

Journal of Mental Health Law

Articles and Comment

Taking Stock

The Deprivation of Liberty Safeguards – essential protection or bureaucratic monster?

'Publicity v Privacy: finding the balance'. When and how to publish reports of mental health homicide independent investigations

Lost in a Legal Maze: Community Care Law and People with Mental Health Problems.
The Law Commission's Review of Adult Social Care Law

A Pilot Study of the Early Experience of Consultant Psychiatrists in the Implementation of the Mental Capacity Act 2005: Local Policy and Training, Assessment of Capacity and Determination of Best Interests

Is Capacity "In Sight"?

Policing Care in the House of Lords

First Do No Harm. Second Save Life?

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Hospital Orders: Detention in a Place of Safety Pending Transfer

Not Now So Unexacting? The Section 139 Threshold Re-Defined

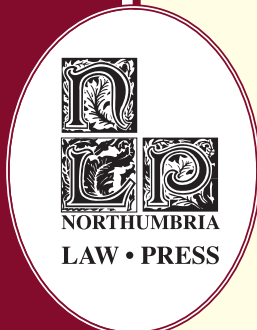
Book Reviews

Coercion and Consent. Monitoring the Mental Health Act 2007–2009

Mental Illness, Medicine and Law

A Tendency to Laugh and Sing: Some Notes on Mental Health Law

Some Recent Publications



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Footnotes and references

Footnotes to sources should be numbered in one consecutive series of Arabic numerals and placed at the foot of the page. Footnote style

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Foreword

Yet again, and not without some considerable embarrassment, I find myself apologising for the lateness of an issue. The ‘autumn’ issue has become a ‘winter’ issue (indeed a late winter issue). Many apologies are due to all subscribers and contributors. I am relieved to say however that no such apology will need to accompany the next issue. The 20th issue is to be the promised ‘special’ issue devoted to consideration of one matter, namely the viability and appropriateness of ‘*A model law fusing incapacity and mental health legislation*’ (the title of the issue). Its lengthy gestation period is nearly complete, and publication is expected within weeks of publication (in March 2010) of this *Winter 2009* issue.

So far as this issue is concerned, I am delighted that once more¹ Brenda Hale has authorised the Journal to print the text of a conference speech she has delivered. It opens this issue. On 9th October 2009 Lady Hale addressed a conference in Manchester organised by the Approved Mental Health Professionals Association (North West and Wales) and Cardiff Law School, entitled ‘*Taking Stock: The Mental Health and Mental Capacity reforms: the first year*’. In ‘**Taking Stock**’, Lady Hale reflects on the development of, and “upheavals in”, mental health and mental capacity law in recent times, commencing her reflection in 1971 when she first started teaching mental health law as an academic at Manchester University. We are very grateful both to her and the conference organisers.

April 2009 witnessed the most recent of the upheavals – the introduction of the Deprivation of Liberty Safeguards². That same month the Law Society (with the support of the Royal College of Psychiatrists) hosted a conference in London, ‘*The Mental Health Act 2007 six months on: Issues and challenges*’. Roger Hargreaves, independent social care consultant and trainer, and the ‘lead’ for the British Association of Social Workers in the parliamentary considerations of the Draft Mental Health Bill 2006, addressed the conference, asking the question ‘**The Deprivation of Liberty Safeguards – essential protection or bureaucratic monster?**’. With several months experience of the DoLS in practice to draw upon, Mr. Hargreaves has kindly updated his answer to the question, lamenting the shortcomings of the new procedures and making clear his consequent grave concerns.

In the Spring 2009 issue we were pleased to revisit the controversial area of Homicide Inquiries³. Within this issue Lucy Scott-Moncrieff (solicitor) and Ed Marsden (Managing Director of a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations) explore the issue of anonymity in such Inquiries. In ‘**Publicity v privacy; finding the balance**’ they consider ‘**When and how to publish reports of mental health homicide independent investigations**’. The authors draw heavily on the experience of the litigated Michael Stone Inquiry Report⁴, explore the competing demands of Articles 8 and 10 of the European Convention on Human Rights, and provide helpful guidance to authors of future Homicide Inquiry Reports.

1 ‘What can the Human Rights Act do for my mental health?’ was published in the JMHL May 2005 (pp 7–16); ‘The Human Rights Act and Mental Health Law: Has it helped?’ was published in the JMHL May 2007 (pp 7–18)

2 Schedules A1 & 1A Mental Capacity Act 2005

3 ‘Learning Lessons: Using Inquiries for Change’, Gillian Downham and Richard Lingham, JMHL Spring 2009 (pp 57–69)

4 Considered in ‘The Michael Stone Inquiry – A Reflection’, Robert Francis QC, JMHL May 2007 (pp 41–49)

In the Introduction to their book *'Community Care and the Law'* (2007)⁵, Luke Clements and Pauline Thompson bemoan the fact that:

"Community care law remains a hotchpotch of conflicting statutes, which have been enacted over a period of 50 years; each statute reflects the different philosophical attitudes of its time. Community care law is in much the same state as was the law relating to children in the 1980s. The law was in a mess; there were no unifying principles underlying the statutes; there were many different procedures for essentially similar problems A great deal of this confusion and nonsense was swept away by the *Children Act 1989*, which repealed many statutes, in full or in part, and replaced them with a unified procedure underscored by a set of widely accepted basic principles. It takes no great genius to realise that community care law is crying out for similar treatment."

The Law Commission are now facing this challenge. As a Law Commission lawyer, Tim Spencer-Lane is ideally placed to summarise the nature and extent of the Commission's task, and this he does in **'Lost in a Legal Maze: Community Care Law and People with Mental Health Problems. The Law Commission's Review of Adult Social Care Law'**. Since this article was accepted for publication, the Consultation Paper to which the article refers in its conclusion has been published, and a period of consultation now follows⁶.

We then move onto two articles about 'capacity'. Professor Ajit Shah (University of Central Lancashire) and colleagues report on the results of **'A Pilot Study of the Early Experience of Consultant Psychiatrists in the Implementation of the Mental Capacity Act 2005: Local Policy and Training, Assessment of Capacity and Determination of Best Interests'**. Neil Allen (Barrister and Clinical Teaching Fellow at the University of Manchester) attempts to answer the question he set himself at the October conference organised by the Approved Mental Health Professionals Association (North West and Wales) and Cardiff Law School referred to above, namely **'Is Capacity "In Sight"?'**. Once more we are grateful to the conference organisers for raising no objection to publication.

Developments in the Courts have prompted the next two articles. In **'Policing Care in the House of Lords'** Professor Ralph Sandland (Nottingham University) considers two decisions of the House of Lords on 21st January 2009: *R (on the application of Wright) v Secretary of State for Health* (2009)⁷ and *Trent Strategic Health Authority v Jain* (2009)⁸. As Professor Sandland states: "The issue was the same in each case: Is a system which removes the right of a person to work in or to operate a care home, or to provide care services to a person in their own home, without giving that person any meaningful ability to defend or challenge the allegation against them, acceptable in the era of human rights?". In **'First do no harm. Second save life?'** Neil Allen provides a second article for this issue. He considers the House of Lords deliberation of the case of *Savage v South Essex Partnership NHS Foundation Trust* (2009)⁹ (the appeal from the Court of Appeal decision¹⁰ which he reviewed for the JMHL in May 2008¹¹), before moving on to an exploration of the High Court decision in *Rabone v Pennine Care NHS Trust* (2009)¹². The link between the cases is a hospital patient's suicide; Carol Savage was a detained patient whereas Melanie Rabone was

5 Published by Legal Action Group (4th ed.) (2007)

6 'Adult Social Care', *The Law Commission Consultation Paper No. 192. The period of consultation closes on 1st July 2010.*

7 [2009] UKHL 3

8 [2009] UKHL 4

9 [2008] UKHL 74

10 [2007] EWCA Civ 1375

11 'Protecting the suicidal patient', Neil Allen, May 2008 (pp 93–100)

12 [2009] EWHC 1827 (QB)

informal. The House of Lords and the High Court respectively grappled with the circumstances in which a failure to avert death might result in a conclusion that the ECHR Article 2 right to life has been violated.

In the Casenotes section, David Hewitt (Solicitor and Visiting Fellow, Law School, Northumbria University) generously reviews two cases. In **'Hospital Orders: Detention in a Place of Safety pending Transfer'**, the decision of the Court of Appeal in *R (DB) v Nottinghamshire Healthcare NHS Trust* (2008)¹³ that a hospital order will cease to have effect if its subject is not admitted to hospital within 28 days, is analysed. In **'Now not so unexactng? The Section 139 threshold re-defined'**, Dr. Hewitt reports on the High Court's re-visiting in *Johnston v The Chief Constable of Merseyside Police* (2009)¹⁴ of the test for the granting of leave for the bringing of civil proceedings as a consequence of an act purporting to be done under the *Mental Health Act 1983*.

Under the heading 'Book reviews', readers are invited to consider reviews of **'Coercion and Consent. Monitoring the Mental Health Act 2007 – 2009'** (the former Mental Health Act Commission's 13th and final Biennial report), **'Mental Illness, Medicine and Law'** (a compendium of essays published as a volume of Ashgate's *International Library of Medicine, Ethics and Law*), and **'A Tendency to laugh and sing: Some notes on mental health law'** (Northumbria Law Press's publication of a number of essays and articles by David Hewitt over recent years). I myself conclude the issue with a 'round-up' of **'Some recent publications'**.

As always sincere thanks are due to those who have so generously contributed to this issue of the JMHL, and also to the anonymous referees whose conscientious input is so critical to the quality of each issue.

John Horne

Editor

13 [2008] EWCA Civ 1354

14 [2009] EWHC 2969 (QB)

Taking Stock¹

*Brenda Hale*²

Many congratulations to Cardiff Law School and the Approved Mental Health Professionals Association (North West and North Wales) for organising this timely conference. I am looking forward to learning a lot from the galaxy of mental health law practitioners and scholars here today. It is a special pleasure to be back in Manchester, where I spent 18 years of my professional life and first encountered mental health and the law.

We shall be reflecting on the experience of the three recent upheavals in mental health and mental capacity law – the *Mental Capacity Act 2005*, most of which came into force on 1 October 2007, accompanied by a Code of Practice; the *Mental Health Act 2007* amendments to the *Mental Health Act 1983*, most of which came into force on 3 November 2008, accompanied by its two Codes of Practice; and the *Mental Health Act 2007* amendments to the *Mental Capacity Act 2005*, bringing in the so-called deprivation of liberty safeguards or DOLS, on 1 April this year, together with another Code of Practice. That is a huge amount of new law for us all to get to grips with. Things have changed a great deal since I first started teaching Mental Health Law to social workers and psychiatrists in this very City in 1971 – nearly 40 years ago.

There was no such thing as mental health law then. The *Mental Health Act 1959* had only been in force for ten years. The only law books were large practitioners' tomes (Shaw's *Mental Health Services*³ and Heywood and Massey's *Court of Protection Practice*⁴). For many mental health professionals, including Kathleen Jones, whose *History of the Mental Health Services*⁵ (1972, bringing together *Lunacy, Law and Conscience 1744–1845* and *Mental Health and Social Policy 1845–1958*) was the main academic text of the time, "legalism" was a dirty word. The 1959 Act was hailed as the death of mental health law. The Court of Protection might be necessary to look after the property and affairs of people who were rich enough to make it worthwhile but whose families were not smart enough to devise ways of avoiding its attentions. But everything else could be handled by a presumption of informality.

What lawyers might call safeguards, mental health professionals called formalities. The formal procedures were operated largely by the professionals and only used when the patient's resistance made it necessary to do so. The social workers I taught were deeply uncomfortable with the contradictions between their therapeutic role, based for many of them on psychotherapeutic principles of client responsibility and autonomy, and their power to take that autonomy away. The result was a playing down of the importance of legal safeguards. The law said nothing about what treatment might be given to incapacitated or detained patients in hospital because it was assumed that they could be given whatever treatment their doctors thought best for them.

1 This is the text (with added footnotes) of the keynote address delivered by the author at 'Taking Stock: The Mental Health & Mental Capacity reforms: the first year', a conference organised by the Approved Mental Health Professionals Association (North West and North Wales) and Cardiff Law School in Manchester on 9th October 2009.

2 Baroness Hale of Richmond; *Justice of the Supreme Court*.

3 Now out of print. However, Shaw & Sons Ltd intend to publish in due course its successor 'Gostin on Mental Health Law' (publication date not known).

4 Heywood and Massey: *Court of Protection Practice* is now in its 13th edition (2009) (Sweet & Maxwell).

5 Published by Routledge & Kegan Paul (1972)

A parallel system of court orders was provided for mentally disordered offenders. In theory, they could be neatly pigeon holed into the 'bad' – who should be punished in proportion to the seriousness of their crimes – and the 'mad' who could be kept in hospital until they were cured. But in practice, there was a category of restricted patients who could be kept in hospital for as long as the Home Secretary thought that they might be a danger to the public. For those who could not be cured this meant that they might remain in hospital for a very long time.

The lawyers were hardly involved at all. There was virtually no case law about the 1959 Act in the 1960s. (So it is not surprising that the first edition of my little book⁶, published in 1976, was able to cover the whole of the law in England and Wales, with a supplement on Scottish law, in around 75,000 words and 236 pages.) The underlying policy assumptions were that the NHS could be trusted to look after the health and local authorities to look after the social care of people with mental disorders and disabilities, in much the same way as they looked after people with physical disorders and disabilities. Warehousing patients in large institutions in the countryside was to be phased out.

It is easy to forget what a radical change the 1959 Act had been from the previous approach of both the law and the public services. Much of it we now take for granted: the *United Nations Convention on the Rights of People with Disabilities*, adopted in 2006 and coming into force in 2008 (ratified by the United Kingdom in 2009) uses the conventional language of “mainstreaming”.

But things were changing in the 1970s. Larry Gostin, now at Georgetown University in Washington, brought an American civil rights lawyer's eye to our system and found it deeply wanting (MIND, *A Human Condition*, 1975 and 1977⁷). The Butler Committee on Mentally Disordered Offenders (1975) was sceptical about the pigeon holes. The public remained scared of mentally disordered offenders. Mr X, conditionally discharged from Broadmoor for some years, was summarily returned to hospital because of what his estranged wife told his probation officer. He could do nothing at all to challenge the reasons for his detention before a court which could let him out. The European Court of Human Rights held the United Kingdom in breach of its obligations under article 5 of the ECHR (*X v United Kingdom* (1982) 4 EHRR 188, an application made in 1975 and decided in 1981). Human rights were very firmly on the scene.

The result was the *Mental Health Act 1983*. This left the basic structure intact. But it gave a greatly expanded and enhanced role to mental health review tribunals. It also placed some restrictions on the compulsory treatment of detained patients. Perhaps above all, it created the Mental Health Act Commission. Can we pay tribute to the work of the Mental Health Act Commission⁸ and regret its passing? I hope that the Care Quality Commission will be able to keep up their good and very necessary work on behalf of detained patients, which could all too easily be obscured by the more everyday concerns of a body which has the whole of health and social care to regulate and worry about.

After the 1983 Act, there was a great deal more law for the professionals to know (so the second edition of my little book, published in 1984, had grown to 346 pages and had to drop its Appendix on Scotland). Academic lawyers, most notably Phil Fennell⁹, were now taking an interest and engaging in serious research. But there was still not a lot of case law and only a few practising lawyers were involved.

6 *Mental Health Law* by Brenda Hoggett (Sweet & Maxwell) – now in its 4th edition (1996): The 5th edition is due to be published in June 2010.

7 Now out of print.

8 See a review of the MHAC's 13th Biennial Report in this

issue of the *Journal of Mental Health Law*.

9 Now Professor of Law, Cardiff Law School, Cardiff University. Author of 'Mental Health: The New Law' (Jordans) (2007), reviewed in the *Journal of Mental Health Law* May 2008.

Richard Jones' invaluable *Mental Health Act Manual* did not begin publication until 1985, but has sped to 12 editions¹⁰ in less than quarter of a century.

But soon the legal practitioners did begin to take an interest. I assume that this was because legal aid (technically only assistance by way of representation) had become available before MHRTs. Their enhanced powers over restricted patients meant that heavy weight judges had been drafted in to preside over what became increasingly like ordinary trials. Lawyers began to specialise and the olden days when the tribunal and the mental health professionals knew far more about the law than the lawyers did were left behind. Lawyers also began to bring judicial review proceedings in the High Court. The case law began to develop, though only quite slowly to begin with. So my third edition in 1990 grew only to 369 pages.

By then there was a new concern. Many more people with serious mental disabilities were living in the community and living longer. Their families and carers were very concerned that there seemed to be no legal framework for looking after them. Here again, the assumption was that informality was best. I do not at all question this assumption, but there were no clear principles governing what could be done and no obvious procedures for resolving doubts and difficulties. Behind closed doors, the Family Division of the High Court began granting declarations authorising controversial procedures. In a blaze of publicity in 1989, the House of Lords endorsed this: *Re F (Mental Patient) (Sterilisation)* [1990] 2 AC 1. The Law Society (in the shape of Penny Letts)¹¹ and the Law Commission (in the shape of Brenda Hoggett, as I then was) began to take an interest in reforming the law.

The nineties and noughties saw a massive expansion in activity on three fronts. The Law Commission produced their *Report on Mental Incapacity* in 1995 (Law Com No 231). The Government consulted and produced draft Bills for pre-legislative scrutiny. Eventually, 10 years after the Law Commission's Report, the *Mental Capacity Act 2005* hit the statute books, doing more or less what the Commission had proposed. It was kind of Paul Bowen to call it "an elegant piece of legislative architecture" (*Blackstone's Guide to the Mental Health Act 2007*¹², 2007, p ix).

But when the Act was passed it was already known to be incomplete. This was the result of the rapidly growing case law, even before the *Human Rights Act 1998* came into force. One product of that, as everyone knows, was the *Bournewood* case (*R v Bournewood Community and Mental Health NHS Trust, ex p L* [1999] AC 458). The Court of Appeal, as everyone knows, held that Richard Jones and I were wrong to think that the 1983 Act authorised informal admission and treatment of people who lacked the capacity to decide for themselves to accept treatment. They had not been referred to the legislative history, or to the policy underlying the 1959 Act, or to the case law on necessity, including *Re F*. The House of Lords rescued the situation in 1998, but many thought that the absence of safeguards to protect people who were informally deprived of their liberty in this way was indeed a gap. The facts did not help, as L would clearly have objected to his admission to hospital had he not been sedated in order to get him there. In 2004, the European Court of Human Rights held, in *HL v United Kingdom* (2004) 40 EHRR 761, that the risk of arbitrary and unjustified deprivation of liberty without access to a tribunal meant that there was a breach of article 5 of the European Convention on Human Rights. Something had to be done. But the Government could not decide what to do before the Mental Capacity Bill was passed,

10 *Mental Health Act Manual* by Richard Jones (Sweet & Maxwell) (12th edition) (2009). See 'Some Recent Publications' by John Horne in this issue of the *Journal of Mental Law*.

11 *Now an independent Policy Consultant; then Law Society Policy Advisor and Secretary to the Law Society Mental Health and Disability Committee*.

12 *Blackstone's Guide to the Mental Health Act 2007* by Paul Bowen (Oxford University Press) (2007), reviewed in the *Journal of Mental Health* May 2008.

just before Parliament was dissolved in time for the election in May 2005. Countless breaches of article 5 must have taken place up and down the country while the Government pondered the dilemma. I am not aware that anyone has taken action under the *Human Rights Act* as a result, but perhaps someone here will know. Five years after *HL* we now have the answer in the DOLS.

As Paul Bowen¹³ comments, these are a “decidedly inelegant” addition to the 2005 Act, nearly doubling it in size. I am not sure that I would call it “the new triumph of legalism” because legalism referred to the involvement of lawyers and magistrates in committal procedures, whereas these procedures are, as he points out “labyrinthine and bureaucratic”. I am not sure which is worse.

The Government thinks that there are roughly 500,000 people in England and Wales who have a mental disorder and lack capacity living in institutions (including over 190,000 with severe learning difficulties and about 230,000 older people with dementia). Department of Health analysts concluded that around 10% of these would require additional restrictions for their own protection which might involve deprivation of liberty. For some reason they then predicted that there will be 21,000 assessments in 2009/2010, of which only 25% would lead to authorisation. They also predicted that assessments will rapidly decline to 6,600 in 2015/16 but a similar proportion will result in authorisations. This is because they think that care homes and hospitals will become skilled at avoiding deprivations of liberty. An alternative hypothesis is that they will become skilled at avoiding using these procedures, just as most people managed to avoid troubling the Court of Protection even though they should have done. The Ministry of Justice thinks that only 2.5% of authorisations will result in a Court of Protection hearing. We shall see, but current experience suggests that they have over- rather than under-estimated the numbers. The worry remains that people who are in fact being deprived of their liberty are also being deprived of the safeguards to which they are entitled.

Meanwhile, in another part of the forest, the Government was reviewing the *Mental Health Act*. As always, deeply contradictory forces were at work. On the one hand were the mental health professionals who wanted the law to reflect the realities of modern mental health care, including multi-disciplinary teamwork and treatment in the community. But there was now much a better understanding between the professionals and the lawyers. Jill Peay’s study of “Decisions and Dilemmas” (2003)¹⁴ showed that the professionals were much more respectful of their patients’ autonomy and conscious of their legal rights than they had been when I was sitting on Mental Health Review Tribunals in the early 1980s. The dilemma as always was how to reconcile that consciousness with their perception of their patients’ needs. The lawyers too were beginning to realise that the goal was not always to keep the patient out of hospital at all costs but often how to achieve the care and treatment which the patient really needed. Together they could make common cause. It was that collaboration which produced the 1999 Report of the Expert Committee¹⁵, led by Geneva Richardson. This tried to reflect the realities of modern practice while providing rational and defensible grounds for interfering in autonomy and proper procedural safeguards for doing so.

On the other hand the Government, with a great deal of public support, was increasingly concerned with protecting the public from offenders deemed especially dangerous. This meant detaining them long after the proportionate “tariff” for the crimes they had committed had expired and until they could show that

13 Barrister, Doughty Street Chambers. See n.12.

14 ‘Decisions and Dilemmas: working with Mental Health Law’ by Jill Peay (Hart Publishing) (2003), reviewed in the *Journal of Mental Health Law* February 2004.

15 The report of the Expert Committee ‘Review of the Mental Health Act 1983’ was published by the Department of Health in November 1999.

they were “safe”. This concern was first reflected in the “hybrid” orders brought in by the *Crime (Sentences) Act 1997* but we also see it in the indefinite sentence for public protection. The view that a restriction order was no longer an answer must have increased when the first declaration of incompatibility under the *Human Rights Act 1998* held that it was for the hospital to show that the grounds for detention still existed and not for the patient to show that they did not (*R (H) v Mental Health Review Tribunal* [2002] QB 1).

The battle between these two points of view continued for nearly a decade until the *Mental Health Act 2007*. After the expert report, there was a green paper, a white paper, three draft bills, pre-legislative scrutiny in Parliament, human rights audits by the Joint Committee on Human Rights, and eventually a decision to make only those amendments to the 1983 Act which were thought most necessary. It is not entirely clear that either side has prevailed.

Two examples will have to do. We now have a completely open-ended diagnostic criterion for compulsion – any mental disorder – which removes any connection between the capacity of the patient to make decisions for himself and the power of the state to authorise his detention. But we also have a requirement that appropriate treatment actually be available for the patient before his liberty is taken away¹⁶. We also have community treatment orders – so confusingly called SCT in the Codes of Practice – but considerable limitations on the circumstances in which treatment can be imposed upon a community patient.

So now the mental health law community has to grapple with two pieces of legislation, three Codes of Practice, and a multitude of case law both in the UK and in Strasbourg. Oh, and with different Codes and Regulations in England and Wales. Enormous care has been taken to keep the mental health and mental capacity regimes separate. But why? Some might think that the principles underlying the mental capacity regime were all one needed and the procedures in the mental health regime might be suitably adapted. But that is probably too radical a thought. No wonder all the books are getting fatter.

But I continue to ask myself, what is all this law for? Is it to enable people with mental disorders to obtain the care and treatment most suitable to their needs? Or is it to protect the rest of us from our fear of the harm that a small minority of them may do? Or is it to keep them away from hospitals and doctors and protect them from being treated differently from other people? I think that I might summarise the guiding and unifying principles like this:

- (1) People with mental disorders and disabilities should be enabled to receive the treatment and care which they need.
- (2) This applies to all people, without discrimination on grounds such as sex, racial or ethnic origin, sexual orientation, religion, membership of a particular social group, or the nature of their disorder or disability.
- (3) Enabling does not mean enforcing. Everyone should be assumed to have the ability to decide for themselves whether to accept the treatment or care that others think they need. A person's right to choose what may be done with his body or his mind should only be taken away if he lacks the capacity to make the decision for himself.
- (4) Any restriction on this right should be kept to a minimum. If it is taken away in important respects, for example by depriving him of liberty or obliging him to accept treatment which he

¹⁶ Other than in the case of short-term detentions (ss.5(4), 5(2), 135, 136), detentions for assessment (ss.4, 2) and remands by the criminal courts for reports (s.35).

does not want, there should be effective safeguards against abuse, regular reviews and the opportunity to challenge the decision before an independent tribunal.

- (5) There must always be the appropriate care and treatment in return. The guiding principle in deciding what to do should be the best interests of the patient, but his own personality, wishes, feelings and values are an important part in deciding what will be best for him.
- (6) Underlying and overriding all of these principles is respect for the dignity and humanity of all people, however disabled or disordered in body or in mind or both.

These are undoubtedly the values underlying the *Mental Capacity Act 2005* and translated into law. They are less obviously the values underlying or reflected in the *Mental Health Act 2007*. The amended section 118 of the *Mental Health Act 1983* requires the Code of Practice to say something similar, but reading the Code always suggests a sting in the tail:

“1.2 Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder by maximising the safety and wellbeing of patients, promoting their recovery *and protecting other people from harm.*”

I think it improves with the next:

“1.3 People taking action without a patient’s consent must attempt to keep to a minimum the restrictions they impose upon the patient’s liberty, *having regard to the purpose for which the restrictions are imposed.*”

The next is better still:

“1.4 People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient . . . They must consider the patient’s views, wishes and feelings (whether expressed at the time or in advance).”

As is the next:

“1.5 Patients must be given the opportunity to be involved, as far as practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible ... Carers and families should also be involved.”

But what about the last?

“1.6 People taking decisions under the Act must seek to use the resources available to them and to patients *in the most effective, efficient and equitable way*, to meet the needs of patients *and to achieve the purpose for which the decision was taken.*”

Which is more efficient? To invoke the DOLS where an elderly patient is in fact being prevented from leaving the ward, to find ways of caring for her which avoid this risk, or to find ways of avoiding invoking the DOLS? As we learn more about the new laws and how they are working in the course of today, perhaps we could think about my radical suggestion!

The Deprivation of Liberty Safeguards – essential protection or bureaucratic monster?¹

*Roger Hargreaves*²

The background

The Deprivation of Liberty Safeguards (DoLS), which came into force on the first of April 2009 as an amendment to the *Mental Capacity Act 2005*, are still commonly referred to as the “Bournewood safeguards,” but in fact the concern about the underlying issue long predates the final decision of the European Court of Human Rights on the *Bournewood* case. It goes back at least to 1983, when the new Mental Health Act brought in much greater protection for patients who were formally detained in hospital, and in particular for those who lacked the capacity to consent to treatment and who acquired additional safeguards under Part IV of that Act. However, this in turn highlighted the total absence of protection for those patients without capacity who were “*de facto* detained” under the common law.

I was one of the first Mental Health Act Commissioners, and I can well remember in the mid-1980s visiting large, remote learning disability hospitals some of which still had several hundred patients. Our remit extended only to those formally detained under the Act, who in such hospitals were usually less than 5% of the total, but it was clear to us that the situation of the other 95% was not materially different – all were subject to the same institutional regimes and had minimal control over their own lives, and there was no question that they would be prevented from leaving if they attempted to do so. Nor did most of them have family, friends or social workers outside who could safeguard their interests, and as they had no right of appeal to a tribunal they could not benefit from the post-1983 extension of Legal Aid to tribunal hearings, which was then fuelling an explosion of legal activity in respect of those who were formally detained.

One such patient was HL, who had been at Bournewood Hospital in Surrey since 1962. However, in 1994 he was discharged into the care of professional family carers, and when he was readmitted in 1997 to the “intensive behavioural unit”, and *de facto* detained, they had the ability and the determination to mount a legal challenge on his behalf, which in 2004 established that reliance on common law was incompatible

1 This paper is an expanded version of the one given to the Law Society Mental Health Conference in April 2009

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with Article 5 of the ECHR.³ In 2005 the government consulted as to the best way to remedy this incompatibility, and the prevailing view was that this should be by extension of the *Mental Capacity Act* rather than the *Mental Health Act*.⁴

A lack of Parliamentary scrutiny

So far, so good – there was general agreement both about the need for new powers and about the most appropriate vehicle for them. However, this is where things began to go wrong. There should by then have been a new Mental Health Act, but the government had been forced to abandon not one but two draft Bills, a situation without precedent, and in March 2006 it decided to introduce, on a very tight timescale and with minimal consultation, a Bill to amend the existing Act. It then further decided to tack the deprivation-of-liberty amendments to the *Mental Capacity Act* onto the end of it.

This had a number of consequences. First of all, the preparation of the definitive DoLS proposals, and the consultation on them, had to be telescoped to fit the timetable of the Mental Health Bill, and the senior government lawyers were no doubt preoccupied with Community Treatment Orders (CTOs) and “appropriate treatment” and do not appear to have exercised sufficient oversight of the drafting of the two new Schedules to the *Mental Capacity Act*, A1 and 1A, which are the core of DoLS. At the time of the first stakeholder consultation meeting in September 2006 the scheme appeared to be still in a very raw and unsatisfactory state, with much unnecessary complexity, but we were told that the Schedules had already been “signed off” to go into the Bill and could be amended only in detail; and indeed, we did not even get sight of them until the Bill was published in November 2006, only two weeks before its Second Reading in the Lords.

To be fair to the officials concerned, they were far more receptive to advice than their Mental Health Bill colleagues down the corridor, who appeared to be under instructions to resist all amendments however sensible, and they did their best to compensate for the deficiencies in the Schedules by incorporating our suggestions into the Regulations and the Code of Practice⁵, which were first shown to us in very early drafts. However, this inevitably added to the complications, and it introduced inconsistencies between the Schedules and the Code which are now becoming apparent as practitioners begin to grapple with them. In addition, it was not possible to address fully the issue of the relationship between DoLS and the *Mental Health Act*, since the officials had assumed at the outset that there would be only minimal overlaps of the populations affected, the powers themselves and the personnel operating them, and it appeared only gradually to dawn on them that the interactions between the two schemes would be both substantial and complex.

In theory, this could all have been put right in Parliament, but the Mental Health Alliance was equally preoccupied with CTOs and “appropriate treatment”, and as the lead on the Bill for the British Association of Social Workers (BASW) my priority had to be the Approved Mental Health Professional and the issues related to it. It would not, in any case, have been possible to remedy the defects in the Schedules by a few selective amendments, and in BASW’s Parliamentary Briefing I said that “their complexity is completely disproportionate to the nature of the powers involved, and would be a considerable burden on those required to understand and to implement them ... the draft Schedules

3 *HL v United Kingdom* (2004) 40 E.H.R.R. 761

4 *Protecting the Vulnerable – the Bournewood consultation – summary of responses – Department of Health June 2006*

5 *The DoLS Code of Practice, issued by the Ministry of Justice in August 2008, is a supplement to the main Mental Capacity Act Code “and should be used in conjunction with it.”*

should be withdrawn and the whole scheme should be drastically simplified, paying particular attention to the need to ensure compatibility with the Mental Health Act.”

However, in the context of the war of attrition which was then going on between the Alliance and the government, absorbing all available time in both Houses, there was no possibility that this message would be heeded, and so, apart from a brief consideration by the Joint Committee on Human Rights,⁶ the Schedules passed into law unscrutinised and unamended.

A scheme for hospitals rather than care homes

What we have, therefore, is a scheme which was generally supported in principle but which is severely defective in detail. These defects arise, first of all, from the government’s determination to base it around the *Bournewood* case, despite this being very untypical of the circumstances in which the new power is likely to be needed.

Bournewood Hospital has now closed, as have almost all the other long-stay hospital units for people with learning disabilities. Long-term care for people with any kind of mental disorder is now provided almost entirely outside the hospital system, and this has had an enormous impact on the population of care homes. Even 20 years ago, few care homes would accept residents with an appreciable degree of dementia, but now in England alone there are about 150,000 residents with this diagnosis in homes for older people, 40% of all residents.⁷ People with learning disability and challenging behaviour, or people with behaviour disturbance due to an acquired brain injury are also cared for almost entirely outside hospital, and increasingly even outside the care home system in high-support housing schemes where the care staff are provided by a registered domiciliary care agency.⁸ The potential for deprivation of liberty *outside* hospital (and even outside the DoLS scheme, which applies only to hospitals and care homes) has therefore greatly increased.

