79</sup>. She noted that the CTO regime was well-established in other jurisdictions and was "a measure to enable patients to receive treatment under formal supervision without always having to be in a hospital setting, which is not necessarily the best place for an individual to make a recovery ... CTOs are seen as the modern workable way to manage mental disorder in a community setting<sup>80</sup>". In relation to the target group, namely 'revolving door patients', the aim was to avoid having to wait until they deteriorated to the extent that they needed to be in hospital: the aftercare under supervision provisions were deficient because it was necessary to allow people to deteriorate to the level when they were sectionable before they could be taken back into hospital<sup>81</sup>.

This does not hold water as a matter of law. Detention under the provisions of the Mental Health Act 1983 turns on the nature or degree of the disorder: so a person who suffers from a relapsing illness and who is relapsing or engaging in conduct which the clinical team can say will lead to relapse can be detained on the basis of the nature of the illness without any need for the degree of the illness to become acute. The additional requirement for detention under section 3 of the Act, namely that it be necessary

73 Which were in round terms similar to those as passed.

74 This reflected changes made by the Lords in relation to all instances of civil compulsion (and did not apply in criminal proceedings); it was overturned in the Commons.

75 See the Report stage, 26 February 2007: Hansard Vol 689 Cols 1406–1418; 1427–28.

76 Minister of State at the Department of Health; the speech was to the conference of the Local Government Association and is available at: [http://www.dh.gov.uk/en/News/Speeches/DH\\_072442](http://www.dh.gov.uk/en/News/Speeches/DH_072442).

77 See also the Secretary of State, Patricia Hewitt MP, who at the Second Reading stage in the House of Commons (Hansard 16 April 2007, Vol 459 Cols 52–132, particularly from col 56); she noted that the CTO provisions would help with revolving door patients, whose pattern "features all too often when someone who has

been in contact with mental health services takes their own life—some 1,300 people a year. The same is also true in many of the far smaller number of cases – about 50 a year – when someone else dies at the hands of a mental health patient. We will probably never be able to prevent every such death, but supervised community treatment is essential to help ensure that patients who have been discharged from hospital continue with their treatment in the community, helping to keep them well and thereby helping to protect them, their families and the wider public."

78 10 May 2007; Hansard Public Bill Committee Session 2006–7 Cols 305–358.

79 Starting at col 329.

80 Cols 330–331.

81 Col 333.



for the health or safety of the patient or the protection of others, is also met by conduct (such as failure to take medication) which will lead to a deterioration in the degree of the illness. If there is a problem in practice because the law is not understood or used properly, that is a different matter, but presumably the first line of response to that should be training on the existing law.

Ms Winterton next prayed in aid the report of the inquiry into the homicide committed by John Barrett, noting that it had said:

*“In our view, the only means of securing John Barrett’s compliance with treatment as an out-patient would have been a community treatment order, which is not available under the Mental Health Act.”*<sup>82</sup>

It is worth putting this comment in context. To explain, the inquiry<sup>83</sup> was into the killing by Mr Barrett of a cyclist in a London park; Mr Barrett suffered from schizophrenia. Prior to the homicide, he had been convicted of serious assaults and made the subject of a hospital order with a restriction order (ss37 and 41 Mental Health Act 1983); he had been granted a conditional discharge by a Mental Health Review Tribunal in October 2003, and his life was subject to conditions, including the standard one that he comply with medication. During the period of his conditional discharge, he had a short informal admission in May 2004 because of his concerns that he was hearing voices. The suggestion of a recurrence of symptoms led to a further informal admission on 1 September 2004 to a medium secure unit: his psychiatrist could not see him that day, and he was allowed to leave the hospital but told that he was expected back after an hour. He did not return, and stayed overnight with a friend; responding to auditory hallucinations, he committed the homicide on 2 September. The Inquiry team found various deficiencies which played a part in the homicide, including the failure to detain Mr Barrett formally on 1 September and the decision to give him permission to leave the ward.

The comment referred to by Ms Winterton as to the need for a CTO to secure the taking of treatment by Mr Barrett relates to the Inquiry team’s review of Mr Barrett’s care and treatment in the period to January 2002<sup>84</sup>, which was before the assaults which led to the imposition of the hospital and restriction orders. At the time of the homicide, he was a conditionally discharged restricted patient, and so he was subject to a regime involving conditions of the sort that will be available under the CTO regime. (Moreover, he could not be made the subject of a CTO as a restricted patient.) It was the failure of the team involved with the care and treatment of Mr Barrett to make use of their existing powers, not the absence of a CTO, which was the problem. Indeed, the Inquiry panel specifically stated<sup>85</sup>:

*“6. The remedy for what went wrong in this case lies not in new laws or policy changes. Nor is there any reason to believe that an insufficiency of resources contributed in any way to the shortcomings we have found. The challenge, both organisational and individual, is to ensure that the care of potentially dangerous psychiatric patients is based on sound clinical practice and the systematic application of established principles of risk and organisational management. ...”*

So, when the Minister emphasised the importance of the “recommendation” of the John Barrett inquiry, there was no recommendation<sup>86</sup>; and Mr Barrett was subject to a regime which the CTO provisions will

<sup>82</sup> Col 334.

<sup>83</sup> *Report of the Independent Inquiry into the Care and Treatment of John Barrett, November 2006, NHS London; commissioned by South West London Strategic Health Authority.*

<sup>84</sup> It can be found at p212 of the Report.

<sup>85</sup> See p9, in the chapter summarising its findings and recommendations.

<sup>86</sup> *The most that can be said is that had Mr Barrett been made the subject of a CTO in the period to January 2002, this might have secured his compliance with medication and so have assisted with his management in the period before the assaults which led to the imposition of hospital and restriction orders: but that is a long way from the implicit suggestion of the Minister that the Panel recommended the introduction of a CTO regime.*

emulate for non-restricted patients.

Moving next to the potential for preventing self harm<sup>87</sup>, the Minister noted that the report of a national inquiry<sup>88</sup> indicated that there were “1,300 suicides a year ... carried out by people who have been in touch with mental health services” and that “56 people in the last year had committed suicide following non-compliance with medication or loss of contact with services” and so that was the potential.

Again, it is worth reviewing the primary source. It involved a survey of 6367 suicides between January 2000 and December 2004 by people who were at the time or had been recently been in contact with mental health services: so the average number is some 1300 per year (and it represents some 27% of all suicides). Clinicians felt that 19% of suicides were preventable<sup>89</sup>: however, the percentages vary according to the status of the patient (and the inquiry commented that its calculations were necessarily somewhat crude). So, of the suicides by in-patients (including those released on leave), some 41% were felt to be preventable. There were also those who committed suicide between discharge and their first follow-up, of which 22% were felt to be preventable. Of the other “community suicides”, some 12% were felt to be preventable. The report specifically addressed the issue of CTOs in the following terms:

*“We have no reliable way of calculating how many suicides would be prevented by a community treatment order. Our figures do, however, indicate the potential for prevention. Our sample contains 264 patients who had been detained in their final admission and who died following non-compliance with medication or loss of contact with services, 4% of cases or 56 per year. Overall, 14% of patient suicides were preceded by non-compliance.”<sup>90</sup>*

The inquiry investigated the factors behind non-compliance. A significant one was lack of insight (which was thought to be a factor in 48% of the cases). It also reviewed responses from professionals to the problems of non-compliance: they were the use of higher levels of service provision under the CPA system (in 46% of the cases) and face to face attempts to encourage use of medication (in 73% of cases and 83% of the patients in the group who suffered from schizophrenia). On the question of whether suicides by those who were not compliant with medication were preventable, the inquiry reported that 24% of those suicides were classed as preventable, but the tools to be used were better compliance and closer supervision: new legal powers were specified by respondents to the survey only in 4% of cases (34 out of the 813 instances). At the risk of stating the obvious a mental disorder of a nature or degree to cause suicide is one which can be used to detain.

Whether the figure the Minister should have used was 56 cases per year or the 34 cases over 5 years, either figure represents a number of tragedies. But the focus should have been on the success in reducing suicides in non-compliance cases without the availability of the CTO regime<sup>91</sup> to assess the factors involved in this and build upon them. Moreover, there remain more significant problems in relation to

<sup>87</sup> Col 336.

<sup>88</sup> Taken to be a reference to “Avoidable Deaths: five year report of the National Confidential Inquiry into suicide and homicide by people with mental illness”, University of Manchester, December 2006; available at <http://www.medicine.manchester.ac.uk/suicideprevention/nci/>.

<sup>89</sup> See part 3.9 of the report, page 91 and following. Note that the real issue is one of risk assessment (to the extent that this is ever possible): the risk of suicide was assessed as low or absent in 86% of cases. The obvious conclusion

is that it was errors in the risk-assessment process that were important, not the lack of legal powers.

<sup>90</sup> Moreover, in the period from 1997–2004, the proportion of suicides preceded by non-compliance had fallen from 22% to 14% (ie 71 fewer deaths per year): see part 3.7 of the Report. This non-compliant group (813 of the total of 6337) included 30% diagnosed with schizophrenia (as opposed to 18% of the overall group), and higher proportions who also had alcohol or drug misuse issues or a secondary diagnosis.

<sup>91</sup> Namely 71 fewer deaths per year.

in-patient deaths (856 in the survey period). And the real danger period for those discharged into the community is the first three weeks<sup>92</sup>, which is not the crucial period to which the CTO regime is aimed: Ms Winterton was aiming at the patients who were not in the immediate post-discharge period.

What conclusion can be drawn as to the reason for the introduction of the CTO? The policy objectives mentioned by the government had two themes: one was the structure of modern practice and the other was the need to protect both patients and the public. But modern practice has developed under the 1983 Act without anything termed a CTO among the techniques designed to seek to prevent the revolving door cycle, the need to tackle which is hardly controversial. Moreover, the new regime offers no new legal powers to offer protection to patients or the public. When this is added to the use of figures and quotations by government ministers which are at best misleading and emphasise serious self-harm and danger to the public – matters which tend to grab headlines – it does suggest that this was a political imperative.”

### C. Do CTOs Work?

The further question posed is whether CTOs work in any event, and if so in what form? In “*Community Treatment Orders: International Comparisons*”<sup>93</sup>, Professor John Dawson formed a view that the research as to the efficacy of CTO regimes presented a relatively positive picture<sup>94</sup>. However, he noted that success was more likely when there were well-resourced and co-ordinated systems in operation, which include community visits from clinicians who are committed to the system; and that there were risks, including de-facto detention, overuse in relation to some groups where the efficacy of the CTO was less clear (particularly younger males with concurrent substance abuse problems), and issues about the overuse of CTOs to deal with pressure on beds and inadequate reviews of the ongoing use of CTOs on patients who have been on them for an extended period.

Dawson considered the legal regimes in place in New Zealand, Victoria and New South Wales in Australia, Canada (and in particular Ontario), Switzerland and the British jurisdictions, and also the structure of service provision. His aim was to assess the adequacy of the regime in New Zealand, where a CTO was introduced to the statute book in 1992, but in so doing he provides a detailed analysis of the formats available in the jurisdictions he covered. In particular, he was able to identify what he called “the major fault-lines” in CTO legislation, namely the role of capacity<sup>95</sup> and the extent of the powers given to clinicians to enforce treatment<sup>96</sup>: his conclusions were that capacity should play a role and that there should be no power to enforce treatment outside a clinical setting<sup>97</sup>. As to what was features were required for a successful CTO regime, he suggested that they were powers to control residence, to compel accepting visits from relevant professionals, a duty on the patient to attend out-patient appointments and to accept treatment, though with the proviso as to its enforcement without consent only in a clinical

92 Page 78 of the report. 49% of patients who killed themselves had been in contact with services in the previous week and 19% in the previous 24 hours.

93 May 2005; available at [www.otago.ac.nz/law/otagoCTO/publications/index.html](http://www.otago.ac.nz/law/otagoCTO/publications/index.html).

94 Dawson p4-5, he summarised that they were linked with significant therapeutic benefits, greater compliance with medication (often depot), and reduced hospital admission rates.

95 This is a feature in Ontario, other North American

jurisdictions, and also Switzerland: see pp87–8, 125–7, and 142ff. It is also part of the new Scottish regime – see above.

96 Pages 148ff.

97 Pages 2, 146-8 and 150. On the question of whether there should be a power to compel medication in the community, he notes (at p49) “The line that emerges from study of the statutes, and the law reform debates, as the Rubicon that should not be crossed, is the authorisation of forced medication in community settings” because of concerns about privacy, dignity and security.

setting, and also a swift power of recall with police assistance in the process<sup>98</sup>. This is what the new English regime involves; but also what is available in any event.

Indeed, one of the points which emerges from Dawson's review of the change in New Zealand<sup>99</sup> was that the CTO:

*"did not involve a radical break with past practices... [CTOs] simply replaced the well-established prior practice of granting involuntary patients 'trial leave' from hospital care. That kind of leave had been granted for some years on rather similar conditions to those that would later be imposed on patients under the [CTO] regime."*<sup>100</sup>

In other words, the process of deinstitutionalisation was accomplished without a CTO. The statute in Victoria, the Mental Health Act 1986, was one of the first in the World to provide a CTO regime: no surprise to Dawson because "Victorian psychiatrists have been international leaders in the field of community care"<sup>101</sup>. The period following the introduction of the CTO regime<sup>102</sup> has been marked with a significant reduction in the number of in-patient beds in Victoria<sup>103</sup>. Dawson records<sup>104</sup> that:

*"Many people interviewed considered this rapid reduction in psychiatric beds and the associated shift in resources to the community would not have been possible without the introduction of [CTOs]."*

Of course, the experience in New Zealand was to the contrary: there was deinstitutionalisation before a CTO via the use of leave<sup>105</sup>. In other words, both formal CTOs and detention with the use of leave can achieve the same effect in support of the policy aim of moving psychiatric care into the community so far as possible.

Noting that the particular group targeted by CTOs is "revolving door" patients, the idea, comments Dawson, is to provide sufficient benefits in terms of preventing or reducing the severity of relapse to outweigh the sense of coercion the patients may experience. He notes that this also benefits carers and family, who have less stress from dealing with the illness, as well as reducing the risks of harm<sup>106</sup>. The focus is therefore the benefits to be obtained by patients and others who are potentially affected. A recent

98 See Overview, pp1–3.

99 Through the introduction of the Mental Health (Compulsory Assessment and Treatment) Act 1992, which creates a presumption in favour of a CTO: an in-patient order may only be made (by a judge) if the patient cannot be treated adequately as an out-patient (section 28(2) of the Act), though it is also provided that there must be a finding that there are appropriate facilities available (section 28(4)).

100 Page 19; he gives further figures at p25, to the effect that there were 1700 CTOs in place on an average day in 2003 (amounting to 1 person in 2350 of a population of 4 million), which was similar to the number of patients on leave in the late 1980s (though there has been a slight population growth in the period). There are, he says at p18, more people under CTOs than involuntarily detained in hospital.

101 Page 31.

102 The statutory regime involves a finding that the patient meets the requirements for involuntary treatment, and also a finding that out-patient care is proper, which reflects a "least restrictive environment" approach (p34). Placement on the regime is controlled by senior psychiatrists, though

any extension of an order is subject to review by the Mental Health Review Board (pp 35–7).

103 The figures given (p43) are for 2003, and amount to 2700 people on a CTO out of a population of 5 million and so 1 person in every 1850, so more than in New Zealand; in New South Wales, the figure for 2003 was roughly 1 person in every 2640 (see pp71–3) For further details of figures as to CTO use in different jurisdictions, see A Question of Numbers, Simon Lawton-Smith, Kings Fund, September 2005, particularly at pp21ff. He comments that Australasian use of CTOs is high compared to North America and Israel; he also records that CTO use rose further in Victoria, to a figure of more than 3000 in 2005, and so more than 60 per 100,000 of the population.

104 Page 32.

105 For New South Wales, where the CTO was introduced in 1991 via the Mental Health Act 1990, the use of CTOs is recorded as rising in parallel with the process of deinstitutionalisation (p62ff). However, the number of in-patient beds declined steeply during the 1980s (p63).

106 Pages 11ff.

comprehensive review of studies into the efficacy of CTOs – “*International Experiences of Using Community Treatment Orders*”<sup>107</sup>, prepared by a team based at the Institute of Psychiatry at the Maudsley Hospital in South London<sup>108</sup> – suggests that CTOs originally had a different aim, namely assisting the transition from the use of asylums to the provision of community care, which left a group (including “revolving door” patients) less able to cope and so in need of ongoing intervention. In this context, CTOs were viewed as providing a less restrictive alternative than in-patient treatment and so ethically desirable<sup>109</sup>. But the other conceptualisation which is said to have become more prominent is that CTOs provide health benefits to the patient, usually with a view to preventing a relapse.

In assessing the efficacy of this aim, the Institute of Psychiatry report paints a picture which is less positive than Dawson’s conclusions as to the benefits enjoyed. The researchers – “supported by a Department of Health Grant”<sup>110</sup> – reviewed the 72 research studies which had been carried out into civil CTO regimes in use in various parts of the world<sup>111</sup>. The report notes that there are different forms of CTO, but with three recurring themes, namely (1) whether the criteria are the same as for a hospital treatment order, (2) whether the aim is to treat or to prevent a deterioration, and (3) whether the aim is to provide patient choice for a less restrictive regime than in-patient treatment or to be a tool for involuntary management of patients (such as revolving door patients)<sup>112</sup>. The different aims might well overlap, but the report suggested that it was important to be clear about the reason for the regime because that had implications for how it was to be designed and used in practice, with those based on the least restrictive option having conceptual problems and being difficult to use in practice, whereas those based on preventive aims raise the potential for human rights challenges<sup>113</sup>. However, the different aims did not affect the likely recipients of a CTO, typically people with a long history of schizophrenia-like or serious affective illness<sup>114</sup>. The proposals in what was then the Mental Health Bill 2006 were considered as aiming to prevent deterioration whilst allowing treatment in the least restrictive environment<sup>115</sup>.

As for efficacy, the summary of the report<sup>116</sup> noted:

*“It is not possible to state whether ... CTOs are beneficial or harmful to patients. .... Overall, although some stakeholder views are positive, there is currently no robust evidence about either the positive or*

107 8 March 2007;  
[www.iop.kcl.ac.uk/news/downloads/Final2CTOReport8March07.pdf](http://www.iop.kcl.ac.uk/news/downloads/Final2CTOReport8March07.pdf)

108 Headed by Dr Rachel Churchill.

109 See pp17ff.

110 The report was published after the Lords had finished their debates. As the study was commissioned to assist in the formulation of policy, it is an indicator of poor timing to say the least that it was not made available in time for these debates. The report notes (p17), that the Bill of 2006 was published after the “first submission of this report to the Department of Health”. At the Committee Stage in the House of Commons, (see 10 May 2007, Hansard Public Bill Committee Session 2006–7 Cols 305-358, at col 339) Tim Loughton MP noted “... The report was delivered to the Government last August. The Government were not happy with its conclusions so they told the Institute to go away and think again. The authors did and, not surprisingly, there was little change to the proposals. The Government then decided to sit on the

report.” He then said that the report had only been published “under duress” but on the day after the Lords finished their consideration of the Bill and said that this was “a shameful suppression of key evidence that was absolutely integral to this important piece of legislation.”

111 Defined as regimes for enforceable community treatment with no necessary tie to hospital: Appendix 2, p219; see -- 20.

112 Ch 2, pp28 ff.

113 Ch 6.1, pp176ff.

114 Ch 4.3, pp105ff.

115 Page 27; it was also noted that the provisions for compulsory community treatment were already extensive, with the extended use of s17 leave plus the aftercare under supervision regime: the latter was noted (at p23–4) as being intended for post-hospital management with a view to preventing the risk of harm to self or others – which was one of the themes behind the government’s position in favour of the CTO regime.

116 Page 7. See further details at pp177ff.

*negative effects of CTOs on key outcomes, including hospital readmission, length of hospital stay, improved medication compliance, or patients' quality of life."*

Speaking in favour of restricting the criteria for CTOs at the Report stage in the House of Commons<sup>117</sup>, Tim Loughton MP<sup>118</sup> made the major speech for those opposed to the government's position. He noted "There is no empirical evidence for the efficacy of CTOs where they exist overseas... The Government have been proceeding with a new measure, pioneering new ground affecting new classes of patients, without being able to provide evidence that this arrangement works anywhere in the world where there is an equivalent system"<sup>119</sup>. Turning to the potential for damaging effects, he expressed concern that resource provision for voluntary patients would be lost because of the concentration on CTOs; and he both quoted an expert view as to the risks of increased avoidance of treatment and the continuation of the unequal treatment of people from ethnic minorities, and also noted that there was no proper information as to why the existing powers under ss17 and 25Aff were not working, which should be provided before a new regime was put in place. Despite this, the opposition supported the introduction of the CTO, merely suggesting that the concerns outlined justified a regime with restricted criteria. The proposals from the government were said to be too open-ended and so would cover too many people<sup>120</sup>, particularly in light of tendencies to make use of powers if only to avoid criticism in the event of any problems. The suggestions put forward as to the restrictions to be imposed on the regime<sup>121</sup> were not accepted by the Commons.

In light of the fact that the regime as introduced in the Mental Health Act 2007 is in terms of the legal powers different in form rather than substance, and in the context of the switch to community care which has proceeded whether or not something labelled a CTO was on the statute books, the question arises as to whether the CTO debate was worth the fuss.

#### D. Resources

On one level, the debate during the Westminster proceedings about the structure of community treatment for England and Wales was a complete red herring, given that no new powers were created, rather that existing powers were shifted around. The power that remains absent is one to compel medication in the community: it was never on the table, and international experience suggests that this is no bad thing. Dawson, having set out the consensus position that treatment outside a clinical setting was not appropriate<sup>122</sup>:

117 18 June 2007, Hansard Vol 461 Cols 1088–1210.

118 Con, East Worthing and Shoreham; he was picking up on points he had made at the Committee stage, 10 May 2007; Hansard Public Bill Committee Session 2006–7 Cols 305–358, in particular at cols 343ff.

119 For which he cited the Institute of Psychiatry study.

120 He raised the concern (at col 1187) that the government assumption as to the use of the CTO was a significant underestimate in light of the fact that 23% of treatment orders in Scotland were in the form of CTOs. He also suggested that there was a specific need for a time limit of three years because if a CTO had not achieved its objective within a certain period of time, it was clearly necessary to review its use for the particular patient. On the question of figures, see "A Question of Numbers", Simon Lawton Smith, Kings Fund, September 2005

(available at [www.kingsfund.org.uk](http://www.kingsfund.org.uk)). It noted that the rate of use of CTOs internationally ranged from 2 to 50 per 100,000 of population. Note also that the Regulatory Impact Assessment (November 2006, Department of Health) suggests that the average length of the CTO will be 9 months (see para 35 of Annex A); this is longer than the average in-patient stay of 3 1/2 months – so in its April 2007 Briefing on Supervised Community Treatment, the Kings Fund indicated that it was likely that there would be an increase in the use of compulsion because, inter alia, the length of time on a CTO was going to be longer than the length of in-patient treatment.

121 Such as a requirement that the patient have a history of a previous failure to accept treatment in the community after a formal admission, which resulted in a relapse and then successful treatment under compulsion.

122 Dawson report, p150 – see also n97 above.



*“... this consensus is correct. If we are to take patients’ human rights seriously, the administration of medication by force ... outside a properly supervised clinic or hospital should never be authorised ... [T]he experience of the Australasian jurisdictions demonstrates ... that conferring that kind of power on health professionals is not necessary to encourage the use of CTO regimes...”*

So, one important element of the Parliamentary debate was the undebated conclusion that there should be no element of force outside a hospital setting. Since the availability of force is not the central reason for the uptake of the CTO regime from the perspective of the clinical teams that put the orders in place, what is important? The key seems to be the provision of resources. The Institute of Psychiatry review of studies carried out indicates that

*“Lack of resources was almost universally acknowledged by mental health professionals as a reason for failing to use a CTO, or its failure to work.”<sup>123</sup>*

This was also a concern picked up by Dawson: for example, he records the experience of Victoria in the 1990s where there had been the growth in CTO use but without adequate resources, leading to criticisms from coroners in Melbourne investigating suicides by patients on CTOs. More resources were then found<sup>124</sup>. He added:

*“No one spoken to believed the introduction of CTOs was a successful way to save public money, because, to work effectively, the regime must be backed by well-resourced systems of community mental health care.”*

Given the target group, and the sensible aim of preventing the cycle of relapse into serious illness – preventive medicine having a role to play in mental health practice as much as in general practice – it is obvious that resources are the key. The new powers in the 2007 Act cannot alter the fact that there are patients who present difficulties because of features such as lack of insight or the presence of other problems, often drug and alcohol misuse, which make compliance with treatment a low priority for them. The new CTO regime requires their agreement to the conditions and their co-operation in practice: but if patients are to be nominated for the use of CTOs on account of shared features such as lack of engagement or lack of insight into the need to co-operate, a regime which depends on patient co-operation is unlikely to succeed. Rather, there has to be monitoring and persuasion, and that can only happen if there are people to carry out the monitoring and persuading. Dawson makes this point<sup>125</sup>: the use of CTOs seems most likely to produce positive outcomes when there is a regime which is well-embedded and supported by clinicians, with reasonably intensive resources provided by clinicians who visit patients, but also additional services such as accommodation and alcohol and drug services, plus co-ordination with in-patient services, and continuity of staff who are experienced and assertive. Every point he makes rests on matters of resources or the organisation of services, not on whether the regime is called a CTO.

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123 Churchill Report, p191.

124 Dawson p32.

125 Page 5.

### **E. CTO Fault-Lines**

In addition to the major fault-lines mentioned above, namely the questions of the role of capacity and the limitations on what was permitted by way of compulsory treatment in the community, Dawson identified other common problems, namely over-use of depot medication, de facto detention in sub-standard accommodation, overuse in relation to patients with affective disorders who may regain capacity after initial treatment, overuse for younger males with drug and substance abuse problems, overuse in response to pressure of beds, and inadequate reviews, particularly in relation to patients who have been on CTOs for a long time<sup>126</sup>.

Some of these problems are resource related (particularly the question of the use of the CTO regime for patients whose needs are for in-patient care if the beds are available); some are clinical, such as the over-reliance on depot medication and the lack of evidence of the efficacy of the CTO regime in relation to the two groups he mentions. There is also a question of attitude. Since a CTO does not take away liberty, it may be viewed as less invasive and so easier to justify: this is particularly so if the rationale has changed from it being the least restrictive method of providing treatment (ie as an alternative to detention, and so only available when detention would otherwise follow) to a matter of conferring benefits. Unless the central benefit conferred is viewed as allowing the patient to retain his or her liberty, a CTO will tend to be used more often than would an in-patient order, and so social control will be extended.

Building on the pitfalls identified by Dawson, what is therefore important is that those who use CTOs engage critically with the government's policy position, including any necessary reading between the lines. In the first place, the suggestion that there is some radical new power, along with the suggestion it will allow lives to be saved, must be accepted as political rhetoric. In the second place, the key for success remains the adequacy of resource provision not the nomenclature of the powers that exist as the overlay for those powers. And thirdly, the fact that CTOs are designed for patients who are already subject to intervention by way of detention (and that a CTO requires detention and is enforceable only by way of the pressure of recall to detention) must be borne in mind to ensure that the CTO is not used in relation to patients who would not at present be subject to intervention backed up by the same threat, namely of formal detention being imposed. Naturally, it will also be important for the Mental Health Review Tribunal when considering appeals in relation to CTOs to be aware of these matters.

As for the major fault-lines identified by Dawson, the one relating to forced treatment has been avoided by the legislation. The other, relating to capacity, arises from the basic proposition which usually commands approval in modern medical practice, namely the need to respect patient autonomy, even if the choices made are objectively difficult to follow. This is reflected in the Scottish legislation by the language relating to impairment (not lack of) capacity, and was incorporated by the House of Lords in express language which was removed by the Commons. It could be said to be reflected in practice because of the government's emphasis on the need to have patients accept the conditions of the CTO before it can be put into place and to co-operate in practice (since breach of a condition does not cause recall), and so there is still a requirement that the patient make a choice to co-operate. But the choice is not free in light of the compulsory powers which are in the background: whether viewed as a carrot or a stick, the regime induces co-operation without the patient's acceptance of the intrinsic value of the treatment. So the new legislation misses the opportunity to deal with the capacity fault-line.

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<sup>126</sup> Pages 5–6.

But since the absence of any true choice reflects the reality for patients who do not accept their illness or do not fully co-operate and relapse<sup>127</sup>, could it be said that it introduces greater transparency into the process, as Dawson suggested in relation to its use in New Zealand in place of leave<sup>128</sup> and should be welcomed as such? If a CTO is used in place of leave beyond 7 days (and so in relation to a patient whose present condition justifies liability to in-patient treatment), it really makes no difference whether the patient is liable to be detained or liable to be recalled to detention: the effect is the same, and it would be more honest to stay with the current regime and record the patient as being liable to detention. If the CTO is used in relation to patients currently under the aftercare under supervision regime, and so subject to monitoring and assessment as to whether they should be detained in the event of relapse, changing their status as liable to recall to detention is also less honest because of the perception that might be created that their co-operation is now conditioned by a power to swiftly detain them for breach of the conditions of the CTO, whereas the truth is that it will still depend on their mental condition justifying detention.

So it will come down to how the regime is operated in practice. The legal framework is much less important than resources and good practice: which makes it a real shame that the government made use of smoke and mirrors to create the impression of a problem which was not clearly reflected in the research it relied on and a new solution which merely repackaged what was already there.

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*127 And whose capacity in relation to the question of treatment may often be substantially impaired if they do not accept that they are ill.*

*128 Page 19.*

# Deprivations of Liberty: Mental Health Act or Mental Capacity Act?

Richard Jones<sup>1</sup>

The provisions of the *Mental Health Act 2007*<sup>2</sup> (the 2007 Act) which amend the *Mental Capacity Act 2005* (MCA) so as to provide for a procedure that can be used to authorise the deprivation of the liberty of a mentally incapacitated person<sup>3</sup> are intended to sit alongside existing *Mental Health Act 1983* (MHA) powers. But the nature of the relationship between the two Acts is far from clear. This article suggests that the new MCA procedure could be very much the poor relation of the MHA.

## Guardianship

The Code of Practice on the MCA confidently asserts, at para.13.16, that guardianship cannot be used to deprive a person of their liberty. This is a commonly held opinion, but is it correct? The MHA, as amended by the 2007 Act, provides the guardian of a mentally incapacitated person with the following powers:

- a power to take the person to where he or she does not want to go, using force if necessary (MHA ss.18(7)<sup>4</sup> and 137).
- a power to insist that the person remains at that place (MHA s.8(1)(a)).
- a power to return the person to that place if he or she leaves without authority, using force if necessary (MHA ss.18(4), 137).
- a power to take the person to a place where he or she will receive medical treatment under the authority of the MCA (MHA s.8(1)(b), MCA ss.5,6).

Put bluntly, a person under guardianship can be forced to leave his or her home to go to a place where he or she does not want to go to, can be required to stay in that place and can be returned to that place if he or she leaves without being given permission to do so. Given the interpretation that the European Court of Human Rights and the High Court have given to the meaning of a deprivation of liberty<sup>5</sup>, how can it possibly be argued that a person who is subject to the operation of such powers is not being deprived of his or her liberty? Such a person is clearly subject to the continuous control of the guardian and is not

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1 Consultant in Mental Health and Community Care Law, Morgan Cole, Solicitors. Author of *Mental Health Act Manual 10th ed* (2006) (Sweet and Maxwell) and *Mental Capacity Act Manual 2nd ed* (2007) (Sweet and Maxwell).

2 The provisions of the Act which are referred to in this article are not yet in force.

3 See section 50 *Mental Health Act 2007*.

4 As inserted by Sch.3, para.3(5) of the 2007 Act.

5 See the discussion in the author's *Mental Capacity Act Manual, 2nd ed, 2007*, pp. 95–99.

free to leave the specified place of residence<sup>6</sup>. The fact that the provisions of the MHA that relate to guardianship do not specifically state that guardianship can be used to authorise the deprivation of a patient's liberty is not legally relevant to the question of whether the provisions can have that effect.

In *JE v DE (1) Surrey County Council (2) EW (3)* [2006] EWHC 3459 (Fam), Munby J. held that the crucial issue in determining whether a mentally incapacitated person who is being cared for in a care home is being deprived of his or her liberty is not so much whether the person's freedom within the home is curtailed but rather whether or not the person is free to leave. His Lordship said<sup>7</sup> that the person concerned, who had not been received into the guardianship of the local authority, was not free to leave and "was and is, in that sense, completely under the control of the [local authority]", because it is the local authority who decides the essential matters of where he should live, whether he can leave and whether he can be with his wife. Guardianship would have provided the authority with the power to make such decisions. It follows from *DE* that if guardianship is being used to ensure that a person does not leave the place where he or she is required by the guardian to reside, it is being used to deprive that person of his or her liberty.

Does guardianship comply with Art.5 of the *European Convention on Human Rights*, which is designed "to ensure that no one should be arbitrarily dispossessed of his liberty"<sup>8</sup>? Guardianship is clearly a "procedure prescribed by law" for the purposes of Art.5(1) and the House of Lords has held<sup>9</sup> that Art.5(4), which provides that a person who has been deprived of his or her liberty must be entitled to take proceedings to challenge the lawfulness of the detention, is not breached by virtue of the fact that the person concerned lacks the mental capacity to institute such proceedings. It is also the case that the procedure for making a guardianship application under s.7 of the MHA meets the substantive and procedural requirements for the lawful detention of persons of unsound mind which were established by the European Court of Human Rights in *Winterwerp v Netherlands* (1979–80) 2 E.H.R.R. 387.

The Government could be faced with a compatibility issue under the Convention if a person who has been deprived of his or her liberty on the authority of a guardianship application makes an application to a Mental Health Review Tribunal. Subsequent to the decision of the Court of Appeal<sup>10</sup> which declared that ss.72(1) and 73(1) of the MHA were incompatible with Arts.5(1) and 5(4) because they placed the burden upon the patient to prove that the criteria justifying detention no longer exist, Parliament passed the *Mental Health Act 1983 (Remedial) Order 2001*<sup>11</sup> which placed the burden of proof on the detaining authority. As this Order did not reverse the burden of proof in s.72(4), which deals with applications made by guardianship patients, the Government would have to make a further remedial order to ensure that this provision is compatible with Art.5.

