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Contents

Page

Foreword

It seems probable that publication of this issue of the Journal will coincide with publication by the Department of Health of the eagerly awaited White Paper containing the Government's intended reform of mental health legislation. The last issue contained a number of articles and reflections on both the Green Paper of November 1999 and the Report of the Expert Committee which preceded it. This issue begins with a detailed consideration by Paul Bowen of the Human Rights implications of the Green Paper. The coming into effect of the Human Rights Act 1998 on 2nd October 2000 has made such an analysis of the utmost importance, and we are sure that Paul Bowen's article will be of considerable assistance in the debate that inevitably will be generated by the White Paper's publication.

The White Paper will clarify the Government's intentions for the Mental Health Act Commission. We are grateful to Margaret Clayton, Chairman of the Commission, for summarising within her article, the Commission's view of what they should be. Similarly, given the central role played by the ASW in the application of the provisions of the Mental Health Act 1983, and the speculation about the part to be played following legislative reform, Roger Hargreaves' reflection on the role of the Approved Social Worker is timely.

The White Paper will of course confine itself to the law in England and Wales. It is to the Report of the Millan Committee, due to be published early in 2001, that one must turn for an indication as to how mental health legislation might develop in Scotland. We are pleased to include within this issue, an article by Hilary Patrick, a member of the Committee, which provides an informative preview of what the Report might contain.

Over the last year there have been a number of Court decisions of considerable significance. Kevin Kerrigan has developed an analysis of the House of Lords decision in *R v Antoine* into a comprehensive review of the law relating to unfitness to plead and the special verdict of not guilty by reason of insanity. The other important cases which have been subjected to close examination within this issue are *R v London Borough of Richmond upon Thames ex parte Watson, R v Redcar and Cleveland Borough Council ex parte Armstrong, R v Manchester City Council ex parte Stennett, R v London Borough of Harrow ex parte Cobham* (within one review); *R v London South and South West Region MHRT ex parte Moyle; R v Collins and Ashworth Hospital Authority ex parte Brady; Re F (Mental Health Act: Guardianship); Re F (Adult: Court's Jurisdiction)*.

Finally we have included reviews of four books: *Mental Health Law - Policy and Practice* by Peter Bartlett and Ralph Sandland published by Blackstone Press; the second edition of *Community Care and the Law* by Luke Clements published by LAG; *Advising Mentally Disordered Offenders - A Practical Guide* by Deborah Postgate and Carolyn Taylor published by The Law Society; and *Care or Custody? Mentally Disordered Offenders in the Criminal Justice System* by Judith M Laing published by Oxford University Press.

As always we are very grateful to all those who have generously submitted contributions for inclusion within the Journal.

Charlotte Emmett
Editor

Reform of the Mental Health Act 1983 – Convention Implications of the Green Paper

*Paul Bowen**

[This article is based upon two lectures given by the author to the Institute of Mental Health Act Practitioners on 7 February and 6 March 2000.]

Assessing the Convention compatibility of the Government proposals for reform of the Mental Health Act 1983 set out in the Green Paper[1] is largely an exercise in speculation, for three reasons. First, the proposals are very broad; the detail, where the devil may be found, is yet to come. Second, the Convention does not permit the Strasbourg authorities to review the legality of national legislation in the abstract, but only with reference to particular cases after the proceedings are complete[2]. Although that will not necessarily preclude a domestic court from reviewing the lawfulness of any provision of the new Mental Health Act after incorporation of the Human Rights Act 1998[3], the comments that can be made in this article are necessarily confined to the general rather than the specific.

Third, and perhaps most significantly, it is impossible to predict the impact of the Convention following the coming into force of the Human Rights Act 1998 on 2 October 2000. The consequences of that Act will be far-reaching, but one in particular deserves mention. The Strasbourg Court's decision-making is constrained by the concept of the 'margin of appreciation'. The principle has been developed by the Strasbourg authorities to reflect an appropriate degree of deference by the international court to the expertise of national decision-makers, whether courts or governments, in applying national law to national problems[4]. It also reflects the practical problem faced by the Strasbourg authorities in applying Convention principles in a manner that can be relevant to all the Contracting States, which together present a wide range of different legal approaches to the same problems (and often widely different availability of resources). In practice

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1 *'Reform of the Mental Health Act 1983 - Proposals for Consultation' Department of Health 1999. Cmnd 4480. The Green Paper considers the proposals of the Expert Committee chaired by Professor Richardson, which are set out in their Report 'Review of the Mental Health Act 1983', also published by the Department of Health in November 1999.*

2 *see Hakansson and Sturesson v. Sweden (1990) 13 E.H.R.R. 1, 11, para. 46; the Salabiaku case, 13 E.H.R.R. 379, 390, para. 30; Hoang v. France (1992) 16 E.H.R.R. 53, 78, para. 33*

3 *See R v Directior of Public Prosecutions ex p Kebilene [1999] 3 WLR 972, 996D-F*

4 *See Handyside v U.K. (1976) 1 EHRR 737*

it has the effect of placing an additional hurdle for an applicant to clear in establishing a violation of his Convention rights before the Strasbourg authorities.

However, as Lord Hope recently noted in the House of Lords in *R v DPP ex p Kebilene*[5]

"This technique [the margin of appreciation] is not available to the national court when they are considering Convention issues arising within their own countries."

It follows that it should be easier to prove a Convention violation before the national courts than to do so before the Strasbourg Court[6]. It also follows that the principles developed by the Strasbourg Court (which domestic courts must 'take into account', by s. 2(1) Human Rights Act 1998) are only a *starting-point* in determining the extent of Convention rights as a matter of domestic law. A greater degree of protection must, theoretically, be provided under domestic law than under international law. This paper can only address Convention law as it has been developed by the Strasbourg authorities.

With those reservations in mind, this article addresses the Convention implications of the specific proposals contained in the Green Paper, under the following headings:

The new criteria for the exercise of compulsory powers (Chapters 4 & 5)
The new procedure for Detention (Chapters 4 & 6)
Discharge procedures (Chapters 7 & 10)
Compulsory Community Orders (Chapter 6)
Compulsory Detention in Criminal Proceedings (Chapter 8)
Transferred prisoners (Chapter 8)
Severe Personality Disordered patients (Annex C)
The right to receive treatment
Compulsory treatment and the right to refuse treatment (Chapter 9)
The right to aftercare (Chapter 7)
Children and Incapacitated Adults (Bournewood).

(I) The new criteria for the exercise of compulsory powers

The Government's proposals fall, broadly, under three headings: (a) a single, very broad, definition of mental disorder to replace the four existing categories of mental disorder justifying the use of compulsory powers (Green Paper, Chapter 4, §2-5); (b) a rejection of the Expert Committee's proposed capacity-based detention criteria; (c) a new formulation of the criteria for the exercise of compulsory powers to replace the existing 'appropriateness', 'treatability' and 'safety' tests.

Under the Mental Health Act 1983 an individual cannot be subjected to compulsory powers (whether detention, a supervision order or guardianship) unless his mental disorder falls within one of four categories, respectively 'mental illness', 'psychopathic disorder', 'severe mental impairment' and 'mental impairment. To fall within the definitions of 'psychopathic disorder', 'mental impairment' and 'severe mental impairment', an individual's disorder must be 'associated with abnormally aggressive or seriously irresponsible conduct'. If that criterion is not satisfied the individual cannot be subjected to compulsory powers.

5 *[1999] 3 WLR 972, at 993:*

6 *It should be noted however that Lord Hope went on to recognise that the judiciary would "defer, on democratic grounds, to the considered opinion of the elected body or person whose act or decision is said to be incompatible with the Convention…" This has been referred to as the "discretionary area of judgment" and could be seen as the start of a domestic margin of appreciation doctrine.*

The Government proposes to follow the advice of the Expert Committee and remove the four classifications of mental disorder and replace them with a single definition: 'any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of Mental Functioning' (Green Paper, Chapter 4, §2). The requirement that certain types of disorder be 'associated with abnormally aggressive or seriously irresponsible conduct' before compulsion can be used will be abolished. The rationale for this broader definition is that the more specific definitions in the current Mental Health Act may have the effect of excluding some individuals who should fall within the compulsory powers of the Act. The only express exclusions from the definition are disorders of sexual preference and misuse of alcohol or drugs.

The arguments in favour of a single, broader, definition of mental disorder are powerful. The current definitions, some of which were set in 1959, no longer reflect current clinical diagnoses of the disorders that they represent. Some, such as psychopathic disorder, are stigmatizing. Moreover, to permit the exclusion of some individuals from the definition may be to deny them help and treatment of which they are in need.

On the other hand, the stricter the criteria for admission the greater the protection afforded to the individual against arbitrary detention. The current proposal constitutes an erosion of that protection and requires scrutiny as to its compatibility with the Convention.

The relevant admission criteria for the purposes of Article 5(1)(e) (detention on the grounds of 'unsound mind') are as follows:

(a) The patient must be reliably shown, upon objective medical expertise, to be suffering from a 'true mental disorder'[7]. A person may not be detained simply because his views or behaviour deviate from the norms prevailing in a particular society[8];

(b) The disorder must be of a 'kind or degree' warranting compulsory confinement[9];

The new diagnostic criteria proposed in the Green Paper would cover, for example, a person suffering from a temporary needle-phobia[10]. It must be doubted whether all conditions falling within that broad definition could be termed a 'true mental disorder' for the purposes of Article 5(1)[11]. The exceptions provided in relation to disorders of sexual preference and the misuse of alcohol or drugs may not be sufficient to exclude from the operation of the Act all those whose 'views or behaviour deviate from the norms prevailing in a particular society'. The example of Mrs. S in the case of *R v Collins ex p S*, unlawfully detained under section 2 MHA because of her refusal to undergo a Caesarean, is in point;[12] the new definition would arguably be wide enough to permit her detention[13].

As to the rejection of the 'capacity' test, the Strasbourg cases do not identify capacity, or lack of it, as being relevant in any way in determining the lawfulness of detention under Article 5. It must

7 *Winterwerp v Netherlands (1979) 2 EHRR 387, §39*

8 *ibid, §37*

9 *ibid, §39*

10 *As in Re MB (An Adult: Medical Treatment) [1997] 2 F.C.R. 541, CA*

11 *It should be noted however that Winterwerp referred back to the definition of mental disorder in municipal law, and did not require a State to specify types of mental disorder.*

12 *'The Act cannot be deployed to achieve the detention of an individual against her will merely because her thinking process is unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority of the community at large.', per Judge LJ at [1999] Fam 26, 51*

13 *For another example of a person who would be 'detainable' under the new criteria see Re. F (A Child) (1999) 2 C.C.L. Rep. 445, CA; where the wish of a 17 year old girl leaving care to return to an abusive family home was held not to be 'seriously irresponsible behavior' justifying her admission to guardianship.*

be the case, however, that the detention of a person who has capacity to consent to his admission to hospital, and who refuses that consent, is a relevant consideration in determining whether he is suffering from a disorder of a 'kind or degree' warranting compulsory confinement.

Turning, then, to the proposals for the criteria for the exercise of compulsory powers. Under the current Mental Health Act the criteria for admission for treatment are threefold: the patient must be suffering from one of the four categories of mental disorder of a nature or degree which makes it appropriate for him to be detained in hospital[14] (the 'appropriateness test'); in the case of mental impairment or psychopathic disorder, any treatment must be likely to alleviate or prevent a deterioration of his condition (the 'treatability test'); and 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 (the 'safety test').

The Government proposes a new test, namely (Chapter 5,§7):

(a) that the disorder be of 'such seriousness that the patient requires care and treatment under the supervision of specialist mental health services'; and

(b) that the care and treatment proposed for the mental disorder, and for conditions resulting from it, is the least restrictive alternative available consistent with safe and effective care; and

(c) that proposed care and treatment cannot be implemented without the use of compulsory powers; and

(d) such treatment is necessary for the health or safety of the patient and/ or for the protection of others from serious harm and/or for the protection of the patient from serious exploitation.

These proposals differ little from the existing 'appropriateness' and 'safety test' and incorporate, in all but name, the European concept of 'proportionality': the degree of compulsion must be 'proportionate' both to the nature and degree of the disorder and to the level of risk the patient presents. To that extent, the proposals are capable of complying with the requirements of Article 5 as currently interpreted.

Two aspects of the proposals call for greater scrutiny, however.

First, does the removal of the 'treatability' test mean that a patient suffering from (what is now known as) 'psychopathic disorder' or 'mental impairment' may be detained notwithstanding there is no treatment that will 'alleviate or prevent a deterioration' of their condition? This issue is addressed further, below, in relation to the Government's proposals for the detention of persons with 'dangerous severe personality disorders' (DSPDs).

Second, little is said about the Secretary of State's recall power in relation to conditionally discharged restricted patients (currently s. 42(3) Mental Health Act 1983) (Chapter 8, §27 & 34). This power, as currently interpreted, permits recall in the absence of medical evidence of a qualifying mental disorder[15], which has been held to violate the requirement of Article 5(1) that the patient 'be reliably shown, upon objective medical expertise, to be suffering from a true mental disorder'[16]. The same issue arises in relation to the detention of patients who may be returned to hospital for failure to comply with Compulsory Community Orders (see below).

14 *Similar criteria apply governing a patient's admission into guardianship*

15 *R v Home Secretary ex p K [1991] 1 Q.B. 270*

16 *Kay v United Kingdom (1998) 40 B.M.L.R. 20*

(2) The new procedure for Compulsory Detention

The government proposes that Compulsory Orders, whether requiring treatment in hospital or in the community, beyond an initial defined maximum assessment period, can only be made by an independent judicial body (Chapter 4, §24) (the Tribunal). The burden of proof (if the Expert Committee's proposal is adopted) will be on the care team 'to demonstrate that a further period of compulsory care was justified' (§14). Patients will be able to challenge the application, and such challenges will result in an oral hearing.

The removal of the 'reverse burden of proof' in section 72 MHA 1983, long considered a potential violation of Article 5(1) and 5(4) [17], would be welcomed.

The requirement that the initial detention-for-treatment decision be made by a 'court', rather than the detaining authority itself (of course, in the case of those detained under criminal powers that has always been the case), is aimed at ensuring compliance with the requirement in Article 5(4) of a 'speedy' review by a court of the lawfulness of the detention; whether it does so is considered below under "Discharge procedures".

Two aspects of the proposals raise serious Convention issues.

First, where a patient does not contest a Compulsory Order, it is suggested that 'the tribunal decision should be straightforward, a one-person panel should be sufficient and there should usually be no need for an oral hearing' (Chapter 4, §39). Neither is it considered essential for an independent second opinion to be sought (although the Tribunal would have a discretion to obtain one). There is a real danger that the Tribunal would become a 'rubber-stamp', particularly in the absence of an independent second opinion or a medical member on the sitting in the Tribunal. In those circumstances it would be difficult to say that the patient had been 'reliably shown, upon objective medical expertise' to be suffering from a qualifying disorder, in accordance with Article 5(1). This also engages important issues under Article 5(4), considered below under 'Discharge procedures'.

Second, it is suggested that, at the time of detaining a patient, a Tribunal may order that he cannot be discharged without the Tribunal's approval (see Chapter 7, §5 & Consultation Point I). This conflicts with the principle that 'the validity of any continued detention depend[s] upon the persistence of a [qualifying] mental disorder'. Once the RMO has concluded that the patient no longer suffers from a mental disorder justifying detention, the patient should, in the absence of conflicting medical evidence, be discharged. Any detention between that time and a reconvened Tribunal hearing (which might take weeks) would, arguably, be unlawful. Moreover, where the detaining authority seeks to discharge the patient, for the Tribunal to refuse a discharge puts it in the position of gaoler, not guardian, and would arguably be in breach of Article 5(4). This proposal should be reconsidered.

(3) Discharge procedures

The Government proposals contain few details concerning the procedures for the new Tribunal. I propose setting out, first, the requirements of Article 5(4) and then considering their possible consequences for the proposals in the Green Paper.

17 *O. Thorrold, 'The Implications of the European Convention on Human Rights for UK Mental Health Legislation', [1996] EHRLR 619*

Article 5(4) provides:

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

Relevant requirements of Article 5(4) are as follows:

(a) The review must be by a 'court' that is 'independent both of the executive and the parties to the case'[18].

(b) The 'court' must be of a 'judicial character' in the sense of being competent to take a legally binding decision leading to the patient's release. It was the absence of the Tribunal's power to order the patient's discharge without the consent of the Secretary of State that constituted a violation of Article 5(4) in *X v United Kingdom*[19].

(c) The Tribunal must also have power to mandate the fulfillment of conditions placed upon a patient's discharge, or to amend conditions subsequently so as to avoid an impasse developing[20]. Arguably, it should also have power to compel the fulfillment of conditions that have an impact upon the patient's future release, such as transfer to conditions of lesser security and leaves of absence. To extend the protection of Article 5(4) to decisions affecting a patient's prospects of future release as well as his immediate release is consonant with the approach taken by domestic courts in relation to the standards of procedural fairness required of such decisions at common law[21]. However, in *R v United Kingdom*[22] the European Commission held that the lack of a power to order a patient's leave of absence from hospital did not constitute a violation of Article 5(4). It remains to be seen what the national courts make of the argument.

(d) The 'judicial character' of the court must extend to the giving of procedural safeguards appropriate to the kind of deprivation of liberty in question. Where a lengthy deprivation of liberty is involved, resembling that which might be imposed by a court in criminal proceedings, the guarantees must be 'not markedly inferior' to those guaranteed by Article 6 in criminal proceedings[23], and in some circumstances must be the same[24]. This imports the Article 6 concept, among others, of 'equality of arms', which requires that a detained person must have 'a reasonable opportunity of presenting his case to the court under conditions which do not place him at a substantial disadvantage vis-a-vis his opponent'[25]. Special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves[26]. The specific minimum guarantees that are required include:

  (i) A right to be heard either in person or, where necessary, through some form of representation[27].

  (ii) The right to legal representation, paid for by the state[28]. This has been held to extend to the right to be represented by a lawyer of the patient's choice[29].

18 *De Wilde, Ooms & Versyp v Belgium (1971) 1 EHRR 373, §76*

19 *(1981) 4 E.H.R.R. 188*

20 *Johnson v United Kingdom (1997) 22 EHRR 296, §66*

21 *see R v Home Secretary ex p Duggan [1994] 3 All ER 277, DC per Rose LJ at 288b; Reg. v. Home Secretary, Ex p. Harry [1998] 1 W.L.R. 1741, Lightman J.*

22 *Decision of 18 July 1986*

23 *De Wilde, Ooms & Versyp, ibid, §79*

24 *Megyeri v Germany (1992) 15 EHRR 584, §22*

25 *Neumeister v. Austria, 1 E.H.R.R. 91, at para. 22*

26 *Winterwerp v. the Netherlands (1979) 2 EHRR 387, para. 60*

27 *ibid, para 60*

28 *Megyeri v Germany (1992) 15 EHRR 584, §23*

29 *Cottenham v United Kingdom [1999] EHRLR 530*

(iii) The right (as a component of the principle of 'equality of arms'), in appropriate cases, to independent expert medical opinion[30].

(iv) The right to a 'speedy' hearing. The obligation is more onerous in respect of the first review after detention (or recall of a restricted patient[31]) than for subsequent reviews[32]. For first reviews, a period of 8 weeks between application and final determination has been held to constitute a violation of Article 5(4)[33]. Where, however, the delay is caused at the patient's request, so as to enable the solicitor of his choice to represent him, a delay of 10 months has been found not to constitute a violation of Article 5(4)[34].

(v) Adequate time and facilities to prepare the case. In particular, a time limit should not be placed upon the exercise of the right to apply to a Tribunal which is so short 'as to restrict the availability and tangibility of the remedy'[35].

(vi) The right to a speedy decision following the hearing.[36]

(vii) Right to reasons[37] in 'simple, non-technical language that he can understand', containing 'the essential legal and factual grounds for his [detention]', so the patient may, if he sees fit, 'apply to a court to challenge its lawfulness in accordance with' Article 5(4)[38].

(viii) Right to further reviews at regular intervals [39].

One overriding considerations must also be borne in mind. The obligation is on the Contracting State to secure for its citizens the rights set out in the Convention. It is therefore the Tribunal's responsibility to ensure that the specific safeguards referred to are made available to a patient, including to ensure that delays are not caused by, for example, medical experts appointed by the defence[40]. It is not for the patient to take the initiative in securing those safeguards[41]; nor is the onus on the patient even to apply for a tribunal in the first place[42].

Applying these principles to the Government proposals:

Constitution of the Tribunal. Three alternative models are mooted (Chapter 4, §28-30) which are intended to replace the current Tribunal constituted by a lawyer, psychiatrist and lay member. The proposals stem from the justifiable concern that the current role of the psychiatrist as both witness and judge violates the patient's rights under Article 5(4), which requires that the tribunal be 'impartial'. The first proposed change will retain the psychiatrist, but he will no longer conduct his own assessment of the patient; instead, the assessment will be carried out by an independent psychiatrist drawn from an approved panel who will then give evidence to the Tribunal. In the second option no psychiatrist will sit on the Tribunal, but the lawyer will be assisted by two people

30 *App. No. 24557/94 Musial v Poland, Decision dated 25 March 1999, ECHR, §46; see also Cottenham v United Kingdom, ibid*

31 *Roux v United Kingdom App. No. 25601/94, 16 September 1997*

32 *Khoendjbiharie v Netherlands (1990) 13 EHRR 820*

33 *E v Norway (1994) 17 EHRR 30*

34 *Cottenham, ibid*

35 *Farmakopoulos v Belgium (1992) Series A, No. 235-A, EComHR*

36 *Van der Leer v Netherlands (1990) 12 EHRR 567, para 35*

37 *Both under Article 5(2) and as a component of Article 5(4): (X v United Kingdom (1981) 4 EHRR 188, §66*

38 *(Fox, Campbell & Hartley v United Kingdom (1991) 13 EHRR 157, §40*

39 *Winterwerp v. the Netherlands (1979) 2 EHRR 387, para. 55*

40 *App. No. 24557/94 Musial v Poland, Decision dated 25 March 1999, ECHR, §46*

41 *See, e.g., Megyeri v Germany, ibid, para 22(d) (obtaining legal representation)*

42 *App. No. 33267/96 Croke v Ireland, Admissibility Decision of 15 June 1999, EcomHR*

with experience of mental health services. Independent psychiatric evidence will again be drawn from an expert panel. In the third option the legal member sits alone.

There must be concern about the appointment of second medical experts from a panel, if as a consequence, a patient's ability to appoint an independent expert is to be prohibited or limited. The principle of equality of arms suggests that a patient should be able to choose his own expert. A panel might be preferable to the existing system of an expert Tribunal member, but the existing system (although it has its drawbacks) could be improved by the following suggestions: (1) At the outset of the hearing, the medical member should be asked to identify those matters which he or she considers significant, thereby giving the patient the opportunity to make representations; and (2) at the end of the hearing the medical member should be asked to raise any matters which have not been dealt with in the course of the proceedings.

The onus is on the patient to choose to contest the care team's application to the Tribunal (Chapter 4, §39). This conflicts directly with the principle that the onus is on the state, not the patient, to ensure the guarantees in Article 5(4) are provided.

Power to mandate discharge conditions. The absence of any power to require local health and social services authorities to fulfill conditions of discharge, or to amend conditions, was a factor in the Court's decision that there had been a violation of Article 5(1) in *Johnson v United Kingdom*, by reason of the applicant's continuing detention for 3 years after an order of deferred conditional discharge. The absence of any such powers continues to cause regular delays in discharge and frequent applications to the High Court[43]. There are no proposals in the Green Paper which remedy that situation (see Chapter 8, §34).