At the same time, the need for any new power within hospitals has greatly *decreased*. Hospital admissions are increasingly short-term and for acute treatment only, and the *Mental Health Act* is used much more frequently than hitherto – between 1996 and 2006 the rate of detention increased by 20% whilst the number of beds declined by 29%, with the result that around 36% of in-patients are now detained at any one time.⁹ Indeed, anyone with a learning disability being admitted to a specialist hospital unit for management of disturbed behaviour in similar circumstances to those of HL in 1997 would very probably now be detained under the *Mental Health Act*, as was HL himself when his *de facto* detention was challenged. There are very few circumstances in which an in-patient receiving treatment for mental disorder could be detained under DoLS but not under the *Mental Health Act*, and there are a number of cogent reasons, set out by Richard Jones in the preface to the 11th edition of his *Mental Health Act*

6 See later references

7 *The State of Social Care in England 2007–8, Commission for Social Care Inspection January 2009, paras 4.16, 4.21*

8 *A care home is defined in Section 3 of the Care Standards Act 2000 as one which provides “accommodation together with nursing or personal care”. High-support housing schemes also provide nursing or personal care, but the care is supplied by a domiciliary care agency as defined in Section 4(3) of that Act. Both must be registered with the Care Quality Commission under Section 11. To the uninitiated observer, many high-support housing schemes are indistinguishable from care homes, and are arguably no less likely to be depriving residents of their liberty, but are outside the DoLS scheme.*

9 Keown, P. et al *A retrospective analysis of hospital episode statistics, involuntary admissions under the Mental Health Act 1983, and the number of psychiatric beds in England 1996–2006, British Medical Journal 2008;337:a1837*

Manual¹⁰, as to why the *Mental Health Act* should be preferred, in particular that the procedural safeguards are much greater.¹¹

Although in its initial consultation the government did acknowledge that “there is the potential for people to be deprived of their liberty in care homes as well as in hospitals”,¹² when we first met the officials in 2006 to discuss the detailed scheme their thinking was still very hospital-oriented. This was perhaps understandable in that hospitals were what they knew – the Department of Health deals directly with them, whereas the care home sector has historically related primarily to the local authorities and the social care regulator – but it has had the consequence that the nature of the scheme is basically unsuited to the sector in which the majority of cases are likely to arise.

The responsibility for recognising that deprivation of liberty is taking place, and of applying for an authorisation, rests with the “managing authority”, that is the hospital or the care home.¹³ This should be a straightforward task for psychiatric hospitals, which have staff who are very familiar with the legal issues around capacity and detention, plus a substantial underpinning of management, regulation and legal advice, but the care home sector is very different. There are approximately 20,000 care homes in England and Wales,¹⁴ the majority of which are small independent organisations in which the proprietor is often a hands-on carer. Proprietors and managers frequently have minimal knowledge of mental health and mental capacity law, and many have no ready access to legal advice or training.

This was noted by the Parliamentary Joint Committee on Human Rights, which said “ In *HL v United Kingdom* the Court held (at para 114) that ‘an important ingredient of lawfulness is that all law must be sufficiently precise to allow the citizen – if need be with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail.’ The proposals to amend the *Mental Capacity Act* are detailed and complex, and we question whether they will be readily understood by proprietors of residential care homes, even with the benefit of professional advice.”¹⁵

Moreover, over 30% of care home residents in England are self-funding,¹⁶ and many homes take no publicly-funded residents at all and so have no contractual relationships with the Primary Care Trusts and local authorities who are the supervisory bodies for DoLS. In addition, homes with high quality ratings may now be inspected by the regulator, the Care Quality Commission (CQC), only once every two or three years. The logistics of informing and educating them about the new provisions, and of monitoring their compliance with them, are therefore formidable – in Kent, for instance, there are 16 mental health hospitals but 723 registered care homes.¹⁷

10 Jones R.M, *Mental Health Act Manual 11th Edition*, Sweet and Maxwell 2008

11 *And this position appears now to have been strongly reinforced by the judgement of Charles J in the GJ case ((2009) EWHC 2972 (Fam) 20th November 2009)*

12 “Bournemouth” Consultation, Department of Health March 2005 para 4.2

13 *Mental Capacity Act 2005, Schedule A1 Para 24*

14 *The State of Social Care in England 2007–8, Commission for Social Care Inspection ; Annual Report 2007–8, Care*

and Social Services Inspectorate Wales

15 *Joint Committee on Human Rights, Legislative Scrutiny, Mental Health Bill, 4th Report of Session 2006–7, HL Paper 40/HC 288, para 90*

16 *The State of Social Care in England 2007–8, ibid (note 6 above), based on Laing and Buisson’s Care of Elderly People Market Survey 2008. This is an estimated average; in wealthier parts of the country it may be over 60%.*

17 *CQC Directory of Care Homes and Care Services and Healthcare Services Directory, at www.cqc.org.uk*

The guidance (or lack of it) on deprivation of liberty

The guidance from the government then tells the managing authorities that “deprivation of liberty in a hospital or care home should be a relatively rare occurrence, therefore only a small number of people should need a DoLS authorisation.”¹⁸ Whether or not it is true, this statement is likely to become a self-fulfilling prophecy; if you are a care home proprietor with little understanding of the legal issues and are reluctant to fill in the standard application form, which runs to 12 pages asking 34 separate questions,¹⁹ some of which you don’t fully understand, so that assessors can come and question the way you care for your residents, it will be easy to convince yourself that whatever deprivation of liberty is, if it’s a rare occurrence then it surely can’t be happening in *your* home.

This tendency will then be reinforced by the vagueness and inconsistency of the official guidance. The government told the Joint Committee on Human Rights that it was “not possible” to provide a statutory definition, since the distinction between a restriction on liberty and a deprivation of liberty “was a matter of degree rather than substance”,²⁰ and it says in the Code that “the question of whether someone has been deprived of liberty depends on the particular circumstances of the case” and that “the question of whether the steps taken ... in relation to a person amount to a deprivation of that person’s liberty is ultimately a legal question, and only the courts can determine the law.”²¹

It has, nevertheless, given advice on identification, but this has varied from document to document – for instance, its guidance to supervisory bodies in the Implementation Tool issued in April 2008²² is quite significantly different to that in the Code issued four months later. Its subsequent guidance to managing authorities is based on the Code, but is again not identical to it, and there seems to be no awareness that small differences in wording can make a big difference to the way in which phrases are interpreted by staff on the ground – for instance, “a significant period” in the Code becomes “a long period of time” in the guidance to managing authorities.

The Code is, however, the definitive document to which all parties are required by law to “have regard”²³, and it lists seven factors which it says, very tentatively, “can be relevant to identifying whether steps taken amount to a deprivation of liberty.”²⁴ Several of these factors are, however, no more than very general statements, useful for stimulating discussion in a case conference or as the starting-point for a legal argument but open to too many interpretations, and of little help in closing down discussion and reaching a decision as to whether or not to make an application, which is what managing authorities are required to do.

For instance, the statements that “staff exercise control over assessments, treatment, contacts and residence” and that “the person loses autonomy because they are under continuous supervision and control” could arguably apply to any regime which is providing a very high level of care for people, such as those with severe dementia, who totally lack the ability to make decisions for themselves and who would be at high risk if not continuously supervised. These criteria can be properly understood only with an understanding of the caselaw from which they are derived, but it is not reasonable to expect a care home manager to possess this.

18 *Deprivation of Liberty Safeguards – a guide for hospitals and care homes*, Department of Health/Office of Public Guardian OPG608 February 2009, page 11

19 *Standard Form 4*. In February 2009 the Department of Health issued standard forms and letters for the use of managing authorities and supervisory bodies. These are non-statutory, but reflect closely the requirements of the Schedules and Regulations.

20 *Joint Committee on Human Rights*, *ibid* (note 15 above) para 84

21 *DoLS Code of Practice*, *ibid* (note 5 above) Chapter 2

22 This was guidance from the Department of Health to the Local Implementation Teams to enable them to estimate the likely need for authorisations in their areas.

23 *Mental Capacity Act 2005* Section 42(4)

24 *Code* para 2.5

When in doubt about their legal duties, care homes tend to look to the regulator, now the CQC, but the guidance it has issued to them²⁵ will further compound the problem. It contains yet another set of variations on the Code, and it makes a number of assertions which go beyond what is said in the Code or which could reasonably be inferred from current caselaw. In particular, it says that “a decision about any one thing is unlikely to mean that someone is being deprived of their liberty” (so it might be lawful to chain them in the cellar unless it was also decided to bar their relatives from visiting them there!) and that “periodically restraining someone in order to give them vital care or treatment ... does not alone amount to them being deprived of their liberty”.

The issue as to how frequently and how severely restraint can be applied under the protection of Section 6 of the *Mental Capacity Act* before it amounts to deprivation is an extremely grey area, and in the absence of caselaw the Code (para 2.12) correctly treads very warily – “where the restriction or restraint is frequent, cumulative and ongoing, or if there are other factors present, then care providers should consider whether this has gone beyond permissible restraint.” The CQC variation on this, however, is that “where restraint is used frequently *and* (my italics) other decisions have been taken that significantly restrict a person’s liberty, services should consider whether the person’s liberty is being deprived” (sic). Reading this, a home manager might well be reassured, falsely in view of the lack of caselaw, that frequent use of restraint does not raise a question of deprivation unless other restrictions are also being applied.

An alternative approach

Richard Jones, in the 3rd edition of his *Mental Capacity Act Manual*, has also produced guidance based on the caselaw, but his is more detailed and specific and includes 20 factors which he has divided into two lists, the first being of factors at least one of which would, in his view, need to be present for a court to find deprivation, and the second being of factors which by themselves would amount only to restriction on liberty.²⁶ For instance, where the Code says simply that deprivation may arise “if staff exercise complete and effective control over the care and movement of a person for a significant period,” Jones lists the following factors as likely to point to deprivation:

- Force or threats being used to prevent the person from leaving the hospital or care home in a situation where the person is making a persistent and/or purposeful attempt to leave
- Sedation being used to prevent the person from making an attempt to leave the hospital or care home
- The patient’s access to the community being denied or severely restricted primarily due to concerns about public safety

And the following factors as likely in themselves to point only to restriction:

- The person being treated or cared for in a locked environment
- The design of door handles or the use of key pads making it difficult for a confused person to leave the hospital or care home
- Staff bringing a person who has wandered back to the hospital or care home

25 MCA DoLS; guidance for CQC staff and providers of registered care and treatment services, *Care Quality Commission* 074/09, May 2009.

26 Jones, R. *Mental Capacity Act Manual 3rd Edition*, Sweet and Maxwell 2008, 2-006. Revised lists have been incorporated in Part 6 of the 12th Edition of his *Mental Health Act Manual*, published in October 2009

- Dissuading a confused person from attempting to leave the hospital or care home, using benign force if necessary; this would be the case even if they had attempted to leave the premises on more than one occasion
- A temporary refusal to let the person leave the hospital or care home in the absence of an escort whose role would be to support the person rather than to protect the public.

Lawyers may argue about the validity of particular factors, but the basic approach is sound; my experience in training is that front-line practitioners, including care home managers, can relate these factors much more easily to real-life situations than the seven points in the Code, and that when they have been taken through them they are much more confident that they can recognise when deprivation is taking place, and of equal importance, when it is *not* taking place. This tends to confirm the view of the Joint Committee on Human Rights that “deprivation of liberty is a less flexible and elusive concept than might be thought from the draft illustrative guidance.”²⁷

The scheme will not begin to work properly, therefore, until the government is prepared to issue much more specific guidance which makes practical sense to staff in care homes, and perhaps not even then until it is backed up by positive action by the CQC to identify possible unlawful deprivation.²⁸ However, the CQC’s monitoring programme, for 2009–10 at least,²⁹ will focus almost exclusively on cases where applications have already been made and of ensuring compliance with procedures thereafter, and there is no suggestion yet that its inspectors will pro-actively seek out cases where applications should have been made but have not been.

In the meantime, it is perhaps not surprising that applications have been very slow to materialise. By the end of the first six months, 4068 had been made, a third of what the Department of Health had expected in that period, and leading to around 1550 authorisations³⁰, even though many with experience “on the ground” felt the Department’s annual forecast³¹ to be a serious under-estimate of the true level of deprivation.

Unnecessary bureaucracy

If applications do remain at a low level, however, the second major defect of the scheme will perhaps not matter so much. The government on its DoLS website says that the safeguards “are designed to protect the interests of an extremely vulnerable group of service users whilst avoiding unnecessary bureaucracy” but that’s a government target which has most definitely been missed. Richard Jones sums it up very well – “a procedure has been created that is hugely complex, voluminous, overly bureaucratic and difficult to

27 Joint Committee on Human Rights, *ibid* (note 15 above) para 86

28 In England, the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) Regulations 2009 give the Care Quality Commission powers to monitor the operation of DoLS in both hospitals and care homes. In Wales there are no regulations, but the Welsh Ministers “have provided that as part of their regular inspection processes” DoLS will be monitored by the Health Inspectorate Wales (HIW) and the Care and Social Services Inspectorate Wales (CSSIW). In England, monitoring of DoLS in care homes will for the time being be incorporated into the existing inspection and quality assurance processes which the CQC inherited from the Commission for Social Care Inspection.

29 CQC guidance for staff and providers, *ibid* (note 25 above)

30 Six-month outturn figures (to 30th September 2009) announced on 5th November 2009 by Paul Gantley, National Programme Implementation Manager for the Mental Capacity Act, at the Community Care conference on Safeguarding Vulnerable Adults.

31 Regulatory Impact Assessment, May 2008. This assumed 21,000 assessments in the first year, leading to 5,000 authorisations, but with a peak in the first six months. Many local surveys carried out on the basis of the government’s own Implementation Tool produced estimates of at least double these figures.

understand, and yet provides mentally incapacitated people with minimum safeguards... the fact that key elements of the *Mental Capacity Act* have been rendered largely incomprehensible to both lay people and to many professionals represents a significant failure on the part of both government and Parliament.³²

The Schedules consist of a total of 205 paragraphs, and there are then a further 40 regulations, and all this to define a single, simple power. It is not just the length of the Schedules which makes them so impenetrable, but their obscure language, their relentless over-specification of detail, and their convoluted structure which makes it impossible to find the answer to any question in any one place. The convolutions are such that they may even in some places have defeated the drafters, as practitioners who follow them are now finding themselves in legal cul-de-sacs from which there is no rational line of escape.

As a result, the Code of Practice is not what is conventionally understood by that term, but is largely a summary of the Schedules and Regulations in plain English. It does not even attempt to cross-reference to the Schedules as that would be virtually impossible, so those reading it have no idea what is statute and what is simply guidance, or whether the guidance is consistent with the statute. In some places it is not – for instance, at 3.17 it advises supervisory bodies that on receipt of an application they must “consider whether the request is appropriate and should be pursued” but the Schedule makes no provision for any such screening-out process.

The incomprehensibility of the statute has had a number of consequences, the first of which is that most of the assessors and managers in the supervisory bodies who will be applying the safeguards have been trained entirely on the basis of the Code, and very few have seen the Schedules or even have access to a copy of them. The Code is, however, no more than a summary, and not always an accurate one (for instance, although it purports to apply to Wales it is, because the Welsh Assembly made its own Regulations after it was published, now incorrect for that country at 14 points, of which only 8 have been highlighted in subsequent guidance.)³³ It also uses different language, which may be legally significant – for instance, although the Schedules describe the relevant person as being a “detained resident”,³⁴ the Code only once uses the word “detained,” and that is hidden away in an appendix.³⁵ The dangers, when operating legislation involving deprivation of liberty, of relying on a summary alone will no doubt be apparent to readers of this journal.

A second consequence is that there are in England 36 standard forms and letters running to 188 pages, and the best-interests assessors, to do everything that might fall within their remit, would need to complete 13 of them.³⁶ The Welsh have cut the length of the forms by nearly two-thirds, no doubt with the very laudable intention of reducing the burden on the assessors, but it may have the opposite effect – the saving grace of the English forms is that they do follow the Schedules very closely, and so the assessors can simply answer the questions and tick the boxes without needing to know very much about the underlying statute.

32 *Mental Capacity Act Manual 3rd Edition, ibid, (note 26 above) Preface*

33 *Guidance for Supervisory Bodies / Guidance for Managing Authorities, Welsh Assembly Government, February 2009.*

34 *Schedule A1 Para 6*

35 *Code page 114*

36 *A best-interests assessor may be qualified to carry out up to five of the six assessments, plus the “third-party consideration” assessment, and might also complete forms on behalf of the supervisory body.*

A serious omission

The most serious weakness of the Schedules, however, is that although they are incredibly prescriptive and rigid in respect of peripheral matters which could largely be left to discretion, they are completely silent on a number of issues of substance. In particular, they fail to ensure that the power granted to the managing authority is precisely defined, or to ensure that its use is closely monitored, and they therefore leave the way open for abuse of that power.

The Regulations require the managing authority, but only “if they are available or could reasonably be obtained,” to include on the application form “details of the proposed restrictions on the relevant person’s liberty.”³⁷ If these details *are* provided, the best interests assessor will no doubt address them, although the Code makes no reference to this and simply directs the assessor to “examine any relevant needs assessments and care plans prepared for the person,” this being the sole requirement in the Schedule.³⁸ The unstated assumption appears to be that the care plan will be the main source of the detail of the restrictions which the managing authority is placing or proposes to place on the person’s liberty – “the assessor must consider whether the care plan and the manner in which it is being, or will be, implemented constitutes a deprivation of liberty.”³⁹

The standard (but non-statutory) form then requires the assessor to give their opinion as to whether “the proposed arrangements” are in the person’s best interests.⁴⁰ “Proposed arrangements” is however, not a term which appears in either the Schedule or the Code, nor is there any requirement for the assessor to spell out what they understand those arrangements to be or in which document they are to be found, and it is no more than an assumption that the term refers to the restrictions which are supposedly set out in the application and/or care plan (but which need not be).

If that is the case, then it also assumes that the assessor has approved those arrangements as they were originally presented. However, one of their duties is to ensure that the person’s liberty is restricted to the least extent necessary, even if this still amounts to deprivation of liberty,⁴¹ and they may therefore insist on changes to the arrangements before they are prepared to agree that they are in the person’s best interests. The restrictions which the assessor thinks are acceptable may therefore not be those set out in the application form or the care plan, but the Code does not acknowledge that there may be a process of negotiation, and appears to envisage that the assessor will simply say yes or no to whatever was initially put forward by the managing authority.

The negotiations may in any case be academic, since where an authorisation is given without conditions, there is nothing in the Schedules which requires the managing authority to abide even by the arrangements which it originally put forward, let alone by any revised version agreed with the assessor, and it can therefore institute restrictions over and above those which the assessor regarded as being in the person’s best interests. This can be prevented by defining the “proposed arrangements” which were agreed by the assessor and then imposing a condition that they be adhered to, but the Code fails to advise that this should be done or to warn of the possible consequences of not doing so.

37 *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 Regulation 16 (2) (f)*

38 *Schedule A1 Para 39 (2) (b-c)*

39 *Code para 4.63*

40 *Standard Form 10, question D6 (see note 19 above)*

41 *Since their assessment is governed by the 6th principle in Section 1 of the Mental Capacity Act, that “before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.”*

If no such condition is made at the outset, the supervisory body may then find it difficult to impose one retrospectively, as Schedule A1 prohibits this unless there has been “a change in the person’s case,”⁴² and there is arguably no change simply because the managing authority did not do something which the assessor and supervisory body thought it would do but which it was not actually required to do. Nor is there any statutory mechanism to ensure that the supervisory body *knows* that the managing authority hasn’t done it. Although the Schedule spells out the review procedure in eye-watering and totally unnecessary detail, there is no requirement in either the Schedules or the Code that the supervisory body should monitor closely after an authorisation has been given so that it knows when a review is needed. In those cases where it is also the commissioner of the care, that should happen anyway through the normal processes of care management, but it is yet another unstated assumption that it will maintain oversight in other cases.⁴³

Who will safeguard the Safeguards themselves?

In fact, the only individual with a statutory duty to maintain contact with the detained resident is their representative, and the government has placed great emphasis on this role as being the primary safeguard and has included a number of specific duties in the Regulations.⁴⁴ However, in most cases the representative will be an unpaid relative or friend – in England there is no power even to pay expenses. The supervisory body does have discretion to appoint a paid representative if the best-interests assessor declines to nominate an unpaid one, but there must be concerns that, although it is technically neutral as between the managing authority and the assessors – who act as “independent public bodies” – it may be subject to a conflict of interest in choosing a representative if it is also commissioning the care. It is also questionable whether either supervisory body or best-interests assessor will be inclined to nominate a representative who is likely to challenge the assessor’s decision; anecdotal accounts are already beginning to circulate of “awkward” relatives being passed over, and there may well be challenges, especially from close family members who might well have been the relevant person’s own choice if they had had the capacity to make one.

Although representatives who are also relatives or friends are entitled to support from an Independent Mental Capacity Advocate,⁴⁵ they lack the powers of the Nearest Relative under the *Mental Health Act*, and their only real sanction is to apply to the Court of Protection. To its credit, the government acknowledged concerns about the accessibility of this process relative to the Mental Health Tribunal system, and at the last minute it extended non-means-tested legal aid to appeals,⁴⁶ and introduced a special “fast-track” procedure for all applications involving deprivation of liberty.⁴⁷

42 Para 107

43 *One of the basic principles of the DoLS scheme was that it would be linked to the process of care planning and management by ensuring that the body which commissioned the care was also the supervisory body, hence obviating the need for a specific oversight duty. However, this will frequently not be the case in practice because of self-funding (see note 16 above), and because Primary Care Trusts now place people requiring “continuing nursing care” in care homes where the supervisory body will be a local authority. The principle has effectively been abandoned in Wales in respect of hospitals due to the amalgamation of commissioning and provider bodies.*

44 *Mental Capacity (Deprivation of Liberty: Appointment of*

Relevant Person’s Representative) Regulations 2008, Reg. 12 (1)(a). There are separate, and somewhat different, regulations for Wales.

45 *Mental Capacity Act 2005 (as amended) Section 39D*

46 *Community Legal Service (Financial) Amendment Regulations 2009. The provision covers applications to the Court of Protection by relevant persons or their representatives under Section 21A of the Mental Capacity Act (which provides for appeals against authorisations themselves or any element of them), but it does not cover applications on other issues related to DoLS.*

47 *Practice Direction, Deprivation of Liberty Applications, March 2009 (supplement to Part 10A of the Court of Protection Rules.)*

However, the process is still cumbersome when compared to that available to those detained under the *Mental Health Act*, and it must be questionable whether it is truly compliant with Article 5 of the ECHR as being one by which “the person deprived of their liberty can have the lawfulness of their detention decided speedily by a court”. An application could not practicably be made by a representative without legal assistance, and the hearing centres will for many, be remote – for people in East Anglia the nearest is 100 miles away in London – so it will be very difficult for relevant persons themselves, or staff caring for them, or relatives who are often elderly, to attend in person, and cases will have to be decided purely on the basis of legal submissions and expert reports. The government’s own estimate is that there will be only one application for every 40 DoLS authorisations,⁴⁸ as compared to one Tribunal application for every three detentions under the *Mental Health Act*.⁴⁹

Given all this, it seems likely that despite the mountain of paperwork which DoLS authorisations are bound to create, the main beneficiaries will be the managing authorities – the hospitals and care homes – who will gain legal protection for their actions, and who may then impose restrictions on liberty with more confidence than hitherto, but with very little accountability in return.

48 *Regulatory Impact Assessment, ibid (note 31 above)*

49 *In 2007–8 there were approximately 47,000 episodes of detention under the Mental Health Act in England and Wales, and 15,605 applications to the Mental Health Review Tribunal (Mental Health Act Commission, 12th Biennial Report, 1.18 and 2.111). However, these figures cannot be related directly, as some applications will be in respect of detention commencing in previous years, and patients might not apply twice when a Section 2 is followed by a Section 3. The MHAC, at 2.113, quotes a research finding at one acute hospital that 81% of detentions commencing in 2006 were appealed.*

‘Publicity v Privacy: finding the balance’

When and how to publish reports of mental health homicide independent investigations

Lucy Scott-Moncrieff¹ and Ed Marsden²

In 1994 the Department of Health published its guidance on the discharge of mentally disordered people and their continuing care in the community (HSG (94) 27) which established, for the first time, that when a mental health service user kills someone “*it will always be necessary to hold an Inquiry which is independent of the providers involved*”. The independent investigation (as these inquiries are now called) would take place after the completion of any legal proceedings and its purpose was stated to be: “*To learn lessons for the future*”. The independent investigation would be commissioned by the responsible strategic health authority, which would also decide on whether to publish it and, if so, in what form.

The guidance says “*Although it will not always be desirable for the final report to be made public, an undertaking should be given at the start of the Inquiry that its main findings will be made available to interested parties*”.

The guidance was updated in 2005, saying that independent investigations “*should facilitate openness, learning lessons and creating change*”, and, when dealing with the publication and distribution of the report:

“The SHA and, where appropriate, other organisations should devise a clear communication and media-handling plan for the investigation report’s findings and the actions to be taken in response to any recommendations made. When and how the findings are published should be clearly communicated to all stakeholders, including victim/s, perpetrator, families, carers and staff involved”.

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Most recently, in 2008, the National Patient Safety Agency, in Appendix 1 to its Good Practice Guidance on "Independent investigation of serious patient safety incidents in mental health services" said:

"As a general rule, the greater the degree of legitimate public interest in the outcome of the investigation, the stronger the argument that public accountability will require that professional staff be named in the report, unless there are particular factors such as police concerns about safety"

Openness and creating change, made explicit objectives in 2005, must have been implicit in the 1994 aim of learning lessons; after all, how can lessons be learnt without openness, and what is the point of learning lessons unless it leads to change? We know that there was much debate in the Department of Health about the continued value of these expensive investigations: some, such as the Royal College of Psychiatrists argued that they were not helpful, whereas others, such as the Zito Trust, strongly supported their continuation. The Department was concerned that they did not help learning as much as had been hoped, and we believe that the 2005 amendments were intended to give the guidance sharper focus on the manner in which investigations should be carried out and the use to which they should be put.

The arrival, between 1994 and 2005, of the *Data Protection Act 1998*, the *Human Rights Act 1998* and the *Freedom of Information Act 2000* (FoIA) may also have influenced the decision to give further guidance in this area.

However, despite the attempts at clarification, many organisations still do not accept that the need for openness means that reports of independent investigations should usually be published in full.

Problems have arisen in three main areas: where a report contains confidential personal information, such as in health and social services records; where professionals are seriously criticised in a high-profile case; and where others mentioned in the report may be at risk.

The purpose of this article is to explain the legal principles underlying the question of what and whether to publish, and to offer to commissioners suggestions on how to make decisions in a way that takes proper account of the competing interests of all concerned; victims, perpetrators, families, professionals, and the public (who, it must be remembered, pay those being investigated as well as those doing the investigation). The legal principles to be balanced in each case are the same, but the balance will differ according to the circumstances of the person or group being considered: the names and personal information of those who are more peripheral to the investigation, such as the relatives of victims, are likely to attract a greater right to privacy than the names and personal information of professionals whose activities are particularly under scrutiny.

Guiding principles

We start from the position that full publication is the expected outcome: commissioners of an independent investigation should make their decisions about the report, including what and whether to publish, in accordance with the agreed aims of the investigation. The latest guidance quoted above has created a presumption in favour of publishing the whole report, without anonymity for professionals.

Good grounds for rebutting the presumption would include:

- Confidentiality: that the report contains confidential information about individuals who have a legitimate expectation that their privacy would be respected. An example of this would be where the history of the contact between service user and service providers, which needs to be set out to provide context, is entangled with the contact that the service user's immediate family had with those services, and the family did not consent to the disclosure of their confidential information.

For instance, the authors are aware of a case where both the victim and perpetrator were mental health service-users, with the victim's vulnerability arising from the abuse that she had suffered within her family. It was relevant to speak of the abuse, but it was not part of the investigation's role to lay out the family dynamics in any detail, nor to encroach on the family's right of privacy, so the source of the abuse was not referred to in the report.

- Risk of harm: that publication of all or parts of the report would put certain people at risk of physical or mental harm. We are aware of a case where a perpetrator who had killed a close relative made threats against members of his family if they gave evidence to the subsequent investigation. Although the perpetrator was detained, the threats were taken seriously, and the strategic health authority decided to publish a redacted version of the report, so that the perpetrator would not realise that the threatened family members had given evidence to the investigation. There are also cases where professionals may be assessed as being at risk, as happened in the Stone investigation, discussed in more detail below.
- Discouraging co-operation; that publication of all or parts of the report would militate against the aims of learning lessons and creating change. There is a school of thought that professionals may be unwilling to co-operate with independent investigations if they anticipate that they will be publicly criticised, as they will be afraid of drawing down on their own heads the public vitriol and abuse that has been heaped on other individuals in these circumstances. The Department of Health and some strategic health authorities are also concerned that the learning/no blame culture they are trying to foster will be put at risk if criticised individuals are identified by name. We think these concerns are overrated – even individuals who must realise that they can expect to be criticised are remarkably open and frank in describing and discussing their activities, and most people who are invited to give evidence to inquiries do so without hesitation. Occasionally, potential witnesses are reluctant, but many of them decide in the end that they wish to tell their story. Few people fail to attend, or having attended, fail to speak openly.

In considering whether the presumption of full publication has been rebutted, the principles of Articles 8 and 10 of the *European Convention of Human Rights* (ECHR) will apply, as well as relevant domestic law including case law, the *Data Protection Act 1998* (DPA), and the *Freedom of Information Act 2000* (FoIA). Domestic law has to be interpreted in accordance with the ECHR, so for simplicity's sake we will focus on the ECHR.

Article 8:

- (1). *Everyone has the right to respect for his private and family life, his home and his correspondence.*
- (2). *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedoms of others.*

Article 10:

- (1) *Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This Article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.*

- (2) *The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary.*

These articles create opposing rights, one to privacy (to withhold information from publication) and one to know (to receive and impart information). However there is no paradox here, as both are qualified by exceptions that, in certain circumstances, meet in the middle. So your right to privacy can be overridden by our right to know, and vice versa.

The exceptions apply only if they are 'necessary': in ECHR terms this means that a pressing social need is involved and that the measure employed is proportionate to the legitimate aim being pursued. Deciding in any particular case whether the right to privacy trumps the right to know involves a balancing exercise in which all relevant information has to be identified and then given its correct weight so that the correct result will be achieved. The decision-making body must not only take into account all relevant matters, but also must not be influenced by irrelevant matters and must not fetter any discretion it may have by making decisions in advance with, or little regard for, the facts of the particular case.

For instance, the authors have frequently heard suggestions that the risk of media intrusion into the lives of named staff is automatically a sufficient justification for anonymisation. Whether or not anonymisation on this ground alone would be seen as a proportionate response to a pressing social need (we think not) the creation of a policy not to disclose amounts to the decision-maker fettering its discretion, thus rendering the decision legally flawed and open to challenge. Of course if media intrusion were (probably) likely to lead to risk of physical harm it would be another story, but media intrusion on its own, however unpleasant, is part and parcel of an open society and should not attract the protection of Article 10(2).

Article 8 will carry great weight when the issue relates to the withholding of sensitive confidential information, such as medical records, whereas Article 10 will probably have a head start where the issue relates to non-confidential information, such as the names of criticised professionals. However it will always be necessary to look at both articles.

The most pertinent case to offer guidance on Article 8 and confidentiality is that of Michael Stone.

In *Stone v South East Coast Strategic Health Authority & Ors* [2006] EWHC 1668 (*Admin*) (12 July 2006) Michael Stone, convicted of the murders of Lin and Megan Russell 10 years earlier, went to court to try and prevent the disclosure of his confidential records in the report of the independent investigation set up after his conviction³. The judgment, which went against him, focused on Article 8 of the ECHR, and in structuring the necessary balancing exercise between Mr Stone's right to have the confidentiality of his health and social work records respected and the public's right to have a full understanding of his involvement with services, Mr Justice Davis, said:

"... an ultimate balance has to be struck not only by weighing the considerations for and against a restriction on the right to privacy by reference to Article 8 itself but also by weighing the considerations for and against a restriction on publication by reference to Article 10;" (para 34)

³ Robert Francis QC, who chaired the inquiry, contributed 'The Michael Stone Inquiry- A Reflection' in the *Journal of Mental Health Law*, May 2007 @ pp 41-49. The 'Report of the independent inquiry into the care and treatment of Michael Stone' was commissioned by West Kent Health Authority, Kent County Council Social Services, and Kent Probation Service. It was published in September 2006.

and that the test for publication was high:

“... The protection of personal data, and the need for appropriate safeguards, is of fundamental importance to a person’s enjoyment of the right to respect for private and family life provided by Article 8: and that is particularly so in the case of medical data” (para 31),

and therefore:

“... a compelling case needs to exist to justify publication of this report in its present form” (para 32).

The judge gave great weight to the fact that Mr Stone was entitled to claim a right to privacy, particularly in relation to medical information, which is seen as one of the fundamental privacies to be protected by Article 8. He also recognised that it was in the public interest:

“... first, that persons may talk freely with their doctors, probation officers and other such persons without being deterred by risk of subsequent disclosure (although it has to be said such a risk in any case exists under English common law rules relating to confidentiality, where disclosure is necessary in the public interest); second, that such persons may give access to such information for the purposes of an inquiry without being deterred from doing so through fear of such matters later being released into the public domain” (para 44).

However, on balance, he decided that the public interest in publication outweighed Mr Stone’s right to privacy. The reasons were:

- There was a true public interest in the public at large knowing of the actual care and treatment supplied, or not supplied, to Mr Stone and being able to reach an informed assessment of the failures identified and the recommendations made.
- Such objectives were not met simply by releasing a full version of the report to relevant health professionals.
- Where individuals and agencies were, or were not, to be criticised, the public was legitimately entitled to know the reasons.
- The information was being disclosed solely to provide an informed view as to what went wrong with a view to lessons being learned for the future, both for the assistance of other service-users and for the protection and reassurance of the public.
- Mr Stone’s right to privacy was reduced because the investigation, and therefore the need to seek privacy, arose from his own criminal acts.
- A great deal of detailed information about Mr Stone’s background, treatment and mental health was already in the public domain, as shown by numerous newspaper articles. This did not extinguish Mr Stone’s right to privacy, but did diminish any possible adverse effect of publication.
- The surviving victim, Josie Russell, and her father supported publication.

Having decided against Mr Stone on the balancing act required within Article 8, where the initial premise is in favour of privacy, it was not necessary to spend much time on Article 10, where the initial premise is in favour of publication, and the judge decided in a few words that the balancing provisions required within Article 10 could only support the view he came to on Article 8.