If guardianship can be used to deprive a person of his or her liberty, should it be used in preference to the new MCA procedure given that the Code of Practice on the MCA states, at para.13.20, that decision-makers "must never consider guardianship as a way to avoid applying the MCA"? The new MCA procedure is Byzantine in its complexity, but this factor alone would not provide a "cogent reason" for departing from the guidance in the Code<sup>12</sup>. However, the following factors do provide such reasons:

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6 *HL v United Kingdom* (2004) 40 E.H.R.R. 761, para.91.

7 See para.117.

8 *Shiesser v Switzerland* (1979) 2 E.H.R.R. 417,425.

9 *R (on the application of MH) v Secretary of State for Health* [2005] UKHL 60.

10 *R. (on the application of H) v Mental Health Review Tribunal, North and East London Region* [2001] EWCA Civ 415.

11 SI 2001/3712.

12 *R. (on the application of Munjaz) v Mersey Care National Health Service Trust* [2005] UKHL 58.

- There is a strong argument in favour of the contention that the statement in the Code that guardianship cannot be used to deprive a person of his or her liberty does not represent the true legal position.
- Guardianship provides a greater degree of protection than that provided for in the MCA to both professional and lay carers and the person who is subject to the deprivation of liberty in that:
  - (i) unlike the MCA, guardianship provides explicit legal authority to deprive a person of his or her liberty during conveyance from that person's home to the specified place of residence<sup>13</sup>;
  - (ii) unlike the MCA, guardianship provides explicit authority for the person to be returned to the specified place of residence in the event of the person leaving that place without authority<sup>14</sup>;
  - (iii) the responsible social services authority must arrange for a person under guardianship to be visited at intervals of not more than 3 months, and at least one such visit in any year shall be by a "section 12 doctor"<sup>15</sup>. No similar obligation is to be found in the MCA; and
  - (iv) the MHA provides a patient's nearest relative with powers with respect to guardianship that are intended to protect the position of the patient<sup>16</sup>. The nearest relative has no role to play under the MCA.

There would therefore appear to be no legal impediment to prevent guardianship being used to justify the deprivation of a patient's liberty in a care home in preference to the MCA procedure.

## Sectioning

New Schedule 1A to the MCA sets out the circumstances that prevent a person who is being deprived of his or her liberty from being the subject of the MCA procedure<sup>17</sup>. If Schedule 1A applies, the MHA must be used. However there is nothing in either the MCA or the MHA that prevents the MHA being used to justify a deprivation of liberty in a situation where Schedule 1A does not apply<sup>18</sup>. In this situation, either the MCA or the MHA can be invoked if the patient satisfies the appropriate criteria under either Act. The following factors provide strong support for exercising choice in favour of the MHA:

- Parts IV and IVA of the MHA provide patients with significant protections relating to the provision of treatment for the patient's mental disorder. The provision of such treatment to patients subject to the MCA is unregulated.
- The MHA provides a patient's nearest relative with protective powers relating to the patient's detention<sup>19</sup>. The nearest relative has no role to play under the MCA.
- A MHA patient has a right to make an application to a Mental Health Review Tribunal and his or her case will be referred to the tribunal if this right is not exercised<sup>20</sup>. The MCA provides for no automatic judicial oversight of the patient's detention.

13 MHA s.18(7).

14 MHA s.18(3).

15 SI 1983/983, reg.13.

16 See, for e.g. s.11(4) and 23(2) of the MHA.

17 Sch.1A is considered by Robert Robinson in the May 2007 issue of this Journal at pp.35–37.

18 Confirmed by the "Draft Illustrative Code of Practice on the Bournewood safeguards", Department of Health, December 2006, para.86.

19 See footnote 16, above.

20 See Part V of the MHA.



- The MHA contains explicit authority for the applicant to “take and convey” the patient to the hospital named in the application<sup>21</sup> and for the hospital authority to return the patient to the hospital in the event of the patient absconding<sup>22</sup>. The MCA is silent on these points.
- MHA patients who are subject to s.117 of the Act receive after-care services provided under that section free of charge<sup>23</sup>. MCA patients who are discharged from hospital will be subject to a mandatory charging regime if they are placed in a care home<sup>24</sup> and a discretionary charging regime if they receive domiciliary care services<sup>25</sup>.

## Conclusion

MHA powers provide patients who are being subjected to a deprivation of liberty with a degree of protection that exceeds those contained in the MCA. If the approach outlined above is adopted, the MCA procedure need only be invoked for the small number of patients who are either being deprived of their liberty while being treated in hospital for a physical disorder or who require hospital treatment for a mental disorder but fail to satisfy the criteria for detention under the MHA<sup>26</sup>.

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21 MHA s.6(1).

22 MHA s.18(1).

23 *R. v Manchester City Council, ex p. Stennett* [2002] UKHL 34.

24 *National Assistance Act 1948, s.22.*

25 *Health and Social Services and Social Security Adjudications Act 1983, s.17.*

26 *For e.g., a learning disabled patient who requires detention under s.3 but whose disability is not “associated with abnormally aggressive or seriously irresponsible conduct” (see s.2(2) of the 2007 Act).*

# Children and Young People and the Mental Health Act 2007<sup>1</sup>

Camilla Parker<sup>2</sup>

On 19th July this year the *Mental Health Act 2007* ('the MHA 2007') received Royal Assent. When it comes into force the MHA 2007 will introduce wide-ranging amendments to the *Mental Health Act 1983* ('the MHA 1983'). Although there have been significant improvements to the original Bill, the MHA 2007 retains controversial provisions such as the use of a broad definition of mental disorder and the creation of community treatment orders<sup>3</sup>.

The MHA 2007 has been described by the Mental Health Alliance '*as a missed opportunity for legislation fit for the twenty-first century*'<sup>4</sup>. This charge is particularly apt for children and young people<sup>5</sup>. The need for legal reform in relation to the treatment and care of children and young people with mental health problems has long been recognised. For example, in 1999 the Committee commissioned by the Government to advise on the reform of the MHA 1983 noted that there was a general agreement on the need for clarification in this area of law<sup>6</sup>. Although the MHA 2007 will clarify some issues, there remain a '*bewildering variety of overlapping methods to authorise both admission, detention and treatment against a young person's will*'<sup>7</sup>. Furthermore, the *Mental Capacity Act 2005* ('the MCA 2005'), coming into force in October this year, will introduce an additional layer of complexity as most of its provisions apply to 16 and 17 year olds but not those under 16<sup>8</sup>.

This article considers three areas in which the MHA 2007 has introduced some positive change in relation to children and young people: admission to hospital, age appropriate facilities and advocacy. It also highlights issues of continuing concern. It does so in the light of the *United Nations Convention on the*

1 Readers should note that this article was accepted for publication prior to the publication of the revised draft code on 25 October 2007 (available at [www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_079842](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_079842)). This draft code replaces the draft illustrative code to which reference is made in this article.

2 Mental Health and Human Rights Consultant; Consultant to the Children's Commissioner for England.

3 For an analysis of the concerns about Community Treatment Orders and children and young people, see the joint paper by the Office of the Children's Commissioner for England and the Royal College of Psychiatrists April 2007 available at: [www.childrenscommissioner.org/adult/ccnews/consultation.cfm?id=1971](http://www.childrenscommissioner.org/adult/ccnews/consultation.cfm?id=1971). See also the Joint Committee on Human Rights, *Legislative Scrutiny: Seventh Progress Report*,

*Fifteenth Report of Session 2006–7*, HL Paper 112, HC 555, 30th May 2007.

4 For the Mental Health Alliance's report on the Mental Health Act 2007 see: [www.mentalhealthalliance.org.uk/mentalhealthbill/Alliance\\_MHAct07\\_Final\\_Report.pdf](http://www.mentalhealthalliance.org.uk/mentalhealthbill/Alliance_MHAct07_Final_Report.pdf)

5 This paper refers to 'children' as those under 16 and 'young people' as 16 and 17 year olds.

6 Expert Committee, *Review of the Mental Health Act 1983*, November 1999, 112.

7 Jane Fortin, *Children's Rights and the Developing Law*, 2nd edition, (2003) Cambridge University Press, 142.

8 See section 2(5) MCA 2005 in relation to those under 16. Not all provisions apply to 16 and 17 year olds. For example a person must be 18 in order to make an advance refusal of treatment (section 24 MCA 2005).

*Rights of the Child* ('the Convention'), which was ratified by the UK government in 1991 and applies to all those aged under 18<sup>9</sup>.

## United Nations Convention on the Rights of the Child

Although the Convention is not part of UK domestic law, it is important because by ratifying it, States Parties (i.e. governments) agree to '*undertake all appropriate legislative, administrative, and other measures*' to implement the range of civil and political, economic, social and cultural rights set out in the Convention<sup>10</sup>. In the UK, the Convention is considered to have '*an increasing influence on the Government's and other policy makers' and practitioners' commitment to children's perspectives*'<sup>11</sup>. Furthermore, the Convention can be taken into account by the both domestic and European courts. Increasingly the European Court of Human Rights has referred to the Convention's provisions as '*being of persuasive authority*' when reaching decisions<sup>12</sup>. However the application of the Convention to children and young people with mental health problems is a neglected area. Although there is some discussion on this area in the UK Government's latest report to the Committee on the Convention on the Rights of the Child, which monitors compliance with the treaty, it is very limited<sup>13</sup>.

The Convention recognises that children are in need of protection but also emphasises that they are individuals with their own views and interests and should be able to exercise their rights. (The convention uses the term 'child' to include children and young people up to the age of 18). Thus two core principles of the Convention are that the best interests of the child is the primary consideration in all actions concerning children (Article 3), and that in all matters affecting them, children's views must be '*given due weight in accordance with the age and maturity of the child*' (Article 12). A key concept of the Convention is the '*evolving capacities*' of the child. This concept highlights the importance of ensuring that as children grow and mature, their views and wishes should be given greater weight. Article 5 (Parental guidance and the child's evolving capacities) provides:

*'States parties shall respect the responsibilities, rights and duties of parents... to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.'*

Thus parental direction and guidance has its limits – parents do not have absolute rights over their children. Article 5 seeks to provide a balance between respecting the responsibilities of parents to make decisions on behalf, and in the best interests, of their child and ensuring that the child is able to exercise his or her rights. The concept of the '*evolving capacities of the child*', which takes into account the child's age and maturity, is central to achieving the right balance<sup>14</sup>.

## Admission to hospital

Patients under the age of 18 can be detained under the MHA 1983. However, as the Joint Scrutiny Committee on the Draft Mental Health Bill 2004 noted, it is more common for them '*to be treated under common law or under the authority of those with parental authority who can override the young person's refusal*'.

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9 See Article 1.

10 Article 4.

11 Clem Henricson and Andrew Bainham, *The child and family policy divide: Tensions, convergence and rights*, Joseph Rowntree, 2005:  
[www.jrf.org.uk/bookshop/eBooks/1859353312.pdf](http://www.jrf.org.uk/bookshop/eBooks/1859353312.pdf)

12 Fortin (*op. cit* footnote 7), 49.

13 Available at:  
[www.everychildmatters.gov.uk/strategy/uncrc/ukreport/](http://www.everychildmatters.gov.uk/strategy/uncrc/ukreport/)

14 See *Implementation Handbook for the Convention on the Rights of the Child*, UNICEF (2002) 85–92.

When this happens the safeguards set out in the MHA 1983 do not apply to them<sup>15</sup>.

### Informal admission: context

An area that has caused confusion and uncertainty amongst mental health professionals is the circumstances in which it is appropriate to rely on parental consent to admit a person under the age of 18 to hospital for treatment for mental disorder. *Re W* provides authority for holding that those with parental responsibility may agree to informal admission, overriding the refusal of their child. In *Re W*, Lord Donaldson stated:

*'...no minor of whatever age has the power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court'*.

However, he added:

*'...Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the court in deciding whether themselves to give consent. Its importance increases with age and maturity of the minor.'*<sup>16</sup>

Thus, although the minor's refusal would need to be taken into account, case law appears 'to signpost to professionals that overriding a competent child or young person's opposition to major psychiatric treatment decisions could now take place outside the framework of statutory protection, providing parental consent was obtained'<sup>17</sup>. Another area of concern is the relationship between the parents and their child. Asking a parent to override the wishes of the child by agreeing to the admission might create, or exacerbate existing, tensions in their relationship.

The introduction of the *Human Rights Act 1998* provides a strong argument for adhering to the statutory framework for compulsory powers set out in the MHA 1983 rather than relying on parental consent. Richard Jones suggests:

*'It is likely that the Court [European Court of Human Rights] would hold that a parental consent to the admission of a mentally competent child to a psychiatric hospital violates Art.5 if the child objects to the admission.'*<sup>18</sup>

Overruling the views of children and young people who are able to make such decisions for themselves also engages rights under the Convention. For example it would be at odds with Article 12 of the Convention, which requires the views of the child to be given due weight in accordance with the child's age and maturity.

### Amendments to the MHA 1983

Although section 131(2) MHA 1983 provides that patients aged 16 and 17 who are capable of expressing their own wishes can agree to their informal admission, irrespective of their parents' wishes, it does not address a young person's refusal of admission. Recognising that such situations can raise 'complex ethical problems' and be 'stressful for all concerned'<sup>19</sup>, the Government's Draft Mental Health Bill 2004 removed the power of those with parental responsibility to override the refusal of treatment by patients aged 16 or

15 HL Paper 79-1, HC Paper 95-1, March 2005, 74.

16 *Re W (A Minor) (Medical Treatment)* 1992 4 All ER 627.

17 Anthony Harbour, 'Young People and Psychiatric Treatment' – paper presented to Children and Mental Health and Human Rights Seminar, Law School,

Northumbria University, 22 June 2007.

18 Richard Jones, *Mental Health Act Manual*, Thomson, Sweet & Maxwell, 10th edition, 486.

19 *Reforming the Mental Health Act, Part 1: The new legal framework*, (December 2000) CM 5016–1 paragraphs 3.70–3.72.

17<sup>20</sup>. However this provision was not included in the Mental Health Bill 2006 published in Parliament and it was only in response to concerns raised during the House of Lords debates on the Bill, that the Government introduced what is now section 43 MHA 2007. This will clarify the position for patients aged 16 or 17 by amending section 131(2) of the MHA 1983. The new sections 131(2)(3)(4) will provide that patients aged 16 or 17 who have the capacity to make such decisions can either consent or refuse to arrangements for their informal admission to hospital being made<sup>21</sup>. The young person's capacity will be determined in accordance with the Mental Capacity Act 2005<sup>22</sup>. Specific provision is made in relation to the young person's refusal:

*'If the patient does not consent to the making of the arrangements, they may not be made, carried out or determined on the basis of the consent of a person who has parental responsibility for him'. (Section 131(4))*

### **Situation for 'Gillick competent' children**

While the MHA 2007 clarifies the situation for 16 and 17 year olds who are capable of making decisions about their admission to hospital, 'Gillick competent'<sup>23</sup> children are not mentioned. A 'Gillick competent' child has been assessed as having attained a sufficient level of maturity, understanding and intelligence to make such decisions for him/herself. It is therefore unclear why that child should be treated differently from a young person who has capacity to make such decisions. Accordingly, during the Bill's passage through Parliament, arguments were put forward for an amendment to be introduced to make clear that where a child is assessed to have the competence to make decisions about admission to hospital, that child's refusal should not be overridden by a person with parental responsibility. In such cases, as with 16 and 17 year olds, consideration would need to be given to detaining the young person under the MHA 1983.

However the Government declined to introduce such a statutory provision, insisting that the best place to address this issue would be in the Code of Practice. The draft illustrative Code of Practice to the Mental Health Act ('the draft Code'), published in November 2006, advises clinicians that they should not rely on parental consent in the case of children who are 'Gillick competent' and refusing treatment, stating that if the child needs to be detained in order to give treatment for mental disorder then the MHA 1983 should be used.

### **Admission and children and young people lacking capacity/competence**

The MHA 2007 does not address the position of children and young people who lack capacity (16 and 17 year olds) or competence (those under 16). This is left to guidance in the draft Code. However, for the reasons outlined below, the guidance in the current draft Code requires further explanation.

The draft Code includes flow charts intended to assist practitioners in considering all the options available. These suggest that the first consideration for both under 16 year olds who lack competence and those 16 or 17 years who lack capacity is whether the primary purpose of the intervention is to provide medical treatment for mental disorder. (If the answer to this is 'no', powers under the *Children Act 1989* or other procedures may be more appropriate.)

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20 Clause 202 Draft Mental Health Bill 2004.

21 These provisions will come into effect on 1 January 2008 (Mental Health Act 2007 (Commencement No. 3) Order 2007).

22 See section 131(5)(a) MHA 1983 inserted by section 43 MHA 2007.

23 'Gillick competence' refers to a child who has a sufficient understanding and intelligence to be able to understand fully what is being proposed and to be capable of making up his/her mind about the matter. The term comes from *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

The draft Code states that in the case of a 16 or 17 year old who lacks capacity, the MHA 1983 must be used (subject to the conditions being met) where detention in hospital is required and the primary purpose of the intervention is to provide treatment for mental disorder. There is no discussion of, or reference to further information on, what might amount to detention.

For children under 16, if the primary purpose of the intervention is to provide medical treatment for mental disorder, the next question is whether the decision to authorise treatment falls within the 'zone of parental responsibility'. If the proposed intervention does not fall within the zone of parental responsibility (or parental consent is not given), then the MHA 1983 must be used (if the conditions are met). If the proposed intervention falls within the zone of parental responsibility, and the parent consents, the child can be admitted informally.

It is therefore important to know what falls within the zone of parental responsibility and what does not. However, no precise definition is given for this term. The draft Code suggests that it is the 'sort of decision that a parent would be expected to make' having regard to what is considered to be normal practice, adding that the parameters of this zone will depend on a number of factors, including the nature and invasiveness of the proposed intervention, the age and maturity of the child, whether the child is resisting and the extent to which the child's liberty will be curtailed.

### **The zone of parental responsibility and detention**

The connection between the zone of parental responsibility and what might amount to the child's deprivation of liberty is unclear.

To date the leading European Court of Human Rights ('the ECtHR') decision on the detention of a minor is that of *Nielsen v Denmark*<sup>24</sup>, which was decided nearly twenty years ago. In that case the ECtHR held that the hospitalisation of a 12 year old boy for over 5 months did not amount to a deprivation of liberty, but was the responsible exercise of the mother's custodial rights in the interests of her son. Nielsen has been subject to severe criticism for failing to give adequate protection to children's rights<sup>25</sup>. Arguably, in the light of the Convention and more recent ECtHR cases, if the case were heard today it would be decided differently.

Since the decision in Nielsen the case law concerning the detention of adults has developed considerably. In *Storck v Germany*,<sup>26</sup> the ECtHR held that in determining whether a person is detained, it is necessary to consider both the objective element and subjective element. The objective element is the specific situation of the individual, such as the type and duration of the measure. The subjective element is whether the person has 'validly consented to the confinement in question'.

How the objective and subjective elements of detention relate to children and young people has not as yet been considered either by the ECtHR or by the national courts. In his detailed analysis of ECtHR case law concerning deprivation of liberty, Mr Justice Munby concluded in the recent case of *JE v (1) DE (2) Surrey CC and (3) EW*<sup>27</sup> that Nielsen was 'about the proper ambit of parental authority, albeit that it concerned a child placed in a psychiatric institution', and did not assist in assessing whether an adult is detained. So far as the elements relevant to the question of whether there has been a deprivation of liberty, he commented:

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24 (1988) 11 EHRR 175.

26 Application number 61603/00, 16th June 2005.

25 See for example, David Feldman, *Civil Liberties and Human Rights in England and Wales*, Oxford University Press, 2nd edition, 459 and Jane Fortin (footnote 7) at 55.

27 [2006] EWHC 3459 (Fam) para 70.



*'...different considerations may apply in the case of a child where a parent or other person with parental authority has, in the proper exercise of that authority, authorised the child's placement and thereby given a substituted consent...'*<sup>28</sup>

In *Nielsen* the ECtHR acknowledged that the rights of the holder of parental authority cannot be unlimited and that it is incumbent on the State to provide safeguards from abuse. This suggests that whether a child is detained or not will need to be considered in the light of what restrictions would fall within the reasonable exercise of parental responsibility. There is a range of rights under the UN Convention on the Rights of the Child that are relevant to this question. The best interests of the child will be central to this debate. Article 3 of the Convention requires that in all actions concerning children, the best interests of the child is the paramount consideration. However the interpretation of the best interests of the child must be consistent with the Convention as a whole. For example, Article 16 provides that no child shall be subjected to 'arbitrary or unlawful interference with his or her privacy' and the child has the right to protection of the law against such interference. Furthermore, as discussed above, the Convention incorporates the concept of the 'evolving capacity' – Article 5 of the Convention requires the extent of parental guidance and direction to be 'conducted in a manner consistent with the evolving capacities of the child'. Thus what might be considered within the reasonable exercise of parental responsibility for a young child might not be acceptable in relation to a 15 year old teenager even when that teenager lacks the competence to make decisions about his or her treatment and care.

The scope of the zone of parental responsibility is an issue of crucial importance because those children who lack competence to make decisions for themselves, and are admitted on the basis of parental consent, will have fewer safeguards than those who are admitted under the MHA 1983. The right to a review of their detention by a MHRT will not be available to them, nor will they have a right to an independent advocate save in limited circumstances (such as if ECT is proposed)<sup>29</sup>. In the light of the changes introduced by the MHA 2007 to safeguard the rights of adults who lack capacity and are deprived of their liberty,<sup>30</sup> the lack of safeguards for children and young people in similar situations requires attention.

### Age appropriate facilities

Section 31(3) MHA 2007 provides for the accommodation of patients under the age of 18 (whether detained under the MHA 1983 or an informal patient). This provision was introduced by the Government in response to powerful lobbying by children's charities and the Mental Health Alliance, led by YoungMinds, together with strong support from peers and MPs. Section 131A MHA 1983 will require the hospital managers to 'ensure that the patient's environment in the hospital is suitable having regard to his age (subject to his needs)'. In introducing this amendment the then Minister for Health, Rosie Winterton explained:

*'We have used the word "environment" because what matters to a child or young person goes well beyond mere physical segregation from older people, as I am sure right hon. and hon. Members appreciate. By using the word "environment" we can ensure not only that children and young people have separate facilities, but that they are appropriate physical facilities, with staff who have the right training to understand and address their specific needs as children, and a hospital routine that will allow their*

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28 *ibid*, 77.

29 See section 130C(3) MHA 1983 inserted by section 30(2) Mental Health Act 2007.

30 See Chapter 2 MHA 2007, amending Mental Capacity Act 2005.

personal, social and educational development to continue as normally as possible. We do that by using the word “environment”, and by giving hospital managers a duty to ensure that that is the case.’<sup>31</sup>

In order to decide how to fulfil this duty, the hospital managers must consult a person ‘who appears to them to have knowledge or experience of cases involving patients who have not attained the age of 18 which makes him suitable to be consulted’; i.e. a person known to have experience in child and adolescent mental health services<sup>32</sup>. Primary Care Trusts (PCTs) in England (Local Health Boards in Wales) will be required to advise local social service authorities in their area of hospitals providing ‘accommodation or facilities designed so to be specially suitable’ for patients under 18<sup>33</sup>.

When describing the background to the amendment, the Minister referred to the findings of ‘Pushed into the Shadows: young people’s experience of adult mental health facilities’,<sup>34</sup> commenting that this report was ‘extremely timely in highlighting the bad experiences that some young people have had on adult psychiatric wards’. This report showed that not only are children and young people being admitted onto adult wards (despite national policy objectives seeking to prevent this) but that the level of the care provided to them often fell below an acceptable standard. Moreover, in some cases the children and young people’s experiences gave rise to serious concerns about their safety and welfare. Their descriptions also highlighted a persistent failure to recognise the rights of these young patients under the *UN Convention on the Rights of the Child*. For example:

- Failure of staff to involve and inform the children and young people about their care (Article 12 – Respect for the views of the child)
- Many of the children and young people did not feel safe on the wards and some were able to engage in harmful practices while on the wards such as misusing drugs or self-harming (Article 19 – Protection from all forms of violence).

Crucially, *Pushed into the Shadows* showed that children and young people are being admitted inappropriately onto adult psychiatric wards in contravention of Article 37(c) (Protection for children deprived of their liberty). This article requires States to separate children deprived of their liberty from adults ‘unless it is considered in the child’s best interests not to do so’<sup>35</sup>.

## Advocacy

Section 30 MHA 2007 requires that independent mental health advocates are made available to certain ‘qualifying patients’<sup>36</sup>. This term includes patients who are liable to be detained under the MHA 1983 (other than the short term powers such as emergency admission under section 4 and holding powers under section 5 MHA 1983), those subject to guardianship or community treatment orders and those for whom treatment under section 57 (such as psychosurgery) is proposed. Furthermore, patients under the

31 *House of Commons Debate on the Mental Health Bill* 18th June 2007, Col 1144.

32 See paragraph 104 of the Explanatory Notes to the Mental Health Act 2007.

33 Section 31(4) MHA 2007, amending section 140 MHA 1983. See also section 31(2) which amends section 39 MHA 1983 (Information as to hospitals) so that a court may request information from a PCT or local health board in Wales about the availability of accommodation or facilities for patients under 18 when considering its powers to order detention in hospital under Part III of the MHA

1983.

34 *Office of the Children’s Commissioner for England*, January 2007 [www.childrenscommissioner.org/documents/Pushed%20into%20the%20shadows%20report%20final.pdf](http://www.childrenscommissioner.org/documents/Pushed%20into%20the%20shadows%20report%20final.pdf)

35 See *Children’s Commissioner for England submission to the Mental Health Public Bill Committee*: [www.childrenscommissioner.org/documents/MHBillSubmission.pdf](http://www.childrenscommissioner.org/documents/MHBillSubmission.pdf).

36 It inserts sections 130A–130D before section 131 MHA 1983.

age of 18 for whom electro-convulsive therapy (ECT) is being proposed will qualify for such advocacy services whether or not they are detained.

The assistance given to qualifying patients includes 'help in obtaining information about and understanding' the relevant provisions of the MHA 1983, the person's rights under these provisions and help in exercising these rights (by representation or otherwise). In relation to medical treatment, such help will cover information about any treatment being given or proposed, why it is being given or proposed, the authority for giving such treatment and the requirements that would apply if the treatment is to be given<sup>37</sup>.

The introduction of the right to advocacy will be of huge importance to those under 18. Many of the young people involved in the *Pushed into the Shadows* report commented on the inadequate information about their treatment and care. Some described feeling remote from the decisions made about them and highlighted the need for a greater provision of independent advocates who could speak up on their behalf<sup>38</sup>.

However, save in cases where ECT or treatment under section 57 is proposed, advocacy will only be available for those who are subject to the compulsory powers under the MHA 1983. This means that there is no requirement to make advocacy available when admission to hospital is being considered. This is a particular concern for individuals under 18. Admission to a psychiatric hospital can be traumatic for any individual, but especially so for children and young people. The assistance of an independent advocate to explain issues such as the person's rights, the procedures involved and what to expect on admission would be invaluable in helping the child or young person (and where involved, the parents) decide whether to agree to the admission.

As discussed above, children who are not 'Gillick competent' and are admitted to hospital on the basis of parental consent will not have the right to advocacy. Although it is not clear from the draft Code, it would seem that in some cases (where this does not amount to a deprivation of liberty) young people who lack capacity could be admitted to hospital informally (and treated in accordance with the provisions of the *Mental Capacity Act 2005*). The provisions relating to independent advocacy services will not apply to these young people either.

## Conclusion

While the MHA 2007 is a marked improvement on the Bill originally introduced by the Government, there are still huge concerns about the potential impact of its provisions on people with mental health problems, including children and young people. The additional safeguards such as advocacy and the requirement to provide age appropriate facilities for children and young people are very welcome, although more guidance will be required to ensure that these safeguards are implemented effectively. The group least well served by the MHA 2007 are those children under 16, in particular those considered to lack competence to make decisions for themselves.

Governments are required to take measures to ensure that adults and children alike know about the principles and provisions of the Convention (Article 42). Raising awareness about the Convention rights amongst mental health professionals and all those working with children and young people with mental health problems, as well as parents and the children and young people themselves, will be an important means of safeguarding the dignity and welfare of all children and young people whether subject to the compulsory powers of the MHA 1983 or not.

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37 See section 130B MHA 1983 inserted by Section 30(2) Mental Health Act 2007.

38 *Pushed into the Shadows*, 43.

# Mental health, community care and human rights in Europe: Still an incomplete picture?<sup>1</sup>

Jill Stavert<sup>2</sup>

*'One of the key messages to governments is that mental asylums, where they still exist, must be closed down and replaced with well-organized community-based care and psychiatric beds in general hospitals. The days of locking up people with mental or behavioural disorders in grim prison-like psychiatric institutions must end.'*

World Health Organisation,  
*World Health Report 2001: Mental Health – New Understanding, New Hope*, p4.

## 1. Introduction

### a. The recognition of human rights of those suffering from mental illness

According to the European Union Green Paper *Improving the mental health of the population: Towards a strategy on mental health for the European Union*, more than 27% adult Europeans are likely to suffer from at least one form of mental illness during any one year and by 2020 depression is expected to be the highest ranking cause of disease in the developed world<sup>3</sup>. A recent article which reported the results of a global study in *The Lancet* also comments that “depression impairs health state to a substantially greater degree than other diseases”<sup>4</sup>.

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1 The author would like to thank Douglas Maule (Centre for Law, Napier University) for his very helpful comments on an earlier draft of this article. Any errors or omissions are, however, those of the author.

2 Lecturer, Centre for Law, Napier University, Edinburgh.

3 European Union, *Improving the mental health of the population: Towards a strategy on mental health for the European Union*, Brussels COM (2005) 484, p4, referring to H.U. Wittchen and F. Jacobi (2005), ‘Size and burden of mental disorders in Europe: A critical review

and appraisal of 27 studies’, 15(4) *European Neuropsychopharmacology* 357; World Health Organisation (WHO), *World Health Report 2001: Mental Health – New Understanding, New Hope*, [www.who.int/whr/2001](http://www.who.int/whr/2001) (accessed 8 September 2007).

4 S. Moussavi et al (2007), ‘Depression, chronic diseases, and decrements in health: results from the World Health Surveys’, 370 *The Lancet* 85, [www.thelancet.com](http://www.thelancet.com) (accessed 8 September 2007).

Mental health issues are increasingly finding their way onto national, European and international agendas. Moreover, the term ‘mental health’, though sometimes difficult to define with precision, has been taken to include not only mental ill health but also the maintenance of good mental health in general<sup>5</sup>.

There has also been a growing recognition that persons who suffer from mental ill-health must be protected from discrimination and abuse. The World Health Organization and the European Union have both, for example, emphasised the importance of protecting the rights of those suffering from mental ill-health and of ensuring and maintaining social inclusion for this vulnerable group of persons. In a welcome development, the United Nations finally adopted its *Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities*<sup>6</sup> in December 2006 although it is not yet in force. Amongst other things, this treaty specifically refers to those suffering from mental or intellectual impairment<sup>7</sup>.

It has also gradually become accepted that those suffering from mental illness possess rights which must be respected. Since 1979, the European Court of Human Rights, in particular, has developed a body of case law affirming that certain European Convention on Human Rights (ECHR) rights are relevant to mental health. The emphasis has thus been on civil rights that mainly relate to the detention and treatment of the mentally ill, such as the rights to personal liberty; respect for private and family life; procedural justice; and cruel and the prevention of inhuman treatment<sup>8</sup>. Latterly, this recognition at European level has found expression at national level in that domestic legislation and case law are starting to reflect the relevant provisions of the ECHR. Clearly, in the UK, the *Human Rights Act 1998* has been influential in this respect<sup>9</sup> and relevant ECHR provisions are reflected, to some extent, in the provisions of the *Mental Health (Care and Treatment) (Scotland) Act 2003* and the *Mental Health Act 2007*, and they have created some judicial dilemmas, particularly in the realm of public safety and involuntary treatment<sup>10</sup>.

## b. De-institutionalisation and the increasing importance of socio-economic rights

Given the historical emphasis on civil and political rights in Western Europe, and the fact that traditionally the care and treatment of those with mental illness took place mainly in an institutional setting<sup>11</sup>, it is unsurprising that civil rights associated with the detention and conditions of treatment of the mentally ill were the first to be recognised by the European Court of Human Rights and also within

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5 The WHO, for example, defines mental health as: “a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, *Strengthening Mental Health Promotion*, Geneva 2001 (Fact Sheet no.220)).

6 Doc. A/61/611, 6 December 2006.

7 Article 1. See also *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (1991).

8 For example, on Article 5 ECHR see *Winterwerp v Netherlands* (1979) 2 EHRR 387 (definition of ‘unsound mind’ and detention), *Aerts v Belgium* (1998) 29 EHRR 50 (no detention of mental patients in prison), *Johnson v UK* (1999) 27 EHRR 440 and *Kolanis v UK* (2006) 42 EHRR 12 (timely release from psychiatric institution) and *E v Norway* (1994) 17 EHRR 30 (review of detention). See also *Bensaid v UK* (2001) 333 EHRR 10 (mental

health is a vital aspect of family life), *Keenan v United Kingdom* (2001) 33 EHRR 38 (segregation and extension of prison term), *Peers v Greece* (2001) 33 EHRR 51 (prison conditions), *H L v United Kingdom* (2004) 40 EHRR 761 and *Storck v Germany* [2005] ECHR 406 (involving the interplay of Articles 5, 8 and 3 ECHR).

9 See also J. Stavert (2007), ‘From avoidance to acceptance: Mental health and the role of human rights in Europe’, 356 *Scolag Legal Journal* 119.

10 For example, *A v Scottish Ministers* 2001 SC 1 (concerning the issue of public safety and individual rights and Articles 2 and 5 ECHR); *R (on the application of Wilkinson) v RMO, Broadmoor Hospital Authority* [2001] EWCA Civ. 1545 (involuntary treatment and Article 3) and *R (on the application of N) v M* [2003] 1 WLR 562 (involuntary treatment and Article 3 ECHR).

11 C. Unsworth (1993), ‘Law and Lunacy in Psychiatry’s “Golden Age”’, 13 *Oxford Journal of Legal Studies*, 479.

the UK. That being said, whilst the development of human rights associated with mental health has naturally been very welcome, it nevertheless has not yet appeared to go far enough. An example of this can be seen in the progressive move away from institutionalisation to care in the community. Currently, predominant 'Western' clinical opinion holds that, excepting where it is otherwise necessary to protect the individual or public, persons suffering from mental ill health and disability should be treated and supported in the community<sup>12</sup>.