Power to amend or vary conditions of discharge. Where a Tribunal conditionally discharges a restricted patient, and then defers the patient's release pending suitable conditions being put in place, Tribunals have no power to reconsider the case to amend or remove conditions where they have proved impossible to fulfil[44]. There is no proposal in the Green Paper giving the Tribunal this power. The only option currently is for the Home Secretary to remit the case back to a Tribunal to reconsider the matter afresh, in which case the patient is to be treated as if he had not been discharged at all (section 73(7) Mental Health Act 1983)[45]. This raises profound issues under the Convention and it is strongly arguable that section 73(7) is itself incompatible with Article 5.

Power to mandate leaves of absence and transfers. At present the Tribunal has no power to order leaves of absence or transfer. In the case of unrestricted patients, the decision is taken by the RMO; in restricted cases the Secretary of State must consent. No proposals are made for giving the necessary powers to the Tribunal, notwithstanding (in the case of restricted patients) they already have the greater power of discharge (see Chapter 8, §34). In the light of *R v United Kingdom* (above) it is questionable whether this constitutes a violation of Article 5(4).

Adequate time and facilities to prepare a case. The procedures in the Green Paper are geared disproportionately towards 'speedy' hearings; insufficient regard has been had to the necessary corollary, ensuring effective legal representation and independent expert evidence. One suggestion would be for the Tribunal to grant legal aid for legal representation and, in suitable cases, independent expert evidence at the outset of a patient's detention. Moreover, strict timetables

43 *See, e.g., R v MHRT ex p Hall [1999] 4 All E.R. 883*

44 *R v Oxford MHRT ex p Home Secretary [1988] AC 120*

45 *See R v Ealing HA ex p Fox [1993] 1 W.L.R. 373*

must be laid down and adhered to for the service of the RMO's report and, where appropriate, the Secretary of State's objections, bearing in mind the obligation in Article 5(4) that hearings be 'speedy'. It should be noted, however, that where the Tribunal has given a patient adequate time and facilities to prepare his case by adjourning the proceedings, there is unlikely to be a breach of Article 5(4) if the final hearing does not take place within the usual time limits[46].

Further comment must await more detailed proposals.

(4) Compulsory Community Orders

The centerpiece of the Government proposals is the Compulsory Community Order (CCO) (Chapter 6, §§4-12). The CCO will place patients subject to similar conditions as restricted patients who are currently subject to conditional discharge. It will impose greater restrictions on the patient's liberty than supervision orders imposed under section 25A Mental Health Act, as there will be a power to impose compulsory treatment in the community (albeit in a 'stipulated place').

A CCO will not usually have Article 5 implications as a patient who is subject to conditions upon his freedom of movement (such as conditions of residence, treatment and the like) is not usually 'deprived of his liberty' for the purposes of Article 5; he is merely subject to restrictions on his liberty of movement[47]. Article 2 of Protocol No. 4, which prohibits unjustifiable restrictions on liberty of movement, has not been incorporated by the Human Rights Act. There will be circumstances, however, where the conditions under a CCO (e.g. the requirement to stay in a 'stipulated place') may be so invasive as to constitute a 'deprivation' of liberty; the question is one of the 'degree or intensity' of the restrictions, rather than their 'nature or substance'.

A CCO will, however, have Article 8 (Right to respect for private and family life) implications, although potentially justifiable under the exception in Article 8(2) in relation to 'health' or the protection of the rights and freedoms of others in all cases other than where it will be a 'disproportionate' response to the patient's condition. It will very much depend on the kind of treatment that is imposed in the community as to whether it will be justified under Article 8(2).

The proposed power to convey a patient to hospital (Chapter 6, §12) will, on the other hand, engage Article 5. As with recalled conditionally discharged patients (see above), the recall must be on the basis of objective medical evidence of a 'true mental disorder', with a right to a speedy tribunal hearing, to satisfy the requirements of Article 5(1) and 5(4), other than in emergency situations.

(5) Compulsory Detention in Criminal Proceedings

The Government proposals for compulsory detention in the criminal justice system differ little from the current Mental Health Act Part III procedures (Green Paper, Chapter 8), save in respect of those considered to suffer from Dangerous Severe Personality Disorder (DSPD), considered later in this article. Two Convention issues do arise, however; one from the existing Mental Health Act, one from the new proposals.

46 *Cottenham v United Kingdom [1999] EHRLR 530 (delay of 10 months did not violate Article 5(4) where occasioned by the patient's desire to be represented by the lawyer of his choice)*

47 *Ashingdane v United Kingdom (1985) 7 E.H.R.R. 528, at §41; Johnson v United Kingdom (1997) 22 EHRR 296, §65; W v Sweden (1988) 59 D.R. 158; L v Sweden (1986)).*

First, Section 51 of the Mental Health Act, which permits a Crown Court judge to make a section 37/41 restriction order in respect of a person charged with an offence who is suffering from a mental disorder, without a conviction or a finding that he had 'done the act or made the omission charged' (as required for a finding of Unfitness to Plead or Insanity), where it is 'impracticable or inappropriate to bring the detainee before the court'. There is no appeal against such an order (as an appeal against sentence under section 9 Criminal Appeals Act 1968 requires a person to have been 'convicted'), and there is no power (unlike in the case of a person found unfit to plead) to remit his case back to Court for trial in the event that he recovers. Accordingly, the patient is subject to 'sentence' in criminal proceedings in circumstances where there has been no trial, and where there is no prospect of any such trial in future. Section 51 appears to be incompatible with Article 6.

Second, of some concern is the Green Paper proposal that a criminal court can make an assessment order of up to 3 months, renewable up to 12 months (Chapter 8, §13) - if the proposal is intended to cover unconvicted defendants as well as those convicted. At present a court may only remand an unconvicted defendant to hospital for assessment (s. 35) or treatment (s. 36) for 28 days, renewable for up to 12 weeks. A detention of up to 12 months prior to conviction cannot be justified under Article 5(1)(a) (conviction by a competent court) or Article 5(1)(c) if the offence with which the patient is charged is not one that would justify a remand in custody for such a long period (i.e. most offences). Nor could a detention for such a period for assessment be justified under Article 5(1)(e), which permits detention for only a short 'emergency' *assessment* period of 28 days before the full criteria for detention have to be satisfied.

(6) Patients transferred from prison

The current arrangements for the transfer of prisoners to hospital are not considered to need 'significant legislative change' (Chapter 8, §36). However, two aspects of the current regime do require scrutiny in the light of Convention principles. They are:

(i) Treatment of prisoners with mental disorders.

(ii) Discharge of transferred life prisoners.

Treatment of prisoners with mental disorders. Neither the current, nor the proposed, Mental Health Acts provide any power to treat prisoners with mental disorders without their consent; nor, it follows, are there any statutory safeguards against inappropriate or arbitrary treatment. This is in contrast with the position of patients detained in mental hospitals, who may be treated without their consent provided the safeguards set out in Part IV of the Mental Health Act 1983 are complied with. Those safeguards include the requirement that certain treatment (including any course of medication administered for more than three months) may be given only where a second opinion has been obtained from an independent psychiatrist appointed by the Mental Health Act Commission.

The compulsory treatment of mentally disordered prisoners may be justified at common law under the doctrine of 'necessity', where the prisoner lacks capacity to consent to such treatment which must be in his 'best interests'. This is considered further, below, under 'the right to refuse treatment'. The imposition of such treatment is regulated by Standing Order 25 and Health Care Standards 2.4(f) and 9.4(m), which provide some safeguards (including the requirement of an independent second opinion). However, these guidelines do not have statutory force. Bearing in

mind that any invasive treatment constitutes an interference with an individual's right to private life under Article 8(1), to be justified under Article 8(2) it must be 'in accordance with the law'.

The word 'law' in the expression 'in accordance with the law' covers not only statute but also unwritten law such as the English common law[48]. However, the expression 'prescribed by law' is not limited to the requirement that the measure in question has some basis in 'law', whether statute or common law, but includes the following further requirements: (a) the law in question must be sufficiently accessible: the citizen must be able to have an indication that is adequate in the circumstances of the legal rules applicable to a given case[49] (the 'accessibility test'); (b) the law in question must be formulated with sufficient precision to enable the citizen to regulate his conduct (the 'foreseeability' test). This element of the test requires the law in question to be compatible with the rule of law so as to include sufficient safeguards to protect the citizen from arbitrary interference with his Convention rights[50].

It is extremely doubtful whether the common law doctrine of 'necessity', taken together with the guidance contained in the Standing Order and Health Care guidance, complies with the requirement in Article 8(2) that the interference be 'in accordance with the law'. This is particularly so as there is no means by which a patient may challenge the lawfulness of his treatment other than by bringing an action for damages after the event. There is no requirement for the prison authorities to seek prior authorization of a prisoner's compulsory treatment[51], so no judicial consideration is given to whether the prisoner has 'capacity' to consent to treatment and, if he does not, whether such treatment is in his 'best interests'.

In an action for damages a prisoner will face three particular hurdles which further erode the protection against arbitrary interference with his rights. First, it is for the prisoner to prove absence of consent[52]. Second, the duty of care owed by a prison is a lower one than that owed by a hospital[53]. Third, the defendant will be entitled to rely upon the maxim *'volenti non fit injuria'*, explained by Donaldson MR in *Freeman v Home Office*[54]:

"The maxim "volenti non fit injuria" can be roughly translated as "You cannot claim damages if you have asked for it," and "it" is something which is and remains a tort. The maxim, where it applies, provides a bar to enforcing a cause of action. It does not negative the cause of action itself. This is a wholly different concept from consent which, in this context, deprives the act of its tortious character. "Volenti" would be a defence in the unlikely scenario of a patient being held not to have in fact consented to treatment, but having by his conduct caused the doctor to believe that he had consented."

In those circumstances it appears to the writer that the current legal framework for the compulsory treatment of mentally disordered prisoners does not comply with Article 8. Moreover, the absence of any court hearing prior to the treatment being imposed, and the restrictions on bringing

48 *Sunday Times v United Kingdom (1979-80) 2 E.H.R.R 245, at paragraph [47]*

49 *Sunday Times case, ibid, paragraph [49]*

50 *Malone v United Kingdom (1985) 7 E.H.R.R. 1, paragraphs 67-68; Huvig v France (1990) 12 E.H.R.R. 528, paragraphs [29] to [35]; Winterwerp v Netherlands (1979-80) 2 E.H.R.R. 387, at paragraphs [37] and [39]; X v UK (1989) 4 E.H.R.R. 189, at paragraphs [58] to [59]); Kruslin v France (1990) 12 EHRR 547*

51 *CO/1528/99 R v Managing Medical Officer, HMP Wormwood Scrubs, 27 April 1999 (leave refused by Jowitt J. for an application to move for judicial review of a decision compulsorily to medicate the applicant without first making a 'best interests' application in the Family Division)*

52 *Freeman v Home Office [1984] 1 All ER 1036, CA*

53 *Knight v Home Office [1990] 3 All E.R. 237*

54 *[1984] 2 WLR 802*

proceedings thereafter, together give rise to a potential violation of the right to a fair trial under Article 6.

A further issue arises in relation to the lawfulness of a failure to transfer a prisoner who requires in-patient treatment on the grounds that there are insufficient hospital beds. Although the point has not yet been considered, it is the writer's view that a failure to transfer to hospital a mentally disordered prisoner who requires in-patient treatment constitutes a potential violation of both Articles 3 and 8 (see further, below, under 'Right to Treatment').

Discharge of transferred life prisoners. The second issue relates to the discharge of life prisoners transferred to psychiatric hospitals under sections 47 and 49 Mental Health Act 1983.

As already seen, Article 5(4) requires regular reviews of the lawfulness of a patient's detention. Not all detentions require such regular review, however: they are only necessary where 'the very nature of the deprivation of liberty under consideration would appear to require a review of lawfulness at reasonable intervals'[55].

Two concepts that have been considered to be changeable concepts requiring review at reasonable intervals are mental disorder and the risk posed to self and others. Both concepts are necessarily engaged where patients are sectioned under the Mental Health Act. The requirement under Article 5(4) that the lawfulness of detention under the Mental Health Act be regularly reviewed is satisfied by the powers and procedures of the Mental Health Review Tribunal, in particular the power to discharge restricted patients introduced following the decision in *X v United Kingdom*[56].

Tribunals do not, however, have power to discharge transferred prisoners who are subject to restriction directions, as it is for the Secretary of State to make the final decision as to discharge (see sections 50 and 74). He may permit the patient to be discharged, or may by warrant direct the patient's return to prison[57]. A particular issue arises in relation to transferred discretionary lifers. While they cannot be discharged by a Tribunal[58], nor are they entitled to be released on life licence by a Discretionary Lifer Panel (DLP) under section 34 Criminal Justice Act 1991 until they are returned to prison (*R v Home Secretary ex p Hickey*[59]).

For a discretionary lifer who has served the 'tariff' period of his sentence, this is potentially a violation of Article 5(4). A discretionary lifer is lawfully detained under Article 5(1)(a) (lawful conviction by a court). In respect of the 'tariff' period of the sentence, the requirements of Article 5(4) are satisfied by the sentencing proceedings before the Criminal Court, so no further review is necessary during that period. Thereafter, however, he is entitled to regular reviews by a 'court' with power to discharge him from detention: *Thynne, Willson & Gunnell v UK*[60]. Prior to *Thynne* the Home Secretary retained the power to veto the release of a discretionary lifer; since then, in order to comply with the UK's Convention obligations, section 34 Criminal Justice Act 1991 was introduced to confer the necessary power on the DLP.

55 *Winterwerp v. the Netherlands (1979) 2 EHRR 387, para. 55*

56 *See footnote 16 (supra)*

57 *The Secretary of State does have a policy of designating certain transferred prisoners as 'technical lifers', by which he effectively promises not to remit the patient back to prison in the event of a recommendation for discharge by the Tribunal: R v Home Secretary ex p Pilditch [1994] COD 352. This does not, however, include discretionary lifers who have served the tariff component of their sentences.*

58 *Except those patients who are designated by the Home Secretary as 'Technical Lifers' (whereby the Home Secretary undertakes to abide by a Tribunal's decision on discharge)*

59 *[1995] QB 43, CA.*

60 *(1990) 13 EHRR 666. The same principle applies to youths sentenced to Custody for Life and at HM Pleasure: Hussain v United Kingdom (1996) 22 EHRR 1; T & V v United Kingdom App. No. 24724/94*

Once transferred to hospital, a discretionary lifer is lawfully detained under both Article 5(1)(a) and 5(1)(e). When his tariff expires Article 5(4) entitles him to a review by a 'court' with power to discharge him from detention under both 5(1)(a) (namely, a DLP); in any event, he is entitled to a review by a Tribunal to discharge him from his detention under 5(1)(e). As matters currently stand, such an individual gets neither.

The European Commission has declared admissible an application complaining of a violation of Article 5(4) in precisely these circumstances; the case has yet to be heard on its merits[61].

For mandatory lifers, those convicted of murder, Article 5(4) is satisfied by the initial sentencing process by the criminal court; no further review is necessary so the same anomaly does not arise[62].

(7) Dangerous People with Severe Personality Disorders

The Green Paper confirms the Government's proposals for this category of patient, originally set out in their July 1999 consultation paper 'Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development' (the DPSD Paper).

The Government proposes to remove the so-called 'treatability' requirement in relation to patients falling within the category of 'psychopathic disorder', permitting the indefinite detention – and, where released, power of recall - of such individuals solely on the ground of their dangerousness. The proposals are intended to apply both in criminal proceedings and in civil proceedings. Such individuals would not be detained in either a prison or a hospital, but in custom-built detention centers.

The Government defines a person with DPSD as having an 'identifiable personality disorder to a severe degree, who pose a high risk to other people because of serious anti-social behaviour resulting from their disorder' (DPSD Paper, Part 2 Para 1). It is estimated that in the United Kingdom between 300 and 600 men, and no more than 18-20 women, fall within this category.

In determining the compatibility of these proposals with the Convention, a distinction should be drawn between offender and non-offender patients. In relation to offenders, it is lawful to detain those who have committed serious criminal offences by way of life sentences, and to recall them after release on licence[63], under Article 5(1)(a). It may also be lawful to impose an indefinite sentence, with a power of recall, upon recidivist offenders under Article 5(1)(a)[64]. In both cases, Article 5(4) requires adequate judicial scrutiny of the continued detention and of any recall[65]. It is also lawful to detain a person under Article 5(1)(e) as a 'vagrant' without any reciprocal right to treatment[66]. There is plainly no need for the individual to receive treatment for detention to be lawful under Article 5(1)(a).

However, where the justification for the person's detention is that they are of 'unsound mind', the issue of treatability becomes very live indeed. There is conflicting authority as to whether a patient must be 'treatable' to be lawfully detained under Article 5(1)(e).

The Strasbourg Court has expressed the view in the past that no 'right to treatment' can be derived from the fact of a person's detention under Article 5(1)(e) on the grounds he is of 'unsound mind'.

61 *App. No. 28212/95 Benjamin & Wilson v United Kingdom, Admissibility decision 27 October 1997*

62 *Wynne v United Kingdom (1995) 19 EHRR 333, ECHR*

63 *Weeks v United Kingdom (1987) 10 EHRR 293, ECHR*

64 *Van Droogenbroeck v Netherlands (1982) 4 EHRR 443*

65 *Weeks, ibid*

66 *De Wilde, Ooms & Versyp v Belgium (1971) 1 EHRR 373*

In *Winterwerp v Netherlands* the Court stated that 'a mental patient's right to treatment appropriate to his condition cannot as such be derived from Article 5(1)(e)'[67]. All that Article 5(1)(e) requires is that the detention is effected in a 'hospital, clinic or other appropriate institution'[68]. Detention without treatment may raise issues under Article 3[69], but treatment is not a necessary ingredient for a lawful detention under Article 5(1)(e).

The House of Lords has, however, reached a different conclusion. In the recent case of *Reid v Secretary of State for Scotland*[70], the House of Lords held that, in order for domestic law to comply with Article 5(1)(e), the 'treatability' criterion had to be considered by a Sheriff on an application by a patient for his discharge from hospital. Accordingly, if a patient is 'untreatable' then he must be discharged. Lord Clyde said:

> "It was pointed out that the European Court did not specify the treatability of the patient as a condition to be examined by the court. But the court was concerned with the procedures rather than the grounds for discharge and it is not to be concluded from what the court said that in the present case the susceptibility of treatment may not be a proper criterion in determining discharge."

The question is likely soon to arise before the Privy Council. In *Anderson, Doherty & Reid v Scottish Ministers*[71], the Scottish Court of Session rejected arguments that section 1 Mental Health (Public Safety and Appeals) (Scotland) Act 1999 violated the Appellants rights under Articles 5(1) and 5(4). By section 1 of that Act a Sheriff must refuse to discharge a restricted patient suffering from a mental disorder 'the effect of which is such that it is necessary, in order to protect the public from serious harm, that the patient continue to be detained in a hospital, whether for medical treatment or not'. The Court of Session ruled that for a detention to be lawful under Article 5(1)(e) it was necessary only for the patient to be detained in a hospital or other appropriate institution; it did not require that the patient should actually be treated. This case is currently on appeal to the Privy Council.

The question therefore awaits a conclusive determination. In this writer's opinion, however, it must be that any patient, whether one who has committed a criminal offence or not, has a right to receive treatment that is reciprocal to his detention on the grounds that he is of 'unsound mind', and any such detention will be unlawful unless it is for the purpose of administering such treatment. An exception may be justified where the person is truly 'untreatable'.

The argument is easier to put in relation to those who have not committed an offence. The following points may be made.

Without a requirement that a mental disorder (particularly a personality disorder) is 'treatable' to justify detention, there is a danger that patients will be detained on the grounds only that their 'views or behaviour deviate from the norms prevailing in a particular society[72]', contrary to Article 5(1)(e). This was acknowledged by the Percy Commission in its 1957 Report[73], at §338:

"If one concentrates on the patient's behaviour rather than on the mental condition which lies behind it, one comes very close to making certain forms of behaviour in themselves grounds for segregation from society, which almost amounts to the creation of new criminal offences."

67 *Winterwerp v. the Netherlands (1979) 2 EHRR 387, para. 51; see also Ashingdane v United Kingdom (1985) 7 E.H.R.R. 528, §44*

68 *Aerts v Belgium (2000) 29 E.H.R.R. 50*

69 *B v United Kingdom (1984) 6 EHRR 204*

70 *[1999] 2 WLR 28*

71 *Times, 21 June 2000*

72 *Winterwerp, ibid, §37*

73 *Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency ('Percy Commission'), HMSO, 1957, Cmnd 169*

It should be noted that the importance placed by the Percy Commission upon the requirement of 'treatability' led to proposals that personality disordered ('psychopathic') patients who were over 21 *could not be detained at all*, as by then the prospects of their benefiting from treatment were considered to be too small to justify detaining them. That recommendation was incorporated into the 1959 Mental Health Act and was not removed until the Mental Health (Amendment) Act 1982. The current proposals demonstrate a radical departure from the liberal philosophy that underpinned the 1959 reforms.

Furthermore, it is arguable that an untreatable personality disorder is insufficient to constitute, on 'objective medical expertise', a 'true mental disorder … of a kind or degree warranting compulsory detention', as required by Article 5(1)(e)[74], bearing in mind:

(a) Between 10-13% of the population are considered to suffer from a personality disorder;

(b) The condition is notoriously difficult to define; it is not known what causes it, how it is to be measured, what interventions are effective and how to measure the consequences of intervention[75].

(c) The proposals require psychiatrists (and psychologists) to assess the risk of offending in the future. Quite apart from the question of whether it is proper to use the medical profession to justify that which would not otherwise be justifiable, there must be grave concern as to the reliability of any assessment of dangerousness where a patient has not been proved to have committed any offence.

This leads to a further, more disturbing question. What of an individual who is tried, and acquitted, of a serious offence? Can he then be detained indefinitely as suffering from DSPD on evidence that a criminal court has decided is insufficient to convict him of a criminal offence? If so, the fundamental premise of the criminal justice system that a person is innocent until proved guilty (expressly preserved by Article 6(2) of the Convention) is undermined.

These points are all relevant to an assessment of whether indefinite detention is a proportionate response in any case other than where a serious criminal offence has been committed or where the individual is a serious recidivist. It may be, in practice (given that only 300-600 individuals are considered to fall within the DSPD category) that these new powers will not, in practice, be exercised so as to lead to violations of Article 5(1)(a) or (e). But the existing powers of the Criminal Courts to impose life sentences are already sufficient, it is submitted, to deal with those individuals.

(8) The right to treatment

The Expert Committee recommended that a new Mental Health Act should create a positive right to treatment, flowing from the principle of reciprocity[76], one of the guiding principles the Committee considered should be enshrined in the new legislation (Expert Committee Report, §§2.21, 3.2). The Government has not accepted those proposals. The principle of reciprocity is not to be included in the Act itself (The Green Paper, Chapter 3, §5) and no mention is made of a 'right

74 *This is a different question from that faced by the House of Lords in Reid v Scotland [1999] 2 WLR 28*

75 *Evidence of Dr. Reed to the Fallon Enquiry Report, Cm 4194-II, §6.1.75*

76 *The principle of reciprocity: 'Where society imposes 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 appropriate services, including ongoing care following discharge from compulsion.'*

to treatment'. However, the Government does intend to impose duties upon health and local authorities to provide health care and social care, including residential care, to people who are subject to an order providing for compulsory care and treatment (The Green Paper, Chapter 7, §11). It remains to be seen what form those duties take in the final legislation.

