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Articles and Comment

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Foreword

Over the last six months there have been two significant legislative developments in mental health law. In March, Scotland pressed ahead with its programme of mental heath law reform with the passage of the *Mental Health (Care and Treatment) (Scotland) Act 2003* through the Scottish Parliament. The new Act broadly reflects the recommendations contained in the *Millan* Committee report *New Directions* (2001), and includes a new system of mental health tribunals, improved safeguards for patients receiving compulsory treatment and a range of new orders, including the controversial community treatment orders. The Act is underpinned by a comprehensive set of ethical principles promoting good practice and, with some minor exceptions, has received widespread general approval. We are pleased to be able to provide a timely review of the new Act by Hilary Patrick in this issue of the Journal.

As the current parliamentary session draws to a close south of the border, there continues to be uncertainty over the exact fate of the *Mental Health Bill* for England and Wales published in June 2002. However, considerable consolation can be drawn from the publication of the draft Mental *Incapacity Bill* on the 27th June. The Bill is the culmination of over a decade of lengthy consultation carried out by the Law Commission and Lord Chancellor's Department, and is based on recommendations contained in the consultation paper *Who Decides?* published by the Lord Chancellor's Department in 1997 and the Government's Policy Statement, *Making Decisions*, in 1999. Both papers followed the earlier recommendations and draft Bill published by the Law Commission in 1995.

The new Bill aims to provide a comprehensive legal framework for decision-making on behalf of those who lack the capacity to make decisions for themselves. The Bill contains a number of key principles that aim to ensure incapacitated adults enjoy 'a maximum level of autonomy in the decision making process' and to safeguard the vulnerable from abuse. Some of its more important proposals for change include the abolition of the present Court of Protection, which is to be replaced by a new superior court of record with extended jurisdiction to intervene in decisions about a person's welfare and healthcare as well as financial decisions. Enduring powers of attorney are also to be replaced by a new system of lasting powers of attorney, again, with extended application to welfare and healthcare, as well as financial matters. Over the forthcoming months, the Bill will be scrutinised by a joint committee of both Houses of Parliament, which will hear representations from interested groups. The Committee aims to present a report to the Government later in the year. Unfortunately, due to the timing of the publication of the draft Bill we have not been able to publish detailed comment on its proposals in this issue of the Journal. Space will be set aside for its consideration in the next issue of the Journal, which will be published in December.

Following the renewed focus on mental incapacity laws, it seems appropriate that we lead this issue of the Journal with two empirical studies that focus on the assessment of mental incapacity, conducted by Dr John Bellhouse, Professor Tony Holland, Isabel Clare, Professor Michael Gunn and Peter Watson. The first study seeks to determine the extent to which informal and formal patients are capable of consenting to admission to hospital. The second study looks at the capacity of patients to consent to medical treatment and the relationship between capacity to consent to treatment, diagnosis and the present legal status. In both contexts, the reliability of the capacity assessments undertaken is explored to see whether capacity can be assessed with a reasonable level of agreement to enable consistent clinical practice. Both the timing of these studies and their findings are of tremendous importance – not least because the Government's plans for a new Mental Health Act to date, have not included making capacity assessment part of the criteria for the use of compulsion. The authors conclude that this is not only a 'missed opportunity' on the part of the Government, but also that such a change would neither be unworkable nor have disastrous consequences.

In June this year, Northumbria University and Eversheds Solicitors jointly hosted the North of England Mental Health Law Conference in Newcastle upon Tyne. The aim of the one day Conference was to address topical legal issues in mental health in the light of the Government's proposed legislative reforms and the Human Rights Act 1998. In this issue, we are pleased to be able to publish a paper delivered at the Conference by Fenella Morris, which focuses on the complex legal framework governing confidentiality and information sharing in a mental health context. The paper considers the nature and extent of the duty of patient confidentiality, the circumstances in which it may be overridden and the rights of access to health information for incapacitated adults and applicants to the Mental Health Review Tribunal.

Since its introduction in the 1959 Mental Health Act, the role of the nearest relative has attracted widespread controversy. Joan Rapaport's article examines the nearest relative from its historical origins to present day function under the provisions of the *Mental Health Act 1983* (MHA). In doing so, she explores the relationship between the nearest relative and the Approved Social Worker and goes on to analyse the problems that have so often been associated with the nearest relative's role. As the Government moves to abolish the nearest relative under its proposed legislative reforms, this article is a useful reminder that without careful and serious consideration of the current problems associated with the role, history may have a tendency to repeat itself.

The common law doctrine of necessity allows treatment to be given to compliant incapacitated patents for their mental disorder, so long as the proposed treatment is considered to be in the best interests of the patient. Nevertheless, many practitioners still feel it necessary to detain incapacitated patients under the MHA 1983 and invoke the safeguards contained in section 58 of the Act when administering ECT. Robert Robinson's comment explores the reasons why ECT is seen as somehow different from other forms of treatment for mental disorder and considers whether recent case law on non-consensual psychiatric treatment of detained patients suggests that powers to administer ECT to incapacitated patients under common law may have to be qualified in light of the Human Rights Act 1998.

In our case review section Oliver Lewis reviews the case of *Edwards v United Kingdom (2002)* which came before the European Court of Human Rights early last year following the homicide of Christopher Edwards in prison custody in 1994. The judgment and the tragic circumstances that surround this case are a stark illustration of the way that a State system may fail not only to protect the life of an individual in its care, but also to conduct an adequate investigation into the circumstances surrounding the death of that individual. The case is of interest for clarifying the required standards of the procedural aspects of Article 2 of the Convention regarding a State's positive obligation to investigate such homicides and the role of relatives and other secondary victims in the process.

David Hewitt reviews the important decision of *R (on the application of DR) v Mersey Care NHS Trust (2002)*, which joins an increasing number of cases focusing on the renewal of detention under the MHA 1983. The controversial judgment of the Administartive Court confirms that a patient on s17 leave who is receieving treatment at a hospital, such treatment being a significant component of that patient's treatment plan, is able to have their detention renewed even though there is no intention that the patient is to resume 'in-patient' status.

Robert Robinson reviews the Court of Appeal decision in *R (on the application of the Secretary of State for the Home Department) v Mental Health Review Tribunal and PH (2002)*. In this significant case, the Court considered whether the conditional discharge of a restricted patient by a Tribunal to another institution where liability would be restricted, which could include another hospital, amounted to a discharge for the purposes of s73 of the MHA 1983 or whether it amounted to a hospital transfer, in which case the Tribunal had exceeded its powers in making the order. The judgment in *PH* is of particular relevance for Tribunals dealing with cases of restricted patients where the possibility of conditional discharge arises.

Our final review by Anna Harding considers the Court of Appeal judgment in *R (on the application of B) v Ashworth Hospital (2003)* which overturned the previous Administrative Court decision of Sir Richard Tucker on the construction of section 63 of the MHA 1983 and whether it would be lawful to provide compulsory treatment for a disorder which is different to the classified disorder for which a patient was originally detained for treatment. The review pays particular attention to the leading judgment of Dyson J which clarifies that the requirements that Part IV of the MHA must be interpreted by looking at the whole of the Act and that therefore Part IV is only concerned with mental disorders that are treatable and which justify detention for their treatment.

As ever, we are grateful to all the authors for their useful contributions to this issue of the Journal.

Charlotte Emmett

Editor

Capacity-based mental health legislation and its impact on clinical practice: 1) admission to hospital.

*John Bellhouse**
*Anthony J. Holland***
*Isabel C.H. Clare****
*Michael Gunn*****
*Peter Watson******

INTRODUCTION

In "On Liberty", John Stuart Mill wrote

> "*…the only purpose for which power can be exercised over any member of a civilised community against his will is to prevent harm to others…*" J.S. Mill (1859)[1]

Mill's philosophy underlies the established principle within many democratic jurisdictions that medical treatment without consent, which may or may not include admission to hospital, of an adult is a battery actionable within the criminal and civil law[2]. Whilst it has been argued that any treatment without consent is incompatible with liberal principles[3], an approach that always respects a refusal of treatment can also be criticized. In this context the evocative expression "dying

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[1] *Mill, J. S. (1859) On Liberty (2 edn): Parker.*

[2] *Schloendorff v Society of New York Hospital 211 New York Reports 125 (1914); Re T (Adult: refusal of treatment [1992] 4 All England Law Reports 649*

[3] *Szasz, T. (1999) Medical incapacity, legal incompetence and psychiatry. Psychiatric Bulletin, 23, 517–519; Gunn, M. (2000) Reform of the Mental Health Act 1983: the relevance of capacity to make decisions. Journal of Mental Health Law, 3, 39–43.*

with their rights on" has been used to describe the plight of adults with mental illness allowed to exercise their autonomy and refuse treatment with serious adverse consequences[4]. In England and Wales it is the rulings from case law, and in the case of hospital-based treatment for a mental disorder, the *1983 Mental Health Act*, which together provide the framework for resolving such potential dilemmas.

In a UK Government sponsored review of mental health legislation in England and Wales, an Expert Committee chaired by Professor Genevra Richardson recommended that any new legislation should be based on specific ethical principles. These included the principle of non-discrimination whereby the principles stated in case law that determine the basis for treatment of a physical disorder also applied in the case of mental disorder[5]. This principle is that it is for a capable person to decide for him/herself whether to agree to hospital admission or treatment and in the case of a person who was incapacitated, admission and treatment could take place if it was in his/her best interests. If a person had the capacity to consent, then neither admission or treatment without consent could take place except in circumstances in which the nature of the person's mental disorder was such that others were at risk. However, the UK Government has rejected this approach to mental health legislation for England and Wales, although a compromise is proposed for Scotland[6].

The ethical arguments for and against capacity based mental health law have been discussed in detail elsewhere[7]. However, empirical data relating to the feasibility and consequences of such change in the law are not currently available. This absence of data may have been one factor in the UK Government deciding not to adopt the Richardson Committee's proposals, though, at the time of writing the exact form of any proposed Mental Health Act was still not certain. Significant factors appear to have been the political emphasis being placed on public protection rather than the right to, and need for, treatment. There may have been concern that such legislation would have been 'too lenient', and not enabled those people who might harm others to be detained.

In this study, as capacity is 'decision-specific', we have assessed the capacity of men and women to make decisions about admission and treatment separately, using the Law Commission's definition of incapacity[8]. In this paper, we focus on a person's capacity to consent to admission. Surprisingly, the courts in England and Wales have not directly explored the nature of the information relevant to a decision about admission to hospital. Admission without consent constitutes false imprisonment, which is both a civil tort, and a crime[9]. Whilst the lawful admission of those who do not consent has been one area of concern, the recent 'Bournewood'

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[4] *Treffert, D. (1973) Dying with their rights on (letter). American Journal of Psychiatry, 130 (1041).*

[5] *Report of the Expert Committee (1999) Review of the Mental Health Act 1983. London: Department of Health. Paragraph 2.15*

[6] *Reforming the Mental Health Act. Part 1 The New Legal framework, Department of Health, 2000; Adults with Incapacity (Scotland) Act, 2000.*

[7] *Authors arguing for such legislative change include Zigmond, A. & Holland, A. J. (2000) Unethical mental health law; history repeats itself. Journal of Mental Health Law, 3, 49–56 and Szmukler, G. & Holloway, F. (1998) Mental health legislation is now a harmful anachronism. Psychiatric Bulletin, 22, 662–665. Authors arguing against include Robinson, R. (2000) Capacity as the gateway: an alternative view. Journal of Mental Health Law, 3, 44–48 and Szasz, T. (1999) Medical incapacity, legal incompetence and psychiatry. Psychiatric Bulletin, 23, 517–519.*

[8] *The Law Commission (1995) Mental Incapacity (Law Commission No 231). London: The Stationery Office.*

[9] *For recent authorities see Collins v Wilcock [1984] 3 All England Law Reports 374 and R v Rahman (1985) 81 Criminal Appeal Reports 349)*

case involving Mr L highlighted a different concern[10]. This was the absence of a legal framework safeguarding the rights of those apparently assenting to admission but, owing to the nature of their mental disability, not having the capacity to make that decision for him/herself. When Mr L's case was considered by the Court, his incapacity was taken as given, and what he needed to understand in order to give consent was not explored. The Appellate Committee of the House of Lords subsequently overturned the initial judgement that patients in L's situation ought to be formally detained using mental health legislation so that their statutory rights can be protected. Nevertheless, one of the members, Lord Steyn, thought that there was an argument that persons such as L should be detained if they required treatment of a mental disorder. As he pointed out: "Given that [compliant incapacitated] patients are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of *The Mental Health Act 1983* from a large class of vulnerable mentally incapacitated individuals…The only comfort is that counsel for the Secretary of State has assured the House that reform of the law is under active consideration" (p. 306, *R v Bournewood* op.cit.).

Though there have been many discussions of the difficulties raised by the 'Bournewood' case[11], a solution has yet to be found. Recently, the Government suggested that the safeguards currently offered by the Mental Health Act Commission to men and women who are detained should be extended to those like Mr L[12]. However, no legal source in England and Wales has examined what is meant by capacity to consent to admission despite the estimate that a further 22,000 detentions a year might occur if compliant patients had to be admitted formally[13], The MHA does not demand a consideration of this issue at any point, and it is therefore not specifically addressed in the Mental Health Act Manual[14].

In contrast, in the U.S.A., the Courts have considered the issues relating to consent to admission. In one important case, *Zinermon v Burch*[15], the Supreme Court ruled that voluntary admission entails more than simply the willingness to be admitted, but no guidance was given as to the information and abilities involved in meaningful consent. In the absence of such guidance, others have considered this issue. Hoge (1994), for example, proposed a 'weak' and a 'strong' model[16]. The 'strong' model entails understanding of all the ramifications of admission to a psychiatric facility, including eventualities such as stigma on discharge. However, he rejected this on the grounds that it demands more understanding than is required for other decisions. Instead, consistent with the principle established in English case law[17], he favoured the 'weak' model. In this model, an understanding of information provided in 'broad terms and simple language' is sufficient.

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[10] *R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998] 3 All England Law Reports 289.*

[11] *Dickenson, D. (2001) Decision-making competence in adults: a philosopher's viewpoint. Advances in Psychiatric Treatment 7, 381–388; Dickenson, D. & Shah, A. (1999) Bournewood: an indefensible gap in mental health law: Law Commission's proposals for incapacity jurisdiction strike reasonable balance (letter) British Medical Journal 318, 126–127.*

[12] *Reforming The Mental Health Act, Department of Health, 2000, see Chapter 7.*

[13] *Eastman, N. & Peay, J. (1998). Bournewood: an indefensible gap in mental health law. British Medical Journal 317, 94–95.*

[14] *Jones, R. (2003). Mental Health Act Manual. Eighth Edition. Sweet and Maxwell: London,*

[15] *Zinermon v Burch, 494 United States Reports 113*

[16] *Hoge, S.K. (1994). On being "too crazy" to sign into a mental hospital: The issue of consent to psychiatric hospitalisation. Bulletin of the American Academy of Law and Psychiatry 22, 431–455.*

[17] *Chatterton v Gerson [1981] Queen's Bench 432.*

A similar position was reached by a task force of the American Psychiatric Association[18] and has been proposed by the Law Commission of England and Wales (see 7 above).

Many of the early studies of consent to admission to hospital judged participants against a standard based on the 'strong' model. For example, Olin and Olin[19] interviewed one hundred consecutive in-patients in a single State of the U.S.A. All the participants were in hospital voluntarily, and had signed their State's pre-admission contract for voluntary admissions. *Inter alia*, this contract stated that they needed to give three days' notice of an intention to leave hospital, and that a single doctor might then say that they were not allowed to leave. This was understood by only eight (8%) of the patients. Similar findings were also reported in another American study[20], in which the understanding of legally and clinically significant information by fifty voluntary in-patients admitted 24–48 hours earlier was assessed. Less than a third of the participants appeared to have a satisfactory legal or clinical understanding of the admission process.

Following the APA's report, research based on the 'weak' model was carried out. Poythress *et al*[21] compared the understanding of voluntary and involuntary in-patients of a very simple disclosure. This contained four facts about admission to hospital. Sixty-five of one hundred and twenty participants (54%) were unable to understand and retain the information. However, the study population may have been unusual in that, regardless of their subsequent status, all the participants had initially been admitted for assessment against their will. This suggests that they may all have had severe mental health problems. In a study of 100 voluntarily admitted patients each was assessed using an even lower standard of understanding[22]. The participants were asked to demonstrate they understood that they had been admitted to a psychiatric facility for treatment and that, if they requested release, it might be delayed. The relevant information was given to the participants before testing and their understanding of the disclosures assessed by both asking them to recall the information given and then to recognise as 'true' or 'false' further statements relating to the purpose of admission and discharge arrangements. Following the disclosure, 53 of the 100 participants were able to recall fully both elements of understanding and 82 of the participants were able to identify correctly as 'true' or 'false' the relevant information when presented to them.

At first sight, decisions relating to admission to hospital may seem relatively trivial compared with, for example, decisions about receiving medication. After all, for voluntary patients, admission involves making a decision, which can be reversed almost immediately, about entering a building and staying for a period of time. However, a more detailed examination indicates that admission to hospital has significant consequences. First, in a ward environment, the freedom to make choices (e.g., about when to eat meals or whether to drink alcohol) is inevitably restricted, and there is a loss of privacy. In addition, there is a risk of physical or sexual assault[23]. Secondly, when it comes

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[18] *American Psychiatric Association (1993). Consent to voluntary hospitalization. Task Force Report No 34. American Psychiatric Association: Washington DC.*

[19] *Olin, G. B. & Olin, H. S. (1975). Informed consent in voluntary mental hospital admissions. American Journal of Psychiatry 132, 938–941.*

[20] *Appelbaum, P. S., Mirkin, S. A. & Bateman, A. (1981). Empirical assessment of competency to consent to psychiatric hospitalisation. American Journal of Psychiatry 138, 1170–1176.*

[21] *Poythress, N., Cascardi, M. & Ritterbrand, L. (1996). Capacity to consent to voluntary hospitalisation: searching for a satisfactory Zinermon screen. Bulletin of the American Academy of Psychiatry and the Law 24, 439–452.*

[22] *Appelbaum, B.C. Appelbaum, P. S. & Grisso, T. (1998). Competence to consent to voluntary psychiatric hospitalisation : A test of a standard proposed by APA. Psychiatric Services 49, 1193–1196.*

[23] *Crowner, M., Stepcic, F., Peric, G. & Czobor, P. (1994) Typology of patient-patient assaults detected by video-cameras. American Journal of Psychiatry 151, 1669–1672 and Nilbert, D., Cooper, S. & Crossmaker, M. (1989) Assaults against residents of a psychiatric institution. Journal of Interpersonal Violence 4, 342–349.*

to psychiatric admission, an individual's decision not to remain on the ward cannot always be exercised. Under the current legislation in England and Wales, patients who have been admitted informally can later be detained on the opinion of one, often junior, psychiatrist. In addition, in contrast with hospitalisation for a physical disorder, decisions about psychiatric admission are rarely based simply on diagnosis. More often, in psychiatric practice, a decision to admit reflects concern about the probable degree of risk the person may pose to him/herself or others. Thus, the capacity to make such a decision can only be evaluated in the context of a person's understanding of the potential risks associated with their psychiatric disorder, including self-harm, suicide, and interpersonal violence. The decision-making in relation to admission to hospital is therefore, arguably, as complex and significant as that involved in accepting medical treatment. In addition, coercion can be experienced whether admission is by a compulsory legal process or "voluntary"[24].

The aims of this part of the study were, therefore, to determine the extent to which informal and formal patients were capable of consenting to admission. We hypothesised

a) That the presence of psychotic illness and/or a learning disability would be the best clinical predictors of incapacity.

b) That a significantly greater proportion of those presently detained under the MHA would lack the capacity to consent to admission compared to those who were informal.

c) A proportion of those admitted informally would be found to be lacking in the capacity to consent to their admission.

METHODS

Ethical permission was obtained for the whole study from the Local Research Ethics Committee. The studied aimed to be as naturalistic as possible, mimicking the procedure that would have to be followed if capacity-based mental health legislation was in place. The criteria used for capacity were firmly based on case law and on the guidance listed above. We took the view that, as occurs with the current MHA (for example, judging nature or degree of mental disorder), the determination of capacity required a judgement on the part of the clinician.

Participants

A consecutive series of patients between the ages of 16–65 years newly admitted to hospital in the local mental health and learning disability services were asked to participate in the study within 48 hours of admission (excluding those with eating disorders or primarily substance misuse[25]). Information was obtained from case notes regarding legal status, psychiatric diagnosis (ICD-10 criteria), and medication. Following the first interview, participants were asked if they would be re-interviewed one week after admission.

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[24] *Hoge, S.K., Lidz, C., Mulvey, E., Roth, L., Bennet, N., Siminoff, L., Arnold, R. & Monahan, J. (1993) Patient, family, and staff perceptions of coercion in mental hospital admission: an exploratory study. Behavioural Science and the Law 11, 281–293.*

[25] *The former owing to their inclusion in another study which was to occur locally of capacity to consent in eating disorders and the latter owing to their specific exclusion form the 1983 MHA.*

Assessment of capacity to make a decision about admission to hospital

Relevant information

Since there is no clear legal precedent in England and Wales, a mental health lawyer (MG) identified the information relevant to decision-making about hospital admission from case law relating to treatment decisions, and from the existing literature. Law relating to treatment decisions seemed most closely analogous and admission can be considered as the provision of nursing care in a specific place. Initially, five elements were identified. However, following a pilot study, the list was amended as it became clear that discussion of the 'purpose of admission' could only occur once the nature of and behavioural consequences of the illness had been explicitly discussed. The final seven elements comprised: (i) perception of illness requiring admission (ii) perception of the behavioural consequences of illness (iii) the nature of admission – practical (iv) the nature of admission – legal (v) the purpose of admission (vi) risks of admission and (vii) risks of non-admission.

Establishing criteria for assessing responses

A scheme for assessing participants' responses was devised, based on existing case law related to capacity to consent to treatment and the work of the Law Commission and modified so that it was applicable to decisions about admission. The thresholds were reviewed by one of the authors, a mental health lawyer (MG). These are set out element by element in Figure 1.

Improving capacity

An information sheet written in 'broad terms and simple language' and meeting all the legal requirements for relevant information relating to a decision about admission was prepared, and given to each person after the initial stage of capacity assessment.

Statistical analysis

The Statistical Package for the Social Sciences Version 9.0 (SPSS–Inc, 1999) was used for data analysis. The association between dichotomous variables was examined by calculation of odds ratios and their 95% confidence intervals, presented below as (Odds Ratio….. 95% CI…..). Correlation between dichotomous variables was examined by calculation of the Kappa correlation coefficient. The binomial distribution was used to compare proportions. In all tests significance was assumed where the p value was equal to, or less than, 0.05.

RESULTS

Participant characteristics

Sixty-seven patients newly admitted to inpatient services because of psychiatric problems were approached and asked to participate. Forty-nine individuals (73%) agreed to take part and all completed the assessment of capacity to consent to admission. The sample comprised 28 men and 21 women with a median age of 36 years of whom 43 were recruited from general psychiatric services and six from inpatient services for people with a learning disability. Of these, twenty-two

Element	Understanding required
Perception of illness requiring admission	That there was a problem internal to the participant not simply due to external factors or physical illness even if these had played a role in causation.
Perception of behavioural consequences of illness	That there was a risk of serious adverse consequences for the participant's health, safety, social network or other people of the disorder above.
Nature of admission – Practical	That admission was different to being at home with respect to the freedom to do as the individual chooses and it involves sharing a space and living with others.
Nature of admission – Legal	Informal participants – Understanding that admission was voluntary. Detained participants – Understanding that the admission was involuntary due to a legal process and therefore was different from the normal circumstances.
Purpose of admission	The potential of admission to alleviate the illness or to reduce the risk of the behavioural consequences of the illness.
Risks of admission	That admission constrains the participant's freedom and involves sharing a space with others.
Risks of non-admission	To understand the risk of occurrence of the behavioural consequences of the illness.

Figure 1 – Level of understanding of each element required for participant's response to be judged 'satisfactory'

had the following psychotic illnesses: schizophrenia (10), drug induced psychosis (1), unclassified psychosis (5), mania (2), psychotic depression (2), prominent hallucinations in the context of alcohol withdrawal (2).

Ten (20%) people were admitted using the provisions of the *Mental Health Act 1983*. This figure is comparable to the proportion normally admitted compulsorily to the in-patient mental health or learning disability services in Cambridge Health District. The mean delay between admission and interview was forty-four hours. Examination of the case notes indicated that the participants did not differ significantly from those who did not take part with respect to age, gender and diagnosis.

Inter-rater agreement

The reliability of the judgements of capacity to consent to admission made by the interviewer (JB) was assessed using transcripts of the interviews with ten (20%) of the participants. An experienced psychiatrist (AJH) independently rated these transcripts.

Agreement with respect to understanding in individual elements

Kappa correlations were calculated separately for agreement between the raters for each element relevant to an admission decision. The level of agreement between the raters was statistically significant ($p<0.05$) for six of the seven elements. For understanding of the risks of admission, there was a negative correlation due to the raters having different views about rating people who perceived no risks to admission.

Agreement with respect to overall capacity

The level of agreement about overall capacity was satisfactory ($k=0.737$, $p=0.16$). There was only one disagreement where raters disagreed over understanding of the purpose of admission and hence overall capacity.

Capacity to consent to admission

Overall, thirty-three (67%) of the participants were judged to have the capacity to consent to their admission.

The group judged to have capacity

On average, at least six of the possible seven elements were understood by this group (mean: 6.5; range: 3–7). Twenty of the 33 (60%) men and women responded satisfactorily in all seven elements. Thirteen of the 17 (76%) sub-categories which the capable participants were judged not to have answered satisfactorily related to understanding the nature of admission in practical and legal terms.

The group judged not to have capacity

Sixteen people were judged unable to consent to admission. Nevertheless, everyone could understand at least one element of information related to his or her admission. The average number of elements in which those judged to lack capacity overall demonstrated adequate performance was less than four (mean: 3.88; range: 1–5).

Relationship between overall judgements of capacity and adequacy of response to each element

Using logistic regression analysis, it was found that a judgement of incapacity was associated with an unsatisfactory response to the element 'perception of risks posed by illness' (χ^2 (1df) = 12.89, $p<0.001$), and an unsatisfactory understanding of 'the purpose of admission' (χ^2 (1df) = 10.09, $p<0.01$). Once these elements had been considered, no other significant relationships were found.

The use of these two elements alone predicted correctly the independent clinical judgements of 47 (95.9%) of the 49 participants. On its own, 'perception of risk' predicted 45 (91.8%), whilst 'understanding of purpose of admission' alone allowed the correct prediction of 41 (83.67%) judgements.

Association between capacity to consent to admission and legal status

Thirty-one of the 39 informal patients (79%; 95% CI: 66–92%), and two of the detained patients (20%; 95% CI: 0–44.9%) were judged to have capacity to consent to admission. A clinical judgement that the person had capacity was therefore significantly more likely when he or she had been admitted informally (Ratio of odds of capacity (informal/formal) = 15.5; 95% CI: 2.74–87.74).

Association between capacity to consent to admission and diagnosis

There was a significant relationship between having a psychotic illness and incapacity to consent to admission. Fourteen of the sixteen persons unable to consent had such a diagnosis (Ratio of odds of incapacity (psychotic/non-psychotic) = 21.73; 95% CI: 4.07–111.11). In contrast, all twelve participants with a diagnosis of non-psychotic depression were able to consent to admission.

Relationship between capacity to consent to admission and in-patient service

Although only two of the six receiving care in the in-patient service for people with mild learning disabilities were judged to have the capacity to consent to admission, there was no significant association between admission to this service and the ability to make this decision (Ratio of odds of incapacity (learning disability services/general adult services) = 5.15; 95% CI: 0.83–32.26). The lack of statistical significance reflects the relatively small number of admissions to this service over the time of the study.

Effect of information on understanding of admission decisions

The effect of the information sheet was categorised using a three-point scale: 'no effect', 'some effect' or a 'significant effect'. This last category referred to a change in a particular response from unsatisfactory to satisfactory. Whilst there were no participants for whom the overall judgment of capacity changed following the presentation of the information, Figure 2 shows that it had a considerable impact on several of the individual elements. It appears that the information is of most value where it relates to admission generally, for instance the legal aspects of admission, rather than a person's individual circumstances such as their personal risk of suicide or self-neglect.

Follow-up interviews

Eighteen (36%) of the participants were re-interviewed one week after their initial interview. Not surprisingly, perhaps, all the twelve patients who were judged at the first interview to have the capacity to consent to admission remained able to make this decision. There was a change in only one of the six patients without initial overall capacity; at follow up he was judged to have capacity as there was a marked improvement in his understanding of the purpose of admission.

Element	No effect	Some effect	Significant effect
Illness	46	3	0
Behavioural consequences of illness	48	1	0
Nature of admission – practical	46	3	0
Nature of admission – legal	43	2	4
Purpose of admission	47	2	0
Risks of admission	47	2	0
Risks of non-admission	48	0	1

Figure 2 – Effect of information about admission decisions on the participants' (N=49) responses

Understanding of information about the admission

To identify which elements of the relevant information appeared most complex, we have reported the numbers whose performance was judged unsatisfactory in each element, giving examples of their responses to questions used to elicit information.

Perception of illness needing admission

The responses of seven participants were judged unsatisfactory on this element. All were diagnosed as having a psychotic illness, (Ratio of odds of unsatisfactory performance in this category (psychotic/non-psychotic) = 1.467; 95% CI: 1.10–1.95), and all were considered lacking capacity to consent to admission overall (Ratio of odds of incapacity (unsatisfactory performance in this element/satisfactory) = 1.77; 95% CI: 1.15–2.73). Three participants were judged unsatisfactory due to an external attribution of problems leading to admission, e.g., "My dad stole my crisps and then I went out…now I'm here". Two responses were judged to be delusional e.g. "The man upstairs has been spraying white powder all over my flat…every time I turn my back….it's made me right ill". Two responses were considered unsatisfactory on the grounds of being unclassifiable, e.g. "It's all to do with cognitive maps, Rubik's cubes and space and time".

Perception of behavioural consequences of the illness

Sixteen people (32%), including all seven who had performed unsatisfactorily on the previous element, did not consider that there was any risk associated with their disorder. An unsatisfactory rating on this element was associated with a high risk of overall incapacity (Ratio of odds of incapacity (unsatisfactory performance on this element/satisfactory) = 108.5; 95% CI: 13.84–856.5), with 14 of the 16 participants lacking capacity overall. Two participants, rated as unsatisfactory on this element, were judged to have overall capacity to consent. Neither was rated as unsatisfactory in any other element. Being a detained patient was highly associated with an unsatisfactory response in this category (Ratio of odds of unsatisfactory performance in this element (detained/Non-detained) = 7.78;95% CI: 1.67–36.43). Seven participants were judged unsatisfactory as risks were anticipated, but not linked to illness, e.g. [In response to a delusion] "I've just got to go out and kill that bastard, he's ruined my life." Four participants were unable to anticipate any consequences at all of their disorder, and two perceived trivial consequences of their disorder, e.g. a female admitted dehydrated with psychotic depression who described the risks as "I was having trouble talking to people.". Two were unable to consistently appraise the risks e.g., "I get suicidal thoughts…I don't pose a danger…I stopped eating….I was probably going to start again." One participant, suffering from mania, was able to see the consequences but did not believe them.

Understanding of nature of admission (practical)

Ten people failed to give satisfactory responses when questioned about this element of decision-making about admission to hospital. Having no prior experience of psychiatric admission was not a risk factor for unsatisfactory performance on this element. Only two of the naïve participants demonstrated unsatisfactory performance (Ratio of odds of unsatisfactory performance (no previous experience/previous experience) = 0.64; 95% CI: 0.12–3.48). Nine participants were judged unsatisfactory with respect to this element due to provision of unsatisfactory or irrelevant information e.g. "They've got a toaster, you know", or, as in one case, because the person asserted that there was no difference between hospital and his home.

Understanding of nature of admission (legal)

The performance of twelve participants was judged as unsatisfactory with respect to this element of understanding. Eleven of these were informal patients, all of whose responses were judged unsatisfactory due to their lack of appreciation of the possibility of leaving the hospital if they wished to. The detained patient who responded unsatisfactorily in this element was aware of the fact that he was not able to leave, but saw this simply as a perverse decision of the nurses caring for him.

Nine participants (2 detained; 7 informal) displayed a higher level of legal understanding, for instance detailed knowledge of the workings of the *Mental Health Act*. There was no association between this higher level of understanding and the number of previous admissions or detentions.

Understanding of the purpose of admission

Eight participants did not satisfactorily understand the purpose of admission, three of these being detained patients. All eight people unable to understand the purpose of their admission were in the group eventually found to lack capacity to consent to admission. This is a significant relationship (Ratio of odds of overall incapacity (unsatisfactory performance in this element/satisfactory) = 5.13; 95% CI: 2.75–9.54). The three people demonstrating an unsatisfactory perception of illness but able to understand the purpose of their admission perceived that they had gone to hospital for a therapeutic reason, to remove them from an externally perceived problem, or from a delusional problem.