This shift away from a mainly institutional approach to an emphasis on 'care in the community', together with the recognition that people suffering from mental health problems form a vulnerable group worthy of protection under the law, has occurred over the last century. In the UK, this gradual approach can be discerned from the *Mental Treatment Act 1930* to the Percy Commission Report in 1957<sup>13</sup>, through the *Mental Health Act 1959* and *Mental Health (Scotland) Act 1960*, the *Mental Health Act 1983* and the *Mental Health (Scotland) Act 1984* to, finally, the *Mental Health (Care and Treatment) (Scotland) Act 2003* and the *Mental Health Act 2007*.

It is generally recognised, in most Western European states at least, that for vulnerable members of society to be fully protected and enabled to seek and obtain those goods, services and support that they need and want, there must be clearly stated and defined rights which are underpinned and enforced by law. Recognised and enforceable human rights standards may stem from international and regional treaties, but these, in turn, must be incorporated or transposed within states through legislation and by receptive courts<sup>14</sup>.

As the move away from institutionalisation has progressed, there has emerged an appreciation of those civil, social and economic rights necessary to ensure adequate treatment and support outside the confines of institutions, and of the need to respect and protect such rights<sup>15</sup>. Indeed, we are nowadays arguably moving beyond the development of civil rights of judicial process towards a conception of entitlement to the least restrictive, but adequate, manner of treatment<sup>16</sup>.

It is accordingly essential that socio-economic rights are recognised and enforced if care in the community and social inclusion<sup>17</sup> are to be effective and more than merely aspirational<sup>18</sup>. The purpose of this article is therefore to reflect on this issue in the light of direction from Europe.

12 WHO (2007), *Community mental health services will lessen social exclusion, says WHO*, News, 1 June 2007; *World Health*; WHO, *World Health Report 2001*, *op cit*.

13 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency. 1954–1957*. Chairperson: Lord Percy. Cmnd 169. HMSO, May 1957.

14 WHO (2005), *Mental Health: Human rights and legislation*, p6.

15 L. Gostin (2001), 'Beyond moral claims – A human rights approach to mental health', *Special section: Keeping human rights in the bioethics agenda*, 10(3) *Cambridge Quarterly of Healthcare Ethics* 264.

16 L. Gostin (1983), 'Perspectives on Mental Health Reforms', 10 *Journal of Law and Society* 47. Gostin was writing about the *Mental Health Act 1983* in England and Wales; P Fennel (1999), 'The Third Way in Mental

*Health Policy: Negative Rights, Positive Rights, and the Convention*', 26 *Journal of Law and Society* 103, p105.

17 By "social inclusion" the author means access to those goods and services which are necessary for individuals to fully and effectively participate in society or the communities in which they live. Note also that 'social inclusion' and 'care in the community', whilst sharing a number of common attributes, are not the same.

18 Note also that, in some cases, there should be rights of access to and receipt of appropriate services in order to support those caring and supporting others with mental illness (and, conversely, rights for those suffering from mental illness to protect them from abusive carers and relatives). See, for example, J. Atkinson (2006), *Private and Public Protection: Civil Mental Health Legislation*, Edinburgh: Dunedin Academic Press, pp59–68.



## 2. Rights for inclusion in the community: Beyond civil rights

When ascertaining precisely which rights are required to enable a person with mental illness to successfully participate in society outside institutions it is necessary to first separate two aspects of community care.

On the one hand, there is a need to consider those situations where certain restrictions and requirements must exist in order to ensure that the individual can function within the community whilst, at the same time, protecting other members of society<sup>19</sup>. Here, although all categories of rights are applicable, civil rights (for example, relating to liberty, the right to life<sup>20</sup> and protection from cruel and inhuman treatment) tend to take on greater prominence. Reciprocity is important, in that if an element of compulsion exists in community care and treatment, then there should be commensurate obligations on public authorities to provide appropriate services<sup>21</sup>.

On the other hand, whilst civil rights (for example, rights relating to procedural fairness and non-discrimination in terms of accessing and receiving services and guardianship) are of course relevant, so are those socio-economic rights which enable individuals to seek, access and receive those goods, services, and support which enable them to function to the best of their ability in the communities in which they live. This includes rights to health services (for both mental and physical health), benefits and rehabilitation services, housing and access to education and employment. Non-discrimination and equality are also vital components in the provision of such assistance.

As already stated, for such rights to be effectively implemented, there needs to be a relevant international and/or regional human rights framework supported by appropriate legislation and recognition by domestic courts. It is therefore necessary to first consider which international and regional socio-economic rights standards exist that are relevant to mental health care in Europe.

## 3. International and European frameworks for mental health and related socio-economic rights

### a. International instruments

At international level, various documents have aligned socio-economic rights with mental health, either expressly or by implication. *The International Covenant on Economic, Social and Cultural Rights* (ICESCR) does not expressly refer to persons with mental illness, or indeed with any form of disability, but the Committee on Economic, Social and Cultural Rights makes it clear that such persons are included under the Covenant<sup>22</sup>. It has stated that the obligation of states parties to promote progressive realisation of full participation and equality in society requires 'positive action'<sup>23</sup>. The Committee further states that 'this almost invariably means that additional resources will need to be made available for this purpose and that

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19 However, it is arguable that the public safety risk, though tragic when supervisory systems provide to be ineffective, may be over-exaggerated, particularly by the media. Indeed, evidence suggests that severe mental illness of itself does not necessarily equate with greater criminal activity and that factors such as being in receipt of state benefits and having no fixed accommodation may be more influential. See C.T. Sheldon et al (2006), 'Social disadvantage, mental illness and predictors of legal involvement', 29 *International Journal of Law and Psychiatry* 249, p253. This article presents data collected in a study conducted in Ontario, Canada. See also WHO,

*World Health Report 2001, op cit, p4.*

20 This includes members of the public and those who are mentally ill.

21 Atkinson, *op cit*, pp76–78.

22 *Persons with disabilities :General Comment 5. 09/12/94 Doc. E/1995/22, para 3 (adopting the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, Annexed to General Assembly resolution 48/96 of 20 December 1993 (Introduction, para. 17)).*

23 *General Comment 5, ibid at para 9.*

a wide range of specially tailored measures will be required'. Rights which are specifically relevant to mental health are identified as the right to work, to social security, to protection of the family and of mothers and children, to an adequate standard of living (including accommodation), to physical and mental health (including the right to rehabilitation services), to education, and to participate in cultural life and enjoy the benefits of scientific progress<sup>24</sup>. Equality and non-discrimination are also important. Sadly, however, the Committee has also noted that states parties' promotion of such rights has not always been encouraging<sup>25</sup>.

Similarly, the *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*<sup>26</sup>, refers to the right to be treated in the community<sup>27</sup> and in the least restrictive environment<sup>28</sup>. Likewise, Article 1 of the *UN Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities* makes it clear that the term 'disability' includes mental illness and, amongst other rights, Article 19 contains specific provisions relating to integration into society for those with mental illness. This includes the opportunity to choose how and where to live<sup>29</sup> and access to a range of services to assist and support in such integration<sup>30</sup>.

Against this international background, European regional instruments are more directly reflected at municipal level.

### b. European instruments

The Council of Europe's original 1961 and revised 1996 versions of the *European Social Charter* (ESC) contain socio-economic rights which are relevant and applicable to integration into society of those with mental illness. Provisions of the ECHR, such as Article 6 in terms of procedural matters relating to the assessment and provision of goods and services, may also have relevance here. However, being an instrument of civil and political rights, the ECHR is better at protecting individuals from unnecessary or uninvited treatment and detention than at ensuring they receive that which is essential for them to effectively integrate into society<sup>31</sup>. For example, it protects individuals from unwarranted and excessive detention and treatment under Articles 5, 3 and 8, and ensures fair procedures when matters are adjudicated. However, these negative rights are insufficient by themselves if those suffering from mental ill health are to be fully and effectively integrated into the communities in which they live and work and cared for and supported there. The ESC therefore has a potentially important supplementary role.

In terms of social integration, Article 15 ESC is the most prominent,<sup>32</sup> although, given the Charter's provisions on non-discrimination and equality, its other provisions are clearly applicable. The objective of Article 15 of the Revised ESC is that persons with disabilities, including those with mental illness, are able to function to the best of their ability within their communities and therefore includes the right to "independence, social integration and participation in the life of the community"<sup>33</sup>. This takes forward the right contained in the original 1961 version of the Charter which provided for "the effective exercise

24 ICESCR Articles 6–8, 9, 10, 11, 12, 13, 14 and 15 respectively. See *General Comment* *ibid*, Parts III and IV.

25 *General Comment* 5, *op cit* at para 10.

26 Adopted by General Assembly Resolution 46/119 of 19 December 1991.

27 Principle 7.

28 Principle 9.

29 Article 19(a).

30 Article 19(b) and (c).

31 B. Hale (2007), 'Justice and equality in mental health law: The European experience', 30 *International Journal of Law and Psychiatry* 18.

32 Council of Europe, *Rights of people with disabilities: Fact sheet on Article 15 of the Revised European Charter*.

33 Article 15 Revised European Social Charter 1996. See also European Committee of Social Rights (2003), *Statement of Interpretation on Article 15, Conclusions*, p10, and European Committee of Social Rights (2006), *Digest of the Case Law*, December, p114.

of the right of the physically or mentally disabled to vocational training, rehabilitation and resettlement” to be achieved through the provision of public and private training facilities and employment<sup>34</sup>.

Article 15 of the Revised Charter<sup>35</sup> refers to “the effective exercise of the right to independence, social integration and participation in the life of the community” and stipulates that this includes the provision of mainstream or, where this is not possible, specialised “guidance, education and vocational training”<sup>36</sup>. It also states<sup>37</sup> that this includes the promotion of employment in the ordinary workplace where this is possible. In regard to other measures to promote access to employment, states are afforded a margin of appreciation, but this will not prevent the Committee from considering whether or not such measures effectively comply with the provision<sup>38</sup>. Article 15(3) also places an obligation on States to promote “full social integration and participation in the life of the community” using measures “to overcome barriers to communication and mobility and enabling access to transport, housing, cultural activities and leisure”. This obligation includes providing effective remedies for those who have been unlawfully treated<sup>39</sup>. Moreover, in relation to housing, the European Committee of Social Rights has stated<sup>40</sup> that “The needs of persons with disabilities must be taken into account in housing policies;”<sup>41</sup>.

However, despite these provisions, in terms of direction and effectiveness, the European system has its imperfections.

## **4. Human rights and community care: An intricate web?**

### **a. Council of Europe direction**

The socio-economic rights referred to in the aforementioned international and European instruments have to be realised and implemented at national level. The problem is that, unfortunately, state promotion of these rights, despite the realisation in recent years that these should be given equal weight to civil and political rights<sup>42</sup>, has tended to lag behind that of civil and political rights. In terms of leadership and direction, the Council of Europe has also been slower in pursuing this category of rights, particularly in relation to persons with disabilities. The social right to independence, social integration and participation in community life for those with disabilities set out in Article 15 of the ESC are not ‘core’ rights under the Charter, notwithstanding the fact that mental health and rights has been gathering momentum.

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34 *This includes specialised placing services, facilities for sheltered employment and measures to encourage employers to employ disabled persons.*

35 *See also Council of Europe Parliamentary Assembly, Recommendation 1185 (1992) on rehabilitation society policies for the disabled which also notes the need for those suffering from a disability (including mental illness) to be fully integrated into society and to have greater ownership in regard to the process of such integration.*

36 *Article 15(1). See European Committee of Social Rights (2006), Digest, ibid and Autism Europe v France, Complaint No. 13/2002, Decision on the merits of 4 November 2003, para 48. “...The underlying vision of Article 15 is one of equal citizenship for persons with disabilities and, fittingly, the primary rights are those of “independence, social integration and participation in the life of the community”. Securing a right to education for children and others with disabilities plays an obviously important role in advancing these citizenship rights. This explains why education is now specifically mentioned in*

*the revised Article 15 and why such an emphasis is placed on achieving that education “in the framework of general schemes, wherever possible”. It should be noted that Article 15 applies to all persons with disabilities regardless of the nature and origin of their disability and irrespective of their age. It thus clearly covers both children and adults with autism. See also European Committee of Social Rights (2005), Conclusions, p96 (regarding Cyprus).*

37 *Article 15(2).*

38 *European Committee of Social Rights (2006), op cit, p115; European Committee of Social Rights, Conclusions XVII- 2, Belgium, p152.*

39 *European Committee of Social Rights (2006), op cit, p116.*

40 *Ibid, p116.*

41 *Ibid, p116.*

42 *See, for example, the UN Vienna Declaration and Programme of Action, A/CONF.157/23, 12 July 1993.*

To date, apart from the European Committee of Social Rights commenting once on Article 15 compliance under the reporting system<sup>43</sup>, there only appear to have been two complaints brought under the European Charter which specifically relate to mental disability<sup>44</sup>. There are none relating specifically to mental illness. That being said, the Committee appears to adopt a strict approach to the interpretation of the Charter when presented with alleged violations. The complaint of *IAAE v. France* related to insufficient educational provision, in both mainstream and specialist institutions and services, for children and adults with autism. IAAE alleged that, whilst French law was *prima facie* in compliance with Articles 15(1), 17(1) (The right of children and young persons to social, legal and economic protection) and E(non-discrimination) of the Revised Charter, in terms of implementation it did not comply. It also noted that the allocation of insufficient resources was an important factor. The Committee decided that all three articles had been violated, and, whilst it made no specific comment on the adequacy of resource allocation, it can be reasonably inferred that the Committee did not consider it to be sufficient in this particular case. States may even try to use their own non-acceptance of Article 15 to avoid responsibility under the ESC. For example, in *Mental Disability Advocacy Center v Bulgaria*, the Bulgarian government argued that, as it did not accept Article 15(1), a complaint to the Committee concerning the lack of education provided for children living in homes for the mentally disabled was inadmissible, on the grounds that, although the complaint was made under Articles 17 and E of the Revised Charter, it should have correctly been made under Article 15(1)<sup>45</sup>. Encouragingly, however, it would seem that the Committee gave short shrift to this argument<sup>46</sup>. It considered that the case was admissible on the basis that, although the rights of persons with disabilities are guaranteed under Article 15(1), this does not exclude relevant issues being raised elsewhere under the Revised Charter. Accordingly, as this case was also about education, it could legitimately be considered under Article 17(2) of the Revised Charter.

## b. Resourcing

Even where a particular country's laws and constitutional structure ostensibly provide the means to seek respect for and protection of the rights of those with mental disabilities, the implementation of these is often an entirely different matter<sup>47</sup>. Council of Europe standards and national laws can thus only go so far and are inevitably subject to political influences and resources. Implementation of economic and social rights requires that positive steps be taken by the state, generally progressively and often including the allocation of substantial amounts of resources. Yet, insufficient funding is allocated to mental health expenditure<sup>48</sup>. Only those states that possess, or are prepared to allocate, the resources and relevant information will ensure that the implementation of these standards is other than illusory<sup>49</sup>. According to the EU Green Paper, the UK spends in the region of 12% of its total health expenditure on mental health and Luxembourg slightly under 14%, Slovakia only 2% and the Czech Republic 3%, and France 5%<sup>50</sup>.

43 European Committee of Social Rights (2003), *European Social Charter: Conclusions XVII-2, vols 1 and 2 and European Committee of Social Rights, European Social Charter (Revised) Conclusions 2003, vols 1 and 2*.

44 *International Association Autism-Europe (IAAE) v. France Complaint No. 13/2002, Decision on the Merits, 7 November 2003 (violation of Articles 15(1), 17(1) and E of the Revised Charter) and Mental Disability Advocacy Center v Bulgaria Complaint No. 41/2007, Decision on Admissibility, 26 June 2007 (alleged violations of Article 17(2) and E of the Revised Charter)*.

45 At para 8.

46 A paras 9–11.

47 O. Lewis (2002), "Mental disability law in central and Eastern Europe: paper, practice, promise", 8 *Journal of Mental Health Law*, 283.

48 D. McDaid et al (2005), "Mental Health III: Funding mental health in Europe", Policy Brief, WHO European Centre for Health Policy, Brussels.

49 Kwame Aduffo (2004), "The involuntary detention of persons with mental disorder in England and Wales – A human rights critique", 27 *International Journal of Law and Psychiatry* 109, p131.

50 European Union (2005), *Improving the mental health of the population: Towards a strategy on mental health for the European Union*, Brussels COM 484, p21.

Indeed, the assessment of entitlement to goods and services which support integration in the community, may require those suffering from mental ill-health to compete with other vulnerable groups of persons. Moreover, allocation of these resources is often subject to a number of different, and occasionally contradictory, policies and laws. This is particularly evident in, but not confined to, the case of accommodation. In Scotland, a recent decision of the Outer House of the Court of Session, whilst not specifically referring to social rights, appears to highlight some of the difficulties faced in relation to establishing a priority need for housing for those suffering from mental illness and the allocation of resources. In this case, *Morgan v Stirling Council*<sup>51</sup>, it was held that the petitioner, who suffered from “depression and nervous disability”, did not fulfil the criteria to establish a priority need under s.25(1)(c)52 of the *Housing (Scotland) Act 1987* for local authority accommodation. The sub-section states that for a priority need to be established one must show that one is vulnerable as a result of *inter alia* mental illness. Adopting the comparative assessment test in *Wilson v Nithsdale District Council*<sup>53</sup> and judgments in the English cases *R v London Borough of Camden ex p Pereira*<sup>54</sup> and *Griffin v Westminster Council*<sup>55</sup>, the court stated<sup>56</sup> that, in order to establish that the petitioner is vulnerable under this sub-section, all the circumstances must be taken into account and “it must appear that her ability to fend for herself whilst homeless is more likely to result in injury or detriment to her than would be the case with an ordinary homeless person.”<sup>57</sup> In this case, it was considered that the local authority had applied this comparative test and had acted reasonably in accordance with the *Wednesbury* test in determining that a priority need did not exist. This was despite the fact that the petitioner was homeless, her boyfriend’s parents no longer had room to accommodate her, and her Community Alcohol and Drugs Service community charge nurse expressed concern that her homeless state might have a detrimental effect on her stability and progress in recovery from drug abuse. The court also made it clear that the local authority, and not the court, is best placed to make decisions on priorities, as the local authority possesses the most appropriate knowledge of housing and applicants within its area<sup>58</sup>.

Cases such as this raise the issue of what is and what is not acceptable in terms of ‘progressive realisation’ of socio-economic rights. They also raise the thorny issue of the extent to which the courts should effectively adjudicate on the allocation of resources, given that this potentially strays onto the territory of the other institutions of government. It is certainly the case that the courts in some Eastern European countries, such as Hungary, may, somewhat ironically, seek to maintain the status quo and prevent the erosion of social rights which existed during the Communist era in the face of the currently more market-driven policies<sup>59</sup>. They are, in other words, effectively enforcing social rights negatively. However, the generally positive nature of social and economic rights nevertheless calls into question fundamental constitutional principles such as judicial independence and its potential compromise. This can present difficulties unless the view is adopted that courts play an integral, but not dominant or directive, role in the whole process of recognition and implementation of socio-economic rights<sup>60</sup>.

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51 2006 SLT 962.

52 ‘The following have a priority need for accommodation... (c) a person who is vulnerable as a result of ... (ii) mental illness;’

53 1992 SLT 1131.

54 (1999) 31 HLR 317.

55 [2004] EWCA Civ 108.

56 Lord Glennie at 963.

57 Lord Glennie at 963.

58 Lord Glennie at 965.

59 A. Sajó (2006), ‘Social Rights as Middle-Class Entitlements in Hungary: The Role of the Constitutional Court’, in R. Gargarella et al (eds), *Courts and Social Transformation in New Democracies: An Institutional Voice for the Poor?*, Aldershot: Ashgate, pp83–105.

60 R. Gargarella (2006), ‘Theories of democracy, the Judiciary and Social Rights’, in R. Gargarella et al, *ibid*, pp13–34.

Difficulties may also occur where care and treatment in the community contain elements of compulsion. Questions arise here as to the choices that an individual can and should be able to make<sup>61</sup>. The role of law here may in fact militate against the realisation of human rights. Indeed, where the law provides for compulsory community care it can actually be disempowering to those suffering from mental illness, in that it extends the control of medical practitioners and restricts patient choice<sup>62</sup>.

### c. Fragmented and disjointed laws

Positive rights that might be implied from ECHR principles are not usually interpreted to imply absolute obligations to provide services. For example, although Article 5(4) ECHR provides for the release of patients from detention often into community care,<sup>63</sup> this does not necessarily automatically equate with an absolute obligation being placed on public authorities to provide appropriate support for those persons released into the community. In the UK, for instance, in *R(K) v Camden and Islington*<sup>64</sup> the Court of Appeal held that if the necessary care<sup>65</sup> cannot be found in the community then a breach of Article 5 does not occur if the patient remains in detention. It considered that health authorities are only obliged to make reasonable efforts to comply with the conditions of the discharge order and are not under an absolute duty in this respect<sup>66</sup>.

The split between rights to care and duties of care provision may be exacerbated by fragmented or inadequate laws relating to service provision. In Hungary<sup>67</sup>, for example, programmes providing community-based care are generally inadequate and inconsistent across the country<sup>68</sup>. Likewise, in England there is a confusing array of enactments dealing with community care services starting with the *National Health Service and Community Care Act 1990* and also including Part III *National Assistance Act 1948*, s45 *Health Services and Public Health Act 1968*, s21 and Sch8 *National Health Service Act 1977* and s117 *Mental Health Act 1983*<sup>69</sup>. In Scotland, the *Social Work (Scotland) Act 1968* has been much amended over time to bolster community care provision<sup>70</sup>. However, evaluation is difficult given the lack of availability of the current version of the 1968 Act<sup>71</sup>. Moreover, ss.25, 26 and 27 of the *Mental Health (Care and Treatment) (Scotland) Act 2003*, providing for services for care and support, the promotion of well-being and social development and travel assistance, are important but do not state how long these services will be provided for persons suffering from mental illness. Certainly, it is implicit that these

61 *Hale, op cit.*

62 C. Unsworth (1993), 'Law and Lunacy in Psychiatry's "Golden Age"', 13 *Oxford Journal of Legal Studies*, 479. In addition, the effectiveness of community treatment orders has also not yet been conclusively determined. See J. Dawson et al (2003), 'Ambivalence about Community Treatment Orders', 26 *International Journal of Law and Psychiatry*, 243, which notes this and advocates that more extensive research is undertaken in this area.

63 *Winterwerp v Netherlands, op cit.* See also *Johnson v UK* (1999) 27 EHRR 440 and *Kolanis v UK* (2006) 42 EHRR 12.

64 [2002] QB 198. See also *R (H) v Secretary of State for Home Department* [2004] 2 AC 253 (Article 5 ECHR is not violated if a person of 'unsound mind' is detained but may be better cared for in a different way).

65 The issue in this case involved a condition requiring medical supervision of a conditionally discharged patient in the community. However, a doctor who would agree to

supervise the patient in the community could not be identified.

66 pp228–229.

67 Which ratified the original ESC and has signed but not yet ratified the Revised Charter.

68 *Human Rights and Mental Health: Hungary, op cit*, pp58–64.

69 See P. Bartlett and P. Sandland (2007), *Mental Health Law: Policy and Practice*, 3rd ed. Oxford University Press, pp435–496.

70 By the *National Health Service and Community Care Act 1990*, *Community Care (Direct Payments) Act 1996*, *Carers (Recognition and Services) Act 1995* and generally strengthening *Community Care and Health (Scotland) Act 2002*.

71 H.Patrick (2006), *Mental Health, Incapacity and the Law in Scotland*, Edinburgh/Haywards Heath: Tottel Publishing, p27.



services are only to be provided for those persons who are subject to compulsion under the Act<sup>72</sup> and may therefore lead to a lack of uniformity in service provision<sup>73</sup>.

#### **d. Cultural and political interpretations**

Underlying implementation of socio-economic rights – in fact, of human rights in general – is the issue of the impact which different cultural and political attitudes and ideologies have on the recognition and implementation of human rights, including socio-economic rights. This is compounded where the human rights of those with mental ill health are concerned. The extent to which those suffering from mental ill health are indeed entitled to “rights” and the manner in which “mental health” and “mental illness” is interpreted is very pertinent. In terms of different political attitudes, the Russian State<sup>74</sup> has in the past and is still prepared to detain its opponents in psychiatric hospitals<sup>75</sup>. Larisa Arap<sup>76</sup> was involuntarily detained and treated only this year after her criticisms of state psychiatric provision. Although she was eventually released, her initial detention was without judicial sanction and later, alarmingly, with it.

In terms of cultural attitudes, we might consider Hungarian out-patient programmes for the mentally ill, which lack provision for supported accommodation and employment, psychological rehabilitation and advocacy services<sup>77</sup>. A lack of funding is a major contributor to this<sup>78</sup>, but cultural interpretations of mental health are also influential. Although the situation is slowly changing, mental illness tends to be stigmatised and with symptoms, rather than the actual condition, being treated by the medical profession. Moreover, the residue of stigmatisation of certain social problems, such as unemployment, from the communist era remains, and may be experienced by the sufferers as symptoms which equate to mental illness<sup>79</sup>. Both sufferers and community have also generally considered in-patient care as being the only adequate form of treatment for mental illness<sup>80</sup>.

Nor is it certain that the European Union’s Charter on Fundamental Rights,<sup>81</sup> if and when it becomes legally binding, will bring about improved human rights protection. It has all the correct ingredients, including civil, political, social, economic and cultural rights, and it refers to responsibilities as well as rights. Whether this will appeal to the wide spectrum of political and cultural ideologies across Europe remains to be seen. Socio-economic considerations may have traditionally been of greater concern to non-Western European states<sup>82</sup>. It would, however, be unwise to assume that all new Member States share

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72 Atkinson, *op cit*, p77.

73 *Ibid*, p77.

74 Which signed both the original and Revised ESC but has ratified neither and has ratified the ECHR.

75 See, for example, Mental Disability Advocacy Center, ‘Psychiatric ‘care’ still a political weapon in Russia?’, Media Release, 21 August 2007.

76 In July 2007, Larisa Arap, a political activist and opponent of the Russian government, was involuntarily detained and treated in a psychiatric hospital after she had published a story criticising state psychiatric care of children. Her initial detention was without judicial oversight. A court order, authorising the detention and treatment, was obtained approximately two weeks later. The Russian Human Rights Ombudsman ultimately confirmed that her detention had been illegal and she was released after 47 days. There was considerable support amongst human rights commentators for the view that this was an example of state abuse of psychiatry. See Mental

Disability Advocacy Center, ‘Psychiatric ‘care’ still a political weapon in Russia?’ *ibid*.

77 Mental Disability Rights International (1997), *Human Rights and Mental Health: Hungary*, Washington D.C., 58, p61.

78 *Ibid*, p62.

79 *Ibid*, p67.

80 *Ibid*, p67. See also J. Füredi and B. Buda (1987), ‘Recognition Problems for Psychiatry as an Independent Discipline in Hungary’, 7 *American Journal of Social Psychiatry* 199.

81 Charter of Fundamental Rights of the European Union 2000 O.J. (C364) 1.

82 R. Nordahl, ‘A Marxist Approach to Human Rights’ in A.A. An-Na’im (ed) (1995), *Human Rights in Cross-Cultural Perspectives: A Quest for Consensus*, Philadelphia: University of Philadelphia, 162, p162; J.J. Shestack (1998), ‘The Philosophical Foundations of Human Rights’, 20(2) *Human Rights Quarterly* 201, p210.

common political, social and cultural traditions<sup>83</sup>. It must also not be forgotten that Western European states have historically tended to place greater emphasis on civil and political rights and their implementation. Moreover, whether accession to the EU will bring about more widespread human rights observance in general within Member States is debateable, even though the EU proclaims respect for the rule of law, democracy and human rights. Despite the rulings in *Carpenter*, *Schmidberger* and *Omega Spielhallen*<sup>84</sup>, the importance which the European Court of Justice will ultimately ascribe to fundamental rights is at present not yet completely clear<sup>85</sup>. Some pessimism certainly exists on the issue of whether accession to the EU will result in better human rights respect and protection for those persons with mental disabilities in central and eastern European countries given the EU's predominantly economic focus<sup>86</sup>. That being said, the fact that there is ostensibly greater reciprocity in terms of the benefits that membership of the EU may bring might perhaps encourage greater and more effective implementation.

## 6. Conclusion

Over the last two decades we have come some way in Europe towards recognising that those suffering from mental illness require enforceable rights so that they are not subjected to abuse and neglect. These rights are, however, mainly civil rights which are applicable to the patient-institution relationship. If care takes place outside institutions, a far greater emphasis on socio-economic rights is required. This will enable those with mental illness to access and receive those services and that support which is necessary for them to function as effectively as possible within the communities in which they live. Yet, despite international and European standards<sup>87</sup> to this effect, the actual realisation of these at national level is slow<sup>88</sup>. Undoubtedly the lack of imperative is largely owing to the very nature of socio-economic rights and the positive obligations they place on states.

Adequate rights and the law do not alone, of course, provide the answer to full and effective care in the community. There is always a balance to be struck between the desire to provide community care and availability of resources, the rights of the person suffering from mental ill health and public safety.

Socio-economic rights are, however, incontrovertibly an important component in the achievement of the 'well-organized community-based care' envisaged by the WHO<sup>89</sup>, the community care provisions in the *Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities*<sup>90</sup> and 'independence, social integration and participation in the life of the community' referred to in the Revised ESC<sup>91</sup>. Their recognition and implementation, together with adequate resourcing and proper coordination between relevant care givers, will reduce the risk that individuals will ultimately not benefit from care in the community, and possibly become subject to compulsory admission to psychiatric units or the criminal justice system<sup>92</sup>.

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- 83 O. Lewis (2002), 'Mental Disability law in central and eastern Europe: paper, practice, promise', 8 *Journal of Mental Health Law*, 293, p293; See also M Ishay (2005), 'The Socialist Contributions to Human Rights: An Overlooked Legacy', 9(2) *International Journal of Human Rights* 225 (in which the author argues that the so-called international human rights instruments were in fact influenced by socialist ideals).
- 84 Case C-60/00 *Carpenter* [2002] ECR I-6279, Case C-112/00 *Schmidberger* [2003] ECR I-5679; Case C-36/02 *Omega Spielhallen* [2004] ECR I- 9609. The rulings in these cases, amongst others, indicate that the European Court of Justice is increasingly prepared to give weight to human rights considerations.
- 85 See, for example, S. Douglas-Scott (2006), 'A Tale of Two Courts: Luxembourg, Strasbourg and the Growing European Human Rights Aquis', 43 *Common Market Law Review* 629 and J. Morijn (2006), 'Balancing Fundamental Rights and Common Market Freedoms in Union Law: *Schmidberger* and *Omega* in the Light of the European Constitution', 12(1) *European Law Journal* 15.
- 86 O. Lewis, *op cit*, p303.
- 87 See Section 3 above.
- 88 See Sections 3 and 4 above.
- 89 WHO, *World Health Report 2001*, *op cit*, p4.
- 90 Article 7.
- 91 Article 15.
- 92 See H.W. Wales and V.A. Hiday (2006), 'PLC or TLC: Is the outpatient commitment the/answer?', 29 *International Journal of Law and Psychiatry*, 451-468, p452. who consider this risk to be significant.

# Mental Health in the Workplace (2) – Mental Health and Discrimination in Employment<sup>1</sup>

Kay Wheat<sup>2</sup>

## Introduction

People with mental health problems are stigmatised and in particular there is concern about stigmatisation in employment<sup>3</sup>. The *Disability Discrimination Act 1995* (“the Act”) was introduced to address the problems of disabled people, both in employment and in the provision of education, goods and services<sup>4</sup> and the legislation is concerned with mental as well as physical health. However, its basic premise is that disability has to be long-term and must be defined in terms of the individual disabled person. Many people with mental health problems are not disabled within the meaning of the Act, and because of the individualised approach what has been described as institutionalised discrimination has not been addressed<sup>5</sup>. This article examines the current employment protection for those with mental health problems offered by the Act and elsewhere. It will be argued that there are particular problems associated with mental health that are not addressed by the current law and that recent attempts to address these have resulted in a missed opportunity, and that a more radical approach is necessary because of the nature of mental health and the perceptions and prejudices surrounding this area.

## PART I – DISABILITY DISCRIMINATION

### History of disability discrimination in the UK

Although it would probably not have been thought of as a piece of anti-discrimination legislation, the *Disabled Persons (Employment) Act 1944* was, for 50 years, the only legal vehicle, not for the prevention

1 This is the second article by the author published in the *Journal of Mental Health Law* about mental health in the workplace. The first was published in the May 2006 issue, pp 53–65.

2 Reader in Law, Nottingham Law School, Nottingham Trent University.

3 See J Read and S Baker *Not Just Sticks and Stones: A Survey of the Stigma, Taboos and Discrimination experienced by People with Mental Health Problems* (1996, London: Mind), and G Thomicroft *Shunned –*

*discrimination against people with mental illness* (2006, Oxford: Oxford University Press).

4 This protection came into force in a staggered timetable in 1996, 1999 and 2004. For a comprehensive account of disability discrimination see B Doyle, *Disability Discrimination: Law and Practice*, (2005, Bristol: Jordans).

5 See the Disability Rights Commission website at [http://www.drc-gb.org/library/policy/employment/drc\\_short\\_briefing\\_on\\_eq\\_ualit.aspx](http://www.drc-gb.org/library/policy/employment/drc_short_briefing_on_eq_ualit.aspx)

of discrimination, but for a rather crude acknowledgement that there should be some concession made towards disabled people and work. The legislation provided for a form of positive discrimination in the form of a quota for disabled workers in any employment undertaking and a number of reserved occupations<sup>6</sup>. The Act repealed this and set up a new structure of protection for disabled people in an attempt to address the growing concern<sup>7</sup> that disabled people were suffering from difficulties in obtaining employment and from prejudice once they managed to find their way into the workplace.