Does the Convention guarantee a right to treatment that is reciprocal upon the patient being subject to compulsory powers? There are two very distinct questions in issue here. The first is whether it is lawful to detain a person under Article 5(1)(e) on the grounds that he is of unsound mind without treating his mental disorder, discussed above in relation to patients with DSPD. If it is right that no detention is lawful under Article 5(1)(e) without treatment, then clearly the Convention creates a reciprocal right to treatment. If that is not the case, the second question engages, namely whether such a right to treatment can be derived from any other Convention Articles.

There is no generally recognized right to treatment in the European Convention, nor in any of the other international human rights instruments[77]. The Court has recognized, however, that, in limited circumstances, there is a positive obligation on the state to provide treatment. For example, the removal of life-saving treatment may violate a patient's rights under Articles 2 (right to life) and 3 (right not to be subjected to torture or to inhuman or degrading treatment)[78]. Articles 2 and 3 impose a positive obligation to provide life-saving treatment in circumstances where the State has knowledge of the individual's circumstances and it would be reasonable for it to provide such treatment[79]. A particular duty to provide treatment has been found to exist in relation to detained persons[80]. Moreover, the detention of a patient in hospital without any treatment for that disorder was held potentially to give rise to a violation of Article 3 by the Commission in *B v United Kingdom*[81].

The positive rights created by Articles 2 and 3 are similar to the right to emergency treatment conferred by the South African Constitution, which does not guarantee a right to longer-term treatment, even where that is life-saving[82]. The question whether absence of resources will justify refusing life-saving treatment has yet to be considered by the Strasbourg Court[83], but a distinction might be drawn between emergency treatment and longer-term life-saving treatment, such as arose in *R v Cambridge HA ex p B*[84], particularly where resources are limited. The issue is a difficult one as neither Article 2 or 3 permit of any exceptions, by contrast with, for example, Articles 5 and 8.

A failure or refusal to provide any treatment that is unjustifiably discriminatory will be unlawful, either under Article 14 (prohibition on discrimination) or the Disability Discrimination Act 1995[85]. So far as Article 14 is concerned it should be noted that the right is not a stand-alone

77 *Lawrence Gostin and Jonathon Mann ,'Health & Human Rights', Routledge, 1999, p. 54… the human rights community has rarely written or litigated in the area of public health. Even so fundamental a human rights concept as the right to health has not been operationally defined, and no organized body of jurisprudence exists to describe the parameters of that right.'*

78 *D v United Kingdom (1997) 24 EHRR 423*

79 *Keenan v UK, App. 27229/95, ECssnHR Report 6 September 1999; Hughes v UK (1986) 48 DR 258, ECssnHR*

80 *Cyprus v Turkey 4 EHRR 482, EcssnHR Report 10 July 1976*

81 *(1984) 6 EHRR 204*

82 *Soobramoney v Minister of Health, KwaZulu-Natal (1997) 50 BMLR 224*

83 *[1995] 1 WLR 898*

84 *[1995] 1 W.L.R. 898 (judicial review refused of a Health Authority's refusal to provide expensive treatment that had little prospect of saving the applicant's life)*

85 *Note the approach of the Supreme Court of Canada in Eldridge v A-G of British Colombia (1997) 3 BHRC 137 (failure to fund sign-language violated deaf persons' right to equal treatment)*

prohibition on discrimination. It may only be relied upon in conjunction with another Convention right. This may be contrasted with the new Protocol 12 to the Convention which the UK Government is yet to sign.

Article 8 also imposes positive obligations, which might include (in appropriate circumstances) an obligation to provide treatment to a patient where otherwise his right to private and family life will be interfered with in a disproportionate manner. One example would be a person suffering a debilitating long-term condition that can be alleviated by treatment. Another example is a patient detained in hospital, most obviously in High or Medium Security, for years on end without appropriate treatment being given. Those patients will often spend years longer in hospital than they would had they received the treatment they required at an earlier stage. Although it might not be open to allege a violation of Article 5(1)(e) in relation to those 'extra years' in detention, a failure to treat in those circumstances could well amount to a violation of Article 8 and (in the most extreme cases) Article 3.

In summary, it is strongly arguable that a limited right to treatment reciprocal upon a patient's detention on the grounds of mental disorder can be derived from Articles 3 and 8. It should be noted that recommendation no. R(83)2 concerning the legal protection of persons suffering from mental disorder placed as involuntary patients, which was adopted by the Committee of Ministers on 22nd February 1983 under Article 15(b) of the Statute of the Council of Europe, recommends that patients detained involuntarily in hospital have the right to receive appropriate treatment and care. This recommendation is now the subject of consultation by the Council of Europe in their White Paper on Human Rights and Mental Health dated 3rd January 2000.

(9) The right to refuse treatment

Both common law and the Convention provide some protection, at present, for patients who do not wish to submit to treatment that their clinician considers necessary. The proposals in the Green Paper will permit compulsory medication of detained patients (similar to the existing powers under Part IV Mental Health Act 1983) and of those subject to compulsory community orders, although in the case of the latter such treatment may only be administered in a 'stipulated place' (Green Paper, Chapter 6, §9), or in hospital. The Expert Committee's proposal that compulsory treatment be capacity-based – giving those detained patients who have capacity greater rights to refuse treatment - was rejected. For those not subject to a compulsory order, the lawfulness of the patient's treatment will continue to be determined by the common law, at least until the Government's proposed incapacity legislation (which is separate from the proposed mental health legislation) has been introduced[86].

The questions arise, here, as to whether the existing common law 'power' of treatment, and the proposed statutory powers of treatment, are compatible with the Convention.

Common law. At common law the individual's right to integrity of the person and to self-determination are fundamental human rights[87]. The right of a *capacitated* individual to refuse consent to treatment[88] and nutrition[89] are well established. As a matter of convention law, a state

86 *In the Green Paper 'Who Decides?' Cm 3803, December 1997, the Government broadly endorses the Law Commission's proposed Incapacity Bill published with its 1995 report 'Mental Incapacity', Law Com 231.*

87 *Airedale NHS Trust v Bland [1993] A.C. 1, per Lord Goff at 864*

88 *Re. T (Adult: Refusal of Medical Treatment) [1993] Fam. 95*

89 *Robb v Secretary of State for the Home Department [1995] 2 W.L.R. 722*

will not violate Article 2 by respecting decisions of capacitated individuals to refuse treatment and nutrition, even where it leads to the individual's death. The capacitated individual's rights under Article 3 and Article 8, which (partly) reflect the common law rights of integrity of the person and self-determination, should prevail[90].

The situation differs where the patient lacks capacity to make such decisions[91]. At common law the doctrine of necessity justifies action that would otherwise constitute an assault which is taken in the 'best interests' of an incapacitated individual[92]. However, in cases where 'there remains a serious doubt about the patient's competence, and the seriousness or complexity of the issues', doctors are required to seek guidance by way of a 'best interests' declaration from the High Court, Family Division before carrying out the proposed treatment.

Lack of capacity will also justify unwanted treatment under both Article 3 and Article 8 of the Convention, provided that treatment is considered necessary by the patient's doctors. In *Hercegfalvy v Austria*[93] the patient had been forcibly administered food and narcoleptics, isolated and attached with handcuffs to a security bed for some weeks, following a number of violent episodes and consistent refusals of medical treatment and nutrition. The Court, while emphasising the need for 'increased vigilance' in relation to psychiatric patients, given the 'inferiority and powerlessness' of their situation, noted that it was for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic method to be used, if necessary by force, to preserve the physical and mental health of incapacitated patients. In the circumstances there was no violation of Article 3.

Lack of capacity is not essential, however, for unwanted treatment to be justified. In *Grare v France*[94] the Commission held that the administering of drugs with unpleasant side-effects was insufficient to constitute a violation of Article 3; moreover, although the treatment constituted an interference with the applicant's right to private life under Article 8(1), it was justified by the need to preserve public order and the protection of the applicant's health under Article 8(2). The applicant's capacity, or lack of it, did not form part of the Commission's reasoning.

As seen above in relation to the treatment of prisoners (and below in relation to children), to be justified under Article 8(2) such treatment must be 'in accordance with the law'. Put shortly, unless the treatment has either (a) been administered under statutory powers or (b) has been authorized in advance by the High Court by way of a 'best interests' declaration, it is arguable that it will contravene Article 8 as not being 'in accordance with the law'. Where the treatment has been so authorized, it will be compatible with Article 8[95].

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90 *Harris, O'Boyle and Warbrick, 'Law of the European Convention on Human Rights', 1995, p. 40. Note, however, in X v Germany (1984) 7 EHRR 152, the Commission found that the force-feeding of a prisoner on hunger strike did not violate Article 3, referring to the state's obligation to preserve life under Article 2; the question of the patient's capacity did not enter the equation. It is questionable whether this decision would now be followed (Harris, O'Boyle and Warbrick, ibid, p. 40, n.18)*

91 *A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent or to refuse a proposed interference with their rights or liberties (invariably, some form of treatment). That inability will occur when (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question; (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision: Re. MB (An Adult: Medical Treatment) [1997] 2 F.C.R. 541, CA, at 553H-554B per Butler-Sloss LJ*

92 *Re. F [1990] 1 A.C. 1*

93 *(1992) 15 EHRR 437, at §83).*

94 *(1992) 15 EHRR CD 100*

95 *See Re. F (Adult Patient), (Unreported) 26 June 2000, CA, per Sedley LJ*

Statute. The Government's rejection of a capacity-based test for the exercise of compulsory statutory powers of treatment is unlikely to fall foul of Articles 3 and 8 of the Convention. A question does arise, however, as to the compatibility of such treatment with Article 6 of the Convention. The right to integrity of the person and to self-determination are clearly 'civil rights' under Article 6, and compulsory treatment is an interference with that right. Whether it is a lawful interference is a question upon which the individual should be entitled to a determination by a court, under Article 6. There is no statutory right of appeal from an RMO's decision to treat a patient. An application for a 'best interests' declaration will be inappropriate, bearing in mind that statutory powers are involved. The only option is to judicially review the treatment decision, but on such an application the Court cannot consider the case on its merits. This issue is currently being considered by the Court of Appeal[96] where the Article 6 implications will be fully explored.

(10) The right to after-care

Health and local authorities will be required to provide services for patients needing aftercare following discharge from a compulsory order (Green Paper Chapter 7, §11). This duty will replicate the existing section 117 duty, which goes much further than the Convention in guaranteeing discharged patients the right to free health care, social services and accommodation. The right to treatment has been considered. It is relevant, however, briefly to consider the limited extent to which the Convention operates to safeguards the right to accommodation and other community care services.

In one of its earliest decisions the ECHR ruled that Article 8 does not confer upon an individual the right to be housed[97]. The more recent case of *Burton v United Kingdom*[98], suggests that Article 8 may, in appropriate circumstances, impose a positive obligation upon the State to provide accommodation, although that cannot extend to a 'positive obligation to provide alternative accommodation of an applicant's choosing'. A similar proposition was accepted by the European Court in *Marzari v Italy*.[99]

Burton and *Marzari* do open the way, however, to a successful challenge to a local authority's refusal to provide basic accommodation to a homeless individual or family. It is as likely as not that such a refusal, to contravene Article 8, would be unlawful as a matter of domestic administrative law in any event, bearing in mind the wide range of circumstances in which local authorities are bound by existing statutes to provide suitable accommodation[100].

The most likely scenario where a local authority will come under a positive obligation to provide accommodation is where the applicant is in need of housing by reason of age, disability or ill health, and a failure to provide accommodation will violate their rights under Articles 2 or 3. In *D v UK*[101] the UK was found to have violated Article 3 by its decision to deport the Applicant,

96 *CO/967/2000 R v Broadmoor Hospital ex p W. The applicant is seeking to overturn the Judge's ruling in R v Collins and Ashworth Hospital Authority ex parte Brady (2000) (reviewed elsewhere in this issue of the JMHL) that the question of whether the treatment is "treatment for the mental disorder from which he is suffering" is not a question of precedent fact. If a question is one of precedent fact, a court in judicial review proceedings decides the question on its merits rather than by applying the Wednesbury test.*

97 *X v Germany (1956) 1 Yearbook 202*

98 *(1995) 22 EHRR CD 135*

99 *[1999] 28 EHRR CD 175*

100 *The domestic courts have come close to recognising a common law right to basic shelter, R. v Lincolnshire CC Ex p. Atkinson (1996) 8 Admin. L.R. 529. See also R v Wandsworth LBC ex p O Times, 18 July 2000*

101 *(1997) 24 EHRR 423*

who suffered from AIDS, to St. Kitts where by virtue of there being inadequate medical facilities for his condition he would inevitably die sooner, and with greater suffering, than if he remained in the UK. Similarly, a local authority will be obliged to offer accommodation to such an individual if a failure to do so will hasten their death, a proposition that found favour with Moses J in 1997 when overturning a local authority decision refusing to provide accommodation under s. 21 NAA to a terminally ill overstayer in *R v Brent LBC ex p D*[102].

Article 8 primarily protects a person's right not to be subjected to unjustified interference with their right to a 'home' and 'private life', and will have greatest relevant where local authority decision-making impacts upon a person's enjoyment of an existing home. This issue is most likely to arise in a mental health context where it is proposed to remove long-stay patients from residential care homes.

A decision to remove a person from their home may engage Article 8 even where the person is not permitted, as a matter of domestic law, to inhabit the property. In *Wiggins v UK*[103] the applicant owned a house but had no legal permission to occupy it; nevertheless the Commission found that it was his 'home' for the purpose of Article 8. Similarly, in *Buckley v United Kingdom*[104] the ECHR held that the absence of planning permission did not disqualify the applicant's caravan from being a 'home' for the purpose of Article 8. A more restrictive approach was taken in *S v UK*[105], where the Commission held that the applicant's right to occupy her home ended when her lesbian partner, in whose name the lease was held, had died; accordingly, Article 8 was not engaged[106].

Where a person's dwelling does qualify as a 'home' for the purpose of Article 8, local authorities will find domestic courts ready to strike down unjustifiable decisions to remove them from their homes. In the community care context, in *R v North & East Devon HA ex p Coughlan*[107], the Court of Appeal found that the local health and social services authorities' decision to close Mardon House, (Mrs. Coughlan's home for 6 years and, it had been promised to her, her home for the rest of her life), violated her right to a home under Article 8, notwithstanding alternative residential accommodation was to be provided elsewhere.

Coughlan provides a template for the application of Article 8 in challenging local authorities' decisions as to how social services needs are met. Whenever a person is assessed as being in need of community care services, Article 8 may be invoked so as to compel the local authority to provide those services in the person's home, rather than by the more cost-effective measure of removing them to a residential care home. Where the decision is taken to remove the person from their home, it will therefore need to be judged by the criteria in Article 8(2) if it is to be justified.

102 (1999) 31 H.L.R. 10

103 (1978) 13 DR 40

104 (1996) 23 EHRR 101

105 (1986) 47 DR 274

106 Same-sex partners now have right of sucession to a statutory or protected tenancy: Fitzpatrick v Sterling Housing Association [1999] 3 W.L.R. 1113, HL

107 [1999] Lloyd's Rep. Med. 306

(II) Children and Incapacitated adults (the Bournewood case)

The Green Paper states that the Government has not yet come to a conclusion on the precise nature of any new arrangements to provide safeguards for long-term incapacitated patients not requiring formal detention under the Mental Health Act (Green Paper, Chapter 11, §7). The so-called 'Bournewood gap'[108] - the absence of statutory safeguards for 'informal patients' - therefore remains unfilled.

The *Bournewood* case has been taken on appeal to Strasbourg, alleging violations of the applicant's rights under Articles 3, 5(1), 5(4), 8 and 14. The violations under Articles 5 and 8 are founded on the argument that the common law doctrine of 'necessity' does not satisfy the requirement under Article 5(1) that a detention be 'lawful' and under Article 8(2) that any interference with the right to private life be 'in accordance with a procedure prescribed by law', primarily because of the absence of any safeguards against inappropriate or arbitrary detention and treatment of such patients. The government's proposals to introduce safeguards is a recognition of the fact that the informal admission to hospital of incapacitated individuals is a violation of their Convention rights, but we must await the Strasbourg court's conclusions.

There remains, however, a similar 'gap' in relation to the informal admission to hospital, and treatment, of children. A child under 18 cannot refuse to consent to treatment if their parent or guardian (in the case of a child in care, the local authority) consents to such treatment on their behalf, even if they have capacity to do so (known as 'Gillick' competence[109]). Such a child only has the right to consent to treatment in the face of a parental refusal of that treatment. 'Treatment' in the present context would include informal admission to hospital: see *R v Kirklees MBC ex p C*[110]and §31.6 Mental Health Act 1983 Code of Practice (1999).

Although section 25 Children Act 1989 prohibits the detention of a child (including by way of an 'informal' admission) without certain statutory safeguards being observed, it is limited to detention in 'secure accommodation'. Not all hospitals or other places where a child is 'deprived of his liberty' (for the purposes of Article 5(1)) amount to 'secure accommodation'. In *Re C (Detention: Medical Treatment)*[111], Wall J. held that a psychiatric unit for the treament of eating disorders did not constitute 'secure accommodation'. Notwithstanding, however, he ruled that equivalent safeguards to those in Section 25 should be incorporated into the order of the Court.

There is little danger of a child being inappropriately or arbitrarily detained in non-secure accommodation where an application has first been made to a judge of the Family Division to authorise that detention. However, there is no obligation on the parent or guardian to make such an application. In the writer's opinion, there is a very real possibility that an informal detention in hospital of a Gillick-competent child, with his parent or guardian's consent but against his will, constitutes a violation of Article 5(1)(e) as such a detention will not be 'lawful'.

108 Following the decision of the House of Lords in R v Bournewood Community Mental Health NHS Trust ex p L [1999] 1 A.C. 458

109 Gillick v West Norfolk and Wisbech Area Health Authority and the DHSS [1986] 1 A.C. 112

110 [1993] 2 FLR 187

111 [1997] 2 F.L.R. 180

112 (1988) 11 EHRR 175

This argument is undermined, however, by the Strasbourg Court's decision in *Nielsen v Denmark*[112], in which the ECHR took a surprisingly paternalistic approach in relation to the detention of children with their parents' consent. The applicant had been admitted to a psychiatric hospital with his mother's consent rather than under the Danish equivalent of the Mental Health Act, but against his and his father's wishes. The ECHR, by a bare majority, concluded that the mother's parental rights, which were safeguarded by Article 8, were paramount, to the extent that considerations under Article 5 were not engaged at all. The decision has been heavily criticised and it is very possible that a different conclusion would now be reached, particularly in the light of *A v United Kingdom*[113], where the Court did not consider that a parent had any right to chastise their child by virtue of Article 8.

It is therefore strongly arguable that such an 'informal' detention would be a violation of both Article 5(1) and Article 5(4) by reason of the absence of adequate safeguards against arbitrary detention – particularly the right to review of the lawfulness of detention by a tribunal. By the same reasoning, any sufficiently invasive treatment administered to a child with his parent or guardian's consent, but against his wishes, may violate his rights under Article 8.

113 (1999) 27 EHRR 611. Moreover, Nielsen did not consider the Convention on the Rights of the Child, which was ratified by the United Kingdom in 1991, article 12 of which requires that decisions concerning the child should take into account the views of the child. The present situation constitutes a violation of that principle.

Unfitness to Plead, Insanity and the Mental Element in Crime

*Kevin Kerrigan**

Introduction

Whenever a person is found to be unfit to plead at the time of his or her trial, a jury must determine whether s/he "did the act or made the omission charged as the offence".[1] Similarly, when a court decides that a person was insane at the time of an offence being committed, part of the jury's task is to determine whether s/he "did the act or made the omission charged".[2] In either case, if the jury is not so satisfied then it must return a verdict of acquittal.

An issue that has caused the courts some considerable concern recently is the extent to which, if any, the mental element of the crime is relevant to the question of whether the accused "did the act". This article reviews the existing authority and concludes that, although the courts have imposed a uniform test and may thus be said to have achieved consistency between the two situations, this may result in considerable injustice in some cases.

Trial of the facts when the accused is unfit to plead

The test for unfitness is that set out in *R v Pritchard*[3]:

"... whether he is of sufficient intellect to comprehend the course of proceedings on the trial, so as to make a proper defence - to know that he might challenge any [jurors] to whom he may object - and to comprehend the details of the evidence ... if you think that there is no certain mode of communicating the details of the trial to the prisoner, so that he can clearly understand them, and be able properly to make his defence to the charge, you ought to find that he is not of sane mind. It is not enough that he may have a general capacity of communicating on ordinary matters."[4]

Unfitness to plead is not the same as insanity and it is clear that a person may be found to be unfit to plead despite the fact that s/he does not satisfy the *M'Naughten* test for insanity.[5] In 1960 Lord Parker stated as follows in respect of the then statutory test for unfitness:

"[The test has] in many cases ... been construed as including persons who are not insane within the

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1 *Criminal Procedure (Insanity) Act 1964 (the 1964 Act) section 4A, as amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 (the 1991 Act).*

2 *Trial of Lunatics Act 1883 (the 1883 Act) section 2(1), as amended by the 1964 Act.*

3 *(1836) 7 C & P 303*

4 *Ibid, per Alderson B at pp.304-5.*

5 *R v Governor of HM Prison Stafford ex parte Emery [1909] 2KB 81. In that case the accused was deaf and was unable to read or write. Although he was not insane in the "general" sense, he was "incapable of ... understanding and following the proceedings by reason of his inability to communicate with others..." per Darling J at page 87.*

M'Naughten Rules, but who by reason of some physical or mental condition, cannot follow the proceedings at the trial and so cannot make a proper defence in those proceedings. A well-known illustration is that of a deaf mute who is also unable to write or to use and understand sign language."[6]

Once it has been established that the accused is unfit to plead,[7] then the trial shall not proceed further. However, the jury must determine "whether they are satisfied in respect of the count or each of the counts on which the accused was to be or was being tried, that he did the act or made the omission charged against him as the offence."[8] The legislation is silent on the burden of proof but, given the adversarial nature of the proceedings and the issues to be ascertained, it seems clear that the Crown would have the burden to the criminal standard.[9]

If the jury is not satisfied that the accused did the act or made the omission they must return a verdict of acquittal "as if on the count in question the trial had proceeded to a conclusion"[10] and the accused is discharged in the normal way. S/he will not be subject to any order of the criminal court.[11] This procedure, known as the trial of the facts, means that the unfit person is not at peril of conviction but may still be acquitted if the jury is not convinced that s/he did the act or made the omission charged.[12]

If the jury decide that the accused did do the act or make the omission charged, then, although the finding does not amount to a conviction, the trial judge has a range of disposal powers under the 1964 Act.[13] In summary, s/he may impose a hospital admission order with or without restrictions on discharge, a guardianship order, a supervision and treatment order or an order for absolute discharge. This wide range of permissible disposals was introduced in 1991 in order to give the judge an ability to make the disposal fit the risk posed by the accused[14]. One constraint on the trial judge's discretion is that where the offence charged is murder the only possible disposal is an admission order with a restriction order without limit of time.[15]

Trial of the facts in insanity cases

The procedure when insanity is claimed, is dealt with in section 2 of the Trial of Lunatics Act 1883.[16] Section 2(2) provides as follows:

"Where in any indictment or information any act or omission is charged against any person as an offence, and it is given in evidence on the trial of such person for that offence that he was insane ... at the time when the act was done or omission made, then, if it appears to the jury ... that he did the act or made the omission charged, but was insane as aforesaid at the time when he did or made the same, the jury shall return a special verdict that the accused is not guilty by reason of insanity."