Understanding of risks of admission

Only six participants were not able to describe the risks of admission satisfactorily. Five of the six participants judged as giving an unsatisfactory response on this element were found to lack capacity overall (Ratio of odds of overall incapacity (unsatisfactory performance on this element/satisfactory) = 14.55; 95% CI: 1.53–138.51). All six judged as performing unsatisfactorily were informal patients, this association being statistically significant (Ratio of odds of overall incapacity (informal/detained) = 1.30; 95% CI: 1.10–1.57).

The usual reason for being judged as giving an unsatisfactory response was the assertion that hospital was good or enjoyable. Clearly one's overall impression may well be that hospital is enjoyable, but there are always drawbacks, such as lack of control over meal times. It was felt important that people acknowledged, however minimally, these problems, even if they overall rated the experience as neutral or enjoyable. This was the major source of disagreement between the raters.

Understanding of risks of non-admission

Nine participants were judged as not satisfactorily understanding the risks of their non-admission to hospital. Eight of these were eventually judged to lack overall capacity, a significantly relationship (Ratio of odds of overall incapacity (unsatisfactory performance in this element/ satisfactory) = 32.00; 95% CI: 3.48–294.20). Six of the nine lacking capacity for this element were detained. This was a significant excess (Ratio of odds of unsatisfactory performance in this element (detained/non-detained) = 18; 95% CI: 3.20–101.38). Seven were simply unable to perceive the consequences of their illness and thus not able to comment upon what might happen if they were not admitted, and two participants with diagnoses of depression simply made "don't know" replies. Though able to perceive their suicide risk, they answered "I just don't know" when questioned on possible events if they had not been admitted.

DISCUSSION

In this study a method for assessing the capacity of a person to consent to admission to hospital has been developed, and it has been shown that two raters can agree broadly on capacity judgements. The relationship of decision-making capacity to current legal criteria for detention has been investigated. Whilst English courts have not yet considered this matter, by extrapolating from legal sources dealing with capacity to consent to treatment, and taking fully into account the law relating to false imprisonment, it was possible to devise elements of relevant knowledge.

In the pilot study it was clear that a determination of the person's perception of his/her illness was a necessary first step in the assessment process. As with assessment of capacity to consent to treatment, this makes explicit that which has been implied in previous case law and it clearly represents information relevant to the decision in hand. Acknowledging that there is at least the possibility that one is 'ill' is a necessary pre-condition of recognising the need for admission and/or treatment. However, in the assessment of admission decisions, a further element of information was added, that of 'perception of risks posed by the illness'. The justification for this requires consideration of the purpose of hospital admission. In the case of psychiatric disorders, admission is not fundamentally to treat the illness in itself, but to prevent the potential adverse behavioural consequences of a mental disorder during recovery, whether spontaneously or in response to treatment. Admission may have a therapeutic role of itself, for instance, by removing a person from a home situation that has perhaps precipitated an episode of illness. However, in the absence of potential risks, medication and other specific interventions are the effective treatment, not hospital admission. For example, a person suffering from depression can make a decision whether or not to have antidepressant treatment based on his/her understanding that he/she has depression. However, the understanding that one has depression does not, of itself, explain why in-patient treatment, as opposed to out-patient treatment, is necessary. This distinction is in terms of the potential suicide risk, damage to relationships and social networks, and/or the need for satisfactory nutrition and hydration whilst ill.

Seven participants did not satisfactorily perceive that they might be ill. All of these suffered from a psychotic illness and all were judged as unable to consent or withhold consent to admission. However, sixteen people in total lacked capacity and were unable to satisfactorily understand the risks posed by their illness. There were also nine people who understood that they were ill, but not the problems and risks that their disorder posed to them or others. Fourteen of the sixteen unable to understand the risks posed by their illness were found to lack capacity overall.

The decision to use this element of ‘risks posed by illness’, not explicit in previous case law, might be criticised on the grounds that it turns a capacity assessment into a risk assessment. This is not the case. The participant was judged on his/her understanding of the risks posed by his/her illness, not by the magnitude of the risks. The functional approach demands that people make decisions in full possession of the facts. It does not demand that these decisions always ensure a good outcome.

Two people in the study were detained on the grounds of risk, and actually understood the risks, one believing that the risks he posed to others were justified by their behaviour towards him and that, in any case, he would prefer to be arrested than sectioned as arrest is more “manly” and less patronising. The other could see the risks posed by his manic behaviour to his business credibility, but felt that the loss of his business was preferable to compulsory admission and treatment. It might be argued that though these participants were acting in possession of all the facts, they still made decisions they would not have made when well. The proposal (Report of the Expert Committee, 1999) that capacity might be extended to include judging people incapable when they make decisions they would not make when well was made by the Richardson Committee. It has great face validity and is certainly a tempting option when people apparently in possession of the facts still seem set to act unwisely. The difficulty is that it allows any decision made by a person with a mental illness to be overridden by the treating clinician by invoking this formulation of incapacity. It is impossible for the patient to refute it on objective grounds. We did not use it in this study as it would be possible to categorise any dissenting or unwise decision made by a mentally ill person as incapable, and although the doctor could not prove the link, neither could the patient disprove it, and the doctor’s opinion would trump that of a patient.

When the results of this part of the study are considered together with the ‘treatment’ study[26] there are a proportion of people unable to make decisions regarding admission, but able to consent to treatment. Thus, there is a group who could be detained compulsorily but not made to have

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[26] *Bellhouse, J.E., Holland, A.J., Clare, I.C.H. et al Capacity-based mental health legislation and its impact on clinical practice: 2) treatment, J. Mental Health Law (2003) page 24.*

treatment unless they were willing to consent. The reason this difference exists is that treatment decisions are conceptually much simpler than admission decisions. Admission decisions are more likely to represent a life and death decision, and as such, more stringency is needed in assessing capacity/incapacity.

The proposal that people with mental disorder ought to receive compulsory treatment only when they are unable to make the decision for themselves has a strong ethical appeal. On what other basis should an adult's decision be overridden? This principle is considered adequate for the physically ill. However neat the ethical arguments appear on paper, such a proposal should remain theoretical and not be implemented until the feasibility of the proposals and their consequences are known. A sound ethical basis is necessary, but not sufficient, for ethically sound law. Such an approach could not be considered truly ethical if many more suicides and homicides resulted, or it proved unworkable. In the treatment paper we discuss the feasibility of assessing capacity to treatment of people newly admitted. Taking admission and treatment together we are in a position to say something about the likely consequences of such legislative change. The main points are as follows:

1. Although there is considerable overlap, capacity-based mental health legislation, as described in the Introduction, would not result in exactly the same people being liable to be detained as under the current MHA.
2. A small proportion of people who are currently detainable may not be if this proposal were adopted. Two of ten detained people in the study were capable of consenting to admission. One of these would still be detainable if risk to others was considered sufficient grounds for overriding a competent adult. Whether competent adults who pose a risk to others should be dealt with using mental health law or criminal law is a debatable point[27].
3. Admission and treatment are currently considered together. If they were to be considered separately, as a functional approach to capacity demands, then the problem of a person who can be detained in hospital but not treated would need to be addressed. This is an issue in parts of the USA where admission occurs using risk based "commitment criteria" but involuntary treatment is a competency issue.
4. Psychotic illness is a significant risk factor for incapacity and as such the capacity of this group to make significant decisions should be considered closely.
5. There are a number of people in hospital informally who lack the capacity to consent to their admission, and fall into the "Bournewood gap". This needs consideration if assenting incapable people are to have their rights protected.

The Government's plans for a new MHA (at least those set out in the White Paper) do not include making capacity assessment part of the criteria for the use of compulsion. This represents a missed opportunity but the future will present other opportunities for this argument to be aired and for this to be rectified. Presented here are data that support the contention that, as well as a strong ethical argument in support of such change, there is also no reason to think that such change might be unworkable or have disastrous consequences. Furthermore, capacity can be assessed with a reasonable level of agreement, thus enabling consistent clinical practice. Future debate on the ethical and policy aspects of mental health law should, where possible, be informed by empirical study.

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[27] *Szmukler, G. & Holloway, F. (1998). Mental health legislation is now a harmful anachronism. Psychiatric Bulletin 22, 662–665.*

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Capacity-based mental health legislation and its impact on clinical practice: 2) treatment in hospital

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INTRODUCTION

In this paper, the second of two, we consider the capacity of those assessed with respect to their ability to consent to admission to also consent to their treatment with medication. The results of our assessment of capacity to consent to admission are described in our first paper along with the policy background to the study[1]. In comparison to admission decisions, for treatment decisions there is an extensive body of literature and case law that provides guidance on the key principles. In English law (i.e. the law in England and Wales) the wishes of a competent adult offered treatment for a physical disorder must be respected[2]. However, with treatment for a mental disorder the decision of a competent person to withhold consent can still be lawfully overridden using mental health legislation if the health or safety of the person concerned is at risk, or if it is necessary for

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[1] *Bellhouse, J., Holland, A.J., Clare, I.C.H., Gunn, M. & Watson, P. (2003) Capacity based mental health legislation and its impact on clincal practice:1) admission to hospital. Journal of Mental Health Law (2003) page 9.*

[2] *Re C (Adult: Refusal of medical treatment) [1994] 1 All England Law Reports 819; Re T (Adult: Refusal of treatment) [1992] 4 All England Law Reports 649; For discussion see Gunn, M. (1994) The meaning of incapacity. Medical Law Review 2, 8–29.*

the protection of others. At present for those detained under the *Mental Health Act 1983* capacity has only to be considered in two situations. First, when psychosurgery or the surgical implantation of hormones to reduce male sexual drive is proposed (section 57 of the MHA), and secondly, when treatment for a physical disorder is required. However, treatment for a mental disorder has been increasingly widely defined, for example, to include forced feeding[3].

The presumed inevitability of a person's incapacity to consent to treatment when he/she has a mental disorder has been challenged both within the courts[4], and also in empirical studies, in particular the MacArthur Treatment Competence Study[5]. In this large, multi-centred study, decision making ability with respect to treatment was assessed in over 400 men and women newly admitted to hospital with diagnoses of schizophrenia or depression. Most importantly, a group with physical illnesses and a group without any disorder were included for comparison. The study showed that, although decisional abilities were compromised in many individuals with a mental illness, more than half of those who participated performed at a level similar to that of their counterparts with physical health problems, or no health problems at all. Deficits in decisional ability were more frequent in the group with schizophrenia than in the group with depression. The conclusion that a blanket assumption of incompetence among those with mental ill health was not sustainable has been supported by the findings of other investigators[6]. A 'status' approach to the assessment of decision-making ability has therefore been discredited, and a 'functional' model focusing on a person's ability to make a particular decision at a specific point in time, is now accepted[7].

In England and Wales the Expert Committee proposed using a definition of incapacity based on the recommendations of the Law Commission for England and Wales[8], that is, a person is without capacity if at the material time he or she is:

(1) Unable by reason of mental disability to make a decision on the matter in question. That is, if the disability is such that, at the time the decision needs to be made, he or she is unable to:

Understand relevant information

Retain this information

Make a decision based on the information given

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[3] *B v Croydon District HA [1994] 22 Butterworth's Medical Law Reports 13*

[4] *Rogers v Commissioner of Mental Health 390 Massachusetts Reports 489 (1983).*

[5] *MacArthur study – Appelbaum, P. S. & Grisso, T. (1995). The MacArthur Treatment Competence Study. I Mental illness and competence to consent to treatment. Law and Human Behavior 19, 105–126; Appelbaum, P. S., Grisso, T., Mulvey, E. & Fletcher, K. (1995). The MacArthur treatment competence study. II Measure of abilities related to competence to consent to treatment. Law and Human Behavior 19, 127–148; Grisso, T. & Appelbaum, P. S. (1995). The MacArthur Treatment Competence Study. III Abilities of patients to consent to psychiatric and medical treatments. Law and Human Behavior 19, 149–173.*

[6] *For example Grossman, L. & Summers, F. (1980). A study of the capacity of schizophrenic patients to give informed consent. Hospital and Community Psychiatry 31, 205–206; Kitamura, F., Tomoda, A. Tsukada, K. Tanaka, M. Kawakami, I. Mishima, S. & Kitamura, T. (1998). Method for assessment of competency to consent in the mentally ill:rationale, development and comparison with the medically ill. International Journal of Law and Psychiatry 21, 223–244; Wong, J. G., Clare, I. C. H., Watson, P., Gunn, M. & Holland, A.J. (2000). The capacity of people with a "mental disability" to make a health care decision. Psychological Medicine 30, 295–306.*

[7] *Wong, J., Clare, I.C.H., Gunn, M.J. & Holland, A.J. (1999) Capacity to make health care decisions: its importance in clinical practice. Psychological Medicine 29, 437–446.*

[8] *The Law Commission (1995) Mental Incapacity (Law Commission No 231). London: The Stationery Office. paras 3.14, 3.17.*

(2) Unable to communicate a choice on that matter because he or she is unconscious or for any other reason.

This definition was formulated for forthcoming legislation concerning proxy decision-making for mentally incapacitated adults. It represents a synthesis of previous case law and academic work[9] and is intended to be relevant to many types of decision-making, not simply to decisions relating to healthcare. The abilities and information necessary to make a legally valid decision about treatment have been examined in several English court cases and guidance is also provided in the *Mental Health Act* Code of Practice[10]. These sources indicate that, in English law, specific abilities and information are considered relevant to treatment decisions. The Law Commission's definition of capacity differs in some respects from definitions adopted in case law in England and in other jurisdictions. It does not explicitly demand 'appreciation', that is, the ability to believe that the information applies to oneself. This was part of the test proposed in *Re C* and was part of the assessment process in the MacArthur Study. In fact, its introduction to the proposed legislation was considered and was deliberately avoided because of problems inherent in the concept[11]. Instead the Law Commission proposed that "a decision based on a compulsion, the overpowering will of a third party or any other inability to act on relevant information as a result of mental disability is not a decision made by a person with decision-making capacity."[12]. The belief in relevant information is not assessed or weighed, but a strong lack of belief, or disbelief, of relevant information may make the decision invalid.

In the leading case, *Re C*[13], the decision making process was considered to consist of "weighing information in the balance, balancing risks and needs, so as to arrive at a choice". Similarly, in the MacArthur study[14] the decision making process was assessed under the heading "thinking rationally about treatment". In the case of *Re MB*[15], the judge said "a competent woman may for religious reasons, other reasons, irrational reasons or for no reason at all choose not to have medical intervention". The difficulties of separating capacity from rationality have also been recognized[16]. English law does acknowledge that in certain situations people are unable to use information to arrive at a decision, for example in *Re W*[17] concerning a young person with anorexia nervosa refusing food. Whilst care should be taken in applying cases concerning those less than 18 years of age to adults, part of this case is relevant as it was said that anorexia nervosa "creates a compulsion to refuse treatment or only to accept treatment that was likely to be ineffective". Essentially, the decision to refuse is incompetent because he/she cannot *but* refuse it. Under these

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[9] *Lord Chancellor's Department (1999). Making Decisions. The Government's Proposals for Making Decisions on Behalf of Mentally Incapacitated Adults: A Report Issued in the Light of Responses to the Consultation Paper "Who Decides?" (Cm 4465) The Stationery Office: London.*

[10] *See Re C (Adult: Refusal of medical treatment [1994] 1 All England Law Reports, 819; Re T (adult: refusal of treatment) [1992] 4 All England Law Reports, 649 and Jones, R. (2003). Mental Health Act Manual. Eighth Edition. Sweet and Maxwell: London.*

[11] *Slobogin, C. (1996). "Appreciation" as a measure of competency: some thoughts about the MacArthur group's approach. Psychology, Public Policy and the Law 2, 18–30; Roth, L. H., Appelbaum, P.S., Sallee, M., Reynolds III, C.F. & Huber, G. (1982). The dilemma of denial in the assessment of competency to refuse treatment. American Journal of Psychiatry 139, 910–913.*

[12] *See note 8 at paragraph 3.17.*

[13] *See note 10 – Re C.*

[14] *See note 5*

[15] *Re MB (An Adult: Medical treatment) (1997) 38 Butterworths Medical Law Reports 175.*

[16] *Pomerantz, A. & de Nesnera, A. (1991). Informed consent, competency and the illusion of rationality. General Hospital Psychiatry 13, 138–142.*

[17] *Re W (A Minor)(Medical Treatment) [1992] 4 All England Reports 627.*

circumstances there is no decision-making process. Similar reasoning was applied in the case of *Re MB*, where the judge quoted from an earlier case saying "one object may so force itself upon the attention of the invalid as to shut out all others that may require attention"[18]. Thus, the decision-making process is presumed intact unless it is clear that the mental disorder precludes the ability to "weigh up" the information to reach a decision.

In English law if, because of the presence of a mental disorder, capacity is in doubt, the person has to be shown to understand the following information, if he/she is to be considered to have capacity (see Jones[19]): (i) The nature of treatment (ii) the purpose of treatment (iii) the risks of treatment and (iv) the risks of non-treatment. The level of information demanded is in "broad terms and simple language", a standard adopted from the case *Chatterton v Gerson*[20] and later adopted by the Law Commission[21].

Given the ethical considerations stated by the Expert Committee, and the central importance of decision-making capacity in case law in the treatment of physical disorder, it is surprising that capacity-based mental health legislation has been rejected[22], and nor is it in the legislation of other countries[23]. This may, in part, reflect concerns as to whether 'capacity' can be reliably assessed in persons with mental disorders, and whether it will enable the detention of those people with mental disorders in need of treatment. This study specifically set out to investigate, in as naturalistic a way as possible: a) the capacity of people to consent to both admission[24] and treatment for a mental disorder; b) the reliability of the capacity assessments undertaken; and c) the relationship between capacity to consent to treatment, diagnosis, and present legal status.

Similar hypotheses obtained in this part of the study as in the capacity to consent to admission part of the study. In addition, we were able to examine the extent to which there was a correlation between the two separate decisions (admission and treatment).

METHODS

The purpose of the semi-structured interview developed for the study (see below) was to maximize the reliability of that judgment, and ensure its validity by basing it on the legal definition of capacity and on the legal guidance of what was required to be known in order to be capable.

Participants

The same consecutive series of patients between the ages of 16–65 years newly admitted to hospital in the local mental health and learning disability services were asked to participate in this part of the study.

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[18] *See note 15*

[19] *See note 10*

[20] *Chatterton v Gerson [1981] Law Reports: Queen's Bench 432.*

[21] *See note 8 at paragraph 3.18*

[22] *At the time of writing the proposed shape of the new Mental Health Act is not clear. However, if the White Paper (see www.doh.gov.uk/mentalhealth/whitepaper2000.htm) is a guide to intent, it seems likely that the principles of the Richardson committee will not be central.*

[23] *Appelbaum, P.S. (1997) Almost a revolution. An international perspective on the law of involuntary commitment. Journal of the American Academy of Psychiatry and the Law 25, 135–147.*

[24] *See note 1*

Developing the capacity assessment interview

A semi-structured interview, based on the four elements considered legally important for capacity, (the nature and purpose of treatment, and the risks of treatment, and of not receiving treatment) was developed for the study. The semi-structured interview was designed to explore the person's understanding of the relevant information, his/her ability to retain that information, and to make and communicate a decision based on the information about each of these four elements, and also understanding overall. Following a pilot study a question about the participant's 'perception of his/her illness' was added to the interview schedule as part of the exploration of the person's understanding of the 'purpose of treatment'. Also the section concerned with 'understanding the nature of drug treatment' divided naturally into two parts, one part related to understanding the legal issues pertaining to taking medication and the other, the practical aspects.

Final interview schedule

The interview was therefore revised to assess the person's ability, as described above, with respect to the following six elements of information relevant to treatment decisions:

1. The illness necessitating pharmacological treatment
2. The nature of the proposed treatment in practical terms
3. The nature of the treatment in legal terms
4. The purpose of treatment
5. The risks of treatment
6. The risks of non-treatment.

The semi-structured interview was administered by one of the authors (JB), an experienced psychiatrist. Initially a single prompt was used to elicit general understanding of treatment, and then further prompts used to assess understanding within each of the elements. After this first assessment, information sheets providing all the relevant knowledge were read to the participants and the same questions repeated to determine whether capacity had been improved.

Criteria for, and determination of, capacity

Guidance from common law was used to establish criteria for judging the adequacy of responses provided by participants. These were reviewed by one of the authors (MG – a mental health lawyer). These are set out element by element in Figure 1.

The different elements did not explicitly carry different weights, and the final decision as to whether the person should be considered to have overall capacity was a judgment based on all the available information. Some participants were considered capable overall despite unsatisfactory performance in one or more elements. For the purpose of analysis, judgments about final capacity and performance on individual elements were based upon the highest level of understanding whether that was before or after the use of the information sheet. Once the best level of performance had been graded, the level of performance prior to and following the disclosure of relevant information was assessed in order to examine the contribution of the information sheet

Figure 1 – Criteria for judging responses of each element relevant to a treatment decision

The following indicated a satisfactory understanding within each element

Element	Understanding required
Perception of illness requiring treatment	That there was a problem internal to the participant not simply due to external factors or physical illness even if these had played a role in causation. That this problem would be appropriately treated with medication.
Nature of drug treatment - Practical	The physical aspects of that medication e.g. for a tablet, that it was a tablet to be swallowed.
Nature of drug treatment – Legal	Informal participants – Understanding that the drug treatment was voluntary Detained participants – Understanding that treatment might be legally forced upon them
Purpose of treatment	The potential of treatment to alleviate the disorder or significant symptoms due to the disorder.
Risks of treatment	The potential of the treatment to cause side effects. Specific side effects did not need to be known unless they were serious or very likely to occur.
Risks of non-treatment	To understand the risk of not getting better, getting better at a slower rate or deteriorating without treatment

to that participant's understanding. The contribution of the disclosure was graded on a simple scale (see Results).

Statistical analysis

Described in the first of the papers (See note 1).

RESULTS

Participant characteristics

During the course of the study, 67 people newly admitted to acute psychiatric and learning disability in-patient services were approached. Forty-nine agreed to be interviewed. There were no significant differences between this group and those who did not participate with respect to gender, diagnosis, legal status, or place of admission. Three left the interview after completing a related study[25]. Of the remaining 46, three were being observed in a medication-free state, and two were not receiving medication for treatment. Therefore, forty-one participants (61%) completed an assessment of their capacity to consent to treatment with medication. Sixteen agreed to be re-interviewed one week later. The mean interval between admission and first interview was 44 hours.

The group (n=41) was composed of 25 men and 16 women with a median age of 36 years. Four (9%) were recruited from the learning disability services; seven (17%) were detained under the *Mental Health Act 1983*, a figure comparable to the proportion of people admitted formally to local mental health services (twenty percent, personal communication, Cambridgeshire Social Services). The composition of the group who participated is shown in Figure 2.

Admitting diagnosis		n
Schizophrenia		9
Psychosis – not yet classified		2
Psychosis – drug induced		1
Bipolar disorder	Manic Depressed	1 4
Unipolar depression	Non-psychotic Psychotic	12 2
Crises due to alcohol misuse		5
Deliberate self harm		3
Learning disability – no other diagnosis given		1
Total		41

Figure 2 –Diagnosis of participants (n=41)

Of these, seventeen had the following psychotic illnesses: schizophrenia (9), unclassified psychosis (2), psychotic depression (2), prominent hallucinations in the context of alcohol withdrawal (2), drug-induced psychosis (1) and mania (1).

Where a person was taking multiple drugs, understanding was assessed relating to the medication most relevant to the treatment of the mental disorder that had resulted in admission. The classes of drug chosen for the purposes of the assessment of consent to treatment at initial interview and follow-up are shown in Figure 3. At follow-up the medication was the same in all but in two people where mood-stabilizing medication had been started.

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[25] *Bellhouse, J., Holland, A.J., Clare, I.C.H., Gunn, M. & Watson, P. (2003) Capacity based mental health legislation and its impact on clincal practice:1) admission to hospital, Journal of Mental Health Law (2003) page 9.*

Class of drug	Admission (n=41)	Follow-up (n=16)
Neuroleptic	9	4
Atypical neuroleptic	7	3
Anti-depressant	17	7
Benzodiazepine	8	–
Mood stabiliser	–	2
Total	41	16

Figure 3 – Classes of medication used in the assessment of capacity to consent to treatment

Inter-rater agreement

Inter-rater agreement was assessed using the verbatim transcripts for eight of the 41 interviews (20%) on five of the elements; the legal significance of treatment was not included. A psychiatrist (AJH) independently rated these transcripts.

Agreement with respect to understanding in individual elements

Kappa correlations were calculated for agreement between the raters for each element relevant to a treatment decision. The level of agreement between the raters was statistically significant for three of the five elements. With respect to the two remaining elements, understanding of the purpose of treatment and the risks of non-treatment, the level of agreement was not statistically significant (p=0.064).

Agreement with respect to overall capacity

There was a satisfactory degree of agreement between the two raters about overall capacity (k=0.750, p=0.28). In only one of the eight cases was there disagreement.

Capacity to consent to treatment

Thirty-three of the 41 people (80%) assessed were judged to have the capacity to give or withhold consent to their treatment.

The group judged to have capacity

Eleven of the 33 (33%) participants with overall capacity had performed satisfactorily on all six elements. On average, the group displaying overall capacity performed satisfactorily on more than five elements (mean 5.22; range: 4–6).

The group judged not to have capacity

Two of the eight participants lacking the capacity to make treatment decisions did not demonstrate a satisfactory understanding of any of the separate elements. Two of the others only performed satisfactorily on one element. Overall these eight participants performed satisfactorily on less than two elements (mean 1.9; range 0–4).

Relationship between overall judgments of capacity and adequacy of response to each element

Using logistic regression analysis, significant relationships between incapacity and unsatisfactory performance on the elements (i) 'perception of illness needing treatment' (χ^2 (1df) = 3.819, $p<0.05$) and (ii) 'purpose of treatment' and incapacity (χ^2 (1df) =3.82, $p<0.05$) were found. None of the other elements were significantly associated with overall capacity/incapacity.

Association between capacity to consent to treatment and legal status

Twenty-eight of the 34 informal patients (82%; 95% CI 72–95%) and two of the seven detained patients (29%; 95% CI 0–62%) displayed the capacity to consent to treatment. Being admitted informally was statistically significantly associated with being capable of making treatment decisions (Ratio of odds of capacity (informal/formal) = 11.67; 95% CI 1.81–75.08)

Association between capacity to consent to treatment and diagnosis

There was a significant relationship between having a psychotic illness and lacking capacity. All eight participants lacking capacity to consent to treatment had a psychotic illness (Ratio of odds of incapacity (psychotic/non-psychotic) = 1.89; 95% CI 1.20–2.96). These eight had the following diagnoses: psychotic depression (2), drug induced psychosis (1), unclassified psychosis (2), and schizophrenia (3). However, psychotic illness was not invariably associated with incapacity in that six of the nine participants with schizophrenia were capable of consenting to treatment. All twelve participants with depression were able to consent to their treatment.

Of the 17 people assessed with respect to their understanding of treatment with an antidepressant medication, 15 had the capacity to consent to treatment. The remaining two both had a psychotic depression. Three of seven assessed with respect to treatment with an atypical neuroleptic appeared unable to consent, as were three of the nine prescribed and assessed with respect to typical neuroleptics.

Effect of information on understanding of treatment decisions

The effect of access to the information sheet was categorised using a three-point scale: 'no effect', 'some effect' or 'significant effect'. The latter category referred to a change in a person's response from unsatisfactory to satisfactory following their exposure to the information sheet. Figure 4 shows the effect of the information sheet on the performance of participants in the elements of understanding.

Overall, the information sheet improved the performance of two people so that they demonstrated capacity where they had not previously.

Element	No effect	Some effect	Significant effect
Illness	35	4	2
Nature of treatment – practical	36	5	0
Nature of treatment – legal	37	2	2
Purpose of treatment	37	2	2
Risks of treatment	36	1	4
Risks of non-treatment	36	2	3

Figure 4 – Effect of access to the information sheet on performance on the six elements relevant to treatment decisions. Numbers = number of participants improved (total = 41).

Follow-up interviews

Sixteen participants were re-interviewed one week following admission. Over the period of follow-up, improvement had occurred in the performance for some elements relevant to treatment decisions. However, of the 16, 13 had already demonstrated capacity at the admission interview; all of these people were found still to have capacity. Of the three who lacked capacity at admission, two still lacked capacity, but one demonstrated capacity at follow-up. This latter participant had achieved a significant improvement in his understanding of the purpose of treatment.

Understanding of treatment information

The performance of the participants on the different elements is considered here. The judgement of satisfactory or unsatisfactory performance was made after the whole interview, including the disclosure of the relevant information.

Perception of illness needing treatment

For five participants (12%) their perception of illness for which they required medication was judged unsatisfactory. All five lacked capacity overall (Ratio of odds of incapacity (unsatisfactory perception of illness needing treatment/satisfactory) = 12.00; 95% CI 4.06–35.46), and were in the group of participants suffering from a psychotic illness, also a significant finding (Ratio of odds of unsatisfactory perception of illness needing treatment (psychotic/non-psychoatic) = 3.00; 95% CI 1.89–4.76). Two of these five participants were assessed using their understanding of anti-depressant treatment for psychotic depression, and three were assessed with respect to neuroleptics. Four responses were unsatisfactory, e.g., "I've got no idea….I just can't think…just to make me better". One was an irrelevant response "ask the publishers…..it's in their hands" (24 year old male with drug induced psychotic episode).

Understanding the nature of drug treatment (practical)

Twelve participants (29%) did not demonstrate a satisfactory description of the nature of their drug treatment, five of whom were in the group of participants found to lack capacity overall, a significant association (Ratio of odds of incapacity (unsatisfactory perception of practical nature of drug treatment/satisfactory) = 6.19; 95% CI 1.18–32.46).

Understanding the nature of drug treatment (legal)

Fourteen (34%) people did not satisfactorily understand the legal situation with respect to their medicine. The adequacy of understanding of this aspect of treatment did not correlate overall with capacity (Ratio of odds of incapacity (unsatisfactory understanding of legal nature of drug treatment/satisfactory) = 4.44; 95% CI 0.88–22.54). For informal patients (n=13), responses were judged unsatisfactory for two distinct reasons. In ten cases this was an inability to understand that their treatment while in hospital was voluntary, e.g., "I've got to take it...that's the rules in hospital". Three participants did not understand the question, and perceived treatment as involuntary because they were ill, despite repeated clarification, e.g. "No, doctor, I have to take it because I'm not well". The participant detained under the MHA asserted that involuntary treatment was not allowed "I know my rights….they're just not allowed to….OK".

Understanding the purpose of drug treatment

Seven participants (17%) were unable to understand the purpose of their treatment. All seven of these were in the group found to lack overall capacity, a significant relationship (Ratio of odds of incapacity (unsatisfactory understanding of purpose of drug treatment/satisfactory) = 34.00; 95% CI 4.93–234.46). Five participants simply gave an unsatisfactory response, e.g., "I don't know... I just don't understand". The other two displayed a non-therapeutic understanding of the purpose of treatment, e.g. "It's to make me more tired so I can't do anything" or "To cut off the deep thoughts and make me more shallow".

Understanding the risks of treatment

Twelve people (29%) did not understand the potential of treatment to pose risks to their health. Five of these were in the group judged to lack capacity overall and seven in the group demonstrating capacity, an unsatisfactory response in this element, representing a significant risk of incapacity (Ratio of odds of incapacity (unsatisfactory understanding of risks of treatment/satisfactory) = 6.19; 95% CI 1.18–32.46). Four participants were judged unsatisfactory simply due to giving no relevant response. Two asserted that the medicine they were taking was completely without risks. One actively asserted wrong side effects "It causes cancer…all sorts". Five gave irrelevant information about their treatment as a risk, e.g. "Well, it can't make you any taller, that's a fact".

Understanding the risks of non-treatment

Eleven people (27%) were not able to identify the relationship between not taking their medication and adverse health outcomes. In three cases this was related to an unsatisfactory understanding of the illness needing treatment. Nine participants ventured no opinions about the risks of non-treatment. One participant saw trivial risks of not receiving their treatment, e.g. "I could do without it…I do at home – it's a matter of willpower" (52 year old female receiving chlordiazepoxide after an extended period of continuous alcohol consumption). One participant perceived risks as positive, i.e., not as risks at all e.g. "I'd go down and then kill myself which would be best for everyone" (18 year old male with schizophrenia and depression who otherwise understood all aspects of drug treatment).

DISCUSSION

Whilst there are strong ethical arguments for including an assessment of decision-making capacity into mental health law and it was one of the central recommendations of the Government initiated review of current legislation in England and Wales, doubts have been expressed as to the practicality of assessing capacity in people with acute mental disorders and the consequences of such a proposal[26]. This is the first study to examine the feasibility of a capacity assessment of men and women admitted for treatment to psychiatric or learning disability services. The Expert Committee proposed that capacity assessment might occur in the first week of detention and provide a gateway to extended detention.