Following the passing of the Act in 1995, the Government published *Towards Inclusion*<sup>8</sup> and set up the Disability Rights Taskforce. The Disability Rights Commission published its review following the recommendations of the Taskforce<sup>9</sup>. Legislation was also passed to provide for a Disability Rights Commission (“the DRC”)<sup>10</sup>. Subsequent to the 1995 Act the EC Framework Directive 2000/78/EC was issued.<sup>11</sup> A number of amendments have been made to comply with the Directive, principally made by the *Disability Discrimination (Amendment) Regulations 2003* and the *Disability Discrimination Act 2005*. The most significant of these are the abolition of the following: the requirement that any mental impairment must result from a clinically well-recognised illness;<sup>12</sup> the exemption for employers with fewer 15 employees,<sup>13</sup> and the justification defence available to employers if there was a failure to make reasonable adjustments<sup>14</sup>. Most notably, the Act has also been amended to provide that people with HIV, cancer or multiple sclerosis are deemed to be disabled at the point of diagnosis<sup>15</sup>. However, arguably there are still areas of non-compliance with the Directive, perhaps most significantly in the context of the statutory obligation to make reasonable adjustments to accommodate disabled workers<sup>16</sup>. This is explored further below.

## The current structure of disability discrimination in the UK

There are some basic concepts in discrimination law in the UK that are common to the various forms of anti-discrimination provisions. There are two forms of discrimination: direct and indirect. Direct discrimination is where there is less favourable treatment because of the person’s sex or other protected characteristic. Indirect discrimination occurs when a provision, criterion or practice (such as a mobility clause or a certain standard of English) is applied to everyone but which has a disparate impact upon

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6 One significant impetus for this legislation was the effect of the Second World War (see, e.g. A Borsay, *Disability and Social Policy in Britain since 1750* (2005, Basingstoke: Palgrave Macmillan) pp 133–138).

7 In addition at the end of 1993 the United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities were adopted by the United Nations (General Assembly Resolution 48/96). However, the concern had been present for a long time. In 1976 the Union of the Physically Impaired Against Segregation published a strongly worded account of the link between poverty and disability: *Fundamental Principles of Disability* (1976, London: UPIAS) p 14.

8 Department of Education and Employment, *Towards Inclusion – civil rights for disabled people* (2001, Department of Education and Employment).

9 Disability Rights Commission, *Disability Equality: Making it happen* (2003, Disability Rights Commission).

10 *Disability Rights Commission Act 1999*.

11 This was complemented by Council Directive

2000/43/EC which established the principle of equal treatment between persons regardless of racial or ethnic origin (gender discrimination had already been dealt with by the Equal Pay Directive (EC/75/117) and the Equal Treatment Directive (EC/76/2070).

12 Removed by section 18 *Disability Discrimination Act 2005*.

13 *Disability Discrimination (Amendment) Regulations 2003* SI 2003/1673, Reg 7.

14 *Ibid* Reg 4. In any event the defence was otiose as since the law only requires reasonable adjustments to be made, any justification defence would necessarily entail a finding that the employer was being unreasonable.

15 Section 18 *Disability Discrimination Act 2005*.

16 See K Wells, “The Impact of the Framework Employment Directive on UK Disability Discrimination Law” (2003) 32 No 4 *ILJ* 253, and L Waddington, “Implementing the Framework Employment Directive: Room for Exercising National Discretion” in A Lawson and C Gooding (eds) *Disability Rights in Europe* (2005, Oxford: Hart) p 107.

those who come within the protected group. However, this form of discrimination can be justified by the employer in circumstances where it can be shown that the provision, criterion or practice of the employer is proportionate to the legitimate needs of the undertaking<sup>17</sup>.

### Direct discrimination

The *Disability Discrimination Act 1995* protects against direct discrimination only<sup>18</sup>. Direct discrimination is unlawful inasmuch as an employer cannot use the fact of disability as a ground for treating someone less favourably, but less favourable treatment can be meted out for a reason which relates to the disability<sup>19</sup>. This is a distinction of excessive subtlety, and a distinction that would not be tolerated in the context of sex and race discrimination<sup>20</sup>.

Direct discrimination is defined as less favourable treatment when the relevant circumstances of the disabled person and another person (real or hypothetical<sup>21</sup>) without that particular disability are not materially different. The discrimination can be justified if there is a reason that is both material to the circumstances of the particular case and substantial,<sup>22</sup> and the justification will only stand if no reasonable adjustment can be made<sup>23</sup>.

### Reasonable adjustments

UK disability discrimination law is unique in the canon of legislation that offers protection against discrimination in that there is no provision to protect against indirect discrimination. The reason for this was that it was thought that there would be no need for indirect discrimination provisions because of the duty to make reasonable adjustments would render them unnecessary<sup>24</sup>. However, Bell is arguably correct in saying that if employers are mindful of a prohibition on direct discrimination, the more likely they are to move away from this and towards indirect forms of discrimination<sup>25</sup>. Furthermore, some employers at least, may well review their needs if they know that they are vulnerable to an indirect discrimination challenge.

The fact that indirect discrimination is not prohibited is only somewhat ameliorated by the obligation upon the employer to make reasonable adjustments to accommodate disabled workers. In some respects the language of the Act mirrors some of the language of the other discrimination legislation in relation to indirect discrimination<sup>26</sup>. However, as Wells has argued, the obligation to make reasonable adjustments

17 *Sex Discrimination Act 1975* ss 1 & 3, *Race Relations Act 1976* s 3, *Disability Discrimination Act 1995* section 1 and Schedule 1, *Employment Equality (Sexual Orientation) Regulations 2003* Reg 2, *Employment Equality (Religion or Belief) Regulations 2003* Reg 2, and *Employment Equality (Age) Regulations 2006* Reg 3.

18 *Disability Discrimination Act 1995* section 3A. The Act also makes it unlawful to subject a disabled person to harassment for a reason relating to their disability (ss 3B and 4).

19 Section 3A(1), (4) and (5).

20 See e.g. the sex discrimination case of *Webb & Emo Air Cargo Ltd* [1996] 2 CMLR 990, ECJ.

21 The comparator must be someone who has no disability or a different kind of disability or a hypothetical person based upon evidence of others who have been treated differently in broadly similar circumstances (see *Disability Discrimination Act 1995 Code of Practice: Employment and Occupation*, 2004, paras 4.12–4.18).

22 Section 3A (3).

23 The Court of Appeal held that the correct approach in deciding whether direct discrimination is justified is whether the employer has carried out a proper risk assessment, and as long as they have, then its decision will be unassailable unless it is actually perverse, which looks very much like the inappropriate introduction of public law principles *Jones v Post Office* [2001] IRLR384.

24 HC Deb Standing Committee E co 142.

25 M Bell, "Sexual Orientation Discrimination in Employment: An Evolving Role for the European Union" in R Wintemute and M Andeaes (eds) *Legal Recognition of Same-Sex Partnerships*, (2001, Oxford: Hart) p 659.

26 Section 4a of the Act states: (1) Where – (a) a provision, criterion or practice applied by or on behalf of an employer, or (b) any physical feature of premises occupied by the employer, places the disabled person concerned at a substantial disadvantage in comparison with persons who are not disabled, it is the duty of the employer to take such steps as is reasonable, in all the circumstances of the case, for him to have to take in order to prevent the provision, criterion or practice, or feature, having that effect.



does not oblige an employer to take preventative measures and “leaves no scope for a claim relating to an anticipated disadvantage”<sup>27</sup>. By way of contrast Article 2(2)(b) of the Directive<sup>28</sup> does specifically refer to measures that “would” place a disabled person at a disadvantage. Justification of such measures is permitted under the Directive, but the measure must be objectively justified by a legitimate aim and the means of achieving that aim are proportionate and necessary<sup>29</sup>. Another shortcoming of the Act is the specific provision that if the employer cannot be reasonably expected to know of the need for an adjustment this is a defence to an action under section 4A<sup>30</sup>.

The interaction between direct discrimination and reasonable adjustments has been summed up as meaning that the justification defence to an allegation of direct discrimination will not be made out if there has been a failure to comply with a section 4A reasonable adjustments duty<sup>31</sup>. Section 18B of the Act sets out the matters to which regard shall be had in deciding whether an employer has complied with the duty, and there is a very clear emphasis upon cost<sup>32</sup>.

However, Wells argues that in European law ‘reasonableness’ means effectiveness<sup>33</sup>. This is clearly at odds with the cost effective approach of the Act. Fredman has argued that if the employer does not pick up the cost of adjustments then that cost does not disappear; it will either fall on some other third party or the disabled individuals themselves<sup>34</sup>. Although many employment protection measures give rise to issues of cost, there is a compelling argument that this is a necessary price to pay for the cost of inclusion of people with disabilities<sup>35</sup>.

27 K Wells, “The Impact of the Framework Employment Directive on UK Disability Discrimination Law” (2003) 32 No 4 ILJ 253, at 271.

28 EC Framework Directive 2000/78/EC.

29 Article 2(2)(b)(i).

30 Section 4A (3).

31 See *Baynton v Saurus Ltd* [2000] ICR 375, and *Chaudhery v London Borough of Newham* [2003] WL 1935409. Arguably the section 4A duty introduces an element of positive discrimination although it is suggested that this is really a form of positive action., as it does not treat disabled people more favourably but seeks to level the playing field.

32 Section 18B states:

(1) In determining whether it is reasonable for a person to have to take a particular step in order to comply with a duty to make reasonable adjustments, regard shall be had, in particular, to-

(a) the extent to which taking the step would prevent the effect in relation to which the duty is imposed;

(b) the extent to which it is practicable for him to take the step;

(c) the financial and other costs which would be incurred by him in taking the step and the extent to which taking it would disrupt any of his activities;

(d) the extent of his financial and other resources;

(e) the availability to him of financial or other assistance with respect to taking the step;

(f) the nature of his activities and the size of his undertaking;

(g) where the step would be taken in relation to a private household, the extent to which taking it would-

(i) disrupt that household, or

(ii) disturb any person residing there.

(2) The following are examples of steps which a person may need to take in relation to a disabled person in order to comply with a duty to make reasonable adjustments-

(a) making adjustments to premises;

(b) allocating some of the disabled person's duties to another person;

(c) transferring him to fill an existing vacancy;

(d) altering his hours of working or training;

(e) assigning him to a different place of work or training;

(f) allowing him to be absent during working or training hours for rehabilitation, assessment or treatment;

(g) giving, or arranging for, training or mentoring (whether for the disabled person or any other person);

(h) acquiring or modifying equipment;

(i) modifying instructions or reference manuals;

(j) modifying procedures for testing or assessment;

(k) providing a reader or interpreter;

(l) providing supervision or other support.

33 K Wells “The Impact of the Framework Employment Directive on UK Disability Discrimination Law” (2003) 32 No 4 ILJ 253 at 264.

34 S Fredman, *Disability Equality and the Existing Paradigm*, p 210, in A Lawson and C Gooding (eds) *Disability Rights in Europe*, (2005, Oxford: Hart).

35 Legislation that protects e.g. pregnant women, may result in extra cost and inconvenience for employers but as the House of Lords stated in *Brown v Stockton-on-Tees Borough Council* [1988] 2 WLR 935, it is the price to be paid for the equal status of women in the workplace; the same must be true of the equal status of disabled people.

The employer's duty to make reasonable adjustments only arises if, otherwise, the worker is at a 'substantial' disadvantage. The word 'substantial' has a wide range of meaning and "takes colour and meaning from its surroundings", but it was held that it does not have to be more than "worthy of consideration for the purposes of the Act" and that it is not equivalent to "considerable, solid or big"<sup>36</sup>.

### Definition of disability

The issue as to what it means to be 'disabled' is central to this article. Disability is defined under section 1 of the Act as a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities. This has to be read in conjunction with Schedule 1 of the Act that deals with specific conditions that will qualify the person as being disabled and, in other cases, with what is meant by 'long-term effects' and 'normal day-to-day activities'. Long term means that it has lasted for 12 months, or is likely to last for 12 months or for the rest of the life of the person concerned. Normal day-to-day activities are affected for the purposes of the Act only if the impairment affects one of the following: mobility; manual dexterity; physical co-ordination; continence; ability to lift, carry or otherwise move everyday objects; speech, hearing or eyesight; memory or ability to concentrate, learn or understand, and perception of the risk of physical danger<sup>37</sup>. The meaning of normal day-to-day activities was given a commendably wide interpretation in *Paterson v The Commissioner of Police of the Metropolis*<sup>38</sup> where it was held that carrying out an examination or assessment (in this case, the internal assessments carried out by the police for the purposes of promotion through the ranks) is a normal day-to-day activity. The European Court of Justice has considered the concept of disability thus: "Directive 2000/78 aims to combat certain types of discrimination as regards employment ... the concept of 'disability' must be understood as referring to a limitation which results in particular from physical, mental or psychological impairments and which hinders the participation of the person concerned in professional life"<sup>39</sup>. Arguably this definition is more satisfactory because it removes the need to decide upon whether a day-to-day activity is impaired and replaces it with an emphasis upon the applicant's ability to undertake work, which should be the key issue under consideration in an employment disability discrimination claim.

A recommendation made by the Disability Rights Commission in 2003<sup>40</sup> that the ability to communicate should be one of the criteria and that self-harming behaviour should be included has not been adopted. Certain conditions will qualify as imparting a disability without more, and they are: severe disfigurement,<sup>41</sup> cancer (with the proviso that regulations can be made to disapply the 'automatic' designation of disability in certain cases of cancer), HIV and multiple sclerosis<sup>42</sup>. The inclusion of severe disfigurements is interesting because they are rarely disabling in the common sense of the term and are not life-threatening, and yet there is an automatic assumption that they will have a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities. It is unfortunate

36 See *Disability Discrimination Act Code of Practice: Employment and Occupation*, 2004 para 4.6 and *A v London Borough of Hounslow* [2001] Emp LR 1255 EAT at para 54.

37 Para 4 of Schedule 1 of the Act.

38 [2007] UKEAT 0635\_06\_2307.

39 *Chacon Navas v Euresst Colectividades* [2006] IRLR 706, para 43.

40 *Disability Rights Commission, Disability Equality: Making it happen* (2003, Disability Rights Commission) p 60.

41 Para 4 of Schedule 1. 'Severe' is interpreted in relation to its degree and the visibility of the disfigurement (see *Guidance, Part II, para A17*). Disfigurement caused by tattoos is excluded, but Doyle suggests that disfigurement caused by an attempt to remove a tattoo would not be excluded, nor would disfigurement caused by self-harm *B Doyle, Disability Discrimination: Law and Practice*, (2005, Bristol: Jordans), p 28.

42 Para 6A of Schedule 1.

that the statutory framework requires the effect on the ability to carry out day-to-day activities (i.e. what might be called the 'functional' formula) to be mentioned at all because it is fictitious in the case of most severe disfigurements, particularly because, as Doyle says: "This is a rare example of the legislation acknowledging a social model of disability rather than a purely medical one"<sup>43</sup>.

The issue of recurring impairments is dealt with in section 2(2) of the Act. If the disability in the past has had a substantial adverse effect on carrying out normal day-to-day activities, then if it ceases and recurs then it is treated as continuing to have that effect.

Those who have been disabled in the past are also protected by the Act (there is no time constraint so it does not matter that the earlier disability pre-dates the Act) on the basis that it would be inconsistent to give protection to those who are currently impaired, but not to protect from discrimination on the very same basis, those who have now recovered, particularly as part of the recovery process might be getting them back into employment<sup>44</sup>. However, the definition of disability still applies to past disabilities; the person still has to show that in the past they had a physical or mental impairment that had a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.

### Knowledge of the disability

As we have seen, disability discrimination protection has two arms. First there is a prohibition on direct discrimination which in itself has two elements. It is absolutely prohibited to mete out less favourable treatment on the ground of the disability; if the less favourable treatment is for a reason related to the disability then this is prohibited unless the employer can justify it. Secondly, there is a duty to make reasonable adjustments to accommodate the worker's disability. In this case the Act specifically provides that there is only a duty on the employer who knows or can be reasonably expected to know of the disability. There is no specific requirement of 'knowledge' in the case of direct discrimination. In *O'Neill v Symm & Co Ltd*<sup>45</sup> the Employment Appeal Tribunal ("EAT") held that it is not possible for an employer to treat a person less favourably for a reason related to the disability without having actual or constructive knowledge of the disability or its 'material' features. A differently constituted EAT in *HJ Heinz & Co Ltd v Kenrick*<sup>46</sup> stated that the test is one of objective causation: did the employer, in fact, act on the basis of disability even if the disability or its material features were absent from the employer's thinking? A disability might not be apparent to the employer, but its manifestation might be. The decision of the Court of Appeal in *Clark v TDG Ltd t/a Novacold* suggests, on the basis of statutory interpretation, that the latter view is to be preferred, and that it is more probable that Parliament meant "the reason" for the treatment to refer only to the facts constituting the reason for the treatment, and not to make the additional requirement of a causal link with disability<sup>47</sup>.

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43 B Doyle, *Disability Discrimination: Law and Practice*, (2005, Bristol: Jordans), p 27.

44 HL Deb vol 564, col 1655.

45 [1998] IRLR 233.

46 [2000] IRLR 144.

47 [1999] ICR 951, at 963.

## Models of disability and discrimination

### Disability – medical and social models

The definition of disability has raised both practical problems<sup>48</sup> and the accusation that the UK is following a ‘medical’ model of disability and not a ‘social’ model<sup>49</sup>. The debate on the two models goes back to the 1980s when disabled people questioned the premise upon which disability rights were based<sup>50</sup>. It assumed that disabled people suffered from some form of medical abnormality which meant that they did not fit into the regular world upon whom they were then dependent for largesse of one kind or another<sup>51</sup>. The ‘social’ model’s basic premise is that disabled people are disadvantaged because of society placing unnecessary constraints upon their inclusion<sup>52</sup>. It is part of the view that successful, and powerful people are largely white, male and able-bodied and that this profile dictates the terms upon which (inter alia) disabled people can succeed in the employment field<sup>53</sup>.

The ‘individualised’ medical model is the predominant model, at least as far as the UK legislation is concerned. The emphasis is on impairment of the individual; the test is whether the impairment has a substantial effect upon that person’s ability to carry out day-to-day activities which are defined by reference to the word ‘normal’. In *Goodwin v The Patent Office* it was stated that there should be no attempt to define a day-to-day activity but that “it is not directed to the person’s own particular circumstances, either at work or home”,<sup>54</sup> and this implies that there are objective ‘normal’ activities. Furthermore, it has been argued<sup>55</sup> that the medical model is endemic in international conceptions of disability, such as the World Health Organisation’s International Classification of Impairments, Disabilities and Handicaps, which defines disability as: “any restriction or prevention of the performance of an activity, resulting from an impairment, in the manner or within the range considered *normal* for a human being” (emphasis added)<sup>56</sup>. As Barnes says, the medical model means that people with impairments “become objects to be treated, changed, improved and made normal”<sup>57</sup>. This is reinforced by the need for the individual disabled person to find another ‘individual’ with whom to compare him/herself. On the other hand, a social model means that the focus is on the adaptation of attitudes, social structures and the physical environment to accommodate people who do not fall into the mould<sup>58</sup>.

48 In 2002, the most common reason for the failure of claims was the inability to satisfy the definition of ‘disability’ (Disability Rights Commission, *Disability Equality: Making it happen* (2003, Disability Rights Commission) p64).

49 K Wells, “The Impact of the Framework Employment Directive on UK Disability Discrimination Law” (2003) 32 No 4 ILJ 253 at 261.

50 E.g. *The Chronically Sick and Disabled Persons Act 1970 and the publicity surrounding the United Nations designation of 1981 as the International Year of Disabled Persons*.

51 This is exemplified by the fact that it was the World Health Organisation that produced the International Classification of Impairments, Disabilities and Handicaps in 1980.

52 M Oliver *Understanding Disability: From Theory to Practice* (1995, Basingstoke: Palgrave Macmillan).

53 *Ibid.*

54 [1999] IRLR 7, at 7.

55 K Wells, “The Impact of the Framework Employment Directive on UK Disability Discrimination Law” (2003) 32 No 4 ILJ 253

56 WHO 1980. (Sometimes language can be misleading: at the same time as writers such as Oliver have been striving to get away from society’s strictures on what is normal, there has also been a drive towards a process of ‘normalisation’, particularly towards those with learning disabilities, which has, in effect, been trying to achieve the same, see e.g. J O’Brien and A Tyne, *The Principle of Normalisation*, (1981, London: Campaign for Mentally Handicapped People).

57 C Barnes, *Disabled People in Britain and Discrimination*, (1991, London: Hurst & Co) p24.

58 C Barnes “A Working Social Model? Disability, Work and Disability Politics in the Twenty-First Century” (2000) 20 *Critical Social Policy* 221.

### Tackling discrimination – individuals, groups, everyone

In the context of sex and race discrimination, Lacey distinguishes between individuals and groups, pointing out that the individual norm is white and male (and in our case, not disabled), and further distinguishes between group rights that claim the right to be different, and those that see the aim to achieve remedial rights, where socio-economic disadvantage is the key<sup>59</sup>. Traditionally, disability rights have fallen into the latter group, although it is arguable that the right to be different is the better route as it has a more positive and empowering effect<sup>60</sup>. In the context of mental impairment this distinction is interesting. The right to be different can be particularly compelling, particularly amongst, say, people in creative jobs<sup>61</sup>.

Fredman's analysis of discrimination in the context of disability traces a progressive line from individual to universal rights<sup>62</sup>. Stressing the rights of the individual, she argues is part of the liberal ethic of rational self-interest that ignores more communitarian instincts and ignores the fact that individual merit is itself a social construct, implying that the individual should fit the job and not the other way round. Moving on to looking at minority group rights, she finds this inadequate, implying as it does discrete and insular groups united by a defining characteristic: a model that is unsuited to impairment in all its disparate forms. Fredman argues that universalism, where the range of the normal is widened and where differences are respected will promote universal access to all activities. Clearly we are a long way from this at present as both the Act itself and its interpretation<sup>63</sup> emphasise the normal and the abnormal dichotomy.

Arguably, therefore, a social model of disability together with a universalist approach via the principle of toleration, should be tempered by an approach that treats disabled people as non-disabled people should be treated: as unique individuals.

### Ill-health outside the Disability Discrimination Act 1995

The two main categories of people who are unprotected by the Act are those who have an existing health problem but cannot satisfy the definition of disability, and those who have no health problems now but who have had problems in the past (as we shall see, an issue of specific concern in relation to mental health)<sup>64</sup>. Such people are unprotected unless they have at least one year's qualifying employment to enable them to bring claims for unfair dismissal. Unfair dismissal claims can be brought if employees are dismissed on the basis that they are incapable of doing the job and in such circumstances the dismissal may be fair<sup>65</sup> as long as a fair procedure has been followed and as long as there is no other available job within the organisation that the employee could reasonably have been offered<sup>66</sup>. There is also a possibility

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59 N Lacey "From Individual to Group?" in B Hepple and E Szyssczak (eds) *Discrimination: The Limits of the Law* (1992, London: Mansell Publishing Ltd).

60 Note the potentially empowering effect of Marc Quinn's statue of a pregnant Alison Lapper in London's Trafalgar Square. Alison Lapper was born with no arms and shortened legs due to a chromosomal condition called Phocomelia. She was brought up in a care home and is now a recognized artist who was awarded an MBE in 2003.

61 See, e.g. a discussion of 'the creative voice' v 'the psychotic voice' by Maxwell Steer at <http://msteer.co.uk/analytical/creativotext.html>

62 S Fredman *Disability Equality and the Existing Paradigm*, pp 203–208, in A Lawson and C Gooding (eds) *Disability Rights in Europe*, (2005, Oxford: Hart).

63 See e.g. *A v London Borough of Hounslow* [2001] Emp LR 1255.

64 *O'Brien v Prudential Assurance Co Ltd* [1979] IRLR 140 EAT.

65 Section 98 (2)(a) *Employment Rights Act 1996*.

66 See e.g. *Links, A & Co Ltd v Rose* [1991] IRLR 353 Ct of Session.

of claiming unfair constructive dismissal if the employer breaches a term of the contract<sup>67</sup>. This could be a breach of an express term such as changing the job content or reducing pay, or it could be a case of breaching an implied term such as that of the obligation to maintain trust and confidence<sup>68</sup>. Nevertheless, until the 1995 Act, disabled workers had no protection qua disabled workers. The provisions of the *Disability Discrimination Act 1995* mean that disabled workers are afforded some job security in circumstances hitherto not available.

Ironically, the emphasis on a medical perspective in the Act, where protection is available from the time of applying for a job, is absent when looking at ill-health in the workplace that does not amount to a disability. Dismissal can take place on the basis that the employee is absent through ill-health and the more the medical evidence suggests that the person is incapable of doing the job concerned, the easier it is for an employer to dismiss. Only when the 'ill-health' is such as to amount to a disability does protection kick in.

## PART II – MENTAL HEALTH

### Mental health and employment

It is important to acknowledge that not only do people currently having mental health problems face difficulties in employment, but that previous mental ill-health can continue to give rise to prejudice and discrimination. There may, in the past, have been some form of mental condition which was disordered or thought to be disordered and, therefore, in need of treatment. In this case it will form part of the medical history of the person concerned about which s/he may be asked questions, either prior to being engaged or, as an enquiry prior to being offered a formal contract<sup>69</sup>. The case of *O'Brien v Prudential Assurance Co*<sup>70</sup> illustrates the difficulties that can arise. Mr O'Brien had a history of mental illness which included some hospitalisation, but at the time of making his job application he had not had any treatment or symptoms for over four years. The company's policy of not employing anyone with a history of mental illness if (as in this case) they would be visiting people in their own homes was reflected by a question on the application form and a question asked in person during the course of a pre-employment medical examination. The question asked whether he had ever consulted a psychiatrist or suffered from nervous or mental disorder. He answered in the negative, was offered and took the job and became respected for his work. The following year he applied for life assurance with the company and consented to the disclosure by his GP of his medical records. As a result of this disclosure he was dismissed on the advice of the company's senior medical adviser. Mr O'Brien's previous problems were a matter of fact and the suggestion that the tribunal should have taken into account the evidence of up to date medical evidence to the effect that he was no longer ill was rejected, and the tribunal found that it was a fair dismissal as the company policy was fair.

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67 Section 95(1)(c) of the *Employment Rights Act 1996* defines constructive dismissal as where: "the employee terminates the contract under which he is employed (with or without notice) in circumstances in which he is entitled to terminate it without notice by reason of the employer's conduct."

68 See *Gogay v Hertfordshire County Council* [2000] IRLR 703, where an unjustified suspension from duty caused

clinical depression and the claimant successfully claimed damages for personal injury flowing from the breach of the implied term.

69 See, for example, *Farnsworth v London Borough of Newham* [2000] IRLR 691.

70 [1979] IRLR 140.



Of course, O'Brien lost his job because of the dishonest response to a pre-employment enquiry. However, it was admitted by the company that had Mr O'Brien revealed his history of mental illness, he would not have been employed. The EAT said that if the employment had been of a different nature then it may not have been justifiable, either in terms of the enquiry itself or in terms of enforcement to the point of dismissal. O'Brien's case is over 25 years old and although the approach may be different now, it is likely that the same decision would be made. There is nothing to protect someone with a history of treatment for a mental health condition if they choose not to reveal it. Paradoxically, under the Act, if they have an existing rather than a past mental health condition they have a chance of bringing themselves within the ambit of protection.

### Mental health – special considerations

Terminology in this area is fraught with difficulty. It is important to move away from the notion that all mental 'conditions' that are not typical or conventional, are necessarily disabling, whilst at the same time acknowledging the prejudice, fear and misunderstanding that exists in relation to people who might have had treatment for a non-physical 'disorder'<sup>71</sup>. The expression 'disorder' is problematic in itself, with its implication some sort of order needs to be imposed or restored. Mental 'illness' often suggests psychosis<sup>72</sup>. Further, none of these expressions is appropriate in cases of learning disabilities. I try, therefore, to use the expression 'mental health', which has the disadvantage of medicalisation, but the advantage of referring to the positive of health rather than the negative of a medical condition.

Mental health issues particularly point up the division between the medical and social models. Firstly, mental health is harder to define than forms of physical health. It rarely has any physical manifestations and it is inevitably bound up with the personality of the person concerned. A mental health atypicality can be nothing more than a minor behavioural eccentricity,<sup>73</sup> yet it can have a significant effect on the person's interaction with others (in our case, in the workplace) in a way in which a minor physical atypicality would not even be noticed. Secondly, there might be concern that diagnosis of mental disorder is more woolly and uncertain than in the case of physical conditions. However, there is no real evidence for this save for the inevitable difficulty already mentioned that one's mental state is also about one's personality. Thirdly, there is a fear that people can more readily fake or embellish mental disorder than physical disorder and this has long been part of the debate in the context of civil liability for psychiatric damage. However, the Law Commission has reported on this area and concluded that fraudulent or exaggerated claims can be made in respect of physical conditions too and that this should not be a reason for treating them differently<sup>74</sup>. Finally, mental conditions are often linked to dangerousness in the eyes of the general public<sup>75</sup>. In this regard, note the O'Brien case and the policy of the insurance company in

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71 "I had a cleaning job for three years, but when I mentioned I had an appointment with a psychiatrist I received a letter the next week to say my services were no longer required." This is quoted in J Read and S Baker *Not Just Sticks and Stones: A Survey of the Stigma, Taboos and Discrimination experienced by People with Mental Health Problems* (1996, London: Mind) p 9.

72 *The Mental Health Act 1983 does not define mental illness, but many of the characteristics of psychosis were included in a consultative document prior to the 1983 Act (Department of Health and Social Security, Consultative Document on the Mental Health Act 1959, (1976, London: HMSO)).*

73 *A mild form of autism, say.*

74 *Law Commission Liability for Psychiatric Illness* (1998, London: The Stationery Office) para 6.7.

75 See National Centre for Social Research, *British Social Attitudes Survey 2006/07* (2007: Sage Publications: London). It should also be noted that arguably the adverse publicity surrounding the Michael Stone case ([http://news.bbc.co.uk/1/hi/in\\_depth/uk/2001/michael\\_stone\\_verdict/default.stm](http://news.bbc.co.uk/1/hi/in_depth/uk/2001/michael_stone_verdict/default.stm)) was at least part of the impetus behind the Government's attempts to do something radical about patients with personality disorder (see Home Office and Department of Health *Managing People with Severe Personality Disorder* (1999 Department of Health: London)).

excluding people who had received treatment for mental disorder from any jobs that entailed them visiting customers at home.

### Stigma and mental health

Stigma surrounding mental health issues arguably brings more socio-disadvantage than the problems that arise for the physically impaired. Some who have physical impairments, such as mobility problems are more acceptable in a social framework; the split between some of physically impaired people<sup>76</sup> and mentally impaired people is not unlike the split between the deserving and the undeserving poor that originated in the Victorian workhouses<sup>77</sup>. Indeed statistics bear out the emphasis on disability being associated with physical conditions<sup>78</sup> and the fact that those with mental health problems are categorised as being socially unworthy<sup>79</sup>. Yet despite this, it is acknowledged that even a period of short-term depression can have a seriously adverse effect on people's working life<sup>80</sup>.

Where the 'social' model of disability comes into its own is when examining issues of stigma, and, in particular, past episodes of mental health problems that are likely to attract as much discrimination as a current mental health problem, and, arguably, more so than a current physical health problem. These stigmatising conditions are much more akin to other aspects of people that attract prejudice e.g. skin colour, gender reassignment and so are deserving of exactly the sort of anti-discrimination protection that these have<sup>81</sup>.

## Mental health and the Disability Discrimination Act 1995

### The definition of disability

As we have seen, a person is disabled for the purposes of the Act if "he has a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities" and this impairment must have lasted for at least 12 months or be reasonably expected to last for at least that period or the rest of the person's life. The earlier provision that mental impairment had to arise from an illness which was 'clinically well-recognised' has now been removed to bring it into line with physical impairments where there has never been any such requirement<sup>82</sup>. This had been inserted on the basis that it would screen out "obscure conditions unrecognised by reputable clinicians"

76 It must nevertheless be acknowledged that some 'shocking' physical impairments can attract just as much stigma.

77 See D Lipsey "The National Wealth Service at [http://www.publicfinance.co.uk/opinion\\_details.cfm?News\\_id=26224](http://www.publicfinance.co.uk/opinion_details.cfm?News_id=26224)

78 52% of those surveyed did not think of someone with schizophrenia as being disabled, yet 31% regarded a person with a broken leg as being disabled. National Centre for Social Research, *British Social Attitudes Survey 2006/07* (2007, London: Sage Publications).

79 *Ibid.* More than 70% of people surveyed said that they would not feel comfortable living next door to someone with schizophrenia, and half would not want someone with depression as a neighbour.

80 Disability Rights Commission, *Disability Equality: Making it happen* (2003, Disability Rights Commission), p23. See also Office of the Deputy Prime Minister, *Social Exclusion Unit Mental Health and Social Exclusion* (2004,

Wetherby: ODPM Publications), and G Thomicroft *Shunned – discrimination against people with mental illness* (2006, Oxford: Oxford University Press), Chapter 3.

81 'Stigma' is well-recognised outside the context of discrimination. Defamation law depends upon its existence (a defamatory statement can be one that causes a claimant to be shunned and avoided; see *Villers v Monsley* (1769) 95 ER 886) and it has crept into the common law of employment, whereby a disadvantage on the job market due to a stigmatising association, has been held to be compensatable (*Malik v Bank of Credit and Commerce International SA* (In Compulsory Liquidation) [1997] 3 WLR 95).

82 Section 18 Disability Discrimination Act 2005. In *Dunham v Ashford Windows* [2005] IRLR 608 the EAT held that this requirement did not apply to learning disabilities.

or “moods and minor eccentricities”<sup>83</sup>. It will be suggested below that when this was re-examined by Parliament there was a missed opportunity to reform radically the particular issues surrounding mental health, and that the screening out of such things as minor eccentricities might not necessarily be wrong.

The DRC Review made two recommendations that are relevant for our purposes. Firstly, that the list of normal day to day activities should be revised to include “the ability to communicate with others” and to ensure that self-harming behaviour is covered<sup>84</sup>. These have not been acted upon. Secondly, the Review recommended that for those whose day-to-day activities are substantially affected as a result of depression the requirement that the effects last twelve months should be reduced to six months. They cited a number of cases where claims had failed because of an inability to satisfy the twelve month rule, for example, a case of a man who had attempted suicide and had his job offer withdrawn but whose claim failed as he could not establish that the substantial effects of his depression were likely to last twelve months or more<sup>85</sup>. This recommendation was not taken up when reforms were made. Direct discrimination raises issues of stereotyping<sup>86</sup>. For people affected by mental health problems this is particularly pertinent. As we have seen from the *O’Brien* case, protection is needed by people who have a history of mental health problems. Unfortunately, the protection offered by the Act on recurring and past disabilities still incorporates the definition of disability i.e. long term substantial adverse effect on carrying out normal day-to-day activities, so many people with mental health problems e.g. clinical depression, will not qualify as having a current, past or recurring disability.