Despite the procedure being dictated by statute, insanity is a common law defence. The legal test

6 *R v Podola [1960] 1 QB 325 at page 353.*

7 *See the 1964 Act 1991 section 4 for the procedure to be adopted. See Archbold Criminal Pleading Evidence and Practice 2000 4-167-174; Blackstones Criminal Practice 2000 D 10.8. In R v O'Donnell [1996] 1 Cr.App.R. 121 the Court of Appeal provided detailed guidance on the procedure to be followed.*

8 *1964 Act section 4A(2).*

9 *This is the view of the government in the circular that accompanied the Act: see HO Circular no. 93/1991 paras. 4(a) and 9.*

10 *Ibid. section 4A(4).*

11 *Obviously, there may still be civil admission procedures instigated under Part II of the Mental Health Act 1983.*

12 *For a useful discussion of the reforms see White, The Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 [1992] Crim LR 4.*

13 *1964 Act section 5, as substituted by the 1991 Act section 3. See also the 1991 Act section 5.*

14 *Prior to the 1991 Act the only permissible disposal was an admission order subject to a restriction order without limit of time.*

15 *1991 Act Sch.1 section 2(2).*

16 *The special verdict was altered by the 1964 Act to become "not guilty by reason of insanity" rather than "guilty but insane". The 1991 Act required the evidence of 2 medical practitioners, one of whom was Mental Health Act approved before the special verdict could be returned.*

for insanity is set out in the *M'Naughten Rules*.[17] The accused must prove[18] that "at the time of the committing of the act, [he was] labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong."[19]

There is no separate trial of the facts in cases where insanity is alleged. The decision-making process is not as structured as that in the 1964 Act. In particular, there is no explicit requirement in the 1883 Act that a "normal" acquittal (as opposed to a special verdict) must follow if the jury are not satisfied that that accused did the act or made the omission. Nevertheless, the wording of the section seems to permit no other interpretation. The Court of Appeal has recently confirmed this position:

"... those who are legally insane should not be deprived of their liberty by or, nowadays, made subject to orders of the courts exercising criminal jurisdiction, unless they have behaved in a way which constitutes the *actus reus* of a criminal offence ...

... in our judgment the criminal law should distinguish between providing for the safety of the public from those who are proved to have acted in a way which, but for their mental disability, would have made them liable to be convicted and sentenced as criminals, and those whose minds, however disturbed, have done nothing wrong."[20]

Given this it seems that the Crown bears the burden of proving that the accused did the act or made the omission. There are thus four possible outcomes following the 1883 Act procedure: the jury will find the accused guilty of the offence if they think s/he was guilty and was not insane; they will find the accused not guilty if they decide that the accused was not insane but nevertheless had not committed the crime; they will return the special verdict if they find that s/he did the act or made the omission but was insane at the time; and finally if the jury find that the accused was insane but are not satisfied to the criminal standard that s/he did the act or made the omission the proper verdict is acquittal *simpliciter*.

If the jury does return the special verdict of not guilty by reason of insanity then the judge has the same powers of disposal as noted above in relation to unfitness to plead.[21]

In summary, the statutory phrase "did the act or made the omission" is of crucial importance in respect of both unfitness to plead and insanity cases. It can make the difference between a bare acquittal and a coercive order from a criminal court.

The problem of the mental element

The problem posed by the mental element is whether or not the Crown must prove that the accused had the relevant *mens rea* in addition to committing the *actus reus* of the offence. Although the wording used is the same for the test in unfitness cases as in insanity cases, it will be seen that the two conditions give rise to very different considerations.

17 *M'Naughten's Case (1843) 10 CL & F 200. Their Lordships' answers are reproduced in Archbold 2000 17-79 - 17-82.*

18 *The accused bears the burden of proof (to the civil standard) - R v Smith (Oliver) (1910) 6 Cr App R 19. The Crown may also allege insanity in response to a defence of diminished responsibility in a murder charge - Criminal Procedure (Insanity) Act 1964, section 6 - and if it does so, it bears the burden of proof to the criminal standard.*

19 *This is the classic exposition of the test for insanity. Despite its doubtful status as authority (the judgment did not arise out of a case but was a response to questions posed by parliament) It has been adopted and applied by the courts ever since. See R v Sullivan [1984] AC 156.*

20 *Attorney General's Reference (No 3 of 1998) [1999] 3 All ER 40 per Judge LJ at pages 47-48.*

21 *1964 Act section 5(1)(a).*

Unfitness and the mental element

Prior to the passage of the 1991 Act, the Butler Committee on Mentally Abnormal Offenders reported and recommended the introduction of a trial of the facts procedure.[22] It stated as follows:

"If the defendant is found to be under a disability, there should nevertheless be a trial of the facts to the fullest extent possible having regard to the medical condition of the defendant. The object of this proposal is primarily to enable the jury to return a verdict of not guilty where the evidence is not sufficient for a conviction. ... the judge should direct the jury that if they are not satisfied that the defendant did the act with the necessary mental state they must return a verdict of not guilty. The issues to be established by the prosecution include the defendant's state of mind. If this were not so, the defendant would not obtain his verdict of not guilty even though there was insufficient evidence that he had the requisite intention or other mental state for the crime - indeed, he would not obtain it even though it was clear that the affair was an accident. This would clearly be unsatisfactory."[23]

Thus the report that initiated the debate about a trial of the facts procedure was firmly of the view that an acquittal should follow in the absence of proof of *mens rea*. Even then the report recognised that there was still a risk of injustice given the inability of the accused to defend him/herself:

"There is, of course, always the possibility that some explanation could have been given if the defendant had been able to defend himself - an explanation that does not appear from the evidence that is available; so there is the possibility of a wrong verdict. It is because of this possibility that we are not proposing that this verdict should count as a conviction, nor that it should be followed by punishment."[24]

Thus the risk of prejudice to an unfit accused was to be tackled first, by removing the risk and consequences of conviction, and, second, on the trial of the facts, by requiring evidence that, but for the inability of the accused to defend him/herself, the prosecution would have established guilt.

On the other hand if someone is unfit to plead in the sense that s/he is incapable of comprehending the proceedings or evidence, or unable to communicate with his or her lawyers, it might seem impracticable to expect the court to assess his or her *mens rea* at the time of the offence. S/he will not be in a position to answer questions about it[25] and will not be able to instruct lawyers to adequately cross-examine Crown witnesses or call witnesses on his or her behalf. Moreover, the unfit person no longer faces the risk of being convicted of an offence, so proof that he possessed full criminal responsibiilty should no longer be an imperative.

This view is reflected in the reasoning of the government of the time during the passage of the Bill that became the 1991 Act:

"It would be unrealistic and even contradictory where a person is unfit to be tried properly because of his mental state, that the trial of the facts should nevertheless have to consider that very aspect."[26]

The Home Office Circular accompanying the 1991 Act followed the view of the government in the parliamentary debates. It stated that *mens rea* was a matter which it was "not intended should be taken account of during the trial of the facts."[27]

22 *Report of the Committee on Mentally Abnormal Offenders, 1975, Cmnd. 6244.*

23 *Ibid. paragraph 10.24.*

24 *Ibid. paragraph 10.25*

25 *Lord Hutton in R v Antoine [2000] 2 All ER 208 at page 214 suggested that careful consideration should be given to whether it is right to call a person to give evidence when s/he has been found to be unfit due to mental disability.*

26 *Hansard 186 HC (6th Series) col. 1280, 1 March 1991, per John Patten MP, minister of state at the Home Office. This statement would not be helpful to a court under the rule in Pepper v Hart [1992] 3 WLR 1032 due to the fact that the legislation was a Private Members Bill.*

27 *HO Circular 93/1991 paragraph 8.*

Insanity and the mental element

The special verdict of insanity relates to the accused's mental state at the time of the alleged offence. It is recognition that a person may not be responsible for their actions due to their mental condition, and thus leads to acquittal.[28] Earlier judicial authority appears to be fairly clear that *mens rea* is irrelevant to determining the "act" or "omission" in insanity cases. In *Felstead v R*[29] Lord Reading explained the special verdict as follows:

"... this verdict means that, upon the facts proved, the jury would have found him guilty of the offence had it not been established to their satisfaction that he was at the time not responsible for his actions, and therefore could not have acted with a 'felonious' or 'malicious' mind ... It is obvious that if he was insane at the time of committing the act he could not have had a *mens rea*, and his state of mind could not then have been that which is involved in the use of the term 'feloniously' or 'maliciously'."[30]

The 1883 Act was not the first statute dealing with acquittal of insane defendants. The procedure was first introduced in the Criminal Lunatics Act 1800. The Act provided that when a person was acquitted following evidence of insanity, "the jury shall be required to find specially whether such person was insane *at the time of the commission of such offence*, and to declare whether such person was acquitted by them on account of such insanity; and if they shall find that such person was insane *at the time of the committing such offence*, the court ... shall order such person to be kept in strict custody...". (Emphasis added.)

The 1883 Act continued the special verdict procedure but replaced, "commission of such offence" with, "did the act or made the omission charged". In *Attorney General's Reference (No 3 of 1998)*[31] Judge LJ referred to this as a "significant amendment" and went on: "The difference is material. The original phrase 'committed the offence', appears to encompass the relevant act, together with the necessary intent. By contrast, 'act' and 'omission' do not readily extend to intention. This change of language, apparently quite deliberate, has been left unamended for over a century and for all present purposes remains in force."

In summary, we have seen that the amendments introduced by the 1991 Act required the prosecution to prove that an accused who was unfit to be tried nevertheless did the act or made the omission charged as the offence. In this it adopted the wording of the 1883 Act, which already had an apparently settled meaning. However, the 1991 Act did not go further and explain what the "act" or "omission" meant. Specifically, it did not say whether, in the context of unfitness as opposed to insanity, the phrase was capable of importing the mental element of crime. Given that it was preceded by a report that recommended just such an approach, it is not surprising that there has been litigation.[32] What is unexpected is the mess that the courts at all levels have managed to make of the issue.

Mens rea becomes relevant: *R v Egan*

R v Egan[33] was the first case to consider the mental element in the context of the trial of the facts under the new procedures inserted by the 1991 Act. E was charged with theft by snatching of a woman's handbag. He was found by the jury to be unfit to plead under section 4. There followed

28 *As far back as 1739 Hawkins' Pleas of the Crown asserted: "... those who are under a natural disability of distinguishing between good and evil, as ... ideots and lunaticks ... are not punishable by any criminal prosecution." In R v Sullivan [1983] 2 All ER 673 Lord Diplock said, at page 676, that the test for insanity defined "the concept of mental disorders as negativing responsibility for crimes."*

29 *[1914] AC 534.*

30 *Ibid. at page 542.*

31 *[1999] 3 All ER 40.*

32 *White op. cit. note 12 at pages 8-9 neatly anticipated the difficulties ahead.*

33 *[1998] 1 Cr App R 121; (1996) 35 BMLR 103.*

a trial of the facts under section 4A at which E gave evidence denying he had been the snatcher. The jury found that he "did the act" charged as theft and he was made subject of a hospital admission order under section 5 of the 1964 Act. He appealed against the finding on the basis that it was essential that the Crown prove all the ingredients of the offence of theft, including the mental element, and that the trial judge had misdirected the jury in respect of dishonesty.

The Crown did not demur from the first proposition but contended that the judge's direction on dishonesty was acceptable. The Court of Appeal agreed with the parties in respect of the central proposition, Ognall J stating as follows:

"It will be apparent that the use of the phrase "the act" in the statutory provision to which we have already referred and in other sections of both the 1964 and 1991 Criminal Procedure Act is to avoid a person being afflicted with the stigma of a criminal conviction when at the time he or she was in fact under a disability. It would be wrong in those circumstances, manifestly for such person to be the subject of a criminal record for the commission of that offence. But that in no way exonerates the Crown in an instance of this kind from proving that the defendant's conduct satisfied to the requisite extent all the ingredients of what otherwise, were it not for the disability, would be properly characterised as an offence. Accordingly we are satisfied, and indeed both counsel agree, that although the words "the act" are used in the relevant legislation, the phrase means neither more nor less than proof of all the necessary ingredients of what otherwise would be an offence, in this case theft."[34]

Was the Court of Appeal in *Egan* correct?

The decision of the court that "act" included *mens rea* received a mixed reception from commentators. Professor JC Smith in his commentary in the Criminal Law Review observed as follows:

"The court holds that the words in section 4A of the 1964 Act, 'that he did the act or made the omission charged against him as the offence', mean all the ingredients of the offence, not just the *actus reus*. ... The section could have been more clearly worded but there is no doubt that this is the meaning intended."[35]

Mackay and Kearns commented on the requirement to prove mens rea as follows: "While this is certainly at the expense of simplicity, it does have the merit of acting as a better protective device for unfit defendants."[36]

On the other hand, the editors of *Archbold* 1999 edition criticised the decision as follows:

"... it is extremely doubtful that [*Egan*] is correct; and no argument to the contrary having been addressed to the court on this point (counsel for the prosecution having apparently agreed with this submission), its authoritative status must be limited. If it is correct, it would cut across the plain purpose of the legislation; and would have results which could not possibly have been intended. If, for example, a person who killed another was plainly suffering from such mental illness as to make him both insane within the *M'Naghten Rules* and unfit to be tried, he would have to be acquitted and discharged, even though he might be highly dangerous and likely to kill again ... The legislation is premised on the recognition that where the accused is unfit to be tried, it is

34 *[1998] 1 Cr App R 121 at pages 124-125. The Court upheld the appeal on the facts as it thought that an adequate direction on dishonesty had been given.*

35 *[1997] Crim LR 225 at page 226.*

36 *R D Mackay and G Kearns The Trial of the Facts and Unfitness to Plead [1997] Crim L R 644 at page 650. In addition, White op. cit. note 12 had advocated the approach of Egan shortly after the Act became law.*

unreal to suppose that there can be a meaningful trial of the mental element of an offence."[37]

It is submitted that the decision in *Egan*, although not without its difficulties, did go a long way to providing the correct balance between, on the one hand, protecting the person who has done no wrong from interference with his or her liberty, and, on the other, protecting society from those who can be proved to have acted in a dangerous manner.[38] The main reason for this view is the fundamental difference between unfitness to plead and insanity. The former focuses on the condition of the accused at the time of the trial. The latter examines the accused's mental state at the time of the alleged offence. A significant period of time often passes between commission of an offence and trial, particularly where psychiatric reports have to be compiled. The important point for present purposes is that a finding of unfitness to plead says nothing about the state of mind of the accused at the time of the incident that led to the charge. He or she may have been perfectly healthy at the time of the offence but may have degenerated, relapsed or suffered injury since. This explains the desire of the Butler Committee to ensure that the trial of the facts explored all aspects of criminal liability, albeit within the strictures imposed by the mental state of the accused at the time of the hearing.

The rationale for including the mental element in the trial of the facts is that, if the accused was capable at the time of the offence of forming or not forming the appropriate *mens rea*, his or her conduct should be judged in light of the standards we expect of ordinary people. To remove *mens rea* from the equation would be to impose a lesser test for establishing responsibility by those who are unfit to plead than exists for those who are fit to plead, despite the fact that at the time of the offence they may have had the same mental capability. If the mental element is removed from the test altogether, then even if there is reliable evidence as to the accused's *mens rea* at the time of his or her actions (or if reasonable inferences may be drawn) this will have to be ignored, leading to potentially perverse results. Contrary to the suggestion in *Archbold*, it is submitted that it is often possible to have a meaningful trial as to the accused's mental state at the time of the *offence* despite the fact that at the time of *trial* s/he is unfit to plead.

Mental element ruled out in insanity cases: *Attorney General's Reference*

In *Attorney General's Reference no.3 of 1998*[39] the accused was charged with aggravated burglary and committed for trial to the Crown Court. Armed with a snooker cue he had forced entry into a house and attacked the owner in the belief that he was Jesus Christ and that he had to escape from evil. The parties agreed that at the time of the incident the accused was legally insane. The issue for the jury, therefore, was whether under section 2(1) of the Trial of Lunatics Act 1883 he "did the act or made the omission" charged. The trial judge considered himself bound by the Court of Appeal decision in *R v Egan* and thus required the Crown to prove all the relevant elements of the offence, including *mens rea*. Psychiatric evidence presented at the hearing suggested that at the material time, the accused was unable to form a criminal intent. The judge thus ruled that there was no evidence of the required intent[40] and directed the jury to acquit the defendant. Thus a potentially highly dangerous man walked free from the court.[41] The bizarre situation arose whereby a person could avoid conviction due to his or her insanity and then use the insanity again to avoid even the special

37 *Archbold 1999 4-174. See also Criminal Law Week 1999/14/4: "[Egan] would seem unlikely to survive, as there seems to be no justification for giving the same expression different meanings in the two different statutes. This would be a welcome result for Egan represented a position which was a variance with the purpose of the legislation and was liable to lead to results which could not have been intended."*

38 *It should be acknowledged at this stage that this view is not shared by the (at the latest count) eleven judges of the Court of Appeal and House of Lords who have had cause to consider Egan.*

39 *[1999] 3 All ER 40.*

40 *The Crown had successfully applied to amend the indictment to include a count of affray but the judge thought that this failed for the same reasons as the aggravated burglary - lack of evidence of mens rea.*

41 *It is not known if he was subsequently dealt with under the civil procedures in the Mental Health Act 1983.*

verdict and secure a simple acquittal. Had it stood, the decision would have rendered the special verdict otiose, as any finding of insanity would necessarily involve an acquittal.[42]

The Court of Appeal unsurprisingly found that the judge was not bound to follow *Egan*. Judge LJ analysed *Felstead v R*[43] and concluded as follows:

"... nothing in the legislation suggests that if the jury has concluded that the defendant's mental state was such that, adapting Lord Diplock's observation in *R v Sullivan*, his mental responsibility for his crime was negatived, it should simultaneously consider whether the necessary *mens rea* has also been proved. ... once it is decided that the defendant was indeed insane at the time of his actions, in accordance with *Felstead v R*, *mens rea* becomes irrelevant."[44]

The court went on to note that there was no authority cited for the propositions of the court in *Egan* and that no reference was made to the statutory history or framework in that case. Judge LJ said that *Egan* "appears to have been decided per incuriam"[45] and in any event had no application to cases of insanity.[46]

The Court of Appeal in *Attorney General's Reference* was undoubtedly correct in its ruling relating to insanity. Insanity means that the accused could not form the relevant *mens rea* at the time of the offence and thus it is unsurprising (indeed essential) that *mens rea* is irrelevant to the determination of whether s/he did the act or omission. Where the court fell into error, it is submitted, is in thinking that the test for the act or omission in an unfitness case should be the same. It thought that the two statutes (the 1893 Act and the 1964 Act, as amended) were "inextricably linked". But are they? Granted they both adopt the same language, but that cannot be decisive as there are numerous instances of the courts giving identical statutory provisions different meanings in different contexts.[47] The contextual difference here is crucial. A court faced with a person who is unfit to plead makes no finding as to whether s/he was capable of forming *mens rea* at the time of the alleged offence. In the absence of evidence establishing the contrary, we must therefore assume that s/he was so capable. Thus the justification, expressed in *Felstead*, for eschewing the need for *mens rea* in a case of insanity is not present in a case of unfitness. If this is correct, then *Egan* was not decided *per incuriam*, as *Felstead* dealt with fundamentally different subject matter.

Defences and insanity

Given that *mens rea* is irrelevant to whether an insane accused did the act or made the omission, to what extent might s/he be permitted to argue that s/he has a defence? The Court of Appeal in *AG's Reference no. 3 of 1998* thought that there should be scope for the outright acquittal of insane defendants in certain circumstances despite the fact that they have committed the act that has led to the criminal charge. First it qualified the absence of a requirement for *mens rea* by saying that it would be insufficient simply to show that the defendant *caused* the injury or other harm. It must be caused in circumstances which, but for the insanity, would amount to an offence. Thus the *actus reus* imported a sense of unlawfulness. Judge LJ said at page 47:

"So far as the criminal courts are concerned, we do not accept that public safety considerations can properly be deployed to justify the making of orders against those who have done nothing

42 *See the searing criticism of the trial judge's error by Professor J.R. Spencer in [2000] C.L.J. 9. It is conceivable that a defendant who relied on the "wrongness" limb of the insanity test would still have the requisite mens rea in a trial of the facts. See the discussion at text and note 58, below.*

43 *Op. cit, note 29, above.*

44 *[1999] 3 All ER 40 at page 47.*

45 *The decision would be per incuriam if it was decided in ignorance of binding authority. In this case it was said to be the consequence of the failure of the court to consider Felstead.*

46 *[1999] 3 All ER 40 at page 48.*

47 *For example, the different way that recklessness is dealt with under the Criminal Damage Act 1971, section 1(1) (Caldwell recklessness) as opposed to the Sexual Offences Act 1956, section 1(2)(b) (Cunningham recklessness).*

which can fairly be stigmatised as a criminal act."

He thought that an insane accused ought nevertheless be able to argue that his or her conduct occurred by way of self-defence or accident so as to make it lawful. If the jury agreed, it would not find that the accused had done the (unlawful) act and would thus acquit rather than returning the special verdict. His Lordship offered two examples where it would be unjust to expose the accused to the consequences of the special verdict. The first was a mentally disabled person in a public swimming pool who touches another swimmer in circumstances that may well have been accidental. S/he ought to avoid a special verdict if charged with indecent assault. His Lordship contrasted this with a situation where an apparently deliberate touching takes place in what appear to be indecent circumstances. In such a case the insane accused should not be able to rely upon his or her own mistaken perception, or lack of understanding, or indeed any defences arising from his or her own state of mind.

The second example was an individual surrounded by a group of larger, aggressive and armed youths who strikes out and causes one of them to fall and sustain a fatal head injury. His Lordship thought that he should still be able to argue self-defence even if, due to his insanity, he believed that the youths were a mob of devils attacking him. Even excluding his own damaged mental faculty at the time, the jury might still conclude that although he *caused* death, his actions were not *unlawful* and so did not amount to the *actus reus* of murder or manslaughter.

These examples show that for conduct to be the *actus reus* of an offence it must often be more than a mere *causa sine qua non*. It assumes some unlawful circumstances, which are negatived by, for example, self-defence or accident. One problem is that, although on one view self-defence relates to the *actus reus* of offence, it is also clear that the need for self-defence and the requirement for force to effect the defence are to be judged on the facts as the *accused* honestly believed them to be.[48] One issue is whether an accused's insane mistaken belief as to the nature and extent of the threat may be taken into account in determining whether the defence has been established. The Court of Appeal seemed to think that the accused's view would be discounted and the jury would be invited to consider whether the circumstances, on an objective examination, would give rise to the defence. This clearly twists the meaning of the defence as hitherto interpreted by the courts.

The swimming example would not appear to cater for the defendant who, due to his mental illness, mistakenly believed that the victim was his own son and, had that been the case, the touching would not be indecent. The touching would clearly be deliberate and the accused's own perceptions are to be ignored. The case also leaves unanswered other issues such as whether a defence of duress of circumstances or necessity might be available to the defendant.