Although approximately one-third of men and women newly admitted did not wish to take part in the study, this group of people did not differ in terms of age, diagnosis, or gender to those who took part. However, there were three people who the interviewer was not permitted to approach owing to a perceived risk of aggression. This group of people may pose particular problems for capacity assessment, as they do for assessment under current legislation. For a variety of reasons, the numbers seen for follow-up were small. Thirty participants agreed to a second interview, but only 16 were re-interviewed due to discharge, transfer, or a change of mind. This includes self-discharge or no longer wishing to take part in research.

Acknowledging the limitations of the study, we feel able to draw the following conclusions. First, decision-making capacity can be reliably assessed during the first week after admission, and healthcare practitioners familiar with capacity assessment can agree about capacity judgements. This is especially true where explicit criteria are used for judging the adequacy of responses. It is not known how the reliability of capacity assessment compares with the reliability of present MHA assessments, as no published figures exist for the latter. Secondly, as predicted, those with psychotic illnesses are at a high risk of incapacity, and therefore of incompetent decision-making when their illness is such that they require admission to hospital.

Two important findings were first, that a majority of people detained under the present MHA had the capacity to make this decision for themselves, and secondly, a proportion accepting treatment

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[26] *Fulford, K.W.M.(1989) Treatment. In Moral Theory and Medical Practice. Cambridge University Press: Cambridge; Sayce, L. (1998) Transcending mental health law. Psychiatric Bulletin 22,669–670.*

voluntarily were not capable of consenting to it. Thus, in the case of the former group, if it had been physical illnesses they would have had the right to refuse treatment. In the case of the latter, capacity-based mental health legislation would provide a solution to what has been referred to as the 'Bournewood gap' (i.e. the lack of legal safeguards for assenting incapacitated people admitted to hospital).

Critics of a capacity test point out that there has been disagreement about how to define capacity. If the definition provided by the Law Commission becomes statute, that particular debate will have been settled, at least in England and Wales. However, uncertainty as to the nature and extent of 'relevant information' remains. We described in the Methods section how legal sources were used to provide elements of information relevant to treatment decisions and thresholds against which to judge the adequacy of the performance of participants in the study. All the elements of information used in the study were firmly based in case law except that of 'perception of illness', although it can be argued that this is implicit in understanding the 'purpose of treatment'. It was clear in the pilot studies that clarifying the participants' 'perception of their illness' at the start of the interviews allowed the discussion that followed to be conducted meaningfully. Using the Law Commission's terms, this information is highly relevant to the decision in question. It is important to stress that we did not demand that the person concerned agree that he/she had an "illness" requiring treatment, only that there was a possibility of a problem located within their psyche. Other models of distress were acceptable, although the problem had to be recognised as internal to the participant even if external causes were put forward.

There was a high level of agreement between the two raters, as one would expect when account is taken of the fact that both raters had explicit criteria for judging the adequacy of responses in each element. However, it was not possible to produce such criteria for making judgements of overall capacity. Still, both raters seemed to weigh performance on each element similarly and to come to the same conclusions overall. The weight given to the elements 'perception of illness' and 'purpose of treatment' in making overall judgments may reflect the judgements of clinicians as to what is the most relevant information for making meaningful treatment decisions. Other professional groups may believe that other informational components are of more importance, and service users might take a different view again. For example, legal opinion might emphasise the importance of understanding that treatment is voluntary, whereas service users might emphasise that meaningful decisions in this area can only occur if people understand the potential side effects of drug treatment and in some cases, that there are alternatives, such as established psychological and complementary treatments.

All participants unable to consent to their acute drug treatment had a diagnosis of a "psychotic illness". It has been suggested intuitively that the people in need of compulsory treatment are those with psychotic symptoms, rather than a specific diagnosis or risk[27]. An emphasis on the alleged risk posed by people with a mental illness might mean detaining people who fall outside this ethical "intuition" and a capacity test might usefully narrow the applicability of risk-based criteria. It may be, though, that the correlation between incapacity and psychotic symptoms would leave people suffering from non-psychotic disorders at risk of suicide and other adverse health outcomes.

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[27] *Fulford, K. & Hope, T. (1994) Psychiatric Ethics: a Bioethical Ugly Duckling. In Principles of Health Care Ethics (ed. R.Gillon). John Wiley and Sons: Chichester.*

Seven participants were detained using the existing legislation, the *Mental Health Act 1983*. Five of these were able to consent. This might indicate that capacity-based mental health law is so different from current law that it renders liable to detention a very different group of people, although the numbers detainable are similar[28]. An alternative explanation is that detention using the MHA is related to one's understanding of admission decisions and the need to be in hospital, rather than one's understanding of treatment decisions (see note 1).

Empirical studies cannot illuminate the ethical aspects of the debate regarding the use of capacity in making detention decisions. However, if the principle that a person who can make decisions should be allowed to make them is accepted, then the practical questions raised by importing this doctrine into mental health law become the issue. Two important practical aspects of such a proposal are defining capacity satisfactorily and the consequences of such a change in the law. Future debate about the practicality of such legislation ought to be informed by empirical work and it is hoped that the data presented here will inform that debate.

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[28] *See note 25 above.*

Confidentiality and the Sharing of Information

*Fenella Morris**

Introduction

This paper considers the nature and extent of the duty of patient confidentiality in the mental health context, and examines the range circumstances in which it might be overridden, and the way in which such decisions may be taken. Particular consideration is given to the justifications given for breaches of patient confidentiality in the name of public safety and victims' rights. The paper also addresses rights of access to health information in the case of the incapable adult and the applicant to the MHRT.

The legal framework

Disclosure and sharing of information about a person's health (and social "condition") is governed by a complex statutory and common law framework. Individual access to and disclosure of records is governed principally the Data Protection Act 1998 ("DPA") – established to provide an over-arching scheme for all, not just health or social work, information. It is supplemented by the Access to Health Records Act 1990. Disclosure before and during litigation is governed by s33 and 34 Supreme Court Act 1981, s52 and 53 County Courts Act 1984 and Part 31 Civil Procedure Rules. There is guidance on confidentiality and disclosure such as that contained in The Protection and Use of Patient Information Guidance HSG(96)8 and HSC(2000)9, which may require higher standards than the DPA, and Confidentiality: Protecting and Providing Information issued by the GMC in June 2000. Since the coming into force of the Human Rights Act 1998 in 2000, public authorities and the Courts have further had to have regard to individual rights and positive obligations arising out of Art. 6 and 8 ECHR in respect of access to, and disclosure of information. Despite these extensive statutory structures, however, the common law retains an important role, demonstrated in the cases that still require the determination of the Courts where disclosure or sharing of information is concerned.

Description and discussion of the detailed provisions of the DPA is beyond the scope of this paper. A particularly useful summary of its provisions in relation to the health and social work records of those subject to the Mental Health Act 1983 ("MHA") is provided by Hale LJ in *R (S) v Plymouth City Council*[1]:

**Fenella Morris, Barrister, 39 Essex Street Chambers*

[1] *R (S) v Plymouth City Council [2002] 1 WLR 2583*

> All of the material requested is "personal data" within the meaning of the Act and so much of it as related to [the patient's] "physical or mental health or condition" is "sensitive personal data" within the meaning of section 2(e). But the processing of even sensitive personal data is permitted where it is necessary in order to protect the vital interests of the data subject or another person in a case where consent cannot be given by or on behalf of the data subject (paragraph 3 of Schedule 3); or for the purpose of, or in connection with, any legal proceedings (including prospective legal proceedings) or for the purpose of obtaining legal advice, or where it is otherwise necessary for the purposes of establishing, exercising or defending legal rights (paragraph 6); or where it is necessary for the administration of justice, or for the exercise of any functions conferred on any person by or under an enactment (paragraph 7). It is common ground therefore, that the 1998 Act does not prevent the local authority disclosing this information. Nor, however, does it require the authority to do so.[2]

Article 8 of the ECHR provides:

(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.

The European Court has held that Art. 8 protects personal data, including health records, and that respect for the confidentiality of health records is a fundamental right in *Z v Finland* (1997) 25 EHRR 371:

> … the court will take into account that the protection of personal data, not least medical data, is of fundamental importance to a person's enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention. Respecting the confidentiality of health data is a vital principle in the legal systems of all the contracting parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general. Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community. The domestic law must therefore afford appropriate safeguards to prevent any such communication or disclosure of personal health data as may be inconsistent with the guarantees in article 8 of the Convention.[3]

Disclosure of any information for other than the purpose for which it was collected may also in itself constitute a breach of Art. 8(1) ECHR[4].

As to the justification for breaches of Art. 8(1) contained in Art. 8(2), the European Court interprets the exceptions narrowly[5]. Firstly, for a disclosure to be in accordance with law it must be in accordance with a procedure which enables the data subject to foresee its operation

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[2] *above judgment paragraph 25 page 2593*

[3] *Z v Finland (1997) 25 EHRR 371 paragraph 95 page 405–406*

[4] *T V v Finland DR 140 (1991)*

[5] *Klass v Germany (1978) 2 EHRR 214 and Funke v France (1993) 16 EHRR 297.*

reasonably clearly[6]. There should be have adequate legal safeguards to protect against arbitrary interference in Art. 8(1) rights[7]. Secondly, the disclosure must be not only for one of the objectives identified in Art. 8(2), but the disclosure must be proportionate to that objective: a "fair balance" must be struck between the interests of the individual and society as a whole. In *Z v Finland* the European Court held that disclosure of an individual's HIV status was only justified where there was an overriding public interest.

The common law will protect information given in confidence where it has the necessary quality of confidence[8] and where the person proposing to disclose the information has obtained it in circumstances giving rise to an obligation of confidence[9]. In *R (Source Informatics) v Department of Health*[10] the Court held that there was no breach of confidence where the information provided did not disclose the identity of the data subject, in that case about his use of medication. The common law obligation of confidence may be overridden where there is a legal requirement of disclosure, where the subject consents and where there is an overriding public interest. For instance, in *W v Egdell*[11] the Court of Appeal upheld the decision of a doctor asked to prepare an independent report on a patient for the MHRT to disclose the report to the Secretary of State although the patient had decided not to disclose it to the MHRT, and withdrawn his application. The report drew attention to a number of factors relevant to W's treatment and dangerousness that had not previously been identified. It was held that the importance of the information with regard to public safety was so great that it outweighed the usual duty of confidence. Indeed, following the decision of the European Court in *Osman v UK*[12], it may be said that there is a positive obligation on public authorities, which might arguably include responsible medical officers, who have information that identifies a risk to the life of another individual, to disclose that information in order to protect his right to life under Art. 2 ECHR.

The nature and extent of the duty of confidentiality to patients

The nature and extent of the obligation of patient confidentiality was recently explored by the House of Lords in *Ashworth Hospital Authority v MGN Ltd* when their Lordships considered an application by the hospital for the disclosure of the identity of a journalist's informant who had provided him with material concerning Ian Brady's medical care. The parties agreed that leaks to the press of confidential information are undesirable because they have:

> … a detrimental effect on security; treatment of patients and staff morale, because they may inhibit proper recording of patient information about patients; may deter patients from providing information about themselves; may damage the patient-doctor relationship, which rests on trust; may lead to assaults by patients on a patient about whom information is disclosed; may create an atmosphere of distrust amongst staff, which is detrimental to efficient and co-operative work; and give rise to fear of future (and potentially more damaging leaks).[13]

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[6] *Petra v Romania (2001) 33 EHRR*

[7] *Malone v UK (1984) 7 EHRR 14*

[8] *Saltman Engineering v Campbell [1948] RPC 203*

[9] *Marcel v Police Commissioner [1992] 1 AllER 72*

[10] *R (Source Informatics) v Department of Health [2000] 1 AllER 786*

[11] *W v Egdell [1990] 2 WLR 471*

[12] *Osman v UK (2000) 29 EHRR 245*

[13] *Ashworth Hospital Authority v MGN Ltd [2002] 1 WLR 2033, per Lord Woolf CJ paragraph 17 page 2037*

It was also accepted that it was particularly important that patient records be full and accurate in special hospitals because otherwise warning signs might be overlooked inhibiting preventative action.

The question for the Court was how this substantial public interest in preserving patient confidentiality weighed against the public interest in the protection of journalists' sources. The newspaper invoked Art. 10 ECHR, the right to freedom of expression, in its defence and the oft-cited "chilling effect" of an order for source disclosure on the freedom of the press.[14] Their Lordships ultimately found that on that occasion an order for disclosure was both necessary, in that it met a pressing social need, and not disproportionate, in respect of the aim which was being pursued.[15] It was persuaded, in particular, by the following matters advanced on behalf of Ashworth:

> … it is essential for the care and safety of individual patients and the safety of other patients and staff that relevant information is entered in the patients' notes … those entries having been made, their integrity and confidentiality should be preserved … psychiatry, more than any other branch of medicine, depends on a trusting relationship between therapists and patients … the basis of virtually all assessment, diagnosis, treatment and analysis of risk is dependent on information provided by others …if the staff feel that there is a possibility of what they report entering the public domain their reporting will be inhibited as they will think that this will place staff or patients at risk …[16]

The Court relied upon *Z v Finland* as a guide to the significance of the wrong done by those who disclose medical records. It held that it would be "no bad thing" if its judgment had the effect of discouraging such disclosure in the future.

Their Lordships' judgment was not, however, the end of the story for Ashworth. The order for disclosure it obtained in the Lords was against the newspaper which duly identified the journalist who had provided it with the information. The journalist himself then refused to disclose his source. Proceedings were issued against him. An application for summary judgment on the grounds that his defence had no real prospect of success in the light of their Lordships' earlier judgment failed[17]. The Court of Appeal held that the issues in respect of Mr Ackroyd were different from those in respect of the newspaper and would not necessarily be determined in the same way, given the balancing exercise that the Court must carry out. The key factor was Mr Ackroyd's history as an investigative journalist exposing wrong-doing at Ashworth and other hospitals. There was a public interest in the exposure of wrong-doing at the hospital which might, at trial, justify non-disclosure. It might even be justified by Mr Ackroyd's need to protect his sources so as to enable him to expose wrong-doing in the future. It was also significant that Mr Ackroyd's sources received no payment for the disclosures. May LJ concluded the lead judgment thus:

> Although there is a clear public interest in preserving the confidentiality of medical records, that alone cannot, in my view, be automatically regarded as an overriding requirement without examining the facts of a particular case. It would be an exceptional case indeed if a journalist were ordered to disclose the identity of his source without the facts of his case being fully examined.[18]

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[14] *Goodwin v UK (1996) 22 EHRR 123 at paragraph 39 page 143*

[15] *Pages 2050–2051 judgment*

[16] *Paragraph 63 page 2051 judgment*

[17] *Mersey Care NHS Trust v Ackroyd Times, 21 May 2003 and [2003] EWCA Civ 663*

[18] *Paragraph 70 judgment per May LJ*

Carnwath LJ, however, was concerned to guard the status of medical records more closely. His Lordship held:

> …it would be inconsistent with the decision of the House of Lords to approach the present case other than on the basis that, other than in exceptional cases, there is an over-riding public interest in the protection of medical records from disclosure. In the interests of certainty in the law and the assurance of those responsible for such records, I would oppose any watering-down of that principle, even if it were open to sue to do so. There may be circumstances in which a departure from the normal rule if justified by the public interest; but the circumstances must be truly exceptional, and they must be directly relevant to the need for disclosure of the records in question.[19]

Examples of where the public interest in disclosure might outweigh the interest in medical confidentiality may therefore include not only "whistle-blowing" in respect of hospitals, but, on Mr Ackroyd's submissions, in the care and treatment given to particularly high-profile individuals. He submitted that there is a public interest in knowing about their treatment, and even the basis for their criminal acts, and that argument was not rejected by the Court.

Although the decision in *Ackroyd* was merely concerned with whether his defence had no prospect of success, the judgment appears to have opened up the field of interests that might outweigh those of medical confidentiality. Certainly, it must be debatable whether the confidence of a high-profile criminal or notorious patient is more easily overridden than that of the unknown one. After all, such individuals cannot always be said to have voluntarily put themselves in the public eye where their crimes have been committed when seriously disordered. Further, if the care and treatment of such individuals may legitimately be a matter of overriding public interest, what aspects might be included? Difficulties often arise over leaks and reporting of rehabilitation trips for high-profile offenders. Once there is publicity it can become almost impossible for them to take place, to the detriment of the individual's health, and perhaps prolonging his detention. If it is allowed that the public interest in such matters is so significant that it warrants disclosure, then the balancing exercise becomes extremely complex.

In almost the opposite situation, the right to protect their sources has been invoked by those protecting patients, those in residential care homes or receiving any social service. They argue that "whistle-blowers" or others who bring wrong-doing to light should have their identities protected. In *Leach v National Care Standards Commission*, unreported, Master Yoxall, 30 October 2002, upheld the NCSC's refusal to disclose the source of, ultimately disproved, allegations of abuse and neglect at a residential care home for the elderly. The claimant sought disclosure in order to bring defamation proceedings given the damage the allegations had caused to his business. The Court found that the public interest in the protection of the vulnerable from abuse, and the particular need for independent reporting in respect of those who may not be able to raise the alarm themselves, outweighed the claimant's interests in disclosure.

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[19] *Paragraph 75*

The administration of the obligation of confidentiality and the right to access: incapable adults and the DPA[20]

A significant defect in the all-embracing scheme provided by the DPA is its failure to deal comprehensively with incapable adults as data subjects.[21] While s7 DPA gives the data subject a range of entitlements to the provision of information[22] it does not say who may make the requests on behalf of an incapable adult, or to whom the information requested should be provided. The DPA does not require that a request come from the data subject himself, and therefore it is arguable that it may be made on his behalf. The guidance in HSC2000/9 supports the view that a third party may make the request on behalf of the incapable adult.[23]

However, even if a third party may properly request information on behalf of an incapable adult, the response may only be given to the data subject under s7 DPA. This undermines the utility of a request being made by a third party if the data subject is incapable of understanding the product. More fundamentally, it is questionable whether, given the restrictions on processing information, the DPA is intended to allow a third party to request and receive information on behalf of a data subject. It is quite easy to see how such an arrangement might be abused. It is right that there is an obligation on the data controller not to disclose information if it would be likely to cause significant harm to the physical or mental health or condition of the mental subject or any other person, or where the information was provided in the expectation that it would not be disclosed[24], however, this falls far short of the "best interests" test upon which reliance is usually placed when taking decisions about the lives of incapable adults.

While abuse by the third party is a risk, equally a lack of information creates another set of risks for the incapable adult. Information is required for relatives and carers to have proper input into decisions about the health and social care of the incapable. In the absence of a clear statutory scheme under the DPA, it is left to the discretion of individual professionals to decide whether to, and how much, information to disclose. Questions may arise not only as to the suitability of particular treatments or placements, but also as to the entitlement to free care, for instance under s117 MHA or because eligibility criteria for continuing health care are met. Without information, those acting on behalf of the capable are significantly hampered.

What then, are the alternatives, for allowing access to information for a person acting on behalf of an incapable adult? Some decisions about the disclosure to third parties of health and social care information concerning incapable adults can be made within existent statutory frameworks. Firstly, a nearest relative has the following entitlements under the MHA:

1. To have a doctor examine a patient for the purpose of advising as to the exercise of the nearest relative's power of discharge. The doctor concerned has the right to require production of and to inspect records in relation to the detention and treatment of the patient. (s24 MHA)

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[20] *I am grateful for the assistance of Kristina Stern and Nicola Greaney of 39 Essex Street in preparing this part of the paper.*

[21] *The repealed scheme did deal with the issue.*

[22] *Being informed whether or not data about him is being processed, the purpose of the data-processing, the persons to whom it may be disclosed, being provided with the data itself, decision-making about him.*

[23] *Paragraph 5.2*

[24] *Regulation 5 of the Data Protection (Subject Access Modification) (Health) Order 2000 and the Data Protection (Subject Access Modification) (Social Work) Order 2000*

2. To have a patient examined and to require production of medical records relating to detention and treatment for the purposes of advising whether an application to an MHRT should be made. (s76 MHA)
3. Hospital managers are obliged to inform the nearest relative, unless the patient objects, of the provisions under which the patient is detained, and their rights to apply to the MHRT. (s132 MHA)
4. To have all the documents before the MHRT disclosed, where the nearest relative is the applicant, unless the MHRT is satisfied that the disclosure would adversely affect the health or welfare of the patient or others. (r12 MHRT Rules 1984)

The entitlement of the nearest relative to information concerning an incapable adult subject to the MHA in circumstances broader than this was tested in *R (S) v Plymouth City Council*[25]. S, the mother and nearest relative of a person subject to guardianship, sought disclosure of confidential medical and social work information concerning her son to allow her to make decisions about the exercise of her powers as nearest relative. S particularly sought disclosure of medical records, including medical recommendation forms, not only to herself but also to two experts engaged to advise her whether or not to apply to discharge her son from guardianship. The local authority refused disclosure. Hale LJ held that the issue fell to be decided with reference the common law and the Human Rights Act 1998 both of which required that:

> …a balance must be struck between the public and private interests in maintaining the confidentiality of this information and the public and private interests in permitting, indeed requiring, its disclosure for certain purposes.[26]

As to the content of the material sought, Hale LJ took the view that it was not uniform in character. Where files contained information that was, for example, a "straightforward description of everyday life" it would not need to be treated as confidential.[27] Further, Hale LJ held that an obligation of confidence may have different "breadths": a report brought into existence for certain authorised purposes may be disclosed to those concerned with those purposes, although not to others.

Applying that approach to S's case, Hale LJ saw little difficulty in disclosing medical recommendation forms to the nearest relative, with whom there had to be consultation about the matters addressed there, or documents that would be before an MHRT to which S was entitled to apply.[28] There was a clear distinction for her Ladyship between disclosure to an identified individual for an identified purpose, and wider disclosure.[29]

Finally, Hale LJ relied upon the requirements of procedural fairness, at common law and under Art. 6 ECHR, which require that anything relevant to a Court's adjudication is disclosed to both parties unless there is another sufficiently powerful interest to outweigh it, for example, a risk of harm to a child.[30] For such an interest to outweigh that of fairness, it must, as usual, have a proper objective, and be proportionate to that objective.

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[25] *R (S) v Plymouth City Council [2002] 1 WLR 2583*

[26] *above paragraph 32 page 2594*

[27] *Paragraph 33 page 2594. Although this approach may beg the question of what is confidential which may often depend on context.*

[28] *Paragraph 34 page 2595.*

[29] *Paragraph 49 page 2599*

[30] *Paragraph 36 page 2595*

Hale LJ found that the relevant interests in S's case could be summarised thus:

> …the confidentiality of the information sought; the proper administration of justice; the mother's right of access to legal advice to enable her to decide whether or not to exercise a right which is likely to lead to legal proceedings against her if she does so; the rights of both C and his mother to respect for their family life and adequate involvement in decision-making processes about it; C's right to respect for his private life; and the protection of C's health and welfare. In some cases there might also be an interest in the protection of other people, but that has not been seriously suggested here.[31]

Balancing these considerations, the Court concluded that they favoured an order for disclosure of the information sought to S and the experts that she had instructed.

There are three further authorities which offer some assistance in defining the nature and extent of common law rights and obligations in respect of the health records of incapable adults. In *R v Mid Glamorgan Family Health Services Authority ex p Mann*[32] the Court considered the extent of hospitals' rights over health records. It held that a hospital must act in the best interests of its patient, or in that case ex-patient, in deciding to what to do with his records. The case was resolved by an agreement that the records would be disclosed to the applicant's expert.

In *R v Secretary of State for the Home Department ex parte Amnesty International, Kingdom of Belgium and others*, unreported, 15 February 2000, the Court directed the disclosure of the medical report on General Pinochet to those states which sought his extradition. It was satisfied that the requirements of fairness outweighed those of confidentiality.

In *A Health Authority v X*[33] the Court of Appeal again identified a particular public interest that outweighed that of confidentiality – the public interest in effective disciplinary proceedings. The Court held that the substantial public interest in the proper administration of professional disciplinary proceedings, particularly in the field of medicine, was analogous to the public interest in the administration of the criminal justice system.

Having regard to these dicta, it might be argued that an appropriate scheme for access to and disclosure of the heath and social work records of incapable adults should emerge from a broad construction of the DPA and its associated regulations in the light of the common law. The Data Protection (Subject Access) (Modification) (Health) Order 2000 proceeds on the basis that a person with parental responsibility, in the case of a child, or a person appointed by the Court of Protection[34], in the case of an adult incapable of managing his property and affairs, may request information on behalf of the child or incapable adult concerned. In the absence of such an individual, a litigation friend, nearest relative, or other "statutory" individual with an appropriate interest in the information sought, should be permitted to make a request on the incapable person's behalf. Where no relevant statutory scheme is engaged by the subject matter of the request, an appropriate individual, having regard to the incapable adult's best interests should be permitted to make the request. Certainly, it seems appropriate to tie the right of the third party to make the request and receive the information to both its subject matter and the third party's involvement in the life of the incapable adult. Indeed, it might be said that the assumption that an

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[31] *Paragraph 48 page 2599*

[32] *R v Mid Glamorgan Family Health Services Authority ex p Mann [1995] 1 AllER 356*

[33] *A Health Authority v X [2001] EWCA Civ 2014*

[34] *Guidance suggests that this might also be an attorney under an Enduring Power of Attorney.*

attorney or individual appointed by the Court of Protection should be entitled so to act is flawed since their powers are expressly limited to business, legal and financial matters and do not extend to decisions about health and social care.[35]

The data processor's decision to disclose should be made having regard, first, to the restrictions imposed by the DPA itself, and then, second, to the best interests of the incapable adult. While it must be admitted that such an approach involves a great stretch in the words of the DPA, it nevertheless provides a workable framework that does not deprive incapable adults of the benefits conferred by the DPA while at the same time providing them with a reasonable amount of protection from abuse.

Interpreting the DPA thus would fulfill the State's positive obligations to allow access to personal information (held to be a potential obligation in *Gaskin v UK*[36]) and to take steps to ensure the physical and psychological integrity of the disabled (establised in the context of the provision of community care services in *Botta v Italy*[37]and *R (Bernard) v LB Enfield*[38]).

MHRT: withholding and disclosure of reports

Rule 6(4) MHRT Rules 1984 empowers those required to provide reports to the MHRT on a patient to withhold part of the report from him[39] if, in the opinion of authority preparing the report, it should be withheld on the ground that its disclosure would adversely effect his health or welfare of him or others. Rule 12(2) MHRT Rules provides that the MHRT must, in respect of documents which have been so withheld, consider whether disclosure to the patient would adversely effect the health or welfare of the patient or others. Plainly, the Human Rights Act 1998 now requires that the MHRT carrying out this balancing exercise informed by the ECHR. However, the rights potentially engaged are numerous, and each may point in a different direction:

1. Art. 2 may require non-disclosure to the patient where to do so would threaten the life of, say, an informant
2. Art. 8(1), similarly, may impose a positive obligation not to disclose to protect the physical and psychological health of another person, particularly a vulnerable person
3. Art. 8(1) ECHR may impose a positive obligation not to disclose where to do so would jeopardise the physical and psychological health of the patient,
4. Art. 8(1) might also require disclosure to the patient where he should be allowed access to personal information about himself
5. Art. 6, the right to a fair hearing, may also require disclosure to the patient and to his representatives, to enable him to meet the case against him. This right might be in direct conflict with the positive obligation to protect a patient's health under Art. 8(1).

In this sense, the human rights context introduces no trump consideration into the deliberations of an MHRT on the question of disclosure.

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[35] *Re F [1990] 2 AC 1*

[36] *Gaskin v UK (1989) 12 EHRR 36*

[37] *Botta v Italy (1998) 26 EHRR 241*

[38] *R (Bernard) v LB Enfield [2002] EWHC 2282 (Admin).*

[39] *Or the nearest relative if he is the applicant.*

Where the MHRT must balance the interests of the patient against the wider community, and those concerned with his treatment and care, it is reasonably clear how each party may make its case. However, a particular difficulty arises where the individual who may be threatened by the disclosure of information contained in a report to which the patient seeks access is not a party to the MHRT. Art. 6 would usually require that such an individual be enabled to make representations on the issue of disclosure, but there is no express provision in the Rules for such an application. It might be undesirable to make that individual a "party" to the MHRT under r7(f) MHRT Rules where it would be inappropriate for him to have access to all the reports or to attend the hearing. However, the MHRT might allow the individual concerned to make representations on the issue of disclosure alone pursuant to r22(4) MHRT Rules.

MHRT: victims' rights to information

The Code of Practice issued under s118 MHA gives the following guidance as to he information to be provided to victims and their families in respect of patients detained under Part III of the Act.

> Where a patient detained under Part III of the Act is both competent and willing to agree to the disclosure of specified information about his or her care, this should be encouraged to enable victims and victims' families to be informed about progress. It can be important to a patient's rehabilitation that victims understand what has been achieved in terms of modifying offending behaviour … Without prejudice to a patient's right to confidentiality, care teams should be ready to discuss with him or her the benefits of enabling some information to be given by professionals to victims, within the spirit of the *Victim's Charter (Home Officer, 1996)*. The patient's agreement to do so must be freely given and he or she will need to understand the implications of agreeing to information being given to the victim(s). Care must be taken not to exert any pressure on the patients or this may bring into question the validity of the consent.[40]

The position of victims or the relatives of victims in the MHRT was considered in two cases concerning, G, a patient, and T, his ex-partner and mother of the child he killed. T believed that she was at risk from G, should he be discharged. She was notified of his application to the MHRT by the local police. T attended the MHRT hearing asking to see the medical reports, be present throughout the hearing and make submissions to the MHRT. G did not agree. The MHRT did not think it appropriate to accede to T's request given the information it already had before it, believing that T could draw any other relevant information to its attention by making written representations, which she was invited to do under r14(1) MHRT Rules 1983. T applied for judicial review of the MHRT's decision but permission was, perhaps not surprisingly, refused.

The parameters of the power of the MHRT to allow victims, past or potential, to involve themselves in its proceedings are circumscribed thus:

1. It may give notice of the proceedings to any person who, in its opinion, should have an opportunity of being heard. (r7(f) MHRT Rules)

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[40] *In Munjaz [2003] EWCA Civ 1036 the Court of Appeal held that, in respect of seclusion, the Code should be observed unless there is good reason to depart from it in relation to specific groups of patients with well-defined characteristics, or individual patients. Although this decision was concerned with seclusion, it is arguable that a similar approach should obtain in respect of all matters where fundamental rights are engaged. That should include patient confidentiality.*

2. It must sit in private unless the patient requests a hearing in public and it is satisfied that a hearing in public would not be contrary to the patient's interests. (r21(1))
3. It may admit to the hearing such persons on such terms as it thinks fit. (r21(3))
4. Information about proceedings before it, and the names of the persons concerned must remain private, save as the MHRT may direct. (r21(5))
5. Subject to rule 21(4), which gives the MHRT power to exclude persons from its proceedings, the MHRT may allow any person to take such part in a hearing as it thinks proper. (r22(4))
6. Before or during any hearing it may call for such further information or reports as it may think desirable, and may give directions as to the manner in which and the persons by whom such material is to be furnished. (r15)

It is readily apparent, however, that these rules might allow a MHRT to form the view that it was appropriate to allow a victim to attend, even if that involved him hearing the evidence. Such a decision should, however, involve the most careful balancing of the public interest in patient confidentiality as against safety, or, arguably, a fair hearing. It is difficult to imagine what interest an individual such as T might have which could not adequately be met by being allowed to make written, or perhaps oral, representations, without knowing what was said about the patient before the MHRT. Further, it is doubtful whether the MHRT would have the power to disclose the reports before it to such an individual given that the Rules only provide for service of them on the patient, responsible authority and Secretary of State.

In G's case the MHRT, having given T the opportunity to make representations, went on to direct that he be conditionally discharged. T, on learning of this decision, then asked to be told the conditions on G's discharge, and the reasons for its deferral. The MHRT declined, relying on the House of Lords' judgment *Pickering v Liverpool Daily Post and Echo Newspapers plc*[41] where it was held that it was a contempt of Court to publish the fact that a named patient had made an application to the MHRT for discharge, the date, time or place of the hearing, that he had been released from detention, or the conditions on his discharge or the reasons for its decision. T applied for judicial review of that decision.[42] In the course of that application she sought further information about the level of risk G was believed to pose to others.