## Discussion

As was stated in the Report of the Social Exclusion Unit, paid employment improves self-esteem and that can only have a beneficial effect upon mental illness<sup>87</sup>. The centrality of work to the lives of most of us is well-recognised among labour lawyers. For example Blanpain states:

*For the majority of citizens, work represents the best path to a meaningful way of life, affording them access to the market of goods and services, offering the possibility of making a positive contribution to their own family and to society at large, and providing enriched human contacts. It contributes to self-development, to the development of the human personality and objective and subjective human culture. In this view of things, unemployment comes to represent marginalization and exclusion. Indeed, work is a question of human dignity.*<sup>88</sup>

Given this, and the well-recognised disadvantages experienced by those who have had some spell of mental ill-health, and the even greater disadvantages of those workers or potential workers who have existing mental health problems that might not come within the ambit of the Act, there is a strong argument that, either the Act should be amended to take account of the special issues that have been under discussion, or mental health should be treated as a separate category of discrimination protection.

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83 As per William Hague, HC Deb Standing Committee E, col 71.

84 Disability Rights Commission, *Disability Equality: Making it happen* (2003, Disability Rights Commission), p 66.

85 *Compton v Bolton MBC*, Manchester Case No 2400819/00.

86 E.g. assumptions about typical male and female behaviour (see *Alexander v Home Office* [1988] 2 All ER 118 CA.

87 See also Office of the Deputy Prime Minister, *Social Exclusion Unit Mental Health and Social Exclusion* (2004 Wetherby: ODPM Publications) p 51.

88 R Blanpain, *The Changing World of Work*, in R Blanpain and C Engels *Comparative Labour Law and Industrial Relations in Industrialized Market Economies* (1998, The Hague: Kluwer Law International) p 23.

### Amending the Act

There might be considerable political resistance to extending the ambit of disability discrimination law. However, such objections would have to contend with the fact that there are two defences available to a claim: justification, and refusal to make adjustments that are not reasonable. There is a parallel situation in the context of indirect discrimination in other areas. For example, many employers can and do require employees to work shifts or unsocial hours. This can immediately give rise to claims that these work patterns have a disparate impact upon women who find it difficult to combine them with their traditional role of carers. However, as long as the work patterns are a proportionate response to a legitimate need, an employer has a defence. It is unfortunate, as has already been noted,<sup>89</sup> that, from the perspective of applicants this form of wording was not incorporated into the Act, but the fact remains that there are defences available to employers.

The most obvious reform is to make a past or present diagnosis of a mental health problem or a recognition of a learning disability, the same as a diagnosis of HIV or cancer. An objection could be raised that it would not necessarily be linked to a present or even a recurring medical condition. However, given that HIV is, in many cases, a 'bare' and symptom-free diagnosis, this objection is flawed. Furthermore, as mentioned above, the inclusion of severe disfigurement in the Act does not sit with the functional approach to disability, as there is no necessary connection between a person's ability to carry out activities of any sort and a disfigurement. There is, therefore, a precedent for such an inclusion.

It might be argued that to introduce this new category of protection would be to include an unacceptably large number of people. However, currently a diagnosis of cancer is sufficient for someone to be disabled under the Act<sup>90</sup>. This is despite the fact that many cancers are curable and many more are treatable over a very long period of time without significant impingement on the working lives of the persons concerned. Furthermore, one in three people will develop some form of cancer at some point in their lives<sup>91</sup>. The incidence of mental health problems is considerably smaller, whereby one in ten will be diagnosed as having a mental health problem and only a quarter of these will require specialist mental health services<sup>92</sup>. There could be no principled opposition to including this new category unless we wish to return to the deserving and the undeserving disabled dichotomy: people with cancer attract sympathy,<sup>93</sup> but as we have seen many people with mental health problems are stigmatised.

Furthermore, given that the proposal is to introduce a new special category of protection within the Act, the requirement that the diagnosis be of a 'well-recognised condition' could be re-established, but without the qualification that it must be 'clinically' recognised. Although the requirement was offensive in the original Act because the requirement was not applied to physical conditions, in practice, the undesirable results could be as a consequence of evidential problems in the conduct of specific litigation rather than of an underlying failure of principle<sup>94</sup>. Nevertheless, some might argue that it reinforces the medical model and that it harks back to the old accusations that malingering is easy and/or more prevalent in the context of mental health. On the first point, it might well do this, but we have already established that

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89 See the argument above under 'Reasonable adjustments'.

90 Schedule I section 6A(2) gives the Secretary of State power to make regulations to exclude minor cancers.

91 See Cancer Research website:  
<http://info.cancerresearchuk.org/cancerstats/incidence/risk/>

92 See the Mind website:  
<http://www.mind.org.uk/Information/Factsheets/Statistics/Statistics+>.

93 Although are not necessarily regarded as 'disabled'. National Centre for Social Research, *British Social Attitudes Survey 2006/07* (2007, London: Sage Publications).

94 As in *Morgan v Staffordshire University* [2002] IRLR 190, where the claim failed because there was no medical report available, despite the disclosure of GP records diagnosing depression and anxiety.

the medical model is reflected by the Act and to reject a reform that might help those who suffer from a prejudice<sup>95</sup> is cutting off one's medical nose to spite one's social face. Furthermore, this disparity of treatment could be dealt with by making the 'well-recognised' requirement apply to both physical and mental impairment<sup>96</sup>.

Moreover, it is arguable that by treating mental health in terms of social disadvantage only, rather than having had or currently experiencing a treatable condition on a par with a physical condition, one is being patronising and refusing to treat the persons concerned as being able to control and develop their own lives<sup>97</sup>. In any event, those with physical conditions can fall foul of difficulties in diagnosis<sup>98</sup>.

The strongest argument, however, is one that disposes of the above argument and the suggestion that malingering is easy where mental health is concerned. This is that well-recognised diagnostic criteria are already implicit in the inclusion of HIV, cancer and multiple sclerosis at the point of diagnosis i.e. when the recognised diagnostic criteria of these conditions have been satisfied.

Arguably, it could be said that this is further pandering to the medical model. However, the expression 'well-recognised' is not restricted, either in physical or mental impairment, to ill-health models. It could be clinically recognised or recognised by other means. Even under the old structure it was not necessary for learning disabilities to be clinically well-recognised<sup>99</sup> and some conditions require no medical involvement at all, let alone a formal clinical diagnosis. No medical training is necessary to recognise the fact that someone has no legs; nor would it be appropriate to regard such a person as being unhealthy. The same can be said of disfigurement. The criticism inherent in the medical versus social models is that there is a suggestion that the impaired person is abnormal and therefore only to be accommodated if relatively easy to do so. On the other hand, Wells has argued that there has to be some form of impairment, otherwise the protected group will extend to anyone who is socially disadvantaged<sup>100</sup>. Note, however, that there is scope for a very wide interpretation of impairment, e.g. Mabbett has argued that someone who has a skill deficiency caused by lack of educational facilities should be seen as having an impairment<sup>101</sup>. Certainly, just as severe disfigurements can be regarded as impairments, so can stigmatisation.

### **A new discrimination category?**

A more radical proposal would remove mental health issues from the Act's framework all together and treat them as a separate category of discrimination. There is precedent for this in both the protection from discrimination on the ground of gender reassignment and sexual orientation. Although the European Court of Justice had specifically included gender reassignment as an aspect of sexuality that was protected by European sex discrimination provisions<sup>102</sup> the government made it clear beyond doubt by introducing

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95 *Of course the proposed reform is not just about protecting against this prejudice; it is about protecting against those who draw unjustifiable conclusions about a person's mental health such as the assumption of dangerousness.*

96 *Tribunals in any event emphasise the need for medical evidence. See, for example, the Court of Appeal judgment in McNicol v Balfour Beatty Rail Maintenance Ltd [2002] EWCA at paragraph 26.*

97 *See N Cobb "Patronising the mentally disordered? Social landlords and the control of 'anti-social behaviour' under the Disability Discrimination Act 1995" (2006) Legal Studies Vol 26 Issue 2 238, in which he argues that the*

*Act patronises the mentally disordered by overly protecting them.*

98 *In Millar v Commissioners for HM Revenue and Customs [2006] SC 155 the appellant's claim failed when he could not establish a physical cause of his physical symptoms.*

99 *Dunham v Ashford Windows [2005] IRLR 608.*

100 *K Wells, "The Impact of the Framework Employment Directive on UK Disability Discrimination Law" (2003) 32 No 4 ILJ 253 at 261.*

101 *D Mabbett "Why have disability categories in social security?" (2003) Benefits 11 (38) 163.*

102 *P v S [1996] All ER (EC) 397.*

specific legislative protection<sup>103</sup>. This is a good example of a social inclusion of persons who may be significantly stigmatised. Similarly, although the European Court would not interpret 'sex' to include sexual orientation (inconsistently, but no doubt with policy in mind<sup>104</sup>) the subsequent Framework Directive recognises that (inter alia) sexual orientation is a valid category for protection<sup>105</sup>. Gay people suffer from prejudice and as a result can be disadvantaged in the workplace. To introduce a new mental health protected interest has a particular resonance because of both the old medical<sup>106</sup> and general social attitudes towards homosexuality; it would be a further step away from flawed, prejudiced thinking.

The Government is concerned about social inclusion and has stated the aim of ensuring that health and social services should promote mental health for all and should combat discrimination and social exclusion associated with mental health problems<sup>107</sup>. There is no doubt that mental health problems can exclude people from the mainstream of society and from rewarding and empowering work. This article has suggested ways in which this might be avoided.

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103 *The Sex Discrimination (Gender Reassignment) Regulations 1999* SI 1999/1102 inserted new s 2A and 7B into the *Sex Discrimination Act 1975*.

104 *Grant v South-West Trains* [1998] All ER (EC) 193. By 'policy' I mean that the court may well have had an eye on the prevalence of homosexuality compared with that of transsexualism.

105 *EC Framework Directive 2000/78/EC, and the Employment Equality (Sexual Orientation) Regulations 2003* SI 2003/1661.

106 Until 1973, the American Psychiatric Association actually classified homosexuality as a form of mental illness. See [http://www.psych.org/psych\\_pract/copptherapyaddendum83100.cfm](http://www.psych.org/psych_pract/copptherapyaddendum83100.cfm)

107 Standard 1, *National Service Framework for Mental Health: Modern Standards and Service Models* (1999, Department of Health).



# Casenotes

## *Human Rights and the Provision of Residential Care under the National Assistance Act 1948*

Ralph Sandland<sup>1</sup>

YL v Birmingham City Council and Others

House of Lords 20 June 2007

[2007] UKHL 27

### Introduction

The 'Welfare State' was established in the 1940s to provide health, housing, education and welfare services 'from the cradle to the grave'<sup>2</sup> to those in need. One key piece of welfare state legislation was the *National Assistance Act 1948*, which required the provision of a broad swathe of welfare services by local authorities. In particular, section 21(1)(a) of the 1948 Act placed a duty on local authorities to provide residential care for those in need by reason of age or ill health (and later also disability), or for any other reason, if the required care and accommodation was 'not otherwise available to them'. Such accommodation, which was and remains means-tested (section 22), could be provided by the local authority in question or it could draw on the resources of another local authority or a voluntary organisation (sections 21(4) and 26 of the 1948 Act), in which case the local authority with responsibility would pay the provider direct and then recoup any means-tested contribution from the person provided with the accommodation.

The policies implemented in the 1940s enjoyed bipartisan political support (at least in public) until the time of the Conservative administration of the 1980s and early 1990s, at which time there was a significant recasting of the relationship between the public and private sectors, with the introduction of a 'mixed economy of care'. To this end the *National Health Service and Community Care Act 1990* made significant changes to the 1948 Act. Now, the duty of a local authority is to 'make arrangements for providing' care and accommodation rather than having to provide it (although that remains a possibility: section 21(4)), and local authorities could henceforth utilise private providers of care and accommodation (section 26(1A)). In subsequent years the role of the private sector grew exponentially and these days it provides most residential care.<sup>3</sup>

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1 Associate Professor, School of Law, Nottingham University.

2 See Sir William Beveridge (1942) *Social Insurance and Allied Services* Cmd 6404.

3 See Bartlett P and R Sandland (2007) *Mental Health Law and Policy* (Oxford: OUP, 3rd edition) 66–67.

In part, the 1990 Act was a pragmatic response to the problem of under-supply of local authority or voluntary sector accommodation, which had led to a situation in which many persons had been accommodated in privately-run care homes with the costs of that accommodation met, at great expense to the public purse, through the benefits system; or as long-term patients in psychiatric hospitals, again at considerable expense. In either case, it was far from clear that the services provided were in the best interests of the client or constituted the best use of public funds<sup>4</sup>.

However, such pragmatic considerations were underpinned by an ideological agenda to 'roll back the frontiers of the state'. At stake was the question of the proper responsibilities of the state for its vulnerable citizens and, as Lord Neuberger noted in *YL v Birmingham City Council*, 'unattractive as it may be to some people, one of the purposes of contracting-out at least certain services previously performed by local authorities may be to avoid some of the legal constraints and disadvantages which apply to local authorities but not to private operators'. [152] This question was given a new impetus when the *Human Rights Act 1998* came into force, because now the 'legal constraints' that might be avoided by contracting out might include the Convention rights brought into UK law by that Act, which are inescapable by a government body, or, in the terminology of section 6(1) of the 1998 Act a 'public authority'.

Whether this was so is not, however, clear on the face of the Act, because although section 6(1) provides that 'It is unlawful for a public authority to act in a way which is incompatible with a Convention right', the scope of the concept of a 'public authority' was left to be defined by the courts. Section 6(3)(b) provides that, in addition to government bodies (often referred to as 'core' public authorities for these purposes) a public authority includes 'any person certain of whose functions are functions of a public nature' although this must be read together with section 6(5), which states that 'In relation to a particular act, a person is not a public authority by virtue only of subsection (3)(b) if the nature of the act is private'. Those caught by section 6(3)(b) have come to be known as 'hybrid' public authorities, a phrase which attempts to capture the part public, part private, nature of the persons or bodies in question. In the years since 2000, the courts have adjudicated on the meaning and effect of these provisions in the context of the 1948 Act on a number of occasions, the most recent of which is the *YL* case, decided in June 2007, which is the subject of this note.

## The Facts

Shortly after New Year, 2006, *YL*, who was 84 years old and suffered from Alzheimer's disease, moved into a care home run by Southern Cross Ltd ('SC'), her husband (83 years old) and her family being unable to provide her with care at home any longer. Her placement was arranged, and largely funded, by her local authority ('LA'), in the performance of its duties under the Acts of 1990 and 1948. The placement involved various legal agreements. A care home placement agreement, the parties to which were the LA, SC, and *YL*, detailed the obligation of SC to provide care and accommodation to *YL*, *YL*'s obligation to pay (a 'top-up fee') to the LA, and the LA's obligation under its contract with SC, and towards *YL* as required by the 1990 Act. A further agreement involving all three parties detailed the specific terms under which *YL* was to be accommodated by SC. This provided that SC could give *YL* four weeks notice to quit the accommodation if, inter alia, in the opinion of SC, *YL*'s continued residence was 'seriously detrimental to the home or the welfare of other residents'.

There was also a service provision contract between the LA and SC, under the terms of which SC agreed

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<sup>4</sup> Griffiths R, (1988) *Community Care: Agenda for Action* (London: HMSO).

to provide care and accommodation for residents placed with them by the LA, with the LA to pay an agreed price per resident (60 of the 72 residents in the accommodation in question and 80% of the 29,000 residents accommodated by SC nationally were placed by local authorities under section 26(1A) of the 1948 Act). Further terms required that SC could give a person placed in its care home notice to quit 'only for a good reason', and that SC and its employees would act at all times in a way compatible with the Convention rights detailed in the *Human Rights Act 1998*.

In June 2006 YL was given notice to quit by SC because it alleged that YL's husband and daughter were a disruptive influence in the home, although this was disputed. The Official Solicitor, on hearing that notice to quit had been given to YL, sought declarations from the High Court in respect of her best interests and the applicability of the 1998 Act to her case (if the Act was held to apply, YL's Article 8 rights would be at issue, along with those of her husband, who visited her every day). This latter question was heard as a preliminary issue. The High Court and subsequently the Court of Appeal held that SC was not performing 'functions of a public nature'. YL appealed to the House of Lords.

## **The Decision**

The House of Lords also held, by a majority of three to two, that SC was not performing functions of a public nature and hence YL had no direct cause of action against SC under the Human Rights Act. The majority comprised Lords Scott, Neuberger and Mance, with Lord Bingham and Baroness Hale in the minority.

## **The Majority**

Each member of the court gave a separate judgment, of varying degrees of length, breadth, and complexity. However, there is a good deal of common ground between the Opinions of the majority. For each of them, the starting point was that the provision of care home accommodation by a private company to a self-funding resident for profit is a private act. [Lord Mance at 115 and Lord Neuberger at 133, Lord Scott at 27]. All three were also concerned that if it was held that SC was performing functions of a public nature, the floodgates might thereby be opened. For Lord Scott, for example, if an outside contractor is engaged by a LA to provide cleaning, catering or other essential services, it would be 'absurd' to view the provision of such services as comprising the performance of 'functions of a public nature' and 'The owner of a private care home taking local authority funded residents is in no different position'. [27] 'Where', his Lordship asked rhetorically, 'does it end?' [30] Much the same view was expressed by Lords Mance [82] and Neuberger. [164] A second obvious problem was that, given that the relationship between self-funding residents and a private provider does not entail the performance of a function or act of a public nature by the latter, then to hold that it did in the case of LA-funded residents would create an anomalous situation whereby those residents, but not self-funders, would be protected a priori by Convention rights. [Lord Mance at 117, 119, Lord Neuberger at 169]

However, the crux of the issue is the meaning of, and approach taken towards, the phrase 'functions of a public nature'. Lord Mance started by accepting the point made by Oliver,<sup>5</sup> that, in his Lordship's words, 'it is a fallacy to regard *all* functions and activities of a core public authority as inherently public in nature' [110]. This view, which must in general terms be correct, is based on an analysis of the structure of section 6 of the 1998 Act. Section 6(1) applies to all functions and acts of a core public authority, irrespective of whether they could be classified as 'public' or 'private', so that it cannot be assumed, merely on the basis

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5 Oliver D, (2004) 'Function of a public nature under the Human Rights Act' *PL*. (Sum) 329–351 at 336.

that a function or act is performed by a core public authority, that it is public. And for Lord Mance 'I do not regard the actual provision, as opposed to the arrangement, of care and accommodation for those unable to arrange it themselves as an inherently governmental function'. [115] This is because 'In contrast with the position relating to the national health service, the default position is one in which the local authority is not involved'. [115] In the same vein, Lord Neuberger expressed his view, that 'the services provided in this case are very much of a personal nature'. [168]

Interestingly, Lord Scott, making up the majority, seems not to have taken the same approach. Although stating that the act of giving YL notice to quit 'affected no one but the parties to the agreement. I do not see how its nature could be thought to be anything other than private', [34] and therefore excluded from section 6(3)(b) by virtue of section 6(5), he also seemed to accept that where accommodation is provided by a LA in-house that 'is unquestionably a function of a public nature'. [20] He reached the same conclusion as Lord Mance, however, because in his view there are 'very clear and fundamental differences' [29] between in-house and contracted out accommodation provision, viz. that the LA acts pursuant to statutory duties imposed by public law whereas a private provider does not. It is submitted that the analysis of Lord Mance is, in principle, to be preferred on this point. It must be correct that not every act or function of a LA is necessarily 'public'. On the other hand, it is debatable whether Lord Mance is correct in this instance. There is a good argument to be made, and which was in fact made by both minority Opinions (see below), that although some functions or acts of an LA are not public, those functions connected to the duties in the 1948 Act are not examples of that.

In either case, this would seemingly be enough to dispose of the appeal, but all members of the majority gave further consideration to the test appropriate for distinguishing public from private functions. This question has been raised in earlier caselaw. In *Poplar Housing and Regeneration Community Association Ltd v Donoghue*<sup>6</sup> D had been given a weekly non-secure tenancy by a LA pending its assessment of whether she was entitled to social housing on a more permanent basis by reason of being homeless, or whether, as intentionally homeless, she did not qualify for such housing. Whilst D's tenancy was still existent, the LA transferred the property in question to the appellant, a housing association which it had created to manage a good proportion of its housing stock. It was later decided that D was not intentionally homeless and the association sought an order for possession.

The pertinent issue was whether the housing association was a public authority for these purposes. Lord Woolf CJ, giving the unanimous judgment of the Court of Appeal, held that it was. Although of the view, not interrupted by any of the later caselaw, that 'The fact that a body performs an activity which otherwise a public body would be under a duty to perform cannot mean that such performance is necessarily a public function', [67] Lord Woolf reached his conclusion that the housing association was performing a function of a public nature because 'the role of Poplar [the housing association] is so closely assimilated to that of Tower Hamlets [the local authority]' [70] on the particular facts of the case<sup>7</sup>. The problem with this, in terms of statutory interpretation, is that although discussing the nature of the function, the court actually decided the case by reference to altogether different criteria, concerned with the nature of the relationship between the LA and the contractor. The decision was criticised on this basis by Oliver<sup>8</sup>, and in YL, both Baroness Hale [61] and Lord Mance [105] specifically overruled *Donoghue*

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6 [2001] EWCA Civ 595, [2002] Q.B. 48.

7 The court emphasised that 'Poplar was created by Tower Hamlets to take a transfer of local authority housing stock; five of its board members are also members of Tower

Hamlets; Poplar is subject to the guidance of Tower Hamlets as to the manner in which it acts towards the defendant'. [70]

for precisely this reason. The tests in section 6, in short, are functional not relational: and the nature of the function in question does not change whether performed by the LA or by a private contractor<sup>9</sup>. [Lord Mance at 110]

This was confirmed in the later House of Lords decision in *Aston Cantlow and Wilmcote with Billesley Parochial Church Council v Wallbank*<sup>10</sup>. The facts of this case need not detain us here, but what is relevant is the approach to determining whether a function is public that was elaborated by Lord Nicholls, which was utilised by both the majority and minority in *YL*. His Lordship held that there could be no simple test for determining whether a person or body is performing functions of a public nature. Instead, he endorsed a factor-based approach, elaborating that

*Factors to be taken into account include the extent to which in carrying out the relevant function the body is publicly funded, or is exercising statutory powers, or is taking the place of central government or local authorities, or is providing a public service* [12, cited by Lord Mance at 91]

However, the presence of one or more of these features is not necessarily decisive. For example, Lord Mance explained, statutory powers may have been bestowed on the person or body in question ‘for private, religious or purely commercial purposes’. [101] Instead, ‘it is necessary to look at the context in which, and basis on which, a contractor acts’ rather than ‘to look at what a contractor ‘does’ [102]. This is potentially confusing, as a little later in his Opinion Lord Mance emphasised that ‘In every case, the ultimate focus must be upon the nature of the functions being undertaken’, [105] but his meaning is fairly clear. It is not that what a contractor does is irrelevant, but rather, that what the contractor does is to be assessed by reference to the context in which those functions or acts are done. He gave the example of a private firm engaged by a LA to enforce road traffic laws on the public highway compared with the same firm being employed by a private person or indeed by a LA to enforce parking restrictions on private land [102]: in the former case the firm will be performing a function of a public nature, in the latter it will not.

Applying Lord Nicholls’ approach led each member of the majority to the conclusion that SC was not performing functions of a public nature. First, SC was not publicly funded. Lord Mance distinguished the situation under which the capital support for a venture undertaken by a non-governmental body is wholly provided by the state, from ‘payment for services under a contractual arrangement with a company aiming to profit commercially’. [105] Lord Neuberger made a similar distinction, [149] as did Lord Scott, holding bluntly that ‘It is a misuse of language and misleading to describe Southern Cross as publicly funded’. [27] Secondly, SC was not exercising any statutory powers in providing *YL* with care and accommodation. [Lord Mance at 84, 104 and 121, Lord Neuberger at 150, 160 and 166, Lord Scott at 28] Thirdly, SC was not in any way standing in the shoes of the LA because the 1948 Act in its present form ‘is deliberately phrased in terms of a duty on the local authority to make arrangements. That duty never passes to the care home, which does no more than provide care and accommodation under contract’ [Lord Mance at 113, see also Lord Neuberger at 147] and therefore the involvement of the LA in arranging and paying for *YL*’s accommodation by SC does not convert SC’s function from private to public. [139] The fourth consideration – whether SC is performing a public service – has already been discussed above. The majority conceptualised SC as engaging in private acts rather than providing a public service. The provision of residential accommodation for the vulnerable, who otherwise would not have that need met,

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8 *Op. cit.*, n.5, at 336.

10 [2004] 1 AC 546.

9 Craig P, (2002) ‘Contracting Out, the Human Rights Act and the Scope of Judicial Review’ 118(Oct) *LQR* 551-568 at 556.

is of course, generally speaking, in the public interest, but it does not follow 'as a matter of logic or policy' [135] that the provider is therefore performing a public function. This also explains why the fact that private providers are closely regulated by the *Care Standards Act 2000* does not imply that they are performing a public function. If anything, according to Lord Mance, [116] it implies the contrary.

### The Minority

In a relatively short judgment, Lord Bingham applied the *Aston Cantlow* criteria as had the majority, but doing so compelled him to the opposite conclusion. [4–10] For him, for example, the distinction between 'arranging' and 'providing' on which the majority had placed so much emphasis, was 'not...very significant' [16] because for Parliament the important thing is that necessary accommodation and care is provided 'but the means of doing so is treated as, in itself, unimportant'. [16] What matters is that 'By one means or another the function of providing residential care is one which must be performed'. [16] Also significant was the detailed statutory and regulatory control of providers, [17] and the fact that the state would pay if the service user was unable to do so, as 'It is indicative of a function being public that the are public are, if need be, bound to pay for it to be performed'. [18] In his view, a consideration of the context did not point towards the importance of commercial principles, but rather towards the vulnerability of those who have recourse to care home accommodation, and the risks that such vulnerability might leave residents open to abuse. For Lord Bingham 'These risks would have been well understood by Parliament when it passed the 1998 Act... it can scarcely be supposed that residents of privately run care homes, placed in such homes pursuant to sections 21 and 26 of the 1948 Act, would be unprotected'. [19] In particular, section 6(3)(b) was in his view 'clearly drafted' [19] to ensure that the modern policy of contracting out did not alter the broader policy on the provision of residential care which, 'for the past 60 years or so... has been recognised as the ultimate responsibility of the state'. [15]

Baroness Hale also applied the *Aston Cantlow* criteria, and like Lord Bingham, found that they 'tell heavily in favour of section 6(3)(b) applying in this case'. [65] The salient points for the Baroness were that the state has undertaken responsibility for ensuring that the services in the 1948 Act are provided, and in her view that renders it 'artificial and legalistic to draw a distinction between meeting those needs and the task of assessing and arranging them'. [66] The public interest in having these functions carried out, and the fact that they are, where necessary, publicly funded were also telling factors, [67, 68] as was the possibility that any person in receipt of residential care and accommodation by reason of mental disorder (such as Alzheimer's disease) is 'potentially vulnerable to detention under section 5 of the Mental Health Act 1983', [69] and 'The use or potential use of statutory coercive powers is a powerful consideration in favour of this being a public function'. [70] The fact that some people make and fund their own arrangements for care and accommodation does not mean that when others avail themselves of the state's willingness to undertake responsibility the state should be relieved of its obligations, including those voluntarily accepted under the terms of the Convention. In summary, this meant that SC was performing a function of a public nature and its acts in pursuit of this function were also public. [73]

For Baroness Hale this analysis of section 6(3)(b) chimed with its intended purpose. She referred, amongst other things, to the White Paper that preceded the 1998 Act,<sup>11</sup> which provided that it was the Government's intention that the Act should apply to 'companies responsible for areas of activity which were previously within the public sector', [54] and to the explanation of the scope of the legislation as it made its way through the legislative process given in Parliament by the then-Home Secretary Jack Straw,

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11 Home Office (1997) *Rights Brought Home: the Human Rights Bill* Cm 3782.



who said<sup>12</sup> that the Human Rights Act utilised a definition of a public authority which ‘took account of the fact that, over the past 20 years, an increasingly large number of private bodies, such as companies or charities, have come to exercise *public functions* that were previously exercised by public authorities’ (my emphasis).

## Discussion

When the House of Lords decides a case by a majority of one it is as a general rule fair to assume (i) that the case could have gone either way, and (ii) the fact that it went one way and not the other is more a matter of preference and politics than of legal interpretation. Indeed, something very close to this was frankly admitted by Lord Neuberger. [128] And if this is so, then the judicial recourse to statutes, precedent, and principle is to engage more in rhetoric than in logic or objective analysis. This much, I would suggest, is evident from the very different use made by the majority and the minority of the *Aston Cantlow* criteria, which seems to suggest that meaning is imposed on, rather than residing in, section 6 of the 1998 Act, and the difference of approach is explicable in terms of the underlying sympathies of the members of the House.

Lord Bingham, as noted above, situated his judgment in the context of the 60-year history of the welfare state, and Baroness Hale similarly spent quite some time discussing the history of the 1948 Act, the welfare state more generally, and the philosophy behind it. [49–53] Their conclusion on the law was rooted in that welfarist history. The majority, by contrast, had their eyes firmly on the present. Lord Mance, although seeing fit, tellingly, to refer approvingly to the famous historical figure and advocate of the free market, Adam Smith, [105] cut the modern law off from its history (still evident on the face of the legislation: section 21 of the 1948 Act continues to be headed ‘Duty of local authorities to provide accommodation’ for example), holding that ‘it is appropriate to focus on the modern form of the 1948 Act’ [114], and was concerned that to impose ‘public authority’ status on privately run care homes ‘fit[s] in my view uneasily with the ordinary private law freedom to carry on operations under agreed contractual terms’. [116] In other words, his approach is underpinned by an affiliation to free market principles, and rests on his view that ‘I do not regard the actual provision... of care and accommodation... as an inherently governmental function’, [115] a sentence which contains a conclusion which functions also as a point of departure or which, in other words, is entirely circular and self-serving. I do not mean to single out Lord Mance in particular: rather my point is that the same is true of all the Opinions handed down, both by the majority and the minority.

There are some points, however, which are less a matter of opinion than others. For the majority, the outcome was not a defeat for human rights because of the clause in the service provision contract between the LA and SC which obliged SC to act at all times in a way compatible with the human rights of those placed in its care by the LA. Lord Scott, pointing out that ‘No one has suggested that the contractual arrangements [in this case] are not typical’, held that in the light of those terms there is ‘no need to depart from the ordinary meaning of “functions of a public nature” in order to provide extra protection to YL and those like her’ (note the clever sentence construction, with its self-serving use of the word ‘ordinary’) as ‘any breach by Southern Cross of YLs Convention rights would give YL a cause of action for breach of contract under ordinary domestic law’. [32] However, not only are there significant doubts about the degree to which such a term, in the contract between the LA and SC, is enforceable by

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<sup>12</sup> *Hansard (HC)* 16 February 1998, column 773.

a third party, here YL, notwithstanding the passage of the *Contracts (Rights of Third Parties) Act 1998*,<sup>13</sup> but also in contract law the default remedy for breach is damages, which is not obviously the remedy that someone in YL's position would want, and which is remedial rather than preventative, as the *Human Rights Act 1998* is intended to be, and which may on a cost-benefit analysis by a provider be deemed worth paying.

Moreover, it belies the reality of the position of significantly intellectually disabled and vulnerable clients like YL to imagine that the lodging of a claim for breach of contract will easily be within their competence. The contract model assumes an 'equality of arms' (to use the contract lawyer's tellingly militaristic and conflict-model based metaphor) that is, in reality, often likely to be missing. It is true that a resident in privately provided residential accommodation retains his or her human rights as against the LA which owes them the duty to arrange accommodation, but as Lord Neuberger candidly accepted, these 'could be of somewhat less value in practice than if they existed against the proprietor' [149] because, for example, the LA may not be able to prevent actions by the contractor which breach a resident's Article 8 rights in relation to a particular home, and it will be difficult to show that the action of the LA, in placing a service user in a particular private home, was in breach of Article 8<sup>14</sup>. To put this differently and perhaps more starkly, the effect of the decision in this case is that not only do those accommodated on a contracted-out basis have no Convention rights directly exercisable against those responsible for their care, but also the efficacy of their still existent Convention rights as against the LA is also thereby decreased. This 'double whammy' might strike some as problematic.

The 'anomaly' point, relied on by the majority, although not without substance, is itself to an extent anomalous. As discussed above, for the majority it would be anomalous if different residents in the same home had different rights according to their status as LA-funded or self-funded. The majority was of course not unaware that its decision created an anomaly of a different kind, between those in LA provided accommodation who have directly enforceable Convention rights against the managers of their day to day care and those in privately provided accommodation who do not, but for Lord Neuberger, to distinguish between residents in the same home would be 'rather more of an anomaly', [169, see also Lord Mance at 119].

There are two points to be made in response. First, if it has become, or becomes, routine for LAs to write an obligation to protect the human rights of LA-funded residents into their contracts with providers, this is likely, as Baroness Hale suggested, to increase the human rights protection of all residents. Lord Mance suggested that the outcome reached by the minority might mean that self-funders are treated less well than those funded by a LA when it comes to making difficult decisions, for example, about which wing of a home to close [117]. But this is (wrongly) to assume that care homes house residents differentially by reference to the source of their funding, which is simply not the case: as Lord Scott noted, the source of a resident's funding 'is of no concern to the care home'. [29] Given this, it is not feasible to have a policy of acting in accordance with the human rights of some but not all residents. It is much easier to construct a policy which applies across the board. This would also neutralise any cost differences as between LA-funded and self-funding residents, as well, of course, as giving due respect to the importance of human rights protection to the vulnerable.

Secondly, it is disputable which is the greater anomaly in terms of the policy of the 1990 Act, to promote

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13 Donnelly, C (2005) 'Leonard Cheshire Again and Beyond: Private Contractors, Contract and S. 6(3)(b) of the Human Rights Act' *PL. (Win)* 785–805.