Mental element ruled out in unfitness cases: *R v Antoine*

In *R v Antoine*[49] the Court of Appeal and then the House of Lords had a further opportunity to consider the decision in *Egan*, this time in the context of the trial of the facts. The appellant had been charged with murder as a secondary party to a ritualistic killing. His co-accused was convicted of manslaughter on the grounds of diminished responsibility following acceptance of his plea by the Crown. The appellant was found to be unfit to plead and the trial judge ruled, following *Egan*, that the Crown had the duty of proving both the *actus reus* and the *mens rea* of the crime of murder. Secondly he ruled that the accused was not permitted to rely on the defence of diminished responsibility in the course of the trial of the facts. The jury found that the accused had done the act charged as murder for the purposes of section 4A and the judge therefore had to impose a hospital admission order with restrictions on release without limitation of time. The accused appealed against the finding[50] asserting that he ought to have been able to raise diminished responsibility.

48 *See Williams (Gladstone) [1987] 3 All ER 411 (CA) and Beckford v R [1988] AC 130 (PC).*

49 *[2000] 2 All ER 208 (HL); [1999] 3 WLR 1204 (CA).*

50 *The appeal was brought under sections 15 and 16 of the Criminal Appeal Act 1968, as amended.*

Both the Court of Appeal and the House of Lords rejected this contention on the grounds that the defence of diminished responsibility applied only to a person who "but for this section would be liable ... to be convicted of murder...".[51] Since a finding of unfitness prevents the trial from proceeding,[52] the accused is no longer liable to be "convicted of murder" and thus the section 2 defence is inapplicable. This swift reasoning was sufficient to deal with the certified question, but both courts went on to express an opinion as to the correctness of the approach in *Egan*. Lord Bingham CJ in the Court of Appeal noted that there was no challenge to the *Egan* principle in the instant case, but he shared the doubts of the court in the *Attorney General's Reference* case. He said:

"If Parliament in enacting section 4A(2) of the 1964 Act intended to require the prosecution, when proving that the defendant did the act or made the omission charged against him as the offence, to establish all the ingredients of the offence including the *mens rea*, it is strange that language was borrowed, almost unaltered, from section 2(1) of the 1883 Act which did not have that effect. It is far from clear that Parliament ...intended to give effect to the recommendation of the Butler Committee ... It seems to us at least arguable that the burden on the Crown under section 4A(2) is no more and no less than in relation to insanity under section 2(1) of the 1883 Act."[53]

Lord Hutton (who gave the only speech) in the House of Lords devoted the bulk of his judgment to what he called the wider question - whether *mens rea* had to be proved in the trial of the facts. His Lordship surveyed the earlier litigation and suggested that *Egan* was inconsistent with *Attorney General's Reference no. 3 of 1998* and should not be followed. The main reason for this was the contrast between the words "committed the offence" in the 1800 Act and the words "did the act" in the 1883 Act, which, he said, "points to the conclusion that the word 'act' does not include intent."[54] He took support for this view from the "examination of the facts" procedure in Scotland, the equivalent of section 4A.[55] There the accused will be acquitted unless the Crown can prove that s/he "did the act or made the omission constituting the offence",[56] wording that is similar, though not the same, as in English law. However, his Lordship pointed out that if a Scottish court is satisfied that the accused did the act but it appears that the accused was insane at the time of doing it, the court must state whether the acquittal is on the ground of such insanity.[57] This, he thought, made clear that Parliament contemplated that a person may do the "act" but at the same time be insane. Since insanity negatives *mens rea*, the "act" must relate only to the *actus reus*.

At first sight the logic of this argument is attractive. However, as the appellent retorted, a person could be insane under the M'*Naughten* test but nevertheless still have *mens rea* - this would apply where s/he was insane under the second head of the test so that s/he knew the nature and quality of the act but did not know that it was wrong. As Professor JC Smith points out, "awareness of 'wrongness' is not an element in *mens rea*."[58] This would offer a possible explanation for the Scottish provision while keeping alive the argument that the "act" includes *mens rea*. If insanity does not always negative *mens rea* then there would be nothing illogical about the "act" in Scotland encompassing the mental element while at the same time contemplating that it may be committed by someone who was insane. Such an argument might have re-opened the whole issue of the mental element in insanity cases and his Lordship swiftly rejected it. He said:

"My Lords, a person who kills when he is insane because he does not know that what he is doing is wrong may have the intention to kill, but I consider that insanity under either limb of the

51 *Homicide Act 1957 section 2(3).*

52 *1964 Act section 4A(2).*

53 *[1999] 3 WLR at page 1210*

54 *[2000] 2 All ER 208 at page 218.*

55 *Criminal Procedure (Scotland) Act 1995, section 55.*

56 *Ibid. section 55(1)(a) and section 55(3). Although not relevant to his Lordship's argument, the court must also be satisfied on the balance of probabilities that there are no grounds for acquitting the accused, thus importing consideration of the mental element. There is no equivalent in English law.*

57 *Ibid. section 55(4).*

58 *Smith and Hogan Criminal Law 9th Edition page 206.*

M'Naughten Rules negatives the mental responsibility of the defendant: see *R v Sullivan* [1983] 2 All ER 673 at 676 per Lord Diplock."[59]

No issue is taken with the accuracy of this statement, but it is submitted that it does undermine the strength of the argument his Lordship based on the wording of the Scottish legislation. It can be seen as parliamentary recognition of the difficulties inherent in the test for insanity.

His Lordship went on to criticise the recommendation of the Butler Committee, previously quoted, as being "unrealistic and contradictory". He was confident that in using the word "act" and not the word "offence" Parliament had, "made it clear that the jury was not to consider the mental ingredients of the offence." He thought that a measure of protection was found in section 4 of the 1964 Act, which permits postponement of the question of fitness to be tried up to the opening of the case for the defence. This permits the defence to test the prosecution evidence and to ask for a finding of no case to answer if the Crown's case does not disclose a prima facie case to answer, including *mens rea*. It is submitted that in reality there is little scope on a submission of no case to answer for the court to consider *mens rea*. It would be a rare instance indeed where the Crown had secured a prima facie case on the *actus reus* but could not persuade the court that there was a case to answer in respect of *mens rea*. Even in the absence of direct evidence of the accused's mental state the prosecution may ask the court to draw inferences as to *mens rea* from the evidence that has been given of the accused's conduct.

The central plank of his Lordship's reasoning is that by using the word "act" rather than "offence", Parliament must be taken to have intended the same rules to apply in respect of unfitness as already applied to insanity cases. It has already been suggested that this is defective, given the differences in context and purpose of the two tests.[60] A further reason is the difference in *definition* of the two tests. As has been seen, a person may be unfit to plead even though s/he does not satisfy the M'*Naughten* test. In other words, a person may be unfit to plead and sane at the same time. It is acknowledged that such a situation would be rare, but it serves to illustrate the conceptual difference between the tests. If such a person committed an offence and was later tried for it, s/he would be unable to secure the special verdict and his or her *mens rea* would clearly be relevant to the determination of guilt. That being so, why should unfitness at the time of trial prevent the mental element of earlier conduct from being relevant to the trial of the facts?

Unfitness and defences

Lord Hutton dealt finally with the question of whether, assuming the trial of the facts relates only to the *actus reus*, a person who is unfit should nonetheless be able to submit that s/he had an arguable defence of accident, mistake or self-defence and should thus be acquitted. He recognised the problem that such defences almost invariably involve some consideration of the mental state of the accused. He resolved this by ruling that such a defence would be available but only if "objective" evidence establishing it was available. He offered two examples. First a witness who saw a "victim" attack the accused with a knife prior to the accused striking a fatal blow would be able to give evidence to establish self-defence. Secondly, if a witness saw a woman sit down at a restaurant and put her own bag next to another's and then, on leaving, picked up the other's the evidence would be able to be given to establish mistake. His Lordship said the same principles would apply if the defence wished to argue that the accused's conduct was involuntary as a result of, say, a convulsion - there would need to be evidence to establish the condition. This approach creates the same problems as when insane defendants seek to rely on such defences. It necessitates a distortion of the defence to remove the mental element of the accused. It is submitted that in cases of unfitness it would be much better, and fairer, to use all available evidence, including that relating to the personal perceptions of the defendant.

59 *[2000] 2 All ER 208 at page 220.*

60 *See text and note 47.*

In summary, the House of Lords has in effect overruled the principle in *Egan* that the "act" in section 4A includes consideration of the mental element. In its place the Court seems to have imposed a similar requirement in relation to unfitness cases as the Court of Appeal in *Attorney General's Reference no.3 of 1998* did for insanity. The defence may not argue absence of *mens rea* at all; they may argue mistake, accident, self-defence or involuntariness but only if there is objective evidence independent of the accused's mental state to establish such defences. This article has sought thus far to argue that the approach that has now been adopted is not necessary as a matter of law and, more importantly, is wrong in principle. It is recognised that if the matter is to be resolved it requires Parliamentary intervention. The remainder of this article will be devoted to explaining why such intervention is thought to be necessary.

Injustice caused by the current law

Assume that A is charged with theft of a car from the forecourt of a showroom. He was arrested in possession of the car shortly afterwards. After he was bailed, A met a mechanic from the dealership and a confrontation ensued during which the mechanic suffered a broken jaw. A was arrested again and during interview explained that the mechanic had been shouting abuse and had reached into his tool bag. A said that he feared the mechanic was going to grab a tool to attack him with and that he pushed him away in self-defence but that the mechanic fell against a wall. He was charged with grievous bodily harm with intent under section 18 of the Offences against the Person Act 1861. Unfortunately, following the incident, A was hit by a lorry and suffered significant brain damage. When the trial was listed A was found to be unfit to plead.

At the trial of the facts the lawyer assigned to A wishes to argue that, although he appropriated the dealership's property, he did not act with intention to permanently deprive the owners and he did not act dishonestly. Her argument is that A had been told by someone he took to be a salesman that he could take the vehicle for a test drive. She wishes to adduce the testimony of A's friend who overheard the conversation with the fake salesman. According to the rule established by the House of Lords in *Antoine* this evidence is inadmissible. Although it is "objective" evidence, it goes only to whether or not A had the requisite intention and was dishonest. It thus enters the prohibited arena of *mens rea*.

At the trial of the facts regarding the assault, A's lawyer seeks to establish self-defence as permitted in *Antoine*. However, given his unfitness, the only evidence she can point to is the coherent account A offered in the police interview. This would not be allowed, as, although it relates to self-defence, it is not "objective" and independent of the defendant's state of mind.[61]

In both instances there is reliable evidence suggesting that the accused may well not have committed the offence. There was no issue relating to the mental capacity of the accused at the time of the incidents. However, due to the artificial strictures of the *Antoine* test, the evidence must be ignored and A would no doubt be found to have committed the "acts".[62] The important point is that real injustice would have been done to A due to his inability to raise his own mental element. Such an approach is understandable in cases of insanity at the time of the incident but it seems to be wholly unjustified when the mental incapacity arises only as a bar to the presenting of an effective defence.

A further point of interest arises from the scenario. The assault was initially charged as grievous bodily harm with intent. This entails a specific intent in the accused to cause really serious harm. The Crown, in reviewing the file will not maintain such a charge unless it is confident of being able to persuade the jury that such intent was present. In A's case, once he has been found unfit to

61 *Thus the only permissible account relating to the assault would come from the mechanic, the alleged victim.*

62 *This assumes that the courts will not permit any further inroads into the Antoine rule than identified in the House of Lords case itself. There is likely to be extensive argument in future cases about the nature and extent of the exceptions that already exist.*

plead, all such considerations disappear and there is no incentive at all to reduce the charge. This is due to the fact that the *actus reus* of causing grievous bodily harm with intent under section 18 is the same as inflicting grievous bodily harm under section 20. The difference lies in the intention of the actor and this is reflected in the respective sentences - maximum life imprisonment for section 18; 5 years for section 20. There is therefore less protection against over-charging for defendants who are unfit to plead. So long as they are proved to have "done the act" they will be dealt with as people who are more dangerous.

One could argue that this is not really a problem as there is no conviction and thus the maximum sentence is irrelevant. The judge would be able to take all factors into account when deciding on the appropriate disposal for a person who is found to have done the act. However, it is unrealistic to suggest that judges are not influenced by the choice of charge.[63] Moreover, if we assume for a moment that the mechanic had died of his injuries an even greater power is given to the prosecutor when deciding the charge. The *actus reus* of murder is the same as manslaughter so, accepting that A did the act which caused the death, and discounting the mental element, the prosecutor would know that a murder finding would be just as easy to secure as a manslaughter finding. However, the consequences are hugely different for A. If the prosecutor chose to include murder on the indictment then the judge would have no discretion but to impose a hospital order with restriction on release without limit of time.[64] If *mens rea* is irrelevant, justice would suggest that the prosecutor should select a charge that was the lowest that the facts would allow. In the absence of effective protection[65] there is a risk that a person will face serious consequences due to arbitrary decision-making by the prosecuting authorities.

Conclusion - the way forward

The problems highlighted in this paper are a result of the government's desire for a simple procedure for the trial of the facts, uncontaminated by consideration of mental element and defences. This desire led the drafters to adopt the same language in the statute as already existed in respect of the special verdict. It has become clear that the government's view was over-simplistic in that it failed to accommodate the elementary difference between unfitness to plead and insanity. The courts have only now begun to grapple with the complexities of the trial of the facts and it seems inevitable that there will be further high-level litigation on the relevance of the mental element.[66] The concerns go right to the root of criminal responsibility and the difference between a prohibited act and a guilty mind. It is acknowledged that there is no easy solution. Lord Hutton provided a potent illustration of the problems that would arise if *mens rea* always had to be proved in the trial of the facts. A person who was insane at the time of an offence and who remained so at the time of the trial, with a resultant finding of unfitness, would be able to lead evidence of his or her insanity at the trial of the facts to show a lack of *mens rea*. S/he would have to be acquitted and would thus be released, potentially putting the public at danger.[67]

63 *Over-charging could have particularly serious consequences as there is no right of appeal against an order imposed following a trial of the facts. The order does not follow a conviction and thus may not be appealed under section 9 of the Criminal Appeal Act 1968. Section 15 of the 1968 Act contains a right of appeal against a finding of unfitness and also against a finding that the accused did the act. However, there is no power to appeal against a disposal once such a finding has been lawfully made.*

64 *Sch 1 s.2(2) Criminal Procedure (Insanity and Unfitness to plead) Act 1991.*

65 *Presumably some protection could be afforded by the discretion of a judge to stay prosecutions as an abuse of process.*

66 *Lord Hutton in Antoine also noted the potential difficulties if the defence sought to raise the defence of provocation on a section 4A hearing alleging the act of murder and that difficult questions could arise as to the meaning of the word "act" in relation to a person charged as a secondary party to murder where another person had carried out the actual killing. In neither situation did he feel it was necessary to offer a final opinion.*

67 *This example was also used by the editors of Archbold 1999 to criticise the decision in Egan. See text and note 37.*

Ironically, in voicing these concerns his Lordship may have provided the key to the way forward. What is required is a procedure that permits the mental element to be considered where it is relevant but not where, due to insanity, it is inappropriate. The legislation ought therefore to permit the jury to consider, as in Scotland, insanity within the context of the trial of the facts of an accused who is unfit to plead. When an opportunity presents itself, Parliament ought to consider amending the 1964 Act to make clear that in unfitness cases the Crown is required to prove the *actus reus* and the *mens rea* and that an acquittal will follow if it cannot do so, but that, if it fails due to the accused being insane at the time of the incident the jury will return the special verdict of not guilty by reason of insanity. There would thus be three possible consequences following a finding of unfitness. A bare acquittal would follow if the jury were not satisfied that the accused committed all elements of the offence, including any requirement as to state of mind. A section 5 disposal would follow if s/he did commit all the elements of the offence. Finally, a special verdict would be returned if the jury were not satisfied that the accused committed all the elements of the offence by reason only of his or her insanity.

"A Mere Transporter" - the Legal Role of the Approved Social Worker

*Roger Hargreaves**

Introduction

The role of the Approved Social Worker in the 1983 Mental Health Act is an unsatisfactory amalgam of legal, professional, administrative and practical functions which has accumulated on a largely *ad hoc* basis over the last two centuries. The current review of the legislation offers an opportunity to redefine this role in a way which is both clear and internally consistent. This article reviews the history of the role and suggests that more fundamental changes are needed than the proposed in the Report of the Expert Committee.

The issues

Under the civil provisions of the 1983 Mental Health Act, virtually all applications for admission are made by Approved Social Workers (ASWs), who are required by Section 114 to be appointed by local social services authorities and to have "appropriate competence in dealing with persons who are suffering from mental disorder"- which means in practice that they must be qualified and experienced social workers who have undergone a course of additional training prescribed by the Central Council for Education and Training in Social Work.

However, whilst the Expert Committee chaired by Professor Genevra Richardson received "strongly voiced arguments...in favour of retaining the ASW as the applicant" in a new Act, it noted that "some respondents suggest that other mental health professionals are as capable of independence as ASWs whatever their employment status" and recommended that "consideration be given to the gradual extension of the role of applicant to include other mental health professionals who are not psychiatrists."[1] In practice "other professionals" would mean the Community Psychiatric Nurses (CPNs) employed by the Trusts, who have over the last twenty

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1 *Department of Health 1999, "Report of the Expert Committee: Review of the Mental Health Act 1983" paras. 5.11 - 5.13.*

years progressively replaced social workers as the major professional group in the community mental health services; this, plus an increasing difficulty in recruiting ASWs, suggests that a transfer of their statutory role to CPNs would be the next logical step. However, this raises the questions, first, as to whether there is any intrinsic merit in this role continuing to be performed by employees of local authorities as opposed to the NHS, and secondly, whether it is a role which *ought* to be perpetuated in the new Act, at least in its present form.

The history

The genesis of the role can be found as far back as 1808, in the County Asylums Act which gave the Justices of the Peace the power to build asylums to house "pauper lunatics." The parish Overseers of the Poor were given the task of identifying those considered to be lunatics, bringing them before the Justices and obtaining a warrant, arranging transport to the asylum and making provision from parish funds for their upkeep. From that point on, the role can be traced as a continuum right through to the present day, albeit that it has undergone as many metamorphoses as Dr. Who; from ASW to CPN would be the sixth such transformation.

The Overseers in due course became Relieving Officers, and the mass of mental health legislation was finally consolidated in the 1890 Lunacy Act, which, repeatedly and heavily amended, remained the basis of mental health law until 1959. The central figure in the 1890 Act was the Justice; since a finding of lunacy often led to disinheritance, the middle classes had become alarmed about the possibility of collusion between grasping relatives and their private medical attendant, and so the Justice's role was extended to include private patients.[2] The Relieving Officer's duties however, continued to relate only to pauper patients and to "persons found wandering" (although these two groups would have made up the vast majority of patients dealt with under the Act - then as now, the association of mental illness with poverty and homelessness was very strong.)

In an emergency the Relieving Officer could, under Section 20, detain on his own authority for up to three days, but in other circumstances he would, when he "had knowledge that any pauper... is deemed to be a lunatic" and that there was no relative able or willing to take action, bring that person before the Justice (or more commonly, bring the Justice to the person.) It was then the Justice's responsibility to obtain a medical opinion, usually from the GP or Poor Law Medical Officer, before signing the "certificate" which gave authority for the Relieving Officer to convey, and for the asylum to admit and detain; as often as not, however, the sequence was reversed, with the doctor, as the first on the scene, initiating the process and requesting the Relieving Officer to make an application to the Justice.

In its essentials, this whole process would still be familiar to a modern ASW with the exception that a psychiatrist, not a Justice, is now the third party; but the Relieving Officer was a very different animal to the modern social worker. In the one office (and in many rural areas, the one *person*) he combined the functions of a large chunk of modern local government, the Benefits Agency, and the NHS - in his practice manual the guidance on mental health matters is sandwiched between regulations for "outdoor relief" and burial of the pauper dead, and a chapter on acting as a census enumerator, infectious diseases in lodging houses and procedures for- vaccination.[3]

2 *Jones, K. 1972 "A History of the Mental Health Services" Routledge.*

3 *Hadden's Relieving Officer's Handbook, 1935 edition, Chapter XI*

He exercised most of these multifarious powers as a statutorily designated official rather than as a mere agent of his employing Poor Law Union, and it was therefore entirely logical that he should also act as an individual under the Lunacy Act and be personally liable at law. However, in 1929 the Poor Law functions were transferred to local authorities, where the legal traditions were very different; local government officers are faceless beings acting solely on behalf of their chief officer, who in those days would have signed every letter and memo, although the Relieving Officers for the time being retained their statutory designation.

This transfer also brought the Relieving Officers into contact with the health departments, which in the most progressive local authorities were taking the first tentative steps towards the development of community services for people with mental health problems by appointing "Mental Welfare Officers" (MWOs); and it meant that, for a brief period, the Relieving Officers and the mental hospitals were accountable to the same body, the asylums having been taken over by the new local authorities in 1889. In a few places psychiatrists held joint appointments in the hospital and the health department, thus bringing about a temporary fusion of hospital and community services.[4]

The potential of such arrangements was, however, never developed, as war intervened and then, in 1948, the hospitals were transferred to the new National Health Service; at the same time, the Lunacy Act was amended yet again, and with the abolition of the Poor Law the mental health duties of the Relieving Officers were transferred to "Duly Authorised Officers" (DAOs) in the local authority health departments.

If you believe the media, community care of the mentally-ill began in 1993 and has been a disaster; in fact, it began in 1948 and has been, on the whole, a success. It started slowly, however, but gathered speed during the late 1950s. At first, the DAOs were mostly ex-Relieving Officers, and they continued to combine their statutory mental health role with other administrative duties, but in time the role began to be combined with that of the Mental Welfare Officers, many of whom had trained as psychiatric nurses; in Lancashire by 1953 only one-third of the MWOs had begun their careers as Relieving Officers.[5] The DAOs/MWOs were not, however, yet seen as "social workers;" a Psychiatric Social Worker, (PSW), postgraduate-trained and working mainly in hospitals and clinics, was an altogether superior being, and when, during the hearings of the Percy Commission in 1955, Lord Percy inadvertently confused the two he was sharply corrected by a doctor - "the PSW is in a class apart; they are a very special group of people. The name is a trademark, and you must not call anybody else a PSW."[6]

This kind of attitude permeated the Commission's deliberations as to the role which the DAO/MWO ought to play in the proposed replacement for the Lunacy Act. It was stressed at great length, even by the DAOs themselves, that they were almost entirely subservient to the doctors, although everyone knew that the reality was very different; GPs had virtually no training in psychiatry, whilst the DAOs had vast practical experience - for instance, in Liverpool each DAO carried out an average of 96 compulsory admissions a year,[7] whilst the average GP would be involved in perhaps three or four, and the GPs were therefore heavily reliant on the DAO's advice.

4 *Jones, K. supra*

5 *Jones, K. 1961 "Mental Health and Social Policy" p.161, Routledge.*

6 *HMSO 1957 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, Minutes of Evidence, Q5383*

7 *Ibid. Q4916*

However, even the most ignorant doctor was officer-class, whilst the DAOs were, at best, mere sergeants, and the medical witnesses to the Commission were appropriately patronising:

Lord Percy: "I confess the name Duly Authorised Officer rather puzzles me. For half the time he is a mere transporter, and that is how he is usually thought of.....on the other hand, he has certain independent duties to watch over the safety of the public.....and the two functions do not really fit in together?"