Scott Baker J, as he then was, deciding T's application, held that *Pickering* was concerned with protecting patients from press intrusion. It was not authority for the proposition that the MHRT was never empowered to provide the information sought by T to others.[43] Their Lordships left open the possibility, in accordance with the provisions set out above, that the cloak of privacy around MHRT proceedings might be lifted at the MHRT's discretion. Scott Baker J took the view that this interpretation accords with the words of s78(2)(e) MHA[44] and that r21 of the 1983 Rules must be read in that way.[45]

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[41] *Pickering v Liverpool Daily Post and Echo Newspapers plc [1991] 2 AC 370*

[42] *(R (T) v MHRT [2002] Lloyd's Rep Med 324)*

[43] *Paragraphs 18–21*

[44] *Which creates a power to make provision "For enabling a Tribunal to exclude members of the public, or any specified class of members of the public, from any proceedings of the tribunal, or to prohibit the publication of reports of any such proceedings or the name of any of the persons concerned in such proceedings".*

[45] *Paragraphs 28–34*

Scott Baker J held that the MHRT, when considering whether information should be disclosed, should ask what "need" the person concerned has for the information sought.[46] Scott Baker J then applied that test to the information sought by T, which she said was necessary in the interests of her safety. His Lordship found that the usual conditions on discharge as to residence, supervision and medical treatment were not relevant to T. However, a condition that the patient should not live in a particular area or communicate with a particular individual might be relevant, and there was "no reason" why information of that nature should not be made public.[47] T's arguments advanced under Arts. 2 and 8 ECHR were rejected on the grounds that the evidence was inadequate to show that the threshold for engagement of those provisions was met in her case.[48]

It was believed at the time of the judgment that the making explicit of this power of the MHRT would create a new decision-making burden on it and pave the way for a significant number of applications. However, I and my colleagues are not aware of any. It is interesting to consider what other information it might in other circumstances be appropriate for the MHRT to disclose and to whom. It seems difficult to identify information beyond that allowed by Scott Baker J in his judgment which it might be appropriate to disclose when, fundamentally, a victim or his relatives must be obliged to rely on the expert judgment of the MHRT in making decisions as to discharge, and health and social care providers in managing the patient in the community.

It should also be noted that, while s69 Criminal Justice and Court Services Act 2000 imposes an obligation on the probation service to consult victims of violent and sexual offenders, on whom a "relevant" custodial sentence has been imposed, on the conditions and requirements that should be imposed on the offender on release, Parliament has made no equivalent provision in relation to patients detained under Part III MHA.

Information-sharing and MAPPs

The Code of Practice contemplates information-sharing between health professionals and others in the public interest, particularly the protection of personal and health safety, but considers that it will be "occasional".[49] In recent years, however, information-sharing between health, social services, the police and probation has become something more than occasional, particularly in the sphere of forensic psychiatry and patients detained under Part III MHA. There is a detailed statutory framework for the registration, monitoring and information-sharing of sex offenders and those who may pose a risk to children and vulnerable adults under the Sex Offenders Act 1997, Protection of Children Act 1999, Education (Restriction of Employment) Regulations 2000, Care Standrards Act 2000. These statutory provisions define quite closely what steps may be taken in the regulation of the lives of such individuals. Less well-defined, however, and used increasingly in respect of the group of patients mentioned above, are Multi-agency Public Protection Panels ("MAPPPs"). These were established in fulfillment of the obligation imposed on police and probation agencies by s67 Criminal Justice and Courts Service Act 2000 to "establish arrangements for the purposes of assessing and managing the risks posed in that area by … relevant sexual and

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[46] *Paragraph 26*

[47] *Paragraph 27*

[48] *Paragraphs 40–49*

[49] *Paragraph 1.8: "Ordinarily, information about a patient should not be disclosed without the patient's consent. Occasionally it may be necessary to pass on particular information to professionals or others in the public interest, for instance where personal health or safety is at risk. Any such disclosure should be in accordance with the principles set out in the Guidance [i.e. HSG(96)18]*

violent offenders, and other persons who are considered by (them) to be persons who may cause serious harm to the public". The Home Office's publications acknowledge that MAPPs' memberships now extend far beyond the police and probation to include social services, education services, housing services and mental health care providers.

The involvement of MAPPs in considering the arrangements for persons with mental disorder has two key consequences. Firstly, it is increasingly common for the MAPP or the police to make representations to an MHRT considering an individual's discharge based on their assessment of the risk that he may pose if discharged, focussing solely upon "risk" and without specific regard to the context of the individual's mental disorder. Thus, where an individual poses a risk regardless of his mental disorder, the police and probation may become involved in decisions about his discharge. MHRTs appear prepared to allow police representatives to attend hearings and make representations, although I am not aware of cases where they have been permitted to remain present to hear all the evidence.

The second consequence of MAPPs for patients is that they have established a new, statutory forum with the purpose of information-sharing. Of particular concern in a human rights context is the extent to which health information is shared at a MAPP. A MAPP meeting at which health care providers attend has the potential to create a de facto expectation that information will be shared in the interests of public protection, rather than the historical position reflected in the guidance where information might be shared "occasionally" and in "exceptional circumstances". Moreover, information that might properly be shared with one individual or agency, may then be shared with others for whom there is not the same justification. There is little or no opportunity for scrutiny of the decisions made to share health information in those fora. In those circumstances there must be a residual concern that patients' Art. 8 rights are not adequately protected by these arrangements. Health information may be shared for purposes other than for which it was originally collected. It may be shared in circumstances where patients know little about MAPPs and their work, what information will be shared there and the use to which it will be put. It may be shared in circumstances where a Court may not be satisfied that there is an overriding public interest in its disclosure, having regard to the requirements of proportionality, for example, where more than necessary information about an individual's health is disclosed to the police.

The Ghost of the Nearest Relative under the Mental Health Act 1983 – past, present and future

*Joan Rapaport**

Introduction

The 1990s have been characterised by an emphasis on public protection in response to high profile psychiatric homicides. This has led to greater use of compulsion and community controls and hence an increased need for civil liberties safeguards. This paper examines the background and safeguard potential of the nearest relative and its relationship with the Approved Social Worker. It further considers the implications of findings of the most wide-ranging in-depth research into the nearest relative against proposals to replace the designation with two new roles in anticipated legislative reform.

The term patient is used to describe people who are subject to the compulsory powers of the Mental Health Act, liable to be detained or in hospital on an informal basis. The term service user refers to individuals who receive psychiatric services but are neither hospitalised nor subject to compulsion.

Overview of the main issues

The nearest relative as defined in section 26 of the Mental Heath Act 1983 has discretionary powers to influence the case for or against a close relative's compulsory admission. Although the role was introduced in 1959 without a set of governing principles or clearly defined purpose, it has become officially recognised as a patient safeguard[1]. However, since its inception the role has sparked controversy because of longstanding concerns about relatives' powers to manipulate admissions and the lottery of family relationships. Dr Edith Summerskill the then shadow spokesperson for health, pithily located the main problem in the second reading of the Bill preceding the 1959 Act:

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[1] *DHSS (1976) Consultative Document A Review of the Mental Health Act 1959, HMSO, para 6.6; DoH (1999) Reform of the Mental Health Act 1983, Proposals for Consultation, Stationery Office, Chapter 10.*

> "There is another point I want to make about the nearest relative. It is easy to dismiss this, but it is quite conceivable that the nearest relative is not necessarily the person most concerned to promote the welfare of the patient. … At the moment we are discussing imponderables, but I confess that I find it difficult to suggest an alternative. No doubt we are thinking of our relatives and that "but by the grace of God there goes …" some of us. We should be quite content that our relatives should be there to look after our welfare, but can that be said about all people?"[2].

In spite of the importance of the nearest relative, the potential for bias and the length of its existence, its research and literature base is meagre. However, the fact that the role is set to disappear in legislative reform suggests it has not been seen as a resounding success.

The importance of safeguards

Under the Mental Health Act 1983 an order to detain a patient in hospital is in most cases founded on two medical recommendations and an application made either by an Approved Social Worker (ASW) or (rarely) the patient's nearest relative. A person being assessed with a view to compulsory admission is considerably disadvantaged, not least by the disabling effects of mental illness. A relative or carer may be the only person who is present who is independent of the assessing team able to give an account of the crisis. However, as already identified, such accounts are prone to bias. Although the Code of Practice to the Mental Health Act 1983 allows for the presence of an advocate[3] the urgency of the situation may prevent this from happening. Further Boyle contends that the assessment process arguably fulfils lower standards of jurisprudence than those exercised by the courts.[4] With regard to the latter, people from ethnic minorities and those with special communication needs may be especially vulnerable as, contrary to official policy[5], interpreters are not always available when an assessment takes place[6] or even after admission[7] when issues relevant to it arise. Yet the stakes are high. In addition to loss of liberty and the imposition of hospital regimes, patients can be subjected to chemical controls that have unpleasant and sometimes serious side effects.

Whilst there are times when compulsory admission is the only realistic option for the patient's welfare and or for the protection of others, proper safeguards are highly important to ensure the State, families and others in authority do not abuse the psychiatric system. In exercising their powers professionals are exhorted to use their discretion to ensure compulsion is only used as a last resort[8]. Important safeguards to promote appropriate, and guard against inappropriate compulsion are part of the role of the nearest relative and the reciprocal duties of the ASW.

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[2] *Hansard House of Commons 598 736.*

[3] *DoH (1999) Mental Health Act Code of Practice, 3rd Edition, Stationery Office, para 2.13.*

[4] *Boyle, M. (1996) Diagnosis Science and Power, video of conference "the Construction of Psychiatric Authority) Department of Psychiatry, University of Newcastle on Tyne. Boyle compares the operation of juridical and therapeutic or purposive law that combine in mental health legislation, the former operating in public according to strict legal codes and the latter in private by professionals according to diagnostic categories. Boyle challenges the scientific validity of psychiatric categories suggesting these have been reached with less rigour compared with similar processes carried out in general medical science.*

[5] *Code of Practice as above para 1.4.*

[6] *Rapaport, J. (2001) Am I making myself clear? Professional Social Work, British Association of Social Workers, February issue; 11-12; SSI (1999) Detained: SSI Inspection of Compulsory Mental Health Admissions, Department of Health.*

[7] *Warner, L. et al (1999) Improving Care for Detained Patients from Black and Ethnic Minorities, Sainsbury Centre.*

[8] *Code of Practice as above, 2.7.*

Both roles have been influenced by political and social change. The nearest relative will be replaced by the roles of Carer and Nominated Person and the ASW by the Approved Mental Health Applicant (AMHP) if the Mental Health Bill[9] comes into force. Patient advocacy will also be enhanced. The Bill has generally been criticised by professional, user, carer and other groups for widening the grounds for compulsion and weakening patient safeguards[10]. In view of the proposed changes research into the nearest relative's background, current value and lessons for the future was both timely and necessary.

Historical and contemporary contexts

The nearest relative role

The origins of the nearest relative and also medical recommendations lie in an Act of 1774 to regulate private madhouses. This Act introduced the process of certification for the admission of private "lunatics" and required the names of the person sending the patient, usually a relative, and the advising physician or apothecary to be stated in the admission certificate. The role of relatives was hereafter shaped by the interplay between the legal, policy and social developments of the nineteenth and first half of the twentieth centuries that focused on the growth of the asylums and institutional care. The 1959 Mental Health Act introduced a hierarchy to identify the nearest relative based on British genealogical traditions, intentionally "the person closest in affection rather than nearest relative in kinship"[11], and assigned to the role powers consolidated from previous mental health laws, including the contentious power to make the application for compulsory admission. The nearest relative hierarchy and powers were modified under the Mental Health Act 1983 by which time the Victorian asylums were being closed under an ethos of community care.

Under section 26 of the Mental Health Act 1983 a "relative" is defined as any of the following:

a) husband or wife
b) son or daughter
c) father or mother
d) brother or sister
e) grandparent
f) grandchild
g) uncle or aunt
h) nephew or niece

The highest relative in the hierarchy is usually identified as the nearest relative. However, additional rules also apply. For example, the nearest relative must be 18 years of age or over and living in the United Kingdom (UK) if the patient also resides in the UK. The eldest at each rung takes priority.

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[9] *DoH (2002) Draft Mental Health Bill, Cm 5538-1, Department of Health.*

[10] *Mental Health Alliance Response to the Consultation on Proposed Mental Health Act Reforms, (2003) MIND/Rethink; Church of England (2003) Emerging Issues in Mental Health Report by the Mission and Public Affairs Division.*

[11] *N.K.H. (1959) Drafts of the Mental Health Act, Volumes 1-12, Office of Parliamentary Counsel.*

Divorce or permanent separation ends the nearest relative tie. Partnerships of six months or more are counted as husband and wife relationships and, as a result of case law developments since the introduction of the Human Rights Act 1998,[12] this provision now also applies in the case of same sex partners. The 1983 Act added a non-relative with whom the patient had been living for five years of more to the list. Significantly, a relative living with or caring for the patient was also afforded priority with the effect that the nearest relative is now in many cases also the patient's carer.

The discretionary powers of the nearest relative interact and, in respect of the applicant functions, overlap with the ASW's duties. Under the civil sections of the Act the nearest relative is assigned the following legal powers:

- To require the local social services authority to direct an ASW to carry out an assessment of a patient to decide whether or not he or she needs compulsory hospital admission (section 13 (4));
- To make an application to detain the patient in hospital (section 11(1)) for assessment (section 2) or treatment (section 3);
- To make an application for the patient's reception by the local authority into guardianship (section 11(1); section 7);
- To notify the ASW that he or she objects to an application for admission for treatment or reception into guardianship (section 11(4));
- To seek to discharge the patient from 1) an assessment or treatment order or 2) from guardianship by a written application in the first instance to the hospital managers and in the second, to the local social services authority (section 23).

From the late 1980s and early 1990s there was a pronounced policy shift from the specific role of the nearest relative to that of the carer. As a result of carer initiatives carer nearest relatives are additionally entitled to an annual assessment of their own needs where they provide regular and substantial care[13] and access to carer services[14] (Carers and Disabled Children's Act, 2000). The carer's assessment is part of the ASW's remit. The round of carer's initiatives relate to the Government's interest in sustaining community care[15].

The Approved Social Worker and core duties

The ASW's origins lie in the Poor Laws[16], public protection duties introduced under the 1744 Vagrancy Act and separate roles of the Duly Authorised Officer (DAO) and professionally qualified Psychiatric Social Worker (PSW)[17] who worked in child guidance clinics. The DAOs who became the Mental Welfare Officers (MWOs) under the 1959 Mental Health Act were unqualified

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[12] *R. (on the application of S.S.G.) v. Liverpool City Council, the Secretary of State for Health and L.S. (Interested Party), 2002.*

[13] *Carers (Recognition and Services) Act 1995; DoH (1999) National Service Frameworks for Mental Health, Department of Health, Standard 6; DoH (1999) Caring about Carers: National Strategy for Carers, Department of Health.*

[14] *Carers and Disabled Children Act 2000.*

[15] *Parker, G. Clarke, C. (2002) Making ends meet: do carers and disabled people have a common agenda? Policy and Politivs, Volume 30, number 3; 347-359.*

[16] *Curran, C. Grimshaw, C. (1997) The Role of the Approved Social Worker (ASW), Openmind 87, Sept/Oct; 21.*

[17] *For an historical analysis see Ramon, S. (1985) Psychiatry in Britain, Meaning and Policy, Croom Helm, Chapter 6.*

and generally regarded as practical officials who dealt with the legal and logistical formalities of an admission.[18] They were not then in a position to provide a non-medical professional opinion to inform an assessment for admission, a factor that largely contributed to the nearest relative's retention of the applicant role. By the time of the 1983 Act, as a result of improvements in social work training and organisational changes, many of the social workers undertaking the MWO duties were professionally qualified, and in some cases were PSWs.

The 1983 Act introduced the ASW as a professional social worker specially qualified in mental health issues and law. Social Services Departments were additionally required to appoint a "sufficient number" (never defined) of ASWs to carry out duties conferred under the Act (section 114). Whilst the nearest relative retained all the rights and powers of the 1959 Act, changes to the social work role emphasised the discretionary nature of the nearest relative's powers. The introduction of section 13(4) (identified above) was pivotal in this regard. The power simultaneously confirmed that the nearest relative was under no obligation to make the application and that the ASW was the preferred applicant.

Core functions underpin the ASW statutory role. These comprise 1) observance of civil liberties to ensure procedures are properly followed 2) an independent professional opinion and 3) advocacy to observe the principle of the least restrictive alternative[19]. Specifically, the Act requires the ASW to interview the patient in a "suitable manner" and make a thorough exploration of all the circumstances to satisfy him or herself that an application ought to be made (sections 13(1) and 13(2)). The local authority must respond to a nearest relative's request for an assessment under section 13(4) and in such circumstances, where no application is made by the ASW directed to undertake the assessment, written reasons must be given. Where the nearest relative objects to an application for treatment or reception into guardianship the ASW cannot make the application, unless narrow legal criteria to displace the nearest relative on grounds of unfitness to act or unreasonable use of the role are met (section 29). If conversely the nearest relative makes the application the ASW has no power of veto. However, the Act requires the local social services to arrange for a social worker to visit the patient and provide the hospital managers with a social circumstances report after the admission.

ASW duties at the point of assessment (section 13(4), and duties to provide information and consult the nearest relative regarding an admission (sections 11(3) and 11(4)) arguably enhance the civil liberties and public protection functions of the nearest relative's powers. Examination of Parliamentary debates highlights that section 13(4) was introduced to secure an early social assessment of the patient's circumstances with a view to seeking the least restrictive alternative to hospital admission[20]. The nearest relative's power to object to an application for admission for treatment strengthens the role's position to argue for the least restrictive alternative, as does the power of discharge. However, in spite of the critical importance of the interaction of the ASW and nearest relative the Act does not require Social Services to publicise information about the two roles. Furthermore, a national audit of the critical point of assessment under the Act has never been instituted.

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[18] *See for example HC 562 1696-7.*

[19] *Manktelow, R. (1999) Approved Social Work in Northern Ireland: time for change, Practice, Volume 11, Number 1; 23-34.*

[20] *Hansard House of Lords 426 556; Baroness Faithfull promoted the early involvement of the social worker, sufficiently informed and with expert knowledge of community resources to advise relatives on the alternatives to hospital.*

The ASW like the nearest relative has undergone considerable identity-change. Since the 1990s most ASWs have moved from working in local authority teams to multi-agency Community Mental Health Teams. Recent research suggests that the ASW's professional independence from the psychiatrist and healthcare team is not apparent to carers and patients and service users[21]. Shortages in ASW numbers are reported[22] and whilst community services have diversified and increased, real alternatives to hospital are still lacking[23]. These factors have influenced the ASW's ability to divert people from hospital in the spirit of the 1983 Act.

Problems in practice

The nearest relative has been most seriously discredited because of the lottery attached to the identification process and weaknesses in the displacement criteria to address real-life problems of abusive and poor relationships. In spite of concerns about allegations of abuse, particularly sexual abuse made by the patient against the relative[24] essential recommendations made by the Mental Health Act Commission in 1991 to address the deficiencies of the displacement criteria of the Act[25] were ignored, thus allowing this serious situation to continue. Local authorities have also faced costly and time consuming litigation where relatives have objected to detention or guardianship although the patient has been deemed to be in serious need of treatment[26]. In a few instances relatives have challenged the validity of a detention order because of ASW failures to identify and consult the right relative[27]. These problems have tarnished the nearest relative's image. The case for changes to the nearest relative under legislative reform was finally won with the advent of the Human Rights Act 1998 and two cases that successfully highlighted the role's potential to breach Article 8 of the European Convention on Human Rights (ECHR)[28]. However, the proposals to reform the current Mental Health Act have been delayed. In an ever lengthening interim, the Government's failure so far to honour its undertaking to allow a patient to change his or her nearest relative in reasonable circumstances[29] has come under judicial consideration.[30]

With regard to the positive safeguard potential of the role the picture is equally bleak. A small body of literature suggests that relatives generally do not know their rights and that the powers are little used[31], although applications to discharge may be less rare than assumed[32]. The outcomes of

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[21] *Hogman, G. Pearson, G (1995) The Silent Partners, The needs and experiences of people who provide informal care to people with severe mental illness, National Schizophrenia Fellowship; Barnes, M. et al (2000) "There Ought to be a Better Way", Compulsion Under the 1983 Mental Health Act, Birmingham University.*

[22] *Cited in MHAC (1999) Mental Health Act Commission 8th Biennial Report 1997-1999, HMSO, para 4.36.*

[23] *Barnes et al (2000) as above.*

[24] *Hegarty, D. (1989) Escape from a nearest relative, Social Work Today, Volume 20, Number 3: 20-21; Rapaport, J. (1999) Rise and Demise of the Nearest Relative, Professional Social Work, June; 14-15.*

[25] *MHAC (1991) Mental Health Act Commission 4th Biennial Report, HMSO; para 11 3d.*

[26] *for example R v Wilson and another ex parte Williamson [1996] COD 42.*

[27] *For example S-C [1996] 2 WLR 146.*

[28] *JT v UK, 26494/95; FC v UK 37344/97*

[29] *JT as above.*

[30] *R. (on the application of M.) v. Secretary of State for Health (2003) ADMINISTRATIVE COURT.*

[31] *Silent Partners as above, Hart, L. (1998) Nearest and Dearest, Openmind 94, December; 14; Gregor, C. (1999) An Overlooked Stakeholder? The Views of the Nearest Relative on the Mental Health Act Assessment, Anglia Polytechnic University.*

[32] *Rapaport, J. (2000) Survey of the Institute of Mental Health Act Practitioners – The use of the Nearest Relative Powers, Detention and Discharge, The Care Programme Association, Issue 15, October; 11-13; Shaw, P. et al (2003) In relative danger? The outcome of patients discharged by their nearest relative from Sections 2 and 3 of the Mental Health Act, Psychiatric Bulletin, Volume 27; 50-54.*

research into assessments under the Act[33] support the case that ASWs more generally practise risk avoidance, whilst risk taking models that exploit crisis situations to help people use their strengths to grow and change are largely ignored[34]. Yet the successful outcomes of models supporting hospital diversion[35], family group conferencing[36] and a substantial body of psychoeducation literature[37] suggest that more could be done to develop hospital diversion and supportive frameworks that involve the nearest relative and family unit. This conclusion is in part further supported by a recent six-year study that found discharges by the nearest relative against psychiatric advice were not associated with a poor clinical outcome[38].

The nearest relative and ASW have operated in a climate of pre-occupations with risk assessment[39] following a spate of highly publicised homicides committed by people with psychiatric histories. These incidents have contributed to increased use of compulsion[40] and an emphasis on the "social policing" role of social workers and health workers rather than extra community resources, and a culture of blaming professionals when tragedies occur[41]. Although the numbers of psychiatric homicides are proportionately small and are actually declining[42], they continue to have a powerful impact on the media, Government policy and professional practice. The introduction of supervised discharge (section 25A-J) and expansion in medium secure provision are key public protection strategies. The high-risk environments in which users of psychiatric services are often forced to live[43] and inadequate community re-provision following the closure of the Victorian

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[33] *Barnes et al, (1990) Sectioned, Social Services and the 1983 Mental Health Act 1983, Routledge; Keeble et al, (1995) What users and significant others think about Barnet's Mental Health Crisis Intervention Service, LB Barnet; Quirk et al, (2000) What really goes on in Mental Health Act assessments? Findings from and observational study, Conference 6th March 2000, Royal College of Psychiatrists Research Unit; SSI, (2001) Detained: SSI Inspection of Compulsory Mental Health Admissions, Department of Health.*

[34] *Ramon, S. (2002) From Risk Avoidance to Risk Taking Mental Health Social Work, BASW Conference 20th November, 2002, Birmingham.*

[35] *Identified in Keeble et al, as above. For example the study by Keeble et al found that in two thirds of assessments people were successfully treated at home. This contrasts with two thirds of assessments ending in compulsion as found by Barnes et al in a study involving 42 local authorities and the recent study conducted by the SSI as above.*

[36] *Essex County Council (2002) Supporting People Together, North Essex Mental Health Partnership Trust. – Family group conferences involve service users, families and professionals in care planning and strengthen client support networks with positive outcomes – study of 16 families shows a high satisfaction rate.*

[37] *see for example Falloon, I. et al, (1984) Family Care of Schizophrenia, Guilford Press; Buchkremer, G. et al (1987) Psyhoeducational psychotherapy for patients and their key relatives of care givers: results of a 2-year follow-up, Acta Psychitrica Scaninavia, Volume 96; 483-498. Psychoeducation programmes teach families problem solving, communication and management skills. These programmes are shown to be successful in reducing relapse, especially in the short term and where additional therapies are used. They are however criticised notably because they require high levels of professional input and are highly selective in respect of the families identified for help. Psychoeducattion is identified here as having a contribution to make in providing hospital alternatives.*

[38] *Shaw et al, 2003 as above.*

[39] *Bech, U. (1999) World Risk Culture, Polity.*

[40] *Wall, S. et al (1999) Trends in the use of the Mental Health Act: England: 1984-96, British Medical Journal, Volume 318; 1520-1521.*

[41] *Hansard House of Commons 262 193 argued vehemently by Ann Coffey MP for Stockport a former social worker in the Second Reading of the Mental Health (Patients in the Community) Bill. Regarding the vulnerability of workers – "They are the people at whom a finger can be pointed when something goes wrong, enabling the Minister to wash his hands of any responsibility to provide resources for them to do their jobs. As the Minister is aware, even social policemen need resources".*

[42] *Taylor, P. Gunn, M. (1999) Homicides by people with mental illness: myth and reality, British Journal of Psychiatry, Volume 174; 9-14.*

[43] *Davis, A. (1995) Risk Work and Mental Health, In Kemshall, H. Pritchard, J. (Eds) Good Practice in Risk Assessment and Risk Management, Kingsley Publishers; 109-120.*

asylums[44] are not highlighted as prime concerns. The ASW's "wider" responsibilities to support individuals and families in crisis and duties to seek alternatives to hospital[45] have thus been clipped by political pressure as well as resource and personnel shortages.

Replacement roles under legislative reform

The tough risk-conscious climate both intensifies the need for civil liberties safeguards and threatens their functioning and future. Indeed, under the proposals to reform the 1983 Act the replacement roles of nominated person (appointed by the patient although subject to the AMHP's approval) and carer will have rights[46] not powers that even when combined in no way equate with those possessed by the nearest relative. The carer and nominated person (who may be one and the same) are distinguished in that the former has the right to request an assessment of the patient whereas the latter can make an appeal to the new tribunal, convened within 28 days of a preliminary assessment, on the patient's behalf. Both roles have rights to be consulted about care plans and discharge and staff will have duties to provide information about services and how these can be accessed. However, professionals appear to be given enhanced discretion to exclude the carer from consultations especially where:

> "consultation will be inappropriate or counter-productive, for example where there is conflict of interest between the patient and carer".[47]..

This seems to assume that professionals have a crystal ball and that conflict, far from being commonplace and relevant, is inappropriate. Clause 8 considerably reduces the new carer's position in comparison with the statutory authority of the nearest relative and also possible opportunities for helping the patient and his or her carers to address important issues through crises. It also threatens the continued existence of traditional social work responsibilities towards families located in the nearest relative and suggests that complex relationships can be surgically removed. Brazier's wisdom however suggests otherwise:

> "It is very dubious whether it is ever possible to divorce the interests of the individual entirely from the interests of the carer"[48].

The hardening attitude towards mental health carers visible in the unfolding proposals to reform the Mental Health Act 1983 conflict sharply with generic carer policies, previously identified, that declare intentions to raise the carer profile. Furthermore, the proposals have been made in the absence of research into the nearest relative, who is often the patient's main carer and against a background of largely negative information.

The Government rejected the recommendations of its Expert Committee to incorporate the principle of reciprocity into the proposed legislative refom[49]. Although the Committee's intention was to compensate compulsory patients with appropriate services, the principle has wider relevance and is embedded in the nearest relative functions under the current Act. However, the reciprocal potential of the nearest relative and its interface with other professionals, in particular the ASW, has not previously been explored.

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[44] *Ramon, S. (2000) A Stakeholder's Approach to Innovation in Mental Health Services A reader for the 21st Century, Pavilion, Chapter 1.*

[45] *LAC 86 (15) Mental Health Act 1983 – Approved Social Workers, para 14.*

[46] *Draft Mental Health Bill as above paras 127,128,153,160 and 161.*

[47] *DoH (2002) Draft Mental Health Bill Explanatory Notes, Department of Health, Clause 8.*

[48] *Brazier, M. (1992) Medicine, Patients and the Law, New Edition, Penguin Books; 109.*

[49] *DoH (1999) Reform of the Mental Health Act as above; Chapter 3, para 1.*

Empirical study

The nearest relative was introduced under the Mental Health Act 1959 and modified under the consolidating Act of 1983. Robust stakeholder representation was not involved at either stage. There has been little research into the operation of the 1983 Act[50] and the attitudes and knowledge of those responsible for its implementation[51]. The nearest relative is a particularly neglected topic[52] and has not even been subject to routine monitoring. In view of negative stereotypes of relatives implicating families in the aetiology of mental illness[53], and the problems of abuse and exploitation of patients by relatives, perceptions regarding the role's value are particularly vulnerable to the impacts of negative attitudes and bias.

Although since the 1990s Government policy has emphasised the importance of stakeholder consultation, those most affected by the role were not fully represented on the Government appointed Expert Committee that recommended its abolition.[54] Thus the deficits of the two previous reforms have been repeated for a third time. Yet experiences shape personal meanings and understanding of real-life-situations[55]. The case for research to investigate the views of main stakeholders involved in the nearest relative role, viz. carers, users of psychiatric services and ASWs, was both timely and necessary.

Main methods and findings

The main aims of contemporary research undertaken by the author as a PhD[56] were to investigate the values, attitudes and actions of carers, users of psychiatric services and ASWs in relation to the nearest relative and their views about legal change. The historical element provided an important starting point for the contemporary study, a means of co-ordinating fragmented information and a comparative perspective to assist the analysis of the empirical data. The contemporary study was of an exploratory nature and used qualitative methods. Grounded Theory[57] and the Case Study[58] method provided frameworks for the research design, data collection and analysis, and for comparing outcomes. Focus group[59] interviews comprising homogenous groups of carer, user and ASW stakeholders were augmented by topic guides, vignettes, information guides and group exercises to generate data. The research used

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[50] *Wall et al, 1999 as above.*

[51] *Eastman, N. et al (2000) A study of attitudes, legal knowledge, decision processes and decisions outcomes of professionals with responsibilities under the Mental Health Act 1983, Conference 6th March 2000, Royal College of Psychiatrists.*

[52] *Gregor (1999) as above.*

[53] *Laing, R. Esterson, A. (1970) Sanity, Madness and the Family, Penguin Books. Laing and Esterson belonged to the anti-psychiatry movement. The movement described schizophrenia as a meaningful response within dysfunctional families.*

[54] *Stakeholder representation: Users were originally invited – they either withdrew or were withdrawn from the Committee because of disagreement over the Government's insistence on the introduction of community treatment orders. The carer was atypical as he was also a GP. The social work representative although a very senior manager had no ASW experience.*

[55] *Giorgi, A. (1985) Sketch of phenomenological research, Dusquesne University Press; Brandon, D. (2000) Autobiography and Innovation, In: Ramon, S (Ed) A Stakeholder's Approach to Innovation as above.*

[56] *Rapaport, J. (2002) A Relative Affair The Nearest Relative under the Mental Health Act 1983, PhD thesis, Anglia Polytechnic University.*

[57] *Grounded Theory: A systematic method of analysing complex social phenomena and building theory.*

[58] *Case Study: An empirical inquiry that investigates a topic in its real-life context.*

[59] *Focus group: A special type of group defined by purpose, size, composition and procedures. It facilitates carefully planned discussion.*

"methodological triangulation"[60] and additional qualitative approaches to enhance scientific rigour. Five carer, four user and four ASW groups participated, a total of thirty-six carers, twenty-one users and twenty-four ASWs. The research incorporated county and urban locations and Afro-Caribbean carer and user groups. Carers and users were interviewed twice to ascertain their understanding of the role and to verify their views about its relevance. The empirical element of the research was conducted between 1997 and 1999. All except one of the interviews were completed before the Expert Committee's recommendations were announced.

The findings covered three main areas regarding stakeholder views about the benefits and burdens of the role namely, the identity of the nearest relative, carer and user knowledge base and implementation of the powers.

Safeguard and identification

Participants quickly identified the safeguard concept of the nearest relative to protect the patient's best interests. However, whether the safeguard principle was likely to be fulfilled depended entirely on the relationship between the nearest relative and patient. If the relationship was good, the nearest relative had the patient's best interests at heart and was able to be assertive the role was an effective safeguard. Conversely, if the relationship was poor, the nearest relative had abused the patient or vice versa, or the relative did not know the patient well enough the safeguard was worse than useless and certainly a violation of patient privacy (Article 8). Several accounts of manipulations by relatives to force hospital admission came to the fore mostly, although not exclusively, from user and ASW groups. One user alleged that her husband had used his powers to enhance his case for custody of their children. ASWs also recounted several stories of husbands seeking to "ditch" their wives (husbands were seemingly never such victims). Further, with serious implications regarding patient choice of nearest relative or equivalent representative, in some cases the nearest relative's true motives in prompting an admission only emerged over a considerable period of time.