The decision was based on the facts of the case, and involved the records of a perpetrator, but the considerations set out in the judgment are of general application and should also guide decision-makers if someone other than a perpetrator, for instance a surviving victim, or a family member of either victim

or perpetrator, seeks to prevent publication of confidential records.

There are many cases dealing with Article 10 and restrictions on the right to know. We consider the case of *In re S (A Child) (Identification: Restrictions on Publication) [2004] UKHL 47*, to be particularly helpful in showing how the balancing exercise between Articles 10 and 8 should take place where anonymity is being sought: the issue was whether, in the interests of protecting a child whose mother was to be tried for the murder of his brother, the identity of his mother should be kept out of media reports of the trial. Articles 8 and 10 were engaged, and Lord Steyn, who gave the leading judgement, commented:

“The interplay between articles 8 and 10 has been illuminated by the opinions in the House of Lords in Campbell v MGN Ltd [2004] 2 WLR 1232. For present purposes the decision of the House on the facts of Campbell and the differences between the majority and the minority are not material. What does, however, emerge clearly from the opinions are four propositions. First, neither article has as such precedence over the other. Secondly, where the values under the two articles are in conflict, an intense focus on the comparative importance of the specific rights being claimed in the individual case is necessary. Thirdly, the justifications for interfering with or restricting each right must be taken into account. Finally, the proportionality test must be applied to each.”

Lord Steyn also agreed with the first instance judge, who described his approach thus:

“...in carrying out the balance required by the ECHR, to begin by acknowledging the force of the argument under article 10 before considering whether the right of the child under article 8 was sufficient to outweigh it”.

In our experience, the careful, thorough and principled approach to decision-making described in these two judgements is the exception rather than the rule, particularly where anonymisation is sought: there is no consistent method of evaluating the need for anonymisation; decisions are made on widely different criteria, and decision-making processes range from robust to inadequate. Inconsistent decisions, decision-making processes and, indeed, legal advice, give an impression of arbitrariness which is undesirable in so important an area.

The decision-making process

The commissioners should prepare the ground by making it clear at the outset that it intends to publish in full unless the law requires otherwise.

Whether the law does require otherwise will depend on the limitation on publication that is being sought.

Withholding confidential information

The steps to be taken in reaching a decision on publication of confidential information should start from the position that those writing and commissioning the report must not publish any such information unless there is a strong public interest to do so. If they are satisfied that there is, they should:

- seek consent to publish;
- make every reasonable effort not to include information unnecessarily (for instance by précisising parts of the report if this would not damage its value);
- give the subject of the information an opportunity to make representations; and
- provide detailed justification for publishing the information, by reference to any representations made by the subject of the information and to the principles of Article 8 and, if necessary, Article 10.

Example

The judge was complimentary about the thorough and principled way the authors of the Stone report had gone about this exercise:

“The Panel had, in preparing its report, been well aware of issues of confidentiality and of the rights of Mr Stone under Article 8. Indeed, the Panel had been at pains to obtain Mr Stone’s written consent for the inquiry to have access to details about his treatment and care, which was given. (It was not, however, disputed at the trial before me that Mr Stone was subsequently free to refuse to give his consent to actual publication of the resulting report). It is notable that in a letter dated 9th July 2004 Mr Francis had explained that in preparing its report the Panel had considered whether the facts set out were (in the view of the Panel) necessary to be included in the public interest after taking account of Mr Stone’s rights in respect of his privacy and the confidentiality of his records. I unhesitatingly accept that as being the Panel’s approach. Specific examples are given of matters excluded from the final version of the report by the Panel as not satisfying this requirement”.

A version of the report with the confidential information removed was prepared, but was rejected by the commissioners. The judge accepted that they were right to do so because:

- The deletions of the details would have prevented the public from knowing precisely what facts had prompted the conclusions and comments of the Panel as set out in Chapter 8. The conclusions and comments were necessarily based on the preceding details.
- The actual details of what was in the medical and other records was crucial for assessing (and for forming an opinion on) what other professionals, dealing with Mr Stone, either at the time or subsequently, should have known or should have done – ie what did they know but not act upon, what did they not know but which they should have known, and what information and records were, or were not, passed on to other agencies?
- To the extent that individuals and procedures were criticised (or not criticised) in the report, the reader needed to know the details of what such individuals knew or could reasonably be expected to have known in order to assess such criticisms.

Consideration of the criteria in *Stone* will help decision-makers in future cases. Once the relevant elements (and only the relevant elements) have been identified and weighted, a decision can be made as to whether the right to know outweighs the right to privacy in the particular case.

Using these measures, set within the strong presumption in favour of respecting the confidentiality of health and social care records, it seems likely that a family member of a perpetrator or of a victim would be able to insist on their name being withheld and on the confidentiality of their records being respected. This issue arises only when the records of family members, particularly siblings, are inextricably entangled with those of the perpetrator or victim, and ingenuity may be necessary to protect the privacy of family members when their relationship with the perpetrator or victim is a matter of public knowledge.

Anonymisation

As mentioned previously, the commissioning strategic health authority is responsible for determining whether and how an investigation report is published. There is no doubt that reports can be anonymised; the National Patient Safety Agency guidance makes this clear, the Stone report and others have been anonymised without challenge, and the Information Commissioner, in a Decision Notice dated 2nd June 2008 concerning Hertfordshire Partnership NHS Trust (ref: FS50124800) has confirmed that, in

principle, names can be withheld even if an application is made under the FoIA for full publication.

Article 10(2) provides that publication can be restricted if full publication would put an individual or the public at risk of harm. The most likely scenario is where professionals in a high-profile case are strongly criticised and it is feared that they may become the targets of vigilantes. Article 10(2) is also relevant when the question is whether publication of the names of criticised professionals will damage the effectiveness of future investigations through reducing the willingness of professionals to speak freely about their involvement in the events under investigation. Here the test is whether publication should be withheld on the grounds of “*public safety, for the prevention of disorder or crime, or for the protection of health or morals*”, on the basis that if investigations become less effective as a result of professional reticence, the likelihood of lessons being learned and change occurring will be reduced, and violent crimes may take place that otherwise might not have. However solid evidence would be needed that this was a likely consequence of publication, and the evidence available so far is to the contrary.

Many of the same matters must be weighed in the balance as in decisions on whether or not to publish confidential information, but the emphasis is different where the information is not confidential. Many types of investigation take place in the public sector, and it is often clear from the outset that the information obtained from staff in these investigations will not be published. Therefore, to avoid the risk of misunderstanding, it is crucially important that people giving evidence to an independent homicide investigation are told in advance that what they say may be published in the final report, and that they may be identified as the source of that material unless there are legitimate public interest reasons why this should not be the case.

Once this has been done, the question of anonymisation can be dealt with, by following the procedure set out in *In re S (A Child)* (2004) (referred to earlier in this article). The commissioners should establish the justification for publication under Article 10, starting with the official guidance quoted above, and considering the various matters mentioned Mr Justice Davis in the *Stone* case. They should bear in mind that the greater the significance of the case, and the greater the public concern, the stronger the case for publication with names. This will be the case whether the case is of local or national importance, as the courts accept that people get their information from local media as much, or more, than from the national media.

They would then need to consider whether there was any justification for anonymity under Article 10(2): public safety, the prevention of disorder or crime, the protection of health or morals, or the protection of the reputation or rights of others.

Concerns might be that:

- Staff may be at risk from a perpetrator.
- Staff may be less willing to co-operate with investigations if they know what they say may be published.
- If individual staff members are at fault this should be dealt with by their employing agency and they should not be pilloried in public.
- Individual staff members have no effective means after publication of defending themselves.
- Other reports do not name staff so this one should not.
- Where a report is critical of individuals, publication can only lead to the ‘name and shame’ culture which increasingly stigmatises public services and individuals and is inconsistent with a learning organisation.

- Naming individuals adds nothing to the report's value in identifying and commenting on issues of concern which the organisations involved should address.
- Naming clinical staff can adversely affect their relationships with other patients/service-users.

Some of these concerns will attract the protection of Article 10(2), and some will not. If the concern does not fall within one of the pressing social needs identified in Article 10(2) then there is no protection, and even if it does, it is also necessary to establish that anonymisation is proportionate to the legitimate aim being pursued.

Someone who had a well-founded belief that he or she would be harassed, victimised or attacked or made ill if details of his or her involvement were published, would certainly have a case that public safety, the prevention of crime, the protection of health and the protection of their rights and reputation would be engaged. Therefore if a professional seeks anonymity on any of these grounds, the employer would have to undertake a proper risk assessment, involving, if necessary, police and medical assessments. If it is thought that a realistic risk exists, the nature, seriousness, extent and duration of the risk should be quantified, so that proper weight can be given to this in the subsequent balancing exercise. It should be remembered that even if a risk of harm is identified, publication may still be justified if the risk is thought to be manageable and acceptable. Whatever the outcome, the employer would have a responsibility to seek to mitigate any risk to the employee.

It is also important to see whether the feared undesirable outcomes will occur whether or not professionals are named. For instance, the perpetrator will be entitled to copies of his medical and other records, and it would not be difficult for the names of criticised staff to be identified in this way. Neither the perpetrator nor his/her family have any duty of confidentiality towards the professionals, and if they believe that professionals are being unfairly protected from public criticism, they could easily rectify the situation.

Similarly, the involvement of individual members of staff is likely to be well known within the service, and criticism will be accurately attached to the right person, whether or not their name is published.

If the case is of sufficient public interest (and such cases are likely to throw up these issues) it is also likely that an application for full publication will be made under the FoIA. The process of applying is cheap and simple, and the Information Commissioner is bound to order publication unless one of the limited exceptions apply.

It seems likely that if anonymisation will not be effective in protecting people mentioned in the report, it will not be seen as a proportionate response to a pressing social need.

A number of the concerns mentioned are not generated by the anticipation of harm, but rather by the upset that criticism of named individuals will have on those criticised, on their colleagues, and on specialist mental health services generally. These concerns are sincerely held, but nonetheless they need to be robustly interrogated, and mere assertions that certain consequences will flow from publishing names should never be accepted without supporting evidence. The fact that individuals may feel vulnerable and frightened is not, in itself, a good reason for withholding their identities from a published report, although it would be an good reason to offer them support before, during, and after publication.

Example⁴

The commissioners of the Stone report provide an example of an excellent decision-making process. The justification for anonymisation was measured against agreed legal principles, and was required to be supported with robust evidence with commissioners instructing lawyers to guide them through the process

At a joint meeting in 2001 of the three agencies that commissioned the inquiry into the care and treatment of Michael Stone (West Kent Health Authority, Kent County Council and Kent Probation Service), concerns were expressed that given the horrific nature of the original crime and Mr Stone's continued denial of the offence, naming staff in the report might place them at risk. In recognition of the seriousness of this concern, the agencies sought the advice of Kent Police. A detective superintendent who was well acquainted with the case but who had not been part of the criminal investigation was nominated to conduct a formal risk assessment. The assessment was commissioned in April 2001. It found evidence to suggest that certain individuals would be at risk if named in the report. In July 2002 the assistant chief constable wrote to the commissioning agencies recommending that all names should be removed from the report before publication.

The commissioning agencies discussed the implications of the risk assessment with their lawyers and with the authors of the report. The chairman said that the panel's role was to conduct the inquiry and present their report to the commissioners and that it was for the commissioners to decide what form publication might take. He said the panel felt, however, that the report should be published in full.

The legal advice was that the commissioning agencies had a duty to satisfy themselves as to the strength of the evidence upon which the police risk assessment was based. Accordingly, in October 2002 representatives of the commissioning agencies met Kent Police to review the evidence. The meeting decided that certain members of staff were entitled to anonymity and the commissioners then considered the possible effect of granting anonymity only to them and not to the others directly involved in Mr Stone's care. They decided that, in the interests of all the staff directly involved with Mr Stone's care, all should be anonymised so that none stood out and none could be identified by a process of elimination. However the commissioners did not agree to anonymise the whole report, and published the names of managers in senior positions of responsibility.

In deciding partially to anonymise the report the commissioning agencies had to balance the public interest of protecting care staff and others against the public interest in open and transparent publication. During this process suggestions had been made that the risk of media intrusion against named and criticised staff justified anonymity, but leading counsel advising the commissioners indicated that he did not consider that this alone was a justification for anonymity.

Conclusion

The framework for decision-making in public services is long established and well-known to those who have to use it: the purposes of independent investigations are clearly articulated, and authoritative judicial guidance on the matters to be taken into consideration when balancing rights protected by Articles 8 and 10 is now readily available.

⁴ *The source of many of the statements of fact which are set out in the paragraphs which follow, is the 'Report of the independent inquiry into the care and treatment of Michael Stone' (September 2006). See n. 3 above.*

In the interests of the credibility of the public services concerned, decision-making must demonstrably be both consistent and transparent.

To build on existing good practice, the decision-making processes in the Stone case should be replicated, proportionately, in other independent homicide investigations involving a challenge to full publication. In most cases it will not be necessary to obtain external legal advice, but decisions should always be evidence-based, in accordance with the law, and made by the strategic health authority board or one of its delegated committees.

We hope that greater consistency in publication, coupled with the proposals for a structured independent post-review process to track the implementation of recommendations, (as proposed in *Learning Lessons: Using Inquiries for Change* (2009) by Gillian Downham and Richard Lingham⁵) will boost the value of homicide investigations to all stakeholders.

5 *Journal of Mental Health Law*, Spring 2009 pp 57–69.

Lost in a Legal Maze: Community Care Law and People with Mental Health Problems

The Law Commission's Review of Adult Social Care Law

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In June 2008, the Law Commission published its Tenth Programme of Law Reform, which includes a project to review adult social care law in England and Wales. Adult social care impacts on a wide range of individuals, including older people, people with learning disabilities, physically disabled people, people with mental health problems and carers.

This article considers the particular problems and challenges that community care law presents for people with mental health problems and how the Law Commission's review proposes to address this.

What is adult social care?

Adult social care refers to the responsibilities of local social services authorities for adults and their carers. This includes the range of services that may be provided or arranged to be provided by social services departments, and in some cases by health authorities and other organisations or individuals. Examples of adult social care services include care homes, day centres, equipment and adaptations, meals and home care services. Adult social care also includes the mechanisms for delivering these services, such as assessments and direct payments, and the responsibilities of local social service's authorities for safeguarding adults from abuse and neglect.

¹ *Lawyer, The Law Commission.*

The need for reform

A confusing legal structure

Adult social care law consists of a confusing patchwork of conflicting statutes enacted over a period of 60 years. Some of these statutes reflect the disparate and shifting philosophical, political and socio-economic concerns of various post-war governments. Other statutes were originally Private Members' Bills and represent an altogether different agenda of civil rights for disabled people and their carers. The law has developed with an inconsistent regard for previous legislation: some statutes amend or repeal previous legislation; others repeat or seek to augment previous law; and others can be categorised as stand alone or parallel Acts of Parliament.

The complexity of adult social care law has been described by Mr Justice Scott Baker, as he was then, in the following terms:

*Community care legislation has grown piecemeal through numerous statutes over the last half century. There are many statutes aimed at different targets whose provisions are drawn in differing language. Each Act contains its own duties and powers. Specific duties have to be distinguished from target or general duties and duties from discretions. Sometimes a local authority has several ways in which it can meet an obligation. Some provisions overlap with others and the inter-relationship is not always easy.*²

Added to this perplexing legislative structure is the vast array of case law, regulations, directions and soft law in the form of guidance and circulars that has accumulated over the years. For example, in order to carry out a comprehensive community care assessment in England of a person with mental health problems (and their carer), a social care professional would need to have regard to: four sets of general assessment guidance;³ four sets of guidance on carers' assessments;⁴ specific policy guidance relating to mental health service users;⁵ and directions.⁶

Outdated concepts of disability

Adult social care law is widely criticised for perpetuating outdated and discriminatory concepts of disability. For example, the *National Assistance Act 1948* was constructed around the widely held presumption, when the Act was passed, in favour of institutional care for disabled and older people. While section 21 of the Act, therefore, establishes a strong duty to provide residential accommodation in certain circumstances, section 29 establishes a much weaker target duty to provide domiciliary services.⁷

2 *A v Lambeth LBC* [2001] EWHC Admin 376, [2001] 2 FLR 1201 at [24].

3 Department of Health, *Community Care in the Next Decade and Beyond: Policy Guidance* (1990); Department of Health Social Services Inspectorate, *Care Management and Assessment: A Practitioners Guide* (1991); LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*; and Department of Health, *Fair Access to Care Services: Practice Guidance* (2003).

4 Department of Health Social Services Inspectorate, *Carers (Recognition and Services) Act 1995: Practice Guidance* (1996); Department of Health, *Carers (Recognition and Services) Act 1995: Policy* (1996); Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled*

Children: Practice Guidance (2001); Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Policy Guidance* (2001); and Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005).

5 Department for Health, *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (2008) and *New Horizons: A Shared Vision for Mental Health* (2009).

6 LAC(2004)24, *The Community Care Assessment Directions 2004*.

7 *R v Islington London Borough Council ex p Rixon* (1997–98) 1 CCLR 119.

This rapidly became outdated with the development of care in the community and today looks archaic alongside the dominant philosophies of self-directed support and citizenship.

Furthermore, section 29 of the *National Assistance Act 1948*, which is considered to contain the principal definition of a disabled person for the purposes of community care legislation, includes a heading describing the content of the section as: “welfare arrangements for blind, deaf, dumb and crippled persons, etc”. Section 29 goes on to describe those who are potentially eligible for welfare arrangements as persons aged 18 years or over who are:

Blind, deaf or dumb, or who suffer from mental disorder of any description and other persons aged 18 or over who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.

This definition is widely accepted as being “out of date, offensive and does not provide a useful starting point for enabling disabled people to fulfil their roles as citizens”.⁸ However, the need to update adult social care law goes beyond removing offensive terminology, although this remains a central reason for reform. The outdated and discriminatory nature of adult social care law may also filter through into types of services and support that can be provided for disabled and older people. If, for example, services are being designed for people who are “substantially and permanently handicapped by illness, injury, or congenital deformity”, then they are more likely to be based on assumptions of dependency and deficiency rather than providing disabled people with access to full citizenship.

Human rights concerns

The enactment of the *Human Rights Act 1998* has given rise to a number of concerns about the compatibility of aspects of adult social care law with the European Convention on Human Rights.

A key example is section 47 of the *National Assistance Act 1948*, which enables the removal of certain people from their homes and their detention and maintenance in hospitals or other places for the purpose of securing necessary care and attention. Of particular concern is the range of persons who could be detained under this power, which extends beyond the categories authorised under Article 5(1)(e). Furthermore, the limited ability of potential detainees to challenge the use of this power, and of detainees to seek a review, may breach Article 5(4). The review provides an ideal opportunity to visit these questions.

One of the reasons that section 47 is seldom used is that most people who potentially come under its auspices can be more appropriately dealt with under the provisions of the *Mental Health Act 1983* and the *Mental Capacity Act 2005*. Indeed, there may be some confusion for those district council officers who are responsible for administering section 47 orders about the alternative legislative provisions available. Baroness Murphy has pointed to research indicating that up to 70% of section 47 detainees could have been removed using mental health legislation “if someone had thought to use it properly”.⁹

Costs

The costs incurred because of the current legal framework of adult social care are difficult to quantify due to incomplete, or a lack of reliable, information. However, it is likely that the current state of adult social care law leads to inefficiency, since negotiating complex and outdated law takes longer and requires more resources. A clearer and more cohesive legal framework would lead to less time being spent on law and litigation.

8 Prime Minister's Strategy Unit, *Improving the Life Chances of Disabled People* (2005) p 73.

9 *Hansard* (HL), 21 May 2008, vol 701, col GC589. Referring to P Wolfson and others, 'Section 47 and its use with Mentally Disordered People' (1990). *Journal of Public Law Medicine* 9.13

The provision of community care services to people with mental health problems

The various powers and duties that enable community care services to be provided are scattered across a range of legislation. The formula adopted by most of the statutes is to entitle a specific client group or different groups of clients, to certain services. However, most of the statutes cover the same or similar services and the definitions of client groups often overlap. Some of the statutes establish a duty to provide services and others give discretion. This means that eligibility for different services, and sometimes the same service, can vary according to which statute is being used.

A number of the community care statutes mention specifically people with a “mental disorder” as being eligible for certain services. Indeed, in some cases the legislation gives special rights to mentally disordered people. The broad definition of mental disorder, “any disorder or disability of the mind”, means that even people with low-level or transient mental health needs are entitled to community care services if they have an assessed eligible need.¹⁰

Community care services can be provided to people, on the basis of a mental health problem, under one or more of the legislation:

Section 29 of the *National Assistance Act 1948*

Section 29 of the 1948 Act places a general duty on local authorities to provide certain services, aimed at “promoting the welfare” of disabled people. As set out above, the definition of disability for the purposes of this section includes, explicitly, people with a mental disorder.

The services that can be provided include: instruction; workshops; suitable work; recreational facilities; social work services and support and advice; facilities for social rehabilitation and adjustment to disability; facilities for occupational, social, cultural and recreational activities; holiday homes; free and subsidised travel; assistance in finding accommodation; and warden services.

Section 2(1) of the *Chronically Sick and Disabled Persons Act 1970*

Section 2(1) of the 1970 Act places a strong and individually enforceable duty on local authorities to arrange certain non-residential services, if the authority has concluded that it is necessary in order to meet the needs of a disabled person. The definition of a disabled person is the same as that set out in section 29 of the *National Assistance Act 1948*.

The services that can be arranged include: practical assistance at home; a wireless, television, library or similar recreational facilities; lectures, games, outings or other recreational facilities; assistance in taking advantage of educational facilities; travel to the facilities; assistance in arranging home adaptations or providing additional facilities designed to ensure safety, comfort or convenience; facilitating the taking of holidays; the provision of meals; and assistance in obtaining a telephone and any special equipment to use it.

Section 117 of the *Mental Health Act 1983*

Section 117 of the *Mental Health Act 1983* imposes a joint duty on health and social services authorities to provide after-care services to people who are detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act, who then cease to be detained and leave hospital.

“After-care services” are left undefined in the legislation. The Code of Practice in England advises that

¹⁰ *Mental Health Act 1983, s 1.*

they can include services provided directly by Primary Care Trusts and local social services authorities, as well as services they commission from other providers.¹¹ Although the Code does not give any examples of after-care services, it does set out a broad list of potential needs that a care plan might address.¹² However, the National Framework for NHS Continuing Healthcare suggests that after-care services must be provided for a reason related to mental disorder and may not include services to meet physical health problems.¹³ The Code of Practice in Wales defines after-care as services provided to meet an assessed need “arising from the patient’s mental disorder”, and are aimed at “reducing the likelihood of the patient being readmitted to hospital for treatment for that disorder”; examples include social work assistance and the administration and monitoring of medication.¹⁴

The definition of after-care services has also been developed through case law which has established a wide definition that includes:

Social work, support in helping the ex-patient with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities.¹⁵

The NHS Act 2006 and NHS (Wales) Act 2006

This legislation enables community services to be provided for the purpose of “the prevention of illness, for the care of people suffering from illness and for the after-care of persons who have been suffering from illness”. This would include people with mental health problems. In addition the relevant approvals and directions provide that local authorities must provide certain services for the prevention of mental disorder or in relation to persons who have been suffering from mental disorder. These services include centres, facilities, domestic facilities and various social work services.¹⁶

Negotiating the legal maze

In order to establish whether an adult with mental health problems is eligible for non-residential services requires a detailed knowledge of the inter-relationship between the various statutes. They may be eligible for services under section 29 of the *National Assistance Act 1948*. Under section 29(6) of the 1948 Act; however, a service cannot be provided if it is “required” to be provided under the *NHS Act 2006* or the *NHS (Wales) Act 2006*.

Directions issued under the NHS Acts require local authorities to make the following arrangements for the prevention of mental disorder, or in relation to people who are or have been suffering from mental disorder: the provision of centres (including training and day centres) or other facilities (including domiciliary facilities) for training and occupation; and social work support and related services and other domiciliary and care services to people living in their own homes and elsewhere”.¹⁷ The wide ranging

11 Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 27.4.

12 As above, para 27.13.

13 Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care; July 2009 Revised* (2009) paras 115–116.

14 Welsh Assembly Government, *Mental Health Act 1983: Code of Practice for Wales* (2008) para 31.2.

15 *Chunis v Camden and Islington Health Authority* [1998] 3 All ER 180 at 225.

16 LAC(93)10, *Approvals and Directions for Arrangements from 1 April 1993 Made Under Schedule 8 to the National Health Service Act 1977 and Sections 21 and 29 of the National Assistance Act 1948*, Appendix 3.

17 LAC(93)10, *Approvals and Directions for Arrangements from 1 April 1993 Made Under Schedule 8 to the National Health Service Act 1977 and Sections 21 and 29 of the National Assistance Act 1948*, Appendix 3, para 3(2).

nature of these categories of services suggests that the relevant legislation for a person with mental health problems seeking domiciliary services would, primarily, be the *NHS Act 2006* or the *NHS (Wales) Act 2006* rather than the *National Assistance Act 1948*. In addition, schedule 20 paragraph 3 of the *NHS Act 2006* places a duty on local authorities to provide home help to households where such help is required on the basis of illness.

However, a person with mental health problems may be eligible for services under section 2(1) of the *Chronically Sick and Disabled Persons Act 1970*. There has been some confusion about whether section 2(1) of the *Chronically Sick and Disabled Persons Act 1970* is a means of delivering services under section 29 of the *National Assistance Act 1948* or whether it provides a free standing duty to provide services. Case law has now established that services provided under section 2(1) are not free standing but instead are provided through section 29 of the *National Assistance Act 1948*.¹⁸ For example, in *R v Powys County Council ex parte Hambridge*, Mr Justice Popplewell held that:

When providing welfare services under section 2 the local authority are exercising their functions under section 29. They are not providing services under section 2; they are making arrangements under the 1948 Act for the provision of their services.¹⁹

However, as was pointed out by Lord Justice McCowan in *R v Gloucestershire CC ex p Mahfood*, the consequences of this interpretation are “unattractive”, since it would follow that the duty to provide home help under the *NHS Act 2006* would prevent such services being provided under section 2(1) of the *Chronically Sick and Disabled Persons Act 1970*.²⁰ Similarly, it would mean that most practical assistance in a person’s home could not be provided under the 1970 Act, since these have been directed under the *NHS Acts 2006*.

Finally, the person may be eligible for community services under section 117 of the *Mental Health Act 1983* if he or she has been detained in hospital for treatment at some point in the past under section 3, 37, 45A, 47 or 48 of the Act. If this were the case, the person would have the additional advantage of not being charged for section 117 services.²¹

The Care Programme Approach

In addition to the challenging community care legal structure, many people with severe mental health problems must negotiate a parallel care planning system known as the Care Programme Approach (CPA), which governs the provision of secondary mental health services. The CPA was established in 1991 by a joint Health and Social Services Circular.²² It requires health authorities, in collaboration with social services departments, to put in place specified arrangements for the care and treatment of those with severe mental health problems in the community.

There are four distinct aspects to the CPA:

1. systematic arrangements for assessing the health and social needs of people accepted by the specialist mental health services;

18 For example, see, *R v North Yorkshire CC ex p Hargreaves* [1997] 96 LGR 39; *R v Kirklees MBC ex p Daykin* (1997–98) 1 CCLR 512 and *R v Powys CC ex p Hambridge* (1997–98) 1 CCLR 458.

19 *R v Powys CC ex p Hambridge* (1997–98) 1 CCLR 182, at 189(E). The Court of Appeal subsequently held that

section 2(1) is not free-standing, see: *R v Powys CC ex p Hambridge* (1997–98) 1 CCLR 458.

20 *R v Gloucestershire CC ex p Mahfood* (1997–98) 1 Community Care Law Reports 7 at 17C.

21 *R v Manchester City Council ex p Stennett* [2002] UKHL 34, [2002] 2 AC 1127.

22 HC(90)23/LASSL(90)11.

2. the formation of a care plan which addresses the identified health and social care needs;
3. the appointment of a care co-ordinator to keep in close touch with the person and monitor care; and
4. regular review, and if need be, agreed changes to the care plan.

Up until October 2008, there were two levels of support provided under the CPA:

1. *standard* support for individuals receiving care from one agency, who are able to self manage their mental health problems and maintain contact with services; and
2. *enhanced* support for individuals with multiple needs from a range of agencies, likely to be at higher risk and to disengage with services.

The CPA has now been “refocused” to describe the approach used in secondary mental health care to “assess, plan, review and co-ordinate the range of treatment, care and support needs of people with complex mental health needs”.²³ Those service users who would have formerly been given standard CPA support no longer come under the CPA. The guidance advises that where a service user has straightforward needs and contact with only one agency, then an appropriate professional in that agency will be the person responsible for facilitating their care.²⁴

One of the problems associated with having parallel care planning systems is that confusion can arise about the relationship between the different regimes. A person with mental health problems is likely to be entitled to an assessment for community care services under section 47 of the *NHS and Community Care Act 1990* and for specialist mental health care under the CPA. The two assessments are linked and often carried out at the same time but crucially they are different assessments, and the existence of the CPA should not obscure the need to carry out a community care assessment. Thus, in *R (HP) v Islington LBC*, where a man with mental health difficulties had been assessed and rejected for support from specialist mental health services using the CPA guidance, and was also found to be ineligible for community care services on the basis of this assessment, the court held that a proper community care assessment had not been carried out.²⁵

There are a number of potential outcomes that arise when a person with mental health problems has been assessed under section 47 of the *NHS and Community Care Act 1990* and the CPA. They may be eligible for community care services and support from secondary mental health services under the CPA. In such cases the requirement to plan, review and provide services is normally carried out via a multi disciplinary team, which includes social workers. They may be eligible for community care services but ineligible for secondary mental health services under the CPA. In such cases, the local authority is required to plan, review and ensure that services are provided. It is also possible for a person with complex mental health needs to be ineligible for community care services but eligible for support under the CPA. In such cases the requirement to plan, review and provide services is normally carried out by a multi disciplinary team and could (but is not required to) include the involvement of a social worker.

Of course, there are sound arguments in favour of client specific care planning systems, such as the CPA, that run in parallel to the care planning process for adult social care. For example, they often facilitate the provision of integrated health and social services. The downside, however, is that they add to the complexity of the law for people seeking support services.

²³ Department of Health, *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (2008) p 11.

²⁴ *As above*.

²⁵ [2004] EWHC 7 (Admin), (2005) 82 BMLR 113.

The Law Commission's review

The above discussion illustrates some of the difficulties that pervade adult social care law. Our review aims to provide a more coherent and modern legal framework for the provision of community care services. The following is a brief summary of the areas of law that our review covers.

Statutory principles

One of the main criticisms of adult social care law is that the lack of a consolidated statute means that there is no coherent set of overarching principles to direct and assist local authorities, courts and others in carrying out their functions in this area. Increasingly, contemporary social welfare statutes include a statement of fundamental principles, upon which the legislation is based, as an initial point of reference. The main examples are the *Children Act 1989*, the *Family Law Act 1996*, the *Adoption and Children Act 2002* and the *Mental Capacity Act 2005*. Our review will therefore consider the desirability of introducing statutory principles into a consolidated adult social care statute, and develop proposals for their content, status and application.

Assessments

The primary duty to carry out assessment for community care services is provided in section 47 of the *NHS and Community Care Act 1990*. However, this was preceded by a number of earlier versions, none of which have been repealed; for example section 2(1) of the *Chronically Sick and Disabled Persons Act 1970*. Our review will put forward a single and explicit duty to carry out a community care assessment.

There are also two main statutes that enable a carer's assessment to be carried out: the *Carers (Recognition and Services) Act 1995* and the *Carers and Disabled Children Act 2000* (both of which have been amended substantially by the *Carers (Equal Opportunities) Act 2004*). In addition, the *Disabled Persons (Services, Consultation and Representation) Act 1986* provides an alternative, although more limited, right to a carer's assessment. Furthermore, the National Assembly for Wales (Legislative Competence) (Social Welfare) Order 2009 extended the legislative competence of the National Assembly for Wales to include "supporting the provision of care by carers" and promoting their "well-being"²⁶. Our review will, therefore, seek to simplify this complex and fragmented area of law.

The provision of services

The various powers and duties which enable social services authorities to provide adult social care services are scattered across a range of statutes and secondary legislation. As noted earlier, the various legal provisions sometimes reflect incompatible principles, and are often convoluted and frequently overlap.

The review will consider whether all of these legislative provisions could be rolled into a single provision, which sets out the various services that can be provided, arranged or authorised by local authorities. This might be achieved by providing a statutory list of services. Alternatively, community care services could be left undefined in legislation, which may give local authorities wider scope to provide a range of services tailored to meet individual needs. Examples of this latter approach include carers services and (as noted above) section 117 services.

Most of the main adult social care statutes, which authorise the provision of services, adopt the same

26 WSI 2009 No3010. At the time of writing, the proposed *Carers Strategy (Wales Measure) 2010* has been introduced and would enable requirements to be placed on NHS and local authorities to publish and implement carers' strategies.

approach of making eligibility for services dependent on whether the individual fits into one or more categories or client groups. The review will consider whether a single and up to date definition of disability should be established for the purposes of community care legislation – or whether any such definition is necessary at all.

The review will also cover the mechanisms that enable services to be provided such as personal budgets, direct payments and care plans.

Charging for services

The review will consider whether the different provisions on charging for services could be rolled into a single legal provision. This would not change who would have to pay for services but it would aim at simplifying the law. We would expect that the vast majority of the detail on charging procedures would continue to be set out in regulations and guidance.

We would not seek to remove any of the current exemptions that apply to charging (such as services provided under section 117 of the *Mental Health Act 1983*). However, we would consider whether the law could be clearer about which services are provided for free, for example by providing a clear statement in secondary legislation.