Doctor: "He does ...other things...he prepares the documents....I think one always feels a little doubtful about it, but....they do their work very well on the whole. They are quite an intelligent crowd of people."[8]

The Commission struggled with this contradiction that the "mere transporter" had independent legal powers, even though "statutory designation" had now ceased and he was in all other respects just an ordinary local government officer. Under Section 14 of the original Act he had not been required to exercise any personal judgement as to the alleged lunatic's state of mind before calling in the Justice - it was "sufficient if by common report the person is a lunatic whether he is in fact one or not"- but in 1946 Section 14 was amended to require him to have "reasonable ground for believing that a person....is a person of unsound mind" before taking action, and it was later confirmed by caselaw[9] that this required him to exercise at least a degree of personal judgement, especially in the case of Section 20 where he acted alone (and so convenient was this procedure than in 1955 it accounted for 27 % of all compulsory admissions.)[10]

In the event, however, the Percy Commission saw no use for this personal judgement in the new order of things, in which the doctors would be in the ascendant. It recommended that the DAO should become in law what by that time he usually was in practice, a Mental Welfare Officer, but that in the process he should "lose the greater part of his powers, becoming now merely a substitute for the nearest relative as the applicant for admission. Since the nearest relative could not be expected to exercise any professional judgement, nor therefore could the MWO, and he was no longer required to have "reasonable grounds" before acting, the application being "founded on the medical recommendations," with no recognition that there might be any social dimension to the question of compulsion.

However, it was agreed that the MWO should retain a degree of independence, anomalous though it now was, although this was seen purely as a "conscience clause" rather than as a licence to defend the patient's civil rights:

"(A psychiatrist and the patient's GP) are better qualified than anyone to diagnose the patient's medical condition, to assess his need for treatment, and to judge the probable effect if treatment is not provided. No responsible....MWO would lightly disregard or dissent from their advice....(but) if an MWO is asked to take the responsibility of signing an application ....he must in the last resort be free to do so."[11]

8 *Ibid. Q758*

9 *Buxton v. Jayne (1960) 1 W.L.R.783*

10 *Cmnd 169, Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1954-57 Appendix IV*

11 *Cmnd. 169 Ibid. para 404*

The MWO did not, however, in practice revert to being a "mere transporter" under the 1959 Mental Health Act. As previously, his actual status vis-a-vis the other participants was far higher in practice than in legal theory, and although the paperwork was now much simpler and many relatives could deal with it, he (and now occasionally she) was rarely cut out of the admission process altogether; - his expertise as "crisis manager," co-ordinating doctors, ambulance and police, was far too valuable to be dispensed with, and in return he could expect his advice to be taken seriously. This status was reinforced by the rapid development of the community services after 1959; the number of MWOs trebled in ten years, and by 1967 there were 1,500 of them, nearly one-quarter holding social work qualifications (including an increasing number of PSWs and at least as many more being qualified psychiatric nurses).[12]

Training had been seen by the Percy Commission as being likely to induce greater conformity with medical opinion, the British Medical Association suggesting, (on the basis presumably that disagreements between doctors and laymen are always due to ignorance on the part of the latter), that the MWOs should be given "sufficient training that they will not want to over-ride the opinion of an experienced psychiatrist."[13] In practice, of course, what happened was the exact opposite, since training caused the MWOs to identify with the emerging profession of social work, and the willingness of MWOs to stand their ground was bolstered also by their central role in the expanding community mental health services.

This was on the whole a constructive tension, since the MWOs were accepted, albeit sometimes patronisingly, by psychiatrists as being experts in their own field. However, in 1971 they were transferred from the Health Departments to the new Social Services Departments, and their duties were progressively taken over by "generic" social workers, often social science graduates, who had little or no mental health experience, but who had absorbed the notions of the "anti-psychiatry" school of sociology and who seized on their powers under the Mental Health Act as a means by which they could defend the labelled and stigmatised from the reactionary medical profession. Not surprisingly, relations deteriorated, and many psychiatrists chose instead to use the nearest relative as applicant, thus exposing the weakness of the MWO's legal position.

The present law

In 1975 the government commenced what was to become a very protracted review of the 1959 Act, the tone of which was set by MIND'S Legal Officer, Larry Gostin, who in his report "A Human Condition"[14] launched a well-researched assault on the supposed infallibility of psychiatrists, and their tendency to interpret the Act for their own convenience at the expense of the patient's rights. He noted the weakness of the MWO's legal position, which rendered them powerless to resist these abuses, and argued that as a counterbalance to medical opinion "the social worker should make an independent evaluation of the prospective patient...(focussing on) the person's family and community environment...and should refuse to authorize an admission if there are less restrictive community settings in which treatment can be provided."[15]

12 *Cmnd. 3703, Report of the Committee on Local Authority and Allied Personal Social Services 1968 (Seebohm Report) Appendix F para 273*

13 *HMSO 1957 supra. Q 5392*

14 *Gostin, L.O 1975 "A Human Condition Vol I" MIND*

15 *Gostin, 1975 supra p. 37*

In its evidence, the British Association of Social Workers (BASW) echoed this view, noting that "in law, the social worker's role has traditionally been regarded as administrative rather than professional; but as its precise limits are not defined, social workers have interpreted it in various ways...we now see the social worker as having an independent role which complements the medical opinions....but this must clearly be seen to be from a basis of professional autonomy...the social worker is usually, nowadays, a comparatively junior member of a large, hierarchical department, and the independent status conferred upon him by law is often difficult to sustain in practice. We support the principle of independence, as a valuable safeguard for the patient, and think that it should be more clearly spelt out in the Act."[16]

In return for this clearly-defined professional role, BASW proposed that there should be mandatory additional training for social workers, and that they should be formally approved under the Act as was already the case for psychiatrists. The government accepted the case for a parallel "social assessment," and for training and approval, but was unwilling to do more than tinker with the 1959 Act, and so the issue of the social worker's legal independence was never addressed. In 1983 the MWO's mantle was duly passed on to the Approved Social Worker, who was required under Section 13(2) to "interview the patient in a suitable manner and to satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need." This is not dissimilar to the duty of the Justice under the Lunacy Act, who had to "examine the said person and make such inquiries as he thinks advisable...and (be satisfied) that the said person is a lunatic and a proper person to be detained"[17]; but the Justice had come, by 1959, to be regarded as a dangerous amateur, who lacked the knowledge to recognise mental illness in all but its grossest forms, whilst the ASW was to be trained to an increasingly high standard.

The government did not, however, accept BASW's argument that the nearest relative's power to make an application should be removed, although in the subsequent Code of Practice the ASW became the "preferred applicant." However, if the ASW did not believe that detention was appropriate, and therefore refused to make an application, the Code nevertheless required him or her to "advise the nearest relative of his or her right to make an application" and to "assist the nearest relative with conveyance to hospital if requested"[18] - thus effectively requiring the ASW to act contrary to his or her professional judgement. Although this situation arises very rarely, it is clear that even in the present law the ASW can still be reduced on occasion to the status of a "mere transporter."

16 *British Association of Social Workers, 1977 "Mental Health Crisis Services - A New Philosophy."*

17 *Lunacy Act 1890 Section 16*

18 *Department of Health and Welsh Office 1999 "Code of Practice -Mental Health Act 1983" 3rd edition paras. 2.32, 11.9*

The problems

A more common difficulty in practice, however, is that although Section 13(4) of the 1983 Act places a specific duty on the ASW to visit in response to a request for assessment from the nearest relative, the psychiatrist is under no corresponding legal or contractual obligation to set foot outside the hospital. This had been a problem since 1959, and it was compounded, in 1974, by the transfer of all community health functions from the local authorities to the new health authorities. This allowed the NHS, frustrated by the failure of the new Social Services Departments to build on the sound foundation of the pre-1971 mental welfare services, to set up its own community mental health provision, appointing CPNs alongside the District Nurses and Health Visitors; and, since they could be drawn from a pool of 45,000 hospital staff[19] it was only a matter of time before they outnumbered the social workers and became the dominant force in community mental health.

However, whilst the CPNs stepped into the vacant welfare role of the former MWOs their employing health authorities (now provider Trusts) did *not* inherit the duty to provide a response to emergencies in the community, which remains to this day with the ASWs and with Social Services. It is not surprising, therefore, that "the difficulty in obtaining reliable and speedy attendance of Section 12 (Approved) doctors....is the single issue which is raised most consistently on (Mental Health Act) Commission visits"[20] since the Trusts have a very limited interest in resolving the problem. Their responsibility begins only when the patient arrives at the hospital, and to deploy psychiatrists into the community to deal with emergencies would cost them money and reduce the medical cover available to the wards and out-patients, so the ASW still has to rely on persuading a psychiatrist to do an extra-contractual "domiciliary visit," for a fee and usually in the evening. For the same reason, CPNs in joint community teams, in contrast to their ASW colleagues, have no duty to respond to emergencies other than those involving clients already known to them.

The Expert Committee concludes that "whilst the cause of this problem is complex, its lack of resolution is unacceptable and it must not become a feature of the implementation of new legislation. We recommend that a clear duty be imposed on health authorities....."[21] It also recommends that people with mental health problems, including those unknown to services, should have the right to a specialist assessment of their mental health needs via their GP, but it is delightfully vague as to how this should be achieved, suggesting only that "it would be necessary for the Code of Practice to supply the details of how the scheme might work."[22] In reality, unless the duties of provider Trusts are enlarged to include the provision of an emergency assessment service in the community, using both psychiatrists *and* CPNs there is a danger that it may "work" by means of the GPs requesting ASWs to fulfil their obligations under Section 13(4), even in cases where compulsory admission is not an issue.

ASWs are also becoming increasingly anxious, on two fronts, about the question of legal independence. Until 1983 the possibility of being sued was entirely theoretical, since there had been no successful action against an MWO/DAO/Relieving Officer since 1890 and the protection of what is now Section 139 was thought to be watertight; however, that was before Legal Aid was extended to Tribunal hearings and a new breed of specialist lawyers began to proliferate. ASWs

19 *Cmnd. 6233 "Better Services for the Mentally-Ill" 1975 Chapter 9*

20 *Mental Health Act Commission, Eighth Biennial Report 1997-99, para. 4.31*

21 *Department of Health 1999, supra. para 5.16*

22 *Ibid. para. 3.23*

now feel very vulnerable, not least because, unlike the doctors employed by the NHS Trusts, they have no contractual indemnity but must rely on the goodwill of their employers if they get into trouble; and in its initial evidence to the Expert Committee, the Association of Directors of Social Services called for a "properly informed debate" on the issue as to whether they should continue to be personally liable, given their "unique position" within Social Services. However, it would be impossible, if they were to revert to the normal legal status of local government officers, for them to perform the duties currently laid on them by the Act, since they would be acting purely "on behalf of the Director of Social Services" and could not therefore exercise the necessary personal judgement.

However, even if the ASWs retain their personal liability, the extent of their independence vis-a-vis the psychiatrist and the receiving hospital, and the need for such independence, is now being brought into question.

The official performing the present ASW role has not always been independent of the hospital - from 1929-1948 the hospital staff and the Relieving Officers were both employed by the local authority - but under the Lunacy Act a hospital doctor could not sign a certificate for admission. However, under both the Lunacy Act and the 1959 Act, doctors employed by the Poor Law Union or in the Health Department will frequently have written certificates or recommendations for their Relieving Officer/DAO/MWO colleagues, and this was not seen as problematic even when - as would have been the case after 1948 - there was an hierarchical relationship between them; but this was, of course, seen as a relationship of officer and sergeant rather than of two autonomous professionals, and in a context where the independent scrutiny of medical judgements was provided not by the DAO but by the Justice.

By 1959 the standing of the medical profession was so high that virtually no-one saw any further need for that scrutiny, and Dr. Broughton, was a lone voice when he protested in the House of Commons that "power for compulsory detention... is given by the Bill to the medical profession. I maintain that it is the duty of doctors to report and to make recommendations. I hold the opinion strongly that doctors are not qualified to take over administrative functions of such gravity as taking away a person's freedom and restricting civil rights."[23] However, within the next 16 years the anti-psychiatry movement had undermined much of that standing, and in 1983 the government accepted MIND's and BASW's argument that, in the absence of any judicial scrutiny, the exercise of medical power should at least be moderated by an independent social work assessment.

At that time the legal independence of social worker from doctor was not seriously in question, as they worked for completely separate organisations which were sometimes barely on speaking terms with one another. However, successive governments have rightly refused to tolerate such separateness in what should be a "joined-up" service, and recent years have seen the rapid spread of joint mental health services in which the NHS and Social Services "provider" staff are brought under a single management line, and the prospect, encouraged by the Health Act 1999, of a complete fusion of services in many places; indeed, the NHS Plan now makes it clear that where such arrangements are not arrived at by local agreement, they will be imposed by the creation of "Care Trusts."[24] Given the balance of forces, most such mergers will result in ASWs albeit

23 *Hansard, House of Commons Vol 598, Mental Health Bill, 3rd reading 6.5.59 p.418*

24 *Department of Health, 2000 The NHS Plan para. 7.11*

retaining their local government employment contracts, being supervised on a day-to-day basis by nurses who are themselves accountable to the managers of the hospital and its medical staff. There is no legal barrier to such an arrangement and, although it is being resisted in some places on professional grounds,[25] it seems certain to become the norm rather than the exception.

The way forward

In order to determine the future of the ASW role in the new legislation it will first be necessary to disentangle the several strands of that role which have become entwined over the last two centuries. The oldest of these strands is that of "crisis manager", which goes right back to 1808 - the responsibility for getting the doctors and other participants to the scene and transporting the patient to hospital. This role, albeit rather more than Lord Percy's "mere transporter," requires no independence and is not intrinsically different to the management of a non-statutory mental health crisis, and it should therefore be brought within the normal arrangements for meeting urgent mental health needs, with a responsibility being placed equally on Social Services and the NHS Trusts to provide an emergency assessment service in the community.

The second strand is that of "social assessor" which, although always implicit, has been formally expressed in the legislation only since 1983. It is less easy, 17 years on, to sustain Gostin's argument that a social work assessment is a necessary counterbalance to a narrow medical view, since the present generation of psychiatrists is far more conscious of the importance of social and environmental factors; and nor is it now safe to assert that ASWs have a greater understanding of these factors than CPNs especially where they work together in joint teams. Rather than defend an exclusive role for the ASW it would perhaps be better to apply to statutory assessments the same principle which is now applied throughout the mental health services, that major decisions should not be taken by a single professional without prior consultation with other disciplines. This principle is already enshrined in the present Act, in the provisions in Part IV (Consent to Treatment) for consultation by second opinion doctors, and in Sections 25 A-J (After-Care Under Supervision), and would in practice require the psychiatrist to seek the view of at least one non-psychiatrist colleague, preferably one who has knowledge of or an involvement in the case.

The third strand is the most controversial, since it concerns the question as to whether it is necessary to have an independent check on the exercise of medical judgement in order to prevent unlawful or oppressive action; and, if so, whether the ASW is the right person to exercise it. Such a check was seen in 1890 as being very necessary, but not at all in 1959, and the enhancement of the social worker's role in 1983 was not intended to revive the role of the Justice, but merely to broaden the scope of the assessment process. In practice, however, they do tend to portray themselves as the guardians of the patient's liberties, and as they have received training in the law, and the psychiatrists until very recently received none, it is accepted that they have the primary responsibility to ensure the legal and procedural correctness of an admission. However, this is essentially an administrative function, and one which is shared with the Mental Health Act Officer who scrutinises the documents at the receiving hospital, and it does not of itself elevate the ASW to a quasi- judicial role.

25 *Anderson, S. "Viewpoint", Community Care 1-7 June 2000*

Nor can ASWs claim to be disinterested parties, which is an essential element of any such role. The detention process is still "founded on the medical recommendations" and the ASW cannot make his or her application until these have been completed, thus giving the appearance that the doctors are the initiators of the process; however, the opposite is frequently the case. Most ASWs are nowadays full-time mental health specialists, acting as care co-ordinators under the Care Programme Approach and as after-care supervisors under the provisions of Section 25; indeed, this is desirable in order to maintain competence in the "social assessment" role and to meet the criteria for continued approval. As a front-line practitioner, with a responsibility for the protection of others as well as the patient, the ASW will frequently be the first to recognise the need for compulsory action and may well be the main advocate for it; for instance, a recent independent inquiry noted how an ASW had protested strongly to a psychiatrist at his refusal to detain a patient whom she considered to be dangerous.[26]

It could therefore be argued that an ASW is just as likely as a psychiatrist to apply the law in an oppressive manner, and that the main safeguard against this is that the ASW and the psychiatrist act as a check on each other; but this then raises the possibility of collusion or undue influence. There has long been a debate within social work as to whether an ASW who is a close colleague of the psychiatrist will be more, or less, effective in a "civil rights" role than an ASW from outside the multi-disciplinary team, a debate which first surfaced in 1974 when the hospital-based PSWs were transferred to local authority employment and therefore became eligible for appointment as MWOs.[27] Many authorities were initially reluctant to appoint them as such, on the grounds that they had traditionally been subservient to the psychiatrists within the hospital hierarchy and that, in Gostin's words, "the doctor's status and authority may lead him to exercise an undue influence on the social worker's decisions."[28]

However, the PSWs successfully persuaded BASW to support their case for appointment, on the grounds that their expertise, plus the respect in which they (in stark contrast to their generic colleagues) were held by the psychiatrists, enabled them to exercise a constructive influence behind the scenes which would in practice be more effective than outright confrontation. Doubts persisted, however, and in its evidence to the review of the 1959 Act BASW recommended that a doctor and a social worker who were part of the same multi-disciplinary team should be prohibited from acting jointly, as was already the case with two doctors who worked together.[29]

With the passage of time, the grounds for concern about "undue influence" have diminished - the present generation of psychiatrists is less authoritarian, and the ASWs are better-trained and more confident. However, as a consequence, the dangers of collusion have greatly increased, as the ideological differences between the two professions have narrowed and multi-disciplinary decision-making has become the norm rather than the exception. In many cases, psychiatrist and ASW will have a close and mutually-dependent working relationship, in a joint service where they share common management, and in such a situation it is difficult to see the ASW as being, in the terms adopted by a recent White Paper of the Council of Europe, a "relevant independent

26 *Wigan and Bolton Health Authority, May 2000, Report of the IndeÚpendent Inquiry into the Care and Treatment of Garry Lythgoe p.19*

27 *"Detention In Your Own Hospital" Social Work Today Vol 5 No 5 30.5.74*

28 *Gostin, 1975, supra. p. 37*

29 *BASW, 1977 supra. para 21.4*

authority confirming involuntary placement or treatment" whose independence "could be verified by the fact that it was a different authority than the one which proposed the measure and by the fact that its decision was a sovereign decision not influenced by instructions from any source whatsoever.[30]

This then raises the question as to whether such an "independent authority" would in fact be needed at the initial stage under new legislation in which the final decision on compulsion would be taken by a Tribunal. The Expert Committee, in its original proposals, suggested that in view of its recommendation that there should be a Tribunal hearing after seven days, "it may be less important to demand independence" of the ASW vis-a-vis the doctor.[31] However, the subsequent Green Paper casts doubt on the practicability of this timescale, opening the possibility that the admission might not be confirmed by a Tribunal until 14 days or even longer (and which would mean in practice that a high proportion of admissions would not be confirmed at all, since the patient would by then have been discharged or made informal.) This is surely too long a period, and would not meet the requirement for timeliness in the Council of Europe White Paper, which envisages that compulsion should be confirmed immediately other than in "an emergency situation."[32]

This points to the need to recast the present role in an explicitly quasi-judicial form. The present training, and the statutory duty set out in Section 13 of the present Act, are not inappropriate to this - what is needed is a greater degree of demonstrable independence and detachment, firstly from the psychiatrist and secondly from the body or bodies providing the treatment and care. In order to ensure the former it might be sufficient simply to enact BASW's 1977 recommendation that the ASW and psychiatrist must come from different multi-disciplinary teams, but this would not meet the second requirement in jointly-managed services or "Care Trusts"; the most practicable way of achieving this would be to make the ASW in respect of his or her statutory role, accountable to an external body which is not a service provider. The obvious candidates for this would be either the Mental Health Act Commission or its successor body, or the local Health Authorities or Commissions. In the latter case, it would be feasible in the new arrangements under the Health Act 1999 to make the ASW service a jointly-commissioned service, thus retaining the local government connection.

This would in turn make it easier both to contemplate the extension of the role to CPNs and to resolve the question of personal liability. Although there are questions about the appropriateness of their training and experience, the strongest case against the inclusion of CPNs at present is that as Trust employees there is not even a nominal separation between them, the psychiatrists and the hospital, and that their terms of employment require them to follow medical instructions on clinical matters.

In respect of personal liability, it seems clear that the nature of the judgements required, and the fact that they must be made "on the spot," without reference to management, is incompatible with corporate responsibility. Health Authorities, however, have much less difficulty than does local government with the issue of employees exercising personal judgement and having personal

30 *Council of Europe DIR/JUR (2000)2 White Paper on the Protection of Human Rights and Dignity of People Suffering From Mental Disorder p.7*

31 *Dept. of Health April 1999, Draft Outline Proposals by Scoping Study Committee - Review of Mental Health Act 1983 para 61*

32 *Council of Europe, supra. p.8*

liability, and it should be relatively easy within such a framework to give ASWs or their successors both the status and the degree of indemnity which would be necessary for them to act in a quasi-judicial capacity.

Whatever the final outcome, it is essential that the role of the ASW or of any successor should be properly thought-through and redefined in a way which is both clear and internally consistent. The present role, designed originally for an autonomous Poor Law official in the days of chains and madhouses, is an amalgam of legal, professional, administrative and practical functions which have accumulated on a largely *ad hoc* basis over two centuries, and which do not sit comfortably on the shoulders of a modern social worker in a present-day mental health service.

Reviewing Scottish Mental Health Law: Any Lessons for England and Wales?

*Hilary Patrick**

Introduction

This article looks at the Millan Committee's review of Scottish mental health law, with some reference to the work of the Richardson Committee[1] and the Government's response to it[2]. Whilst the issues raised were similar, the Scottish approach is likely to differ in certain significant respects. It is hoped that the article will, therefore, add to the debate south of the Border.

Remit of Millan Committee

The Millan Committee was appointed in February 1999 to undertake a comprehensive review of the Mental Health (Scotland) Act 1984. Its chairman is the Rt Hon Bruce Millan, a former Secretary of State for Scotland and European Commissioner. Members of the Committee include the usual psychiatrists, nurses, social workers, lawyers and representatives of voluntary organisations and also, unlike Richardson, user and carer representatives.

The Committee has taken evidence from a wide range of groups and individuals and has carried out separate consultation processes with users, carers and people with learning disabilities. Like Richardson, however, our work has been made more difficult by the short time frame within which we had to operate, just over 18 months for a fundamental review of legislation last reviewed in the 1960s. (It is instructive to note that the Percy Commission[3] took four years to reach its conclusions.)

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1 *The expert committee chaired by Professor Genevra Richardson whose Review of the Mental Health Act 1983 ('the Richardson Report') was published in November 1999 .*

2 *Reform of the Mental Health Act 1983- Proposals for Consultation (1999) The Stationery Office.*

3 *The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, whose report [(1957; Lord Percy) Cmnd 169, HMSO, London] led to the 1959 Mental Health Act for England and Wales and the 1960 Act in Scotland.*

The Committee will be issuing its final report early in 2001 and this article cannot pre-empt its conclusions, but it may be instructive to indicate key areas of concern, particularly where the Committee appears to be diverging from Richardson.

Those key areas are: capacity and the grounds for compulsion, compulsory treatment in the community, protection for voluntary patients, whether learning disability should be included in mental health legislation and advance directives.