14 *R (Heather) v Leonard Cheshire Foundation* [2002] EWCA Civ 366; [2002] 2 All E.R. 936 provides an example of exactly this situation.

a 'seamless' community care service. The position adopted by the minority at least has the virtue that the line is drawn between those in receipt of community care provided by the state and those who are not, whereas the line drawn by the majority renders that policy far from seamless by linking the rights of community care service users to the technical status of their accommodation, as LA or privately provided. This might make sense to a lawyer but I for one would not like to have to explain this situation to a community care service user placed by a LA in private accommodation, for whom these technical questions are, as Baroness Hale rightly observed 'artificial and legalistic'. [66]

There were some points on which all members of the House were agreed. Where the performance of a duty owed by a public authority is delegated to a private person or body, the latter will fall within section 6(3)(b). There was also agreement that section 6(3)(b) will also catch a private person or body who is given 'special statutory powers over residents entitling them to restrain them or to discipline them in some way or to confine them to their rooms or to care home premises', [Lord Scott at 28] even if there was no unanimity on what might constitute such coercion (for what it's worth, Baroness Hale's point, that there is real potential for coercion in the, sometimes implicit, threat of being 'sectioned' under section 5 of the *Mental Health Act 1983* is absolutely valid, even if the law cannot see the coercion)<sup>15</sup>. Thus, it was common ground that privately run prisons or psychiatric facilities which accept detained patients under the *Mental Health Act 1983*<sup>16</sup> (or as amended by the new *Mental Health Act 2007*, when in force) are public authorities for this reason. It also seems likely that psychiatrists who refuse to accept a detained patient discharged by a tribunal would be held to be performing functions of a public nature on the same basis<sup>17</sup>.

Oliver has argued that a test based on the presence of coercive powers is 'the only workable test for "function of a public nature"',<sup>18</sup> and it would appear that this is also the view of the majority in *YL*. This, I would suggest, points to the main objection against the approach of the majority. It is a political not a legal objection, and it is that the majority constructs the state as the locus of coercion but not of care: care, it seems, is a private act, even if performed by a public authority. But is the uncaring state the state we want? I would hope and suggest not.

Is it worth taking this case to Strasbourg? There is in fact a good deal of discussion of Strasbourg caselaw in *YL*, particularly on the part of Lord Mance, and to a lesser extent Lord Neuberger and Baroness Hale, because in *Aston Cantlow* the House had held that the 1998 Act was passed to make available in the UK the same, but no greater, rights than would be available in Strasbourg; and hence it should be possible to determine the intended reach of section 6(3)(b) by looking at the caselaw before the European Court of Human Rights. Not surprisingly, Lord Mance and Lord Neuberger found that that caselaw supported their interpretation of section 6(3)(b) whilst Baroness Hale found that it supported hers. I do not intend to undertake an analysis of their respective positions here, other than to note that students of mental health law are not strangers to the situation in which an applicant succeeds before the European Court having failed before the House of Lords,<sup>19</sup> and that section 2(1)(a) of the 1998 Act requires the domestic courts to 'take into account' the jurisprudence of the Strasbourg court but that does not prevent, as has been accepted as part and parcel of the 1998 Act since its inception, human rights jurisprudence developing more quickly and reaching further in the domestic courts than in Strasbourg.

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15 *Op. cit.*, n.3, at 112–114.

16 See *R (A) v Partnerships in Care Ltd* [2002] EWHC 529 (Admin); [2002] 1 W.L.R. 2610; [2002] M.H.L.R. 298, approved by Baroness Hale [65] and Lord Mance. [121].

17 This point was left open by the appellate courts in *R. (IH) v SSHD and SSH* [2002] EWCA Civ 646 (CA), [2003] UKHL 59 (HL).

18 *Op. cit.*, n.5, at 337.

19 *HL v UK* (2004) 40 EHRR 761.

## Concluding Comments

Some readers may feel that Baroness Hale's reference to the intentions of the Government in passing the 1998 Act should have been treated as decisive: section 6(3)(b) was intended to catch private care homes and so that it is what the courts should hold. However, the majority avoided addressing this point, holding that it had been determined in *Aston Cantlow* that reference to Hansard on this question is not permissible, [89] which gave them the space to arrive at the opposite conclusion. It is unfortunate that such legalistic and technical devices should be deployed in relation to such important matters of social policy. Moreover, it seems arbitrary and anti-democratic that important questions such as this should be left to be decided in an almost random way by the courts. A differently staffed House of Lords may have come down on the side of the minority, and the implications of this case for thousands of care homes and hundreds of thousands of residents in such homes would then have been very different.

## ***The Re-call of Conditionally Discharged Patients – the breadth of the Secretary of State’s discretion.***

**Roger Pezzani<sup>1</sup>**

**R (on the application of ‘MM’) v Secretary of State for the Home Department**  
**Court of Appeal; 6 July 2007**  
**[2007] EWCA Civ 687**

### **Introduction**

This decision of the Court of Appeal addresses the circumstances in which the Secretary of State may lawfully exercise his discretion in section 42 of the *Mental Health Act 1983* (MHA) to recall to hospital a patient who has been conditionally discharged from detention for treatment.

### **The Facts**

MM suffers from paranoid schizophrenia. He has a history of drug abuse. In May 1996 he was convicted of an offence of unlawful wounding: he believed that the victim was having an affair with his girlfriend, and had struck him on the leg with a hammer. MM was detained for treatment in hospital pursuant to section 37 MHA with a restriction order being imposed under section 41 MHA.

In June 1997 MM was conditionally discharged by a Mental Health Review Tribunal. The history of MM’s subsequent admissions to and discharges from hospital discloses an extraordinary succession of conflicting decisions by the tribunal and the Secretary of State for the Home Department, culminating in a claim in judicial review. On numerous occasions, following a conditional discharge by the tribunal, the Secretary of State exercised his power of recall under section 42 MHA. The longest period of recall was from February 2004 to December 2005.

On 13 December 2005 MM was again conditionally discharged by the tribunal. His responsible medical officer and approved social worker supported the discharge. The RMO gave evidence that MM was as well as he was ever going to be with regards to his schizophrenia, and noted that if he was going to relapse in the future it would be due to a lack of compliance with medication and illicit drug use; he recommended that the threshold for considering an assessment under the MHA should be low if his mental state suggested psychotic relapse. The tribunal imposed various conditions on the discharge pursuant to its discretion in section 73(4)(b) MHA, relating to residence, community treatment and random drug testing.

In the following month, MM admitted to his community RMO that he was using cannabis. He was warned that if his mental state was affected, he would be recalled. In the next month, MM’s father told the social worker that MM had been taking rock cocaine and associating with drug users. MM had also refused a drug screen. The social worker was of the view that this constituted a relapse signature. On 28 February 2006 the community RMO informed the Secretary of State of these developments, and

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commented that MM's community placements historically failed because of drug use and consequent rapid relapse, On 2 March 2006 the Secretary of State decided to recall MM to hospital; the case was referred to the tribunal pursuant to section 75(1)(a) MHA.

The tribunal met on 25 April and 9 May 2006; on the latter date it ordered MM's conditional discharge. The RMO had once again recommended discharge, on the basis that MM had been symptom free throughout the admission; he stated that MM's mental state was unchanged from the time of discharge in December 2005. The conditions of discharge were similar to those imposed in December 2005.

On 8 June 2006 one of MM's supervisors informed the Secretary of State that he had tested positive for cocaine use. The following day he was again recalled.

On 4 September 2006 MM was again conditionally discharged by the tribunal; once again, he had not exhibited any psychotic features during the admission. One of the conditions of discharge was that he abstain from illicit drugs; it soon became clear that he was in breach of this condition, although he continued to be free of psychotic symptoms. He was sent a warning letter by the Secretary of State, but a few days later it became apparent that he had continued to use a variety of drugs. On 19 September 2006 MM was once again recalled.

Judicial review claims were issued by MM and the Secretary of State during this time, but were abandoned because of the swift developments in the case. Finally, on 12 October 2006, MM was granted permission to pursue a claim in respect of the March and September recalls. On 23 November 2006 Mitting J dismissed the claims, and MM appealed, resulting in the present judgment.

In the meantime, MM was yet again conditionally discharged by the tribunal on 11 January 2007, and yet again recalled, on 12 February 2007.

## The Law

The case centres on the Secretary of State's power in section 42(3) MHA to recall to hospital a patient subject to a section 41 MHA restriction order who has been conditionally discharged. The MHA does not provide any substantive or procedural rules about how the power is to be exercised.

It was accepted on behalf of the Secretary of State that the power is limited by the requirements of Article 5 of the European Convention on Human Rights and Fundamental Freedoms. *Winterwerp v Netherlands* (1979) 2 EHRR 387 requires that, where a person is detained on the ground that he is of "unsound mind", three conditions must be satisfied in addition to compliance with domestic law: (i) except in emergency cases, he must be clearly shown to be of unsound mind, i.e. a true mental disorder must be established before a competent authority on the basis of objective medical expertise; (ii) the mental disorder must be of a kind or degree warranting compulsory confinement; (iii) the validity of continued confinement depends upon the persistence of such a disorder.

Further, before the Secretary of State can lawfully recall a conditionally discharged patient, there must be "up to date medical evidence about the applicant's mental health"; *K v United Kingdom* (1998) 40 BMLR 21 (a Commission decision), i.e. there must be medical evidence upon which he can properly conclude that the relevant *Winterwerp* criteria are satisfied.

It was agreed by both parties that mere breach by a patient of the conditions of his discharge does not provide a freestanding ground for recall; the breach must enable the Secretary of State to form a reasonable judgment on the evidence before him that the criteria for recall are established.



Stephen Simblet (Counsel) argued on behalf of MM that for recall to be warranted, the medical evidence had to show that his mental state would warrant detention for treatment under the conditions provided for in section 37, and that no such view could reasonably be formed on the evidence in MM’s case: his continued drug consumption created no more than a risk of deterioration, and recall could not be warranted until psychotic symptoms had either recurred or become an immediate inevitability.

## **The Decision**

The Court held that the language of the first of the statutory admission criteria (the “nature or degree” test) would be unduly circumscribed if there had to be either psychotic symptoms or the certainty of psychotic symptoms in the imminent future before detention for treatment could be appropriate. Treatment has a broad meaning, an obvious part of which is the avoidance or minimisation of risk, and there was no reason in law to prevent detention of a patient in MM’s position before psychotic symptoms recurred or were certainly imminent.

In order for recall to be lawful, the Secretary of State must have reasonable grounds to believe that information has emerged of sufficient seriousness to justify recalling the patient. He must have up to date medical evidence about the patient’s mental health, and only in exceptional circumstances would he not seek the patient’s RMO’s opinion.

On the facts, whilst the RMO had not explicitly recommended recall on either of the challenged recalls occasions, the Secretary of State had had sufficient information about MM to exercise his discretion to recall lawfully. MM’s appeal accordingly failed.

## **Comment**

The foundation of the Court’s decision is that Stephen Simblet’s formulation was wrong, and that there is no requirement for active or imminent symptoms of mental disorder to be present before a patient is detained. The court thereby provided a statement of what the law is not, but the judgment is less helpful on the question of what the law is in these circumstances. Toulson LJ merely observed that

*“...determining the point at which the risks are such as to make detention for treatment appropriate may involve a difficult judgment on the facts of a particular case.” [48]*

and concluded:

*“For the Home Secretary to recall a patient who has been conditionally discharged by a MHRT, he has to believe on reasonable grounds that something has happened, or information has emerged, of sufficient significance to justify recalling the patient... he must have up-to-date medical evidence about the patient’s mental health “ [50]*

In other words, the Secretary of State may lawfully recall a patient where the decision is *Wednesbury* reasonable. One might respond that this is a rather trite statement that does no more than beg the question before the Court.

The Court seemed to accept, without saying so explicitly, that in order for recall to be lawful, the criteria for detention in section 37 MHA must be satisfied. Thus at paragraph [47] Toulson LJ relates those criteria to the evidence in MM’s case, and rejects the argument advanced on MM’s behalf by reference to them. On a somewhat generous analysis, the Court was relying here on the “nature” aspect of the test for detention for treatment, in that it was the nature of MM’s illness that it could be made symptomatic by his use of drugs and, once symptomatic, he could become a danger to others. Thus even though MM

was asymptomatic, and even though he was not a risk at the time of the decision to recall, his further detention was justified by reference to the fear that all that might change, and change quickly.

This brings us to the real issue in this case – probability. It is often said in tribunal proceedings about a patient who suffers from a mental illness, but who is currently asymptomatic, that at some point in the future it is likely he will require detention again. The present state of the law is that the mere prospect that at some unspecified future time in-patient treatment will or might be required, is not a justification for detention: *R (Epsom & St Helier NHS Trust) v Mental Health Review Tribunal [2001] MHLR 8*, per Sullivan J at [52].

If that is right, then Stephen Simblet's formulation was correct. Relapse, indeed sudden relapse, may have been a probability, and to that extent foreseeable, but if the period of time within which that probability operated was not readily identifiable, MM's case would fall into the category identified by Sullivan J in the *Epsom & St Helier* case.

In essence, the Court held that detention was justified *before* the patient reached a detainable state in order to *prevent* that detainable state arising. The difficulty with this reasoning is that it involves a blatant paradox: if the patient's mental disorder is not symptomatic when he is detained, and detention will prevent it becoming symptomatic, then detention itself will eliminate the grounds for that detention.

Paralysis is the inevitable consequence of paradox, as it was in this case. It was inevitable that the patient's RMO could not argue that he was detainable at each tribunal hearing, because detention had prevented him becoming detainable; similarly, it was inevitable that each successive tribunal would be obliged to direct discharge following every recall.

The paradox is further illustrated by Toulson LJ's rather airy assertion that "An obvious part of [treatment's] purpose is the avoidance or minimisation of risk." MM's RMO had repeatedly given evidence to the tribunal that MM was not suffering from psychotic symptoms. Indeed, he had gone so far in December 2005 to say:

*"At this point I feel that a further stay in a low secure unit may become counter-productive as we have reached a therapeutic point where he is as well [as] he is ever going to be with regards to schizophrenia."*  
[5]

Moreover, at the April/May 2006 tribunal, the RMO said that MM's mental state was "unchanged from the time of discharge" [15]. One might then ask: what exactly did the Court of Appeal envisage him being treated for following recall?

What is immediately striking about this case is that a series of judicial decisions by the tribunal were nullified by successive decisions by the State. The question arises as to whether the actions of the Secretary of State were an expression of anything more than disagreement with the tribunal decisions. If that was the case, then it is hard to see the multiple recalls as legitimate exercises of executive power. In this respect, the argument advanced on behalf of the Secretary of State before the Court of Appeal is interesting. It was submitted that Mitting J at first instance was wrong to say that deterioration must be 'likely to occur' in order for recall to be justified; rather, the Secretary of State should ask himself whether there had been such a material change of circumstances since the Tribunal's previous decision that he could reasonably form the view that the detention criteria were now satisfied. This formulation commends itself for two reasons: first, it is at least a positive statement of principle, and second, it recognises the difficulty created by the tension between conflicting decisions of an independent court and the State.

This argument is in fact an extension of the principle established by the House of Lords in *R v (1) East London & City Mental Health NHS Trust (2) David Stuart Snazell, ex parte Count Franz Von Brandenburg (Aka Nicholas Hanley)*[2003] 3 WLR 1265, dealing with the lawfulness of administrative decisions to detain patients who have recently been discharged by a tribunal. It is easy to see why it was put forward by the Secretary of State as a reasonable approach to the interaction of the executive and the courts, and it is perhaps unfortunate that the Court does not appear to have endorsed it.

In this case therefore the Court of Appeal allowed the Secretary of State a greater breadth of discretion in relation to his power to recall conditionally discharged patients than the Secretary of State had himself asked for. Whilst this is of course an intensely difficult area, involving the balancing of personal liberty and autonomy against real risks to the public, this judgment’s lack of clear reasoning and failure to make any positive statement of principle beyond the obvious represents a missed opportunity.

## Protection from what? The nullifying effect of section 139

David Hewitt<sup>1</sup>

Seal v Chief Constable of South Wales Police  
House of Lords, 4 July 2007  
[2007] UKHL 31

*Where leave is required, the failure to obtain it will render proceedings null and void*

### Introduction

Philosophers, it is said, spend their time reflecting on questions such as whether a blind man, able to distinguish by touch between a cube and a sphere, would, if he were made to see, be capable of recognising them purely by sight<sup>2</sup>. Or how many grains one would have to remove before a heap of sand ceased to be such<sup>3</sup>. The House of Lords has recently had an opportunity to indulge in a similar exercise<sup>4</sup>. Their Lordships' reflections did, however, have a very real impact on one would-be litigant.

### The Facts

On 9 December 1997, Mr Seal was arrested for breach of the peace after an incident at his mother's house. The facts are contested, but it seems that he was taken out of the house and into the street, and that as a result of what happened there, he was removed to a place of safety under section 136 of the *Mental Health Act 1983* ('MHA 1983'). Mr Seal was detained, initially in the place of safety and then under section 2 of the Act. He was discharged just over a week later.

Mr Seal wished to argue that his detention had been unlawful and to claim damages against the police. At first, he was represented by solicitors, but when, finally, he issued proceedings, he was acting in person. That was on 8 December 2003, immediately before the six-year limitation period was due to expire. The Chief Constable served a defence, which addressed the substance of Mr Seal's claim but also relied on section 139 of MHA 1983. The Chief Constable argued that because Mr Seal had not obtained leave before issuing his claim, it should be struck out. That was what happened, and the strike-out was upheld, both by the High Court and by the Court of Appeal<sup>5</sup>. As the limitation period had by now expired, Mr Seal could not issue fresh proceedings for the same cause of action. It seems this represented a significant loss to Mr Seal, because he would have had a strong claim<sup>6</sup>.

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2 This problem was posed by William Molyneux to John Locke in 1688. See <http://plato.stanford.edu/entries/molyneux-problem/>

3 The so-called 'Sorites paradox'. See <http://plato.stanford.edu/entries/sorites-paradox/>

4 See, for example: Adrian Oliver, *Statute barred, Solicitors Journal*, 20 July 2007, p 942.

5 *Seal v Chief Constable of South Wales* [2005] EWCA Civ 586, [2005] 1 WLR 3183.

6 See, for example: *Baroness Hale at [60]*.

## The Law

In MHA 1983, section 139 is headed ‘Protection for acts done in pursuance of this Act’. At the relevant time, the first two sub-sections stated:

- “(1) No person shall be liable, whether on the ground of want of jurisdiction or on any other ground, to any civil or criminal proceedings to which he would have been liable apart from this section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules made under this Act, or in, or in pursuance of anything done in, the discharge of functions conferred by any other enactment on the authority having jurisdiction under Part VII of this Act, unless the act was done in bad faith or without reasonable care.
- “(2) No civil proceedings shall be brought against any person in any court in respect of any such act without the leave of the High Court; and no criminal proceedings shall be brought against any person in any court in respect of any such act except by or with the consent of the Director of Public Prosecutions.”

## The issue

There was only one issue before the House of Lords. It concerned the section 139(2) requirement for leave: what would become of any proceedings that were initiated without it? Would they be a nullity or should they simply be stayed until leave could be obtained?<sup>7</sup>

Baroness Hale sought to explain the context in which this issue arose. She noted that both the domestic courts and the European Court of Human Rights (‘ECtHR’) had taken particular care to ensure that prisoners were able to gain ready access to the courts,<sup>8</sup> and she said they

*“should be no less vigilant to safeguard the rights of mental patients, most of whom have done no wrong and very few of whom are suffering from mental disorders which make them more likely than others to bring vexatious claims.”*<sup>9</sup>

## The Decision

Their Lordships divided three-to-two on the issue, with the majority comprising Lord Bingham of Cornhill, Lord Carswell (who simply agreed with Lord Bingham)<sup>10</sup> and Lord Brown of Eaton-under-Heywood, and the minority, Lord Woolf and Baroness Hale of Richmond. In the course of their judgments, they considered the legislative background to section 139, some relevant authorities (including the *Griffiths* case) and three other propositions.

### (a) Legislative background

Lord Bingham, Baroness Hale and Lord Brown discussed the provisions that had preceded section 139.

- (i) The *Lunacy Acts Amendment Act 1889* gave immunity from civil or criminal liability to anyone acting in good faith or with reasonable care. Unless those things were lacking, any proceedings might be struck out, but they could at least be issued without leave. These provisions found their way into the *Lunacy Act 1890*.

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7 See: Lord Bingham at [2]; Lord Woolf at [23]; Baroness Hale at [37]; and Lord Brown at [65].

8 See, for example: *R v Secretary of State for the Home Department, ex parte Leech* [1994] QB 198; *R v Secretary of State for the Home Department, ex parte Simms* [2000]

2 AC 115; *R (Daly) v Secretary of State for the Home Department* [2001] UKHL 26, [2001] 2 AC 532; and *Golder v United Kingdom* (1975) 1 EHRR 524.

9 Baroness Hale at [38].  
10 At [63].

- (ii) The *Mental Treatment Act 1930* offered the same immunity as that contained in the 1889 Act,<sup>11</sup> but instead of providing a defence, it shifted the onus onto the plaintiff by requiring that he or she obtain leave before issuing proceedings<sup>12</sup>. For leave to be granted, the court would have to be satisfied that there were substantial grounds for the contention that the proposed defendant had acted in bad faith or without reasonable care<sup>13</sup>. This provision was preserved by section 141 of the *Mental Health Act 1959*.
- (iii) The *Mental Health (Amendment) Act 1982* preserved the existing immunity from suit and the requirement for leave<sup>14</sup>. With regard to criminal proceedings, however, it said that such leave must be obtained, not from the High Court, but from the Director of Public Prosecutions. In addition, it would no longer be necessary for an intending plaintiff to show that there were substantial grounds for believing that his or her opponent had acted in bad faith or without reasonable care<sup>15</sup>. (Ultimately, the test would be simply whether a case deserved further investigation by the court<sup>16</sup>.) Finally, neither the substantive defence nor the procedural protection would now apply to proceedings against the Secretary of State or the NHS<sup>17</sup>. It was these provisions that were consolidated as section 139(1) & (2) of MHA 1983.

Before the 1982 amendment and its 1983 consolidation, section 141 of the 1959 Act had been considered by two official inquiries<sup>18</sup>. According to Lord Bingham, these established that the requirement for leave

*“was criticised as unduly restrictive, ill-directed (because not directed to litigants who had shown themselves to be vexatious) and unjustified by the very small number of applications for leave made each year.”*<sup>19</sup>

However, “it was also known that staff working with mental patients were anxious about their legal position and the protection available to them”<sup>20</sup>. To this, Baroness Hale replied:

*“[P]rotection from what? It cannot have been intended or expected that staff would be protected from all knowledge of possible claims. [...] What staff are protected from is having to defend a baseless action. Such protection is not undermined if an action is, whether through ignorance or inadvertence, begun without leave and the defendant takes the point or the court takes it of its own motion. The burden is still on the claimant to establish that the case should go further.”*<sup>21</sup>

Their Lordships also considered a number of relevant decisions.

### (b) Authorities

Perhaps the clearest example of the protective effect of section 139 came in the *Griffiths* case<sup>22</sup>. There, a nurse was convicted of assaulting a patient but, it later emerged, no leave had been obtained for the relevant criminal proceedings. Were those proceedings therefore a nullity? Counsel for the prosecution

11 *Mental Treatment Act 1930*, s 16(1).

12 *Mental Treatment Act 1930*, s 16(2).

13 Lord Bingham at [9]; Baroness Hale at [46].

14 *The Mental Health (Amendment) Act 1982*, s 60.

15 Lord Bingham at [10]; Baroness Hale at [47].

16 *Winch v Jones* [1986] QB 296.

17 Why the statutory protection continued to be enjoyed by local authorities is considered in: David Hewitt, *Something less than ready access to the courts: section 139 and local authorities*, *Journal of Mental Health Law*, February

2000, pp 73–82.

18 *Department of Health and Social Security, 1976, A Review of the Mental Health Act 1959; Department of Health and Social Security, the Home Office, the Welsh Office and the Lord Chancellor's Department, 1978, Review of the Mental Health Act 1959, Cmnd 7320. See also: Dr Larry Gostin, A Human Condition, MIND.*

19 Lord Bingham at [11].

20 *Ibid.*

21 Baroness Hale at [49].

22 *R v Bracknell Justices, ex parte Griffiths* [1976] AC 314.



and the defence both thought so, and the *amicus* instructed by the DHSS did not demur. Intriguingly, he was Harry Woolf, who, when suitably ennobled, would rule that Mr Seal's claim was not in fact null and void<sup>23</sup>. The appeal court in *Griffiths* took the same view as the advocates and quashed the nurse's conviction<sup>24</sup>.

Lord Bingham said it was "of significance that very eminent counsel and judges accepted it as so clear as to be unworthy of argument that proceedings brought without the required leave were a nullity"<sup>25</sup>. Speaking of the understanding reached in the case, Lord Brown noted there had "been no suggestion amongst academic commentators that this concession might have been wrongly made or might not apply in a civil context."<sup>26</sup>

Those of their Lordships that were in the minority were wary of the *Griffiths* case. Lord Woolf, whose connection with the case was particularly intimate, did not consider it conclusive as to the outcome of Mr Seal's appeal, "since the question of whether non compliance meant the criminal proceedings were a nullity was not in issue before the House of Lords, this having been conceded by eminent leading counsel for both parties in the court below, without objection by myself as *amicus*"<sup>27</sup>. He was unable to add further elucidation, however, and concluded, perhaps ruefully, "At this distance of time I cannot explain my inactivity or counsels' concession"<sup>28</sup>.

The second of the three grounds upon which Lord Woolf sought to distinguish the decision in *Griffiths* was that it preceded a judgment in which, he said, Lord Hailsham "provided much needed illumination on the consequences of non compliance with a statutory provision"<sup>29</sup>. That judgment was in *London & Clydeside Estates Ltd v Aberdeen District Council* [1980] 1 WLR 182 and Lord Hailsham's illuminating decision might, perhaps, be summarised as follows:

- (i) Any statutory requirement that governs the performance of a legal authority must "be obeyed down to the minutest detail."
- (ii) Any disobedience to such a requirement must, however, be judged according to its impact "on the rights of the subject viewed in the light of a concrete state of facts and a continuing chain of events."
- (iii) There might be flagrant cases, in which disobedience could be used by an innocent party "as a shield or defence without having taken any positive action of his own."
- (iv) Conversely, disobedience "may be so nugatory or trivial" that the errant party should be allowed to proceed.
- (v) In the majority of cases, it would be wise for a disobedient party to throw himself upon the mercy of the court, and for the court to dispense its mercy generously, "so as not to deprive the subject of his due or themselves of their power to act"<sup>30</sup>.

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23 Lord Woolf at [30]–[31].

24 There was a similar outcome in *R v Angel* [1968] 1 WLR 669, *Secretary of State for Defence v Wain* [1970] AC 394 and *R v Pearce* (1980) 72 Cr App R 295.

25 Lord Bingham at [13].

26 Lord Brown at [71]. See, for example, Larry Gostin, *Mental Health Services – Law and Practice*, 1986, Shaw & Sons, at para 21.26.2.

27 Lord Woolf at [30].

28 Lord Woolf at [31].

29 Lord Woolf at [32].

30 *London & Clydeside Estates Ltd v Aberdeen District Council* [1980] 1 WLR 182, per Lord Hailsham of Marylebone LC at 189–90.

- (vi) The courts need not try “to fit the facts of a particular case [...] into rigid legal categories[,] or to stretch or cramp them on a bed of Procrustes invented by lawyers for the purposes of convenient exposition”<sup>31</sup>.

Lord Woolf concluded:

*“[I]n the majority of cases the court would have the task of determining what would be the just decision to take in all the circumstances, Parliament having not made clear what were to be the consequences of non-compliance with the statutory requirement.”*<sup>32</sup>

This gloss was derived from Lord Woolf’s own judgment in *R v Secretary of State for the Home Department, ex parte Jeyeanthan* [2000] 1 WLR 354, a case in which, according to Lord Bingham, he “made plain the court’s general reluctance to hold that the effect of failure to comply with a procedural requirement is to render proceedings null”<sup>33</sup>. Lord Brown, however, did not think that section 139 was “remotely akin” to the procedural requirement under consideration in *Jeyeanthan*<sup>34</sup>.

The final ground upon which Lord Woolf sought to distinguish *Griffiths* was that it involved criminal proceedings whereas Mr Seal’s was a civil claim. He said that as far as the consequences of non-compliance were concerned, there was “a fundamental distinction” between the two, for in a criminal case, “there is no question of the defendant being deprived of his right [of] access to a court to protect his rights. On the contrary the statutory requirement is a protection against his being prosecuted”<sup>35</sup>.

For Baroness Hale, too, this distinction was significant. Even if the concession in *Griffiths* were correctly made, she said, it need not apply to both civil and criminal proceedings under MHA 1983:

*“Although both are mentioned in section 139(2) it does not follow that the consequences of non-observance are identical. [...] Prosecutions are brought, not to serve any private interest, but to protect the public interest. That is why those who exercise prosecutorial discretion [...] take a wider range of factors into account in deciding whether or not to prosecute than the High Court will consider when deciding whether or not to grant leave to bring a civil action.”*<sup>36</sup>

Lord Brown, however, was not convinced by this argument. He would find that Mr Seal’s proceedings were a nullity, and he called Baroness Hale’s “an impossible conclusion”. He noted that the only distinction MHA 1983 draws between criminal and civil proceedings is as to who might grant leave, and he continued:

*“Of course prosecutions are brought to serve the public interest rather than any private interest[,] and clearly for that reason a wider range of factors will be taken into account in deciding whether leave should be granted for criminal rather than civil proceedings. But there is no reason to doubt that High Court judges followed that same approach when exercising their power up until 1983.”*<sup>37</sup>

Even more importantly, Lord Brown said, civil proceedings brought without leave had always been considered a nullity and the alteration made by the current Mental Health Act “provides no logical basis for supposing [that they] should suddenly in 1983 change character”<sup>38</sup>.

31 “In Greek legend Procrustes was a robber of Attica, who placed all who fell into his hands upon an iron bed. If they were longer than the bed he cut off the overhanging parts, if shorter he stretched them until they fitted it. [...] Hence, any attempt to reduce men to one standard, one way of thinking, or one way of acting, is called ‘placing them on Procrustes’ bed’” (Brewer’s Dictionary of Phrase & Fable, 2005, seventeenth edition, Weidenfeld & Nicolson).

32 Lord Woolf at [33].

33 Lord Bingham at [6]. See also: Lord Bingham at [7].

34 Lord Brown at [74].

35 Lord Woolf at [34].

36 Baroness Hale at [51]–[52].

37 Lord Brown at [72].

38 *Ibid.* See also: Lord Bingham at [16].

There was a further authority upon which the minority relied. The case of *Rendall v Blair* (1890) 45 Ch D 139 concerned section 17 of the *Charitable Trusts Act 1853*, which provided that the Charity Commissioners should be notified before any proceedings were commenced for obtaining relief against a charity; that they would then decide whether to authorise the proceedings; and that no proceedings “shall be entertained or proceeded with” without such an authorisation<sup>39</sup>.

In this case, both the majority and the minority were in agreement as to the import of these conditions. Baroness Hale said they were “no less peremptory”, and Lord Bingham that they were “not markedly weaker than”, section 139<sup>40</sup>. Baroness Hale noted that in *Rendell*, the Court of Appeal was able to find for the plaintiff, with Lord Bowen holding:

“Unless the duty [to obtain leave] is complied with by the litigant, the Court must hold its hand. But it does not oblige the Court to close the gates of mercy upon the applicant, but enables it to stay proceedings until that consent, which as a matter of duty ought to be obtained in the first instance, is obtained at last.”<sup>41</sup>

Lord Brown, however, felt able to distinguish that decision from the case of Mr Seal. He said that the context and history of section 17 were markedly different from those of section 139, and that those differences “provide ample grounds for reaching different conclusions as to their effect”<sup>42</sup>.

Aside from the authorities, Lord Bingham also commented that the House had not been referred to any judicial opinion or scholarly commentary suggesting that failure to obtain leave was merely a procedural irregularity that might be cured, rather than a flaw that rendered the proceedings null. He concluded that when section 139 went through Parliament in 1982 and 1983, there was “a clear consensus of judicial, professional and academic opinion that lack of the required consent rendered proceedings null,” and that Parliament must be taken to have legislated on that basis<sup>43</sup>.

### (c) Other propositions

The House also considered several other propositions.

#### (a) Clear words are required

Those of their Lordships that found themselves in the minority laid great store by the finding of Viscount Simonds in *Pyx Granite Co Ltd v Ministry of Housing and Local Government* [1960] AC 260 that

“It is a principle not by any means to be whittled down that the subject’s recourse to Her Majesty’s courts for the determination of his rights is not to be excluded except by clear words.”<sup>44</sup>

For her part, Baroness Hale found more recent support for this principle in the *Simms* case and the *Daly* case,<sup>45</sup> and she explained the effect of these dicta upon her:

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39 The decision in that case was followed in *In re Saunders (A Bankrupt)* [1997] Ch 60.

40 Baroness Hale at [43]; Lord Bingham at [6].

41 *Rendell v Blair* (1890) 45 Ch D 139, per Bowen LJ at p 158.

42 Lord Brown at [76].

43 Lord Bingham at [15].

44 *Pyx Granite Co Ltd v Ministry of Housing and Local*

*Government* [1960] AC 260, 286. See, for example, Lord Woolf at [29]. A similar requirement was imposed in *Bradford Corporation v Myers* [1916] 1 AC 242 and *Magor and St Mellons RDC v Newport Corporation* [1952] AC 189.

45 *R v Secretary of State for the Home Department, ex parte Simms* [2000] 2 AC 115, per Lord Hoffmann at 131; *R (Daly) v Secretary of State for the Home Department* [2001] UKHL 26, [2001] 2 AC 532, per Lord Cooke of Thorndon at [30]–[31].

*“I approach the task of construing section 139(2), therefore, on the basis that Parliament, by enacting the procedural requirement to obtain leave, did not intend the result to be that a claimant might be deprived of access to the courts, unless there is express language or necessary implication to the contrary.”*<sup>46</sup>

Baroness Hale concluded:

*“The statutory language makes it clear that if anyone, including the claimant, appreciates the point, then leave must be obtained. It does not make it clear that if no one, including the court or the defendant, does so, the proceedings are a nullity.”*<sup>47</sup>

The requirement for clear words was never, however, in doubt. What distinguished the minority from the majority was that in the view of the latter, clear words was precisely what section 139 contained.