Section 117 of the *Mental Health Act 1983*

The nature of the duty to provide aftercare services established under section 117 of the *Mental Health Act 1983* is not within the scope of our project. The courts have confirmed that section 117 is not a general target duty but imposes an enforceable joint duty on both local authorities and health bodies to consider the after-care needs of each individual to whom it relates.²⁷ Our review also does not extend to the prohibition on charging for section 117 services. We therefore envisage that section 117 would remain as a stand-alone community care provision in the *Mental Health Act 1983* and would not be brought into a consolidated community care statute.

However, our review will consider whether section 117 could or should be more fully integrated within the legal framework for the provision of adult social care services. In particular, one of the consequences of the House of Lords decision in *R v Manchester City Council ex parte Stennett* is that the *National Assistance Act 1948 (Choice of Accommodation) Directions 1992* do not apply to accommodation provided under section 117.²⁸ Amongst other matters, this has led to uncertainty about whether service users or third parties can pay top-up fees for accommodation provided under section 117.²⁹ Further difficulties are caused because different rules apply to determining which authority is responsible for a patient's section 117 after-care, and determining which local authority is responsible for the provision of services under the *National Assistance Act 1948* and the *Chronically Sick and Disabled Persons Act 1948*.³⁰ This is the case even though there is no real difference in the types of community care services that can be provided under these provisions.

27 *R v Ealing Health Authority ex p Fox* [1993] 1 WLR 373.

28 *As above*.

29 For example, see *Local Government Ombudsman, Complaint No 05/C/13158 against North Yorkshire County Council*, 24 July 2007.

30 The relevant guidance is HSC 2000/003 and LAC(2000)3 *After-Care Under the Mental Health Act 1983*.

Safeguarding adults from abuse and neglect

Our review will also consider the legal framework for safeguarding adults from abuse and neglect. Unlike in Scotland, there are no specific statutory provisions for adult protection; the legal framework is provided through a combination of the common law, local authority guidance, general public law obligations and general statute law.

The review will consider whether this legal framework is sufficient to tackle cases of abuse and will discuss whether it would be desirable to introduce a statutory duty to investigate cases of suspected abuse and neglect of vulnerable adults. This has been introduced in Scotland by the *Adult Support and Protection (Scotland) Act 2007*, which places a duty on councils to investigate where an adult may be at risk. The review will also consider the term “vulnerable adult” as well as its legal definition, as both have been subject to criticism in recent years. Furthermore, the abolition of the compulsory removal power under section 47 of the *National Assistance Act 1948* and the introduction of statutory adult protection boards will be considered by the review.

Conclusion

There are many reasons why community care law is in urgent need of reform. One of the key reasons, however, is the difficulty that the law presents for service users, such as people with mental health problems. The aim of the review is to provide a clearer and more cohesive legal framework for adult social care.

We published a scoping paper in November 2008, which sets out in detail the legal framework and our agenda for reform.³¹ The next stage of the review is the publication of a consultation paper and a four month public consultation³². Following this, we will report on our conclusions as to how the law should be structured in a Final Report. The final phase of the project would be the production of a draft bill to implement the conclusions of our Final Report.

We welcome the involvement of mental health lawyers, professionals and service users, all of whom are a vital source of knowledge about the problems that exist in adult social care law and how the law should be reformed.

31 A copy can be downloaded at: http://www.lawcom.gov.uk/adult_social_care.htm.

32 It is intended to publish the Consultation Paper at the end of February 2010, with the consultation period lasting from May to June 2010.

A Pilot Study of the Early Experience of Consultant Psychiatrists in the Implementation of the Mental Capacity Act 2005: Local Policy and Training, Assessment of Capacity and Determination of Best Interests

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Introduction

The Mental Capacity Act 2005 (MCA)⁷ was partially implemented in April 2007 and fully implemented in October 2007 in England and Wales (with the exception of the Deprivation of Liberty Safeguards which were implemented in April 2009). The government estimated that up to 2 million adults in England and Wales may have issues concerning their decision-making capacity (henceforth 'capacity'), and these will include 840,000 people with dementia, 145,000 people with severe learning disability, 1.2 million people with mild to moderate learning disability and 120,000 people with severe brain injury⁸. Additionally, the prevalence of schizophrenia, mania and serious depression are 1%, 1% and 5% respectively⁸, and some of these individuals may also lack capacity. Moreover, up to 6 million family and unpaid carers are estimated to provide care or treatment for individuals lacking capacity⁸. Furthermore, many other people who do not lack capacity may use aspects of the MCA for future planning.

In an English study of acute admissions to general medical wards, 31% of patients lacked capacity pertaining to their main treatment or investigation, but only a quarter of these were recognised by clinicians to lack capacity⁹. A similar study of psychiatric inpatients revealed 44% of inpatients lacked capacity¹⁰. An English study of capacity to consent to geriatric psychiatry inpatient admission revealed 48% of the sample lacked this capacity¹¹. A recent systematic review concluded that up to 50% of psychiatric inpatients lacked capacity to consent to their admission¹². Moreover, it is particularly likely to apply to people with severe and enduring mental illnesses, including those with schizophrenia, bipolar affective disorders, dementias and other organic disorders, and people with learning disabilities^{11,12}. Therefore, clinicians working in the speciality of psychiatry are likely to have greater experience in the use of MCA.

The MCA has been broadly welcomed by stakeholders and is supported by a Code of Practice¹³. The latter has been developed following extensive consultation and includes case scenarios. Training materials have been developed by the Social Care Institute of Excellence (SCIE) including: core training set; community care and primary care training set; mental health training set; acute hospital training set; and, residential accommodation training set¹⁴. Nevertheless, there are likely to be a range of difficulties for stakeholders in implementing the MCA. Potential difficulties include: implications for the workload of clinicians and the adequacy of resources to implement the MCA^{15,16}; delays in developing training, policy and guidance for a diverse group of clinicians and Independent Mental Capacity Advocates

7 Department of Constitutional Affairs (2005) *The Mental Capacity Act 2005*. www.opsi.gov.uk/acts/acts2005/20050009.htm.

8 Ministry of Justice (2007) *Mental Capacity Act 2005. Equality Impact Assessment*. www.justice.gov.uk/docs/mc-equality-impact.pdf

9 Raymont V, Bingley W, Buchanan A, David AS et al. (2004) Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. *Lancet*, 364, 1421–1427.

10 Cairns R, Maddock C, Buchanan A, David AS, Hayward P et al., (2005) Prevalence and predictors of mental incapacity in psychiatric inpatients. *British Journal of Psychiatry*, 187, 379–385.

11 Mukherjee S, Shah AK (2001) The prevalence and correlates of capacity to consent to a geriatric psychiatry admission. *Ageing & Mental Health*, 5, 335–339.

12 Okai D, Owen G, McGuire H, Singh S, Churchill R, Hotopf M (2007) *Mental Capacity in psychiatric patients.*

Systematic Review. British Journal of Psychiatry, 191, 291–297.

13 Department of Constitutional Affairs (2007) *Mental Capacity Act Code of Practice (2007 final edition). Code of Practice to the Mental Capacity Act 2005*. www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf.

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(IMCAs)^{15,17}; availability of local training for healthcare and social care professionals¹⁸; availability of local policies on the implementation of the MCA and their clarity¹⁸; variable knowledge of the definition of capacity and factors that may trigger an assessment of capacity among healthcare and social care professionals¹⁸; potential for erroneous perception by carers that capacity is an “all or nothing phenomena” and consequent misuse of the MCA¹⁵; potential for disagreements between doctors and IMCAs, donees and court appointed deputies¹⁹; inability of carers to keep written records¹⁵; and, the potential difficulties with the Deprivation of Liberty Safeguards introduced into the MCA^{20,21}. There are also likely to be positive benefits for patients, carers and clinicians.

Therefore, a pilot study to examine the early experience of consultant psychiatrists in the implementation of the MCA was undertaken as part of a larger study to examine several other aspects of the early implementation of the MCA. The particular areas examined in this study included: local policy and training in the application of the MCA, the assessment of decision-making capacity and the determination of best interests.

Methods

This study was undertaken after the MCA had been fully operational for three months in order to ascertain the early experience of consultant psychiatrists in implementing the MCA.

1. Identification of consultant psychiatrists

Consultant psychiatrists working in England and Wales were identified from the Royal College of Psychiatrists' database. Members of the Royal College of Psychiatrists have access to this database and one of the authors (AS) is a member of the Royal College of Psychiatrists.

2. Questionnaire survey of consultant psychiatrists.

All identified consultant psychiatrists working in England and Wales in the specialities of general psychiatry, liaison psychiatry, forensic psychiatry, psychiatry of learning disability and child and adolescent psychiatry were sent an explanatory letter and a specially designed questionnaire in the first week of January 2008 (three months after the full implementation of the MCA); consultant psychiatrists in old age psychiatry were not included because a similar (but separate) study was also being conducted with them from an earlier grant from the Department of Health and SCIE. The questionnaire was anonymous. However, a separate postcard was also sent with the questionnaire. The responding consultant psychiatrist was asked to post the questionnaire and the postcard separately. The postcards allowed identification of consultant psychiatrists who had not been able to respond, whilst maintaining anonymity and confidentiality of the responders' questionnaires. This, in turn, allowed a reminder to be sent to consultant psychiatrists who had not responded within six weeks. One such reminder was sent to those who did not respond.

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18 Myron R, Gillespie S, Swift T, Williamson I. (2008). *Whose Decision? An exploration of the preparation for and implementation of the Mental Capacity act in statutory and non statutory services in England and Wales.* www.mentalhealth.org.uk/our-work/research/all-age-groups/whose-decision/. Viewed 8th May 2008.

19 White SM, Baldwin TJ (2006) *The Mental Capacity Act 2005 – implications for anaesthesia and critical care.* *Anaesthesia*, 61, 381–389.

20 Khan K, Bhatkal S, Shah AK (2007) *Bournemouth proposals: practical considerations.* *Geriatric Medicine*, 37, 37–38.

21 Shah AK, Heginbotham C, Kinton M. (2008) *The newly introduced deprivation of liberty safeguards in England and Wales.* *Geriatric Medicine*, April 2009.

The questionnaire was designed to examine several aspects of the early implementation of the MCA and is available from the first author. The areas covered in the questionnaire included:

- The availability and utility of local Trust policy on capacity to consent.
- The availability and utility of local Trust policy on the implementation of the MCA.
- The availability and utility of local training in the use of the MCA.
- The documentation of the assessment of capacity.
- The issues for which capacity was routinely assessed.
- The criteria used for the assessment of capacity. This was ascertained by asking the question “What criteria do you use in assessing capacity?”, and required a descriptive answer.
- The criteria used in the determination of best interests. This was ascertained by asking the question “What criteria were used to determine best interest?”, and required a descriptive answer.
- Identification of professional groups conducting an assessment of capacity.

3. Data analysis

Descriptive answers for the two questions “What criteria do you use in assessing capacity?” and “What criteria were used to determine best interest?” were manually examined and coded by the researchers using a qualitative thematic approach to ascertain common themes. One of the authors (AS) first manually examined and coded the descriptive answers using a qualitative thematic approach, and these were subsequently verified by one of the other authors (NB). Descriptive statistics were used to analyse the categorical responses to all the other questionnaire items pertaining local policy and training in the application of the MCA, the assessment of decision-making capacity and the determination of best interests.

4. Ethical approval

Ethical approval was ascertained from the Faculty of Health Ethics Committee at the University of Central Lancashire.

Results

All identified 955 consultant psychiatrists in the specialities of general psychiatry, forensic psychiatry, liaison psychiatry, learning disability and child psychiatry were sent the study questionnaire; and 865 reminders were sent. One hundred and twenty-six (13%) of these consultant psychiatrists responded and 113 (12%) of these questionnaires were useable as the remaining 13 were blank. Table 1 illustrates the number of questionnaires sent to consultant psychiatrists in each speciality and their response rate. However, the denominator for the number of responses for the examined items from the questionnaire was not 113 because some respondents did not answer these questions.

1. Local policy and training

As illustrated in Table 2, 70% or more of the responding consultant psychiatrists reported that there was a local Trust policy on capacity to consent and that this policy was used, there was a local Trust policy on the implementation of the MCA and that this policy was used, and local training on the application of the MCA, including refresher training and training for new staff, was available. However, less than 50% reported that the training on the MCA was mandatory. As illustrated in Table 3, almost 50% reported that half or more of the staff received training in the application of MCA.

2. Assessment of decision-making capacity

As illustrated in Table 4, over a third of the responding consultant psychiatrists reported that half or more patients had a routine assessment of capacity, and a third reported that half or more patients had the assessment of capacity routinely documented. As illustrated in Table 5, almost two-thirds reported that the capacity was assessed separately for each issue and treatment decision, but about a quarter reported that this was not the case.

Table 6 illustrates the broad issues for which capacity was routinely assessed as reported by the Consultant Psychiatrists. Over two-thirds reported that capacity was routinely assessed for healthcare decisions. About half reported that capacity was routinely assessed for financial welfare. However, less than 50% reported that capacity was routinely assessed for personal care and social care.

The descriptive answer to the question “What criteria do you use in assessing capacity?” were manually coded using qualitative thematic analysis into 15 separate individual categories as listed in Table 7. Around 90% of the responding consultant psychiatrists reported using the four criteria for the specific test of capacity described in the MCA whereby the patient must be able to:

- Understand the information relevant to the decision.
- Retain the information.
- Use or weigh that information as part of the process of making the decision.
- Communicate the decision.

As illustrated in Table 8, over half reported that in at least half the patients having an assessment of capacity both carers and other professionals were consulted.

Table 9 illustrates the proportion of assessments of capacity conducted by different multidisciplinary professionals as reported by consultant psychiatrists. Almost 50% of the responding consultant psychiatrists reported that more than half of the assessments of capacity were conducted by consultant psychiatrists. Almost two-thirds reported that fewer than half of the assessments of capacity were conducted by junior doctors, nurses, psychologists, social workers, occupational therapists and others.

3. Determination of best interests

As illustrated in Table 10, over 90% of the responding consultant psychiatrists reported using the best interests principles for making decisions on behalf of patients lacking capacity.

The descriptive answer to the question “What criteria were used to determine best interest?” were manually coded using qualitative thematic analysis into 14 separate individual categories as listed in Table 11. Over 60% of the responding consultant psychiatrists reported the following five criteria used in the determination of best interests: “involve the patient in the decision-making process”, “seek views of carers and relatives”, “seek views of carers and relatives about what may have been the patient’s views”, “consider the views of patients” and “consult other professionals involved in the care of the patient”.

Table 12 illustrates the proportion of patients lacking capacity, as reported by consultant psychiatrists, to have had a best interests determination conducted, and had their previous wishes considered, their carers consulted, and advance decisions considered in the determination of best interests. Over 50% reported that over 50% of patients lacking capacity had a determination of best interests. Three-quarters reported that over 50% of patients lacking capacity had their previous wishes considered in the determination of best interests. Almost two-thirds reported that in over 50% of patients lacking capacity their carers were

consulted during the determination of best interests. A third reported that a third of patients lacking capacity had advance decisions considered in the determination of best interests.

Discussion

There may be several explanations for the overall response rate being only 12%. First, it is possible that the Royal College of Psychiatry database may not have been accurate. However, there is no evidence to support this suggestion and the Royal College of Psychiatrists updates this database on an annual basis. Second, Consultant Psychiatrists may have been very busy with many competing priorities at a time when the National Health Service is undergoing many simultaneous changes. Third, the total time interval of 12 weeks given to complete the questionnaire (the initial questionnaire and a reminder sent after six weeks to those who did not respond) may have been too short. Fourth, the questionnaire may have been perceived to be too long and covering too many issues. Fifth, the questionnaire may not have been relevant or less relevant to some psychiatric specialities (e.g. most of the MCA does not apply to those under the age of 16 years and so may have been less important to consultant psychiatrists in child and adolescent psychiatry). Sixth, consultant psychiatrists may have felt that the findings of this study may have little impact in improving the difficulties they may have experienced because the MCA had already been fully implemented (except the Deprivation of Liberty Safeguards added to the MCA, which were implemented in April 2009). Seventh, consultant psychiatrists may have felt that they had insufficient experience to complete the questionnaire because the MCA had only been implemented for three months at the time the questionnaire was first sent out.

Caution should be exercised in extrapolating the findings to other disciplines working in the field of mental health and to specialities other than psychiatry. Caution should also be exercised in the interpretation of findings because of the low response rate. However, the low response rate may be less important in interpreting qualitative data because the absolute number of responses may have been sufficiently large to reach saturation for the qualitative thematic analysis. Moreover, consultant psychiatrists in old age psychiatry were not included in this study because a similar parallel, but separate study, was currently being conducted with them.

Given the early concerns about delays in developing training, policy and guidance for a diverse group of clinicians and IMCAs^{15,17,18}, it was encouraging that 70% or more of responding consultant psychiatrists reported that there was a local Trust policy on capacity to consent and that this policy was used, there was a local Trust policy on the implementation of the MCA and that this policy was used, and local training on the application of the MCA, including refresher training and training for new staff, was available. Development of local policy and availability of local training on the application of the MCA may have been supported and encouraged by the case scenarios in the Code of Practice accompanying the MCA and the availability of training materials, including those developed by the Social Care Institute of Excellence (SCIE)¹⁴. The availability of training in the application of the MCA in some Trusts may have been further facilitated by novel approaches whereby local clinicians were trained to train other colleagues in the application of the MCA – for example, the “train the trainer” initiatives used in the West London Mental Health NHS Trust.

Less than 50% of responding consultant psychiatrists reported that the training in the application of the MCA was mandatory. This may explain the observation that only 50% of responding consultant psychiatrists reported that half or more of the staff received training in the application of the MCA. These two observations were of concern because the MCA requires all decision-makers, including healthcare or social care professionals, to follow the principles laid down in the MCA. A study of professionals working

in learning disability reported that professionals requested more training in the application of the MCA¹⁸. Moreover, there is no statutory requirement for healthcare and social care professionals to undertake formal training in the application of the MCA. Ideally, all healthcare and social care providers should ensure that training in the application of the MCA is readily available to all multidisciplinary staff and that the uptake of this training should be mandatory.

The observation that about a third of responding consultant psychiatrists reported that half or more patients had a routine assessment of capacity and that half or more patients had the assessment of capacity routinely documented may be explained by the first statutory principle of the MCA whereby an individual must be assumed to have capacity unless lack of capacity has been formally established. Thus, capacity may have been presumed in a significant number of patients in the absence of evidence to the contrary. This is supported by the qualitative thematic analysis of the criteria used in the assessment of capacity whereby one of the identified criteria was the presumption of capacity unless there was doubt about capacity. Furthermore, some patients lacking capacity may have been subject to the Mental Health Act 1983 (MHA) and there is no requirement in the MHA to formally assess capacity and document the assessment of capacity other than for treatments covered under Part 4 and 4A of the MHA. The circumstances leading to a formal assessment of capacity for a specific issue require identification in future studies.

The observation that almost two-thirds of responding consultant psychiatrists reported that the capacity was assessed separately for each issue and treatment decision was encouraging given the clear stipulation in the MCA that the assessment of capacity should be for a specific decision and that this assessment should occur at the time the decision needs to be made. However, the observation that about a quarter of responding consultant psychiatrists reported not assessing capacity separately for each issue and treatment decision was of concern. Although the potential for erroneous perception by carers that capacity is an “all or nothing phenomena”¹⁵ has been reported, such concern has not been reported in relation to professionals, including consultant psychiatrists. The precise reasons for capacity not being assessed separately for each issue requires clarification in future studies. Also, formal training for clinicians in the application of the MCA should ensure that clinicians are unequivocally made aware that the assessment of capacity should be decision-specific.

Over two-thirds of responding consultant psychiatrists reported that capacity was routinely assessed for healthcare decisions. This observation, although encouraging, was not surprising because responding consultant psychiatrists are usually involved in making healthcare decisions. The observation that about half of the responding consultant psychiatrists reported that capacity was routinely assessed for financial welfare may reflect a recognition of the vulnerability of psychiatric patients to financial exploitation and mis-management of their finances due to their illness (e.g. patients with bipolar illness manic type may, as part of their illness, spend large sums of money), and that financial affairs of psychiatric patients may have important implications for their long-term management (e.g. funding for placement into a care home is subject to “means” testing by social services). The observation that less than 50% of responding consultant psychiatrists reported that capacity was routinely assessed for personal care and social care was not surprising because capacity on these issues is more likely to be assessed by other professionals including nurses and social workers.

Almost 50% of responding consultant psychiatrists reported that more than half of the assessments of capacity were conducted by consultant psychiatrists. This may be a reflection of the complex circumstances of many psychiatric patients, who may therefore require a senior experienced clinician to assess capacity.

It may also reflect a culture engendered by the requirement under the MHA (prior to its amendment) that capacity should be assessed by the (then) Responsible Medical Officer (usually the Consultant Psychiatrist) in patients whose treatment is subject to Part 4 of the MHA. With the emergence and implementation of “New Ways of Working” increasing numbers of psychiatric patients are initially assessed and subsequently managed by a range of multidisciplinary clinicians²². However, the observation that almost two-thirds of responding consultant psychiatrists reported that fewer than half of the assessments of capacity were conducted by junior doctors, nurses, psychologists, social workers, occupational therapists and others was not consistent with the basic philosophy of “New Ways of Working”. Collectively these observations suggest that consultant psychiatrists conduct majority of the assessments of capacity despite the MCA clearly stating that the decision-maker for a particular decision should be responsible for the assessment of capacity for that decision. This may, in part, explain the reported increased workload of consultant psychiatrists as result of the implementation of the MCA. The precise reasons for consultant psychiatrists conducting majority of the assessments of capacity and other multidisciplinary clinicians conducting comparatively fewer assessments of capacity requires clarification in future studies.

The reported criterion for the assessment of capacity that there was presumption of capacity unless there was doubt about capacity is consistent with the first statutory principle of the MCA. The reported criteria for the assessment of capacity that capacity should be decision-specific and time-specific are also consistent with the same stipulation in the MCA. The reported criterion that the patient should not be subjected to undue pressure in the assessment of capacity, although not described as a specific criterion for the assessment of capacity in the MCA, is in keeping with the spirit of the MCA and the five statutory principles. The criterion of Gillick competence in the assessment of capacity was reported by a consultant psychiatrists in child and adolescent psychiatry. A child may be Gillick competent to consent to an intervention if s/he has sufficient understanding and intelligence to enable him/her to understand fully what is involved in the proposed intervention.

About 90% of responding consultant psychiatrists reported using the four criteria for the specific test of capacity described in the MCA and listed above in our presentation of results. The criteria described in the MCA for the first stage of the assessment of capacity are:

- Does the individual have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works?
- If so, does the impairment or disturbance mean that the individual is unable to make a decision in question at the time it needs to be made?

Although none of the respondents specifically reported the above two criteria, about 15% of responding consultant psychiatrists reported the presence of cognitive impairment or mental health problems as criteria for the assessment of capacity, and these could be considered in the context of the first stage of the assessment of capacity as described above. It was encouraging that consultant psychiatrists reported using the criteria listed in the preceding paragraphs as they were mostly consistent with those described in the MCA.

A small number of consultant psychiatrists reported the criteria for the assessment of capacity to include “assessment of capacity being in the best interests of the patient” and “seek views of a consultee (e.g. relatives)”. These were not consistent with the specific criteria for the assessment of capacity described in the MCA. Moreover, inclusion of these criteria in the assessment of capacity suggests that there may

22 Department of Health (2005) *New ways of working for psychiatrists: enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexts. Final report 'but not the end of story'*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122342

have been confusion between the concept of the assessment of capacity and the concept of the determination of best interests. A small number of consultant psychiatrists also listed age and functional ability as the criteria for the assessment of capacity. These were also not consistent with the criteria for the assessment of capacity described in the MCA. The design of the current study did not allow examination of the reasons for using the four criteria described in this paragraph in the assessment of capacity. The precise reasons for using these four criteria in the assessment of capacity require clarification in future studies. Formal training for clinicians in the application of the MCA should unequivocally clarify the criteria for the assessment of capacity described in the MCA and that the assessment of capacity and the determination of best interests are different (albeit related) concepts.

Over half of the responding consultant psychiatrists reported that in at least half the patients having an assessment of capacity both their carers and other professionals were consulted. This was encouraging because it is important to ensure that the decision for which the assessment of capacity is conducted is the most appropriate decision, and the contribution of carers and other professionals on deciding the appropriateness of a particular decision is important.

It was encouraging that over 90% of responding consultant psychiatrists reported using the best interests principles for making decisions on behalf of patients lacking capacity. Moreover, over 50% of responding consultant psychiatrists reported that over half of the patients lacking capacity had a determination of best interests. The descriptive answer to the question “What criteria were used to determine best interest?” were manually coded using qualitative thematic analysis into 14 separate individual criteria used in the determination of best interests by consultant psychiatrists. It was encouraging that 13 of these 14 criteria were consistent with many of the factors that must be considered in the determination of the best interests as described in the MCA:

- Careful consideration should be given to all circumstances pertaining to the individual lacking capacity.
- Every effort should be made to enable an individual lacking capacity to participate in making the decision.
- Consideration should be given to the possibility that the capacity may be regained (e.g. after treatment of a mental illness) and whether the decision-making can be postponed until the capacity is regained.
- Careful consideration should be given to the past and present wishes and feelings, beliefs and values of an individual lacking capacity. This includes any written statements made when the individual had capacity.
- Careful consideration should be given to the views of other people (close relatives, friends and others who take an interest in the person’s welfare) who are close to an individual lacking capacity, anyone engaged in caring for the individual, anyone previously nominated by the individual to be consulted on the decision in question or similar issues, donees of Lasting Power of Attorney or Enduring Power of Attorney, Court-appointed Deputies and Independent Mental Capacity Advocates (IMCAs).
- Special conditions apply to decisions about life sustaining treatment, whereby the decision-maker should not be motivated by a desire to end life.
- There are circumstances when an IMCA must be instructed.
- Careful consideration should also be given to least restrictive alternatives that may be in the best interests of an individual lacking capacity.

Furthermore, it was encouraging that three-quarters of responding consultant psychiatrists reported that over half of the patients lacking capacity had their previous wishes considered in the determination of best interests, and almost two-thirds reported that in over half of the patients lacking capacity, their carers were consulted during the determination of best interests.

A third of responding consultant psychiatrists reported that only a third of patients lacking capacity had advance decisions considered in the determination of best interests. There may be several explanations for this observation in addition to the methodological issues described above. First, consultant psychiatrists may not have had sufficient experience of advance decisions within the first three months of the full implementation of the MCA. Second, psychiatric patients may be less likely to make advance decisions, or may have been less likely to have done so within the first three months of the full implementation of the MCA. Third, consultant psychiatrists may have used the Mental Health Act to over-ride advance decisions. Fourth, this finding may be genuine. The precise reasons for the low rate of consideration of advance decisions in the determination of best interests require clarification in future studies.

It was disappointing that the following factors described in the MCA were not reported to have been considered in the determination of best interests:

- Determination of best interests cannot be based on an individual's age, appearance (including racial appearance or religious dress), condition or behaviour.
- Every effort should be made to enable an individual lacking capacity to participate in making the decision including use of appropriate methods of communication (including professional interpreters) and using other people to facilitate the person to participate in the decision-making process.
- Special conditions apply to decisions about life sustaining treatment, whereby the decision-maker should not be motivated by a desire to end life.

There may be several explanations for these factors not being considered in the determination of best interests in addition to the methodological issues described above. First, the first two factors in the above list may have been assumed to be implicit in the other criteria that consultant psychiatrists reported using in the determination of best interests, and therefore they may not have been specifically described in response to the question designed to ascertain the criteria used in the determination of best interests. Second, consultant psychiatrists are unlikely to have had experience of life sustaining treatment, particularly within the first three months after the implementation of the MCA, because clinicians working in general hospital and primary care settings are much more likely to experience this.

Two consultant psychiatrists in child and adolescent psychiatry reported that the determination of best interests was a parental responsibility. This response was not surprising because most of the MCA does not apply to individuals under the age of 16 years.

Collectively, the above findings suggest that consultant psychiatrists were generally well aware of the criteria for the assessment of capacity and the principles for the determination of best interests described in the MCA and the accompanying Code of Practice.

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A Pilot Study of the Early Experience of Consultant Psychiatrists in the Implementation of the Mental Capacity Act 2005: Local Policy and Training, Assessment of Capacity and Determination of Best Interests

Table 1: Response rates of consultant psychiatrists

Speciality	Number of questionnaires sent	Number (%) of responses
General psychiatry	497	69 (14)
Forensic psychiatry	78	6 (7)
Liaison psychiatry	44	4 (9)
Learning disability	88	11 (13)
Child psychiatry	248	21 (8)
All specialities	955	113 (12)

Table 2: Local policy and training in the application of the MCA

Item	Total number of responses	Number (%) of "Yes" responses	Number (%) of "No" responses	Number (%) of "Did not know" responses
Presence of local Trust policy on capacity to consent	111	84 (76)	17 (15)	10 (9)
Local Trust policy on capacity to consent being used	100	73 (73)	15 (15)	12 (12)
Presence of local Trust policy on the implementation of the MCA	106	76 (72)	16 (15)	14 (13)
Local Trust policy on the implementation of the MCA being used	93	65 (70)	14 (15)	14 (15)
Availability of local training on the MCA	110	97 (88)	9 (8)	4 (4)
Training on the MCA being mandatory	104	49 (47)	43 (41)	12 (11)
Availability of refresher training and training for new staff on the MCA	102	72 (69)	17 (16)	13 (13)

Table 3: The proportion of staff who have received training in the application of the MCA

Proportion	Consultant psychiatrists (%)
Nil (0%)	2 (2)
Some (1–49%)	22 (23)
Half (50%)	10 (10)
Most (51–99%)	28 (29)
All (100%)	6 (6)
Did not know	29 (30)
Total number of respondents	97 (100)

Table 4: Routine assessment of decision-making capacity and the routine documentation of decision-making capacity

Proportion	Routine assessment of capacity (%)	Documentation of the assessment of capacity (%)
Nil (0%)	5 (5)	6 (7)
Some (1–49%)	25 (27)	29 (32)
Half (50%)	5 (5)	8 (9)
Most (51–99%)	14 (15)	6 (7)
All (100%)	17 (18)	15 (17)
Did not know	27 (29)	26 (29)
Total number of respondents	93 (100)	90 (100)

Table 5: Assessment of decision-making capacity separately for each issue

	Assessed capacity separately for each issue (%)	Did not assess capacity separately for each issue (%)	Did not know (%)	Total number of respondents (%)
Consultant psychiatrists (%)	59 (61)	24 (25)	13 (13)	96 (100)

A Pilot Study of the Early Experience of Consultant Psychiatrists in the Implementation of the Mental Capacity Act 2005: Local Policy and Training, Assessment of Capacity and Determination of Best Interests

Table 6: Broad issues for which decision-making capacity is routine assessed

Broad issue for the assessment of capacity	capacity routinely assessed (%)	capacity not routinely assessed (%)	Did not know (%)	Total number of respondents (%)
Personal care	32 (36)	41 (47)	15 (17)	88 (100)
Health care	69 (73)	13 (14)	13 (14)	95 (100)
Social care	39 (45)	33 (38)	15 (17)	87 (100)
Financial welfare	49 (54)	28 (31)	14 (15)	91 (100)

Table 7: Criteria used by consultant psychiatrists in the assessment of decision-making capacity

Category	Consultant Psychiatrists (%)
Presumption of capacity unless doubt about capacity	11 (13)
Cognitive impairment	13 (15)
Mental health problems	14 (17)
Age	2 (2)
Functional ability	1 (1)
Gillick competent	1 (1)
Understanding information	80 (94)
Retaining information	78 (92)
Weighing up in the balance	79 (93)
Communicating the decision	76 (89)
Patient not subjected to undue pressure in the assessment of capacity	7 (8)
Assessment of capacity being in the best interests of the patient	4 (5)
Seek views of a consultee (e.g. relatives)	2 (2)
Assessment of capacity being time-specific	5 (6)
Assessment of capacity being decision-specific	7 (8)
Total number of respondents	85 (100)

Table 8: Consultation with carers and other professionals during the assessment of decision-making capacity

Proportion	Consultation with carers (%)	Consultation with other professionals (%)
Nil (0%)	9 (10)	2 (2)
Some (1–49%)	11 (13)	15 (17)
Half (50%)	8 (9)	2 (2)
Most (51–99%)	11 (13)	10 (11)
All (100%)	28 (32)	40 (46)
Did not know	19 (22)	18 (21)
Total number of respondents	86 (100)	88 (100)

Table 9: The proportion of assessments of decision-making capacity conducted by different professional groups.