> ASW 1 "… the nearest relative is not always … the most appropriate person to be consulted.
>
> ASW 2 … I would agree … the whole category is an historical anachronism … we've got to think quite carefully about what we're going to replace it with. It's just riddled with all sorts of contradictions and problems for relatives who use the powers … and for users as well. … You can't make assumptions until you know people quite well. … You may also have nearest relatives who've been themselves subjected to violence as a consequence of which they might not be willing to use the powers as they might precipitate violence".

The role was also a potential imposition on the privacy of burdened carers (particularly widows) who had no one to whom to delegate their responsibilities. Nearest relatives in these circumstances cannot totally divorce themselves from their role. ASWs are not required and the research participants were not supported by the workplace infrastructure to help nearest relatives to find willing and suitable alternatives. Although nearest relatives can choose to do nothing ASW duties to contact and consult them could impose an unwanted burden. In addition, the role might unexpectedly make disagreeable demands. One inner city carer described how she had been "forced to sign" her son into hospital. There had been no ASW present and she had not known of the ASW role. She described the incident as her "worst nightmare".

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[60] *Yin, R. (1994) Case Study Research Design and Methods, Sage; 92.*

Whilst the identification process could select the worst person it could also exclude the very best. Equally involved relatives, also found by Carter[61] and gay partners highlighted by Lindow[62] and recent case law[63] were discriminated against. The role did not in all cases suit Afro-Caribbean matriarchies: involved relatives living abroad were also excluded. ASWs felt professionally compromised when occasionally required to contact and consult relatives about the patient's detention regardless of the patients wishes and their own best judgement. In some cases this caused terrific patient anger. Patients and other family members probably wise to the system overcame the difficulty by withholding family information.

ASW powers to displace the nearest relative were found to be hopelessly inadequate. Even where the grounds existed the process could be very long-winded and arduous. The interim displacement order enabling the court to resolve the issue of nearest relative displacement under the ex parte provisions of the County Court[64] had only just been identified and was not widely known. Even so budgetary constraints were important factors to be considered before making the application and could sometimes override professional decision-making. One influential nearest relative had connived with senior management against the autonomy of the ASW who was seeking to displace the nearest relative in order to detain the patient under section 3. To the ASW's great relief the nearest relative went abroad just before the court hearing and another relative signed the application. Another nearest relative, aided by legal advice, had discovered a way of protracting her displacement endlessly by repeatedly re-assigning her powers to different relatives. The responsible medical officer had found the process wearing and discharged the patient who immediately left hospital and vanished without trace. In addition, displacement was perceived as a poor solution as the customary replacement of the nearest relative with the Director of Social Services removed the independent characteristics of the role and imposed a sense of officialdom.

The role additionally failed patients who had no identified or committed relative. Discretionary powers to find substitutes for such patients failed largely because suitable and willing volunteers were generally unavailable. The problem was particularly acute in the inner city area where a large proportion of patients had seemingly lost contact with their families. Yet all stakeholders agreed that inappropriate and disaffected relatives should be displaced (as advised by the Mental Health Act Commission in 1991) and that, as revealed by the hospital inquiry reports[65], patients without relatives were particularly vulnerable. To resolve the main current problems users, ASWs and the majority of carers favoured full patient autonomy in the choice of relative or representative, backed up by safeguards.

Knowledge base and implementation

With reference to the principle of fair process underpinning Articles 5 (security of the person) and 6 (fair trial) of the ECHR the research found that users did not know how the role could enhance or restrict their prospects of freedom. As carers were also generally unaware of their powers to

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[61] *Carter, D. (1999) The Nearest Relative under the Mental Health Act, MA thesis, Anglia Polytechnic University.*

[62] *Lindow, V. (1998) Threats & promises, Openmind 94, November/December; 11.*

[63] *R. (on the application of S.S.G.) Liverpool City Council 2002 as above.*

[64] *R v Central London County Court ex parte Ax London [1999] 3 All ER 991*

[65] *Martin, J. (1985) Hospitals in Trouble, Blackwell cited in Rogers, A. Pilgrim, D. Mental Health Policy in Britain, MacMillan Press Ltd; 73.*

access treatment and prevent unnecessary admission, the potential benefits of the role were immediately thwarted. Because of this poor knowledge base the powers were rarely implemented, although carers and users identified personal scenarios that underlined the role's relevance.

The research revealed the inadequacies of information systems and resources. In some cases ASWs had problems identifying the nearest relative because hospital databases did not record the nearest relative. They also had problems contacting relatives on holiday, out at work or whose mobile phones were not working. The inner city ASWs who felt overwhelmed by the volume of requests for statutory assessments, were unable to pursue relatives who were not immediately available at the assessment stage. Where such situations arose, in spite of official policy[66], the nearest relative might never be located and hence would not receive information about the role. Furthermore, ASWs were rarely involved during the pre-crisis stage and were reluctant to provide information in the heat of a crisis, when the patient and his/her relatives were in a state of emotional turmoil. Information from hospitals sent to identified nearest relatives about the legal aspects of detention (section 132((4)) and the imminent discharge of the patient (section 133(1)) (where the patient allowed) was either not received or not read. However, the repeat interviews also revealed that participants had problems recalling and understanding the role, although it was explained in a variety of formats.

Carers really wanted recognition, respect, information, support and responsive services and viewed their powers as a "last resort" measure. However, the power to procure an assessment under section 13(4) was keenly valued. If they had known of this power and of the ASW and ASW duties, tragedies that had occurred (actual and very serious attempts of suicide) might have been avoided. The research indicated that mental health professionals were also ignorant of section 13(4):

> Carer: " … Every time we've approached a mental health worker we are seriously told there's nothing we can do about him. Basically he's practically got to kill himself before we can do anything about it. Now if that applies (refers to S13(4)) when we were given that advice we would have done that without hesitation. ,,, If I had known of this position in law … my son would never have committed suicide, or tried to. … He had horrific injuries. … I'm horrified no one has ever told me that I could ask a social worker before now. … If I'd known that … it wouldn't change the fact that my son was seriously ill but it would have been a much happier story".

ASW information also indicated that section 13(4) policy required under the Code of Practice[67] had not been instituted. Carers were in addition mystified that although they were "in a sense recognised people", in practice they were often excluded from decision-making and had to be "pushy" to obtain information, even where the patient would be returning to their care. Some carers were also reluctant to give information to psychiatrists fearing that their carer confidences would be indiscriminately passed on to the patient. However, others felt that communications had improved where section 25A-J, authorising carer consultation, had been imposed. Also on a positive note, ASW duties to consult and involve the nearest relative resulted in three, possibly four, successful diversions from hospital. Individual examples of ASWs helping nearest relatives to attain their "encoded" right to be involved in decision-making embedded within the role[68], procure a carer's assessment and debrief after the trauma of a compulsory admission emerged.

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[66] *Code of Practice as above paras 2.15 and 2.16.*

[67] *Code of Practice as above para 2.38 a & b.*

[68] *Twigg, J. (1994) Carers, Families and Relatives: Socio-legal Conceptions of Care-giving Relationships, Journal of Social Welfare and Family Law, Volume 3, 279-98 (quote from page 295).*

An ASW also provided a scenario of the carer's assessment having given the "whole picture" of a patient's circumstances. This had apparently prevented a precipitous discharge and also helped the patient to understand the effects of his behaviour on his carers. Users generally liked the idea of the carer's assessment as they foresaw better prospects for themselves and were aware that their carers needed support and information to help them withstand the emotional burdens of care.

With regard to hospital diversions promoted by nearest relative interventions, the few stories that emerged suggest that the relatives concerned had very assertively used their powers. Reciprocal nearest relative powers and ASW duties were fundamental to these rare examples of the role's positive potential. By supporting the nearest relative to exercise his or her powers the ASW was empowered to apply rigorously the principle of least restrictive alternative and seek community solutions. These usually entailed providing extra support to the carer. The process of supporting the carer also enhanced the importance of the social work role.

Interpreters and ethnic insights

Afro-Caribbean carers were concerned that their facial expressions and behaviour could be misinterpreted and that such situations could lead to an inappropriate admission. This information underlines the importance of involving someone familiar with the patient in the assessment and hence the relevance of the nearest relative in general, as well as in specific cultural contexts. However, a particular difficulty emerged in relation to non-English-speaking people and those with communication impairments, as ASWs in some areas could not find interpreters to attend the assessment. At the point of desperation the empowered nearest relative was occasionally used as the translator, although the social workers concerned were aware of the nearest relative's increased potential to manipulate the outcome. A senior ASW said that she had been trying to raise the issue of access to interpreters with senior management for three years, but without success. This situation additionally highlights the general picture of woeful neglect of the assessment process and patient safeguards.

Conclusions and observations on the proposals for reform

The research confirmed that the nearest relative was better known for its vices than its virtues and in its current form was generally a poor safeguard. On the vices tack, whilst breaches of Article 8 in respect of patients were confirmed, the role could also intrude on the privacy of carers, especially widows living on their own who missed the support of their deceased partners. However, the research also showed that the role's positive potential was grossly overshadowed by a negative image that might have been considerably remedied had the vital recommendations of the Mental Health Act Commission to revise the displacement criteria in the Act not been ignored.

Although carers generally wanted recognition, support and responsive services rather than actual powers, the role was shown to have positive potential in achieving several successful hospital diversions and engaging caring carers. These scenarios support the findings of Gregor[69] and Shaw et al[70] that the nearest relative is an overlooked but very important lay safeguard. The apparent effort required to attain these goals suggests that if more relatives had been supported to use their

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[69] *Gregor (1999) as above.*

[70] *Shaw et al (2003) as above.*

powers, more alternatives to hospital care might have come to light. Even so, nearest relative information was not publicised and rarely provided before the crisis situation. Most carer and user participants, even those with repeated statutory experiences, professed ignorance of the ASW role, let alone section 13(4). Section 13(4) policies were missing. Interpreters were not always available when required. The workplace infrastructure did not fully support the ASWs to expedite nearest relative and related patient duties, adding to a general impression of nearest relative and ASW marginalisation. These findings have further implications for the nearest relative's civil liberties and human rights potential, and also highlight the iniquity of absent monitoring systems.

Research lessons and the future Act

Whilst many of the nearest relative's shortcomings could and should have been remedied, the research also highlighted that the role was outdated. The findings support the introduction of the nominated person and carer roles under the proposed legislation, although further clarification is required to disentangle their overlapping functions. The introduction of the nominated person should at least resolve many of the problems associated with inappropriate nearest relatives. In line with the Expert Committee's thinking the majority of the stakeholders agreed that the patient should be allowed to choose their representative, albeit in the context of safeguards. It was also clear that the roles of patient representation and carer combined in the nearest relative were sometimes incompatible and potentially burdensome. However, ASW problems in ascertaining the nearest relative's true motives strongly suggests that the patient should initially have full autonomy to choose the nominated person, rather than be subjected to the AMHP's approval, with provision to alter the arrangement at a later date if hard evidence shows this to be necessary. In addition, whilst the new arrangements technically cover patients without relatives, the problems of finding substitute nearest relatives suggests that local pools of potential nominees should be identified to ensure that the proposed safeguard is universally available.

The research revealed that the principle of reciprocity, recommended by the Expert Committee but rejected by the Government, has silently underpinned the positive objectives vested in a role that has suffered from political neglect and is not widely understood. At a general level this finding highlights the dangers of ignoring the importance of governing principles and objectives in shaping legislation and offers a new perspective on the principle of reciprocity. More specifically, the carer and nominated person and also AMHP roles run the risk of sharing the nearest relative's fate unless these key elements, supported by monitoring systems, are put in place. With regard to the safeguard objective the carer and nominated person will have rights rather than powers. Whilst the research found that carers generally wanted recognition, information, support and responsive services, the removal of powers considerably weakens the safeguard potential of the new roles. However, given the suggestion that reciprocity has silently underpinned the intended objectives of the nearest relative, the new roles may have more influence if they are properly supported by the reciprocal functions of professionals who are themselves properly supported to fulfil their obligations. This would mean that contrary to the current position the new roles and the reciprocal duties of professionals should be publicised, with support and advice available at every step through the admission process. Steps should be taken to ensure that policies are expedited and that policy consultations involve all the relevant stakeholders, contrary to the hapless position of section 13(4). Professionals should also have access to a range of community resources to fulfil their obligations to seek the least restrictive alternative to hospital, including psychosocial interventions that support families in crisis and enhance the carer's contribution. To address negative stereotypes of carers, multi-agency training on carers' needs, abilities and responsibilities will also be essential for the new roles to be effective. In addition, carer involvement should be given greater ethical prominence, rather than subject to diminution as currently indicated under Clause 8 of the Bill's guidance.

The ASW like the nearest relative will undergo changes if the new Act is implemented, although these largely concern the extension of the role to other non-medical professionals rather than radical changes to the role itself. The research found that ASWs were struggling to fulfil even basic statutory functions because of high workloads, missing policies, and poor and at times undermining management systems. Yet the applicant role is important not only in expediting the requirements under the Act but also in enabling lay roles, whether nearest relative, carer or nominated person, to fulfil their potential to help the patient attain his or her rights. The AMHP should expect the support of management in respect of access to effective databases, interpreters and other professional support systems to safeguard not only the integrity of the assessment process, but also to promote the importance of the applicant role. Given that the AMHP will not be independent of the assessing team it will be even more vital that these elements are addressed to ensure the new applicant is respected as a distinctive professional role, not only by users, carers and other professionals, but also the role-holders themselves.

Finally, whilst the delay in the proposed legislative reform provides opportunities to address the above concerns, it has the serious disadvantage of perpetuating problems associated with abuser relatives. This matter requires very serious attention as the law as it stands has adversely affected many people's lives. However, although judgements made by the European Court of Human Rights require changes to the nearest relative, there is still no sign that the Government is proactively considering interim remedies.

The author wishes to thank the carers, users and ASWs who participated in the project and also Professors Shula Ramon and William Bingley for their support throughout the period of research and preparation of this article.

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ECT and the Human Rights Act 1998

*Robert Robinson**

In the current edition of the Mental Health Act Manual[1], Richard Jones condemns the practice of detaining mentally incapacitated patients for the purpose of giving treatment which could lawfully be administered under common law. Jones draws particular attention to the 'sectioning' of compliant patients who require electroconvulsive therapy (ECT).

> 'There is a widespread practice of making applications to detain patients who require medical treatment for their mental disorder despite the fact that such patients are both mentally incapable and compliant, in that they are not exhibiting dissent to being in hospital at the time the application is made. In particular, it is felt that a compliant elderly mentally ill patient who needs to be given ECT as a treatment for depression must be detained under this Act before the treatment can be given, even though the effect of the depression has been to render the patient mentally incapable. As the provision of medical treatment to a mentally incapable patient, using force if necessary (*Re MB (Medical Treatment)* [1997] 2 F.L.R. 426 at 439) is authorised under the common law if the treatment is considered to be in the patient's best interests … the "sectioning" of the patient for the purpose of providing "authority" for medical treatment for his mental disorder to be given is unnecessary. Such action is also almost certainly unlawful because the "sectioning" of a compliant incapable patient would not be warranted for the purposes of section 2 (see s.2(2)(a)) and it would not be possible to satisfy the requirement in section 3 that the treatment "cannot be provided" unless the patient is detained under that section (see s.3(2)(c)). It would also not be possible for an approved social worker to claim under section 13(1) that it was "necessary and proper" for an application to be made as it is neither necessary nor legally proper to make an application in respect of a patient who is not attempting to leave the hospital and whose medical treatment is authorised under common law.'[2]

Jones's analysis of the common law is surely correct. Nonetheless, the administration of ECT to mentally incapable patients under the common law principle of necessity causes disquiet, not least among psychiatrists and approved social workers, and thus the practice which Jones deprecates is still widespread. This disquiet does not arise simply from ignorance of the law. There is a perception that because ECT is somehow different from other common forms of treatment for

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[1] *Mental Health Act Manual, Richard Jones, Sweet and Maxwell (8th edition) (2002).*

[2] *Jones at p.299.*

mental disorder there should be safeguards when it is administered to mentally incapacitated patients[3]. Such safeguards exist where the patient is detained under the Mental Health Act because of the requirement of s. 58 that, in the absence of the patient's informed consent, the treatment may only be given if approved by a second opinion appointed doctor (SOAD). It is for this reason that some doctors and social workers choose to detain such patients. They believe that they are acting in the patient's best interests by invoking the statutory safeguards.

There can be no doubt that, despite evidence of its clinical effectiveness, ECT remains controversial. This has recently been highlighted by the National Institute for Clinical Excellence (NICE) in guidance on the use of ECT.[4] The guidance contains the following description of ECT and its side-effects:

> '3.1 During ECT, an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalised seizure activity. The individual receiving treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. The ECT electrodes can be placed on both sides of the head (bilateral placement) or on one side of the head (unilateral placement). Unilateral placement is usually to the non-dominant side of the brain, with the aim of reducing cognitive side effects. The amount of current required to induce a seizure (the seizure threshold) can vary up to 40 fold between individuals.
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> 3.2 Although ECT has been used since the 1930s, there is still no generally accepted theory that explains its mechanism of action. The most prevalent hypothesis is that it causes an alteration in the post-synaptic response to central nervous system neurotransmitters.
>
> 3.4 ECT administration affects the central nervous system and causes changes in cardiovascular dynamics, which dictates the need for special caution in those individuals who are at increased risk of a cardiovascular event. There are also other immediate potential complications, such as status epilepticus, laryngospasm and peripheral nerve palsy, which overall have an estimated incidence of 1 per 1300 to 1400 treatments. The mortality associated with ECT is reported not to be in excess of that associated with the administration of a general anaesthetic for minor surgery.
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> 3.5 ECT may cause short- or long-term memory impairment for past events (retrograde amnesia) and current events (anterograde amnesia). As this type of cognitive impairment is a feature of many mental health problems it may sometimes be difficult to differentiate the effects of ECT from those associated with the condition itself. In addition there are differences between individuals in the extent of memory loss secondary to ECT and their perception of the loss. However, this should not detract from the fact that a number of individuals find their memory loss extremely damaging and for them this negates any benefit from ECT.'

As well as taking evidence from clinical experts, the Appraisal Committee took account of the experience of people who have received ECT. Of particular concern to many people are the side-effects associated with ECT.

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[3] *The Government's recognition of the need for safeguards in respect of ECT both for patients made subject to compulsory measures and for Part 5 'qualifying patients' is reflected in the Draft Mental Health Bill 2002 (Cm 5538-I) within clauses 118–120 and 131.*

[4] *National Institute for Clinical Excellence, Guidance on the Use of Electroconvulsive Therapy, Technology Appraisal 59, April 2003.*

> '4.3.2 The evidence submitted to the Committee, both written and verbal, demonstrated that, on balance, current opinion is that ECT is an effective treatment for certain subgroups of individuals with mental disorders. However, opinion varies from those who consider that its adverse effects are tolerable to those who consider that it is associated with unacceptable side effects including brain damage, severe confusion and considerable cognitive impairment in both the short and longer terms. While some individuals considered ECT to be a beneficial and lifesaving treatment, others reported feelings of terror, shame and distress, and found it positively harmful and an abusive invasion of personal autonomy, especially when it was administered without their consent.
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> 4.3.3 In consideration of these extremes of opinion, the Committee concluded that the wishes of the patient must be of paramount importance and that it is essential that all attempts should be made to obtain valid and informed consent, following recognised guidelines. The Committee felt strongly that consent should never be obtained by coercion – either explicit or implicit – through threat of compulsory treatment under the Mental Health Act, and mechanisms to monitor and prevent this from occurring should be developed and implemented, in consultation with appropriate professional and user organisations.'

While the guidance says nothing about additional safeguards for mentally incapacitated patients, it does contemplate ECT being administered to people who lack capacity to consent.

> '1.5 In all situations where informed discussion and consent is not possible advance directives should be taken fully into account and the individual's advocate and/or carer should be consulted.'

That ECT is disliked by some people and is associated with adverse side-effects does not detract from Jones's legal analysis: under common law, the treatment can lawfully be given to the mentally incapable patient without consent provided it satisfies the best interests test.[5] However, NICE's discussion of ECT brings to mind the words of Lord Steyn in the *Bournewood* case, drawing attention to the lack of safeguards under common law.

> 'The common law principle of necessity is a useful concept, but it contains none of the safeguards of the 1983 Act. It places effective and unqualified control in the hands of the hospital psychiatrist and other health care professionals. It is, of course, true that such professionals owe a duty of care and that they will almost invariably act in what they consider to be the best interests of the patient. But neither habeas corpus nor judicial review are sufficient safeguards against misjudgments and professional lapses in the case of compliant incapacitated patients.'[6]

Recent case law on non-consensual psychiatric treatment of detained patients suggests that the power to administer ECT to incapacitated patients under common law may have to be qualified in the light of the Human Rights Act 1998. The cases of *Wilkinson*[7] and N[8] both concerned challenges by detained patients to the administration of antipsychotic medication which was being given

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[5] *See the discussion in Jones (ante) pp. 298 to 306 on medical treatment of the mentally incapable. The essential requirements of the best interests test are first, that the treatment is carried out either to save the patient's life or to ensure an improvement or prevent deterioration in the patient's physical or mental health; and second, that the treatment is in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question.*

[6] *R v Bournewood Community and Mental Health NHS Trust, ex p. L [1998] 3 All E.R. 289, HL at p.308.*

[7] *R v the Responsible Medical Officer, Broadmoor Hospital, the Mental Health Act Commission Second Opinion Appointed Doctor and the Secretary of State for Health ex p. Wilkinson [2001] EWCA Civ. 1545.*

[8] *R v Doctor M and others ex p. N [2002] EWHC 1911 (Admin) and [2002] EWCA Civ 1789 (Court of Appeal).*

without consent but in accordance with the procedure under s.58, having in each case been authorised by a SOAD. Both cases make clear that such treatment potentially engages Articles 3 and 8 of the European Convention on Human Rights. Compliance with the statutory procedure under s.58 is thus a necessary but not sufficient condition for lawfulness.

In his extensive judgment in N, Silber J approached the case in the following way. He first satisfied himself that the s.58 procedure had been followed. He then considered the patient's capacity and, having found that she lacked capacity according to the common law test, he decided that the proposed treatment could lawfully be given under the principle of necessity. Finally, he determined whether the treatment infringed the patient's rights under Articles 3 and 8 of the Convention. In relation to Article 3 he concluded (at paragraph 112 of his judgment) that:

> 'where medical treatment is administered on a patient against his or her will, Article 3 will be contravened if (a) the proposed treatment on the patient reaches the minimum level of severity of ill-treatment, taking into account all the circumstances, including the positive and adverse mental and physical consequences of the treatment, the nature and context of the treatment, the manner and method of its execution, its duration and if relevant the sex, age and health of the patient and (b) the medical or therapeutic necessity for the treatment has not been convincingly shown to exist.'

In relation to Articles 8, he found (para. 120) that:

> 'Individuals have the right not to be subject to compulsory physical intervention and treatment and Article 8 can be engaged even where the minimum level of severity required in Article 3 cases was not reached. Thus, a prima facie breach of Article 8 may occur when treatment is given to a patient without consent, unless it is justifiable under Article 8(2).'

One of the justifications allowed by Article 8(2) is the protection of health. The Judge found that because the treatment was likely to alleviate or prevent a deterioration of N's psychotic condition it was justified under Article 8(2).

The Court of Appeal, which was concerned only with Article 3, upheld Silber J's judgment. Dyson LJ, who gave the judgment of the court, dealt with non-consensual treatment in the following way (at paragraphs 16/17 of his judgment):

> 'An important question is what standard of proof is required before a court can properly be satisfied that it is appropriate to give permission for treatment where the patient does not consent to it. The judge was right to say that he had to be satisfied that the proposed treatment was both in the claimant's best interests and "medically necessary" as that phrase should be understood and applied for the purposes of Article 3 of the Convention. The best interests test goes wider than medical necessity: see *Re S (Sterilisation:Patient's Best Interests)* [2000] 2 FLR 389. The focus of the argument before us was on the requisite standard of proof for the purposes of Article 3. In *Herczegfalvy v Austria* (1992) EHRR 437, 484, the ECtHR said:
>
> > "82. The court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention is being complied with. While it is for the medical authorities to decide, on the basis of the recognisable rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit no derogation. The established principles of medicine are

> > admittedly in principle decisive in such cases; as a general rule, a method which is a therapeutic necessity cannot be regarded as inhuman or degrading. The court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist."
>
> In the light of this decision, it is common ground that the standard of proof required is that the court should be satisfied that medical necessity has been "convincingly" shown.'

The situation of the compliant incapacitated patient to whom ECT is administered differs from that of the patients in *Wilkinson* and *N* in one important respect. They had both refused and were actively opposing the treatment. The treatment was therefore being given against the patient's will. This is apparent from the extract from Silber J's judgment above and also formed part of Hale LJ's analysis in Wilkinson (at paragraph 79):

> 'One can at least conclude that forcible measures inflicted upon an incapacitated patient which are *not* a medical necessity may indeed be inhuman or degrading. The same must apply to forcible measures inflicted upon a capacitated patient. I would hesitate to say which was worse: the degradation of an incapacitated person shames us all even if that person is unable to appreciate it, but in fact most people are able to appreciate that they are being forced to do something against their will even if they are not able to make the decision that it should or should not be done. The [European Court of Human Rights] understood how vulnerable such patients can be and how much in need of the protection of the world outside the closed world of the psychiatric institution however well meaning.'

It follows that where treatment, which is capable of being inhuman or degrading, is given to a mentally incapacitated patient, Article 3 will be engaged if the treatment is not medically necessary. On this analysis it is surely irrelevant whether the patient is compliant or is actively resisting the treatment. The potential breach of human rights arises from the position of the patient who is confined in a psychiatric institution and, in Lord Steyn's words, is subject to the 'effective and unqualified control' of health care professionals and is thus vulnerable to 'misjudgments and professional lapses'.

Taking account of the views of those who have experienced ECT, there can be little doubt that ECT reaches Silber J's minimum level of severity. That is to say it would be inhuman or degrading to administer ECT to a person who is not capable of consenting and for whom it is not medically necessary. It is irrelevant whether the patient is actively refusing the treatment. The test under Article 3 is whether medical necessity can be convincingly shown to exist.

It then becomes a matter of weighing the evidence. The simplest way to establish medical necessity convincingly is for the doctor in charge of the patient's treatment to seek a second clinical opinion. The opinion of two (or more) doctors that ECT is medically necessary will be more persuasive than that of a single doctor. This would also effectively reproduce for informal incapacitated patients the safeguards enshrined in the statutory procedure under s.58.

If this analysis is correct, Article 3 of the Convention requires that medical necessity be convincingly demonstrated before ECT can lawfully be administered to a mentally incapable patient, whether or not the patient is resisting. If medical necessity is to be convincingly shown, the clinician in charge of the patient's treatment will have to obtain a second opinion supporting the proposed treatment. In the case of an informal incapacitated patient such an opinion cannot be that of a SOAD appointed under s.58, but the requirements of Article 3 would be met by a second opinion from a suitably qualified clinician.

This is consistent with Jones's analysis and would also allay the disquiet of mental health professionals when ECT is given under the common law principle of necessity to compliant incapacitated patients.

Scottish Parliament acts on Mental Health Law Reform

*Hilary Patrick**

Introduction

The Mental Health (Care and Treatment) (Scotland) Act was passed by the Scottish Parliament on 20 March 2003 and received Royal Assent on 25 April 2003. The largest piece of legislation to pass through the Scottish Parliament, the Act represents a major reform of mental health legislation in Scotland. This article offers a short introduction and will serve as yet another example of how devolution is leading to major divergences in welfare law and practice north and south of the border.

Background

The Act replaces the 1984 Mental Health (Scotland) Act, which is broadly similar to the Mental Health Act 1983 which applies in England and Wales.

The 1984 Act was reviewed by an expert committee chaired by the Rt. Hon. Bruce Millan, a former Secretary of State for Scotland[1]. Its report, *New Directions*[2] was the result of widespread consultation, including the holding of consultation events with a wide range of bodies and the taking of oral evidence.

The Scottish Executive, in its policy paper *Renewing Mental Health Law*[3], broadly welcomed the Millan report, with some significant exceptions. Following a detailed scrutiny of the Bill by the Parliament's committees, notably the Health and Community Care Committee, major changes were made in the Committee stages of the Bill and the Act now broadly reflects the Millan recommendations.

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[1] *See H Patrick, Renewing Scottish Mental Health Law: Any lessons for England and Wales? JMHL Dec 2000, p147–156.*

[2] *New directions: Report on the Review of the Mental Health (Scotland) Act 1984 Scottish Executive January 2001.*

[3] *Scottish Executive, September 2001.*

Statement of principles

An interesting feature of the Act is its setting out of the principles which should apply whenever a person is carrying out functions under the Act. Some principles are set out in the Adults with Incapacity (Scotland) Act 2000 ('AWIA')[4] and in the Children (Scotland) Act 1995[5], but the 2003 Act's statement of principles is considerably more comprehensive. The statement in the Act is intended to reflect the ten principles recommended by the Millan Committee and accepted by the Executive.

The principles are taken as representing accepted good practice. As such they are not controversial, but it is unusual to see such statements set out in full in legislation, albeit not as extensively as some campaigners would have wished.

As recommended by Millan, the principles are as follows. *Non-discrimination* – people with a mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs. *Equality* – powers under the Act should be exercised in a non-discriminatory manner. *Respect for diversity* complements this. Care and treatment offered should take into account users' age, gender, sexual orientation, ethnic group and social, cultural and religious background.

The important principle of *reciprocity* states that where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

The principle of *informal care* recognises that wherever possible, care, treatment and support should be provided without recourse to compulsion. Any compulsion used should be the *least restrictive alternative*.

The *participation* principle attempts to ensure that service users are as fully involved as possible in all aspects of their assessment, care, treatment and support. *Respect for carers* is the corollary to this.

The Act mirrors the AWIA by including a principle of *benefit*. Any intervention under the Act should be likely to produce a benefit that cannot reasonably be achieved other than by the intervention. This is paralleled by the principle of *child welfare* – the welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Many campaigners remain unhappy that the way in which the principles have been incorporated into the legislation has reduced their clarity and impact. However the principles have had a significant impact in shaping the form of the legislation. They will continue to be relevant in influencing the content of the Code of Practice which will flesh out the provisions of the Act.

Introduction of Mental Health Tribunals

A new system of mental health tribunals (influenced by but different from MHRTs in England and Wales) will be introduced. These will replace the sheriff courts as the forum for dealing with applications for admission, appeals and variations of orders. As in England and Wales, there will be a legal chairperson, a medical member and a general member. Decisions will be by majority verdict. The controversial medical examination by the medical member will not be required. It is made clear that the general member may be appointed because of experience of mental health care gained as a user of services or a carer.

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[4] *Benefit, least restrictive alternative, taking account of adult's wishes and feelings, respect for views of relatives and carers and encouraging skills of adult where possible.*

[5] *Welfare of child to be paramount.*

Criteria for compulsion

The criteria for the use of compulsory measures are reformulated. Compulsory powers can be used only if there is a significant risk to the health, safety or welfare of the patient and if treatment is available which can prevent the patient's health from deteriorating or alleviate the symptoms or effects of the disorder.

While a strict incapacity test has not been imposed, compulsion can be used only if a patient's ability to take medical decisions is 'significantly impaired'. The criteria will also have to be read in conjunction with the principles, particularly those of benefit, informal care and least restrictive alternative.

Community treatment orders

The Act contains a range of new orders, including, controversially, a community treatment order where this is appropriate and the least restrictive option. The Mental Welfare Commission will closely monitor the new orders. The Scottish Executive has retained the power to impose further conditions on the use of such orders if experience proves this is necessary.

In an attempt to reduce the number of emergency 72-hour admissions (against which there is no appeal under the 1984 Act) a new form of 28-day short-term detention straight from the community is introduced. Two doctors and the mental health officer, the equivalent of the approved social worker in England and Wales, must approve the new order.

New duties on health boards and local authorities

New duties are imposed on health boards and local authorities. The duties to provide occupation and training for people with a learning disability and after-care (already wider than the duties in s117 of the Mental Health Act 1983) are replaced by wide duties to provide care and support services and to promote well being and social development. This includes the provision of recreational, training and employment services.

The Act also broadly gives effect to the Scottish Law Commission recommendations for the protection of vulnerable adults[6], insofar as these relate to people with a mental disorder.

The Scottish Executive was initially reluctant to impose specific duties on health boards, which have general duties under the National Health Service (Scotland) Act 1978. However in the Parliament the Bill was amended to include a duty on health boards to provide age appropriate services for young people with mental disorders (whether or not they are subject to compulsory measures) and to provide mother and baby units for women with postnatal depression.

Right to advocacy

Health boards and local authorities are given the duty to provide adequate advocacy services, including collective advocacy. Every person with a mental disorder in Scotland will have a right to such advocacy.

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[6] *Vulnerable adults Scottish Law Commission Report No 158, 1997.*

Patient representation

Users are given the right to nominate a 'named person' to act as their next of kin in mental health matters. This can be a family member, carer, friend or homosexual partner. This recommendation partly fulfils the UK government to reform the rules relating to nearest relatives following *JT v the United Kingdom*[7].