Lord Bingham said he wished to “echo and endorse” the words of Viscount Simonds in *Pyx*, but added that section 139 was “a clear and emphatic prohibition”. In fact, he said, “the House has been referred to no enactment in which clearer or more emphatic language is used”<sup>48</sup>. The provisions in that section did not contradict the judgment in *Pyx*, and to find against Mr Seal “is not to sanction a departure from what Viscount Simonds rightly considered to be a fundamental rule”<sup>49</sup>.

(b) *The ECHR requires the right of access to a court*

Article 6 of the European Convention on Human Rights (‘ECHR’) implies that everyone has the right of access to a court,<sup>50</sup> and in *Seal*, both the majority and the minority referred to the *Ashingdane* case<sup>51</sup>. Baroness Hale cited the following portion of the judgment of the ECtHR in that case:

*“Certainly the right of access to the courts is not absolute but may be subject to limitations; these are permitted by implication [...] Nonetheless, the limitations applied must not restrict or reduce the access left to the individual in such a way or to such an extent that the very essence of the right is impaired.*

*Furthermore, a limitation will not be compatible with Article 6(1) if it does not pursue a legitimate aim and if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be achieved.”*<sup>52</sup>

Lord Bingham did not think that this requirement was breached by section 139. Citing *Ashingdane* himself, he said that it was a legitimate objective of legislation to protect those responsible for the care of mental patients from being harassed by litigation;<sup>53</sup> and citing domestic authority,<sup>54</sup> he added that the threshold for obtaining leave under section 139 “has been set at a very unexact level. An applicant with an arguable case will be granted leave”<sup>55</sup>.

Baroness Hale did not agree. She said that in order to comply with Article 6, a restriction on a fundamental right must first bear a rational connection with the legitimate aim pursued<sup>56</sup> and also be proportionate to that aim<sup>57</sup>. There was obviously such a rational connection where court-access was denied to people “who have previously abused that right”, but “it is not obviously rational to brand every person who is or has been subject to the compulsory powers in the Mental Health Act as a potential

46 Baroness Hale at [41].

47 Baroness Hale at [54]. See also: Lord Woolf at [35].

48 Lord Bingham at [7].

49 Lord Bingham at [18].

50 See, for example: *Golder v United Kingdom*, *supra*.

51 *Ashingdane v United Kingdom* (1985) 7 EHRR 528.

52 *Ashingdane v United Kingdom*, *supra*, para 57; cited by

Baroness Hale at [56] [emphasis supplied by Baroness Hale].

53 *Ashingdane v United Kingdom*, *supra*, para 58. See also: *M v United Kingdom* (1987) 52 DR 269, 270.

54 *Winch v Jones*, *supra*.

55 Lord Bingham at [20].

56 Baroness Hale at [57]–[58].

57 Baroness Hale at [59]–[61].

vexatious litigant”<sup>58</sup>. For that reason, Baroness Hale thought that section 139 went too far. In another sense, however, she felt that it might not go far enough. She noted that it only relates to acts done in pursuance of MHA 1983, and, she added:

*“If certain mental patients are ex hypothesi vexatious litigants, then people who exercise authority over them otherwise than under the Mental Health Act may also deserve protection.”*<sup>59</sup>

Baroness Hale suggested that Mr Seal’s was a case in point:

*“Police officers lead difficult and dangerous lives. They have to make snap decisions in complex situations where there is no time for quiet contemplation. They deserve the support of the public, the courts and the law. But it has not been shown why they should need more protection and more support when they remove people to a place of safety under section 136 of the Mental Health Act 1983 than they have when they conduct an ordinary arrest.”*<sup>60</sup>

With regard to her second point, Baroness Hale said that although, in some cases, the effect of section 139 might be proportionate, in others it would not:

*“If section 139(2) has the effect that proceedings are always a complete nullity, thus depriving a claimant of a good claim, that is an effect out of all proportion to the aim which it is attempting to pursue.”*<sup>61</sup>

Lord Brown attacked the suggestion that section 139 was disproportionate, which, he said, “seems to me fanciful”<sup>62</sup>.

(c) *A price worth paying*

The minority argued that it would be unjust to invalidate Mr Seal’s proceedings merely because he had failed to comply with a statutory requirement of which he was ignorant and at a time when a statutory time-bar prevented him from retrieving his position<sup>63</sup>.

Baroness Hale argued that if it were discovered in time, a failure to obtain leave could be put right with ease and without prejudice to the defendant; and that if it were not discovered in time, and judgment were entered for the claimant, no injustice would be done to the defendant (presumably because the judgment demonstrates that if it had been sought, leave would have been granted). A serious injustice would, however, be done to the successful claimant if his or her judgment were set aside, the more so if any fresh proceedings would by then have become statute-barred. Baroness Hale concluded:

*“That a claimant who has suffered a wrong should be deprived of his remedy merely because of a procedural failure which no one noticed at the time is an affront to justice.”*<sup>64</sup>

Lord Bingham was less sympathetic. As he pointed out, if Mr Seal had issued proceedings at any time before the very end of the six-year limitation period, his failure to obtain leave would not have debarred him from prosecuting his claim. Thus, “the provision which effectively denies him the opportunity to proceed is not section 139 of the 1983 Act but section 2 of the Limitation Act 1980”<sup>65</sup>.

In fact, Lord Bingham went further, finding very clear utility in Mr Seal’s predicament. Parliament must, he said, “have recognised the risk that hard cases, such as Mr Seal’s, may occur, but have considered the

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58 Baroness Hale at [57].

59 Ibid.

60 Baroness Hale at [58].

61 Baroness Hale at [59].

62 Lord Brown at [75].

63 See, for example: Lord Woolf at [27].

64 Baroness Hale at [53].

65 Lord Bingham at [17].

occasional occurrence of such a case to be a price worth paying for the reassurance and protection given by” section 139<sup>66</sup>. Lord Brown added that in circumstances such as those of Mr Seal,

*“the loss of the claim is the price paid for certainty – just as there is a price to be paid for the established principle (and the assurance it provides) protecting various classes of prospective defendant against claims in negligence”.*<sup>67</sup>

Putting the counter-argument, Lord Woolf said he could not accept that nullity “should be inferred to be Parliament’s intention”, because, as the facts of this case illustrated, “to do so may cause grave injustice”. To allow the likes of Mr Seal to prevail, however,

*“cannot cause any injustice to those for whom the provision is meant to provide protection. This is because the person against whom the proceedings are brought at most would need to write a letter to the court drawing attention to the fact that the proceedings require leave and this had not been obtained. Such a letter would place that person in exactly the same position as if the claimant had, in accordance with the section, requested leave before commencing his action. If the proceedings are ones in which the court would give leave it should do so retrospectively if this would prevent injustice occurring, but, if it was a case in which leave should be refused the court could in addition to refusing leave strike out the proceedings.”*<sup>68</sup>

## Comment

In the case of the unfortunate Mr Seal, the judgments of the majority and the minority diverge only in their conclusion. There was virtual unanimity as to the relevant authorities and what they required. But it is surely the reasoning of the majority, hard-nosed though it might seem to be, that is most compelling.

In effect, Lord Woolf argued for a return to the position that obtained under the *Lunacy Acts Amendment Act 1889*: the failure of a claimant to obtain leave would be merely something to be taken into account if his or her opponent raised it in the course of the proceedings. And yet, if there’s one thing we can be sure of it’s that our legislators long ago fell out of love with the 1889 position. We know this because, in the legislation it passed subsequently, Parliament made sure to reverse that position. It is the procedure introduced by the *Mental Treatment Act 1930*, with its requirement for ‘up-front’ leave, that has been perpetuated by subsequent statutes and that finds itself reflected in section 139 of the current Act.

Baroness Hale, who was also in the minority, took a similar line, and she suggested that it was clear from section 139 that if anyone, such as the claimant, took the point, leave must be obtained. But the section does not say precisely that. It says that *no proceedings shall be brought* without leave. That is a rather different thing.

As Lord Bingham observed, section 139 takes the form of an emphatic prohibition on proceedings for which no leave has been obtained. It is perhaps surprising, therefore, that their Lordships chose to concentrate on the final phase of such proceedings, and that none of them thought to look at the circumstances in which those proceedings were allowed to come into being. It might prove instructive to consider a further question: at the point of issue, what is the responsibility of the court where no leave has been obtained? Shouldn’t it simply refuse to issue the proceedings? Isn’t that the logical consequence

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66 *Ibid.*

68 Lord Woolf at [26].

67 Lord Brown at [75]. The case he cited was *D v East Berkshire Community Health NHS Trust* [2005] UKHL 23, [2005] 2 AC 373.



of the very clear words *no proceedings shall be brought*? Seen in that light, the philosophical question that faced their Lordships appears a little clearer. If the proceedings should never have been issued, can there be any substantive objection to their being deemed to be at an end?

In stressing the hardship that would be caused to Mr Seal if his proceedings were deemed a nullity, Baroness Hale raised arguments that go more to the *requirement* for leave than to its application in this case. That is not, however, sufficient reason to find for Mr Seal. It is surely permissible to criticise the requirement for leave, but, while it remains, to accept both that it should be properly enforced and that its enforcement will occasionally bear down hard on a dilatory claimant. In fact, it seems that Lord Brown was willing to contemplate that very possibility<sup>69</sup>.

The amendments that the *Mental Health Act 2007* will make to MHA 1983 do not extend to section 139. The *Draft Mental Health Bill 2004* did, in fact, make proposals in that regard<sup>70</sup>. They would have:

- (a) removed the requirement for leave, whether of the High Court or the DPP, before MHA 1983 proceedings were issued;
- (b) changed the emphasis, so that good faith or reasonable care would be a defence, not something whose want a claimant would have to prove;
- (c) given NHS bodies (but not the Secretary of State) the same defence provided for local authorities; but
- (d) prevented the defence being used, not just in judicial review proceedings, but also in civil proceedings for negligence or for battery.

It is unfortunate, perhaps, that those proposals came to nothing, for they might have done a great deal to alleviate the concerns raised by Mr Seal's case, and possibly to prevent similar cases arising in future.

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<sup>69</sup> Lord Brown at [74].

<sup>70</sup> Department of Health, 2004, *Draft Mental Health Bill*, Cm 6305-I, cl 298. See also, Department of Health, 2004, *Draft Mental Health Bill: Explanatory Notes*, Cm 6305-II, paras 492–494.

# Hello, Doli?... or is it Goodbye?

Natalie Wortley<sup>1</sup>

Director of Public Prosecutions v P

Queen's Bench Division (Administrative Court), 27 April 2007

[2007] EWHC 946 (Admin)

## Introduction

Section 34 of the *Crime and Disorder Act 1998* abolished the rebuttable presumption of criminal law that a child between the ages of 10 and 13 was incapable of committing a criminal offence. Most commentators assumed that Parliament had effectively consigned the doctrine of *doli incapax* to the history books. In a remarkable resurrection, the Divisional Court in *Director of Public Prosecutions v P (DPP v P)*<sup>2</sup> suggested that *doli incapax* may still be available as a defence where a child lacks the capacity to understand that his actions are seriously wrong.

## The Facts

P was aged 13 at the date of his appeal. Ever since he was 4, the authorities had had concerns about his development and behaviour. He was diagnosed with Attention Deficit Hyperactivity Disorder at the age of 7 and was prescribed Ritalin. In 2002 he was assessed as having special educational needs. In 2004, P was committed to Teesside Crown Court for trial for a number of serious offences, including kidnapping, false imprisonment and indecent assault. The defence instructed a psychologist, who concluded that P had a full scale IQ of 65 and a mental age of 7 years and 4 months. In his opinion, P would have great difficulty differentiating between conduct that was "seriously wrong" and conduct that was "merely naughty". Further experts were commissioned and all accepted the IQ assessment and agreed that P would be unable to participate effectively in a criminal trial. The prosecution ultimately accepted that P was not fit to plead and proceedings were stayed in June 2005 with no further order.

Five months later, P appeared before the youth court for offences of assault and theft of a car. He denied both matters, accepting by implication that he was fit to plead. P's legal representatives then applied to stay the proceedings as an abuse of process. The original psychologist prepared a new report confirming that little had changed in the intervening months. He concluded that P remained incapable of understanding the nature of the proceedings; he would not be able to concentrate on, or remember, evidence and argument in the courtroom; he had very little understanding of the significance of his behaviour; and he would not have been capable of forming the necessary intent for the alleged offences.

The defence argued that since the rebuttable presumption of *doli incapax* had been abolished, the only way to protect a child such as P was through the doctrine of abuse of process. The District Judge reviewed the law and the medical reports and concluded that P would be unable to participate effectively in his trial and that the proceedings should therefore be stayed. The prosecution appealed by way of case stated.

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<sup>2</sup> [2007] EWHC 946 (Admin).

## The Law

### Fitness to Plead

Issues of capacity and fitness to plead often overlap and both issues arose in P's case. It is not clear why the Crown Court stayed the first set of proceedings without invoking the fitness to plead process set out in the *Criminal Procedure (Insanity) Act 1964*<sup>3</sup>. It may be that the Crown Court Judge considered that P's difficulties were so severe that it would be an abuse of the process of the court to subject him to any proceedings akin to a trial, even if those proceedings amounted simply to a fact finding exercise and could not result in a criminal conviction. The psychologist's comments that P would have difficulty distinguishing conduct that was seriously wrong from that which was merely naughty also suggested that P might be *doli incapax*. We do not know whether this issue played any part in the decision to stay the proceedings.

The 1964 Act does not apply to summary proceedings. In *R(P) v Barking Youth Court*<sup>4</sup>, the Divisional Court confirmed that section 11(1) *Powers of Criminal Courts (Sentencing) Act 2000* and section 37(3) *Mental Health Act 1983* provide a complete statutory framework for dealing with the question of fitness to plead in both the magistrates' court and the youth court. Under these provisions, the court should determine whether the defendant did the act or made the omission charged against him. If satisfied that he did, the court may act under either of the above sections and adjourn the proceedings for a medical report or make a hospital order or guardianship order.

It appears that a youth court also has to consider whether the accused is able to participate effectively in his trial. If he cannot, it appears that a trial would be in breach of Article 6. In *SC v UK*,<sup>5</sup> the European Court of Human Rights held that effective participation presupposes that the accused has a broad understanding of the nature of the trial process; an understanding of what is at stake including the significance of any punishment; an understanding of the general thrust of the evidence with assistance if necessary; the ability to follow what is said by witnesses; the ability to explain his version of events pointing out anything he disagrees with; and the ability to make his lawyers aware of facts to be put forward in his defence.

In *R (TP) v West London Youth Court*,<sup>6</sup> the Divisional Court upheld a district judge's decision to proceed to trial in the case of a 15-year-old defendant who had the intellectual capacity of an 8-year-old. However, the Court accepted that in order to have a fair trial, the accused had to have an understanding of what he was said to have done wrong; the means of knowing it was wrong; an understanding of the defences available; a reasonable opportunity to make representations; the opportunity to consider representations once he understood the issues; and the ability to give proper instructions and participate by answering questions and suggesting questions to his lawyers. The district judge should keep matters under review and had a continuing jurisdiction to stay proceedings if satisfied that the accused could no longer participate effectively.

Thus, following TP, effective participation appears to incorporate a capacity test: the accused must have an understanding of what he has done wrong and "*the court had to be satisfied that the [accused] when he had done wrong by act or omission had the means of knowing that was wrong*"<sup>7</sup>. Where the accused lacks the capacity to distinguish right from wrong, it therefore appears that he cannot have a fair trial and proceedings should be stayed.

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3 Sections 4, 4A and 5.

4 [2002] EWHC 734 (Admin).

5 [2004] 40 EHRR 10.

6 [2005] EWHC 2583 (Admin).

7 *Ibid.* para 7(ii).

However, is a stay of proceedings the most satisfactory resolution to a case where this issue arises? The Divisional Court in *DPP v P* thought not. Although it lacked the benefit of considered submissions from the parties on the issue, the Court speculated that where a child aged between 10 and 13 did not recognise that his act was seriously wrong, he could rely on the defence of *doli incapax*. The Court added that if the defence were available, it was preferable for a child to raise it and have the opportunity of an acquittal rather than merely a stay.

### Doli Incapax

The idea that a person should not be held liable in criminal law if he is unable to distinguish between right and wrong is a familiar one. Where an accused person can show that he was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know that what he was doing was wrong, he has a defence of insanity<sup>8</sup>. This defence is only available where the failure to appreciate the difference between right and wrong is attributable to a disease of the mind.

The law also recognises that an inability to distinguish between right and wrong may arise as a consequence of the youth of the offender. A child was said to be *doli incapax* and therefore incapable of committing a criminal offence if he did not understand that what he had done was seriously wrong as opposed to merely naughty. There was significant debate during the twentieth century over the age at which children should no longer be able to rely on the doctrine of *doli incapax* and should be deemed responsible for their actions.

*Doli incapax* is an ancient doctrine and, as such, there is no clear record of its origins. In 1769, Sir William Blackstone wrote that a child under the age of 10 could not be punished for any crime and “from ten and a half to fourteen, a child was punishable if found to be *doli capaces*, or capable of mischief, but with many mitigations, and not with the utmost rigor of the law”<sup>9</sup>. In relation to capital offences, ancient Saxon law provided that a child under the age of 12 could not be guilty, whereas a child age 12–14 might be guilty, “according to his natural capacity or incapacity”<sup>10</sup>. Since at least the reign of Edward III, an infant under the age of 7 could not be guilty of a capital offence and, “under fourteen, though an infant shall be *prima facie* adjudged to be *doli incapax*; yet if it appear to the court and jury that he was *doli capax*, and could discern between good and evil, he may be convicted”<sup>11</sup>. This rule was later extended to cover all offences.

There are thus two aspects to the doctrine. First, there is an age below which every child is conclusively presumed to be *doli incapax* regardless of whether or not he actually has the capacity to understand that what he is doing is wrong. A child under this age cannot commit a criminal offence. This conclusive, or irrebuttable, presumption of *doli incapax* applied to those under the age of 7, until section 50 of the *Children and Young Persons Act 1933* raised the minimum age of criminal responsibility to 8. It was further raised to 10 by the *Children and Young Persons Act 1963*<sup>12</sup>.

Prior to the *Crime and Disorder Act 1998*, the common law also presumed that a child between the ages of 10 and 13 was *doli incapax*. In order to displace this presumption, the prosecution had to adduce clear and cogent evidence that the child knew that his act was seriously wrong as distinct from an act of naughtiness or childish mischief<sup>13</sup>. The prosecution could not rely solely on evidence of the act that

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8 *M'Naghten's Case* (1843) 10 CL. & F. 200

9 4 *Bl Com* (1st Ed) 22.

10 *Ibid.* 23.

11 *Ibid.* 23.

12 Section 16(1).

13 *R v Gorrie* (1919) 83 JP 136; *B v R* (1958) 44 Cr App R 1; *C v DPP* [1996] AC 1.

constituted the offence, however horrifying or obviously wrong that act might be<sup>14</sup>. Evidence of things said or done before or after the offence might be capable of rebutting the presumption but would not always be relevant. For example, evidence of running away would usually be equivocal, because a naughty child was just as likely to run away as a child who knew that his actions were seriously wrong<sup>15</sup>.

The sort of evidence that might displace the presumption could include the child's responses in interview; a psychological or psychiatric assessment; or evidence from a parent, teacher or social worker as to the child's general ability to distinguish right from wrong. It was suggested that this caused practical difficulties for the prosecution<sup>16</sup>. Both police interviews and expert assessments depend upon the child's co-operation, which might not be forthcoming, and parents, teachers or social workers would often be unwilling to jeopardise their relationship with the child by testifying against him.

There was thus a perception that the presumption placed an unfair burden on the prosecution and in 1994, shortly after the high profile murder of toddler Jamie Bulger by two young boys, the Divisional Court decided in an unrelated case (*C v DPP*)<sup>17</sup> that the presumption was "unreal and contrary to common sense"<sup>18</sup> and held that it was "no longer part of the law of England"<sup>19</sup>. On appeal, the House of Lords held that it was inappropriate for the courts to change the law by judicial decision but urged Parliament to review the position again<sup>20</sup>.

The continuing existence of the presumption was debated in numerous reports, consultations and White Papers from 1927 onwards. In a White Paper published in 1990, the Government confirmed that it did not intend to alter the presumption, "which make[s] proper allowance for the fact that children's understanding, knowledge and ability to reason are still developing"<sup>21</sup>.

In 1997, the new Labour Government reviewed the law and concluded that the irrebuttable presumption that a child under the age of 10 was *doli incapax* should remain but that the rebuttable presumption applicable to children aged 10 to 13 should be abolished. Section 34 of the *Crime and Disorder Act 1998* appeared to achieve this aim:

*The rebuttable presumption of criminal law that a child aged 10 or over is incapable of committing an offence is abolished.*

In *DPP v P*, after considering the wording of section 34 and looking at passages from Hansard, Smith LJ concluded that Parliament intended to abolish only the presumption and not the substantive defence of *doli incapax*. The Court thought that if this was right, the accused would bear the evidential burden of raising the defence and the prosecution would have to prove beyond reasonable doubt that the child was not *doli incapax*.

## The Decision in *DPP v P*

The Divisional Court allowed the prosecution's appeal against the decision to stay the proceedings. The Court held that the district judge's decision was premature and that he ought to have considered a number of important issues, including the possibility that P might have had a defence of *doli incapax*. The

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14 *R v Smith* (1845) 1 Cox C.C. 260; *C v DPP* [1996] AC 1 at 38.

15 *C v DPP* [1996] AC 1 at 39.

16 *C v DPP* [1994] 3 WLR 888 at 894.

17 *Ibid.*

18 *Ibid.* at 890.

19 *Ibid.* at 898.

20 *C v DPP* [1996] AC 1.

21 Great Britain. Home Office. (1990) *Crime Justice and Protecting the Public*. London: The Stationary Office. (Cm. 965) at para 8.4.

Court went on to explore the relationship between issues of capacity, fitness to plead and effective participation in court proceedings and set out the procedure to be followed where such issues arose.

The Court stressed that prosecutors should first consider whether civil proceedings under the *Children Act 1989* might be more appropriate in cases where issues of capacity arose. However, once a decision to prosecute had been taken, a court would have to determine the child's level of understanding. Medical reports were important but not decisive. A judge should consider all of the evidence in the case, including evidence about the offence itself, the child's replies or behaviour upon arrest or in interview and the child's responses in court. Direct exchanges between the judge and the child might be necessary. The court was responsible for ensuring that the child had a sufficient level of understanding and, in an appropriate case, would be entitled to disagree with expert opinion.

It would be rare that a stay should be granted at the start of proceedings. If a child could not take an effective part in the proceedings, either because he was unfit to plead or met the criteria set out in *SC v UK* and *TP*, the court should consider whether to switch to a fact finding exercise and decide whether the child did the act or made the omission charged. Article 6 would no longer be engaged as there would be no prospect of a criminal conviction. A stay should only be granted if no useful purpose could be served by finding the facts. In P's case, the Court concluded that the district judge had erred in staying the proceedings on the basis of the medical evidence alone. He should have considered whether he could defer the decision to see how P coped during the trial. He should further have considered the possibility of a finding of no case to answer or a finding that P was *doli incapax*, either of which would have resulted in an acquittal. Although the appeal was allowed, in the circumstances, the Court declined to remit the matter to the youth court.

## Comment

The decision in *DPP v P* provides a valuable summary of existing powers and procedures for dealing with young defendants who may have difficulty participating in court proceedings. Nevertheless, the headline-grabbing aspect is bound to be the apparent resurrection of the *doli incapax* defence for children over 10, which is much more controversial. But how likely is it that a court properly seized of the issue would conclude that such a defence still exists? Furthermore, given that issues of capacity, fitness to plead and effective participation tend to overlap, would the availability of a defence of *doli incapax* make any difference in practice?

## Statutory interpretation

The Divisional Court was of the view that a literal interpretation of section 34 was consistent with an attempt to abolish only the presumption and not the defence of *doli incapax*:

*"The subject of the sentence in section 34 is 'the rebuttable presumption of criminal law' and the verb 'is abolished' can only apply to the subject. If so, it must be the presumption that has been abolished."*<sup>22</sup>

However, given that the origins of *doli incapax* are unclear, we do not know whether a defence of *doli incapax* ever existed separately from the presumption. If not, then the removal of the presumption is effectively the end of the matter and there is no residual defence for the Court to recognise.

The Court then turned to *Hansard* for assistance. It is well established that where the meaning of an enactment is ambiguous or obscure, a court may have regard to any statement from *Hansard* made by, or

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<sup>22</sup> *Op.cit.* para 40.



on behalf of, the promoter of the Bill which clearly discloses the mischief aimed at or the legislative intention<sup>23</sup>. The court may also have regard to other Parliamentary material insofar as it assists in understanding the statement. In *DPP v P*, the Court cited two relevant statements.

The *Crime and Disorder Bill* was introduced in the House of Lords. During its second reading, Lord Falconer of Thoroton, then Solicitor-General, confirmed that *doli incapax* would still exist as a defence:

*“The possibility is not ruled out, where there is a child who has genuine learning difficulties and who is genuinely at sea on the question of right and wrong, of seeking to run that as a specific defence. All that the provision does is remove the presumption that the child is incapable of committing wrong.”*<sup>24</sup>

The Court also quoted Jack Straw (the Home Secretary at the time) in the House of Commons but found that his statement was consistent with both the abolition of the presumption and the abolition of the defence<sup>25</sup>.

Finally, the Court referred to a Home Office circular published after the *Crime and Disorder Act 1998* came into force. The purpose of the circular was to set out a policy for CPS lawyers dealing with young offenders. According to the circular, children aged 10 to 13 were now to be treated in the same way as older children when deciding whether it was appropriate to prosecute. The Court accepted that the circular gave the impression that a defence of *doli incapax* was not available to a child aged 10 or over but reminded itself that a Home Office circular was not an admissible aid to construction.

In concluding that *doli incapax* remains as a defence, the Court thus relied heavily upon Lord Falconer’s statement, which was made at an early stage of the Parliamentary procedure. It is submitted that having regard to subsequent statements and to the mischief that the Act was aimed at, future courts are likely to conclude that Parliament in fact intended to remove the rule of *doli incapax* altogether insofar as it applied to children age 10 to 13.

### **The Parliamentary history of section 34**

In 1997 the Home Office published a consultation paper entitled *Tackling Youth Crime, Reforming Youth Justice*<sup>26</sup> in which it was argued that the rule of *doli incapax* was in need of reform for the following reasons:

- We now have compulsory education from the age of 5 and children can differentiate right from wrong at an earlier age;
- When *doli incapax* was introduced, children faced the death penalty for crimes less serious than murder. The modern system of sentencing, with its emphasis on preventing re-offending, means that a child who offends should be convicted so that he can be subject to proper control and appropriate intervention with the opportunity for rehabilitation at an early stage;
- It is extremely difficult for the prosecution to prove that a child has the necessary capacity in order to rebut the presumption.

The paper asked whether, in the circumstances, the presumption should be abolished, so as to put a child between the ages of 10 and 13 in the same position as one aged between 14 and 17, or whether it should be reversed. On this basis it appears that the use of the word “abolished” in section 34 is significant and that it was intended to do more than simply alter the presumption.

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23 *Pepper v Hart* [1993] 1 AC 593.

24 *HL Deb* 16 December 1997 c596.

25 *HC Deb* 8 Apr 1998 c372.

26 *Great Britain. Home Office. (1997) Tackling Youth Crime, Reforming Youth Justice: A Consultation Paper.*

The consultation paper was followed by a White Paper entitled 'No More Excuses'<sup>27</sup>. Upon its publication, Jack Straw told the House of Commons that:

*"The present rule of doli incapax – being incapable of evil – can stand in the way of holding properly to account 10- to 13-year-olds who commit crimes, yet young people of that age know that it is wrong to steal, vandalise or commit an assault. We intend to abolish that archaic rule to ensure that such young people are answerable for their offences."*<sup>28</sup>

In answer to a question about whether these proposals might be contrary to European human rights law, he replied:

*"We are convinced that our proposal to remove the concept of doli incapax is fully consistent with the European Convention on Human Rights. Interestingly, there was a period in the Divisional Court – when C v the Director of Public Prosecutions set the law – when doli incapax was effectively abolished. That did not lead to injustice for young offenders, but made for a little more efficiency."*<sup>29</sup>

The reference to abolition of the "rule" of doli incapax and the "concept" of doli incapax suggest that the Government intended to abolish doli incapax altogether. It is submitted that this interpretation is reinforced by the context in which these words are used and particularly the approval of the Divisional Court's decision in *C v DPP*, which temporarily abolished both the presumption and the defence for children over the age of 10.

In December 1997, Lord Falconer made the statement referred to in *DPP v P*, which clearly indicates that a defence of doli incapax would remain. However, following this, a number of references in Hansard suggest that Lord Falconer may have been out of step with the rest of the members of the Government, who intended something entirely different.

During both the committee stage and the report stage of the Bill, the Liberal Peer Lord Goodhart proposed the following amendment to the relevant clause<sup>30</sup>:

*"Where a child aged 10 or over is accused of an offence, it shall be a defence for him to show on the balance of probabilities that he did not know that his action was seriously wrong."*

In response, the Government did not suggest that the amendment was unnecessary because the wording of the clause already left a defence of doli incapax available in an appropriate case. Rather, during the committee stage, Lord Williams of Mostyn argued against the amendment on the grounds that where the *actus reus* and *mens rea* of an offence are present, age should be no defence:

*"If [the sanction of the criminal law] needs to be invoked, the presumption of doli incapax has gone. We then need to demonstrate that the child has the appropriate mens rea and that the act itself was committed. However regrettably, and no one regrets it more than me, if that act has been done, the child is guilty of a criminal offence... [Some] children do wicked acts. No one rejoices in that. No one is happy that at the age of 10, which is very young indeed, those children have done evil things. Very often it is not really their fault because they have been formed by others who have failed to care for them. But the fact is that the act has been committed and the intent demonstrated; otherwise no conviction is possible."*<sup>31</sup>

27 Great Britain. Home Office. (1997) *No More Excuses – A New Approach to Tackling Youth Crime in England and Wales*. London: The Stationary Office. (Cm. 3809).

28 HC Deb 27 November 1997 c1090.

29 HC Deb 27 November 1997 c1100.

30 HL Deb 12 February 1998 c1316; HL Deb 19 March 1998 c829.

31 HL Deb 12 February 1998 c1323.

Lord Williams further argued that the Government's proposals would benefit children because the abolition of *doli incapax* would enable them to receive “*appropriate intervention and the decent opportunity for rehabilitation with care, help and support*”<sup>32</sup>.

Lord Goodhart withdrew his amendment during the committee stage but proposed it again during the report stage, when it was rejected by a significant majority<sup>33</sup>. It is submitted that this clearly indicates a Parliamentary intent to remove the defence entirely.

The progress of the clause was more straightforward in the House of Commons, where there was virtually no debate about the distinction between reversal of the presumption and its abolition. However, in addition to the passage cited by the Court in *DPP v P*, Jack Straw referred to *doli incapax* as a “*legal fiction*” which was to be abolished<sup>34</sup> and, later, confirmed “*we are abolishing the concept of doli incapax*”<sup>35</sup>. Thus when the totality of ministerial pronouncements is considered, there is strong evidence of an intent to remove *doli incapax* completely from the relevant age group.

Further, it is submitted that the complete abolition of *doli incapax* addresses the mischief that the enactment was aimed at, whereas reversal of the presumption does not. One of the main problems that the Government sought to address was the perceived difficulty for the prosecution in rebutting the presumption. Parliament was told that:

“*Lawyers acting for offenders between the ages of 10 and 13 use the presumption of doli incapax—incapacity to commit evil—to run rings around the court system, and to avoid proper sanctions for young offenders.*”<sup>36</sup>

The obvious remedy to this perceived imbalance was to abolish *doli incapax* altogether. If *doli incapax* were to continue to exist as a defence, it would place an evidential burden upon the defendant, forcing the prosecution to adduce evidence to rebut the defence to the usual criminal standard. It is submitted that it would be relatively easy for the defence to adduce some evidence of *doli incapax*, such as the testimony of a parent or the child himself. The prosecution would then face exactly the same difficulties as were apparent prior to section 34.

Thus, having regard to both the full extent of the debates in Parliament, the specific rejection of an amendment which would have reversed the presumption and to the mischief that the statute was designed to remedy, it is submitted that there is little prospect that a court properly seized of the issue would conclude that section 34 permits a defence of *doli incapax*.

### Is Doli necessary?

In any event, it is clear from *DPP v P* that issues of fitness to plead, the ability to participate effectively in a trial, the ability to distinguish right from wrong, and even the capacity to form the requisite *mens rea* will often overlap. It would probably be unusual if a child did not appreciate that his acts were seriously wrong but was capable of understanding court proceedings sufficiently to be considered fit to plead. It is, of course, possible that a child may be fit to plead but lack capacity due to immaturity or to issues concerning his upbringing and development, in which case the question of whether he was able to participate effectively in the proceedings would arise. It appears that having the means to know that an act was wrong is a prerequisite for being able to participate effectively in a trial and an inability to

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32 HL Deb 12 February 1998 c1324.

33 HL Deb 19 March 1998 c838.

34 HC Deb 8 April 1998 c376.

35 HC Deb 3 June 1998 c423.

36 HC Deb 8 Apr 1998 c372.

participate effectively will result in a stay. Thus a child defendant who cannot distinguish right from wrong retains some measure of protection under the criminal law, even though this protection exists in the form of a stay rather than a defence.

*DPP v P* makes it clear, however, that a decision to stay proceedings at the outset on the basis of medical evidence alone is unlikely to be upheld save in exceptional circumstances. The Court gave little guidance as to what this might mean but it may be that if the trial process itself would potentially harm the child, this would constitute an exceptional circumstance justifying an early stay. Experts should therefore give consideration to the likely impact of a trial process, or fact-finding process, on a young defendant.

The Court confirmed that a stay could also be granted if no useful purpose could be served by finding the facts. It appears that even if a defendant would not receive a hospital order or a guardianship order, a useful purpose may still be served by going through the fact finding process. Proceedings in a civil jurisdiction may follow, as they did in P's case, and a youth court's findings may simplify these proceedings. It would seem that if proceedings under the *Children Act 1989* are not available or have already been carried out and a hospital order is not appropriate, there would be no point in switching to fact-finding and, again, this might justify a stay.

### **Conclusion: Will doli go away again?**

Defence lawyers and expert witnesses are right to take seriously the possibility of utilising the doli incapax defence in light of *DPP v P*. Ultimately though, it is likely that the courts will recognise that the true effect of section 34 was to remove both the presumption and the defence. The real value of *DPP v P* lies not in its attempt to resurrect doli incapax as a defence but in its recognition that capacity and understanding of right and wrong are highly relevant to the young defendant's ability to participate effectively in his trial.