Incapacity as a ground for compulsory intervention

The Mental Health (Scotland) Act 1984, like its English equivalent, sets out a series of tests which must be satisfied before a person can be admitted to hospital. Unlike England and Wales, before a long term order can be made, the forum, in this case the sheriff court, has to approve the order. (Both Richardson and the Government appear to have accepted that the Scottish system is preferable, for human rights reasons.) A sheriff can make an order only if satisfied that

- The patient has a mental disorder ('the diagnosis test')
- The disorder is such that it is appropriate for the patient to be treated as an in-patient in hospital ('the appropriateness test')
- The patient needs treatment in the interests of his or her own health or safety or for the protection of other persons ('the risk test') and
- Such treatment cannot be provided unless compulsory measures are used ('the justification test')[4].

If the sheriff is not satisfied as to any one of these elements, a long term order cannot be made.

The Committee's greatest concern was over the appropriateness test. The other tests contain a measure of objectivity which can be challenged by a patient opposing an order. The patient can obtain independent psychiatric reports to challenge the diagnosis test, and can challenge risk assessments made by the doctors[5]. Evidence from social workers or others can be obtained which can demonstrate that there are alternatives to detention in hospital and that the justification test has not been satisfied.

The appropriateness test is less transparent. Leaving aside its automatic linking of compulsion with hospitalisation, which may no longer be appropriate if a principle of minimum necessary intervention is accepted, the test is still flawed. It is based on the doctor's professional judgement that hospital care is necessary, without making explicit the grounds on which the doctor is to reach that decision. All the patient can do is obtain another doctor's opinion stating that hospital is not appropriate. As it is the first doctor who will remain responsible for the continuing care of the patient, the sheriff is likely to give greater weight to her assessment of the patient's needs.

The appropriateness test met with little approval on our first consultation, and many respondents urged the Committee to look at a capacity test to replace it. It was argued that lack of capacity was, in fact, the reason why doctors felt it appropriate to take compulsory measures in particular cases. Lack of capacity was the ethical justifications for the law's discrimination against people with

4 *Mental Health (Scotland) Act 1984, s17(1).*

5 *Although work needs to be done in making risk assessments more transparent and improving the quality of evidence brought before the sheriff - often no more than hearsay.*

mental disorders. It was the reason why they were singled out from other patients and could, in certain circumstances, be compelled to receive treatment against their will. A mental disorder can so incapacitate someone that they lose their own autonomy. Society then has a duty to intervene to protect the patient. An inevitable corollary of this principle is that so long as the patient does retain capacity (however impaired) they should be able to take their own decisions , however unwise, in the same way that non-mentally ill people are able to take unwise and irrational medical decisions[6].

The Committee is still considering the place a capacity test should have in Scots law. There is concern to deconstruct the basis on which doctors make decisions about whether compulsory measures are appropriate and a desire to ensure that the new law has a firm ethical base (not least to comply with ECHR obligations). However there is also concern that lack of capacity may not be the appropriate test to use when determining whether a person should be subject to compulsory measures.

Capacity fluctuates. Is it appropriate that a person should be free to discharge himself from hospital on a day when he is not delusional even if doctors suspect that the next day he will be very different? Capacity, or lack of it, is very difficult to diagnose. (Delegates at our specialist dementia seminar explained how fluid a concept capacity was, requiring observation of the patient over a period of time, with a multi-disciplinary input into the assessment.)

The test in the new Act would have to be functional. A doctor would have to certify that the patient was unable to take medical decisions relating to her mental disorder, because of the mental disorder. The fact that a decision was unwise could not, of itself, lead to a conclusion that the patient lacked capacity; as this would violate the non discrimination principle. Clearly the fact that the patient was rejecting the help offered might be an indication of his mental disorder. However concern was expressed that a patient might be held to 'fail' the capacity test simply because he or she disagreed with what the doctors recommended.

Any capacity test would need to be widely interpreted, and would need to include all the so-called Eastman elements[7] (inability to take a decision, to communicate, to understand information, to understand that one was ill or to make a true choice). However there was concern that there could still be people who were ill, who needed help and yet who might fail to receive the help they needed because they 'passed' the capacity test. To some of the Committee the capacity test seemed unduly legalistic, promoting autonomy (or apparent autonomy) at the expense of the equally important ethical principle of beneficence. Richardson recognised this dilemma and suggested that the decision as to whether there should be an exception to the general rule in this situation was a matter for the politicians[8]. The Millan Committee is likely to go further and attempt to produce a formula which recognises the ethical attractions of the capacity test but tempers this with a common sense and pragmatic approach.

6 *See Sidaway v Governors of Bethlem Royal Hospital [1985] AAC 871 per Lord Templeman. A patient who has capacity is entitled to reject the doctor's advice 'for reasons which are rational or irrational, or for no reason'.*

7 *As discussed in Re C (Mental Patient: Medical Treatment) (1993) 15 BMLR 77.*

8 *Richardson Report, paras 2.10 and 7.23.*

We have tried to consider what it is about mental disorder that should justify special treatment under the law. [While a mental disorder can affect cognition, one of the elements in a capacity test, its effect is more than that.] Feeling, emotion, judgement, all may be impaired. A person may know that they are ill but be compelled by their illness to reject treatment (the true choice test).

There was some feeling in the Committee that the criteria for the use of compulsory measures should be the patient's impaired judgement rather than his or her lack of capacity.

The distinction between impaired judgement and lack of capacity is subtle, but important. 'Impaired judgement', unlike incapacity, is not a legal term of art. If included in a statute, the words would be given their ordinary meaning. The test says that it should not be possible to take compulsory measures in the life of a person who has a mental illness, if their decision making ability in relation to treatments for that illness is unaffected by the illness. But if the illness has distorted the person's ability to decide on treatments, the person should be given the benefit of medical treatment and support. The test is perhaps less legalistic than the incapacity test. It might be closer to the decisions which psychiatrists actually make on the ground. It might also be less stigmatising for those who are found to need compulsory measures.

The distinction between incapacity and impaired judgement may be seen more clearly in the light of some case studies. Impaired judgement (i.e. judgement impaired because of the mental disorder) would be seen in Richardson's depressed housewife who thought life was not worth living[9], in the young woman with anorexia who does not accept she is dying and in the delusional patient who thinks the doctors are trying to poison him or her. While the second two would probably also lack legal capacity, the first might not. However the person with schizophrenia who knows they are ill but who wants to try to live drug free would not be caught. The doctors might not agree with their decision, but if it was made with full understanding of the facts and possible risks, they would have to respect it. Even if the patient's decision was unwise, it would not be the mental disorder which distorted it.

Whether the Millan Committee ultimately decides on a strict capacity test or prefers the impaired judgement criterion may have little effect in practice on the number of people subject to compulsory measures under the Scottish legislation. Research in certain US States which introduced narrow 'dangerousness' criteria into their mental health legislation showed that, while commitment rates dropped immediately after the introduction of the new legislation, they then rose to previous levels. Commenting on this trend the researcher wrote that

> *'When the results of a law narrowly applied will be contrary to the moral intuitions of [those applying the law] they will act at the margins to modify the law in practice to achieve what seem to them to be more reasonable outcomes.'*[10]

The Millan Committee's deliberations are based on this common sense approach: attempting to find solutions which reflect the innate common sense of those operating the law and those who may be subject to its provisions, but which also have a firm ethical foundation.

9 *Richardson Report, para 7.9ii.*

10 *Applebaum, PS (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.*

Compulsory treatment in the community

Unlike Richardson, Millan's remit did not include a requirement that it should find a method of introducing compulsory treatment in the community (CTOs). Hostility to such orders has been strongly expressed in Scotland by, among others, the Scottish Association for Mental Health (similar to MIND south of the border) and the Scottish Users' Network (SUN). However despite the arguments against CTOs, there are also powerful reasons to suggest that some kinds of compulsory measure should be available outside a hospital setting.

The Committee has yet to reach a final decision, but is giving serious consideration to removing the automatic linking of compulsion with hospitalisation. There are several reasons for this.

First, the principle of least restrictive and invasive intervention means that, if a person can be adequately and appropriately helped without requiring in-patient treatment, this should be offered. This should not be at the expense of a proper care plan, looking at the person's needs for health and social supports, however. Treatment should mean more than just medication and any care plan should be approved by the forum and subject to review by them. (Some people who are so ill as to require compulsory measures may, in fact, regard hospital as a less restrictive option. Any new law should allow their wishes to be respected.)

Secondly, while closure of long stay hospitals has taken place more slowly in Scotland than in England and Wales, all the trends are in the direction of community based services. To link compulsion to bricks and mortar rather than to appropriate services might, it was argued, render a new Act obsolete almost from its inception.

Thirdly, the Committee was made very aware of the conditions in our acute psychiatric wards. Successive reports from the Scottish Health Advisory Service have highlighted the strains under which the system is operating. Many of those opposing CTOs (the present author included) did so on the assumption that patients receiving compulsory care in hospital could be guaranteed a certain standard of care and support. That assumption can no longer be made. Provided reciprocity (another principle the Committee is moving towards) is accepted, a patient may receive a better standard of care in the community, with less disruption to their lives.

The Committee does not, however, believe that community orders on their own will solve the problems of those patients with whom services find it difficult to engage. Patients may be required to live in a certain place or to accept forms of medical treatment, but if they are not convinced that services can help them, they will simply vanish. Assertive outreach and new ways of trying to engage with patients are needed.

Informal patients

Another major concern for the Committee was the protection of voluntary patients, some of whom told us that they were only in hospital because they had been told that they would be sectioned if they attempted to leave. How can the law protect these patients?

Some of those coming from a civil rights background would prefer the reluctant voluntary patient to be made subject to compulsory measures rather than stay in hospital under pressure. The detained patient can appeal against detention, have their treatment reviewed by a second opinion doctor and apply the Mental Welfare Commission for discharge. Better to be actually than *de facto* detained. On the other hand there was a strong feeling in the Committee that the principle that the

Act should not be used if a patient was willing to be admitted informally[11] was equally important. A patient who is sectioned has less freedom to negotiate with doctors than the so-called 'voluntary' patient, (perhaps more accurately described as an 'informal' patient) and there may be additional stigma in having been a detained patient.

Many of those who responded to our consultation said that voluntary patients needed extra protection. Clearly bullying a patient to stay in hospital or to accept medication is not acceptable. If a person is truly unwilling to stay, and doctors consider this necessary, formal procedures should be used. A revised and strengthened Code of Practice should make this clear.

However there is a distinction between bullying and information giving. In certain circumstances, if an ill patient asked doctors whether they were free to leave, it would be appropriate for them to be told that, although they were, doctors would use detention measures if they did try to go. It was hard to see a way of protecting patients against this apparent 'threat' so long as compulsion remains a part of mental health law.

The Law Society of Scotland suggested replacing the concept of medical consent with 'evident willingness' to accept the care or treatment proposed. It regarded consent as too passive, not fully recognising the patient as a partner in the medical decision making process. 'Evident willingness' is the term used in some continental systems and would not, it was felt, include the informal patient who clearly did not want to be in hospital or to accept the medication proposed.

Whilst some respondents to our consultation felt that specific legal safeguards needed to be put in place for informal patients, on the whole the feeling of the Committee has been against this. Rather it seems likely that the Committee will recommend general improvements overall to the Act which will strengthen the position of informal patients. Rights to advocacy, new principles stressing participation and respect for the patient's wishes, improved rights to information and a strengthened Code of Practice should improve practice and increase the ability of all patients to participate in their care and treatment.

Patients with incapacities

A sub-category of informal patients is those who, as in Bournewood[12], are unable to take decisions about their treatment. Scotland now has its own incapacity legislation to protect such patients. Under the Adults with Incapacity (Scotland) Act 2000, if a patient is incapable[13] of making medical decisions the doctors can do what is reasonable to promote or safeguard the patient's physical or mental health[14]. The wording clearly includes patients whose mental disorder makes them incapable of deciding about psychiatric treatment.

In Scottish psychiatric wards in the future there could, therefore, be patients all with similar diagnoses but with three different legal statuses: informal patients, detained patients and those being treated under the incapacity legislation.

11 *A principle emphasised by the Percy Commission and found in s17(2) of the 1984 Act.*

12 *R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998] 3 AER 289.*

13 *A person is 'incapable' if he or she is incapable of acting, making or communicating decisions or of retaining the memory of decisions because of mental disorder. (Adults with Incapacity (Scotland) Act 2000, s1(6).)*

14 *Ibid, s47(2).*

The new Act does not, however, allow doctors to admit a patient to a psychiatric hospital against their will[15]. If a patient lacking capacity appeared unwilling to go to hospital the Mental Health Act would have to be used. Nor does the Act allow detention[16]. If a person was *de facto* detained, as some of their Lordships thought the patient in Bournewood was, the Mental Health Act should be used.

There has been some debate in Scotland about proposed new rules for medical treatment for mental disorder for patients with incapacities. New regulations will spell out the safeguards to be imposed for special treatments which fall outside the doctors' general authority to treat. It is thought, for example, that Court of Session approval will be required for non-therapeutic sterilisation of a mentally incapable woman (despite the fact that all other decisions about patients are to be taken by the lower, sheriff courts). More controversially, the Scottish Executive appears to be accepting the recommendations of a working group[17] to extend psychosurgery to patients who are unable to agree to it, provided the need for the operation is confirmed by the Court of Session. (The working party argued that those patients most in need of this rare procedure might be the very ones least able to accept it, such as patients with depression so disabling that they lacked the legal capacity to take medical decisions on their own behalf.)

For the majority of patients, however, the argument is about the special treatments currently set out in s98 of the Mental Health (Scotland) Act, long term drug treatment and ECT. Many of those responding to the consultation argued that the protections for incapable patients should mirror those in the Mental Health (Scotland) Act for detained patients. ECT at any time and drug treatment for over three months should require approval by a second opinion psychiatrist appointed by the Mental Welfare Commission. Protection against inappropriate treatment is vitally important for the person with incapacities, who may even lack the capacity to complain about treatment received.

While the Scottish Executive appears to have accepted the argument in respect of ECT, there appears an unwillingness to extend the rules on long term drug treatments to those with mental incapacities. This appears to be on resource grounds. Many residents of nursing homes currently receive drugs for mental disorder prescribed by GPs and obtaining psychiatric approval of this prescribing would, it is felt, place too great a burden on already stretched services.

Yet evidence has indicated that the problem with medication prescribed to nursing home residents is not merely theoretical. An important study in Glasgow looked at nursing home residents in the south of the city and found that 24% of them were being prescribed the major neuroleptic drugs, and in 88% of these cases the researchers did not regard the drug as clinically appropriate[18].

The Scottish Executive is waiting to publish its regulations until it receives the Millan Committee's report. The Millan Committee is considering whether mental health and incapacity legislation should be consolidated into one act. If it does, there are powerful arguments for requiring that the safeguards for special treatments should be the same for incapable patients as for those subject to compulsory measures.

15 *Ibid, s47(7)(c).*

16 *Ibid, s47(7)(a).*

17 *CRAG Working Group on Mental Illness Neurosurgery for mental disorder. The Scottish Office July 1996.*

18 *A McGrath, G Jackson (1996) Survey of neuroleptic prescribing in residents of nursing homes in Glasgow BMJ, 312, 611-612.*

People with learning disabilities

As in England and Wales, the Scottish Mental Health Act includes in its remit people with learning disabilities, even though on the whole they are not ill and their disability cannot be 'cured'. There were powerful arguments on both sides about whether people with learning disabilities who were not otherwise mentally ill should be included within a mental health act. Currently about 170 people with learning disabilities in Scotland are detained under the Act, some because they are suffering from a mental illness but the majority because of 'abnormally aggressive or seriously irresponsible behaviour'[19].

The Committee took evidence from New Zealand (unfortunately via a video link) which several years ago took learning disability out of its Mental Health Act. The result was that a significant number of people were discharged from hospital and no suitable accommodation was provided for them. Following the inevitable disruption, New Zealand is now introducing new legislation for people with learning disabilities, which will include the use of compulsory powers.

However the Committee heard pressing arguments for excluding learning disability from the legislation. It is not a mental illness and not, generally a medical problem at all. It is only included in the current act as an add-on to an act mainly dealing with the effects of serious mental illness. Only one provision was widely welcomed, that which imposes an unequivocal duty on local authorities to provide free day training and occupation for people with learning disabilities living in the community[20].

Whether learning disability remains in the Act or whether Millan recommends a fundamental review of the law following the Scottish Executive's new strategy for people with learning disabilities[21], it is no longer acceptable for people with learning disabilities to be included in mental health legislation almost by default. The Act should be examined afresh to see what provisions are relevant to them and what are not. Discrete provisisons incorporating rights to services, protection of vulnerable people and secure provision for those who might pose a risk to others, should be put in place.

Advance Directives

A major area of discussion was advance directives. When the Adults with Incapacity Bill was placed before the Scottish Parliament, the Scottish Executive found itself unable to take on the recommendations of the Scottish Law Commission in its Report on Incapable Adults[22] that advance directives in health care be given legal force. The inevitable backlash from the Catholic Church and pro-life groups was one which the new Executive felt itself unable at that stage to withstand.

The Millan Committee will not seek to reopen that discussion, but it is considering the role of advance directives in psychiatric care. This is particularly relevant in the light of its likely recommendation that a new Act stresses the importance of patient participation in care decisions and respect for patients' wishes.

19 *Mental Health (Scotland) Act 1984, s17(1)(a)(ii).*

20 *Mental Health (Scotland) Act 1984, s11.*

21 *The same as you? A review of services for people with learning disabilities The Scottish Executive June 2000.*

22 *Scot Law Com No 151, September 1995.*

Advance directives in psychiatry can take several forms. A patient may fill out a 'crisis card' naming people to contact in an emergency. The card may direct doctors to discuss the patient's care with the named person and may also specify types of treatment that the patient does or does not want. A patient may sign a 'contract' with their consultant setting out the terms of their discharge from hospital and the sort of conditions which might result in the patient being recalled. The contract might spell out the patient' s preferences about future treatment. A patient might appoint another person her 'health care proxy' to take medical decisions on her behalf[23]. Alternatively a person may go to their lawyer and sign a formal document along the lines of a 'living will' stating their treatment options in the event of future incapacity[24].

Many commentators think that even if advance directives are not legislated on, they are already legally binding. The BMA has given advice to doctors saying that doctors should recognise them[25]. However an advance directive can be overruled if the patient is detained under the Mental Health Act. Doctors might take a directive into account when considering treatment options, but would be under no legal duty to do so.

Clearly from the patient's point of view, advance directives represent a way of reducing uncertainty about the future and of giving the patient more control over their lives. If drawn up in partnership with their doctor, they can represent a way of negotiating treatment options. Advance directives can reduce the powerlessness many patients feel when faced with the psychiatric system. They are a way of promoting patient autonomy.

From the doctor's point of view they can reduce the need for compulsion by persuading patients to agree the type of symptoms which might necessitate their readmission. Doctors are supposed to try to consider patient preference when deciding on treatment and the advance directive can help here. It has been shown that compliance with treatment is improved if patients understand the need for treatment and feel their views are listened to and respected.

Most of the respondents to the consultation appreciated these advantages, and most saw a place for advance directives in psychiatry. The dividing line was, perhaps predictably, over the legal effects of directives. While health care providers generally felt they should be persuasive only, social services and voluntary groups felt they should be legally binding.

Some respondents believed that a directive should be capable of being overruled if there was a serious risk to the patient's health or safety. Others (including some GPs and psychiatrists) felt that a properly drawn up advance directive, made by a patient who was well and in full possession of the facts, should be respected, even if the result was the patient's death. These respondents argued that the principle of non-discrimination (which means that generally the law should discriminate against mental health service users no more than strictly necessary) demanded no less. If a Jehovah's Witness is allowed to refuse a blood transfusion which could save his life, a mental health service user should be allowed make an advance refusal of treatment and to stipulate that this should apply even in life-threatening circumstances.

23 *A limited form of health care proxy is incorporated in the Adults with Incapacity (Scotland) Act. (See ss 16 and 50(6).) The proxy's decisions can be overruled if the doctor obtains a second medical opinion.*

24 *A comprehensive (yet strangely intimidating) model is available from the Bazelon Center for Mental Health Law at www.bazelon.org/advdir.html.*

25 *Advance statements about medical treatment The British Medical Association 1995.*

Whether the Millan Committee will accept this principled approach or will adopt a more pragmatic (and it could be argued compassionate) approach, the author will leave readers of this article to surmise.

Conclusion

Many of the discussions of the Millan Committee (on informal patients, learning disability and community treatment orders) mirrored those in England and Wales. The Scots were given longer to carry out their review and were, perhaps, therefore able to carry out a slightly more leisurely and comprehensive consultation process.

Incapacity legislation was passed in Scotland during the life of the Committee, and the Committee had to grapple with the complex issues of its interface with mental health legislation.

Unlike Richardson, the Committee's hands were not tied over the issue of community orders. If Millan does, in fact, recommend such an order, the Committee's final report may make interesting reading for those still involved in the debate.

A Successor Body to the Mental Health Act Commission

*Margaret Clayton**

"The Mental Health Act Commission (MHAC) has a major role in protecting the interests of patients who are subject to the provisions of the 1983 Act. Its principal functions are to:

- ***appoint Second Opinion Appointed Doctors***
- ***review treatments given under sections 57(2) or 58(3)(b) of the Act, ie treatment that requires a second opinion***
- ***visit detained patients and investigate complaints***
- ***keep under review the exercise of statutory powers relating to detained patients***
- ***submit proposals for a code of practice***
- ***look into matters relating to informal patients, when directed to do so by the Secretary of State, and***
- ***report to the Secretary of State every two years on the operation of the Act."***

This is the summary of the functions of the MHAC contained in the Green Paper on Reform of the Mental Health Act 1983. In this brave new world of the Modern NHS, with much enhanced arrangements for local quality assurance and clinical governance, the Commission for Health Improvement, the Commission for Care Standards, the National Institute for Clinical Excellence, the establishment of Patient Advocate and Liaison Services, and the numerous other ways of increasing patient participation which are outlined in the National Plan for England, is a successor body to the Mental Health Act Commission really necessary ?

The Commission's response is an unequivocal "Yes"[1].

* *Chairman of the Mental Health Act Commission. Formerly non-executive member of Lambeth Southwark and Lewisham Health Authority and Under-Secretary of State, Home Office.*

1 *A full version of the paper "The Successor Body" is available on the Mental Health Act Commission website.*

The Green Paper on Reform of the Mental Health Act listed some of the proposals made for a successor body by the Expert Committee and sought comments on them in the context of a statement that the functions of the MHAC successor body would be decided in the light of decisions on the shape of the new Mental Health Act. As well as commenting on the general proposals in the Green Paper, the Commission therefore submitted a separate response detailing its views on the necessity for a successor body and its possible functions.

This article highlights some of the main points made in the Commission's submission and speculates on possible additional functions which could substantially enhance the safeguards available to detained patients. The term 'detained patients' is used generically to include all mentally disordered patients who might be either detained or subject to a Compulsory Order under the Green Paper proposals. It does not speculate on any extension of remit to "de facto" detained patients or others for whom alternative future safeguards are not yet clear.

Before outlining some of the detailed arguments for a successor body, there are two main points to be made:-

- It is the very proliferation of statutory and other agencies with fingers in the same pie and the complexity of their relationships that make a successor body absolutely essential. Proliferation is not conducive to a holistic view across boundaries.
- The judicial role of deciding whether a patient should be made subject to compulsory care and treatment and whether continued use of such powers is justified is different from and should be separate from ensuring that the continuing care and treatment of such a patient complies with the legislation on a day to day basis. This paper is concerned with the second of these.

Both these points are returned to later in the article.