Advance directives

The Act gives some recognition to the concept of advance directives in psychiatry. Most commentators believe that advance directives in respect of treatment for physical disorders are legally binding in Scotland, although there is no case law to confirm this. Some bodies consulted by Millan argued that advance directives in psychiatry should also be legally binding, if validly made and applicable in the circumstances. A psychiatric advance directive made by a competent person should not, it was argued, be capable of being overruled by the compulsory powers in mental health legislation.

However neither Millan or the Scottish Executive was prepared to accept that the time was right for such a radical approach. Instead, the Act aims to encourage the use and development of advance directives, by requiring tribunals and mental health professionals to 'have regard' to their terms.

The tribunal must have regard to any advance directive when making an order. Doctors must take the terms of any advance directive into account when treating the patient or issuing a second opinion authorising treatment. If a patient is given treatment which conflicts with the terms of an advance directive, the doctor must notify the independent Mental Welfare Commission. The Commission will monitor the use of advance directives and has powers to stop treatments in certain circumstances.

Other treatment safeguards

While many of the rules on compulsory treatments remain as in the 1984 Act (largely modelled on those in the 1983 Act), there are significant changes. Drug treatment given by the RMO without consent or second opinion can now be given for only two months, rather than three. ECT cannot be given to a competent patient who refuses the treatment.

Second opinions will be required for forced feeding and for other treatments as set out in regulations (likely to include polypharmacy and the use of drugs for a purpose other than that set out in the product's licence). If the patient is a young person a second opinion must be obtained from an expert in child and adolescent psychiatry.

Similar safeguards will extend to patients treated under the provisions of the Adults with Incapacity (Scotland) Act 2000, except, unfortunately, for the second opinion on long-term drug treatments. The Scottish Executive was advised that it would be unworkable to apply this safeguard to the many vulnerable people living in nursing and residential homes who might have qualified for protection.

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[7] *1998, Application No. 26494/95. This is still a major concern south of the border. See R v Secretary of State for Health ex parte M, The Times 25 April 2003.*

Reform of sexual offences

The Act brings the law relating to sexual abuse of people with mental disorders up to date. There are two offences.

Sexual relationships between people with mental disorders (both mental illness and learning disability) and their professional carers are made a criminal offence, on the grounds that such relationships generally represent a breach of trust.

For other persons the relationship will be a criminal offence if the patient is unable to give a valid consent to the relationship because of his/her disorder or where there is use of fraud, deception, undue persuasion or deceit.

Secure provision

The way in which the criminal courts deal with people with mental disorders is reformed and streamlined. Regulations will be made to replace the mainly common law powers of hospitals to search patients, monitor telephone calls, internet access et cetera. There is little case law in Scotland to justify such controls and clearer rules were thought necessary to comply with human rights law.

Appeal against level of security

A major problem with services in Scotland is the lack of medium secure facilities. Most people requiring secure services in Scotland (and Northern Ireland) are housed in the high security State Hospital at Carstairs, Lanarkshire. One medium security hospital has recently been opened in Edinburgh, and others are promised.

However there are at any time around forty patients in the State Hospital who are regarded as ‘entrapped’, assessed by their care team as not needing the high security of the State Hospital but with nowhere suitable to go. The parents of one of these patients recently brought his situation to the attention of the Scottish Parliament, using its innovative petitions procedure[8].

While the Scottish Executive was initially reluctant to allow such patients a right to appeal against the level of their security, it was forced to bow to pressure in the Parliament and such a right is now included in the Act. This should lead to increased pressure on health boards to develop medium secure facilities. While this section may not be implemented immediately, the Act provides that it will be introduced by 2006 at the latest.

Conclusion

The Act builds largely on the work of the Millan Committee, and has been widely welcomed. As would be expected, the greatest area of concern is the operation of the new community treatment orders, which were generally (but not universally) opposed by the user movement. The new Act is expected to come into effect in early 2005.

The Act was subject to wide consultation and interested parties benefited from open access to

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[8] *Scottish Parliament Petition PE440. See Scottish Parliament Public Petitions Committee Official Report 15 January 2002, Column 1533.*

officials and Parliament at all stages of the process. Its passage through the Parliament was a clear demonstration of the Parliament working at its best. While the 1984 Act might be regarded simply as a modification of the 1983 Act to meet the different legal and social care systems in Scotland, the 2003 Act can be regarded as a distinctively Scottish solution to a Scottish problem.

Casenotes

Right to life – European Convention on Human Rights

*Oliver Lewis**

Paul and Audrey Edwards v. The United Kingdom
(2002) 35 EHRR 19
European Court of Human Rights
Chamber composed of Mr Cabral Barreto (President), Sir Nicolas Bratza, Mr Caflisch, Mr Kuris, Mr Türmen, Mrs Greve and Mr Traja.
Judgment 14 March 2002, Application number 46477/99

Facts

In the early nineties, Christopher Edwards, the applicants' son, showed signs of developing a serious mental illness. In 1994 he moved out of his parents' home and stopped taking his medication. On 27 November 1994 he was arrested by police in Colchester for approaching young women in the street and making inappropriate suggestions. Police officers detained him overnight in the police station, suspecting that he might be mentally ill, but that he did not need urgent medical attention. The next day he was brought to the Magistrates' Court where he confronted a female prison officer and shouted obscene suggestions about women. The magistrates considered remanding him to a psychiatric hospital for assessment, but concluded there was no power to do so under section 30 of the Magistrates' Court Act 1980. No consideration was given to civil detention under sections 2, 3 or 4 of the Mental Health Act 1983 or section 35 which allows for a remand to hospital for assessment. Magistrates remanded him into custody for three days and he was taken to Chelmsford Prison that afternoon.

In the meantime Christopher Edwards's father contacted the probation service at the prison, and informed them that his son had a mental illness and had been prescribed stelazine, though he had been refusing to take it or accept that he was mentally ill. The probation officer visited the prison's health care centre and spoke to the senior medical officer (though there was a later dispute about the detail of what was passed on).

The reception staff at Chelmsford Prison noted that Christopher Edwards's behaviour was "strange" and "odd" and when being placed in the holding cell he was aggressive and tried to punch

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* *Barrister; Legal Director Mental Disability Advocacy Center, Budapest.*

a prison officer. After two hours, he was screened by a non-physician member of the prison health care staff who saw no reason to admit him to the Health Care Centre. This person knew nothing about previous discussions in the court or the concerns passed onto the prison probation officer (and then onto the centre's own senior medical officer) about Christopher Edwards's mental health. There was no evidence of active mental disturbance or bizarre behaviour during the short health care interview. By this time there was no doctor on duty at the centre, nor indeed present in the prison. Christopher Edwards was admitted to the main prison and placed in cell D1–6 on his own.

Meanwhile, Richard Linford was arrested on 26 November 1994 for assault. At Maldon police station, a police surgeon certified that Richard Linford was not fit to be detained, but a psychiatric registrar decided that he did *not* need to be admitted to hospital and was fit to be detained. He was transferred to Chelmsford police station, where the police surgeon also found him fit to be detained. The registrar, who had previously treated Richard Linford, knew that he had been diagnosed at various times as suffering from schizophrenia or as having a personality disorder, but also knew him as someone who became ill when abusing alcohol and drugs. On 28 November 1994, Richard Linford was remanded in custody by Chelmsford Magistrates' Court and arrived at Chelmsford Prison shortly after Christopher Edwards, where he was screened by the same member of the prison health care service who had screened Christopher Edwards. Richard Linford was placed in a cell on his own, but later moved into cell D1–6 with Christopher Edwards. This was due to shortage of space, as all the other cells on the landing were doubly occupied.

Each cell had a green emergency light situated on the wall outside the cell next to the door which illuminated when the call button was depressed inside the cell. When the button was pressed, a buzzer sounded on the landing and a red light illuminated on a control panel in the office on the landing. At 9 p.m., either Christopher Edwards or Richard Linford pressed the call button. A prison officer saw the green light outside the cell and was told that they wished one of the cell lights, operated from the exterior, to be switched off, which he did. The two men were reported to be "getting on all right". He noticed that while the green light had gone on the buzzer which should have been sounding continuously had not done so, but did not report the defect.

Shortly before 1 a.m. on 29 November 1994, a prison officer heard a buzzer sound, but saw no red light on the D–landing control panel. Some time later, he heard continuous banging on a cell door on his landing. On going to investigate he saw the green light on outside cell D1–6. Looking through the spy hole, he saw Richard Linford holding a bloodstained plastic fork and blood on the floor and on Linford's feet. There was a delay of five minutes while officers put on protective clothing. They entered the cell to find that Christopher Edwards had been stamped and kicked to death. Richard Linford was making continual reference to being possessed by evil spirits and devils. D–landing had previously been patrolled at 12.43 a.m., which indicated that up to seventeen minutes could have elapsed from the pressing of the cell call button.

On 21 April 1995, Richard Linford pleaded guilty at Chelmsford Crown Court to the manslaughter of Christopher Edwards by reason of diminished responsibility. The judge imposed a hospital order under section 37 Mental Health Act 1983, coupled with a restriction order under section 41.

A Coroner's Inquest had been opened but adjourned pending the criminal proceedings against Richard Linford. After his conviction, the Coroner closed the Inquest, as there was no obligation to continue in those circumstances.

In July 1995, a private, non-statutory "inquiry after homicide" was commissioned by three agencies with statutory responsibilities towards Christopher Edwards – the Prison Service, Essex County Council and North Essex Health Authority. Its terms of reference included to investigate the extent to which the various authorities corresponded to statutory obligations, to examine the communication between the agencies involved in providing services to *both* men, and to examine the adequacy of the treatment and care as well as the arrest, detention and custody of them both.

On 16 October 1995, the applicants (Christopher Edwards's parents) were advised by the Assistant Chief Constable that there was insufficient evidence to establish the offence of manslaughter by gross negligence on the part of anyone involved in the case.

In February 1996, the applicants were advised by their solicitors that they had a claim for funeral costs and a potential claim for compensation and any pain and suffering between Christopher Edwards' injury and death. However, the high legal costs made it economically disadvantageous to bring such a claim. In April 1996, the Criminal Injuries Compensation Board awarded the applicants £4,550 for funeral expenses but decided that there should be no dependency or bereavement award.

The Inquiry opened in May 1996. The panel was chaired by Kieran Coonan QC with prominent psychiatric, social services, prison and police experts as members. They were assisted by a firm of solicitors. The Inquiry received evidence on 56 days over a period of 10 months. The Inquiry Panel conducted visits to the police stations, magistrates' court and prison concerned. About 150 witnesses attended the Inquiry to give evidence while a considerable number of others submitted written evidence. It sat in private and – as a non-statutory inquiry – had no powers of compulsion of witnesses or production of documents.

Two prison officers refused to give evidence. The Inquiry Report later noted that one of these had potentially significant evidence and his refusal was said to be "all the more regrettable since he had passed by Christopher Edwards's cell shortly before he met his death".

The Inquiry Report was published on 15 June 1998.[1] It ran to 388 pages and reached numerous findings of defects and made recommendations for future practice. It concluded that ideally Christopher Edwards and Richard Linford should not have been in prison and in practice they should not have been sharing the cell. It found "a systemic collapse of the protective mechanisms that ought to have operated to protect this vulnerable prisoner". It identified a series of shortcomings, including poor record-keeping, inadequate communication and limited inter-agency co-operation, and a number of missed opportunities to prevent the death of Christopher Edwards.

Following the publication of the report, the applicants sought advice as to whether there were any civil remedies available to them in the light of the findings of the Inquiry, but were advised by counsel that there were none.

By letter of 25 November 1998, the Crown Prosecution Service maintained their previous decision that there was insufficient evidence to proceed with criminal charges, an opinion supported by counsel for the applicants. Further, it is not possible under the common law to recover damages in tort for the death of another.

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1 *'Report of the Inquiry into the Care and Treatment of Christopher Edwards and Richard Linford: A Report commissioned by North Essex Health Authority, Essex County Council and HM Prison Service in association with Essex Police 2001' (available from the Health Authority).*

By letter dated 15 December 2000, the Police Complaints Authority provided the applicants with a report into their complaints about police conduct in dealing with Christopher Edwards and in the subsequent investigation into the death. The report upheld fifteen of the complaints and made a number of recommendations to Essex Police in relation to practice and procedure.

Judgment

(a) Right to life – substantive aspects

The applicants complained to the European Court of Human Rights that the authorities failed to protect the life of their son and were responsible for his death. They also complained that the investigation into their son's death was not adequate or effective as required by the procedural obligation under Article 2 of the Convention, which provides in its first sentence:

> "1. Everyone's right to life shall be protected by law. ..."

The Court reiterated that the first sentence of Article 2(1) obliges States not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction, primarily by putting in place effective criminal law provisions backed up by law enforcement machinery. It also extends in appropriate circumstances to a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual. The Court said that the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Not every claimed risk to life therefore can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. For a positive obligation to arise, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.

The Court stressed that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them, a duty recognized in English and Welsh law where inquests are automatically held concerning the deaths of persons in prison and where the courts have imposed a duty of care on prison authorities in respect of those detained in their custody.

The Inquiry panel had concluded that any prisoner sharing a cell with Richard Linford that night would have been at risk to his life. For the Court, the essential question therefore was whether the prison authorities knew or ought to have known of his extreme dangerousness at the time the decision was taken to place him in the same cell as Christopher Edwards. The Court was satisfied that the answer to this question was yes.

Notwithstanding the defective buzzer system, the Court concluded that on the information available to the authorities Christopher Edwards's life was placed at risk by placing a dangerously unstable prisoner into his cell. The failure of the agencies involved to pass on information about Richard Linford to the prison authorities and the inadequate nature of the screening process on Richard Linford's arrival in prison disclosed a breach of the UK's obligation to protect the life of Christopher Edwards, in violation of Article 2 of the Convention.

(b) Right to life – procedural aspects

The obligation to protect the right to life under Article 2 of the Convention, read in conjunction with the State's general duty under Article 1 of the Convention to "secure to everyone within [its] jurisdiction the rights and freedoms defined in [the] Convention", also requires by implication that there should be some form of effective official investigation when individuals have been killed as a result of the use of force (see, *McCann and Others v. the United Kingdom*).[2] Such investigations must seek to secure the effective implementation of laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility. What form of investigation will achieve those purposes may vary in different circumstances, but whichever form is employed, the authorities must act of their own motion, once the matter has come to their attention. It is not the duty of the next of kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures.

The Court reiterated that for an investigation into alleged unlawful killing by State agents to be effective the following points must be observed:

The persons responsible for and carrying out the investigation must be institutionally and practically **independent** from those implicated in the events.

The investigation must also be **capable of leading to the identification and punishment of those responsible**, and to a determination of whether any force used was or was not justified in the circumstances. The authorities must take reasonable steps to secure evidence, including eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling short of this standard.

Inquiries must be **prompt**, to maintain public confidence in the adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts. For the same reasons, there must be a **sufficient element of public scrutiny** of the investigation or its results to secure accountability in practice as well as in theory. The degree of public scrutiny required may well vary from case to case. In all cases, however, the **victim's next-of-kin must be involved** in the procedure to the extent necessary to safeguard his or her legitimate interests.

In this case, the Court found that because Christopher Edwards was a prisoner under the care and responsibility of the State when he died from acts of violence of another prisoner, a procedural obligation arose to investigate the circumstances of his death. It was irrelevant whether State agents were involved by acts or omissions in the events leading to his death. Even if civil proceedings were available, such actions initiated by the applicants would not satisfy the State's obligation to hold an investigation of its own motion.

As no inquest was held in this case and criminal proceedings where Richard Linford was convicted did not involve a trial at which witnesses were examined, the investigation at the heart of the Court's examination was whether the Inquiry provided an effective investigative procedure, fulfilling the requirements already identified.

The Court noted that this Inquiry heard a large number of witnesses and reviewed in detail the

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[2] *Judgment of 22 September 1995, Series A no. 324, p. 49, § 161*

way in which the two men were treated by the various medical, police, judicial and prison authorities. The Report of the Inquiry was a meticulous document, Nonetheless, the applicants complained that the Inquiry proceedings failed to reach the required standards under Article 2 on a number of grounds:

(i) Alleged shortcomings in the investigation

The applicants complained that the police omitted certain significant steps in their investigation, a claim which the government denied. The Court found that this did not prevent the Inquiry from establishing the principal facts of the case.

(ii) Lack of power to compel witnesses

As a non-statutory inquiry, the Inquiry had no power to compel witnesses and as a result two prison officers declined to attend. One of the prison officers had walked past the cell shortly before the death was discovered and the Inquiry considered that his evidence would have had potential significance. The Government asserted that this witness had submitted two statements and that there is no indication that he had anything different or additional to add.

The Court noted that he was not available for questions to be put to him which might have required further detail or clarification or for any inconsistency or omissions in that account to be tested. The lack of compulsion of witnesses who are either eye-witnesses or have material evidence related to the circumstances of a death must be regarded as diminishing the effectiveness of the Inquiry as an investigative mechanism. In this case it detracted from its capacity to establish the facts relevant to the death, and thereby to achieve one of the purposes required by Article 2 of the Convention.

(iii) Alleged lack of independence

The applicants alleged that the Inquiry lacked independence as it was set up by the agencies with statutory responsibilities towards both Christopher Edwards and Richard Linford. The Court noted that the chairman was a senior member of the bar with judicial experience, while the other members were eminent or experienced in their fields. None had any hierarchical link to the agencies in question. It is not asserted that they failed to act with independence or that they were constrained in any way. They acted in an independent capacity, therefore the Court found no lack of independence in the Inquiry.

(iv) Alleged lack of public scrutiny

Notwithstanding the public nature of the Inquiry's report, the Inquiry sat in private during its hearing of evidence and witnesses. The applicants, parents of the deceased, were only able to attend three days of the Inquiry when they themselves were giving evidence. They were not represented and were unable to put any questions to witnesses, whether through their own counsel or otherwise. They had to wait until the publication of the final version of the Inquiry Report to discover the substance of the evidence about what had happened to their son. The applicants argued that this did not meet the standards of public scrutiny required by Article 2. The Government argued that the publication of the report secured the requisite degree of public scrutiny, but gave no reason for holding the inquiry in private.

The Court stated that where the deceased was a vulnerable individual who lost his life in a horrendous manner due to a series of failures by public bodies and servants who bore a responsibility to safeguard his welfare, the public interest attaching to the issues thrown up by the case was such as to call for the widest exposure possible. Given their close and personal concern with the subject-matter of the Inquiry, the Court found that the parents cannot be regarded as having been involved in the procedure to the extent necessary to safeguard their interests, in violation of the procedural requirements of Article 2.

(v) Alleged lack of promptness and reasonable expedition

The applicants alleged that the Inquiry lacked sufficient promptness. Christopher Edwards died on 29 November 1994. The decision to hold an inquiry was taken in July 1995 and the proceedings opened in May 1996, with witnesses heard over the following ten-month period. The report was issued on 15 June 1998, some two years after the Inquiry opened and three and a half years after the death.

The Court noted the considerable amount of preparation required for an inquiry of this complexity, the number of witnesses involved in the proceedings (about 150 people gave oral evidence) and the wide scope of the investigation which covered the involvement of numerous public services. It held that authorities acted with sufficient promptness and proceeded with reasonable expedition.

(c) Article 13

Article 13 of the Convention provides:

> "Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

Article 13 guarantees the availability at national level of a remedy to enforce the substance of the Convention rights. Article 13 thus requires the provision of a domestic remedy to deal with the substance of an "arguable complaint" under the Convention and to grant appropriate relief.

The remedy required by Article 13 must be "effective" in practice as well as in law. There must be a mechanism for a victim or family to establish any liability of State officials or bodies for acts or omissions involving the breach of their rights under the Convention. The Court added that in the case of Articles 2 (right to life) and 3 (right to be free from torture, inhuman and degrading treatment or punishment) of the Convention, compensation for the non-pecuniary damage flowing from the breach should in principle be available as part of the range of redress.

On the basis of the evidence adduced in the present case, the Court found that the Government was responsible under Article 2 for failing adequately to protect the life of Christopher Edwards while he was in the care of the prison authorities. The Court recalled that in general actions in the domestic courts for damages may provide an effective remedy in cases of alleged unlawfulness or negligence by public authorities. However the Court did not find that civil action in negligence or under the Fatal Accidents Act 1976 was in the circumstances of the case of practical use. Nor would a case which could be brought under the Human Rights Act 1998, as it would relate only to any continuing breach of the Convention after the entry into force of the Act (2 October 2000) and would not provide damages related to the death of Christopher Edwards which preceded that date.

No other procedure whereby the liability of the authorities can be established in an independent, public and effective manner was referred to. The Court therefore found the applicants did not have available to them an appropriate means of obtaining a determination of their allegations that the authorities failed to protect their son's right to life and the possibility of obtaining an enforceable award of compensation for damages. For a bereaved parent this was an essential element of a remedy under Article 13, which in this case had been violated.[3]

Costs

Under Article 44 of the Convention, the Court ordered the government to pay the applicants £20,000 in respect of non-pecuniary damage and £20,000 in respect of costs and expenses plus taxes.

Commentary

The tragic death of Christopher Edwards and the determination of his parents to seek justice[4] demonstrates the way that a system may fail adequately to protect the life of an individual and then fail to allow that person's grieving family to have a full investigation into the death. Although it was not the purpose of the Inquiry to offer comfort to the family of Christopher Edwards, Inquiries must have in mind not just the feelings of secondary victims of homicides, but also their human rights.

Perhaps the more interesting aspect of this case from a legal perspective is how the procedural aspects of Article 2 – not set out in the Convention itself – have evolved since the mid 1990s in a series of cases brought to the Strasbourg court against primarily the UK and Turkey. It is now clear that where a death occurs – whether or not at the hands of state agents,[5] and whether or not violence was used[6] – there must be an investigation which is independent, public, prompt, thorough, effective, capable of imputing responsibility for the death, and enables effective involvement of the next of kin. This obligation now extends to cases of possible medical negligence in respect of an individual under the care and responsibility of health professionals,[7] and to situations where victims have been paid compensation but there has been no (or an inadequate) investigation.[8]

The death of Christopher Edwards was the central issue of at least six different domestic investigations: *First*, the criminal trial of Richard Linford at which he pleaded guilty to the manslaughter of Christopher Edwards by reason of diminished responsibility. *Second*, the Crown Prosecution Service which decided there was insufficient evidence to proceed with criminal charges. *Third*, the Coroner's Inquest which had closed without hearing evidence after the conviction of Richard Linford. *Fourth*, the Police Complaints Authority reported on police conduct in dealing with Christopher Edwards and in the subsequent investigation into the death,

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[3] *See also Keenan v. the United Kingdom, (2001) 33 E.H.R.R. 38, paragraph 132*

[4] *See Edwards, A, "No Truth, No Justice: A David and Goliath Story of a Mother's Struggle Against Public Authorities to Secure Justice for Her Son, Murdered While in Their Care" Waterside Press, 2002*

[5] *See Yasa v. Turkey (1999) 28 E.H.R.R. 408; Kaya v. Turkey (1998) 28 E.H.R.R. 1; Cakici v. Turkey, Judgment 8 July 1999 (paragraph 87)*

[6] *See McShane v. the United Kingdom (2002) 34 E.H.R.R. 23*

[7] *See Erikson v. Italy, Application no. 37900/97, judgment 26 October 1999, Siemiska v. Poland, Application no. 37602/97, judgment 29 March 2001 and Powell v. the United Kingdom, Application no. 45305/99; admissibility decision 4 May 2000.*

[8] *See Jordan v. the United Kingdom , (2001) 11 B.H.R.C. 1*

upholding fifteen of the applicants' complaints and making a number of recommendations to Essex Police in relation to practice and procedure. *Fifth*, the Health and Safety Executive carried out an investigation focusing on the management of the two people in prison. *Sixth*, the private, non-statutory Inquiry chaired by Kieran Coonan QC which was the subject of the case at Strasbourg.

Notwithstanding the elaborate (not to mention expensive) system of investigating deaths in England and Wales, the Court found that the UK had failed in its obligation under the procedural aspects of the right to life. Principally there were two aspects of the Inquiry which were found to violate Article 2:

First, that the Inquiry sat in private. Thus Christopher Edwards's parents were not allowed to be present or take part in the proceedings. They had to wait two years after the Inquiry opened and three and a half years after the death to find out the circumstances surrounding their son's death. Had there been a full coroner's inquest, the family would have been entitled to be present and be represented (albeit without public funding) by counsel.

In order not to fall foul of ECHR standards in future Inquiries, the Inquiry Chairperson could meet the family of the deceased to enquire into whether they would like to be present during the hearing, and if so, whether they would like to be legally represented. Such representation would have to be funded by the commissioning health or social services authority. In *Edwards* the UK government provided no reasons for the Inquiry being held in private. The Court stated that it "considers that the public interest attaching to the issues thrown up by the case was such as to call for the widest exposure possible".[9] How one would challenge an Inquiry which (with the next-of-kin's consent) sits in private is a matter for speculation. It would be difficult if not impossible for a non next-of-kin to challenge this given the current rules of victim status in Article 34 of the Convention and jurisprudence under that Article.[10]

Second, the Court found that the Inquiry's inability in law to compel witnesses to attend to give live evidence diminished the effectiveness of the Inquiry as an investigative mechanism and detracted from its capacity to establish the facts relevant to the death.[11] Although it has been said that witnesses who do not attend voluntarily are "usually unwilling and unforthcoming witnesses, if not actually unreliable",[12] this was an exceptional case where there were witnesses who could usefully have been cross-examined about information not contained in their written statements.

The UK government has issued no guidance following the *Edwards* case. Given that there are numerous Inquiries taking place across the country, Inquiry panels may find themselves – as many have done in the past – in a position where they want to compel a witness to attend but lack the legal basis on which to do so. In such circumstances (and if the specific statutory criteria are met) the panel or the appointing authority could ask the Secretary of State to establish a statutory inquiry either under section 125 Mental Health Act 1983 or under section 84 National Health Service Act 1977. If this is refused, the Inquiry or appointing authority might contemplate issuing proceedings in the Administrative Court to challenge the Secretary of State's refusal to comply

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[9] *Paragraph 83 of the judgment.*

[10] *Article 34 ECHR states that the Court may receive an application from any individual or group "claiming to be the victim of a violation" of the Convention.*

[11] *The Inquiry lacked the power to compel witnesses as it was non-statutory and thus fell outside the scope of the Tribunals and Inquiries Act 1992.*

[12] *Clothier, C., "Ruminations on Inquiries", in Peay, J. (ed), Inquiries After Homicide, 1996*

with Convention requirements.

A final point of interest is that of victim status. The Strasbourg Court has said that, "[t]he mere knowledge of the killing on the part of the authorities gives rise *ipso facto* to an obligation under Article 2 of the Convention to carry out an effective investigation into the circumstances surrounding the death."[13] Relatives do not need to instigate such investigations, but the Convention allows relatives of those who have died to be regarded as "victims".[14] What happens in cases where there are no family members? There are alarming cases of grossly elevated mortality rates within some State-run mental health institutions within the Strasbourg Court's jurisdiction.[15] When residents die (for example of malnutrition or hypothermia) there are no investigations of any sort. For thousands of vulnerable people facing early and un-investigated death there is often no-one – like Paul and Audrey Edwards – to bring such gross failures to the Court's attention. The Council of Europe should re-visit the Convention's rule on victim status and allow non-governmental organizations to lodge Article 2 complaints in which they are not the primary victim. This may save the lives of numerous people for whom the right to life protection under the European Convention of Human Rights is currently meaningless.

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[13] *Ergi v. Turkey, Judgment 28 July 1998. R.J.D. 1998–IV 1778 (paragraph 82)*

[14] *See Article 34 of the Convention and Yasa v Turkey (1999) 28 E.H.R.R. 408 (nephew of deceased as victim); H v. the United Kingdom, Application no. 9833/82; 42 D.R. 53 (mother of murdered person as victim); Wolfgram v. Germany, Application no. 11257/84; 49 D.R. 213 (parents of deceased as victims).*

[15] *See for example, Amnesty International, "Bulgaria: Where are the men of Dragash Voyvoda?", AI Index: EUR 15/005/2003, which states that, "[t]he most telling indicator of the gross neglect that men of Dragash Voyvoda had been subjected to was the unacceptably high mortality rate in the institution. During 2001, approximately every fifth man in this social care home, which held around 140 men, died apparently as a result of inadequate medical treatment and care."*

There is no magic in a bed – The renewal of detention during a period of leave

*David Hewitt**

R (on the application of DR) v Mersey Care NHS Trust
CO/1232/2002
Administrative Court (7 August 2002) Mr. Justice Wilson.

Where medical treatment in a hospital was a significant component of a patient's treatment plan it would be lawful to renew her detention under the Mental Health Act 1983, even though there was no intention for her to become an 'in-patient'.

Introduction

Since 1986, psychiatrists have been urged to abjure the 'long leash', and to ensure that only those patients who require treatment in a hospital should be detained – or 'liable to be detained' – there. Recent cases, the present one included, may have qualified this injunction, but they do not seem to have displaced it.

Facts

The Claimant, 'D.R,' was a 44-year-old woman who was diagnosed as suffering from schizophrenia. She had first entered hospital for psychiatric care in 1991 and had been subsequently admitted to the Defendant's mental health unit on five occasions. According to Wilson J:

> "[T]he pattern was of her successful treatment with medication within that climate of compulsion; but of her failure, following discharge, to take medication, born of a refusal to accept that she was ill and needed it".[1]

The admission that was the subject of this case began on 12 September 2001, when D.R. was detained under section 3 of the Mental Health Act 1983 ('MHA 1983'). The authority for detention would last until 11 March 2002, unless she was discharged before that date.[2]

Although her mental state improved once she began to receive medication again, D.R. did not engage with hospital staff, and she became isolated within the ward. What was needed, Wilson J. concluded, was

> "a mechanism […] whereby staff could engage with her and thereby enable her to develop an

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* *Solicitor and Partner at Hempsons solicitors; Member of the Mental Health Act Commission. Hempsons represented the doctors in the Hallstrom and Gardner cases and currently represents one of the interested parties in the case of IH (see below for citations)*

[1] *Judgment, para 6*

[2] *MHA 1983, s 20(1)*

> insight into her condition, which, following ultimate discharge, would lead her to continue to take medication voluntarily."[3]

In October 2001, D.R's Responsible Medical Officer ('RMO') used his powers under MHA 1983, section 17 to grant her leave of absence from the hospital. In the words of Wilson J, he hoped "to end the claimant's passage around […] the revolving door."[4]

The leave given to D.R. was extensive: she could go home for all but three days each week, and even on those days she would only have to be back in the hospital between 9.00 a.m. and 5.00 p.m. While on leave she would be visited by members of the 'assertive outreach team', who would ensure that she received her prescribed medication by injection. On 5 December 2001, having heard an application made by D.R. shortly after she was detained, the Mental Health Review Tribunal ('MHRT') decided not to discharge her.

There followed what Wilson J. called a "set-back"[5] in D.R's treatment plan, and on 31 January 2002 she returned to the hospital, where she remained for four days and nights. On 5 February 2002, having examined D.R. in accordance with his statutory duty,[6] the RMO completed a report in Form 30, the purpose of which was to renew her detention with effect from 11 March 2002. In his report, the RMO wrote:

> "She suffers from a mental illness namely schizophrenia. She harbours numerous delusional beliefs and has recently expressed suicidal ideas to the nurses who visit her. She has no insight into her illness. She has been reluctant to take medication. She needs to be detained in hospital in order to administer medication and observe her progress by trained staff."[7]

At the same time as completing his renewal report, the RMO also prepared a fresh treatment plan. It provided that D.R. should have leave of absence again; that members of the assertive outreach team should visit her at home each Tuesday and Thursday; and that a community psychiatric nurse should visit her every fortnight to administer her prescribed medication. Crucially, the new treatment plan also provided that D.R. should return to the hospital for occupational therapy every Friday between 9.00 a.m. and 5.00 p.m, and for the ward round every Monday morning, so that her progress could be monitored.

It will be noted that the second treatment plan envisaged D.R. having less contact with the hospital than had been provided for in the first. Previously, she was required to return for three days each week, whereas now she would only be in the hospital on a Friday, and on Monday for as long as it took to complete the ward round.