Proportion	Consultants (%)	Junior doctors (%)	Nurses (%)	Psychologists (%)	Social workers (%)	Occupational therapists (%)	Others (%)
Nil	3 (5)	21 (36)	24 (43)	29 (54)	31 (59)	35 (57)	35 (66)
Some	9 (15)	21 (36)	13 (23)	9 (17)	7 (13)	3 (6)	3 (6)
Half	6 (10)	1 (2)	2 (4)	0 (0)	1 (2)	1 (2)	0 (0)
Most	14 (23)	1 (2)	2 (4)	2 (4)	1 (2)	1 (2)	0 (0)
All	16 (26)	1 (2)	2 (4)	1 (2)	1 (2)	0 (0)	3 (6)
Did not know	13 (21)	13 (22)	13 (23)	13 (24)	12 (23)	12 (23)	12 (23)
Total number of respondents	61 (100)	58 (100)	56 (100)	54 (100)	53 (100)	52 (100)	53 (100)

Table 10: The proportion of consultant psychiatrists using the best interest principles

Proportion	Consultant Psychiatrists (%)
Used best interests principles	80 (95)
Did not use best interests principles	2 (2)
Did not know	1 (1)
Total number of respondents	84 (100)

Table 11: The criteria used in the determination of best interests

Category	Consultant Psychiatrists (%)
Wait until capacity is regained	20 (31)
Involve the patient in the decision-making process	46 (71)
Seek the views of carers and relatives	42 (65)
Seek the views of carers and relatives about what may have been the patient's views	45 (69)
Consider views of the patient	46 (71)
Consider any advance decision	32 (49)
Consult other professionals involved with the patient	43 (66)
Consult donee of Lasting Power of Attorney	37 (57)
Consult Court-appointed Deputy	31 (48)
Consider the advantages and disadvantages of the decision	35 (54)
Consider that the decision was proportionate to the risk	19 (29)
Consider that the decision was the least restrictive option	16 (25)
Referral to an Independent Mental Capacity Advocate	16 (25)
This being a parental responsibility	2 (3)
Total number of respondents	65 (100)

Table 12: Consideration of the patient's wishes, advance decisions and consultation with carers in the determination of best interest

Proportion	Patients having determination of best interests (%)	Consideration of patient's previous wishes (%)	Consultation with carers (%)	Consideration of an advance decision (%)
Nil	4 (6)	7 (10)	3 (4)	27 (37)
Some	14 (19)	10 (14)	8 (11)	8 (11)
Half	3 (4)	2 (3)	4 (6)	1 (1)
Most	8 (11)	7 (10)	11 (15)	2 (3)
All	30 (42)	31 (43)	33 (45)	21 (29)
Did not know	13 (18)	15 (21)	14 (19)	14 (19)
Total number of respondents	72 (100)	72 (100)	73 (100)	73 (100)

Is Capacity “In Sight”?

Neil Allen¹

“Oh we didn’t talk much about capacity – we used to talk about insight”

Consultant Psychiatrist’s comment at the inquest into a patient’s death

“The MHAC has great concern that ‘consent’ is equated with ‘insight’...”

MHAC, *Risk, Rights, Recovery* 12th biennial report para 6.24

Introduction

Convicted of rape, Mr B was sent to Broadmoor.² His psychiatrist diagnosed bipolar affective disorder and wanted, if necessary, to compulsorily treat him with anti-psychotic medication. In his professional opinion, Mr B lacked insight into his condition and lacked the capacity to refuse the treatment. Baroness Hale once remarked that “psychiatry is not an exact science”.³ If there was ever a case to confirm that view, this is it.

At a tribunal hearing, the medical member of the panel thought that Mr B had schizophrenia. Another doctor could not find any mental disorder at all. The one acting for the Home Office diagnosed schizo-affective disorder but agreed with the responsible clinician that the patient lacked capacity to consent. Meanwhile, the Second Opinion Appointed Doctor (‘SOAD’), called in to approve the RC’s treatment plan, initially diagnosed schizo-affective disorder but then changed his mind to bipolar affective disorder. In his opinion, Mr B *lacked* insight but *had* capacity to refuse.

There was more evidence to follow: two Professors were brought in. Both agreed that Mr B had bipolar affective disorder. The Professor of Psychiatry also agreed with the SOAD on the issue of capacity. In short, the patient was not impaired by his illness and had the capacity to refuse.

So by the time the case reached the courtroom there was some degree of consensus, at least as to diagnosis: Mr B had bipolar affective disorder. But so far as the proposed treatment was concerned, two psychiatrists thought he had capacity to refuse it; two did not. No-one seemed to suggest he had insight.

Disagreement in diagnosis inevitably confuses patients. All of us prefer to believe that we are of sound mind. Mr B preferred to believe that he was mentally well. The most he was prepared to accept was that he was one of those 10% of bipolar affective disorder patients who would not relapse: optimism which the judge described as “an understandable and natural human reaction”. The patient’s ability to recall earlier discussions with doctors around treatment was said to be “remarkable”. And the judge decided that he was able to comprehend and retain all the relevant information.

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² *R (on the application of B) v Dr SS* [2005] E.W.H.C. 1936; [2006] E.W.C.A. Civ. 28.

³ *R (on the application of B) v Ashworth Hospital Authority* [2005] 2 A.C. 278.

In those circumstances, did it really matter whether Mr B had insight into his condition? Was the issue not simply whether or not he had capacity to refuse the drugs? What is the relationship between these psychiatric and legal concepts?

Is Capacity In Sight?

Our understanding of mental capacity is not what it used to be, thank goodness. Long gone are the days when those with mental disorder were automatically assumed to be incapable of making decisions. Thanks to another one of Broadmoor's residents, Mr C who was diagnosed with schizophrenia, English law saw fit to "clarify" (if not invent) the capacity test. He had to decide whether to have a gangrenous leg amputated. The judge held that he would lack capacity if he was unable to comprehend, retain, believe, or weigh the relevant information or if he could not communicate his decision. You might think that Mr C's delusions of medical grandeur and his persecutory thoughts might have prevented him from weighing the information. But they did not. The law therefore respected his decision to die with two feet rather than to live with one.⁴

Nowadays, strictly speaking, mental capacity has two meanings in mental health law. Firstly, under the *Mental Capacity Act 2005 (MCA)*, we lack capacity if at the material time, due to an impairment or disturbance in the functioning of our mind or brain⁵, we are unable to do any one of four things. That is, if we are unable to understand information relevant to the specific decision; unable to retain that information for as long as is required to make the decision; or to use or weigh that information as part of the decision-making process; and, finally, if we cannot communicate our decision.⁶ Notice that there is no mention of *belief*.

Secondly, the amended *Mental Health Act 1983* refers to being capable of understanding the nature, purpose and likely effects of treatment. Baroness Hale (I think rightly) suggests⁷ that the MCA test should be used. Otherwise, the same treatment decision would invite two different legal tests depending on whether the person was informal or detained.

The concept of capacity plays a far more significant role now than it used to. Indeed, some might describe it as a pivotal role. Greater clarity in the law, combined with more reliable empirical research, have each contributed to the cause. For example, studies suggest that "the frequency of incapacity in psychiatric in-patients ... [does] not differ greatly from that in general hospital in-patients".⁸ Okai and others went so far as to suggest that most psychiatric in-patients are capable of making key treatment decisions. It is therefore difficult to disagree with Geneva Richardson who said:

*"While some people with mental disorder will no doubt lack rationality or judgment, by any definition, many will not, and it is the growing realisation that people with mental disorder are still capable of considered judgement that has cast doubt on the old assumptions."*⁹

Such doubt has bred reform. Capacitous foresight, for example, has been reinforced by the MCA: not only can we make advance decisions to refuse treatment; we can now appoint others to make personal welfare

4 *Re C* [1994] 1 All E.R. 819. Such grandeur was no doubt reinforced when, contrary to expert opinion, the gangrene cleared up with medication alone.

5 S.2(1) *Mental Capacity Act 2005*.

6 S.3(1) *Mental Capacity Act 2005*.

7 *R (on the application of Wilkinson) v Broadmoor Hospital Authority* [2002] 1 W.L.R. 419 at para 66. *MHA Code*

of Practice (2008) at p201 agrees with this view.

8 D. Okai et al, 'Mental capacity in psychiatric patients: Systematic review' (2007) 191 *British Journal of Psychiatry* 291, 295.

9 G. Richardson, 'Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions' (2002) 65 *Modern Law Review* 702, 706.

decisions for us in the event of us subsequently losing capacity. Under the deprivation of liberty safeguards, neither PCTs nor local authorities can deprive the liberty of those capable of deciding on their accommodation arrangements. Even for those incapable of making that decision, detained residents retain the right to make those other decisions for which they have capacity. Moreover, the capacitous decisions of 16 and 17 year olds who refuse to be informally admitted can no longer be overridden by their parents.¹⁰

The capacity concept has not surged quite so far into the crevices of the 1983 Act, although that has not stopped the old assumptions from being firmly tested. Unlike the position in Scotland¹¹, capacity still plays no explicit role in the decision to detain, although many professionals take it into account as a matter of good practice. The law also denies detained patients the right to refuse treatment for their mental disorder. Medication can be compelled upon them, at least for three months¹², at which point their capacitous refusal can still be trumped by a SOAD.

And yet Bellhouse found that “a majority of people detained under the present MHA had the capacity” to make decisions for themselves.¹³ It could be argued that capacity is playing an ever-growing role in MHA detentions. All detained patients with capacity are able to refuse all treatment that is not for their mental disorder. Brain tissue cannot be destroyed, nor hormones surgically implanted, without the patient’s capacitous consent and a second medical opinion.¹⁴ Electro-convulsive therapy can no longer be given in the face of a capacitous refusal unless it is immediately necessary to save life or to prevent a serious deterioration in health. Valid and applicable advance decisions to refuse ECT, or those of donees or deputees, must similarly be respected for incapacitated patients.¹⁵ And no treatment can be compulsorily given to capacitous patients on CTOs unless they are recalled to hospital.

So, with capacity making such big legal strides, what is the legal relevance of insight?

Is Capacity Insight?

My concern is that recent research has attempted to use insight as a measurement of capacity. In their empirical study, Cairns and others suggested there is conceptual overlap between insight and mental capacity.¹⁶ They argued that ‘insight’ was the strongest predictor of incapacity.

“The degree of patient insight has a close relationship to capacity and the need for involuntary treatment. It remains possible that this construct, although no less complex than capacity, is more intuitive to mental health professionals and may provide a more reliable basis for coercive-treatment decisions.”

Hotopf¹⁷ acknowledges the strong association between the concepts but contends that it is not an absolute one: it is possible to have insight and lack capacity, and vice versa. That certainly was the view taken by some of the doctors in Mr B’s case.

But what is insight?! Does it sit somewhere between foresight and hindsight? It is a clinical concept which

10 MHA s.131.

11 Mental Health (Care and Treatment) (Scotland) Act 2003 requires judgment to be significantly impaired before detention can occur.

12 MHA s.63 and 58.

13 J. Bellhouse et al, ‘Capacity-based mental health legislation and its impact on clinical practice: 1) Admission to Hospital’ (2003) *Journal of Mental Health Law* 9; J. Bellhouse et al, ‘Capacity-based mental health legislation

and its impact on clinical practice: 2) Treatment in Hospital’ (2003) *Journal of Mental Health Law* 24, 35.

14 MHA s.57.

15 MHA s.58A.

16 R. Cairns et al, ‘Prevalence and predictors of mental incapacity in psychiatric in-patients’ (2005) 187 *British Journal of Psychiatry* 379, 384

17 Hotopf et al, (2008) *British Medical Journal* 337: a902.

seems easier to use than it is to define.¹⁸ Indeed, there is much disagreement over its meaning which is unfortunate, given the obvious, although in many ways unspoken, impact it has on detention, treatment and discharge decisions.

Sir Aubrey Lewis once described insight as “a correct attitude to a morbid change in oneself ... the realisation that the illness is mental ... to see ourselves as others see us”.¹⁹ And there are at least seven other definitions of the term in the literature. Jaspers, for example, described it as the feeling of being ill and changed, plus the ability to evaluate the nature and severity of that illness.²⁰ David described it as being able to relabel mental events as pathological; to recognise you are being affected by a mental disorder; and to admit you need treatment and will comply with it.²¹ I could go on: Greenfeld,²² Amador,²³ Fleming,²⁴ Beck,²⁵ and Marková and Berrios,²⁶ have all come up with their own suggestions.

Returning to Mr B for a moment, what was the correct attitude to his morbid change? Would he have been correct to accept he had bipolar affective disorder, schizophrenia or schizo-affective disorder? Was there in fact a morbid change? After all, two doctors did not even think he had a mental disorder. Can any patient be expected to have insight in the face of disagreement in diagnosis?

Not only does insight have different meanings; there are also different tests for measuring it. There is the Insight and Treatment Attitude Questionnaire;²⁷ the Scale to Assess Unawareness of Mental Disorder;²⁸ the Insight Scale;²⁹ Beck's Cognitive Insight Scale;³⁰ and Birchwood's Insight Scale.³¹ Not to mention David's Schedule for the Assessment of Insight.³² Høyer goes so far as to argue that the content of these tests is virtually meaningless: “[T]hose agreeing with their treating psychiatrist have insight, those who disagree have not”.³³ Is this really what insight boils down to? Agreeing with your doctor because s/he knows best?

The cases of Mr B and Mr C were decided before the MCA. Whether they *believed* the information was, back then, a factor taken into account in determining whether they had capacity. In relation to Mr B, the judge drew a distinction between those who accept that they are mentally ill, or realistically entertain that possibility because they accept that this is the honest and professional diagnosis of doctors; and those who

18 Fulford, 'Insight and delusion: from Jaspers to Kraepelin and back again via Austin' in *Insight and Psychosis* (ed. X. Amador and A. David, 2nd edn, 2004), pp.51–78

19 A. Lewis, 'The psychopathology of insight' (1934) 14 *British Journal of Psychiatry* 332.

20 K. Jaspers, *General psychopathology* (1963).

21 AS David, 'Insight and psychosis' (1990) 156 *British Journal of Psychiatry* 798.

22 D. Greenfeld, JS Strauss, MB Bowers, M Mandelkern, 'Insight and interpretation of illness in recovery from psychosis' (1989) 15 *Schizophrenia Bulletin* 245: The acknowledgement of 1) pathological processes and unusual experiences, 2) need of a treatment, 3) possibility of relapse, 4) pressure by psychosocial stressors.

23 X. Amador, D. Strauss, S. Yale, M. Flaum, J. Endicott, J. Gorman, 'Assessment of insight in psychosis' (1993) 150 *American Journal of Psychiatry* 873: The presence of 1) awareness of symptoms and 2) explanations about the causes of pathology.

24 JM Fleming, J. Strong, R. Ashton, 'Self-awareness of deficits in adults with traumatic brain injury: how best to measure?' (1996) 10 *Brain Inj* 1: Three-level model of

self-awareness: 1) awareness of the injury-related deficits, 2) awareness of the functional implications of deficits for everyday activities, 3) ability to set realistic goals and predict one's future state accurately.

25 A. Beck, E. Baruch, J. Balter, R. Steer, D. Warman, 'A new instrument for measuring insight: the Beck Cognitive Insight Scale' (2004) 68 *Schizophr Res* 319: Conceptualization of 1) intellectual insight versus emotional insight and 2) cognitive insight.

26 IS Marková, GE Berrios, 'Insight in clinical psychiatry. A new model' (1995) 183 *J Nerv Ment Dis* 743; 'The object of insight assessment: relationship to insight structure'

27 McEvoy et al, (1981).

28 Amador et al (1993).

29 Marková and Berrios (1992) and (2003).

30 Beck et al (2004).

31 Birchwood et al (1994).

32 AS David, *ibid* n21.

33 G. Høyer, 'On the justification for civil commitment' (2000) 399 *Acta Psychiatrica Scandinavica* 101.

do not. Mr B did not accept the possibility. To cling on to his beliefs was “understandable”, said the judge, given that they were supported by at least one doctor’s views. However, not believing the other doctors was his downfall:

“In my judgment it follows that Mr B does not believe or accept a cornerstone of the factors to be taken into account in considering the information he has been given about his proposed treatment and therefore is not able to use and weigh in the balance the relevant information as to his proposed treatment in reaching a decision to agree to it or to refuse it.”

His mental illness had so coloured his comprehension of the information that he was not able to process it at a cognitive level. For the Court of Appeal, it was plain that “a patient will lack that capacity if he is not able to *appreciate the likely effects of having or not having the treatment*”.³⁴

In relation to Mr C, this case emphasised that to have capacity, a patient does not have to blindly accept medical evaluation and can have a level of self-assessment of any consequences, at least in so far as physical treatment decisions are concerned.

The requirement for belief is nowhere to be seen in the Mental Capacity or Mental Health Acts. Does this represent a significant change in the law? Is this Parliament’s way of pushing insight to the sidelines? Not according to Munby J:

*“If one does not “believe” a particular piece of information then one does not, in truth, “comprehend” or “understand” it, nor can it be said that one is able to “use” or “weigh” it. In other words, the specific requirement of belief is subsumed in the more general requirements of understanding and of ability to use and weigh information.”*³⁵

Is this right? Are we able to use and weigh information relating to something we do not believe in? Can an atheist, for example, ever have the capacity to consent to a religious wedding if they do not believe in God? Can a Jehovah’s witness ever capacitously decide to have a blood transfusion if they think other people’s blood is evil? Surely it cannot be right; otherwise we would not be able to understand anything that we did not believe in. It would make it impossible to disbelieve a doctor and retain capacity.

Such are the demands of insight that even believing *everything* a doctor tells you may not be enough. Take *B v Croydon Health Authority*,³⁶ where a detained patient described as having a personality disorder spoke of wanting to punish herself and wanting to understand why. Lord Justice Hoffmann said: “It is however this very self-awareness and acute self-analysis which leads me to doubt whether, at the critical time, she could be said to have made a true choice in refusing to eat.”

The Dilemma of Denial

If the law is to recognise a role for insight, its meaning and relationship with capacity requires more thought and greater clarity. At present, the two concepts are like quibbling siblings. They are awkward so-and-so’s, misbehaving under the watchful eye of their parental figures, law and psychiatry. Often both siblings attend to a person’s decision. Occasionally one of them may decide to turn up without the other. Sometimes both siblings are absent.

34 [2006] EWCA Civ. 28 at para 34.

35 *Local Authority X v MM and KM* [2007] EWHC 2003 (Fam) at para 81.

36 [1995] 1 FL.R. 470.

The term, insight, does not appear in any mental health or capacity legislation. Nor does it appear in the MHA Reference Guide and only once is it mentioned in the Code of Practice.³⁷ And we talk about it all the time in mental health. Indeed, it has been described as the single most consistently discussed symptom of mental illness amongst tribunal members.³⁸

Should we be concerned? Diesfeld certainly is. He argues³⁹ that insight remains legally ill-defined and its frequent use as an extra-legislative criterion threatens legal safeguards. There is a risk, in other words, that clinical concepts like insight might become proxy or substitute criteria for legal decisions.

Insisting on one's mental order should not inevitably be seen as evidence of mental disorder. Nor should it inevitably be equated with incapacity. After all, psychiatry itself is not an exact science.

37 MHA Code of Practice at para 25.11.

38 E. Perkins, S. Arthur and J.Nazroo, 'Decision-making in mental health review tribunals' (Central Books, London, 2002) p.124.

39 K. Diesfeld, 'Insight on 'insight': the impact of extra-legislative factors on decisions to discharge detained patients' in *Involuntary Detention and Therapeutic Jurisprudence* (ed. K. Diesfeld and I. Freckelton, 2003) pp.359–382.

Policing Care in the House of Lords

*Ralph Sandland*¹

The rights and interests of carers, and those in receipt of care, are related, directly and indirectly, in myriad, complex and contradictory ways. For example, poor pay and working conditions for carers is more likely than otherwise to lead to demotivated staff, with a corollary negative impact also on the rights and interests of those in receipt of care. Likewise, a carer working in good conditions for good pay is more likely than otherwise to provide a better quality of care. Sometimes, however, it is not the case that what is good for the care recipient is good for the care provider; and when decisions as to what constitutes the 'good' are made by third parties, such as governments, there is always the possibility that the balance between the rights and interests of the two groups will be inappropriately drawn.

Of course, as long as there have been state-provided or -purchased services, there have been Inspectors, Boards of Control, Regulatory Codes and so on. But in these cautious and scandal-ridden times, the tendency of government is to push for further and greater regulation of care providers and individual carers. Legislation such as the *Care Standards Act 2000*,² introducing into the care of vulnerable adults mechanisms such as 'listing' those deemed unsuitable to work in the field, which had previously been used only to police the care given to children, provides an example of this tendency. So too does the new scheme, introduced by the *Safeguarding Vulnerable Groups Act 2006*,³ which replaces both that in the CSA and the earlier regimes for the protection of children from care-related risks. The SVGA seeks to implement the central recommendation of the Bichard Report⁴ into children protection measures, as well as vetting, information sharing and record keeping in Humberside in the wake of the murder of two young girls by Ian Huntley, employed as a caretaker at their primary school. The Report made a number of Recommendations⁵ further to tighten the regulation of those who work with children. The government decided to utilise these recommendations to craft a new system which covers both those who work with children and those who work with vulnerable adults.⁶

The SVGA, however, is focused on the regulation of the individual carer. It makes no substantive change to the regime for the regulation of care providers, in respect of whom the system currently found in the CSA continues to apply. Despite the significant changes that it introduced, the CSA also contains traces of earlier regimes, and in some respects seems increasingly outdated. An example is what is currently s. 20 of the CSA, enacting in virtually identical form s. 30 of the predecessor statute, the *Registered Homes*

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2 Hereafter 'CSA'.

3 Hereafter 'SVGA'.

4 Sir Michael Bichard (2005) *The Bichard Inquiry Report* HC 653 London: The Stationery Office.

5 These are summarised at pp. 13–17 of the Report.

6 The new regime, which transfers responsibility from government to the new Independent Barring Board (IBB), constituted as part of the new Independent Safeguarding Authority (ISA), and which attempts to create a much more joined-up system for vetting, information provision and updating, after being phased in, came fully into operation in October 2009.

Act 1984. This allows the Secretary of State for Health (in practice a health authority or, these days, a strategic health authority) to apply to a magistrate *ex parte* for an order cancelling the registration of a care home when such an order is needed urgently in order to protect residents in the home from a serious risk of harm. Effectively, s. 20 of the CSA provides for a legal ambush. It bears little sign of human rights-based thinking.

On 21 January 2009, the House of Lords gave opinions in two cases, both concerning the policing of care provision in the independent sector. In the first case, *R(on the application of Wright) v Secretary of State for Health* [2009] UKHL 3, the issue was the fairness of aspects of the current system for listing individuals deemed to be unsuitable to work with vulnerable adults. In the second, *Trent Strategic Health Authority v Jain* [2009] UKHL 4, the legality of an *ex parte* application made by the Trent SHA to cancel the registration of the care home run by the respondents – followed by the immediate removal of the care home's elderly residents and consequent financial ruin for the respondents – fell to be decided. In essence, the issue was the same in each case: is a system which removes the right of a person to work in or to operate a care home, or to provide care services to a person in their own home, without giving that person any meaningful ability to defend or challenge the allegation against them, acceptable in the era of human rights?

Barring Carers: The Wright Case

Section 81(1) of the CSA requires the Secretary of State to keep a list of persons considered unsuitable to work with vulnerable adults. This is known as the POVA (Protection of Vulnerable Adults) list. Those who provide care services in the form of care home accommodation or domiciliary services are required by s. 82(1) of the CSA to inform the Secretary of State of any person employed by them who has been dismissed, or would have been dismissed had that person not resigned, retired or been made redundant, or who has been transferred to a non-care position, or who has been provisionally suspended or transferred pending a decision whether to dismiss, if the cause for dismissal, suspension or transfer is that the carer has harmed or placed at risk of harm a vulnerable adult.

The effect of being included on the POVA list is stark. It is a criminal offence to seek or accept any work as a carer once a listing has been confirmed by the Secretary of State.⁷ An employer must ascertain whether an individual is on the list before offering employment; if so, that person must not be employed. If an employer discovers that such a person is already in their employment 'he shall cease to employ him in a care position'.⁸

Inclusion on the POVA list has always been, in the first instance, on a provisional basis. This will be done 'if it appears [to the Secretary of State] from the information submitted...that it may be appropriate'.⁹ The practice of the Secretary of State is to make a judgment as to whether the information supplied is *prima facie* credible. Apparently, around 45% of those referred for listing are provisionally listed.¹⁰ The system has never moved quickly. In the *Wright* case, which involved four appellants all of whom had been provisionally listed, it took four to six months from referral to provisional listing, and a further nine months or so before a final decision whether to confirm the listing or remove the person in question from the list. The criteria applied by the Secretary of State when determining a referral are contained in section 82(7). He or she must conclude '(a) that the provider reasonably considered the worker to be guilty of misconduct (whether or not in the course of his employment) which harmed or placed at risk of harm a

7 S. 89(5) CSA.

9 S. 82(4) CSA.

8 S. 89(2) CSA.

10 *Baroness Hale in Wright at para. 9.*

vulnerable adult; and (b) that the worker is unsuitable to work with vulnerable adults'. Before making that determination he or she must 'invite observations' from the worker and from the person making the referral, on both the incident(s) in question and the observations of each other.¹¹ There is a right of appeal to the Care Standards Tribunal against being confirmed on the list.¹² However, the only protection available to persons provisionally listed is that when a person has been so listed for nine months he or she may apply to the Tribunal for leave to have his or her listing determined by the Tribunal rather than by the Secretary of State.¹³

In *Wright* all four appellants were registered nurses. All had been involved in incidents as part of their employment in care homes leading to dismissal, resignation, or suspension. All had then been placed provisionally on the POVA list several months after being referred. Three were subsequently not confirmed on the list, the other appellant was confirmed but successfully appealed against her inclusion. Their complaint was that the system for provisional listing was in breach of Articles 6 and 8 of the Convention, by reason of failing to provide a right to make representations to the Secretary of State before being provisionally listed, and because of the low threshold criteria for provisional listing.

The only Opinion in the House of Lords was that of Baroness Hale, accompanied by the agreement of the rest of the House. The Baroness held, dealing first with Article 6, that the inhibition of employment opportunities in these circumstances clearly engaged a civil right within the meaning of that Article.¹⁴ Moreover, she accepted that provisional listing would often amount to a 'determination' within the meaning of Article 6, albeit that the starting point in the jurisprudence of the European Court is that 'Article 6 does not apply to proceedings related to interim orders or other provisional measures'.¹⁵ This was because the provisional listing system, in the extent and decisiveness of its impact on the employability of the person concerned, came within the exception to the general rule and so within the scope of Article 6.¹⁶ In her view, 'The problem, it seems to me, stems from the draconian effect of provisional listing, coupled with the inevitable delay before a full merits hearing can be obtained'.¹⁷

Turning to Article 8, she noted the breadth of that Article, and referred to Strasbourg caselaw which demonstrates that the concept of 'private life' includes employment prospects; at least, when those employment prospects have been inhibited by (unfair) state actions. This led her to hold that although it may be that an infringement of Article 8(1) is justifiable in particular fact situations by reference to one of the factors in Article 8(2), 'The point is that the procedures must be fair in the light of the importance of the interests at stake. I would agree that the low threshold for provisional listing adds to the risk of arbitrary and unjustified interferences and thus contributes to the overall unfairness of the scheme'.¹⁸ She concluded, for reasons principally to do with the breach of Article 6(1), that section 82(4)(b) CSA is incompatible with the Convention, and made a declaration to that effect.

The day before Baroness Hale delivered her Opinion in *Wright*, the Independent Safeguarding Authority (ISA), set up under the *Safeguarding Vulnerable Groups Act 2006*, assumed full responsibility¹⁹ for deciding whether an individual should be barred from 'regulated activity' involving either children or vulnerable

11 S.82(5) CSA.

12 S.86(1)(a) CSA.

13 S.86(2) CSA.

14 Para 19., citing *Le Compte, Van Leuven and De Meyere v Belgium* (1981) 4 EHRR 1.

15 Para 20., citing *Dogmoch v Germany app No 26315/03* Sept 2006 unreported.

16 Para 21., again citing *Le Compte*.

17 Para. 29.

18 Para. 37.

19 *In England and Wales. In Northern Ireland, the ISA took over full responsibility for decision-making on 13 March 2009.*

adults. This is not the place for a lengthy discussion of the 2006 Act, and in *Wright* Baroness Hale noted only that she could not comment on the human rights compatibility of the new scheme, knowing only at that time of its intended existence, but not its detail.²⁰ In fact, the new regime is different in a number of ways from that under consideration in *Wright*. The most pertinent distinction for present purposes being that provisional listing does not feature in it, and provisional listing ceased being used when the ISA became responsible for deciding on new referrals for blacklisting. However, the decision in *Wright* does have some bearing on the new regime.

The 2006 Act prohibits a barred person from engaging in any 'regulated activity',²¹ which essentially means any work with vulnerable adults. Employers who engage barred persons, or who fail to engage only those who have been approved – the terminology used in the Act is 'subject to monitoring' to emphasise the ongoing nature of the new vetting procedures – are guilty of a criminal offence,²² as is a barred person who seeks to engage in regulated activity.²³ Employers are under duties to check that they only employ suitable persons²⁴ and to refer any person for listing if he or she has any reason to think that the employee is unsuitable or has engaged in 'relevant conduct',²⁵ which is conduct that has harmed or risked harm, directly or indirectly to a vulnerable person.²⁶

All of this is very similar to the existing regime. One significant difference, however, is that there are now four routes onto the new adults barred list.²⁷ Two of the four routes are fully compliant with the decision in *Wright*. A person may be included on the list if it appears that he or she has engaged in relevant conduct,²⁸ but must be given the opportunity to make representations to the IBB before it makes that decision.²⁹ A person may also be included on the list on the basis of concerns that he or may harm, or cause, incite, attempt or risk harm to a vulnerable person,³⁰ but again, there is a right to make representations before being included on the barred list.³¹ The other two categories are more problematic. A person must be automatically included on the list, but with a right to make representations to the IBB as to why he or she should be removed from it,³² if he or she has been made subject to a sexual harm order under s.123 of the *Sexual Offences Act 2003*³³ or has been convicted of or cautioned for a specified offence.³⁴ A person must also be included on the list, with no opportunity to make representations to the IBB as to why his or her inclusion might be unwarranted,³⁵ if convicted or cautioned in respect of a serious sexual offence.³⁶

On one reading of *Wright*, the third of these categories can only be human rights compliant if the right to challenge one's inclusion on the barred list is speedily achievable. If the new system, in relation to this

20 Para 39.

21 Defined, in respect of vulnerable adults, in s.5(2) and Part 2 of Schedule 4 SVGA.

22 See ss. 8,9,10 SVGA.

23 S. 7 SVGA.

24 Section 11 SVGA. Section 12 applies a similar provision to employment agencies.

25 See para. 10, Sched. 3, SVGA.

26 See ss. 35–37 SVGA.

27 There is a parallel system in the SVGA for the new children's barred list.

28 Para. 9(1), Sched. 3, SVGA.

29 Para. 9(2) Sched. 3, SVGA.

30 Para. 11, Sched. 3, SVGA.

31 Para. 11(2), Sched. 3, SVGA.

32 Para. 8, Schedule 7 SVGA and para. 6, *Safeguarding Vulnerable Groups Act 2006 (Prescribed Criteria and Miscellaneous Provisions) Regulations 2009 SI 37/2009* ('the 2009 Regs'). The IBB should remove that person from the list if their inclusion is 'not appropriate': para. 8(4), Sched. 3, SVGA.

33 S. 2 of the *Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005* if in Scotland.

34 A large number of offences are listed in para. 4 of the Schedule to the 2009 Regs.

35 Para. 7, Schedule 3 2006 Act and para. 5 of the 2009 Regs.

36 These are listed in para. 3 of the Schedule to the 2009 Regs.

category of barred person, were to operate in practice as a continuation of the system of provisional listing, it would seem to fall foul of the decision in that case. Representations against inclusion on, or for removal from, the barred list must be made within eight weeks.³⁷ If this is to be achievable there needs to be much more urgency (and greater funding) for the new system than was the case for the old under which, as seen above, a decision to confirm a person on the POVA list typically took around a year from initial referral.

The fourth category, which allows of no representation before listing and no appeal thereafter, on this reading, is simply incompatible with *Wright*, and therefore with Articles 6 (and possibly 8) of the Convention. This is not the view of the Government, however. It was justified in the Overarching Memorandum produced by the Department of Children, Families and Schools (DCFS) in consultation with the Home Office and Department of Health in February 2008³⁸ on the basis that those to fall into this category have committed offences which ‘indicate, of themselves, that any offender would pose such a high risk to vulnerable groups that they simply could not make a case as to why they should be allowed to engage in regulated activity’.³⁹ The same Memorandum annexes an extract from a DCFS Memorandum to the House of Lords Merits Committee of 19th March 2008, which states that it is the Government’s view that Article 6 does not apply to persons barred automatically on the basis of their criminal record because the act of barring does not constitute the ‘determination’ of a civil right. The relevant Minister, Parmjit Dhanda MP, explained to the Chair of the Joint Committee on Human Rights that ‘As the bar is an automatic one, arising by operation of law, there can be no dispute of law and so I am advised that article 6 has no relevance’.⁴⁰ This *might* be enough to answer any challenge grounded in Article 6, although the failure to provide any right to appeal or review of having being listed is in my view not clearly immune to challenge using this Article. In human rights terms, certainly as they operate in Strasbourg, whether the inhibition of employment opportunities occurs by operation of domestic statute law or domestic judicial or quasi-judicial decision is not particularly relevant. One cannot usually avoid human rights obligations simply by replacing the exercise of judgement with an automatic procedure.

The DCFS Memorandum is, moreover, silent on the relevance of Article 8, which as seen above was an important component of the decision in *Wright*. It is true that the decision in *Wright* rested partly on the low threshold for provisional inclusion on the POVA list whereas the new regime has much more tightly defined criteria and applies only to a limited class of persons, all of whom have been convicted of or admitted guilt in relation to serious sexual offences. Nonetheless it is at least arguable that automatic inclusion, on the basis of *Wright*, *prima facie* infringes Article 8(1), and so its deployment needs to be justified using one of the reasons in Article 8(2) and must be demonstrably proportionate. This does not mean that the new system is *per se* unlawful but it does seem to indicate that there should be a hearing, or at least the possibility of a hearing, at which the case for inclusion is made out on the facts. In pragmatic terms, no system is failsafe; and we should be slow to countenance a system that has the possibility of injustice built into it. The *Jain* case bears witness to that.