# Book Reviews

## *The Nearest Relative Handbook by David Hewitt*

**Published by Jessica Kingsley (2007), £17.99**

ISBN 13: 978-1-84310-522-0

Deciding on a publication date is always a risky business. This text could have become the dinosaur of mental health law books if Parliament had reverted to the Government's original proposals for the "nominated person" to replace the nearest relative. The book went to press before the *Mental Health Act 2007* received Royal Assent, and the author and publishers must be mighty relieved that the changes to the current law on the nearest relative have turned out to be minimal. If anything, too much attention has been paid to the various proposals and to speculation about changes in the nearest relative role, rather than concentrating on the actual position.

Overall this book will be of benefit to mental health professionals working in England or Wales, but I am not sure how useful it will be for one of its target groups, nearest relatives themselves. Despite the range of examples it remains a rather complex text with no basic summaries of key points to make it more accessible. However, anything that prevents professionals from muddling up the nearest relative with the next of kin, and which may enhance their understanding of this crucial role, is welcome. For an actual nearest relative's view of the role, readers might wish to look at the 2005 *Journal of Mental Health Law* article by Victoria Yeates<sup>1</sup>.

David Hewitt is a solicitor who specialises in mental health law and is Assistant Editor of this *Journal*. He was also a Mental Health Act Commissioner for nine years. His practical grasp of how the law operates in this field is excellent, and he has illustrated the text with a broad range of case examples.

The book starts with a brief history of the nearest relative. Hewitt wisely draws on Rapaport<sup>2</sup> for his analysis of the development of the nearest relative's role in relation to a number of areas including: applications for detention, objections to detention, receiving information about the patient and, finally, in the discharge process. These functions then provide the framework for an analysis of problems and proposals for change in the nearest relative's role. There is a very helpful discussion of *JT v UK*<sup>3</sup>. I would have preferred more analysis of the issues raised by the author, and much less on the various proposals which were discussed during the draft stages of mental health law reform. Hardly any of these proposals have seen the light of day, and I would suggest that this part of the book will now be of limited interest. There is a brief summary of what emerged as the final changes at the end of the chapter and this would probably have sufficed. In contrast, the passages on *R (E) v Bristol City Council*<sup>4</sup> and other recent caselaw are very welcome and will retain their relevance despite the changes made by the *Mental Health Act 2007*.

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1 Yeates, V. (2005) *Death of the nearest relative? Carers' and families' rights to challenge compulsion under current and proposed mental health legislation*. *Journal of Mental Health Law*, November 2005, pp123–137.

2 Rapaport, J. (2003) *The ghost of the nearest relative under the Mental Health Act 1983 – past, present and*

*future*. *Journal of Mental Health Law*, July 2003, pp51–65.

3 *JT v UK Application No 26494/95 European Court of Human Rights* (2000) 1FLR 909.

4 *R(E) v Bristol City Council* (2005) EWHC 74 (Admin).

For a fuller analysis of the Bristol case I would recommend readers to look at the article by Helen Kingston<sup>5</sup> in an earlier edition of this Journal.

The second chapter tackles the difficult task of identifying the nearest relative of an adult patient. When I started my career as a Mental Welfare Officer under the *Mental Health Act 1959* we used to have the relevant section (on identifying the nearest relative) printed on the back of the application form for detention for treatment (section 26). This helpful aid disappeared with the introduction of the *Mental Health Act 1983* (MHA) (probably because the equivalent form had less space!), and the various statutory and case law changes have made this one of the most difficult and contentious areas of law for Approved Social Workers. As I live and breathe this area of law my criticisms of this essentially sound chapter may appear a little over zealous. People who should be treated as if they are relatives because they have lived with the patient for five years or more are (in my opinion) incorrectly excluded by Hewitt from taking precedence over others within his own version of the hierarchy. For other relatives his stress on the importance of the phrase “ordinarily resides with or cared for by” is more helpful and there are some useful illustrations. This is an area where mistakes are frequently made and I am not sure that this part of the book is as clear as it might have been. Some of the examples are not helpful. One identifies a brother living with the patient as taking priority over a wife, with no mention of the fact that this would only apply if the wife herself were not living with the patient. Readers will need to be stoical, and occasionally to suspend disbelief, as they work through this chapter. These thirty pages of “how to spot the nearest relative” could provide a new cure for insomnia or, more hopefully, lead to a new respect for those who have worked hard to understand and operate this part of the MHA. They successfully integrate the statute with the plethora of case law that has developed over the last few years. It has always been a relief for ASWs that the relevant expression in the MHA is, as Hewitt cites on page 40, the person “appearing to be the nearest relative”. It would have been helpful to have included some further discussion and opinion on what should happen if others (such as the hospital managers) consider that the ASW has identified the wrong person as nearest relative. This has caused some real difficulties in practice. Another related dilemma is: what should happen if the ASW themselves decides with hindsight that they have identified the wrong person as nearest relative on an application form? How can this be rectified?

Chapter 3 sets out the rules that apply when identifying the nearest relatives of children (i.e. any person under the age of 18). This short chapter should be invaluable for those faced with this issue as it is not easy material to carry in one’s head. Chapter 4 then addresses circumstances in which a person will cease to be the nearest relative. This includes the use of Regulation 14 to delegate authority, as well as the county court’s role in displacement or appointment of nearest relatives. The material on court procedure is very helpful and presented more clearly than in many other texts. A comment on what to do if a nearest relative simply refuses to have any involvement at all would have been useful, as the above routes to delegation or appointment are unlikely to be applicable in these circumstances.

Chapter 5 outlines the nearest relative’s powers when admission to hospital occurs or is being considered. It also looks at guardianship, although unfortunately this is not mentioned in the introduction. Guardianship is an area that often involves difficulties concerning the nearest relative. See for example the recent *JE* case in Surrey<sup>6</sup> where the Approved Social Worker did not pursue guardianship by taking the case to county court when the nearest relative objected to a guardianship application. This case and

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5 Kingston, H. (2005) *The balancing act*. *Journal of Mental Health Law*, November 2005, pp186–190.

6 *JE v DE* (1) Surrey CC (2) EW (3) EWHC 3549 (Fam) 2006.



a further Northern Ireland case (*Connor, 2004*)<sup>7</sup> have led to renewed interest in the relationship between guardianship and deprivation of liberty. The role of the nearest relative in this area is central and a more detailed discussion in any further editions of this book would be welcome.

Returning to admissions to hospital, chapter 5 considers the Code of Practice recommendation that the applicant should usually be the ASW. Given the tiny number of applications made by nearest relatives each year (the Department of Health stopped publishing the details in England when they dropped to single figures) it is interesting that the *Mental Health Act 2007* preserves the nearest relative as potential applicant. One reason suggested for this was a concern that there might be insufficient Approved Mental Health Practitioners to cope with the number of assessments. Yeates argued that the nearest relative should not be the applicant but she stressed the importance of section 13(4) and Hewitt gives good coverage to this area where the nearest relative has a right to an ASW assessment.

There is also some very helpful material in chapters 5 and 7 on the nearest relative's powers to discharge a patient. There is a discussion in chapter 5 of the nearest relative's rights to information. This passage would have been strengthened with a more detailed account of sections 132 and the much neglected 133 (notice by hospital managers of the intention to discharge the patient). There is also some further material on the *Bristol* case. The advice given at paragraph 5.52 that there should be no consultation with the nearest relative in any case where this would cause the patient emotional distress, would seem to rather overstate the implications of the *Bristol* judgement and is in contrast with Kingston's approach of balancing the competing Article 8 rights.

Chapter 6 considers supervised aftercare and considerable attention is paid to this area. This chapter will become redundant when supervised aftercare is replaced by the Community Treatment Order. In the meantime it is useful to have all of the relevant material in just one place. Supervised aftercare is an oddity in that it is the only area in the MHA where the ASW's power to make an application (or in this case, recommendation) is not mirrored by a similar right for the nearest relative. This is balanced by a number of provisions related to supervised after-care where the nearest relative is granted specific rights regarding consultation and appeal. Community Treatment Orders will replicate the ASW's role to the exclusion of the nearest relative and Hewitt observes that the nearest relative loses all of the rights that are currently available to them for supervised aftercare.

There is an error at paragraph 7.4 where it is stated that a nearest relative can order the discharge of a patient subject to a hospital order or guardianship order under section 37. In fact the nearest relative's rights here are limited to being able to make an application to the Mental Health Review Tribunal. Paragraphs 7.7 and 7.22 are also inaccurate in that the 72 hour period does not apply to orders to discharge from guardianship.

Chapter 8 seemed an oddity to me. It concerns the *Mental Capacity Act 2005* and it attempts to draw parallels between the role of the Independent Mental Capacity Advocate (IMCA) and that of the nearest relative. There are areas where the two Acts will overlap and the role of the nearest relative under the MHA may well be relevant where someone has made a Lasting Power of Attorney or where a deputy is appointed. Providing an analysis of these areas of overlap rather than focusing on the role of the IMCA would have been more helpful.

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<sup>7</sup> *Connor, Re An Application for Judicial Review [2004] NICA 45 (14 December 2004) Ref: KERF5153.*

The appendix of statutory extracts is very helpful but there are some notable omissions: section 13(4) covering nearest relative's rights to an assessment; section 23 and the power of discharge; section 25 and the grounds for the RMO's blocking order; and sections 132 and 133 covering information. For those staff and relatives who do not have a copy of the MHA, a more detailed appendix would have been helpful.

Some might think that the subject matter of this book would be worthy of one of the more obscure entries to Mastermind ("Specialist Subject: the full range of powers of the Nearest Relative as defined by the Mental Health Act 1983"). However, I would argue that this is one of the most important areas of the *Mental Health Act 1983* where, in practice, the state meets the family head on. This intelligent and comprehensive analysis is a welcome addition to the currently scant literature in this area.

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***Psychiatry and the Law,  
edited by Warren Brookbanks and Sandy Simpson***

***Published by LexisNexis (2007), NZ\$110***

**ISBN 9780408718509**

This is an excellent book that has gathered together contributions from leading experts representing a variety of disciplines<sup>1</sup> to produce an overview of forensic psychiatric practice, especially where it, “bear[s] the heavy imprint of legislation and legal processes”. The editors themselves are respectively a Professor of Law and a Director of Forensic Psychiatric Services.

The book is designed to replace *Psychiatry and the Law: Clinical and Legal Issues*, published in 1996. It focuses on practice in New Zealand but throughout there is discussion of, and comparison with, other countries (particularly Australia and the UK), so that it has a broad relevance.

It is primarily aimed at forensic psychiatrists and those working in forensic mental health but is expected to be of interest to lawyers and judges as well. The foreword, written by a High Court judge, confirms its usefulness to members of the legal profession and adds that it should be read by politicians, those in the media and others who influence public opinion in this area and who need a clear understanding of the issues involved.

The book is divided into 3 main parts: “Legal Principles”; “Clinical Issues in Relation to Mentally Abnormal Offenders” and “Forensic Psychiatry Service Provision”. The structure is such that you can read it through easily, there being a natural progression which leads you through the content. In practice however it is more likely to be dipped into, and most chapters can stand alone allowing you to do this; this does, of necessity, mean that there is a degree of repetition.

The Introduction by the two editors is subtitled, “Responses to risk: legal parameters and service responses”. They reflect that in the 10 years since the publication of their previous version of this text, various adverse public events have raised the profile of forensic psychiatry, at times in a negative light, but they believe psychiatry has emerged stronger and with “a more focused commitment to its service of the public”. In this time there has also been increasing demands on forensic services worldwide, through factors such as an increasing number of prison inmates. Other challenges faced by forensic services include shifting international trends in the law, from a traditional ‘proportionality’ approach to sentencing to one more focused on risk of re-offending (including dispositions such as preventative detention). The forensic psychiatrist asked to help in this, faces difficult ethical dilemmas. Advances made by forensic psychiatry in this time have included a better understanding of the relationship between mental disorders, violence and substance abuse, and improved risk assessment methodologies. They believe less progress has been made in “our understanding about methods for forensic care and risk management”.

The section of the text dealing with Legal Principles comprises the greater part of the book (9 chapters compared with 3 for Clinical Issues and 5 for Service Provision). It begins with a chapter on ethical issues in forensic psychiatry which admirably manages to pin down the key concerns in a complex area and meaningfully discuss them in a succinct and clear manner. Forensic psychiatry involves a greater degree of value judgements than other medical specialities and these judgements (which can affect the patient,

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<sup>1</sup> *The mix being approximately 50:50 contributions from lawyers and clinicians.*

the public or even the clinician) have to be made in a changing social climate which seems to be shifting from concerns based on welfare to concerns based on justice. Throughout the chapter runs the theme of psychiatrists having to balance a duty to act both for the patient and for society – an often conflicting role. Writing a report for a court which is seeking a risk assessment before deciding on an indeterminate sentence, for example, involves the use of clinical skills to elicit potentially damaging information from a person, while having no therapeutic intent. To negotiate these difficulties it is suggested a forensic psychiatrist needs to adopt a transparent, systematic approach to ethical reasoning, and a suitable framework for doing so is discussed.

The Legal Principles section moves on to the definition of mental disorder, looking in detail at the wording used in the New Zealand *Mental Health (Compulsory Assessment and Treatment) Act 1992*. An aspect of the definition highlighted in the chapter is an abnormal state of mind as characterised by a disorder of volition. This can clearly cause difficulties when attempting to distinguish an “irresistible impulse and an impulse not resisted”. This chapter has been written with much of the emphasis on the importance of avoiding “paternalistic medical dominance”. The conclusion is that the *Mental Health (Compulsory Assessment and Treatment) Act 1992* is comparatively enlightened but would be improved by focusing on a lack of capacity as the measure by which to involuntarily treat someone.

The importance of individual autonomy is the theme running through chapters on the implementation of civil commitment and the application of public law. The efforts to strike a balance between a utilitarian versus a civil libertarian approach to civil commitment, the resulting “new legalism”, and the idea of “therapeutic jurisprudence” (the idea the law can be used to achieve therapeutic ends) are all discussed. A well considered approach to these difficulties is outlined. The authors<sup>2</sup> point out there is suggestive evidence that compulsory admission can be of benefit, but it is important to adopt a multi-disciplinary approach and involve the patient in the decision-making process as much as possible. This can involve preventative ethics, for example, whereby a person with capacity makes treatment plans in case they become unwell once more. While civil commitment allows a “doing to” approach to clinical practice, every effort must be made to adopt a “doing with” approach. The powers involved in civil commitment are nonetheless highly coercive and the principles of public law ensure its proper exercise and control. Human rights considerations are important and there is a very helpful overview of the human rights principles that are commonly invoked when the forensic system is challenged and an excellent overview of recent international case law. An interesting discussion follows about constitutional division of power – executive, legislative, judicial branches of government, federal and state divisions – and its implications for mental health law. The core principles of public law are then examined by considering their application in a given scenario, which is a helpful approach.

The Legal Principles section continues by looking at the insanity defence, fitness to plead and sentencing. It then finishes by discussing the way psychiatrists interact with the courts as expert witnesses and report writers, including a chapter which is a guide to writing reports.

A good history of the insanity defence is given, including, of course, the M’Naughten rules which are the basis for the defence in many western jurisdictions. It is shown how the defence may encounter problems in the face of human rights legislation, ‘disease of the mind’ and ‘unsound mind’ being very different in some circumstances. The UK courts have adopted a “narrow literal interpretation” of the defence while a more “liberal approach” is taken by the courts in Australia and New Zealand. In New Zealand an *understanding* of the nature and quality of the act and its wrongfulness is important not just a *knowledge*.

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2 B McKenna, A Simpson and J Coverdale.

Furthermore, wrongfulness clearly relates to a knowledge of moral wrong not legal wrong and the test of the moral standard is subjective not objective in nature. This approach reflects, in the author's<sup>3</sup> view, "sound common sense" and he makes a persuasive argument. The chapter includes a particularly clear exposition of the potentially confusing concept of automatism, especially in its explanation of the distinction between an internal or external cause.

Fitness to plead is examined in detail. The question of whether international human rights standards are met is again raised in relation to the criteria for fitness to plead and the disposal of those found unfit in the UK, Australia and New Zealand. Recent developments in Australia and New Zealand are outlined, and clinical issues follow with a useful section for psychiatrists on the assessment of fitness to plead and writing the subsequent report.

The sentencing and disposition of Mentally Disordered Offenders is often awkward. They can be less blameworthy but more dangerous, bringing public protection and human rights into conflict. The increasing influence of international human rights standards is a theme that runs throughout this chapter, indeed throughout the entire section on Legal Principles. The general principles that should be adhered to when sentencing are identified, such as facilitating treatment while maintaining proportionality, and there is a discussion of a legalism versus a welfarism approach which favours welfarism. Hospital orders in particular are covered, as used in Australia and New Zealand.

Psychiatrists as expert witnesses are described as "mistrusted guests at the legal table", with judges suspecting the medical expert of entrenched bias towards those who call them. The danger in this, according to the author<sup>4</sup>, is that it drives unsatisfactory ad hoc reform. More considered reforms are suggested, revolving around the need for lawyers and psychiatrists to come to a better mutual understanding; the author does justice to this important point.

During my training, I read several chapters in textbooks or articles in journals offering guidance when writing court reports but the chapter in this textbook by G Galpin is by far and away the best. It offers help with the mechanics of writing a report as well as examining potential legal and contextual complexities. It points out that the report should strive to enhance the options available to a court, bringing flexibility and humanity to the law, without dictating the law or excusing offending. It offers sound practical advice throughout and ends with a useful broad template for reports. This should be read by any psychiatric trainee embarking on their first report and would help to refresh and refocus those with more experience.

'Clinical Issues in Relation to Mentally Abnormal Offenders' is the next distinct part of the text. It has chapters on the 'schizophrenic syndrome' and antisocial behaviour, the assessment and management of violence risk, and those with intellectual disabilities. The schizophrenic syndrome is "central" to forensic mental health practice and the discussion that follows is thought provoking and extremely useful to clinicians. With great clarity, the author<sup>5</sup> argues that the association between the schizophrenic syndrome, violence and antisocial behaviour is inherent to the disorder and its effects on the sufferer's functioning. He warns against an excessive willingness to attribute all problems to drug abuse which often becomes an excuse to offer reduced services to the patient or none at all. Principles for managing those high risk patients with a schizophrenic disorder are identified, offering good, practical, evidence-based advice. Interestingly, the author notes that there is no evidence that the drive to deinstitutionalise the

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3 W Brookbanks.

5 P Mullen.

4 I Freckelton.

mentally ill has led to their increased criminalisation; this is at odds with opinions expressed in later chapters.

The next chapter gives a brief history of risk assessment in mental health systems, culminating in the current use of Structured Professional Judgement (SPJ) instruments, which take into account static and dynamic risk factors. It then describes the two most relevant SPJ instruments, the HCR-20 and START<sup>6</sup>, and points out their strengths and limitations. The chapter also describes a model of integrating risk assessment and management that is currently being put into place across all mental health services in New Zealand. It makes very interesting reading for clinicians working elsewhere, who might be involved in service development. The chapter finishes by emphasising the importance of a good therapeutic relationship and sound clinical practice in risk assessment.

A wide-ranging discussion about intellectual disabilities and the law finishes the section on Clinical Issues. Epidemiological studies are cited that suggest an over-representation of ID offenders in the criminal justice system, but it is pointed out that the association does not necessarily mean the historically assumed causal relationship is true. The intellectually disabled require special consideration at every stage of the criminal justice system from police questioning to disposal, and these issues are examined, together with a detailed look at New Zealand law which appears to have some good specific legislation for those with an intellectual disability. Further space is given to specific problems that can be problematic in forensic work with the intellectually disabled: sexual and violent offending and arson. The chapter finishes with a call for more work to be done in this under-researched area.

The final part of the book, Forensic Psychiatric Service Provision, initially identifies some important broad issues in this area. In 1987, a major investigation into services in New Zealand was prompted by a spate of homicides and suicides. This led to the establishment of some guiding principles for services: Mentally Disordered Offenders should have the same access to treatment as non-offenders; are the primary responsibility of the health rather than correctional system; mental illness should be able to be picked up at any stage in the criminal justice system; cultural understanding and family input are essential, and security and therapy must be integrated. An account of the development of services in New Zealand and their future direction then follows.

People of minority ethnicity are over-represented in forensic mental health facilities, be it in the UK, USA or New Zealand. The New Zealand experience in providing treatment and rehabilitation for Maori is given detailed consideration. Attempts made to address the problem that Maori do not seem to do as well in the current service framework, are obviously specific to New Zealand, but the chapter still makes worthwhile reading for the general lessons it has for health professionals trying to improve services for those of a minority ethnicity.

Chapters on psychiatric services to prisons and liaison with courts, reveals the problems associated with effective service delivery. Although advances have been made in New Zealand since the publication of the book's earlier edition, difficulties remain; especially the identification of mentally ill prisoners and the waiting lists for transfer to hospital due to the slow movement of patients through the system. Liaison services and court diversion schemes are compared and contrasted and although the subject is dealt with well, it is also recognised that the various different models of provision, the array of performance indicators and the lack of research into the area, make it difficult to give clear advice on the best way to develop or improve services.

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6 *Historical Clinical Risk management-20 and the Short-Term Assessment for Risk and Treatability.*



The book finishes with a careful examination of rehabilitation in forensic psychiatry. Differing pathways for patients through services are discussed, together with different strategies for rehabilitation. Specific aspects of rehabilitation (risk assessment, pharmacotherapy and psychoeducation, through to work skills training or substance abuse work) are considered separately in a way that is useful and aids overall understanding.

The editors have been very successful in their aim of providing an overview of forensic psychiatric practice. Their obviously careful choice of subject areas and authors has paid off. Almost without exception the contributions are well-written, informative and interesting, especially to a clinician. I imagine the book would have less direct relevance to lawyers but it is a good aid for those seeking a greater general understanding of the area. I would have liked more detail in several of the chapters but this is bound to be a difficulty when the book's scope is broad and, in fairness, the editors say their remit was to provide a useful primary source of information, fully expecting that a wider inquiry might be needed. It might be difficult to use this book to find the answer to a very specific question but as a resource to quickly become informed on a given area in forensic psychiatry it is invaluable. The book's focus is on New Zealand but it deserves to be read by a whole range of professionals in a variety of countries.

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## Mental Health, Incapacity and the Law in Scotland by Hilary Patrick

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A declaration of possible bias needs to be made at the outset of this review. For some years the book's author, Hilary Patrick, has been in effect the 'Scottish correspondent' of this Journal<sup>1</sup>. She has generously made a number of contributions to past issues<sup>2</sup>, on some occasions in response to an editorial request. She also presented (again on request) a paper to the Comparative Mental Health Law Seminar hosted by the Law School at Northumbria University in October 2005<sup>3</sup>. However challenging though it has been, I have tried to approach this book without any preconceptions as to its quality.

Hilary Patrick is an Honorary Fellow in the School of Law at Edinburgh University. She is vice-convenor of the Law Society of Scotland's *Mental Health and Disability Committee*. She was a steering group member of the *Alliance for the Promotion of the Incapable Adults Bill*, and then became a member of the Millan Committee established to review mental health law in Scotland, which reported in 2001 in a publication entitled '*New Directions*'. It is Bruce Millan, the Chair of that Committee, who has written the Book's Foreword. He says of the author: "She combines expertise in the law with a strong commitment to the rights and needs of those suffering from mental disorder" – qualities which are abundantly clear to anyone who reads the book.

Towards the end of the book (in chapter 42) reference is made to a previous "first edition". I found this puzzling until I revisited the publishers' details at the front of the book, where reference is made to the book's predecessor, entitled '*Mental Health, the Law in Scotland*' (Butterworths, 1990) by John Blackie (now professor of law at Strathclyde University) and Hilary Patrick herself. Sixteen years later a second edition was clearly long overdue, not least as a consequence of the two substantial pieces of legislation passed in the last few years – the *Adults with Incapacity (Scotland) Act 2000* and the *Mental Health (Care and Treatment) (Scotland) Act 2003* (referred to within this review as the 2000 Act and the 2003 Act respectively). Not surprisingly, given the book's title, these two significant statutes form the backdrop of much of the book. However the book is so much more than a description and explanation of their provisions. It is divided into 14 Parts with chapters within each Part. A summary of their contents is provided by the author in the Preface. I cannot improve on it, and so reproduce the following (appropriately edited for reasons of space):

*"Part 1 contains a short look at the social and health care background and examines the legal sources of mental health law in Scotland. ... Chapter 2 looks at the main statutes. Chapter 3 looks at key organisations, and Chapter 4 considers ways in which the service user can be empowered in the process..."*

1 It should be added that (a) others from Scotland have also generously contributed, and (b) further contributions from others are of course most welcome.

2 'Reviewing Scottish Mental Health Law: Any Lessons for England and Wales?' JMHJ December 2000 @ pp 147 - 156; 'Scottish 'public safety' test for discharge of restricted patients held ECHR compatible' JMHJ February 2000 @ pp 43-49; 'Scottish Parliament acts on Mental Health

Law Reform' JMHJ August 2003 @ pp 71-76; 'Reflections from Scotland: Difficult Decisions Ahead' JMHJ November 2005 @pp 169-173.

3 'Mental Health Law in Scotland: Principled yet Pragmatic?' – paper delivered at the Comparative Mental Health Law Seminar held at Northumbria University on 14th October 2005.

*Part 2 deals with issues of general medical law, such as capacity and consent to treatment, the right to insist on certain forms of treatment, confidentiality and planning for future incapacity. Part 3 deals with the impact of compulsory measures and Part 4 with the role of the new Mental Health Tribunal for Scotland.*

*Part 5 looks at decision-making for people who lack capacity to take medical, welfare or financial decisions, both under the Adults with Incapacity Act, and also under common law...*

*Part 6 looks at community care and people's rights to services. Part 7 looks at the protection of people at risk.*

*Part 8 (by Margaret Ross (Senior Lecturer at the University of Aberdeen and Vice-Chair of the Mental Welfare Commission for Scotland)) considers the impact a mental disorder may have on a person's day to day life, whether it is making contracts, serving on a jury or seeking employment or housing.*

*Part 9 (by Lynn Welsh (Head of Scottish Legal Affairs) and Irene Henery (Legal Assistant at the Disability Rights Commission)) considers protection against unlawful discrimination.*

*Parts 10 and 11 are slightly different. They consider the impact of the law on different groups, including women, people from the minority ethnic communities, people with dementia or learning disabilities, refugees and asylum seekers, children and young people, and in Part 11, carers...*

*The interaction of the mental health and criminal justice systems is extremely complex. Part 12 attempts to set out the rules as clearly as possible.*

*Part 13 looks at the bodies responsible for ensuring standards in health and social care, and Part 14 ... attempts to give some guidance as to what happens when things go wrong..."*

Not surprisingly therefore, the book is a weighty tome (as reflected in its price) – 844 pages of text followed by 175 pages of appendices and index. The breadth of the material covered indicates the author's intention that it should serve as a guide and reference book for easy access by many. Ambitiously, the author says in the Preface:

*"While I hope the book will be of use to lawyers, it is not aimed exclusively at them. Many other people have an interest in these matters. Doctors (including GPs), social workers (particularly mental health officers), independent advocates and welfare rights workers may all find something of interest. The book attempts to avoid legalistic language (although some of the legal provisions it describes are very complex) and I hope it will be of use to users of services, families and carers."*

Such an aim is not without risks. The end result can so easily end up satisfying no-one. The lawyers may want more detail; the other professionals can be misled about the law by over-simplification of those complex provisions referred to in the above quote; service users and families may seek more practical advice. Having read through the entire book – admittedly concentrating more assiduously on some sections than on others – I have no doubt that the author has successfully avoided this happening.

It is true that in a number of places I, as a lawyer, *did* want more analysis of the law, and I am equally sure non-lawyers may criticise some of the contents as being too legalistic, but overall I feel the author has got the balance right, and has written a book extremely accessible to all those groups she had in mind as she wrote. Very conscientiously, the author has 'sign-posted' readers to other sources, be it caselaw, statutory provisions, secondary legislation, extracts from Codes of Practice<sup>4</sup>, other books, articles, guides produced

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<sup>4</sup> Readers from outside Scotland might be surprised to learn that there is a 3 volume Code of Practice for the 2003 Act, and that there are seven Codes under the 2000 Act.

by voluntary organisations etc. etc. She also provides what would appear to be a very useful and comprehensive list of 'Contact details', in particular sources of information, advice and assistance. This is indeed an invaluable guide and reference book for all those with any interest in, and involvement with, services for those suffering from a mental disorder in Scotland.

But it is so much more than a reference book and (surely) a 'must have' book for those working in the mental health field in Scotland. Its contents are of considerable interest to those of us *not* working in Scotland who are keen to know how those north of the border have sought to resolve those numerous issues which have occupied the thinking of so many of us for so long in recent years – not only in England and Wales (E&W) but also no doubt in other jurisdictions. I, for one, confess to possession of patchy knowledge and understanding prior to reading this book. I also acknowledge a hitherto long-held belief (based on that limited knowledge, and fuelled by certain observations of such expert observers as Lord Carlile<sup>5</sup> and Lucy Scott-Moncrieff<sup>6</sup>) that by and large (despite concerns expressed in a previous issue of this Journal by the author<sup>7</sup>) they had got things right in Scotland whilst in E&W we continued to struggle with, and fudge the resolution of, what have seemed irreconcilable problems. For what it is worth, my view now is that such a belief is too simplistic. Much of what is now in statutory form in Scotland seems to me (but maybe not others) appealing – *for example* principles on the face of both Acts, the introduction of a 'named person' as a source of support to the service-user, 'significant impairment of decision-making ability' as a pre-detention criterion, and the wide brief of the Mental Welfare Commission – whilst in other ways Scottish provisions seem problematic – *for example* the lack of a statutory provision equivalent to section 5 *Mental Capacity Act 2005*<sup>8</sup> (E&W) would appear to have led to some uncertainty as to when a Court order is required, and the apparent ease with which the view of a medical decision-maker (appointed by someone before loss of capacity) can be overridden by the medical profession does seem (as the author points out) "logically indefensible".

It is very much to the author's credit that she does not shy away from highlighting any lack of clarity in the law and failings which she perceives in the legal provisions. She is critical of certain errors and omissions in the Codes of Practice; and of the compulsory treatment provisions in Part 16 of the 2003 Act, she says:

*"The drafting of part 16 is extremely complex. Many people will not find it easy to understand these important provisions when reading the Act. The Mental Health (Care and Treatment) Act is committed to principles of openness and accessibility. It is regrettable that the parliamentary draftspeople (sic) appear to have found these principles so difficult"*

Another example of her readiness to criticise where necessary, is her wry observation of the provisions within the 2000 Act which enable a person to apply for removal of his/her nearest relative:

*"The Adults with Incapacity Act says that a person cannot apply for the removal of his or her nearest relative unless at the time of the application the adult is incapable as defined in the Act. As the Act's definition of incapacity is always linked to particular decisions, it is not clear what this means. If it means*

5 Chair of the Joint Parliamentary Scrutiny Committee on the Draft Mental Health Bill 2004. See 'Legislation to law: Rubicon to Styx?' by Alex Carlile, JMHL November 2005 @ pp 107–109.

6 Solicitor (London). See 'A sense of Déjà vu - a preliminary (and immediate) response to the report of the Scrutiny Committee on the draft Mental Health Bill' by Lucy Scott-Moncrieff JMHL May 2005 @ pp 77–82 – in

particular her conclusion that "The Government should consider adopting the Scottish Act; lock, stock and barrel."

7 See 'Reflections from Scotland: Difficult Decisions Ahead' by Hilary Patrick JMHL November 2005 @pp 169–173.

8 Protection from liability for certain acts done in connection with care or treatment of a person lacking capacity to decide for him/herself.

*that someone can make an application only when he or she is unable to do so, it is not, perhaps, one of the more enabling provisions of the Act.”*

As I read through the book, inevitably I found myself comparing Scottish provisions with those pertaining to actual and anticipated provisions in E&W, with my notes leading me to a review of the law rather than a review of the book. To some extent the author encourages such a comparison. She has researched widely with several references to decided cases from the English courts and the European Court of Human Rights (and indeed in a few instances to cases from further afield e.g. Canada and South Africa). Of course I wanted her to say more about several such cases but to do so might well have unbalanced the book. Similarly I found myself being critical of some of her succinct summaries of E&W provisions (e.g. “The legal duty [derived from s. 117 MHA 1983] extends only to patients who have been compulsorily detained in hospital for at least six months”, which is potentially misleading) but the book is firmly about Scotland and is *not* a comparative study with other jurisdictions.

Both the author and the publishers should be given considerable credit for the book’s lay-out. It is structured and presented in a way which invites easy ‘dipping into’. Generous and thoughtful use is made of headings, sub-headings and sub-sub headings, and the footnote referencing (so much of which assists the signposting referred to above) is very accessible. There are a few typographical errors, and in a couple of places an annoying failure to cross-reference – for example the term ‘Assessment Order’ is encountered in chapter 16 but not explained until chapter 45 with no cross-referencing from one chapter to the other – but given the size of the book, these are very minor quibbles indeed.

In summary, it seems to me that Hilary Patrick has written an invaluable book. I am in no position to judge the accuracy of her description of the law but I have no reason to doubt that it is anything but correct. I urge that consideration be given to an early second (or is it a third?) edition (possibly a loose-leaf version incorporating both the major statutes?). In numerous places the author refers to ‘the present’ (May 2006) with the implication that debate is ongoing and change may be afoot, and I have no doubt that in several such places law and/or practice has moved on<sup>9</sup>. For this book to be seen as a reliable and authoritative source on mental health and (in)capacity law in Scotland (as it surely deserves to be) both now and in the future, regular up-dating is essential. It would be a considerable loss to those interested in, and affected by, the law, were this not to take place. Certainly another sixteen years must not be allowed to elapse before this occurs.

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9 In addition of course there is ongoing research into the effects of the legislation which should be of interest to the book’s readership. For example, see (1) ‘Psychiatrists’ views and experiences of the Mental Health (Care and Treatment) (Scotland) Act 2003’ by Christine Carswell et

al, *Psychiatric Bulletin* (2007) Vol. 31 No. 3 pp 83/4, and (2) ‘Before and after: Introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003’ by Helen Smith and Tom White, *Psychiatric Bulletin* (2007) Vol. 31 No. 10 pp 374–376.