Although D.R's detention was renewed immediately her RMO 'furnished' his report to 'the managers' of the hospital,[8] those managers met on 20 February 2002 to consider the report and to decide whether to use their statutory power to discharge the Claimant from detention.[9]

At the hospital managers' review meeting, the RMO reiterated the conclusions of his report and expressed the opinion that if D.R. were to be discharged "in her current mental state, she will stop

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[3] *Judgment, para 8*

[4] *Judgment, para 5*

[5] *Ibid, para 10*

[6] *MHA 1983, s 20(3); Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg 10(1)*

[7] *Judgment, para 11*

[8] *MHA 1983, s 20(8)*

[9] *MHA 1983, s 23, MHA 1983 Code of Practice, para 23.7*

taking the medication and her condition will rapidly deteriorate."[10] This view was supported by D.R's Approved Social Worker, whose report stated:

> "Everybody involved with [D.R.] recognises that compliance with medication is the issue. [D.R.] has no insight into her illness and I feel masks her symptoms because she is aware we feel they indicate illness. She has promised to accept the depot injection for two years. I am not convinced she will be able to keep this promise. It may be wise to keep [D.R.] on section 3 a little longer, as this will ensure that she is treated and perhaps the revolving door cycle can be broken."[11]

A report written for the managers' meeting by a nurse suggested that D.R. did not believe she was ill and that she took her medication with reluctance. As to the consequences if she were discharged, it stated:

> "Compliance with treatment is an area of concern with [D.R.]. It is felt she would become non-compliant if discharged. [D.R.] would not remain as an informal patient on the ward if taken off current section. [D.R's] mental health state would deteriorate and she would be a risk to herself/others."[12]

Having received these reports, and having heard from various witnesses, including D.R. herself, the managers decided not to discharge her. In the written grounds for their decision they stated:

> "We are convinced the patient is suffering from a mental disorder which requires treatment. If she were not detained, we doubt her compliance. Given the recent past history and the social worker's evidence about 'revolving door', we think a longer period of detention is necessary."[13]

Her application to the Administrative Court having been initiated on 6 March 2002, D.R. was in fact discharged from detention on 11 April 2002. (The Judge said he had been assured that the second event was not linked to the first.) However, she soon stopped taking her medication, and on 9 June 2002 she was re-admitted to hospital, this time for assessment under MHA 1983, section 2.

Law

When furnishing his renewal report, D.R's RMO had to address the statutory conditions set out in MHA 1983, section 20(4). They require that:

> "(a) the patient is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment, and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
>
> "(b) such treatment is likely to alleviate or prevent a deterioration of his condition; and
>
> "(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and that it cannot be provided unless he continues to be detained."

Of course, section 20(4) concludes:

> "[I]n the case of mental illness or severe mental impairment, it shall be an alternative to the

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[10] *Judgment, para 13*

[11] *Ibid, para 14*

[12] *Ibid, para 15*

[13] *Ibid, para 17*

> condition specified in paragraph (b) above that the patient, if discharged, is unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation."[14]

Wilson J. noted that there was judicial authority to the effect that the word 'detained' in MHA 1983, section 20(4)(c) should in fact be read as "liable to be detained",[15] and he concluded:

> "[A]ccordingly, the conditions for renewal can be satisfied even in relation to a patient who is no longer actually detained but has been granted leave of absence under s. 17 of the Act."[16]

The RMO may only furnish his report "if it appears to him" that these conditions are satisfied.[17]

Argument – the Claimant

On behalf of D.R, it was argued that the MHA 1983, section 20(4) conditions had not been fulfilled and therefore, that the RMO had acted unlawfully in renewing D.R's liability to detention and the hospital managers had acted unlawfully in sanctioning that renewal.

Counsel for D.R, Mr. Stephen Simblet, argued that a patient could only be detained, and any renewal of her detention could only be lawful, if it was planned to treat her as an 'in-patient'. He said that the plans for his client envisaged her treatment as an 'out-patient'.[18] Mr. Simblet claimed support for this argument in the decision of McCullough J. in *R v Hallstrom and another, ex parte W; R v Gardner and another, ex parte L ('Hallstrom'* and *'Gardner')*,[19] which he said had not been materially affected by the judgment of the Court of Appeal in *B v Barking Havering & Brentwood Community Healthcare NHS Trust and Dr Jason Taylor ('Barker')*.[20]

D.R. also ventured what the Judge described as "a late, subsidiary argument".[21] Her counsel noted that MHA 1983, section 23(2) gave hospital managers the discretion to discharge a patient, and to do so even if the renewal conditions were met.[22] He suggested that before deciding not to exercise this discretion, the managers should have considered whether, as an alternative, D.R. might be made subject to After-care under Supervision.[23] The managers had, of course, ignored that possibility, and D.R's counsel argued that they had therefore acted irrationally and in breach of the 'right to liberty' set out in Article 5 of the European Convention on Human Rights ('ECHR').

Argument – the Defendant

The Defendant's Counsel, Miss Kristina Stern, conceded that the renewal criteria would only be satisfied if the plans for a patient included a significant element of treatment in hospital. However, she contended that the terms 'in-patient' and 'out-patient' represented a gloss upon the renewal criteria that was unhelpful and not supported by MHA 1983. She too relied upon the judgment of the Court of Appeal in *Barker*, and she argued that the element of treatment in hospital contained in the plans for D.R. was significant enough to make those plans lawful.[24]

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[14] *MHA 1983, s 20(4)*

[15] *B v Barking, Havering and Brentwood Community Healthcare NHS Trust [1999] 1 FLR 106*

[16] *Judgment, para 21*

[17] *MHA 1983, s 20(3)*

[18] *Judgment, para 5*

[19] *[1986] 2 All ER 306*

[20] *See note 15, above*

[21] *Judgment, para 32*

[22] *R v Riverside Mental Health Trust, ex parte Huzzey [1998] 43 BMLR 167*

[23] *MHA 1983, s 25A–J*

[24] *Judgment, para 5*

The issue

Wilson J. sought to delve beneath what he described as "the battle-lines" in order to identify "the real issue".[25] This he was eventually able to distil into a single question:

> "[W]as it open to the doctor and the managers to conclude that his treatment plan for the Claimant was for 'medical treatment in hospital'?"[26]

If this question could be answered in the affirmative, the Defendant would succeed; if not, the Claimant, D.R, should have been discharged.

The judge set out that reasoning that had led him to this relatively simple formulation. He said:

> "In my view this case is centrally an enquiry into the words 'medical treatment in a hospital' set out in [MHA 1983, section 20(4)] (a) and repeated, by reference, in (b) and (c). The claimant clearly suffers from mental illness so the enquiry at (a) was whether it was of a nature or degree which made it appropriate for her to receive 'medical treatment in a hospital'. The enquiry at (b) […] was whether 'such' treatment was likely to alleviate or prevent a deterioration of her condition. The enquiry at (c) was whether 'such' treatment could not be provided unless she continued to be liable to be detained and unless it was necessary for the health or safety of herself or (for example) her daughter."[27]

Decision

The managers' test for renewal

Wilson J. did not deal with the substantive issue straight away. First, he felt it necessary to determine a preliminary point: whether, when considering the discharge of a patient such as D.R, the hospital managers must have regard to the 'admission' criteria contained in MHA 1983, section 3(2) or the 'renewal' criteria in section 20(4).

Noting that the MHA 1983 Code of Practice states, "the essential yardstick in considering a review application is whether the grounds for admission or continued detention under the Act are satisfied,"[28] the judge concluded:

> "[W]here managers are considering whether to order discharge on expiry of the initial period of liability to detention notwithstanding the doctor's renewal, it is the conditions for renewal set by [MHA 1983,] section 20(4) which logically they should address."[29]

The ECHR and the managers' discretion to discharge

The ECHR argument put forward on behalf of D.R. was given equally short shrift. It was "a central feature", the judge said, of the provisions for after-care under supervision that a patient could not be compelled to receive the medication that had been prescribed for her. However, in this case:

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[25] *Ibid.*

[26] *Ibid, para 22*

[27] *Ibid.*

[28] *MHA Code of Practice, Department of Health and Welsh Office, 1999, London, The Stationery Office, para 23.11*

[29] *Judgment, para 19*

> "[…] the doctor, the social worker and the nurse were unanimous in discerning the major problem to be that, were she to cease to be liable to be detained, [D.R.] would refuse to take the medication. Invocation of the statutory system of after-care under supervision would have represented a failure to address the major problem."[30]

Renewal during a period of leave

As far as the substantive issue in the case was concerned, Wilson J. began by distinguishing the facts of this case from those of *Hallstrom* and *Gardner*. He noted that:

> "In neither of them did the plan which formed the basis of (in the former) the compulsory admission for treatment and (in the latter) the renewal of the authority for detention include any element of treatment in hospital."[31]

In both cases, the Judge continued, the defendant doctors had the same plan, which was

> "for the claimants to remain entirely in the community (apart, in the former, from the very first night, such being a cosmetic provision with no therapeutic purpose)";[32]

and in each case:

> "[T]he motive behind the invocation of compulsory powers […] was to be able to require (or to threaten to require) the claimants to take medication in the community, without which they were considered unlikely to do so."[33]

Wilson J. approved the *basis* of the judgment delivered by McCullough J. in *Hallstrom* and *Gardner*, but he deplored the error into which he had subsequently allowed himself to venture. As a matter of statutory construction, Wilson J. said, it was perfectly proper for McCullough J. to have held,

> "[…] that the powers of admission and renewal under [MHA 1983] ss. 3 and 20 could be used in respect only of patients whose condition is believed to require detention *for treatment in a hospital*".[34]

As we have seen, Wilson J. believed that the plans made in *Hallstrom* and *Gardner* did not include any element of treatment in hospital. The difficulty, he said, was that McCullough J. had gone on "to reach beyond the easy conclusion that the plan for the claimants was not in any way for treatment in a hospital".[35]

With disapproval, Wilson J. cited[36] the following passage from the judgment of McCullough J:

> "The phrase 'his mental disorder … makes it appropriate for him to receive medical treatment in a hospital' in [MHA 1983] section 3(2)(a) also leads to the conclusion that the section is concerned with those whose mental condition requires in-patient treatment. Treatment *in* a hospital does not mean treatment *at* a hospital, as [leading counsel for the defendants], in effect, contends. If his construction were correct there would be a distinction between the patient who could appropriately be treated at home and the patient who could appropriately be treated at the out-patients' department of a hospital. Such a distinction would be without reason.

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[30] *Ibid, para 33*

[31] *Ibid, para 24*

[32] *Ibid.*

[33] *Judgment, para 24*

[34] *Ibid, para 25 [the words in italics had been those of McCullough J.]*

[35] *Judgment, para 25*

[36] *Ibid.*

> When it is remembered that the section authorises compulsory detention in a hospital it is at once clear why a distinction should be made between those whom it is appropriate to treat *in* a hospital, i.e. as in-patients, and those to whom it is appropriate to treat otherwise, whether at the out-patient department of the hospital or at home or elsewhere."[37]

Turning to *Barker*, Wilson J. noted that the treatment plan that the patient sought to overturn would have required her "to be in hospital only for two nights and the majority of two days each week".[38] During this time "she was to be assessed, monitored and tested (in particular for the use of illicit drugs) and to attend occupational and art therapy".[39]

The Judge noted that although the word 'in-patient' is used in MHA 1983, section 5 it is nowhere defined. However, he stated that it "could properly be used to describe the Claimant in [*Barker*]" because it "suggests the allocation and use, albeit not at all times, of a hospital bed".[40]

In fact, when upholding the renewal of the patient's detention, the then Master of the Rolls, Lord Woolf, had specifically described her as an "in-patient". However, Wilson J. now held, this was not because Lord Woolf approved of McCullough J's 'in-patient' / 'out-patient' distinction, but simply because "he held that the proposed treatment should be considered, not atomistically but as a whole".[41] As support for this proposition, the Judge cited[42] the following passage from the judgment in *Barker*:

> "It is the treatment as a whole which must be calculated to alleviate or prevent a deterioration of the mental disorder from which the patient is suffering. As long as treatment viewed in that way involves treatment *as an in-patient* the requirements of the section can be met."[43]

Still on the subject of *Barker*, Wilson J. noted[44] that, in concurring with the Master of the Rolls, Thorpe L.J. had not used the word 'in-patient'; rather, he had upheld the renewal of the patient's detention with the following words:

> "[H]er *home base* remained the hospital despite the fact that she slept many more nights out than in and despite the fact that she had a daily leave of absence for 4 hours on each of the 2 days per week when she returned to the hospital. It seems obvious to me that those 2 days of detention each week were an *essential ingredient* of the treatment […] Her presence in the hospital each Tuesday and Wednesday was an *essential part* of the treatment package, it could only be provided in the hospital and could only be effectively provided if the appellant continued to be detained."[45]

It was this aspect of *Barker*, the Judge noted, that both parties had cited in support of their conflicting arguments. His decision suggests that it supports the Defendant's case rather more fully.

Describing it as "predictable", Wilson J. dismissed the submission made for D.R. He ruled that the distinction that McCullough J. had drawn in *Hallstrom* and *Gardner* between 'in-patient' and 'out-patient' care had been *obiter* and also unnecessary. Further, Wilson J. said that the distinction between treatment *at* a hospital and treatment *in* a hospital was "too subtle for me", and he added:

> "When I eat at a restaurant, I eat in a restaurant."[46]

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[37] *Hallstrom and Gardner, p 315c–e*

[38] *Judgment, para 26*

[39] *Ibid.*

[40] *Judgment, para 27*

[41] *Ibid.*

[42] *Ibid.*

[43] *Barker, para 113G [the italics are those of Wilson J.]*

[44] *Judgment, para 27*

[45] *Barker, p 118A–B and D–E [the italics are those of Wilson J.]*

[46] *Judgment, para 29*

The treatment proposed for the patient in *Barker* had "happened to be of an in-patient character," so it was natural that Lord Woolf should describe it as such. However:

> "[T]hat does not make it become the test, any more than the reference of Thorpe L.J. to a 'home base' renders that concept the test."[47]

Applying the decision in *Barker*, Wilson J. held that it was significant because it established that the renewal of detention could be lawful even though only part of the plan was for treatment in hospital. It would suffice "if that part of the plan was, to borrow another phrase from the judgment of Thorpe LJ, an essential ingredient"; but

> "[I]t would be an impermissible – indeed an illogical – gloss upon the Act to make lawfulness depend upon a plan to put the patient at times into a hospital bed."[48]

By way of explication, the Judge added:

> "There is no magic in a bed; indeed the facility for treatment at night, when the patient is in bed, must be much less than for treatment during the day."[49]

Wilson J. then set about devising his own test. He noted[50] that the statutory definition of "medical treatment" includes "rehabilitation under medical supervision"[51] and that the MHA 1983 Code of Practice states that "leave of absence can be an important part of a patient's treatment plan."[52] Therefore, he held:

> "The question […] is whether a significant component of the plan for the claimant was for treatment in hospital."[53]

He concluded that this question could be answered in the affirmative. The purpose of the leave granted to D.R:

> " […] was to preserve the claimant's links with the community; to reduce the stress caused by hospital surroundings which she found particularly uncongenial; and to build a platform of trust between her and the clinicians upon which dialogue might be constructed and insight on her part into her illness engendered".[54]

The Judge recalled that in *Barker* the Court of Appeal had stressed the importance not merely of granting leave, but also of considering its effect upon the patient. Here, he said:

> "[T]he requirement to attend hospital on Fridays between 9.00 am and 5.00 pm and on Monday mornings was also […] a significant component of the plan. The role of occupational therapy as part of the treatment of mental illness needs no explanation. But the attendance at hospital on Monday mornings seems to me to be likely to have been even more important. Such was to be the occasion for the attempted dialogue; for monitoring; for assessment and for review."[55]

Therefore, Wilson J. held:

> "[…] that a significant component of the plan for the claimant was treatment in hospital and that the conditions for renewal set by [MHA 1983,] s. 20(4) were satisfied".[56]

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[47] *Judgment, para 29*

[48] *Ibid.*

[49] *Ibid.*

[50] *Ibid, para 30*

[51] *MHA 1983, s 145(1)*

[52] *MHA Code of Practice, op cit., para 20.1*

[53] *Judgment, para 30*

[54] *Ibid.*

[55] *Judgment, para 30*

[56] *Ibid, para 31*

He noted that the Government's plans to reform mental health law included provisions that would enable medical treatment for mental disorder to be imposed upon a "hospital non-resident".[57] However, he concluded:

> "Unless and until this reform is enacted, the law will remain (if my interpretation of it be sound) that the compulsory administration of medication to a patient can be secured only by making him liable to be detained or renewing such liability; that such may be achieved only if a significant component of the plan is for treatment in hospital; and that, in such an enquiry, the difference between in-patient and out-patient treatment is irrelevant."[58]

The Claimant's application for judicial review was therefore dismissed.

Comment

Treatment in hospital must form a significant component of the care plan

The circumstances in which a patient's detention may be renewed are now somewhat clearer. In particular, we know that that step may be taken even while a patient is on leave, provided treatment in hospital forms a "significant component" of the plan for him/her.[59]

The decision in *D.R.* joins a growing body of case law on the renewal of detention under the 1983 Mental Health Act. After *Barker*, of course, there had been *R (on the application of Epsom and St. Helier NHS Trust) v The Mental Health Review Tribunal*,[60] in which the Administrative Court considered the case of a detained patient who had been on leave for some time. Sullivan J. held that:

> "[I]f […] it was proposed that the patient should be admitted to hospital for in-patient treatment in the week following the expiration of a six-month period of liability to detention, it would be absurd if the tribunal could not take that fact into account."[61]

However, His Lordship concluded:

> "[T]here will come a time when, even though it is certain that treatment will be required at some stage in the future, the timing of that treatment is so uncertain that it is no longer 'appropriate' for the patient to continue to be liable to detention."[62]

There was no mention of Epsom and St. Helier in the judgment in *D.R*, and the two cases are easily distinguishable (chiefly because definite plans had been made for the patient in *D.R.* to return to hospital in the future). However, they both conceive of psychiatric treatment as something that may be provided elsewhere than in a hospital, and they recognise that patients may still need to be subject to the constraints of the 1983 Act when they have ceased to be confined.

Whether the rationale for the judgments in *Barker*, *Epsom and St. Helier* and *D.R.* represents a flight from *Hallstrom* and *Gardner* is, however, a different question. It is likely that these two groups of cases yielded different results simply because they were concerned with different circumstances. Lord Woolf alluded to this possibility in *Barker*, when he said:

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[57] *See, for example: Draft Mental Health Bill, Department of Health 2002, Cm 5538–I, cl 23(2) and (3); Draft Mental Health Bill: Explanatory Notes, June 2002, Cm 5538–II, para 32*

[58] *Judgment, para 34*

[59] *Ibid, para 30*

[60] *[2001] EWHC Admin 101*

[61] *Epsom and St Helier, para 47*

[62] *Ibid, para 62*

> "It is important to note that in both [*Hallstrom* and *Gardner*] it was accepted that [the patients] did not require treatment as in-patients and the real reason for the doctors' actions was [the patients'] refusal to take medication, which could have been taken as out-patients if they had taken it voluntarily."[63]

In *Hallstrom* and *Gardner*, the words in which McCullough J. dismissed the doctors' practice distinguish it very clearly from the way patients were dealt with in subsequent cases. The judge said, speaking of section 13 of the Mental Health Act:

> "The 'detention' there referred to cannot realistically include a purely nominal period before leave of absence is given, after which the treatment of which the patient stands in need is to begin."[64]

In *Barker* and *D.R*, and also in *Epsom and St. Helier*, the respective claimants had spent a considerable proportion of their time under detention receiving psychiatric care in hospital.

It has been suggested that in so far as it purports to deal with a patient's *initial* detention, the decision in this case was purely *obiter* and should not be followed.[65] However, *Hallstrom* concerned the lawfulness of detention, as opposed to renewal, and, of course, Wilson J. addressed that case in terms.

Rejecting the in-patient/out-patient distinction

It was surely right for Wilson J. to criticise the extended reasoning of McCullough J. in *Hallstrom* and *Gardner*.[66] However, the passage he cited for that purpose is questionable for at least one more reason than he mentioned.

McCullough J's distinction between 'in-patient' and 'out-patient' care had been made in response to the suggestion that, according to a careful construction of section 3(2)(a) of the Mental Health Act, treatment *in* a hospital is the same as treatment *at* a hospital. The judge said:

> "If [that] construction were correct there would be a distinction between the patient who could appropriately be treated at home and the patient who could appropriately be treated at the out-patients' department of a hospital. Such a distinction would be without reason."[67]

Yet, McCullough J's distinction was surely no less irrational. It sought to differentiate instances of precisely the same medical treatment administered in precisely the same place – namely, the hospital – and it did so merely according to the provenance of the patients who received that treatment and the degree of compulsion that could have been applied to them. It would surely be more logical to distinguish between all forms of treatment provided on hospital premises and those administered only in the community. This distinction had been advanced on behalf of the doctors in *Hallstrom* and *Gardner* (and dismissed by McCullough J.), and, having been tacitly approved in *Barker*, was left untouched by the present case.

However, not everything that Wilson J. said in criticising McCullough J. is equally acceptable. His statement "When I eat at a restaurant, I eat in a restaurant"[68] might have been made by one wholly unacquainted with 'fast food', the ubiquitous 'drive-thru', and the hurried consumption of a 'chicken zinger' in a rain-swept car park.

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[63] *See Wilson J's summary of the relevant facts, which is set out above and cited in footnotes 32–34. 31–33*

[64] *Hallstrom and Gardner, pp 315j–316a*

[65] *See, for example: R Jones, Mental Health Act Manual, 2003, Sweet & Maxwell, 1–046*

[66] *Judgment, para 25*

[67] *Hallstrom and Gardner, p 315c–d*

[68] *Judgment, para 29*

The continuing relevance of Hallstrom and Gardner

The judgments in *Barker* and *D.R.* each accept that McCullough J. decided *Hallstrom* and *Gardner* correctly on their facts. That is not surprising, given that, as has been already suggested, the two strands of cases are distinguishable from each other.

Certainly, there is much in the judgment of McCullough J. that still rings true. For example, having made a close analysis of sections 2 and 13 of the Mental Health Act,[69] he concludes:

> "It stretches the concept of 'admission for treatment' too far to say that it covers admission for only so long as it is necessary to enable leave of absence to be granted, after which the necessary treatment will begin. 'Admission for treatment' under s. 3 is intended for those whose condition is believed to require a period of treatment as an in-patient. It may be that such patients will also be thought to require a period of out-patient treatment thereafter, but the concept of 'admission for treatment' has no applicability to those whom it is intended to admit and detain for a purely nominal period, during which no necessary treatment will be given."[70]

This passage does not appear to have been controverted by Lord Woolf or Wilson J. (nor by Sullivan J. in *Epsom and St. Helier*). Therefore, once 'treatment as an in-patient' is replaced by 'treatment in a hospital', it may remain an accurate statement of the law.

The managers' test for renewal

Wilson J. decided that, when they decide whether to discharge a patient whose detention has been recently renewed, the hospital managers must apply the renewal criteria contained in section 20(4) of the Mental Health Act 1983.

This was not a surprising decision, but it does give formal approval to a distinction that can prove significant in some cases. It will apply to patients who suffer from 'mental illness' or 'severe mental impairment'. In order for the detention of patients who suffer from 'mental illness' or 'severe mental impairment' to be renewed lawfully:

(i) it must be unlikely that, if discharged, they will be able to care for themselves, to obtain the care they need, or to guard themselves against serious exploitation; or

(ii) the proposed treatment will have to be likely to alleviate or prevent a deterioration of their condition.

Of course, neither of these requirements are applicable when such patients are first detained; whereas, in the case of patients suffering from 'psychopathic disorder' or 'mental impairment', the second requirement will apply, not only upon any renewal, but even at the point of their initial detention.[71]

A new definition of 'in-patient'?

In *D.R*, Wilson J. adopted a new definition of the troublesome term 'in-patient'. Hitherto, in so far as it was applied to a patient with full mental capacity, it had been taken to signify "one who has understood and accepted the offer of a bed, and who has freely appeared on the ward and who has co-operated in the admission procedure". This definition, which does not appear in Wilson J's

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[69] *Hallstrom and Gardner, pp 315j–316b*

[70] *Ibid, p 315b*

[71] *MHA 1983, s 3(2)(b)*

judgment, was set out in the second edition of the Mental Health Act Code of Practice,[72] and it has subsequently gained some currency.[73]

Wilson J's formulation was somewhat different. He spoke of "the allocation *and use*, albeit not at all times, of a hospital bed".[74] This would seem to go further than the *offer and acceptance* of a bed envisaged by the Code of Practice, and it seems to require more from the putative patient than mere co-operation in the admission process. If so, and if Wilson J's definition is to be preferred, it may make it harder for patients to acquire in-patient status, and for doctors or nurses of the prescribed class to subject them to the holding powers contained in MHA 1983, section 5(2) or (4).

Is a bed necessary?

There is at least one facet of the judgment of Wilson J. in *D.R.* that might prove troublesome if it were to be misconstrued. The judge said:

> "In my view it would be an impermissible – indeed an illogical – gloss upon the Act to make lawfulness depend upon a plan to put the patient at times into a hospital bed. There is no magic in a bed […]."[75]

It is necessary to treat this statement with caution. First, because it is not clear whether Wilson J. saw the existence of a bed as a test – albeit an impermissible test – of the lawfulness of a patient's original detention or merely of its renewal. Of course, the test to which he referred had been adopted by McCullough J. in *Hallstrom* and *Gardner*. However, the first of these cases concerned the criteria for initial admission, and the second, those for renewal. Wilson J. himself suggests that the 'in-patient' / 'out-patient' distinction – which generated that test and was, of course, the chief product of those cases – resulted from a 'gloss' upon the Mental Health Act. This was certainly how it was described by the Defendant's counsel in *D.R.*, when she wished to criticise the approach of the Claimant's counsel to the criteria for *renewal*. It seems likely, therefore, that Wilson J. intended to forswear the 'bed test' merely in so far as it could be applied to the renewal of a patient's detention, and that he did not intend his words to apply more generally, to the criteria for initial admission.

That is perhaps fortunate, for, taken on their own, his words – and in particular, the perhaps plaintive statement that "there is no magic in a bed" – might be thought to suggest that a patient may lawfully be taken into detention without a bed having first been found for him/her. Although there are some mental health professionals who would find this a deeply attractive argument, it has no basis in the judgment in this case.

In the chapter dedicated to 'Assessment', under the heading 'Individual professional responsibility – the doctor', the current Code of Practice states that:

> "The doctor should:
>
> […]
>
> ensure that, where there is to be an application for admission, a hospital bed will be available."[76]

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[72] *Department of Health and Welsh Office, London, HMSO, 1993, para 8.4*

[73] *See, for example: R Jones, Mental Health Act Manual, 2003, Sweet & Maxwell op cit, 1–077. The 1993 definition does not appear, nor is any new definition provided, in the latest edition of the Code of Practice [op cit.], which was published in March 1999*

[74] *Judgment, para 27 [emphasis added]*

[75] *Ibid., para 29*

[76] *MHA Code of Practice, op cit, para 2.22d*

Although this statement does not go so far as to prohibit the making of an application for admission where no bed is available – or the giving of a medical recommendation in support of such an application – it should not lightly be dismissed.

However, as is discussed in the following section, the judgment of Wilson J. does point up a significant, related facet of mental health law.

The compulsory treatment of patients who have not been admitted to hospital

If medical treatment for mental disorder is to be imposed upon a 'detained' patient, s/he will first have to be 'admitted'. This is because the condition of being 'detained' is contingent upon there having been an 'admission'. Section 6(2) of MHA 1983 states:

> "Where a patient is *admitted* […] to the hospital specified in [the] application […] the application shall be sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions of this Act."[77]

Clearly, and as a matter of pure logic, 'admission' must imply the offer and acceptance – even if, to recall Wilson J's formulation, it doesn't strictly require the *use* – of a hospital bed. Therefore, even if it is intended immediately to grant the patient leave – albeit with hospital assessment, monitoring and review as a significant component of his/her treatment plan – it will still be necessary to find him/her a bed to call his/her own. However, medical treatment for mental disorder may be provided to needful patients who are not detained, and even though they have not been 'admitted' to hospital.

The providing of medical treatment for a patient's mental disorder is governed by Part IV of MHA 1983, and in particular, by the provisions in, *inter alia*, sections 58 and 63. The patients to whom those provisions may be applied are listed in section 56. Before setting out a number of exceptions that are irrelevant for present purposes, that section states:

> "(1) This Part of this Act applies to any patient *liable to be detained* under this Act."[78]

As the judgment in the present case makes clear, although all patients who are 'detained' under MHA 1983 may also be said to be 'liable to be detained', the reverse is by no means inevitably the case. In fact, this had been already hinted at in *Hallstrom* and *Gardner*, where McCullough J. stated:

> "Ignoring the position of *a patient in respect of whom authority to detain has come into existence but who has not yet been brought under detention* and of those patients absent without leave, those 'liable to be detained' are, therefore, those who are detained and those who have been granted leave of absence."[79]

So, alongside patients who, having been detained, are now enjoying leave of absence, those in respect of whom an admission application has been "duly completed" are also "liable to be detained", even though that application has not yet been accepted by the managers of the hospital in which it is hoped to detain them.

Of course, the possibility of imposing medical treatment for mental disorder upon such patients will remain for only so long as the application for their admission to hospital under MHA 1983

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[77] *Emphasis added*

[78] *Ditto*

[79] *Hallstrom and Gardner, p 312e [emphasis added]; see also: R Jones, op cit, para 1–703*

continues to be "duly completed". Ordinarily, this will be for 14 days from the date of the later of the two examinations upon which the medical recommendations supporting the admission application are based. This is, of course, the period during which the patient may lawfully be taken and conveyed to the hospital in which s/he is to be detained,[80] and during which the managers of that hospital may lawfully admit and detain him/her.[81]

Developing trends?

The judgment of Wilson J. may be taken to confirm a trend that first became apparent in the cases of *B v Barking, Havering and Brentwood Community Healthcare NHS Trust* and *R (on the application of Epsom and St. Helier NHS Trust) v The Mental Health Review Tribunal*. It now seems to be accepted, where once it might have been doubted, that it should be possible in law to subject psychiatric patients to assessment and review (at the very least) even though they no longer need to be confined in hospital. Other, perhaps more remote, exemplars of this trend might be seen in the introduction of 'after-care under supervision' from 1 April 1996[82] and the judicial strengthening of conditional discharge.[83] If this trend has accelerated recently, that may have been in anticipation of the Government's own proposals to permit the more assertive monitoring of psychiatric patients once they have left hospital.[84]

However, any gaining of pace may equally have been influenced by the European Convention on Human Rights, which was introduced into domestic law by the 1998 Human Rights Act, and with which all public authorities have, as a result, been required to act compatibly since October 2000.[85]

The emphasis of the ECHR is, of course, very much upon 'proportionality'. Although Wilson J. does not appear to have used that word in *D.R*, there is much in his judgment that resembles the approach of the European Court of Human Rights. For example, it will be recalled that, when considering the issue of 'detention' – and when it might, and might not, be said to have been imposed – the Strasbourg Court said:

> "In order to determine whether circumstances involve deprivation of liberty, the starting point must be the concrete situation of the individual concerned and account must be taken of a whole range of criteria such as the type, duration, effect and manner of implementation of the measure in question. *The distinction between deprivation of and restriction upon liberty is merely one of degree, and not one of nature or substance*."[86]

If this is an instance of judicial relativism, it may betray a tendency that is evident in a number of recent domestic decisions, some of which have involved the construction of mental health law. For example, the Court of Appeal rejected the rigid 'change of circumstances' test that had previously determined whether a patient who had been recently discharged by a MHRT might be

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[80] *MHA 1983, s 6(1)*

[81] *MHA 1983, s 6(2)*

[82] *MHA 1983, s 25A–J; see also: Mental Health (Patients in the Community) Act 1995, c 52; Department of Health, Legal Powers on the Care of Mentally Ill People in the Community: Report of the Internal Review, August 1993*

[83] *R v Secretary of State for the Home Department and the Secretary of State for Health, ex parte IH [2002] EWCA Civ 646*

[84] *See note 578, above*

[85] *Human Rights Act 1998, s 6(1) (but cf s–s (2))*

[86] *Ashingdane v United Kingdom (1985) Series A 93, [1985] 7 EHRR 528, para 41 [emphasis added]*

lawfully re-detained.[87] Further, the Courts, influenced by the Strasbourg jurisprudence on ECHR, Article 5(4), have also rejected a single, rigid time limit for arranging MHRT hearings and deciding when that task has taken too long.[88]

Although there are other cases that may exemplify this trend, their collation and analysis are beyond the scope of this paper.

Conclusion

The chief consequence of the decision of Wilson J. in *D.R. v Mersey Care NHS Trust* is to lend clarity to an aspect of mental health law that is becoming more controversial. It establishes that a patient who has received treatment in hospital may have his/her detention renewed even though s/he is on leave. Such a finding had not, of course, been ruled out by the judgment of McCullough J. in *R v Hallstrom and another, ex parte W*; *R v Gardner and another, ex parte L*.

The decision also confirms our understanding of the test that must be applied to any renewal of a patient's detention, and it offers an alternative, perhaps slightly more rigorous definition of 'in-patient' that should not be allowed to pass unremarked. The judgment of Wilson J. also demonstrates that a new Mental Health Act is unnecessary for some psychiatric patients – those who, though they have not yet been 'admitted' to hospital, are already 'liable to be detained' under a duly completed application – to be compelled to take their medicine.