Closing down nursing homes: The *Jain* Case

The *Jain* case centred on actions taken by Nottingham Health Authority in late 1998, in seeking and obtaining an *ex parte* order from a single magistrate under s. 30 of the *Registered Homes Act 1984*⁴¹ to

37 Para. 2(5) *Safeguarding Vulnerable Groups Act 2006* (Barring Procedure) Regulations 2008 SI 474/2008.

38 This is appended to various other Memoranda including that which accompanies the 2009 Regs.

39 At para. 4.4.3.

40 Cited in the DCFS, HO and DH Memorandum, Annex B.

41 The 1984 Act was repealed and replaced by the CSA. The corresponding section in the CSA is s.20.

cancel the licence of, and so close down,⁴² a nursing home in the city run by J. An order under s.30 could only be made if 'it appears to the justice of the peace that there will be a serious risk to the life, health or well being of patients in the home unless the order is made'.⁴³ The home was closed within 24 hours of the order being made, and its 33 residents – with an average age above 80 and all suffering from mental health problems – removed from the premises.

Section 34 of the 1984 Act provided for an appeal to the Registered Homes Tribunal⁴⁴ against the making of an order under s. 30, and J appealed, successfully. The Tribunal was 'scathing in its criticism of the authority', which was found to have given improper consideration to 'irrelevant and prejudicial information', had made 'insinuations... notwithstanding the absence of evidence sufficient to justify any charges of abuse' and had also made 'untrue suggestions' relating to J.⁴⁵ In particular, the Tribunal found 'no justification whatever'⁴⁶ for the decision to apply for the order *ex parte* and without notice to J.

Success before the Tribunal, however, meant little to J. The summary closure of the nursing home had ruined J's business and caused J serious financial harm. Winning the appeal did not remedy that. J sued the Health Authority for negligence. The greater proportion of Lord Scott's speech, with which all other members of the House agreed, was taken up with this question. His conclusion was that no duty of care is owed by a health authority to the proprietor of a care home. This is not surprising. There is a significant body of authority on the same or very similar questions, discussed in detail by Lord Scott, which takes the view that it would be inappropriate to impose a common law duty on a local government body in such a situation. Lord Scott explained the reason for this as follows:

*'Where action is taken by a State authority under statutory powers designed for the benefit or protection of a particular class of persons, a tortious duty of care will not be held to be owed by the State authority to others whose interests may be adversely affected by the exercise of the statutory power. The reason is that the imposition of such a duty would or might inhibit the exercise of the statutory powers and be potentially averse to the interests of the class of persons the powers were designed to benefit or protect, thereby putting at risk the achievement of their statutory purpose'*⁴⁷

There is a second body of caselaw, also discussed by Lord Scott (in particular the decision of the Court of Appeal in *Martine v South East Kent Health Authority* (1993) 20 BMLR 51, which had a fact situation indistinguishable on all material points from *Jain*, and which was expressly approved by Lord Scott⁴⁸), which consistently holds that no duty of care is owed by one party in litigation or in the preparation of litigation to the other(s).

So J's appeal was rejected by the House of Lords, and the paucity of the common law remedies available by which to respond to such a clear injustice as J had suffered is underscored by that rejection. However, although of little consolation to J, the case also demonstrates the difference that the domestication of human rights may have made to those in J's position. As the events in question had taken place in 1998, the *Human Rights Act 1998* was not available to J, but Lord Scott did, albeit 'with some trepidation' consider at some length what the position would have been had the 1998 Act been in force. His Lordship, considering that a nursing home was within the concept of 'possessions' for the purposes of Article 1 of

42 S. 23 of the 1984 Act made it an offence to run a care home without a licence. See now s. 11 CSA.

43 The test, in s.20(1)(b) CSA, is very similar to, but broader than, that in s.30 of the 1984 Act. The only difference is that the CSA applies to 'persons' rather than merely to 'patients in the home'.

44 Section 21 CSA now provides for an appeal to the First-

Tier Tribunal in the unified Tribunal system introduced by the *Tribunals, Courts and Enforcement Act 2007*.

45 Lord Scott at para. 7.

46 At para. 8.

47 Para. 28.

48 At para. 35.

the First Protocol to the Convention, was clear too that, when the deprivation of a citizen's possessions is done pursuant to a court order made on an *ex parte* basis, Article 6 is also brought into play. He noted that, although an infringement of Article 1 of the First Protocol is permissible in the general interest, nonetheless

*'...an application to a court or a tribunal without prior notice to a respondent whose economic interests will be prejudiced, perhaps severely, by the order that is sought has an inherent potential for injustice and can be acceptable, and compatible with the Convention rights guaranteed under Article 6 and Article 1 of the First Protocol, only if hedged around with precautions and procedures designed to limit the injustice so far as practicable.'*⁴⁹

He then compared the lack of procedural safeguards accompanying the making and hearing of an application for an order from a magistrate under s.30 of the 1984 Act with those which ordinarily apply to an *ex parte* application before the High Court. He noted that the s. 30 route lacked (i) the ability for the judge to seek cross-undertakings in damages from the applicant for the order; (ii) the possibility for an order to be stayed or set aside on the immediate application of the respondent pending an inter parties hearing; (iii) any obligation on the applicant to make a full and frank disclosure of all facts known (or at least, the ability of the magistrate to impose and enforce any sanction for failure so to do).⁵⁰ In his view, it was 'very difficult' to see how the 1984 Act procedures could be said to be compatible with either Article 6 or Article 1 of the First Protocol.⁵¹

Baroness Hale was more guarded than Lord Scott. She declined to express any conclusion on the human rights questions as they were not before the House, and thus there was no call, in particular, for consideration of the impact of the duty imposed by s.3 of the *Human Rights Act 1998*, to interpret UK law compatibly with the Convention where possible.⁵² However, elsewhere in her judgment, her ladyship did seem to suggest that she had a good deal of sympathy with the approach taken by Lord Scott, and also hinted that the human rights of the residents of J's nursing home might also be the basis of a claim against the health authority. She said that

*'Controlling the use of premises as a home for vulnerable adults is fairly obviously in the general interest. But that does not mean that it is in the general interest to close down a home and ruin someone's business when, as the tribunal found, there was no good reason to do so; still less does it mean that it is in the general interest to descend upon a home with a number of ambulances and nurses, and remove 33 elderly mentally infirm residents to other hospitals and nursing homes without any notice or opportunity to prepare for such a distressing and potentially damaging disruption to their lives.'*⁵³

This comment seems to ground her ladyship's concern on the actions of the health authority rather than the substantive law, and her proposed solution pointed in the same direction. In her view, 'Authorities can and should refrain from making section 30 applications in cases which do not warrant them. Magistrates can and should refrain from making an *ex parte* order unless there is no alternative'.⁵⁴ Lord Carswell in similar vein advised magistrates faced with an application for an order under s. 30 'to devote care to probing the case made by health authorities', emphasising that: 'It is likely to be a very rare case where an order has to be made without giving the owners an opportunity to state their case'.⁵⁵ Lord Neuberger suggested that even if it may not be possible to comply with the formal requirements for providing notice,

49 Para. 14.

50 Para 16.

51 Para. 17.

52 Paras. 45, 46.

53 Para. 44.

54 Para. 47.

55 Para. 51.

it may still be possible to give informal notice, and consideration should even be given to doing so by telephone or email.⁵⁶ Whether such a course of action would satisfy the requirements of Article 6 remains to be seen: certainly, for Lord Scott, 'If procedural improvements on [the lines suggested by him] are not introduced, the 2000 Act section 20 procedure will continue to appear, as the 1984 section procedure appears to me now, to be incompatible with the Convention rights of those against whom these *ex parte* applications are made'.⁵⁷

To date, s. 20 of the 2000 Act⁵⁸ continues in force, although this decision clearly puts its future in doubt. It would seem clear (but bearing in mind that this issue was not argued before the House and that all comments in this case were hedged with caution) that a law unmodified in the ways he suggested would lead Lord Scott to issue a declaration of incompatibility under s. 4 of the *Human Rights Act 1998*, if and when a similar case came before him. Lord Neuberger expressed a similar view, albeit more briefly.⁵⁹ Baroness Hale, as seen above, was more cautious, and perhaps with good reason.⁶⁰ In her view, 'it may be possible to operate section 30 in a compatible way'.⁶¹ That is, if – as Baroness Hale suggests – it is possible for health authorities to only use the s. 20 procedure in cases where its use is warranted – in Convention language, its use is proportionate – and if it is possible for magistrates only to make an order *ex parte* when warranted/proportionate, there would be no infringement of Article 6 notwithstanding the lack of procedural safeguards, and no infringement of Article 1 of the First Protocol notwithstanding the arbitrary deprivation of the possessions of a care home proprietor in the circumstances which accompany an *ex parte* application.

But those are big 'if's. Some might feel that her ladyship's faith in the competency of health authorities to determine, accurately and routinely, the seriousness of the risk in a given case is overly optimistic. Moreover, the point that the s. 20 system might survive scrutiny in the context of a case where there is a clear justification for urgent action – where there is unambiguous evidence of significant ongoing abuse of residents by staff for example – does not provide sufficient justification for its continued use in the generality of cases. The basic and fundamental point is that the s. 20 system, operating absent the safeguards described by Lord Scott, does not look like the sort of system that Article 6 of the Convention is designed to ensure. Simply, it is not a 'fair' system, in the sense usually associated with that Article (nor, incidentally, in the sense usually associated with the rules of natural justice that have long applied in the U.K.).

On the other hand, if we accept Baroness Hale's claim that health authorities can correctly identify when the use of s. 20 is appropriate, and given the draconian nature of the powers in s. 20 and the purpose for that section, it follows that all s. 20 cases should by definition be 'extreme'. Perhaps then, thinking pragmatically, the lack of the safeguards discussed by Lord Scott is not such a problem. Indeed, the presence of such safeguards might well hinder the effective operation of the s. 20 procedure, as may any other limits placed on the availability of an *ex parte* order, resulting in care recipients being subjected to harm or the serious risk of harm for longer than would otherwise have been the case. As seen above, the current Government is sufficiently confident that a system which denies any right of appeal or challenge against a decision to list a carer is human rights-compliant that it legislated for its introduction in the

56 Para. 56.

57 Para. 39 He suggested that the powers necessary for the making of such procedural rules can be found in ss. 144 and 145 Magistrates' Courts Act 1980.

58 See footnote 41.

59 Para. 54.

60 Lord Rodger gave a short speech, and only in order to state that he preferred not to speculate on what the position would have been had the Human Rights Act been in force at the relevant time (para. 41). Lord Carswell did not discuss the human rights questions but did express agreement with Lord Scott (para. 49).

61 Para. 47.

SVGA. And as Baroness Hale reminds us, it is not only the human rights of care home proprietors that are at stake here.

The arguments, then, are perhaps more finally balanced than would at first glance appear. Ultimately, the position one adopts on such questions involve matters of intuition, faith or one's particular sense of justice, more than of law. My own view is that the risks of bringing the usual safeguards against inappropriate use of the *ex parte* procedure into the s. 20 system do not outweigh the injustice that their absence causes. It is worth noting that all members of the House of Lords in *Jain* who gave opinions expressed sympathy for J and regretted that the law of negligence could not be used to provide a remedy for J.⁶² Are we to accept that the *Human Rights Act 1998* has not changed anything? Baroness Hale said in *Wright*, in finding breaches of Articles 6 and 8, that

*'The care worker suffers possibly irreparable damage without being heard whatever the nature of the allegations against her. The care worker may have a good answer to the allegations no matter how serious they are. There may well be cases where the need to protect the vulnerable is so urgent that an "ex parte" procedure can be justified. But one would then expect there to be a swift method of hearing both sides of the story and doing so before irreparable damage was done'*⁶³

It is not clear to me why exactly the same considerations should not apply to the revocation of a licence without notice, which is no less draconian in its effects than provisional listing under the 2000 Act. It is to be hoped that if and when a post-*Human Rights Act 1998* fact situation comes before the courts this is the approach that will be taken. It would be better still if the Government would act to ensure that adequate safeguards against injustice are in place.

Concluding Comments

We live in times of heightened awareness that there are care homes in this country, and home care services, that are substandard and on occasion, perhaps often, outrageously so.⁶⁴ The need for adequate protection for such vulnerable members of society is obvious and pressing. The pressures on politicians to respond effectively to these very legitimate concerns must be very great, particularly when coupled with concerns about the safety of children raised by cases such as that involving Ian Huntley and the general clamour of intolerance towards paedophiles. The result is legislation which forcefully prioritises the protection of care recipients. In such times, the role of the courts, in protecting the human rights of those caught in the crossfire, attains a heightened importance. In *Wright*, the less politically tricky of the two cases under discussion here, the House of Lords proved equal to the task, although the lasting impact of *Wright* on the new regime introduced by the SVGA remains to be seen. The performance of the House in *Jain* was more ambiguous and, as of yet, the s.20 procedure, despite its fundamental unfairness and the slight yet vital changes that are required to bring it into human rights compatibility, remain unmodified. Those who look to the House of Lords to take a lead in developing human rights law in difficult contexts might justifiably feel that there remains room for further improvement in that regard.

62 See Lord Scott at para. 40, Baroness Hale at para. 48, Lord Carswell at para. 52 and Lord Neuberger at para. 57.

63 Para. 29.

64 The BBC programme *Panorama*, which aired an expose of care home standards in 'Please Look After Mum' on 12 February 2007, and of home care service providers in 'Britain's Home Care Scandal', aired on 9 April 2009, can take much of the credit for making the general public aware of this issue.

First Do No Harm. Second Save Life?

Neil Allen¹

Some 50,352 people killed themselves in England and Wales between 1997 and 2006.² Reducing this human toll of inner turmoil has long been a key national priority for health services.³ But protecting us from ourselves is no easy task when the apparent benefits of escaping life outweigh the agony of having to endure it. Often it is too late for someone's suicidal ideation to come to the attention of the authorities. Sometimes, however, the risk to life is more readily apparent: on average, 1300 patients already known to mental health services commit suicide every year.⁴

Our moral and legal obligations surrounding suicide arguably stand poles apart. English law does not encourage good Samaritanism. Just as the priest and Levite walked past the wounded man on their way from Jerusalem to Jericho,⁵ so too are we permitted to walk past the suicidal man from Jevington to Jarrow. To idly watch a rescuable suicidist leap from a cliff top might raise a moral eyebrow. But such omissions are perfectly lawful at common law⁶ because foreseeing death does not trigger any duty of care to prevent it.⁷ Yet such obligational divergence does not deter volunteers from preventively patrolling the infamous suicide spot of Beachy Head.⁸

The European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 is slowly realigning the moral and legal obligations of public bodies to protect life, with Article 2 imposing three duties upon the state. Firstly, a negative duty to refrain from taking life, save in prescribed exceptional circumstances. Secondly, a procedural obligation to investigate deaths for which it might bear some responsibility.⁹ Finally, there is a positive obligation to take steps to protect our lives which is the exclusive focus of this paper.

1 Barrister, University of Manchester and Young Street Chambers. The author would like to thank an anonymous referee and Dr John Coggon for their comments on an earlier draft.

2 Annual Report, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, University of Manchester (July 2009).

3 The Department of Health aimed to reduce the suicide rate by at least 20% by 2010 (National Suicide Prevention Strategy for England, Department of Health, 2002).

4 Avoidable Deaths: Five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, University of Manchester (December 2006) at pp14 and 32.

5 Luke 10: 30–32, Revised Standard Version of the Bible.

6 *Smith v. Littlewoods Organisation Ltd* [1987] AC 241, 271; *Yuen Kun Yeu v. Attorney General of Hong Kong* [1988] AC 175, 192.

7 *Dorset Yacht Co. Ltd v. Home Office* [1970] AC 1004, 1037–1038; *Hill v. Chief Constable of West Yorkshire* [1989] AC 53, 60; *Mitchell v. Glasgow City Council* [2009] 1 AC 874, 890.

8 See www.bhct.org.uk: June 2009 was their busiest month since 2004.

9 See *R (on the application of JL) v. Secretary of State for Justice* [2009] 1 AC 588; *R (on the application of Allen) v. HM Coroner for Inner North London* [2009] EWCA Civ 623; *R (on the application of P) v. Secretary of State for Justice* [2009] EWCA Civ 701.

Savage¹⁰ Circumstances

Carol Savage was one of 166 psychiatric in-patients who took their own lives in 2004.¹¹ The day after voluntarily attending Runwell hospital, she was detained for treatment under section 3 of the *Mental Health Act 1983* ('the 1983 Act') with a diagnosis of paranoid schizophrenia. Having made a number of attempts to leave the open acute psychiatric ward, checks on her whereabouts were prescribed for every 30 minutes. Believed to be at low risk of suicide, Mrs Savage was allegedly left unsupervised on hospital grounds, from which she was able to abscond, walking two miles to Wickford railway station before fatally jumping in front of a train.

With the coroner's jury having concluded that the hospital's preventive precautions were "inadequate", her daughter claimed that the trust had breached her mother's right to life by allowing her to escape. The House of Lords¹² therefore had to determine the test for establishing the circumstances in which a detained patient's suicide would violate Article 2. Substantive opinions were delivered by Lord Rodger and Baroness Hale, with whom Lords Walker, Neuberger and Scott concurred, the last handing down a short judgment.

Lord Rodger noted¹³ that Article 2's positive obligation to protect life comprised three duties. The primary duty required the state to establish an effective system of criminal law to deter those who threatened life, backed up by law enforcement machinery to prevent, suppress and punish its breaches. Secondly, general protective measures may be required to secure the health and well-being of, for example, prisoners and patients ('the *Powell* duty'¹⁴). These complemented the primary duty and typically obliged the relevant authorities to recruit competent staff, maintain high professional standards, and put in place suitable systems of work so as to protect life. Thirdly, in appropriate circumstances, an operational duty to protect the life of a specific individual may be imposed which was "distinct from, and additional to"¹⁵ that general duty ('the *Osman* duty'¹⁶).

Runwell hospital clearly owed the *Powell* duty to take general precautions which mirrored the position at common law. Failure to do so could amount to both negligence and a breach of Article 2. If these general steps were taken but some medical error nevertheless resulted in death, there may be liability in negligence but not under Article 2. With hospital authorities and their staff already subject to this general obligation, Lord Rodger could not see why they should not also be under the "usual complementary operational obligation"¹⁷ to try to prevent a particular suicide. In fact, there was no valid reason for them not to. Priority had to be given to saving life in such critical circumstances; otherwise negligence and a violation of Article 2 could result.

Baroness Hale reached the same conclusion but covered "somewhat different ground along the way". The positive obligations generally required proper systems to be put in place. But in some circumstances a protective duty towards a particular individual was triggered, although not by ordinary medical negligence alone. There was "little doubt that it [was] right in principle" to apply the *Osman* test to

10 *The Court of Appeal consideration of the circumstances surrounding the death of Carol Savage* ([2007] EWCA Civ 1375) was reviewed by the author in the *Journal of Mental Health Law*, May 2008 pp 93–100.

11 *Ibid.* n2 at p25.

12 *Savage v. South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681. For commentary, see N. Allen, 'Saving Life and Respecting Death: A Savage Dilemma' (2009) 17(2) *Medical Law Review* 262 and N. Allen, 'Protecting

the Suicidal Patient' (2008) *Journal of Mental Health Law* 93.

13 At [30] and [69].

14 *Powell v. United Kingdom* (2000) 30 EHRR CD362.

15 At [72].

16 *Osman v. United Kingdom* (1998) 29 EHRR 245.

17 At [65]-[66].

patients detained under the 1983 Act. After all, the ECtHR had recognised the authorities' obligation to provide necessary healthcare to those detained and it was "difficult to distinguish between different classes of people deprived of their liberty by the state."¹⁸ Indeed, more of their ordinary civil rights were deprived as compared with other forms of detainee. Thus, if the hospital authority knew, or ought to have known, of a real and immediate risk that Mrs Savage would commit suicide, Article 2 imposed an operational obligation on them to do all that could reasonably be expected to prevent it.

When to Save A Life

Article 2's positive limb is broad-shouldered. It applies to "any activity, whether public or not, in which the right to life may be at stake."¹⁹ But, in principle, it falls within the state's margin of appreciation to choose the means for fulfilling its tripartite set of obligations.²⁰ English criminal law is expected to satisfy the demands of the primary duty, although not all threats to life are deterred; suicide being the obvious example.²¹ In fact, criminalising all actions and omissions that put life at risk would no doubt violate other Convention rights.

The general duty is more practical than the primary duty and requires the state to make regulations compelling public authorities to adopt appropriate measures for securing high professional standards and the protection of life. It is undoubtedly owed in the sphere of public and private healthcare as regards the acts and omissions of health professionals.²² That is to say, *all* hospital patients – detained or otherwise – are its beneficiaries. In the community, emergency services, including mountain and sea rescue facilities, similarly owe this duty to those whose lives are knowingly in danger. But it does not obligate any specific result. It may, for example, require a regulatory framework to be put in place for rescuing mountain climbers in distress; but it does not demand a deadline within which aerial ambulances must reach them.²³

The operational duty can be far more onerous. Where others threaten the right to life, the ECtHR has recognised this obligation in a diverse range of circumstances: from policing,²⁴ detention release,²⁵ and domestic violence,²⁶ through to the management of dangerous activities²⁷ and even political journalism.²⁸ Where someone threatens their own right to life, Strasbourg has so far only had the opportunity to recognise the obligation being owed to prisoners²⁹ and army conscripts.³⁰

But how far down the path of suicide prevention might the positivity of Article 2 be prepared to go? *Savage* acknowledged the duty being owed to psychiatric patients detained for treatment. Logic would

18 At [101].

19 *Furdík v. Slovakia* (2009) 48 EHRR SE9 146, 157; *Öneryıldız v. Turkey* (2005) 41 EHRR 20 at [71].

20 *Furdík* *ibid.* at 157.

21 *Suicide Act 1961 s1. Assisting suicide may also not be prosecuted on public policy grounds: R (on the application of Purdy) v. Director of Public Prosecutions* [2009] 3 WLR 403 led the DPP to revise his policy.

22 See *Dodov v. Bulgaria* (2008) 47 EHRR 41 at [70], [79]-[83] and [87]; *Byrzykowski v. Poland* (2008) 46 EHRR 32 at [104] and [106]; *Vo v. France* (2005) 40 EHRR 12 at [89]-[90]; *Tarariyeva v. Russia* (2009) 48 EHRR 26 at [74]; *Powell v. United Kingdom* (2000) 30 EHRR CD 362, 364.

23 *Furdík* *ibid.* n19.

24 *Ibid.* n16.

25 *Tomaši v. Croatia* (Application no. 46598/06, 15 January 2009); *Mastromatteo v. Italy* (Application no. 37703/97, 24 October 2002); *Bromiley v. United Kingdom* (Application no. 33747/96, 23 November 1999).

26 *Opuz v. Turkey* (Application no. 33401/02, 9 June 2009).

27 *Öneryıldız v. Turkey* (2004) 41 EHRR 325; *LCB v. United Kingdom* (1998) 27 EHRR 212.

28 *Gongadze v. Ukraine* (2006) 43 EHRR 44.

29 *Keenan v. United Kingdom* (2001) 33 EHRR 913.

30 *Kilnic v. Turkey* (Application no. 40145/98, 7 June 2005); *Ataman v. Turkey* (Application no. 46252/99, 27 April 2006).

extend it to those detained for assessment,³¹ in emergency circumstances,³² on a temporary holding basis,³³ and under the criminal provisions in Part 3 of the 1983 Act. Might it even extend beyond detention? That was the key issue in *Rabone v. Pennine Care NHS Trust*³⁴ which was the first reported mental health case to test the boundaries of the *Savage* decision.

Informal Patients

Melanie Rabone was informally admitted to a locked ward at Stepping Hill hospital suffering from depression. She was subject to 15 minute observations having attempted suicide three times in the previous seven weeks. With her mood appearing to lift, the psychiatrist granted her request for home leave. The following day she hanged herself from a tree in Lyme Park. The trust accepted negligence but denied any breach of her right to life.

Clearly the general obligation was owed by the trust: institutional precautions therefore had to be taken to protect patients from committing suicide. For example, competent staff had to be recruited, high professional standards maintained, and suitable systems of work put in place. Ms Rabone's psychiatrist was negligent. The medical treatment she received was fragmented and discontinuous. Staff had not been trained in the use of the trust's new care programme approach policy. Old forms were still being used. And no documented risk reassessment was undertaken before leave was granted, with no support plan having been put in place. Yet, according to Simon J., the general duty conferred by Article 2 had not been breached: the circumstances "fell far short of a failure to have a system for the assessment of risk of suicide in mental patients".³⁵ Clinical misjudgement and implementation of the system could be faulted; but not the system itself.

Could the operational duty have been owed to Ms Rabone who, it was held, was not deprived of her liberty? In *Savage*, Baroness Hale had deliberately left this question open.³⁶ Arguably Lord Rodger had not for "[a]ny auction in the comparative vulnerability of prisoners, voluntary patients, and detained patients would be as unedifying as it is unnecessary."³⁷ But Simon J. considered *Savage* to have drawn a distinction "between those who are detained and lack capacity, and those who are not detained and have capacity to consent or object to treatment". The House of Lords had "implicitly confined" the duty to compulsorily detained patients.

A growing body of empirical research suggests that some patients detained under the 1983 Act in fact retain capacity to consent to admission and treatment.³⁸ Conversely, many informal patients lack such capacity.³⁹ So to rely upon incapacity to justify the operational duty does not provide the answer to the *Osman* question. Nor, it is respectfully submitted, does the fact of being detained; otherwise the ECtHR

31 Pursuant to s 2 of the 1983 Act.

32 *Ibid.* ss 4, 135 or 136.

33 *Ibid.* s 5.

34 [2009] EWHC 1827.

35 *Ibid.* at [81].

36 *Ibid.* n12 at [102].

37 *Ibid.* at [49]. His Lordship noted that in *Powell*, where the patient was not detained, the ECtHR might have recognised the operational duty, in well defined circumstances, to

prevent a patient from committing suicide.

38 J. Bellhouse et al, 'Capacity-based mental health legislation and its impact on clinical practice: 1) Admission to Hospital' (2003) *Journal of Mental Health Law* 9; J. Bellhouse et al, 'Capacity-based mental health legislation and its impact on clinical practice: 2) Treatment in Hospital' (2003) *Journal of Mental Health Law* 24. See also, D. Okai et al, 'Mental capacity in psychiatric patients' (2007) 191 *British Journal of Psychiatry* 291.

39 D. Okai *ibid.*

would not have recognised the duty being owed to suicidal army conscripts.⁴⁰ Thus, its scope cannot be limited *solely* to those deprived of their liberty by the state.⁴¹

Simon J. also rejected the assumption of responsibility approach: “All hospitals assume responsibility for the safety and treatment of patients; but that does not mean that the operational duty under Article 2.1 arises in relation to all patients. On the contrary, it is clear that it does not.” Instead, the “important factor” was “the exercise of coercive powers over an individual who (by reason) [sic] of the exercise of such powers is particularly vulnerable”. This was missing and so the duty could not be owed.

The ‘coerced vulnerability’ justification for recognising the operational duty is novel and reflects the growing realisation that “[i]n many respects human rights law is all about the protection of the individual from undue coercion”.⁴² Unfortunately, however, Simon J. does not expand upon it, save to say that “voluntary mental health patients can leave when they want, are not deprived of any Convention rights and have input in their own medical treatment”. Szmukler and Appelbaum⁴³ have sought to particularise the concept of coercion by describing a “spectrum of pressures” ranging from persuasion, interpersonal leverage, and inducements or offers, through to threats and the use of compulsion. Why was Ms Rabone not subject to the necessary degree of coercion, bearing in mind that she would have been detained under the 1983 Act had she attempted to leave the ward? Would her comparative vulnerability with compulsorily detained patients not be as unedifying as it is unnecessary?⁴⁴

Where life is threatened by others, the operational duty is capable of being owed in circumstances where the state is not exercising coercive powers. In *Mitchell v. Glasgow City Council*,⁴⁵ for example, a man repeatedly threatened to kill his next-door neighbour. Both were council tenants. The local authority convened a meeting with the aggressor, at which he lost his temper and became abusive. An hour later he killed the neighbour. The majority of the House of Lords asked the *Osman* question but decided that the duty had not been triggered because the local authority could not have known of any real and immediate risk to his life. Nothing was said or done on the day to alert them of any attack, let alone a risk of death.

Should the right to life be protected differently when life is threatened by one’s own actions? Ms Kerrie Wooltorton suffered from personality disorder.⁴⁶ She had ingested antifreeze before accepting lifesaving dialysis on up to nine previous occasions. She swallowed it a final time, called the ambulance services and, it is reported, capaciously refused treatment, knowing that she would die. Did the consultant renal physician violate Article 2 by failing to take reasonable steps to avert the real and immediate risk to life? Would it make a difference if someone else had administered the poisonous substance if she was still refusing treatment?

40 *Ibid.* n30.

41 See also *Bulut v. Turkey* (Application no. 51480/99, 3 July 2006) at [32].

42 G. Richardson, ‘Coercion and human rights: A European perspective’ (2008) 17(3) *Journal of Mental Health* 245. For the relevance of coercion to Article 5 see N. Allen, ‘Restricting movement or depriving liberty?’ (2009) *Journal of Mental Health Law* 19.

43 G. Szmukler and P.S. Appelbaum, ‘Treatment pressures, leverage, coercion and compulsion in mental health care’ (2008) 17(3) *Journal of Mental Health* 233. See also R. Wynn, ‘Coercion in psychiatric care: clinical, legal, and ethical controversies’ (2006) 10(4) *International Journal of Psychiatry in Clinical Practice* 247.

44 In relation to the inherent jurisdiction, vulnerability has been held to extend to those who are incapacitated “by reason of such things as constraint, coercion, undue influence or other vitiating factors” (Re SA (vulnerable adult with capacity: marriage) [2006] 1 FLR 867 at [79]). See M.C. Dunn et al, ‘To Empower or to Protect? Constructing the ‘Vulnerable Adult’ in English Law and Public Policy’ (2008) 28 *Legal Studies* 234.

45 [2009] UKHL 11.

46 C. Dyer, ‘Coroner rules that treating 26 year old woman who wanted to die would have been unlawful’ (2009) 339 *British Medical Journal* 4070; S.A.M. McLean, ‘Live and let die’ (2009) 339 *British Medical Journal* 4112.

Conclusions

English law still has a long way to go in clarifying the circumstances in which public authorities will violate the right to life by failing to avert death. Rather than relying upon frail distinctions like detention and capacity, perhaps more thought should be given to the relationship between the general and operational duties of Article 2. Are they “distinct from” or “additional to” each other? Whether the source of the risk to life should affect the relevance of the operational duty must then be considered. Must the state do more to prevent threats from others than it does to prevent threats from oneself?

Even if concepts like coerced vulnerability are employed to justify the extension of the *Osman* duty to those not in detention, they only relate to the applicability of the duty. *Savage* recognised that the threshold for triggering that duty is high⁴⁷ which is hardly surprising. Indeed, the ECtHR is wary of imposing disproportionate burdens on public authorities.⁴⁸ But once that threshold is reached, establishing a breach of the duty is harder than establishing negligence.⁴⁹ Health authorities will therefore find that it is “not particularly stringent”⁵⁰ to establish a defence because other Convention rights must be taken into account in determining which steps it was reasonable to expect them to take.

It follows that the operational duty “should not persuade the professionals to behave any more cautiously or defensively than they are already persuaded to do by the ordinary law of negligence”.⁵¹ Therapeutic risks must be taken despite risks to life. Runwell hospital was thus “entitled, and perhaps bound, to allow Mrs Savage a degree of unsupervised freedom that did carry with it some risk that she might succeed in absconding.”⁵² Doctors must first do no harm. But saving life at all costs does not seem to come second.

47 *Savage* *ibid.* n12 at [78] per Baroness Hale. See also *Van Colle v. Chief Constable of the Hertfordshire Police* (Secretary of State for the Home Department intervening) [2008] 3 WLR 593 at [66] per Lord Hope.

48 *Osman* *ibid.* n16 at [116]; *Keenan* *ibid.* n27 at [90]; *Akdo du v. Turkey* (Application No. 46747/99, 18 October 2005) at [45]; *Uçar v. Turkey* (Application No. 52392/99, 11 April 2006) at [84]; *Renolde v. France* (Application No. 5608/05, 16 January 2009) at [82].

49 *Ibid.* n12 at [99]. The House of Lords has yet to consider the appropriate standard of proof in this regard.

50 *Ibid.* at [41] per Lord Rodger.

51 *Ibid.* at [100] per Baroness Hale.

52 *Ibid.* at [13] per Lord Scott.

Casenotes

Hospital Orders: Detention in a Place of Safety Pending Transfer

David Hewitt¹

R (DB) v Nottinghamshire Healthcare NHS Trust

[2008] EWCA Civ 1354

Laws, Longmore and Stanley Burnton LJJ

A hospital order will cease to have effect if its subject is not admitted to hospital within 28 days

Introduction

Where, in the course of criminal proceedings, a person is made subject to a hospital order, the court may direct that he or she be taken to a place of safety and detained there for up to 28 days, pending his transfer to hospital. Occasionally, a transfer cannot take place in time, in which case two questions become relevant: must the person be released from the place of safety and may he still be detained in hospital subsequently? The decision in this case provides a clear answer to each question. That clarity is welcome, because at first instance, the High Court had held that in such circumstances, the person's continued detention would be unlawful, but only until he was finally admitted to hospital.

The facts

In September 2003, the appellant, DB, was convicted of affray and sentenced to a community rehabilitation order. When he breached that order, he was taken into custody, pending a return to court. While there, his behaviour gave cause for concern and he was seen by two forensic psychiatrists, each of whom recommended that he be placed under a hospital order and admitted to a medium secure unit, namely Arnold Lodge in Leicester (of which the respondent NHS trust is 'the managers' for the purposes of the *Mental Health Act 1983*).²

The matter came before the Crown Court at Nottingham on 17 December 2004, when His Honour Judge Teare made a hospital order under section 37 of the *Mental Health Act 1983* (MHA 1983), providing for DB's admission to hospital within 28 days – in other words, by 14 January 2005. For reasons that are unclear, however, the order named not Arnold Lodge, but a hospital in Nottingham that was not a medium secure unit.³

¹ Solicitor, and partner in Weightmans LLP Visiting Fellow of the Law School, University of Northumbria.