Away from its particular facts and consequences, the judgment in *D.R.* may also reveal a move towards judicial relativism. If so, that is surely not inappropriate in an age in which, we are often reminded,[89] the works of John Keats and Bob Dylan are to be appreciated for their intrinsic merits, on an equal footing.

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[87] *R v East London & the City Mental Health NHS Trust and David Stuart Snazell, Approved Social Worker, ex parte Count Franz Von Brandenburg [2001] 3 WLR 588; see, David Hewitt, Detention of a recently-discharged psychiatric patient, Journal of Mental Health Law, February 2002, pp 50–58. R v Ashworth Hospital Authority and others, ex parte H : R v (1) Mental Health Review Tribunal for West Midlands and North West Region (2) London Borough of Hammersmith and Fulham (3) Ealing, Hounslow and Hammersmith Health Authority, ex parte Ashworth Hospital Authority [2002] EWCA Civ 923; see Kristina Stern and David Hewitt, Re-admission under the Mental Health Act following discharge by a Mental Health Review Tribunal, Journal of Mental Health Law, July 2002, pp 169 to 178*

[88] *R (on the application of C) v Mental Health Review Tribunal, London South and South West Region [2001] EWCA Civ 1110, [2002] 1 WLR 176; R v Mental Health Review Tribunal and Secretary of State for Health, ex parte KB and 6 others [2002] EWHC 639 (Admin); B v Mental Health Review Tribunal and Secretary of State for the Home Department [2002] EWHC 1553; see also: David Hewitt, Delays have dangerous ends, New Law Journal, vol 152, No 7031, May 10 2002, p 694*

[89] *See, for example, The Observer, passim*

Conditional Discharges – 'Discharge' from what?

Robert Robinson[*]

R (on the application of the Secretary of State for the Home Department) v Mental Health Review Tribunal and PH (Interested Party) [2002] EWCA Civ 1868

Court of Appeal (19th December 2002) Keene LJ, Sir Anthony Evans and Kay LJ

The Facts

The patient, PH, was admitted to hospital in 1958 having been found unfit to plead to two counts of wounding with intent. He has remained in Broadmoor hospital as a restricted patient ever since and is now in his 70's. He continues to suffer from paranoid schizophrenia and has entrenched delusional beliefs. His physical health is poor.

In October 2001 a mental health review tribunal directed PH's conditional discharge and deferred the discharge until arrangements had been made to meet the conditions which the tribunal imposed.[1] The conditions were as follows:

1. To continue to take and receive medication as prescribed.
2. To accept and comply with regular supervision by a consultant psychiatrist and social supervisor.
3. To reside at suitable specialist accommodation which provides 24 hour trained psychiatric nursing care and daytime trained psychiatric nursing care and appropriate security.
4. Not to leave the accommodation without an escort.

The Home Secretary sought judicial review of the tribunal's decision. The main ground of challenge was that the tribunal had exceeded its powers: under the guise of discharging PH, the tribunal had imposed conditions which in effect continued his detention. One element of the Home Secretary's case was that the conditions could be met by PH moving to another hospital and that as such the decision amounted to a transfer to lesser security. While under s.73 Mental Health Act 1983 the tribunal can discharge a restricted patient, either conditionally or absolutely, it does not have power to order transfer.[2]

In evidence to the Administrative Court, the President of the tribunal said that among the factors underpinning the decision was the tribunal's awareness of PH's need for assistance and care in respect of his physical needs and "in terms of his interaction with the public and with the outside

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[*] *Solicitor – Scott-Moncreiff. Harbour and Sinclair (London), solicitors for PH; Mental Health Act Commissioner; MHRT Legal Member*

[1] *The tribunal hearing took place before the Court of Appeal's Judgment in R (IH) v Secretary of State for the Home Department and Secretary of State for Health [2002] EWCA Civ 646 (for review of which see Deferred Conditional Discharges – The New Regime David Mylan JMHL July 2002 pp 208 – 218)*

[2] *Indeed, by contrast with tribunals concerned with unrestricted patients, it has no statutory power to even recommend transfer.*

world". With reference to the need for "appropriate security" the tribunal had not intended to suggest that PH needed any kind of locked facility but that there would be a degree of supervision in place for the benefit of residents, such as that which obtains for residents with problems such as dementia. As for the requirement that PH be escorted when outside the home, this was imposed by the tribunal so as to facilitate rather than inhibit his freedom. The tribunal was aware that he had not lived in the outside world for many years and there were concerns that he would become disorientated or would find it difficult to cope with such things as traffic and the value of money. There was no evidence that the conditions were imposed for the protection of the public, rather they were designed for PH's own protection.

The Administrative Court rejected the Home Secretary's application[3]. In the opinion of Elias J., the word 'discharge' in section 73 of the Mental Health Act 1983 should be read as referring to a cessation of deprivation of liberty. If the order of the tribunal meant the patient was no longer being deprived of his liberty, the discharge was lawful and within the tribunal's powers. Every case was to be decided on its own facts, and in this case, the Judge decided that since "there will be an opportunity for PH to go into the community and to receive people from the community, albeit that restrictions are imposed" there was a lawful discharge.

Mann J. in *Secretary of State for the Home Department v Mental Health Review Tribunal for the Mersey Regional Health Authority*[4] had held that 'discharge' could "only mean release from hospital". Elias J. disagreed. Although he ruled that on the facts of the case, the institution to which PH was to go was not a 'hospital', he was of the opinion that it could still be a lawful discharge even if the new accommodation was a hospital. He said (at paragraph 30 of his judgment) as follows:

> "In my view, the fallacy is to treat release from discharge as meaning release from hospital. It seems to me that it means release from detention in hospital or sometimes…..from liability to be detained. Release from hospital is neither a sufficient nor a necessary condition for constituting the discharge. If there is such a release but it is to another institution where the patient is detained in the sense that he is deprived of his liberty, then that would not in my judgment, constitute a proper and lawful discharge. By the same token, in my judgment, if the patient is discharged from detention in a hospital such that he is no longer deprived of his liberty, then there is still an effective discharge notwithstanding that the conditions are such that he is required to reside in another hospital pending further consideration of his absolute discharge. The central issue, it seems to me, is whether or not the conditions constitute a continuing detention. If they do not, it is irrelevant where the patient resides thereafter. Indeed if it were thought by the tribunal that the only appropriate institution to which a conditional discharge could properly be made was another hospital, it would seem to me to infringe Article 5 of the Convention to refuse that discharge simply because the only available alternative institution was another hospital. Of course, the nature of the conditions imposed requiring discharge to that other hospital may well be such that they do not in fact constitute a release from the deprivation of liberty, but that will be because of the overall effect of the conditions, not because the discharge is from one hospital to another."

When the Home Secretary's appeal reached the Court of Appeal in December 2002, PH was still detained in Broadmoor as it had not proved possible to meet the conditions imposed by the tribunal, but efforts in this regard were continuing.

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[3] *[2002] EWHC 1128 Admin*

[4] *[1986] 1 WLR 1170*

The Decision

The Court of Appeal approached the case by asking whether the effect of the conditions imposed by the tribunal was, as claimed by the Home Secretary, to continue PH's detention, albeit in conditions of lesser security. In answering this question the Court considered the jurisprudence of the European Court of Human Rights on the meaning of detention for the purpose of Article 5 of the Convention[5]. The Court found that the following principles had been established:

1. A basic distinction is to be drawn between mere restrictions on liberty of movement and the deprivation of liberty;
2. The distinction is one of degree and intensity of the restrictions;
3. The court must start with the actual situation of the individual and take account of a range of criteria such as type, duration, effects and manner of implementation of the measure in question;
4. Account must be taken of the cumulative effect of the various restrictions;
5. The purpose of the measures of restriction is a relevant consideration: if the measures are taken primarily in the interests of the individual who is being restricted, they may well be regarded as not amounting to a deprivation of liberty and so no breach of Article 5 would arise.

Applying these principles to PH's situation, Keene LJ, who gave the Judgment of the Court, referred to the evidence of the President of the tribunal and concluded (paragraph 24):

> "I cannot accept that conditions 3 and 4 *inevitably* mean that this man would be in a regime so restrictive that he would be deprived of his liberty. Condition 3 is sufficiently broadly phrased as to allow for measures which would fall short of such a deprivation, and both it (where it deals with security) and condition 4 have as their purpose the protection of PH himself and would therefore be in his interests. I should add that there is some evidence to indicate that, in at least one care home, the staffing arrangements would be such as to enable PH to go out with an escort whenever he chose to do so. On this principal issue, therefore, I conclude that the conditions would not involve his transfer from one state of detention to another state of detention. They are therefore not *ultra vires*."

The second issue was if, under the terms of the conditional discharge, PH went from Broadmoor to a registered care home which qualified as a "hospital" under the Act, whether he could be said to have been discharged. As noted above, Elias J. had declined to follow Mann J.'s decision in the case of *Secretary of State for the Home Department –v– Mental Health Review Tribunal for Mersey Regional Health Authority*[6] that the word "discharge" means release from hospital. Keene LJ agreed:

> "I find the reasoning of Elias J. at para. 30 of his judgment compelling. If a patient is discharged from detention, that is still an effective discharge, even though he may be required to reside in another institution which qualifies as a 'hospital'. So long as he is not detained there, the tribunal has lawfully discharged him."

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[5] *Specific reference was made to Guzzardi v Italy [1980] 3 EHRR 333; Ashingdane v United Kingdom [1985] 7 EHRR 528; H.M. v Switzerland [2002] MHLR 209; Nielsen v Denmark [1988] EHRR 175*

[6] *See footnote 4 above*

Comment

This is one of a number of recent cases in the field of mental health law where the Human Rights Act 1998 has led to a radically new interpretation of provisions of the Mental Health Act 1983. An important implication of the case is that the fundamental question which must now be asked by tribunals dealing with restricted cases is whether the patient's mental disorder warrants deprivation of liberty. This is hardly a surprising proposition given that, as was said by the Court of Appeal in *R (on the application of H) v Mental Health Review Tribunal for North and East London Region*[7], tribunals must weigh the interests of the patient against those of the public and determine whether detention is proportionate to the risks involved. This question needs to be kept separate from the issue whether there is a continuing need for treatment in hospital. Furthermore, in answering this question the tribunal must apply the Strasbourg jurisprudence.

In some cases, the position will be clear because of the patient's present circumstances. For example, the patient may be on an open ward and enjoying sufficient leave such that the conditions amount to a mere restriction on liberty of movement rather than a deprivation of liberty. It could be argued that such a patient is entitled to be discharged from detention under the Act and to remain in hospital as an informal patient under an absolute or conditional discharge. In other cases, as with PH, the patient will at the time of the hearing be deprived of his liberty but the tribunal will be satisfied that the risks could be managed otherwise than by continuing to deprive the patient of his liberty, even though in-patient hospital treatment remains necessary.

However, whether the patient's condition warrants deprivation of liberty is not the *only* question for tribunals. Detention under the Act is not to be equated with deprivation of liberty. Experience of unrestricted cases shows that there are many patients for whom liability to detention is justified, albeit that deprivation of liberty is not necessary. The usual reason for this is that the patient will only accept treatment while "detained" under the Act. Such a patient is not entitled to be discharged if his mental disorder is "of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment", provided also that hospital treatment continues to be necessary for his own health or safety or for the protection of others[8].

Of course, in the case of a restricted patient compliance with treatment may be secured by a conditional discharge under which the patient is required, as was PH, to take and receive medication as prescribed. To this extent, the continuation of liability to detention may be harder to justify in a restricted case than in a comparable unrestricted case. On the other hand, factors such as continuing dangerousness, may point in the opposite direction.

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[7] *[2001] EWCA Civ 415, where Lord Phillips MR (at paragraph 33) said: "A patient is detained who is unquestionably suffering from schizophrenia. While in the controlled environment of the hospital he is taking medication, and as a result of the medication is in remission. So long as he continues to take the medication he will pose no danger to himself or to others. The nature of the illness is such, however, that if he ceases to take the medication he will relapse and pose a danger to himself or to others. The professionals may be uncertain whether, if he is discharged into the community, he will continue to take the medication. We do not believe that Article 5 requires that the patient must always be discharged in such circumstances. The appropriate response should depend upon weighing the interests of the patient against those of the public having regard to the particular facts. Continued detention can be justified if, but only if, it is a proportionate response having regard to the risks that would be involved in discharge."*

[8] *Section 72(1)(b)*

The Significance of Mental Disorder Classification

Anna Harding*

R (on the application of B) v Ashworth Hospital Authority [2003] EWCA Civ 547
Court of Appeal (15th April 2003) Simon Brown LJ, Dyson LJ, and Scott Baker LJ

"Clearly, following our judgments on this appeal, the question of re-classifying patients to include other disorders will assume a far greater importance than hitherto it has had."[1]

The Facts

B is a restricted patient, having been detained in Ashworth High Security Hospital under sections 37 and 41 of the Mental Health Act 1983 ('The Act') since 1987. The order of the sentencing court specified that the mental disorder for which he was detained was a mental illness, namely schizophrenia. Most of the doctors who had treated B since his admission were of the opinion that B also suffered from a psychopathic disorder, namely a personality disorder (dissocial type). However, his mental disorder had never been reclassified[2] from that of mental illness.

In August 2000, B applied to a tribunal for discharge. His Responsible Medical Officer ('RMO') submitted a report to the tribunal, which stated that B was suffering from a schizo-affective disorder of the manic type. A psychologist's report recommended that B should be transferred to a 'co-morbidity' ward, that is a ward which would be able to provide treatment for both his mental illness and his personality disorder.

In December 2000, B was transferred to a ward that could treat personality disorder, and B was still on this ward at the time of his next tribunal hearing in May 2001. His RMO explained that the reason for the transfer was to treat B's personality disorder traits. At the tribunal hearing B was refused an order for discharge. No reclassification of his mental disorder was made.

In August 2001 B's solicitors wrote to the hospital to express concern that B was on a ward specialising in the treatment of psychopathic disorder. In December 2001 they received a reply from the Chief Executive saying that the clinical team felt that B's needs were best met by the personality disorder service.

B sought Judicial Review of the decision to detain him in a personality disorder ward. The issue was whether Ashworth could lawfully treat B for a personality disorder when he was only classified as suffering from mental illness. Sir Richard Tucker, in the Administrative Court held that they

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[1] *Simon Brown LJ at paragraph 81.*

[2] *It should be noted that the Act does not use the term 'classified disorders'. The expression is used throughout this case review to refer to the disorder specified on the section admission application or hospital order or in a tribunal decision. The heading to section 16 refers to 'reclassification' (see below).*

could do so, and he duly dismissed B's application[3]. B appealed, and in the words of Dyson LJ who gave the lead judgment, the issue for resolution on the appeal was "the true construction of section 63 of the Act".[4]

The Law

The treatment of most detained patients[5] is governed by Part IV of the Act. In particular section 63 provides: "The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within section 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer".

Before proceeding further in outlining the statutory framework of the Act, Dyson LJ made clear that the scope of the treatment provisions could only be construed by reference to the statute as a whole, which provides a scheme for the admission, treatment, review and discharge of people suffering mental disorder[6].

Under section 3, the grounds for an application for a person to be admitted and detained for treatment are as follows:

> "(a) He is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
>
> (b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and
>
> (c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section

As His Lordship pointed out, the basis for the application for admission is to enable the patient to receive treatment for the disorder which justifies his or her detention[7].

By section 16, the RMO has the power to reclassify the patient's mental disorder by furnishing a report to the hospital managers:

> "(1) If in the case of a patient who is for the time being detained in a hospital in pursuance of an application for admission for treatment, or subject to guardianship in pursuance of a guardianship application, it appears to the appropriate medical officer that the patient is suffering from a form of mental disorder other than the form or forms specified in the application, he may furnish to the managers of the hospital, or to the guardian, as the case may be, a report to that effect; and where a report is so furnished, the application shall have effect as if that other form of mental disorder were specified in it.
>
> (2) Where a report under subsection (1) above in respect of a patient detained in a hospital is to the effect that he is suffering from psychopathic disorder or mental impairment but not from mental illness or severe mental impairment the appropriate medical officer shall

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[3] *[2002] EWHC Admin 1442; 1st July 2002*

[4] *Paragraph 14*

[5] *Section 56 of the Act specifies the patients to whom Part IV applies.*

[6] *Paragraph 16*

[7] *Paragraph 19*

> include in the report a statement of his opinion whether further medical treatment in hospital is likely to alleviate or prevent a deterioration of the patient's condition; and if he states that in his opinion such treatment is not likely to have that effect the authority of the managers to detain the patient shall cease.
>
> (3) Before furnishing a report under subsection (1) above the appropriate medical officer shall consult one or more other persons who have been professionally concerned with the patient's medical treatment."

Section 20 provides for the duration of the authority to detain the patient. Subsection (3) allows for the renewal of the authority if the RMO examines the patient and furnishes a report to the hospital managers stating that it appears that the conditions in subsection (4) are satisfied. These conditions are as follows:

> "The conditions referred to in subsection (3) above are that –
>
> (a) the patient is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment, and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; and
>
> (b) such treatment is likely to alleviate or prevent a deterioration of his condition; and
>
> (c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and that it cannot be provided unless he continues to be detained;
>
> but, in the case of mental illness or severe mental impairment, it shall be an alternative to the condition specified in paragraph (b) above that the patient, if discharged, is unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation."

The wording of section 20(9) should also be noted:

> "Where the form of mental disorder specified in a report furnished under subsection (3)... above is a form of disorder other than that specified in the application for admission for treatment..., that application shall have effect as if that other form of mental disorder were specified in it; and where on any occasion a report specifying such a form of mental disorder is furnished.... the appropriate medical officer need not on that occasion furnish a report under section 16 above."

Having similarly outlined these statutory provisions, Dyson LJ paused from his consideration of the statutory framework, and stated as follows[8]:

> "It will be seen that the conditions in section 20(4) are substantially the same as the conditions in section 3(2), and that the scheme of section 20 is very similar to that of section 16. In particular, if the form of disorder specified in a report is other than that specified in the application for admission for treatment, the application shall have effect as if that other form of mental disorder were specified in it. So, once again, the important link is maintained between the mental disorder which justifies the patient's detention and his treatment *for that disorder*."

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[8] *Paragraph 23*

Section 37 makes provision for hospital orders to be made by the courts following criminal proceedings. Where a person is convicted of certain offences and certain conditions are satisfied, the court may authorise his admission his admission to, and detention in, hospital for treatment. Section 37(7) provides that the order shall "specify the form or forms of mental disorder.... from which the offender is found to be suffering"

With some modifications, the provisions of sections16 and 20 apply to patients detained under section 37[9].

The position is different for restricted patients. Section 41 provides that, if certain conditions are met, the court may further order that the offender who is ordered to be detained under section 37, shall also be subject to special restrictions. One consequence of the restrictions is that the provisions of sections 16 and 20 do not apply; another is that no application to a tribunal may be made under section 66.[10] Section 66 enables an application to be made to a tribunal where a report is furnished under sections 16 or 20.

For restricted patients the only way to get the specified mental disorder reclassified is to persuade a tribunal to reclassify in accordance with their apparent power under section 72(5)[11]. The Secretary of State has a number of powers in relation to restricted patients[12], but he does not have the power to reclassify a patient's mental disorder.

Under section 72 (5), where a tribunal does not direct discharge, it "may, if satisfied that the patient is suffering from a form of mental disorder other than the form described in the application, order or direction relating to him, direct that that application, order or direction be amended by substituting for the form of mental disorder specified in it such other form of mental disorder as appears to the tribunal to be appropriate".

Judgment

As already noted, Dyson LJ gave the lead judgment of the Court.

On behalf of the hospital it had been submitted that section 63 allows treatment of any mental disorder from which the patient was suffering regardless of whether or not it was the classified disorder. In support of that contention, counsel made three main submissions:

a) That Part IV makes no reference to classification. Parliament would have been explicit if it was only to apply to classified disorders;

b) That if section 63 does not permit the giving of medical treatment for non-classified mental disorders, there would be no power to treat detained patients in an emergency for non-classified disorders;

c) If the Act only authorised treatment for classified disorders there would be great practical difficulty in cases of co-morbidity.

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[9] *Section 40(4); Schedule 1 Part 1 paragraphs (2), (3) and (6) of the Act*

[10] *Section 41(3) (a) and (b)*

[11] *It should be noted that both Richard Jones in the Mental Health Act Manual (Sweet and Maxwell) (8th edition) (2002) at p.368, and Anselm Eldergill in Mental Health Review Tribunals (Sweet and Maxwell) (1997) at p.555, question whether Parliament intended to confer on tribunals a power to reclassify restricted patients. The Court's judgments contain no reference to this view.*

[12] *Section 42 of the Act*

The Judge accepted that, *in isolation*, Part IV could be read as applying to *any* diagnosed mental disorder, whether it was classified or not. But, he went on, "Part IV must be interpreted in its context"[13]. Looking at the whole of the Act, it was clear that it was dealing with the admission and detention of patients suffering from classified mental disorders. The Act contained provisions designed to ensure that patients were only detained as long as they continued to suffer from such disorders. Part IV of the Act was no more concerned with non-classified mental disorders than it was with physical disorders. It was concerned with mental disorders which were treatable and which justified detention for their treatment. The Act had a continuous theme that the liability to detention was linked to the mental disorder from which the patient was classified as suffering, and that the disorder was considered treatable by the person making the classification.

By looking at the Act as a whole, the Judge concluded that it was "not at all surprising that Part IV does not define the mental disorder for which medical treatment may be given without the patient's consent as the classified mental disorder. That is assumed."[14] The provisions relating to reclassification within the Act were designed to ensure that the essential link was maintained between the mental disorder which justified the patient's detention and his treatment *for that disorder*. It was therefore not lawful to provide compulsory treatment for a disorder other than the classified disorder.

The Judge held that Sir Richard Tucker in the Administrative Court had misinterpreted section 63, and the appeal was allowed.

The Court went on to look in some detail at the case of *R v Oxfordshire Mental Health Review Tribunal ex p Hagan*[15]. In that case the applicant was detained under sections 37/41 and both mental illness and psychopathic disorder had been specified on the Order. He had applied to a tribunal who found that the psychopathic disorder continued to reach the detention threshold but that the mental illness was in remission. However the tribunal had refused to reclassify him so as to remove the reference to mental illness. The issue raised was whether the tribunal had a *discretion* or a *duty* to reclassify when one of the specified disorders would not on its own justify detention. The court held that the tribunal had a *discretion* and there was no duty to remove from the order a form of mental disorder from which the patient still suffered but which would not justify detention. Waller LJ, giving the principal judgment had said that reclassification related to whether the patient suffered from a mental disorder, not whether he was detainable for that disorder if it stood alone.

In the present case it was submitted that *Hagan* had been wrongly decided and that classification was the touchstone for both detention and for treatment. It was suggested that it was open to the Court not to follow *Hagan* as that case had been decided before the Human Rights Act 1998 came in to force. It was accepted that *Hagan* was not determinative of the present issue but some of the reasoning was relevant.

The Court felt unable to agree with some of the reasoning in *Hagan*. It was agreed that the purpose of classification was to identify the mental disorder for which compulsory treatment was needed. The corollary of that was that it was not the purpose of classification to identify a mental disorder for which compulsory treatment was not needed[16]. It was felt that a better view of sections 16,20 and 72(5) would have been that when a mental disorder ceased to meet the section 3 or section 37 criteria, there should be a reclassification to remove the disorder from the application or order[17].

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[13] *Paragraph 42*

[14] *Paragraph 42*

[15] *[2001] LLR Med 119*

[16] *Paragraph 64*

[17] *Paragraph 65*

It was not felt necessary to say that *Hagan* was wrongly decided because the correct basis for that decision was identified in paragraph 32 of Waller LJ's judgment[18]:

> "… The conclusion of the Tribunal was that the mental illness alone would not render him liable to be detained. That conclusion emphasises that Mr Hagan still suffers from mental illness, and that it may recur unless treatment was available. The conclusion I suggest can be fairly read as being that the mental illness, when taken together with the psychopathic disorder which can be alleviated by treatment in hospital, makes it appropriate for him to be detained in hospital for medical treatment in relation to both types of mental disorder…"

It was therefore not felt necessary to consider whether *Hagan* could continue to be considered good law.

Discussion

The purpose of classification and the scope of compulsory treatment provisions.

This case raises the question in the author's mind about whether the court could reasonably have come to any other conclusion. It is submitted that from a 'rights based' angle it could not. At the same time the judgment does have some significant practical implications, which suggest that the conclusion was not always as obvious as it now appears.

The scheme of the Act clearly aims to provide a balance between the two issues of protection and autonomy. Finding the right balance is not always easy and views change about what is the best way to achieve it. Doctors traditionally have a great deal of discretion in their clinical judgement but in the field of mental health there is a visible overlap between what may be said to be a clinical approach and a more legalistic approach. The legal approach recognises the infringements on civil rights and is more concerned to provide an effective check on the use of power. There may be some cases where the position is not clear-cut and where a decision needs to be made by balancing up the competing arguments, which may be strongly made in either direction. It is likely that reasonable and fair people could legitimately disagree about decisions made in this 'grey area'. However, the courts have been quite willing in recent times, particularly since the introduction of the Human Rights Act 1998, to show that any use of power must not be arbitrary, that it must be in accordance with the law, and that the courts will provide an effective check on its exercise.

Ashworth had argued in this case that the correct interpretation of section 63 meant that once a person was lawfully detained under the Act they could be treated for any mental disorder from which they were suffering. This argument does not stand up to a rights based critique. As Simon Brown LJ stated[19]:

> "Two important considerations should be borne in mind when construing section 63: first, that on no view does it extend to treatment for any physical condition, however serious, and however mentally incapacitated the patient may be. Secondly, that a person suffering from a treatable mental disorder, but not one of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital, cannot be detained and treated under the Act. If the patient cannot be forcibly treated in either of those circumstances, why should he be amenable to such treatment for a non-specified mental disorder merely because he is already lawfully detained for the treatment of some other mental disorder?"

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[18] *Paragraph 66*

[19] *Paragraph 78*

Urgent Treatment and Capacity

Although the court gave section 63 a restrictive interpretation, and so gave greater weight to patients' right to self-determination, the way that Ashworth's supporting submissions were dealt with may mean that the rights are more illusory than real.

Ashworth's second submission was that if section 63 did not permit treatment of non-classified mental disorders there would be an important lacuna in the Act. It would mean that there was no authority to administer treatment to detained patients in urgent cases for the non-classified disorder. Although this would be less of a problem for unrestricted patients, where the RMO could quickly furnish a report to the managers[20], in the case of restricted patients, according to both Dyson LJ and counsel for Ashworth, "the only route to reclassification was by a reference to the tribunal by the Secretary of State under section 71, with a view to the exercise by the tribunal of its power to reclassify under section 72(5)"[21].

Further, the submission was that the common law would not help solve this problem because common law powers, in relation to detained patients, were impliedly removed by Part IV of the Act. Counsel relied on the House of Lords decision in *B v Forsey*[22], in which it was held that the hospital's powers of detention conferred by the Scottish mental health legislation were exhaustive and there was no residual common law power to detain. In that case Lord Keith of Kinkel said that "the scheme contains a number of safeguards designed to protect the liberty of the individual. It is not conceivable that the legislature, in prohibiting any successive period of detention under provisions containing such safeguards, should have intended to leave open the possibility of successive periods of detention not subject to such safeguards".

The judge dealt with this submission quite shortly by distinguishing *Forsey*. He said that section 63 of the Act was clearly not exhaustive of the power to treat for mental disorder because it was only concerned with treatment for classified disorders. It followed that, in relation to a non-classified mental disorder, the common law applied in the same way as it did to physical disorders.

What was not clearly expressed was the significance of this finding. This may mean that the court missed an important opportunity for asserting the value of the rights of detained patients. Alternatively, it may bring the validity of their decision into question at some future time.

The Scope of Common Law Treatment

Counsel for Ashworth accepted that, outside the Act, the common law allowed medical treatment without consent where the patient did not have capacity. It seems also to have been accepted that such treatment could be administered to people with capacity in "an emergency". The judge referred to *In re F (Mental Patient: Sterilisation)*[23], and the judgment of Lord Goff at 72–78, to support this contention[24]. However, it would appear that the situations envisaged by Lord Goff when talking about emergency actions, particularly in relation to medical treatment, should more properly be categorised as short-term periods of incapacity (e.g. unconsciousness etc). That leaves

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[20] *Under section 16 of the Act*

[21] *Paragraph 36. A restricted patient's case might also come to the attention of the tribunal by the patient exercising his/her right to apply under section 70.*

[22] *[1988] SLT 572*

[23] *[1990] 2 AC 1*

[24] *This proposition also finds favour in paragraph 15.25 of the Code of Practice (Department of Health and the Welsh Office) (1999). The author agrees with Richard Jones (op. cit. at page 307) that paragraph 15.25 "cannot be correct".*

very few (if any) situations where treatment can be given to a person with capacity when they do not consent. There are significant implications flowing from the Court's failure to analyse the common law position properly.

The expression of the common law doctrine of necessity is frequently shortened but in *Re F* it was expressed in two stages:

> 1) There must be a necessity to act when it is not practicable to communicate with the assisted person; 2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.

'Not practicable to communicate' can either mean that the person does not have capacity to communicate, or may mean that the situation is so urgent as to demand immediate action to the extent that there is not time to ascertain the other person's wishes. Neither of these situations applies to a patient who may need urgent treatment but is mentally capable and refuses it (or who does not have capacity but has made an advance decision to refuse certain treatment).

The Court gave the impression that there was force in Ashworth's submission but that it was mistaken because treatment could be given under common law. However, the Court misstated the common law position. People with capacity are entitled to refuse any medical treatment unless it is authorised by the Act. If the Act only allows medical treatment for the classified mental disorder then treatment for a different mental disorder, where the patient retains capacity, may not be given – even in an urgent situation.

The case is undoubtedly extremely important and it should have a significant impact. Perhaps, in practice, most situations where urgent psychiatric treatment is needed will be assessed as resulting in a loss of capacity, so that treatment can be given under the common law. However, there will at least be an extra step in the process where the doctor has to address his mind to the question of capacity. The Court's failure to recognise the impact of the decision means that any force in Ashworth's submission has not been adequately dealt with. That leaves a good decision vulnerable to future challenge.

Cases of Co-morbidity

Following this judgment there may well be more cases of dual classification as doctors become cautious to ensure that they can administer treatment where necessary. The doubts cast on the *Hagan* judgment will become more significant as patients have the right to be reclassified so as to remove disorders that do not meet the detention criteria.

Counsel for Ashworth had submitted that if treatment under section 63 could only be given for the classified disorder there would be a real difficulty in cases of co-morbidity. The argument was based on the theoretical situation of a patient having been diagnosed as suffering a mental illness, which reached the threshold criteria for detention and treatment, and another disorder e.g. personality disorder that did not reach that threshold. The judgment was to the effect that if the personality disorder was 'free-standing' the patient could not be detained and treated for it, but if it aggravated the mental illness treatment may be administered for it under the guise of it amounting to ancillary treatment for the mental illness.

Unfortunately, the way this issue was dealt with undermines the significance of the rest of the judgment. Treatment for one disorder should never be described as ancillary treatment for another. The passage from *Hagan*, set out above[25], that was expressly said to be correct suggests that there may be situations where a combination of disorders means that the threshold is reached when it might not be if there was just one disorder. Even if that is right, it is not the same as saying that treatment for one is ancillary to treatment for the other. The doctors must decide what disorder they are treating and formulate a treatment plan for that disorder. To say that treatment can be compulsorily given for a non-classified disorder, on the basis that it is ancillary to treatment for another disorder, entirely negates the protection that the Court agreed was afforded by the Act.

What if there is no classification?

Perhaps more significant is the effect of the judgment on cases where there is no classification, for example, under section 2. Patients detained under section 2 are subject to the compulsory treatment provisions as set out in Part IV, but it is not necessary to 'classify' the mental disorder from which they are suffering. In fact, in many cases it would be impossible to do so, and if possible, may be admission under section 3 would be more appropriate.

The Court does not seem to have looked at section 2 in reaching its decision. However, the implication of the judgment is clear. A person detained under section 2 can be given compulsory treatment for any disorder from which they may be suffering even if that disorder does not reach the threshold for detention. This means that people being assessed are more vulnerable under the treatment powers than those who are detained specifically for treatment. This may well affect the perceived attraction of using section 2 before a section 3.

Conclusion

This case may provide a practical example of the fact that compulsory treatment is such a severe infringement of autonomy that any power to exercise it must be expressly provided for by Parliament. The Mental Health Act 1983 clearly does express that power. This case clarifies the limits of that power, and by doing so reinforces the underlying value of autonomy by making it clear that apart from what is expressly removed by the Act, a patient retains the all the same rights as a non-detained person in relation to treatment. However, the Court did not take the opportunity to make a clear statement of principle and may have undermined the significance of their decision by failing to do so.

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[25] *Paragraph 32 of Waller LJ's judgment in Hagan. See footnote 18 above.*