² Stanley Burnton LJ at [3].

³ *Ibid* at [4].

The mistake was noticed before DB was transferred from prison, and on 21 December 2004, Judge Teare amended the order, so as to name Arnold Lodge as the hospital to which he would be admitted and in which he would be detained.⁴ (In fact, the amended order was again completed incorrectly, so that there would not have been a power either to convey DB to or to detain him in a place of safety pending his transfer to Arnold Lodge. No issue was, however, taken on this point.⁵)

Teare J made it clear that although the order had subsequently been amended, it was to be regarded as having been made on 17 December, and that DB might therefore expect to be admitted to hospital within 28 days – in other words, by 14 January 2005.⁶ It seems, however, that those responsible for implementing the order took the view that it was operative only from the date it was amended, and, accordingly, that DB need not be admitted to hospital until 17 January. That more modest goal was achieved, DB being transferred to Arnold Lodge on 17 January 2005.⁷ Subsequently, DB's liability to detention was renewed under section 20(3) of MHA 1983 and his case considered twice by a Mental Health Review Tribunal, which on each occasion decided he should not be discharged.

DB sought judicial review of the decision of the respondent to detain him pursuant to the hospital order. On 7 May 2008, Mr Justice Foskett held that the hospital order ran from 17 December 2004 and therefore required DB to be admitted to Arnold Lodge by 14 January 2005; that because DB had not in fact been transferred for a further three days, his admission and subsequent detention had been unlawful; but that because the order had neither been set aside nor varied, it remained valid, had to be complied with and would permit DB's continued detention in hospital.⁸ The present case was DB's appeal against that decision.

The issue

There was but a single issue in this case: does a hospital order cease to have effect if the offender who is its subject is not admitted to the hospital named in the order within 28 days from the day it is made? Although DB was the subject of a simple hospital order, Lord Justice Stanley Burnton made plain the wider significance of that issue. He said:

“The importance of the point is all the greater if the offender is sufficiently dangerous for a restriction order to have been made under section 41, since a restriction order has no effect if there is not an effective hospital order.”⁹

It seems that the Ministry of Justice was notified of DB's challenge, but that it chose neither to intervene in the appeal nor make representations about it.¹⁰

The legislation

Where a person has been convicted of an offence punishable with imprisonment, section 37 of MHA 1983 permits a court to make a hospital order in respect of him. That order will authorise the person's admission to and detention in the hospital named in the order.¹¹ This power is, of course, subject to a number of conditions, not least that the making of the order be supported by two medical

4 *Ibid* at [6].

5 *Ibid* at [6] & [26].

6 *Ibid* at [5].

7 *Ibid* at [7].

8 *Ibid* at [1] & [8]. See: *X v An NHS Trust* [2008] EWHC 986 (Admin).

9 At [1].

10 *Stanley Burnton LJ* at [2].

11 MHA 1983, section 37(1).

recommendations.¹² Crucially, section 37(4) of the Act states that a hospital order shall not be made unless the court is satisfied,

*“that arrangements have been made for [the person’s] admission to [the named] hospital in the event of such an order being made by the court, and for his admission to it within the period of 28 days beginning with the date of the making of such an order”.*¹³

Once a hospital order has been made, section 40 of MHA 1983 states that it shall be sufficient authority:

- (a) for the person to be conveyed to the named hospital “within a period of 28 days”;¹⁴ and
- (b) for him to be admitted to that hospital and detained there in accordance with the provisions of the order.¹⁵

Pending a person’s admission to hospital within the specified 28-days, the court may, under section 37(4) of MHA 1983, “give such directions as it thinks fit for his conveyance to and detention in a place of safety.”¹⁶ Furthermore, section 37(5) says that if, within the relevant period, it appears to him that “it is not practicable for the patient to be received into the hospital specified in the order”, the Secretary of State may direct that the person be admitted to another hospital.¹⁷ Finally, and by virtue of section 54A of MHA 1983, the Secretary of State may reduce the 28 day period.

The judgment

Stanley Burnton and Longmore LJ each gave judgments of their own, while Lord Justice Laws agreed with both of them.¹⁸

Lord Justice Stanley Burnton’s was the lead judgment. He noted sections 37(4) and 40(1) of MHA 1983:

*“The effect of a hospital order is set out in section 40, which expressly limits the authority conferred by an order made under section 37 to the period of 28 days from the date of the making of the order.”*¹⁹

Applying that analysis to the facts of this case, he concluded:

*“It follows that, once the period of 28 days from 17 December 2004 had expired, the hospital order relating to [DB] ceased to have effect and ceased to provide authority for his conveyance to Arnold Lodge ... or for his detention in that hospital thereafter.”*²⁰

Thus did His Lordship resolve the issue in this case.

For the respondent, it had been noted that section 37(1) of MHA 1983 imposes no time limit, and suggested that as a result, a hospital order need not be complied with within 28 days. Stanley Burnton LJ disagreed. He said:

*“It is immaterial that the period of 28 days is not mentioned in section 37(1), which deals with the making of the order, not its effect. There is nothing in section 40 to limit its purpose in the manner contended for by [the respondent], and no good reason for the reference to the 28-day period to have been included if [the respondent’s] submission as to its purpose were, contrary to my view, correct.”*²¹

12 MHA 1983, section 37(2)-(4).

13 MHA 1983, section 37(4).

14 MHA 1983, section 40(1)(a).

15 MHA 1983, section 40(1)(b).

16 MHA 1983, section 37(4).

17 MHA 1983, section 37(5).

18 Laws LJ at [37].

19 At [16].

20 *Ibid.*

21 *Ibid.*

Lord Justice Longmore suggested that, had section 37 stood alone, a different result might have been achieved, for that section “provides for only two conditions to be met and the 28-day period is not one of them.”²² However, he continued:

*“[E]ven in that situation it would still be the case that the authority to detain a defendant in a place of safety (normally in prison) pursuant to section 37(4) only lasts ‘pending his admission within that period’. Once that period lapses, his detention in a place of safety pending admission to a hospital is unauthorised. In other words, he has to be released, although no doubt consideration can rapidly be given to the question whether the defendant can be compulsorily admitted to a hospital pursuant to Part II of the Act rather than Part III.”*²³

Stanley Burnton LJ commented also upon the effect of section 37(4) and (5) of MHA 1983: it is because the authority for the application of a hospital order expires after 28 days that the first requires a court to be satisfied that there are arrangements for an offender’s admission to hospital within that period; and as for the second,

*“it is impossible to see why the power conferred on the Secretary of State by that subsection is restricted to the period of 28 days from the making of the order ... if a hospital order remains effective after the expiration of that period.”*²⁴

There were other reasons for doubting the respondent’s case. It would, for example,

*“be quite illogical for Parliament to have limited the authority to detain an offender in a place of safety to the 28-day period, so that the offender would then be entitled to walk free, but to have authorised his admission and detention in hospital thereafter.”*²⁵

Moreover,

*“the respondent’s case does not explain how an offender can lawfully be conveyed under compulsion from prison to the hospital after the 28 days have expired.”*²⁶

Finally, the amendment represented by section 54A of MHA 1983

*“indicates that [Parliament] appreciated the importance of compliance with the 28-day time limit. It is difficult to see why the power to shorten the period should have been conferred on the Secretary of State if Parliament’s understanding of the existing statutory provisions were ... that an offender could be lawfully admitted and detained after the expiration of the statutory time limit.”*²⁷

The appeal would be allowed and the decision at first instance overturned. Mr Justice Teare had asked the wrong question:

*“He asked, ‘Was the hospital order valid?’ ... However, the validity of the hospital order was not in issue. The judge should have asked, ‘What was the effect (and in particular what was the duration) of the order made on 17 December 2004 as amended on 21 December?’”*²⁸

Finally, Stanley Burnton J dealt with a number of ‘practical considerations’:

(a) He recommended that the standard form on which a hospital order is recorded be amended, so as to specify the date by which a patient must be admitted to hospital.²⁹

22 At [29].

23 At [30].

24 At [18].

25 Stanley Burnton at [19]. See also: Longmore LJ at [31].

26 Stanley Burnton at [19].

27 Ibid at [20].

28 Ibid at [23].

29 At [25]. See also: Longmore LJ at [36].

(b) He also suggested that it would be sensible for the form to contain a recommendation of the kind already contained in official guidance. A Home Office circular issued in 1980 recommends that if, in the case of a person upon whom a hospital order is imposed, it appears unlikely that he will be admitted to hospital within the 28 days permitted for the purpose, the matter should be reported to the court, so that alternative disposal options can be considered.³⁰

(c) In this regard, the judge noted that a sentencing court now has the power to vary, or even rescind, its order. He said that if one hospital order were rescinded, another might be made subsequently. (He did, however, suggest that this should be a last resort, “since the consequence will usually be to prolong a patient’s detention in prison.”)³¹

A declaration was made that DB’s admission to and subsequent detention in hospital on and after 17 January 2005 were not authorised by the hospital order made on 17 December 2004 and varied on 21 December 2004. However, Stanley Burnton LJ concluded:

*“Whether this will result in his detention under Part II of the Mental Health Act 1983 is, in the first place, a matter for the respondent.”*³²

Discussion

This was not a happy case: not for the patient or the hospital to which he was admitted; not for Foskett J, who, it seems, asked the wrong question; and not for the, doubtless hard-pressed, judicial and clerical staff of Nottingham Crown Court, who managed first to misstate the hospital to which the hospital order applied, and then to miscalculate the period during which DB might be held in a place of safety and to nullify the powers that might be brought to bear upon him there.

Neither is this the first time the intricacies of mental health law have left judges studying their own entrails, if not their navels. The question of whether the law means what it says, and if so, what the consequences will be if it is breached, have come before the senior courts before – most recently in July 2007, when the House of Lords considered the fate of MHA proceedings commenced without the leave section 139 seems to demand.³³ The hard-nosed yet, surely, logical decision in that case is mirrored in this.

30 At [25]. See: Home Office Circular 66/1980.

31 At [25]. See: Powers of Criminal Courts (Sentencing) Act 2000, section 155.

32 At [28].

33 *Seal v Chief Constable of South Wales Police* [2007] UKHL 31. See also: David Hewitt, *Protection from what? The nullifying effect of section 139*, *Journal of Mental Health Law*, November 2007, page 224.

Not Now So Unexacting? The Section 139 Threshold Re-Defined

David Hewitt¹

Johnston v The Chief Constable of Merseyside Police
[2009] EWHC 2969 (QB)

*When considering whether to grant leave under section 139(2) of the Mental Health Act 1983, a court must not only apply the test in *Winch v Jones*, it must also ask whether the proposed claim has a real prospect of success.*

Introduction

This case concerned a proposed claim for damages by a man who had been apprehended by the police, apparently under section 136 of the *Mental Health Act 1983*. With two exceptions, no claim for acts purportedly done or functions purportedly discharged under the Act may proceed without leave of the High Court.²

The facts

On 8 January 2006, Mr Johnson, who has a history of mental health problems going back more than a decade, was at a property in Bootle, Merseyside. As a result of his behaviour, one of the occupants of that property summoned an ambulance. In accordance with usual practice, however, the police attended as well. Mr Johnson acknowledged that he had needed medical help, but he said he had not wanted the police to be called.³

On the basis of the witness statements and expert evidence, there is clearly a profound conflict between the parties as to what happened next.⁴ It would seem to be common ground, however, that:

- (a) CS gas was sprayed at Mr Johnson, resulting in severe skin blistering and damage to the left side of his face, his left ear and his chest.
- (b) He was detained, put in handcuffs and taken to hospital. (The constable in question claimed to have been acting under section 136 of the *Mental Health Act 1983*, but Mr Johnson said no such information had been vouchsafed to him at the time.⁵)
- (c) Mr Johnson was not subsequently charged with any criminal offence.⁶

1 Solicitor, and partner in *Weightmans LLP*, which represents the defendant in this case; Visiting Fellow, School of Law, University of Northumbria.

2 *Mental Health Act 1983*, section 139(2). The exceptions, which are discussed below, are set out in sub-section (4). See the penultimate paragraph of this article and footnote 26.

3 See paragraph [2] of the judgement.

4 See [16]-[21].

5 See [26].

6 See [3].

The claim

Mr Johnson wishes to claim damages for false imprisonment and assault. He served a claim form and detailed particulars of claim on 21st October 2008, but failed also to seek leave under section 139(2) of the *Mental Health Act 1983*.⁷ That point was taken in a defence served on 12th December 2008, and on 23rd of that month, Mr Johnson issued an application for retrospective leave to proceed. That application was discontinued subsequently, because the decision in *Seal* meant it was bound to fail,⁸ and the present application for permission to proceed was made on 24th March 2009. This meant that Mr Johnson faced an additional problem.

The limitation period for a false imprisonment claim is six years,⁹ so it will not expire until January 2012. It is now accepted, however, that the limitation period for a claim of assault is a mere three years.¹⁰ The application for permission to proceed was therefore made two-and-a-half months out-of-time.

The issue

Mr Johnson asked the court to waive the limitation period in this case, and also to give leave so that his claim could proceed to trial. For present purposes, the chief question was as to the test the court should apply when considering an application for leave.

The existing test

The leading authority on section 139(2) remains *Winch v Jones*,¹¹ in which the Court of Appeal gave a claimant the leave she had been denied at first instance. The court said the judge had applied too stringent a test, and Sir John Donaldson, MR noted:

*“As I see it, the section is intended to strike a balance between the legitimate interests of the applicant to be allowed, at his own risk as to costs, to seek the adjudication of the courts upon any claim which is not frivolous, vexatious or an abuse of process, and the equally legitimate interest of the respondent to such an application not to be subjected to the undoubted exceptional risk of being harassed by baseless claims by those who have been treated under the Acts. In striking such a balance, the issue is not whether the applicant has established a prima facie case or even whether there is a serious issue to be tried, although that comes close to it. The issue is whether, on material evidence immediately available to the court, which, of course, can include material furnished by the proposed defendant, the applicant’s complaint appears to be such that it deserves the fuller investigation which will be possible if the intended applicant is allowed to proceed.”*¹²

A claimant should be given leave to proceed, therefore, if his claim deserves fuller investigation. In *Seal*, Lord Bingham said that by this test, “the threshold for obtaining leave under section 139(2) has been set at a very unexacting level [...] an applicant with an arguable case will be granted leave.”¹³ But should the court remain true to this test?

7 See [36] & [37].

8 *Seal v Chief Constable of South Wales Police* [2007] UKHL 31. See: David Hewitt, *Protection from what? The nullifying effect of section 139, Journal of Mental Health Law*, November 2007.

9 Limitation Act 1980, section 2.

10 Limitation Act 1980, section 11(4); *A v Hoare* [2008] 2 WLR 311.

11 *Winch v Jones* [1986] 1 QB 296 (Court of Appeal).

12 At page 305 (emphasis added).

13 *Seal v Chief Constable of South Wales Police*, *supra*, at [20]. In that case, the House of Lords decided, by a majority, that Mental Health Act proceedings commenced without permission were a nullity, and that leave could not, therefore, be granted retrospectively.

Submissions

For the defendant chief constable, it was argued that, 25 years on, the *Winch v Jones* test should be modified; that it should be tightened.¹⁴ This argument was based upon the Civil Procedure Rules (CPR), which, of course, came into effect subsequently. They say that summary judgment may be given where a claim (or, for that matter, a defence) has “no real prospect of success”.¹⁵ It was argued that this should also be the test in section 139(2) cases, and two authorities were put forward for this proposition:

- (a) In *Menagh v Chief Constable of Merseyside*, a claim for false imprisonment and malicious prosecution was struck out after close of proceedings, because there was no direct evidence to support it and “no cogent or positive evidence” to support the inferences that would therefore have to be drawn if the claim was to succeed.¹⁶
- (b) In *Khadine v The Commissioner of Police of the Metropolis*, there was no evidence to support a claim that was based simply on a series of challenges to what was said by police witnesses.¹⁷

Furthermore, the defendant argued that civil procedure had changed since the test was first approved. In those days, on interlocutory hearings, the court simply assumed the correctness of the facts set out in the particulars of claim. In *Winch v Jones*, for example, it was said to be “no part of the judge’s duty, on an application for leave, to conduct a trial on affidavits”.

*“The purpose is to see whether the evidence before him adds up to the answer: if this allegation were tried out, there is no realistic possibility that the case might succeed. It is not, in my judgment, permissible to go further.”*¹⁸

Now, however, the court must consider all the evidence available, to see whether the claim had a real prospect of success.

Decision

The judge, Coulson J, said that, notwithstanding the changes wrought by the CPR, “it would be wrong to modify in any significant way” the *Winch v Jones* test.¹⁹ It was, after all, approved, at least in passing, in *Seal*, and furthermore:

*“It seems to me that the balance to which Sir John Donaldson referred, and the necessity for the court to focus on whether the proposed claim being put forward was frivolous, vexatious or an abuse of process, remains the correct and fair approach to applications of this kind.”*²⁰

That said, the judge did concede that one ‘modification’ was appropriate. He noted that CPR, Part 24 “has introduced a new emphasis on allowing claims to go to trial only where they have a real prospect of success”, and said:

*“It would, I think, be absurd for a court to conclude that a claim was not frivolous, vexatious or an abuse of process, and thus grant permission under section 139(2) of the Act, in circumstances where, if the court had asked itself the CPR Part 24 question, it would have concluded that the proposed claim had no real prospect of success.”*²¹

14 If submissions were made for the claimant on the section 139(2) point, they are not recorded in the judgment.

15 CPR, rule 24.2(a).

16 *Menagh v Chief Constable of Merseyside* [2003] EWHC 412 (QB).

17 *Khadine v The Commissioner of Police of the Metropolis* [2005] EWCA Civ 196.

18 *Winch v Jones*, *supra*, per Parker LJ at page 306.

19 *Johnston v The Chief Constable of Merseyside Police*, *supra*, at [12].

20 *Ibid.*

21 *Ibid.*, at [13].

On an application under section 139(2), therefore, a court must ask whether the proposed claim has a real prospect of success.

Coulson J concluded that Mr Johnson's proposed claim was not frivolous, vexatious or an abuse of process, and that it had a real prospect of success.²² He therefore granted the necessary permission under section 139(2) of the *Mental Health Act 1983*, and, because he also agreed to waive the three-year limitation period,²³ the claim was able to proceed.

Discussion

Section 139 leave continues to exercise the courts, and it seems that the question of the precise status of proceedings issued without it might not have been resolved to everyone's satisfaction. Recently, in proceedings concerning not the *Mental Health Act 1983*, but section 329 of the *Criminal Justice Act 2003*, the Court of Appeal distinguished *Seal*, but also, after a survey that encompassed section 17 of the *Charitable Trusts Act 1853*, section 130(2) of the *Insolvency Act 1986* and "successive" *Limitation Acts*, noted that only section 139 "has been construed as creating a mandatory requirement of prior leave".²⁴

The detention of patients, purportedly under section 136 of the *Mental Health Act 1983*, is also a cause for concern.²⁵ It might fall to the court to determine the truth in this case, but the fact that two people can disagree about whether section 136 was ever mentioned is disappointing. Perhaps the time has come for a short, simple form to be devised for use in 'public place' detentions.

Some potential defendants will be unaffected by the decision of Coulson J. For esoteric, historical reasons, no permission has ever been required for proceedings concerning the acts or omissions of the Secretary of State or many NHS bodies under the *Mental Health Act*.²⁶ Where a claim relates to the use of section 136, however, or to the initial decision to detain a patient in hospital, this case will make a difference.

Winch v Jones remains good law, and the test it established has not been displaced. Now, however, that test is rather more stringent, for a potential claimant will have to show not merely that his case is arguable, but that it has a real chance of success. That is a palpable change, whose effect might well be to forestall claims that would otherwise have proceeded all the way to trial. And plainly, therefore, it is a good deal more 'significant' than the judge was prepared to allow in Mr Johnson's case.

22 See [22]-[27].

23 See [33]-[43].

24 *Adorian v The Commissioner of Police of the Metropolis* [2009] EWCA Civ 18, at [22]. This provision requires that leave be obtained for any assault, battery or false imprisonment claim brought by someone convicted of a criminal offence committed on the same occasion. It was introduced "to protect people from being baselessly sued by criminals for doing no more than try to arrest them or stop them offending" (per Sedley LJ at [20]). Plainly, it can

also be preyed in aid by the police. (The author is grateful to Nick Peel of Weightmans LLP for referring him to this case.)

25 See: David Hewitt, "She took no reasoning": Enticing someone into a public place, *Journal of Mental Health Law*, Spring 2009, page 101.

26 *Mental Health Act 1983*, section 139(4). See: David Hewitt, *Something less than ready access to the courts: Section 139 and local authorities*, *Journal of Mental Health Law*, February 2000, page 73.

Book Reviews

Coercion and consent

Monitoring the Mental Health Act 2007–2009

The Mental Health Act Commission

Thirteenth Biennial Report 2007–2009

The Stationery Office (2009)

£25.00

The thirteenth biennial report from the Mental Health Act Commission is, of course, its last. The review copy arrived with the cover bearing its familiar style and characteristic logo, as well as being illustrated with the most extraordinary evocative and haunting portrait in oil pastels by a woman who underwent two leucotomies in the 1950s, but accompanied also by a Care Quality Commission compliments slip.

Plus ça change? Well, all one can say at this point in time is that it remains to be seen. Reports from around the Country, and not only those originating with mental health services, suggest that the new regulatory body is not going to shy away from being critical, and quite vehemently so, of what it sees as unacceptable practice or below par standards of care. As has been suggested in previous reviews here before¹, this is as it ought to be. But one hopes that the opportunity which this change offers will be seen as one that includes being able to take up the challenge of looking at the bigger picture, the wider horizon, the entire canvas, rather than the focus being on individual elements of what is, after all, a huge and complex construction.

That said, this, the valedictory from the outgoing Commission is, in my judgement at least, rather gentler, perhaps a little less hostile as it could sometimes seem previously even, and more conciliatory, particularly towards mental health services and those doing their best to run, maintain and better them. On page 21 there is reference to being able to “celebrate and appreciate the hard and demanding work undertaken by professionals in acute psychiatric care over the life time of the MHAC.” Also that the most important thing “is the simple human compassion, humour and capacity for hope ... as expressed by both staff and patients alike”. It is vital too though that we all remain mindful of the burden of mental ill health upon those suffering it, and never forget the sense of hopelessness and desolation that accompanies it for some.

As with previous biennial reports the main component of the opening sections deal with the statistics of the detained population and the operation of the Act itself during the relevant period. These I found quite hard going in a way that their equivalent numbers in preceding reports did not seem to be. This is of course a matter of opinion but one for which I confess I am unable to account in any specific way on the basis of objective evidence. Nevertheless they took a deal more concentration than previously. At the same time there is an awful lot contained in them and just the variety of data presented and attendant

¹ The author reviewed the 12th Biennial in the *Journal of Mental Health Law* May 2008 and the 10th Biennial in September 2004. Anselm Eldergill reviewed the 9th Biennial in the *JMHL* February 2002.

issues raised are potentially overwhelming. So perhaps there is a sense in which they seem both potentially too intense, but also diverse, to make for easy reading. In Chapter One for instance, following on from the presentation of what are still vitally important data relating in the main to numbers of detained patients, there are sections centred on matters concerning bed occupancy, the use of security, in the form of locked doors, as a means of clinical, or in some cases non clinical management, others on ward based activities, staffing levels and mixes, the hospital environment, and observation levels, restraint, police involvement in handling potentially dangerous situations on in patient units, and seclusion, as well as ward based telephones, access to computers and pornography, patients' correspondence and emails. And these across all different levels of security, from open units to the special hospitals. This is not to make less of the material. These are important areas. But one needs one's wits about one in assimilating and thinking about these different topics in such quick succession. The secret possibly lies in reading each part as a discreet entity. But then one risks losing any degree of continuity, for these are not all as different as they might superficially seem to be and are certainly not all entirely unconnected subjects. I was left wondering if this was a result of a need and desire to cover so many topics in what is, after all, a limited amount of space, but also at a time when there might have been a sense of this possibly being the last opportunity to do it.

The section on patients' leave from hospital, and indeed absence without leave, I found particularly interesting. It extends across all aspects of what might seem, and certainly should be in most circumstances, a fairly straightforward process. Not so when one must take into consideration definitions of what constitutes leave and where this can be taken, forward planning, risk related issues, recording and communicating decisions, and the availability, or more importantly potential (and actual lack) of availability of escorting staff where they are needed. And this is without the limitations and administrative extras that go with the legal status of restricted patients, where the Ministry of Justice must also be involved which can mean that there are political, as well as Political influences to be taken account of. There is too increasing emphasis placed on victim related matters for those subject to both restricted and non-restricted hospital orders, the latter as a result of the 2007 Act.²

There is an important, though complex, sub section devoted to Supervised Community Treatment (SCT). It looks at all aspects of the powers and includes some initial data and analysis as well as an attempt to assess the early impact of SCT through the experiences of patients placed on the new Order. Suffice it to say that this needs reading by all those involved in using SCT now or contemplating using it in the future. There are already problems arising, around functionalised services and who does what at the point of discharge from hospital and the initiation of the SCT as well as in relation to the requirement for the already over stretched Second Opinion Appointed Doctors service (to which there is an entire section of it's own devoted later) to approve treatment plans for patients subject to SCT, even if they have capacity and are consenting³. Despite these and other issues, there does, from some very early and as yet unpublished findings, seem to be more enthusiasm among psychiatrists for the use of SCT when compared to the now no longer available Supervised Discharge.

The chapter on mentally disordered offenders will be important to those working in their day to day practice with this group of people but it is disappointing that some issues that the Commission has repeatedly raised and referred to in the past are still unchanged. Chapter 6 entitled "Deaths of Detained Patients" is both informative and thought provoking.

2 *Schedule 6 of the Mental Health Act 2007 amends the Domestic Violence, Crime and Victims Act 2004.*

3 *See Sections 64B and 64C Mental Health Act 1983.*

So the Mental Health Act Commission has finished its work, although not completed it as there is always more to do. Its successor comes to the arena at an extraordinary point in time, during which the Government has been seeking views on potential emergency measures and, one might argue, quite significant changes to the safeguards which bind the 1983 Act into what it is if, in the face of the influenza pandemic becoming more serious and widespread, there is a significant temporary or even permanent reduction in the mental health services workforce⁴. Interesting times.

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⁴ See 'Pandemic influenza and the Mental Health Act 1983' Department of Health (September 2009).

Mental Illness, Medicine and Law

Martin Lyon Levine (ed.)

Ashgate (2009)

£135

This compendium of essays is published as a volume of Ashgate's *International Library of Medicine, Ethics and Law*. The general editor of the series is Professor Michael Freeman of University College London, who sets out the rationale of the series in that "few academic disciplines have developed at such a pace in recent years as bioethics, and ... important writing is to be found in a range of books and journals, access to the whole of which is likely to elude all but the most committed of scholars". Scholars of psychiatric ethics can already turn to a number of other published anthologies: Professor Jill Peay's selection of 'seminal' writing on mental health law¹ shares both a publisher and many themes in common with this work; the Oxford University Press *International Perspectives on Philosophy and Psychiatry* series contains important contemporary work on ethics², and for three decades Bloch and Chodoff's *Psychiatric Ethics*, which is now in its fourth edition³, has been a standard anthology of original essays and has generated companion volumes including a 'case-book' and an anthology of journal pieces rather similar in scope to this⁴.

The editor of this particular volume is Professor Martin Levine, whose appointments at the University of Southern California straddle both law and medicine, but who wears his doctor's hat in his introductory overview of the essays selected. Professor Levine was set some ground rules for his selection, the most notable of which was that only full essays could be included, thus ruling out excerpts from longer essays or books. The series aims to include "essays of central theoretical importance", although in the introduction Levine reveals that his working criteria for selection were in fact "the most interesting essays"; essays with a "focus on cutting-edge issues"; or simply "shorter essays". In any case, the book contains fifty-three papers, half of which were published after 1999, although the most recent is dated 2004. These are arranged into eighteen themed groups, with themes including detention; treatment rights; overdiagnosis and overmedication; the social construction of madness; informed consent; confidentiality; false-memory syndrome; intellect-enhancing drugs; professional boundaries, advocacy; and issues on the psychiatrist as expert witness. Papers are reproduced as originally published, with full references. Regrettably there is no subject index, which seems a little mean of the publishers for a volume of this price: the Oxford University Press anthology is roughly the same size and has a subject index, so it is not an unfeasible task.

All but nine papers are by American practitioners: four are from UK practitioners; two from Israel; and there are single papers from Canada, Holland and Sweden. As such, the collection as a whole has a markedly American slant. This, of course, is not a criticism in itself: on a theoretical level, many important writers on psychiatric ethics are American, and even essays dealing with practicalities specific to the United States can be read for broader relevance. For example, the three essays here on the ethical

1 Jill Peay (2005) *Seminal Issues in Mental Health Law*. Ashgate. Reviewed in JMHL May 2006 pp102–106

2 See, for example, Tim Thornton (2007) *Essential Philosophy of Psychiatry*, OUP; Bill Fulford, Tim Thornton, George Graham (2006) *Oxford Textbook of Philosophy and Psychiatry*, OUP.

3 Sidney Bloch, Stephen A. Green (2009) *Psychiatric Ethics 4th edition*, Oxford University Press.

4 Donna L. Dickenson, Bill (KWM) Fulford (2001) *In Two Minds: A Casebook of Psychiatric Ethics*. Oxford University Press; Stephen A. Green, Sidney Bloch (1999) *An Anthology of Psychiatric Ethics*. Oxford University Press.

dilemmas posed by ‘managed care’ raise points relevant to resource limitations in other healthcare systems, and an essay touching on psychiatry and the death penalty sits within, and brings an acute focus to, a chapter focusing on the appropriateness of doctors’ involvement in the legal and testimonial role of forensic psychiatry, however much the combination of serial judicial killing and a ‘western’ forensic psychiatric service must be peculiar to the United States.

However, with an eye to their international audience, many journal editors will require their authors to avoid unintentional parochialism, such as referring to ‘the law’ without specifying the jurisdiction concerned. Some of the essays in this volume appear to have escaped such editorial scrutiny when first published, and as such unwary readers from outside the United States might run into trouble. A minor but colourful example is the contention by Appelbaum, when discussing medical confidentiality, that “the law’s first foray into this area” was the 1828 New York statute granting privilege to medical communications. Such a statement is liable to objection from France, which passed a similar statute in 1810⁵, and perhaps also from England, where the common law position that denies privilege to medical confidences where a court requires disclosure stems from a ruling made at the spectacular 1776 bigamy trial of the Duchess of Kingston⁶.

More seriously, readers in the UK could be confused by apparently general statements such that, for example, “current law embodies the ethical norm that the doctor can only recommend treatment, while it is up to the patient, if competent, to decide whether or not to accept it” (from the editor’s introduction) or that to be “committable in the traditional sense”, a patient must pose “a danger to herself or others” (from Ritchie *et al* on advance directives). Perhaps it is a sign of the eccentricity and isolation of UK law that, within the majority of its jurisdictions, neither statement holds true. But for a reader within those jurisdictions, the ways in which UK law apparently diverges from ‘ethical norms’ (i.e. by allowing treatment without consent of capacitated patients in UK jurisdictions other than Scotland, and detention on the grounds of benefit to health as well as safety throughout the UK) raise enormous ethical questions that are not really explored in this book.

The European reader will also miss reference to the European Convention on Human Rights, and find papers such as Marty and Chapin’s discussion of ‘legislative tenets of treatment in the least restrictive environment and freedom from harm’ in need of some translation to ECHR values. From my reading of this piece, it would seem that the exchange rate in the relative value of such rights echoes that in the currency markets: at least on paper, you get more in the United States.

There is a huge resource of material in this volume that will be of great use to readers in any jurisdiction. In many ways it makes a good companion to Peay’s earlier collection⁷, given its different geographic focus, and inclusion of clinical or biomedical perspectives. There are interesting essays by doctors defending the widespread use of stimulant drugs for attention deficit hyperactivity disorder; discussing children’s suicidality and SSRI drugs; and discussing problems of the ‘clinical significance’ classificatory criteria in the DSM-IV. But it is not all biomedicine: the anthology opens, for example, with a paper from a quite well-known Swedish medical study (Kjellin *et al* from 1997) that attempted to measure ethical benefits and costs of coercion, finding that even those who are detained can feel that they have retained some autonomy, and that self-reported improvement in mental health appeared to be associated with perceived

5 Angus McLaren (1993) ‘Privileged Communications: Medical Confidentiality in Late Victorian Britain’ *Medical History*, 37: 129–147, p.138.

Bigamous Duchess: The Benchmark Precedent for Medical Confidentiality’ Social History of Medicine Vol. 19, No. 1 pp. 37–53.

6 Angus H. Ferguson (2006) ‘The Lasting Legacy of a

7 See n.1 *supra*.

respect for autonomy. Tom Tyler, writing from 1992 in the *Southern Methodist University Law Review*, sets out roughly parallel findings into the psychological consequences of judicial procedures – emphasising the need for respect for dignity, openness and user participation – that should translate not only to judicial settings (such as the Tribunal in England and Wales), but also to mental health law assessments generally. These are useful things to have to hand. Similarly, an article by an academic colleague of the editor provides an excellent summary and classificatory account of the varieties of community treatment order (although readers in England and Wales should watch for the statement that “we do not permit inpatient forcible medication to shorten commitment when the patient is competent”. My copy is now annotated “but *we* do”).

Anti-psychiatry gets an airing with what I would describe as one of Thomas Szasz’s occasional pieces: in this instance a polemic from 2003, aimed across the Atlantic at the UK Home Office’s proposals for ‘dangerous people with severe personality disorder’, which glancingly traces the Szaszian critique as a whole. It is telling, I think, that the response to Szasz by J R McMillan, which is also reproduced in this volume (the two pieces appeared originally in the *Journal of Medical Ethics*), manages to set aside Szasz’s general critique as largely irrelevant whilst agreeing with the points being made against preventive detention. This is an interesting encounter, but it would surely leave Szasz essentially incomprehensible for any newcomer to his work, and has rather the effect of establishing him as the straw man in this volume. Perhaps to provide a balance of iconoclasts between the fields of law and medicine, the volume includes Dennis Fox’s anarchist-orientated paper ‘A critical-psychology approach to law’s legitimacy’, which argues that ‘law fully in command’ displaces ethics, so that questions of right or wrong become a specialty of professionals and justice an industry. As with much anarchist critique, such ideas can be taken either as an argument for equity and cooperation outside the law, or to legitimate the actions of the egoist to himself. In the hands of some consultant psychiatrists it could be a great danger.

Elsewhere there is moderation rather than radical critique, perhaps surprisingly so for a volume that seeks “to focus on cutting edge issues”. In one of the older essays (from a 1977 issue of *Science*), Engel sets out his case for ‘biopsychosocial’ psychiatry, a meeting half-way between biological reductionists and those critical of psychiatry as a branch of medicine at all. This approach has recently been described as the mainstream ideology of contemporary psychiatry and subjected to a thought-provoking (and soon to be book-length) critique by the Massachusetts-based Professor Ghaemi, who argues that the approach has fallen into eclecticism and that other non-reductionist models should be reconsidered, such as Jaspers’ method-based psychiatry or Osler’s medical humanism⁸. In the three decades since Engel’s paper, what has become the biopsychosocial mainstream has also come under attack from the critical psychiatry movement and from the service users that it engages with⁹. None of this – which might have some claim to be ‘cutting edge’ – is evident from the selections in this volume, and there are no contributions from service users.

There is, nonetheless, plenty of thought-provoking material here. Papers by the Yale Professor Jay Katz and by the Maastricht researchers Berghmans and Widdershoven together provide excellent material on ethical aspects of informed consent, with helpful suggestions on practice (I found a third paper included on consent to be too basic, and too specifically orientated towards Israeli law, to be of general application). I thoroughly recommend the charming paper ‘Weaving a tangled web: the deceptions of

8 S Nassir Ghaemi ‘The rise and fall of the biopsychosocial model’ *British Journal of Psychiatry* (2009) 195, 3–4.

9 See Pat Bracken and Phil Thomas ‘Beyond consultation: the challenge of working with user/survivor and carer groups’. *Psychiatric Bulletin* (2009) 33, 241–243 and invited commentaries, p.243–246

psychiatrists' by the San Diego forensic psychiatrist Ansar Haroun and law professor Grant Morris. The authors catalogue concrete examples of the minor deceptions (evasion, suppression, euphemism, exaggeration, disguise, gesture, silence, or inaction) found in psychiatric practice, and ultimately argue that these must be understood in the context that a doctor's role is to be pro-treatment, and as such carries inherent pro-treatment biases, regardless of the doctor's other biases (which are also catalogued for good measure). People who are not doctors – including those charged with making legal decisions – are henceforth “on notice, and if they are deceived, they only have themselves to blame – not the innocent, though lying, psychiatrist”.

One of the longer papers sets out Michael Perlin's thesis that legal decision-makers are driven by the “pernicious power” of “sanism”, which is defined a product of irrational, unconscious and bias-driven stereotypes, analogous to racism or sexism. To this extent, Perlin argues that legal decisions regarding mental health law can be ‘teleological’ in the way in which they ignore or cherry-pick evidence and data. It might be argued that this very broad concept of “sanism” provides a rather vague *telos*; and indeed Perlin soon gets into trouble in identifying whether or not there is teleology at work even in the cases that he cites, or how this influences the efficacy of the outcome in therapeutic terms. That there is teleological decision-making in at least some mental health law cases seems evident enough¹⁰, but as an explanation ‘sanism’ seems to close down rather than provide an understanding of it. The courts appear to go through tortuous argument to deny the wishes and claims of a few notorious forensic patients on the basis of prejudices unconscious or otherwise, but in day to day decision-making the prejudice is likely to be no more sinister than a streak of paternalism; beneficence; confusion at the conflicting reports of experts and ‘social science data’; and pragmatism in the face of less than ideal disposal options. Nevertheless Perlin thus raises a potential critique of ‘therapeutic jurisprudence’ (which is surely just teleological decision-making in its most overt form), albeit one that he pictures as a critical tool to ensure that therapeutic jurisprudence works as intended. I suspect that there is much scope for further critical thought in this area today.

This volume would of course be an asset in any institutional library, where it would certainly fulfill its intention of making certain original texts that would otherwise fall into obscurity once again available to scholars. Even though this work of reference is not unique in its field, there is surely a case for arguing that the more the better, both to give scholars a range of sources and to avoid the canonisation of those sources that make it between library covers.

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¹⁰ See David Hewitt ‘A private function’, *JMHL* May 2005, pp83–95 (especially the final paragraphs). The paper is reprinted in David Hewitt (2008) *A tendency to laugh and sing: some notes on mental health law*, Northumbria Law Press, pp129–138. As Hewitt notes in the introduction to the latter publication (p.ix), “there are some classes of people of whose rights, it sometimes seems, all laws have been contemptuous”.

A Tendency to Laugh and Sing: Some Notes on Mental Health Law

David Hewitt (Northumbria Law Press, 2008) £24.99

Dr David Hewitt probably needs no introduction, but he deserves one anyway as an old friend of this Journal, both in his capacity as Assistant Editor and as a prolific contributor. He is a partner in Weightmans LLP, a visiting Fellow of Northumbria and Lincoln Universities and a judge in the First-Tier Tribunal (Health, Education & Social Care Chamber) (Mental Health) – in other words, a mental health tribunal. He is also an assiduous and highly-regarded commentator in the professional press on issues in mental health law. One wonders how he finds the time.

The present volume is a collection of Dr Hewitt's writings for the legal and professional press over the past few years, together with the transcripts of a couple of lectures. Two were co-written with Kristina Stern, the remainder are pure Hewitt. The earliest article dates from 1995, the most recent from (I think) 2007. Some, particularly those written for this Journal, are detailed and can run to a dozen pages; some of them focus on a single topic, such as the nearest relative, and are a couple of pages long. Most are concerned with the great controversies of their day, but a couple explore unexpected byways and come to surprising conclusions. Together the articles offer a close analysis of the most significant developments in mental health law, both cases and legislation, during the period.

The book is divided into five chapters, based on themes: "The European Convention on Human Rights", "Cases", "Bournemouth and After", "Amending the Mental Health Act" and "Miscellaneous Matters". The pieces in each chapter are arranged chronologically (almost – see later). As Dr Hewitt says in his introduction, this gives a sense of how a line of case law or a set of legislative proposals developed, but it can also have the effect of dividing up articles into different chapters which connect with each other. On the whole, though, the divisions work.

The first chapter is, to this reader at least, the most wholly successful. Dr Hewitt has a keen understanding of both the European Convention and of Strasbourg jurisprudence, and these articles are both erudite and informative. They are also gently sceptical about the Convention's potential for altering the mental health landscape, by contrast with the naïve excitement that some of us felt at the time. Well, he was right and we were wrong.

To some extent this first chapter works so well because the interpretation of the Convention continues to exercise us today. The second chapter, which deals equally thoughtfully with significant issues in the caselaw of the period, makes an interesting historical record but – since the matters are now all settled law – is rather less relevant to current practice. It is also a harder read. A number of the articles deal with the same topic, which can be repetitious. There are, for example, four articles on re-sectioning following discharge, which analyse just two cases – *von Brandenburg*¹ and *H v Ashworth*². They make very good points – particularly with regard to the second of these cases – but several times over; two of the articles would have been enough I think. (It doesn't help that article 13 is out of chronological order.)

There is also the problem that a collection of articles does not always give the whole picture. For example,

1 *R v East London & the City Mental Health NHS Trust and another, ex parte von Brandenburg* [2001] EWCA Civ 239; [2003] UKHL 58

2 *R v Ashworth Health Authority and others, ex parte H* [2002] EWCA Civ 923

Dr Hewitt includes a characteristically careful analysis of the *MH* case in the Court of Appeal³ – and repeats his comments later in the context of the Bournemouth articles – but the fact that the judgment was reversed in the House of Lords the following year⁴ appears only in a small footnote, which this reader missed first time round. Maybe he never wrote about the Lords’ decision (he is entitled to the occasional weekend off, after all), but without a fuller note – in the introduction to the chapter, perhaps – to explain how matters subsequently developed, a reader who is unfamiliar with the case would be misled as to the present state of the law.

These are probably minor niggles. None of the chapter 2 articles is less than informative, and some are positively illuminating. I particularly enjoyed articles 18 and 19, on the bar in section 139 MHA on bringing legal proceedings against mental health professionals without permission of the court, even though they overlap to some extent. And a couple of these pieces are as relevant today as when they were written: see for example Article 21, which deals with the case of DR, whose s.3 detention was renewed although she was spending no time as an inpatient. Dr Hewitt and his co-author, Kristina Stern, set out the implications with admirable clarity.

The third chapter is called “Bournemouth and after”, and covers the development of the law relating to the control of incapacitated but compliant adults, from the 1999 House of Lords decision in that case, via the European Court of Human Rights hearing in 2004, to the Deprivation of Liberty Safeguards which came into force in April this year. To a large extent these pieces simply set out the law at each stage. However one article, on the case of *Re F*⁵, looks very hard at the whole notion of protecting “vulnerable adults”, and concludes that the case widened the so-called “Bournemouth gap”, rather than narrowing it. And on the way Dr Hewitt points out a problem which I confess I had not spotted before⁶: if the DOLS safeguards apply to someone who is “detained in circumstances which amount to deprivation of his liberty⁷”, it must follow that someone can be detained *without* being deprived of their liberty (and maybe vice versa) – so what is the distinction between the two?⁸ It may be a matter of purely academic interest, or it may be a gap that will one day have to be adjudicated upon. Either way, I am glad that it has been pointed out.

Chapter 4 details the various proposals to reform the Mental Health Act 1983: the 2000 White Paper, the draft Bills of 2002 and 2004, and the Bill which, with modifications, was finally enacted in 2007. To those of us who tried to understand these plans at the time they will be oh, so familiar, and yet oh, so long ago. It will, I am sure, be of value to researchers and academics to read Dr Hewitt’s comments on each of these proposals at the time they were published, as they are models of clarity and insight. I found Article 41, which argues that in view of contemporary practice there was little need to reform the MHA at all, the most interesting. I wonder, though, how relevant most of this chapter will be to current practitioners of mental health law.

The fifth chapter is, as the author cheerfully admits, “a ragbag of articles that I could not fit in anywhere else”. To my mind some of these pieces are among the most engaging in the book – particularly the texts of two lectures, on the role and value of Mental Health Act Managers, in which – at last – Dr Hewitt breaks away from his role as scholarly analyst and becomes an advocate, and a polemical one at that. It is as if a batsman who has been carefully and neatly nudging the ball around the infield is suddenly

3 *R (MH) v Secretary of State for Health* [2004] EWCA Civ 1690

4 *MH v Secretary of State for Health* [2005] UKHL 60

5 *In Re F (Adult: Court’s Jurisdiction)* [2000] 1 FLR 192

6 See Article 31 at page 165 ff

7 MCA 2005, Schedule 1, Paragraph 1(2)

8 Since this volume of essays was published, the House of Lords has of course considered this issue in *Austin v Commissioner of Police for the Metropolis* [2009] UKHL 5. In an article entitled ‘Whose Liberty?’ (*Solicitors’ Journal* 17/2/09), Dr. Hewitt analysed their conclusions.

revealed as Freddie Flintoff: thwack! to the Government, Tory and Labour alike; wallop! to the abolition plans in the Draft Bill. I know Dr Hewitt has a reputation to maintain as a serious and level-headed lawyer, but a bit more of this would have been welcome.

So, what to make of the book as a whole? It is, as the author says, a collection of “notes” on mental health law, rather than a coherent whole. As such it is not designed to be read straight through, and I would not recommend doing so. The grouping of articles on the same broad theme has its strengths – particularly for anyone carrying out an historical analysis – but it does make for considerable repetition. This is a pity, as an incisive comment in one article loses some of its force when it is repeated in the next, written in the same period for a different publication. (I particularly regret the fact that an excellent joke on page 195 reappears in a footnote to the subsequent article, just four pages later.)

As I have indicated, I find the value of the individual articles somewhat variable, especially where their subject-matter is no longer under debate. Some do no more than summarise the effect of a case, or legislative proposals, though they are invariably clear and concise, and Dr Hewitt writes well. Occasionally I think he labours his point: the final article, on the interpretation which must now be given to “hospital”, could to my mind be cut by a third. (This may betray my own study habits.) However, the single-topic pieces are invariably illuminating; and the long articles, such as those written for this Journal, give him the space for what he does supremely well: a painstaking analysis of the relevant caselaw and guidance, fully referenced, which leads the reader step by step to the inevitability of his conclusion.

This is particularly effective where the conclusion challenges the current orthodoxy. For example, in Article 24, which considers an unsuccessful challenge to a medical member of a tribunal being employed by the detaining authority⁹, he dissects to devastating effect the tendentious – and, I am now persuaded, wrong – interpretation given by the Court of Appeal to the expression “officer of ... a National Health Service Trust” in rule 8(2) of the former 1983 Mental Health Review Tribunal Rules. Hewitt does not rail against the decision, but merely points out the implications: if an “officer” means someone with managerial responsibilities, as the Court ruled, then the “officer” required to receive the detention papers would likewise have to be a manager, a manager would have to scrutinise the documents, and so on. This is fine advocacy.

(Incidentally, the above article is titled “Officer Class.” Dr Hewitt’s titles are always worth noting. I particularly like the piece on the DOL safeguards headed “Bournewouldn’t”.)

In summary: this is a collection of informative, well-presented, well-researched and occasionally provocative articles on substantial topics in mental health law. I am just left wondering who its natural readership will be. Journalism, however erudite or forceful when it was written, tends to go out of date once the controversy that inspired it has receded into history. Perhaps its enduring value will be in its very contemporaneous nature: “I was there”.

In a rare exception to an otherwise becomingly modest assessment of his own work, Dr Hewitt tells us that Lord Carlisle of Berriew, QC, chairing the Joint Committee on the 2004 Draft Bill, congratulated him on his articles for *New Law Journal*, “one of which I have circulated to the Committee because of the clarity of the picture it presents and the explanations.” Amen to that.

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9 *R (PD) v West Midlands and North West Mental Health Review Tribunal & Mersey Care NHS Trust* [2004] EWCA Civ 311

Some Recent Publications

Although sited within the 'Book Reviews' section of the Journal, this article does *not* contain detailed reviews of the books to which it refers. It is simply a means of informing readers of *some*¹ recent publications which may be of interest. In-depth reviews of any one of the books referred to may be included in future issues.

It seems appropriate to end this issue of the JMHL with this round-up of some recent publications. After all, the issue opens with the text of Brenda Hale's keynote address at the conference held in Manchester in October 2009², organised by the Approved Mental Health Professionals Association (North West and North Wales)) and Cardiff Law School, within which reference is made to several publications about mental health law which have emerged since Lady Hale first starting teaching mental health law in 1971. Within the last year or so a number of publications have appeared. They include:

'Mental Health Act Manual', Richard Jones (12th ed.) (2009)³

Lady Hale makes reference to this celebrated work, and clearly it warrants inclusion within this article because the publication of a new edition deserves to be widely acknowledged and welcomed. Over the 25 years of the life of the Manual there cannot have been a lawyer working in the mental health law field in England and Wales who has not had cause to be very grateful to Richard Jones. Indeed there will be very many social workers, psychiatrists, tribunal members, students and others who will also have benefited enormously from accessing its contents. As all who work in, or study, this field of law know, it has really become essential reading; indeed it has become 'invaluable' as acknowledged by Lady Hale within her address. What distinguishes the 12th edition from its immediate predecessor?

Part 6 of the Manual is new. Headed '*Deprivations of liberty – Mental Health Act 1983 or Mental Capacity Act 2005?*', this section considerably aims to assist the practitioner in shedding light on "the opacity of some of the crucial provisions that are to be found in both the 1983 and the 2005 Acts" (to quote from the Preface), and is therefore most welcome. In addition, as always Jones applies recent case-law throughout, particularly in updating his well-known annotations to the 1983 Mental Health Act ('MHA'). Other significant changes are inclusion of: 1. The *First-tier Tribunal (Health, Education and Social Care Chamber) Rules 2008* (irritatingly missing from the 11th edition (because of inconvenient publication dates)), together with associated Practice Directions (not only the now well-established PD. in respect of information and reports to be submitted in mental health cases, but also the PD. in respect of child, vulnerable and sensitive witnesses); 2. The *Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008*, timely given the arrival of IMHAs in hospitals as from 1st April 2009; 3. The *Mental Health Act 1983 Approved Clinician (General) Directions 2008*, replacing the Directions contained within the 11th edition; 4. The amendments made to sections 120 and 121 MHA by the *Health and Social Care Act 2008* which resulted in the abolition of the Mental Health Act Commission, or rather its absorption by the Care Quality Commission. The Manual runs to 1088 pages, and it is no surprise that Jones, as with the 11th edition, has not been able to make space for the Welsh

1 No attempt has been made to be comprehensive in the article's coverage. No conclusions should be drawn from any failure to refer to any particular publication.

2 'Taking Stock: The Mental Health & Mental Capacity reforms: the first year.' 9th October 2009

3 Published by Sweet & Maxwell (£69)

Code of Practice or Welsh secondary legislation. This will continue to frustrate his Welsh readership, although they will derive some comfort from his assertion that "... the Welsh materials do not differ substantially from their English equivalents". They will be intrigued to note (if they have not previously appreciated the fact) that "... approved mental health professionals in Wales have one advantage over their English counterparts. While the former can section their spouses..., the latter cannot..." (Preface).

It is of course the annotations to the 1983 Act for which the Manual is best known. It is these that get bandied about between professionals. "*But Jones says...*" frequently precedes searching questions from the floor at training events up and down the country (and no doubt in Wales as well). Concern has been expressed by some⁴ that the less knowledgeable sometimes find it difficult to distinguish between the judicially-confirmed legal position and a Jones submission. It is the job of those who teach to ensure that the distinction is understood. That said, it is noteworthy that not infrequently Jones submissions do tally with conclusions subsequently reached by the Courts or/and the Government – for example his interpretation of 'practicable' in section 11(4)⁵, and his view on the 'Section 2 or section 3?' debate⁶. There is already an example of this in the 12th edition. On page 359 Jones asks a question not asked in the 11th edition, namely "Does an application to the tribunal by a s.3 patient lapse on the patient being made subject to a community treatment order (CTO)?" Within the next 30 lines he presents an argument that it does not. On 1st October 2009 (i.e. long after submission of the edition to the publishers) Judge Rowland in the Upper Tribunal⁷ reached the same (to some, surprising) conclusion.

'Mental Health law in England and Wales – A Guide for Mental Health Professionals', Paul Barber, Robert Brown and Debbie Martin (2009)⁸

In recent years lawyers and law students have been particularly well served by various texts as they have aimed to get to grips with the complexities of mental health law. For some time they have had access to the *Manual* and to excellent books by Eldergill⁹ and Bartlett & Sandland¹⁰, and more recently they have had the *Mental Health Act 2007* amendments to the 1983 Act impressively and clearly explained in books by Bowen¹¹ and Fennell¹². Such books are also intended for those with an interest in the subject, albeit not as lawyers¹³, but some do not require or welcome such detail, and for them this book surely fills a long awaited gap.

Written by very experienced trainers (a lawyer, the Director of the AMHP training course in S.W.

4 For example, see the review of the 7th edition by Anthony Harbour and Robert Brown in the JMHL February 2002 (pp 81–84). A similar, albeit implied, concern was expressed in the review of the 9th edition by Simon Foster in the JMHL May 2005 pp 96–99.

5 See the 'submission' on page 81 of the 9th edition, and the subsequent judgment of Bennett J. in *R (on the appl'n of E) v Bristol City Council* [2005] EWHC 74 (Admin)

6 Compare the 'submission' set out on, say, pp 25–26 of the 9th edition, with paragraphs 4.26 and 4.27 of the revised Code of Practice (2008)

7 *AA v Cheshire and Wirral Partnership NHS Foundation Trust* [2009] UKUT 195 (AAC)

8 Published by Learning Matters (£29).

9 'Mental Health Review Tribunals – Law and Practice', Anselm Eldergill (Sweet & Maxwell) (1998). Reviewed in

the JMHL February 1999 (pp 83–84)

10 'Mental Health Law – Policy and Practice', Peter Bartlett & Ralph Sandland (Oxford University Press) (3rd ed.) (2007). The second edition was reviewed in the JMHL February 2004 (pp 86–90).

11 'Blackstone's Guide to the Mental Health Act 2007', Paul Bowen (2007). Reviewed in the JMHL May 2008 (pp 116–119).

12 'Mental Health: The New Law', Phil Fennell (Jordans) (2007). Reviewed in the JMHL May 2008 (pp 112–115).

13 An example of a recent publication of particular interest to Approved Mental Health Professionals is 'The Nearest Relative Handbook', David Hewitt (Jessica Kingsley Publishers) (2nd ed.) (2009). The first edition was reviewed in the JMHL (pp 243–246).

England, and a practising AMHP) *'Mental Health law in England and Wales'* clearly explains how the MHA 1983 (as amended) applies in practice. In 136 pages of text, and contained within 18 chapters, the authors have skilfully set out comprehensively the range of provisions (making considerable use of tables to assist with the explanations), ending each chapter with a summary of 'Key Points'. The MHA 1983 (as amended) is reproduced, as are the *Mental Health (Regulations) 2008* (for both England (including the all important prescribed forms) and Wales), the *First-tier Tribunal Rules* (but no Practice Directions – presumably because they were not available at the time of publication?), extracts from regulations covering transfers to/from Scotland, a summary of the *Human Rights Act 1998* and the European Convention on Human Rights, summaries of key cases ranging from *Winterwerp*¹⁴ to *JE/DE*¹⁵, and (of particular relevance to those “whose involvement with mental health services straddle Offa’s Dyke” (to quote once more from the Preface to the Manual by Richard Jones)) a conversion chart for forms used in Wales and England.

For many years the Law School at Northumbria University has run a short (nine weeks) Mental Health Law option on its Legal Practice Course¹⁶. In 2009 *'Mental Health law in England and Wales'* was the chosen textbook for the course. Students found it to be readable, accessible and informative. Their experience suggests the book does indeed fill a gap in the market.

[It should be noted that *Learning Matters*, the publishers, have also published a series of books in a Post-Qualifying Social Work Practice series – *'The Approved Mental Health Professional's Guide to Mental Health Law'*, Robert Brown, (2nd ed.) (2009)¹⁷, *'The Mental Capacity Act 2005 – A Guide for Practice'*, Robert Brown, Paul Barber, and Debbie Martin (2nd ed.) (2009), and *'The Approved Mental Health Professional's Guide to Psychiatry and Medication'*, Robert Brown, Gwen Adshead and Alan Pollard (2nd ed.) (2009)]

'Children with Mental Disorder and the Law', Anthony Harbour (2008)¹⁸

In his Preface to this book, Anthony Harbour quotes the Richardson Committee (1999) as stating:

“... the law relating to the treatment of children suffering from mental disorder is in need of clarification. The current multiplicity of legal provisions creates a climate of uncertainty, professionals are unsure of their authority and of the legal and ethical entitlements of the children in their care.”¹⁹

Recognising that since 1999 “there has been little clarification, with a climate of uncertainty remaining”, Harbour provides much needed guidance to practitioners. As a solicitor who specialises (both through casework and teaching) in health and social services law, he is highly qualified to write such a book. He regularly lectures about the legal position pertaining to children and young people suffering from mental disorders, and for some years he has been the lead trainer for section 12 training for child and adolescent psychiatrists organised by the Royal College of Psychiatrists.

'Children with Mental Disorder and the Law' is a short book with examples liberally and helpfully utilised to illustrate various points made. Despite the author's statement that he has not written “a legal textbook,

14 *Winterwerp v Netherlands* (1979) 2 EHRR 387

15 *JE v DE and Surrey CC* [2006] EWHC 3459 (Fam)

16 A course undertaken by prospective trainee solicitors.

17 The first edition was reviewed in the JMHL May 2007 (pp 123–125)

18 Published by Jessica Kingsley Publishers (£25)

19 'Review of the Mental Health Act 1983: Report of the Expert Committee' (Department of Health) (1999) (para. 13.1)

rather a book aimed at practitioners who need to ensure that their practice is both lawful and conforms to good practice”, it appears to be both a comprehensive summary of the law and a practical guide to practitioners. Although published before most of the amendments made by the MHA 2007 to the MHA 1983 took effect, the book makes reference throughout to the changes to the legal provisions which were imminent. Its appendices contain: (1) Very helpful sign-posting to further reading; (2) An extract from *Local Authority Guidance Circular (99) 29* (covering Care Plans and Care Proceedings under the *Children Act 1989*); (3) Chapter 39 of the *draft revised MHA Code of Practice*; and (4) Chapter 12 of the *MCA Code of Practice*, ‘*How does the Act apply to Children and Young People?*’. One can only sympathise with the author that chapter 36 of the revised MHA Code of Practice (‘*Children and young people under the age of 18 yrs*’) had not been finalised by the date of publication of his book, and that therefore Appendix 3 needed to be replaced so soon after publication. Hopefully an early 2nd edition will appear to rectify the situation. In the meantime, no doubt practitioners working in the field of child and adolescent mental health services, and those lawyers charged with advising them, will find this book quite invaluable. The law in this area is complex – expert guidance is needed.

‘Mental Health Tribunals – Law, Practice and Procedure’, Jonathan Butler (2009)²⁰

Monday 3rd November 2008 not only saw the coming into effect of most of the MHA2007 amendments to the MHA 1983, but also the birth of the new tribunal system, the First-tier Tribunals and the Upper Tribunal. The Mental Health Review Tribunal became the First-tier Tribunal (Health, Education and Social Care Chamber) Mental Health. New Tribunal Rules appeared, as did a specific Practice Direction in relation to information and reports to be supplied to the Tribunal. The publication of this book by a barrister and part-time Mental Health Tribunal Judge was therefore very timely and to be widely welcomed.

The author’s hope is that the book will be “of use to the entire spectrum of participants (from whichever perspective) who participate in Mental Health Tribunals”. No doubt his hope will be realised. Within his Preface, Butler makes the point that the book on which many (including myself) relied in the past, ‘*Mental Health: Tribunal Procedure*’ by Gostin and Fennell (2nd ed. 1992), is now out of print, and so by implication there is no other work “exclusively on Mental Health Tribunals” to which participants can turn (somewhat surprisingly the author makes no mention of the comprehensive ‘*Mental Health Review Tribunals – Law and Practice*’²¹ by Anselm Eldergill, although (a) this scholarly book is not ‘exclusively’ about tribunals, and (b) much of it is also of course now well out-of-date).

The book is divided into ‘Parts’, and in so doing aims (appropriately in my opinion) to cover as succinctly as possible all relevant areas (i.e. including, for example, criteria, powers and duties, ‘other’ discharge routes, etc.) but no doubt it is those parts which focus on constitutional and procedural matters in respect of the MHT which will be most appreciated by its readership. Similarly Chapter 14 on ‘Remedies’ will be particularly welcomed both by legal representatives for patients and those advising responsible authorities, aggrieved by a MHT decision.

Part F is entitled ‘Statutory Materials (including Tribunal Rules and Practice Direction)’. Amongst the helpful materials included, lawyers will be grateful to find considerable guidance on procedural issues should a decision be made to pursue a matter in the Upper Tribunal or (exceptionally now that the Upper Tribunal has been established) in the Administrative Division of the High Court by means of judicial review.

²⁰ Published by Jordans (£52)

²¹ See n. 9 above.

‘Advising Mentally Disordered Offenders – A Practical Guide’, Carolyn Taylor and Julia Krish (with Dr. Frank Farnham) (2nd ed.) (2010)²²

As is now widely recognised, the criminal justice system is frequented by many (actual or alleged) offenders suffering from mental disorders²³. Given the wide-ranging legislative changes there have been in the ten years which have elapsed since publication of this Guide’s first edition²⁴, publication of this second edition is really very overdue. The authors state:

“This second edition of the book has been expanded to cover representation of mentally disordered offenders not only in the police station and magistrates’ courts, but also the youth court and Crown Court..... It is aimed at all practitioners involved in this area of work and provides a comprehensive analysis of the law and procedures, from arrest until disposal at the Crown Court. It is also intended to help clarify the role of those practitioners and enable them to perform it effectively.”

The Contents page confirms this. Chapter 1 concentrates on ‘medical and legal definitions’, and thereafter the authors take their readers through the police station, and then into the Magistrates Court and the Crown Court. They consider such matters as police station procedures (including the role of the appropriate adult), summary trial, discontinuance, bail, fitness to plead, plea, defences (such as insanity, provocation, diminished responsibility, duress, and automatism), expert evidence/reports, and the whole range of prison, hospital and community sentences. The final third of the book (i.e. 73 of the 220 pages) is devoted to a variety of material which the busy practitioner will be delighted to find in one place.

Inevitably there was yet another piece of criminal justice legislation working its way through the parliamentary process as this book was being finalised – *The Coroners and Justice Act 2009*. At the time of publication, no date had been fixed for the coming into effect of those provisions directly relevant to the subject matter of the book. The authors helpfully provide (both in the text and in Appendix 11) some indication of these provisions (which will change the defences of diminished responsibility and provocation, and the law on infanticide), but of course readers will need to look elsewhere for detailed guidance.

For many years a personal concern of mine has been a perceived tendency for practising lawyers to specialise in either mental health law or criminal law, but rarely in both. In view of this it seems to me that there is a considerable need for both groups of practitioners to at least acquire some expertise in the area less familiar to them. This book acts as a very useful (and in my opinion, necessary) bridge between the two, and will certainly assist criminal lawyers to recognise and apply legal provisions of especial relevance to those of their clients with mental disorders, something which of course must be very warmly welcomed.

‘Assessment of Mental Capacity – A Practical Guide for Doctors and Lawyers’ (General Editor: Penny Letts) (3rd ed.) (2010)²⁵

As with the first two editions of this book²⁶, this is a joint venture of the British Medical Association and the Law Society, with the latter taking on the mantle of publisher. Under the editorship of Penny Letts (whose involvement can be traced back through both the previous editions (1995; 2004)) the two organisations, three barristers and the BMA ethics manager have combined to provide post-*Mental*

22 Published by the Law Society (£39.95)

23 In their Preface the authors acknowledge that: “Despite the development of mental health assessment teams attending police stations, mental health diversion schemes at magistrates’ courts, and pilot mental health courts, a large number of people with mental health difficulties still

find themselves within the criminal justice system.”

24 Reviewed in the JMHL December 2000 (pp 210–211)

25 Published by the Law Society (£39.95)

26 The second edition was reviewed in the JMHL September 2004 (pp 174–177)

Capacity Act 2005 ('MCA') guidance to professionals working with people who lack, or may lack, the capacity to make some decisions on their own behalf. As with the book on offenders referred to above, this up-date is long overdue, and will prove to be a welcome addition to the bookshelves of not only doctors and lawyers, but also those social workers, psychologists, nurses, occupational therapists and others whose work requires them to assess capacity and make 'best interests' decisions.

Appropriately, early within the book, the fundamentals of the MCA are explained – the principles, the tests for determining lack of capacity, and the factors to be taken into account when arriving at a 'best interests' decision. Recognising that the MCA capacity tests are 'for the purposes of this Act' (i.e. for personal welfare decisions, healthcare decisions and financial decisions taken on behalf of people who either permanently or temporarily lack capacity to make those decisions for themselves) the book then devotes many pages in considering the tests that have been developed over the years for determining capacity for certain specific purposes e.g. to make a will, to make a gift, to litigate, to enter into a contract, to marry, to vote etc., and in so doing considers the approach which might be taken to established tests in the light of the MCA. The final 'Part' (of four) is headed 'Practical Aspects of the Assessment of Capacity', and is broken down into two sub-parts – 'Practical guidelines for doctors' and 'Practical guidelines for lawyers' – which, if taken on board by those for whom they are intended, should go some way to improving what can sometimes be poor communication between the legal and medical professions on capacity issues.

As with all the books referred to within this article, the book concludes with helpful appendices. So in the last 85 pages we find: Extracts from the MCA and its Code of Practice; guidance about the Court of Protection; the Court's Practice Direction in relation to serious medical treatment; a summary of the role of the Official Solicitor ('OS'); the OS's Certificate as to capacity to conduct proceedings; the Court's Form COP3 'Assessment of Capacity' and accompanying Guidance Notes; a sample letter to a GP requesting evidence of testamentary capacity; a list of addresses and contact details of numerous organisations; and finally, in Appendix J, such a comprehensive list of 'Further Reading' that in referring the JMHL readership to other publications about the law in respect of mental capacity, I need do no more than refer to that list.

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We have indeed moved on a very long way since Brenda Hale first started teaching mental health law in 1971. As can be seen from this article, and indeed from this issue of the Journal, those of us interested in mental health law (and mental capacity law) in England and Wales, in whatever role, are now extraordinarily well supplied with numerous sources of expert advice and opinion (including of course the JMHL itself), and there is more to come. As Lady Hale's article indicates, in the months ahead we can expect to see the publication of *Gostin on Mental Health Law*²⁷ and the next edition of her own book, *Mental Health Law*²⁸, and of course there may be others. We are indeed very fortunate.

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27 To be published by Shaw & Sons Ltd. (publication date not known)

28 To be published by Sweet & Maxwell in June 2010.