Need for a successor body

The Commission believes that an independent successor body is essential because:-

- The State is under a particular obligation to protect the interests and human rights of those it places under compulsion for any reason, but particularly when mental disorder may reduce a person's capacity to protect him or her self.
- Separation from the NHS and the Department of Health is clearly necessary to fulfil this function if the safeguarding role is to have any credibility.
- Coercive powers imposed by the State for therapeutic reasons can be misused, even with benevolent intent.
- The general public needs to be reassured that all reasonable steps have been taken to prevent this and, more generally, to be confident that mental health legislation cannot be used for social engineering or political purposes.
- Other similar groups of people who are perceived as particularly vulnerable have separate bodies to safeguard their interests, regardless of other relevant checks on service standards and delivery, e.g. the Disability Rights Commission, Commission for Racial Equality, Equal Opportunities Commission.

Main Functions

What should or could a successor body do?

The Green Paper is clearly right in saying that it should not duplicate the functions of management or other quality assurance bodies. The primary role must be to safeguard the interests of people subject to compulsory care and/or treatment. This can only be satisfactorily achieved if all relevant agencies work closely together to achieve complementary objectives. The successor body therefore has a role in facilitating such co-operative working as well as in focussing on individual patients.

The Commission believes that the core work would fall under five main headings:-

- Visiting
- Monitoring
- Reviewing, including deaths and complaints
- Reporting and dissemination
- Acting as a focus for other bodies with an interest in mentally disordered patients.

Visiting

Patients subject to any form of compulsion need to receive independent visits to see that they are:-

- receiving the treatment for which compulsion has been imposed,
- aware of their rights under mental health legislation or have been unable to understand genuine efforts to make them so,
- know how to make a complaint if they are dissatisfied with any aspect of their care or treatment,
- not being subjected to improper use of restrictive powers, e.g. seclusion, search, physical or mechanical restraints, withholding of post or other property, refusal of visits, or access to activities,
- not being abused or neglected, and
- not receiving treatment which has not been properly authorised.

The existing MHAC carries out this visiting function in all health facilities which contain detained patients. It may be argued that more consistently provided advocacy services or the newly suggested Patient Advice and Liaison Service (PALS) could take over this role, but both would have a much wider focus than the particular issues relating to detention and neither would necessarily be seen as fully independent of the facility in which they are based. There seems therefore a clear role here for the MHAC successor body. Whether this role is in direct provision, as at present; in training and possibly accreditation; or in some form of franchising of local services, will depend on the shape of other proposals in the forthcoming White Paper. What must be recognised is the need for a successor body function which ensures consistency and equality of visiting provision for detained people in either health or social service facilities and uses information gained from visiting to validate documentary evidence.

Monitoring

Visiting individual detained patients is definitely not enough to ensure that their interests are safeguarded. The MHAC has been accused of being bureaucratic and over-concerned with documentation but unless careful and accurate records are kept of such matters as risk assessment, care plans, consent to treatment, the administration of drugs, use of seclusion and access to recreational facilities and fresh air, how can anyone be sure that such patients are not being abused? Close monitoring of documentation is also necessary to track whether the progress of an individual through the system complies with statutory requirements. This is going to be even more important than now if compulsion can apply outside as well as within residential facilities. It is only by a combination of meeting patients, either individually or in groups, checking their perceptions against their personal records, and setting these personal records in the context of consistent monitoring of particular aspects of care that a reasonably accurate picture can be obtained of how well any specified facility is managing its detained patients or how well any particular patient is being treated in his/her progress through the system

With the best will in the world, it is extremely unlikely that hard-pressed managers or any national body with a health/social services wide remit could ever give sufficient priority to detained patients to enable this kind of detailed monitoring to be undertaken. A separate independent body with a specialised remit is needed both to provide the necessary protection and to feedback information which would alert those with primary responsibility for quality assurance to the need for remedial action. This monitoring role would be even more valuable if combined with a general facilitative remit to enhance the ability of all concerned to work to common objectives in relation to detained patients. (See "Acting as a focus..." below)

Reviewing, including deaths and complaints

Visiting and monitoring will inevitably disclose areas which merit close scrutiny across the board. Since much of the base material and necessary contacts will be readily available to the MHAC successor body itself, such scrutiny could either be undertaken in-house or commissioned. The MHAC has carried out several very useful thematic reviews, the most recent of which - on aspects of race and equal opportunities - is the subject of ongoing work with the University of Central Lancashire and the Sainsbury Centre. The successor body must have the right to do the same.

Within this general role, the reviews of deaths and complaints are of particular significance. The Commission already receives notification of all deaths of detained patients and reviews their circumstances. An MHAC report on the outcome of these reviews during the past three years is shortly to be published. This will show the advantage of a single body having a review function which enables the build up of expertise and, more importantly, the ability to identify common features and perhaps commonly required preventative action. To give this function to an independent body will provide the credibility which is all too often (however wrongly) perceived as missing in relation to deaths in other types of custody, such as police or prisons.

The review of complaints is more complex. There is already a hierarchy of arrangements for processing complaints on any aspect of health and social services. The MHAC currently has the power to investigate complaints from detained patients but very rarely does so, considering it more constructive to provide support and advice to complainants to assist them in obtaining a response through the relevant quality processes. About 650 such cases are dealt with each year. To attempt

a review or investigation in parallel with existing arrangements would be confusing and could be oppressive to the subject of the complaint, while to replace the normal process would diminish the accountability of those who are responsible for general quality assurance.

Nevertheless, there is little doubt that detained patients are more likely than others to be disadvantaged by the long drawn out processes of the standard complaints procedure and, at the very least, a successor body could give added protection by being able to monitor progress and draw attention to deficiencies. Whether this should be only in relation to complaints about detention or extend to any formal complaint made by a detained patient is for consideration - it can certainly be argued that the need for monitoring of all formal complaints is just as critical in assessing the quality of care for detained patients as of those relating only to their detention.

In its response to the Green Paper, the Commission suggested that its successor body should not have investigatory powers in relation to complaints but should offer information and advice and be consulted on membership and terms of reference for any independent investigation. This more general role would not prevent Commission members from being involved in any investigation but would help to assure the public that the process of setting up such an investigation was itself subject to independent scrutiny.

Reporting and Dissemination

Reporting

One of the most important aspects of visiting and monitoring is alerting local management to issues of concern which can and should be readily remedied. The MHAC finds that considerable change can be achieved in individual facilities through this informal reporting process. This approach to supporting staff who are anxious to improve their service will be essential for a successor body, but it should also be required to report more serious concerns to higher managers and others such as service commissioners who are responsible for quality assurance. Such a requirement will not only enhance the quality assurance capacity but also provide the opportunity for publicity if more serious concerns are ignored.

Publications

The MHAC is convinced that analysing and publishing relevant data relating to all detained patients is one of the most valuable ways in which a successor body could contribute to an improvement of mental health services, both for detained patients and others who experience similar care and treatment. Apart from material aimed specifically to provide information for detained patients, we suggest that the three main needs are for:-

- A wide range of "brand" documents such as special reports, regular reviews, or bulletins that aim to disseminate good practice and draw attention to differences, trends or bad practice which may raise questions about the quality of services.
- A freely available and widely circulated annual report that would meet the needs of public accountability and provide an ongoing record of overall improvements in the performance both of the successor body and of the organisations and functions it will be monitoring.
- A regular statutory report to Parliament - not necessarily biennial - that would continue to provide the broader historical perspective currently supplied by the Biennial Report.

It is arguable that a MHAC successor body should also be responsible for producing relevant Codes of Practice. The Commission believes that this is a proper function of the department(s) with responsibility for the legislation but that the successor body should retain the current right to make proposals for such Codes, as well as having a right to be consulted on the Codes and on all legislation or Government publications relating to compulsion under mental health law.

Advice and training

The MHAC answers numerous written and oral queries about the implementation of the 1983 Act. Mental health authorities and practitioners have greatly welcomed the Guidance Notes issued by the Commission and the training introduced last year on the new Code of Practice. New legislation will require much more such advice and training. The Commission believes that the successor body should have a specific remit to provide advice and guidance on legal issues and good practice as they relate to compulsion in relation to mentally disordered patients, with particular regard to human rights legislation. It will have to provide such advice to its own staff and Commissioners and could therefore provide it to a much wider range of people consistently and cost-effectively.

How such advice should be provided will depend to a large extent on how well-resourced a successor body is to be. A 24 hr.helpline could provide both general advice and a first source of help for individuals liable to be detained. A web-site on mental health law similar to the one recently provided by the Institute of Mental Health Law but now discontinued would be a valuable resource for statutory as well as voluntary bodies and individuals. There could be regular up-dates on issues affecting compulsion under mental health law, perhaps on a subscription basis. There are many possibilities. It is, however, self-evident that to have a single authoritative independent body as the focal point must be beneficial to all concerned in providing one clear centre of expertise.

The role of a successor body in training is more complex. There is a considerable demand for training in mental health legislation and much to be gained by having it provided (not necessarily exclusively) by an independent authority separate from each of the related disciplines. This would ensure consistency of training across disciplines, facilitate multi-disciplinary involvement, which is particularly crucial to the care and treatment of detained patients, and prevent the excessive re-invention of wheels. It would, however, be essential not to intrude on professional training and to ensure close co-operation with all the relevant professional organisations. Relevant examples are training for Second Opinion Appointed Doctors (already undertaken by the MHAC), doctors appointed under section 12 of the 1983 Act, those who give independent advice to Tribunals, and Approved Social Workers.

Training of people who have not necessarily received any professional training in mental health matters creates less difficulty.. These might include non-executive directors of health or social service bodies, administrators, volunteers in various capacities such as advocates or PALS, or other voluntary bodies lobbying or providing services for those with mental disorder.

Acting as a focus for other bodies concerned with mentally disordered patients.

Most of the proposals made above underline the need for detained patients to be recognised as a sub-set of vulnerable individuals whose needs should be examined holistically regardless of where they are placed or who is directly responsible for them. There is otherwise a very real danger that they will not be a high enough priority for any of the agencies concerned with their care for significant improvements to be made.

Resource constraints and different professional objectives make it difficult for any of these agencies - whether statutory or voluntary - to take a lead in trying to draw together the many complex threads of the issues surrounding compulsory care and treatment. This is why the development of a successor body to the MHAC with a clear remit to do this would be so valuable.

How the successor body would achieve closer inter-agency and multi-disciplinary working will be dependent on the shape of the arrangements which will be revealed in the forthcoming White Paper. The possibilities are many. They range from providing a common source of information, advice and training in mental health legislation, as already suggested, to the facilitation of inter-agency and multi-disciplinary conferences, seminars or meetings to:-

- identify and establish boundaries to avoid duplication of demands on patients, carers or staff,
- co-operate in the arrangement of visits/inspections for the same reason,
- discuss significant cross-boundary issues relating to detained patients,
- develop common priorities/targets for improvement,
- develop common standards for quality assurance,
- explore problems of confidentiality and professional ethics which may inhibit the transfer of information to the benefit of the patient,
- exchange best practice and identify reasons for differences revealed by the successor body's monitoring function.

"Joined up" working of this kind would have implications for the many patients who, although not subject to mental health legislation, are often managed in the same facilities and encounter very similar problems.

Additional functions

Relationship with Tribunals

With the exception of the facilitating role just mentioned, the functions already described largely maintain and enhance existing functions of the MHAC. At the beginning of this article an unsubstantiated assertion was made that the judicial function of deciding whether compulsion should be applied and whether its continuance was justified should be separate from assuring ongoing compliance with mental health legislation. There is room for disagreement here, since it is not inconceivable that one independent agency should be responsible for managing both the judicial and the monitoring functions, providing that the two roles were clearly differentiated. This would, however, run contrary to the general constitutional separation between judicial and administrative or executive functions and the possibility is not further considered here.

On the assumption that the tribunal suggested in the Green Paper will have a much more pro-active

role in establishing that a patient should be detained than the existing Mental Health Review Tribunal, there is little doubt that the number of expert opinions required from doctors will increase. The Commission's submission on a successor body suggested that such a body should recruit and train all doctors required either as members of or expert witnesses to the tribunal, as well as continuing to appoint, train and monitor the performance of Second Opinion Appointed Doctors involved in consent to treatment safeguards. This would underline the independence of second opinions and advice as well as enabling the knowledge and skills base of the successor body to be effectively utilised. The maintenance of a common database would facilitate the avoidance of duplication of functions and ensure the best use of scarce medical resources, thus contributing to the achievement of common objectives.

The number of other professionals required to give expert advice to the tribunal will also increase if the Green Paper proposals are implemented, as will the number of patients requiring legal representation. The successor body could have a similar function in relation to other professionals as to doctors. Legal representation could also be facilitated by the successor body directly engaging/appointing legally trained people throughout the country to be available for detained patients or maintaining lists of people who have been franchised by the Lord Chancellor's Department (or by the successor body itself) or simply establishing direct links with local bodies already involved with providing adequate legal representation.

Powers of the successor body

Much of what is suggested above depends on the ability of the successor body to provide consistent, comprehensive and reliable information. The effectiveness of the existing MHAC is limited by the fact that it has no statutory powers to require information or to enforce its recommendations. In its submission to the Department of Health, the Commission suggested that to give the successor body enforcement powers could undermine service providers' managerial responsibilities or priorities or conflict with the responsibilities of other bodies with wider quality assurance roles. We therefore suggested that the successor body should instead have a broad range of statutory rights and duties such as:-

- the right to receive notification of all admissions to, extensions of and discharge from compulsory powers and of a range of other matters relating to detained patients, e.g. deaths, untoward incidents, formal complaints,
- the right of access to detained patients and their records,
- a duty to discuss with local managers matters of concern relating to their management of facilities or detained patients and to report to senior managers any matters requiring their attention,
- a duty to draw to the attention of the Secretary of State and/or the appropriate professional, regulatory or managerial body any cases, trends or practices relating to detained patients which it considers requires their action,
- a duty to publish from time to time such material arising from its remit as might contribute to the improvement of services to mentally disordered people subject to compulsion.

Rights and duties of this kind should provide the successor body with the information and mechanisms necessary to give authority to its activities without duplicating or overlapping with the responsibilities of others.

Structure and organisation of a successor body

Structure follows function. It would therefore be premature to speculate on how the successor body might best be structured and organised to fulfil its functions. What must be recognised, however, is that if it is to fulfil the kind of enhanced role which is suggested in this article, it will need to be more self-evidently independent and differently resourced than at present.

The existing MHAC is a Special Health Authority. In its paper on the successor body, the Commission rejected this status because of the connotation that it is part of the NHS and responsible for the delivery of a health service, whereas it is independent and concerned with a wider range of services which it does not deliver itself. Similarly, the Commission argued that the successor body should be staffed by people from a wide range of disciplines, including full-time professionals, rather than solely by civil servants seconded from the Department of Health (although the latter would be amongst those included in the staff). These views are pertinent whatever functions are allocated.

If the successor body is to have the standing and authority necessary to carry out the full range of functions described, the Commission believes that it must have a stronger senior management structure to support the high level Chief Executive who has recently been appointed. More importantly, it should be a statutory Non-Departmental Public Body headed by people of national standing and credibility in the professions with which it will need to engage. It will require a modern infrastructure based on modern technology and the ability to adapt swiftly and effectively to changing circumstances.

All this will be a small price to pay for ensuring that one of the most vulnerable groups of people in our society have the additional safeguards and support which they need and that the staff and management who strive to look after them are helped to do so in a positive and constructive way. We cannot afford to lose the Mental Health Act Commission. The Government would be foolish to miss the opportunity to enhance its usefulness to all concerned.

Casenotes

Charges for Services Provided Under S.117 Mental Health Act 1983

*Nicola Mackintosh**

R v London Borough of Richmond Upon Thames ex parte Watson, R v Redcar and Cleveland Borough Council ex parte Armstrong, R v Manchester City Council ex parte Stennett, R v London Borough of Harrow ex parte Cobham

Court of Appeal (27th July 2000) 3 CCLR 276

This case has finally confirmed that charges may not be made for aftercare services (including accommodation) provided under s.117 Mental Health Act 1983, and clarifies the circumstances in which such aftercare services must still be provided to discharged patients free of charge.

The proceedings were brought by four applicants against decisions/policies of four local authorities to charge for residential accommodation which was provided to the applicants upon their discharge from liability to be detained under the compulsory treatment provisions of the 1983 Act. Two of the applicants were subject to guardianship under s.7 of the Act, having previously been detained under s.3 (admission for treatment), and were required as a condition of the guardianship provision to reside in the placement, for which they were being charged. One further applicant had previously been detained under s.3. The fourth applicant had been discharged from detention under s.3 and was subject to the 'aftercare under supervision' provisions of s.25A of the Act with a condition of residence in the care home. She had sold her property in order to pay for the residential care home fees.

In addition to the main issue of charging for services under s.117, two subsidiary issues were raised. The first was whether a person who was 'liable to be detained' under s.3 of the 1983 Act and granted leave of absence under s.17 of the Act was a person to whom the provisions of s.117 applied. The second issue was whether the effect of s.19 of the 1983 Act (which provides for the transfer of a patient under s.3 to guardianship) was to erase the existence of the original s.3 detention, and thus render that patient outside the scope of s.117 completely.

The Respondent local authorities argued that s.117 was not a free standing service provision duty. They contended that it merely converted the powers/duties to provide services (including accommodation) under other provisions in community care legislation into an individual duty to the patient concerned. Further, s.21 National Assistance Act 1948 provided a complete statutory

* *Partner, Mackintosh Duncan, Solicitors, London. Solicitor instructed by one of the four Applicants in the case, and the solicitor instructed by the applicant in ex parte Coughlan.*

regime for the provision of accommodation for those in need of care and attention, such as the Applicants, for which charges must be made under s.22 of the 1948 Act. The Respondents sought to introduce extracts from Hansard in support of their arguments. Finally, the Respondents maintained that there would be a 'perverse incentive' created if aftercare services under s.117 were free of charge, as people would take action to ensure that they were detained under the longer treatment provisions of the Mental Health Act in order to avail themselves of free services. Those already in residential accommodation by virtue of their mental disorder would take steps to ensure that they remained there.

In respect of the subsidiary issues, the Respondent local authorities argued that a patient who was on leave of absence was still 'liable to be detained' and thus was excluded from the scope of s.117, as s.117 refers to patients who 'cease to be detained'. Further, the Respondents maintained that s.19 of the Act had the effect of 'cancelling' the patient's detention under s.3 by transferring the person into guardianship, and thus the patient was treated as never having been detained under s.3 so the provisions of s.117 would not apply.

Judgment of the High Court (28 July 1999)[1]

Mr Justice Sullivan accepted all of the submissions made on behalf of the Applicants, and rejected the Respondents' arguments set out above.

He held that s.117 Mental Health Act 1983 is a free-standing duty to provide aftercare services to particular patients detained under the Act. That the duty was free-standing and did not refer back to the other duties/powers under other community legislation was clear from the wording of the section itself, and from s.46(3) NHS and Community Care Act 1990, which defines community care services as those which a local authority had a power to provide under, inter alia, s.117 itself. The fact that 'aftercare services' were not defined was not an argument for reverting to the duties/powers under other legislation. It was not surprising that no restrictive definition was given since the duty was jointly placed upon both the health authority and the local authority and maximum flexibility was intended to be given to the statutory aftercare authorities in the provision of services to this group of patients.

The Court was not assisted by the reference to Hansard extracts, as not only was there no ambiguity in s.117 itself, but there was no clear statement by the Minister and promoter of the Bill of the mischief which Parliament had intended to address. Indeed, if policy was of relevance, it was notable that the Parliamentary Under-Secretary for State, Paul Boateng, had stated in an answer to a parliamentary question on this issue in July 1998 that no charges may be made for services under s.117, whether domiciliary or residential. The submission that if services were free of charge, there would be a 'perverse incentive', was far-fetched.

The duty under s.21 National Assistance Act 1948 to provide accommodation for those 'in need of care and attention' arose only where the accommodation was 'not otherwise available', and as such services were available under the provisions of s.117, the patients were outside the scope of s.21(1). If any further clarification were needed, the prohibition in s.21(8) preventing the local

1 *[1999] 2 CCLR 402. A case note by Nicola Mackintosh describing, and commenting on, this decision, was published in Legal Action in September 1999 (pages 19/20). We are grateful to the Legal Action Group for their permission to reproduce in this article, some of the comments made within that case note by Ms Mackintosh.*

authority from providing any services under s.21which were 'authorised or required to be made by or under any other enactment' left the position in no doubt. In this regard, the Court was assisted by the judgment in *R v North and East Devon Health Authority ex parte Coughlan and Secretary of State for Health and Royal College of Nursing*[2] which confirmed that the words 'by or under' encompassed a wider range of services than those authorised or required to be made 'under the National Health Service Act 1977' (the second limb of s.21(8)).

There was no express or implied statutory provision authorising or requiring the making of charges for aftercare services under s.117. Indeed, it was notable that s.17 Health and Social Services and Social Security Adjudications Act 1983 (which gives local authorities a discretion to charge for some community care services) omitted any reference to s.117.

The scope of 'aftercare services' under s.117 extended to those services which a person required by virtue of their mental disorder, and the duty to make provision continued until a joint decision was made by the aftercare bodies that the patient was no longer in need of those services. The Court was of the view that in the case of a patient who had been admitted to residential care by virtue of mental disorder before detention under s.3, if the accommodation was still required upon discharge due to the mental disorder, it must be provided free of charge. If the accommodation was required as a result of a physical disability or illness, as opposed to mental disorder, then the position might be different, but this would depend on the facts of the individual case.

On the subsidiary issues, the Court held that a patient on leave of absence under s.17 of the 1983 Act was a person to whom the duty under s.117 was owed. It would be 'remarkable' if a person on leave fell outside the scope of s.117 especially as a condition of residence was likely to be imposed in such cases and non-compliance would lead to re-admission.

On the issue of transfer from liability to detention under s.3 to guardianship, it was held that s.19 MHA was intended to prevent an artificial extension of time before a review of the patient's condition took place. Thus the duty under s.117 applied to such patients.

Leave was granted to the Respondents to appeal on the basis that although the Respondents' case was not arguable, the case raised issues of national importance.

The Judgment of the Court of Appeal

The appeal was heard before Lord Justices Otton, Buxton and Mr Justice Hooper, judgment being handed down on 27th July 2000.

As in the High Court proceedings, the authorities argued that:

1. After services under s.117 Mental Health Act 1983 are not defined, thus indicating that the specific powers/duties to provide aftercare services must be found in other social welfare enactments.
2. The aim and purpose of the duty under s.117 is to create a specific individual duty to provide aftercare services, thus reflecting the particular need for persons to whom s.117 applies to be protected from 'falling through the net'.
3. Thus, s.117 MHA is a 'gateway' section, and has no content itself other than refining the powers/general or target duties under other enactments to a duty to an individual service user.

2 *[1999] 2 CCLR 285*

4. S.21 National Assistance Act 1948 provides a complete statutory framework for the provision of residential accommodation for those in need. S.117 places a duty on the authorities to provide accommodation under s.21 NAA where this is required.
5. There is an obligation to charge for residential accommodation under s.21 NAA (s.22 NAA)
6. To permit or indeed oblige the statutory authorities to provide accommodation free of charge would result in a 'windfall' of welfare benefits for those subject to the duty under s.117; result in inequality and absurdity; and create a 'perverse incentive' for the mentally disordered and the professionals involved in their care.
7. The fact that the practical position 'on the ground' as to which services were provided by the statutory agencies had altered since s.117 was enacted, yet the language of s.117 MHA had not been amended since that time; was indicative of an interpretation in favour of a 'gateway section'.

On behalf of the service-users, it was argued that:

1. The starting point must be the language of s.117 MHA itself.
2. There is no reference in s.117 to it being an 'gateway section', unlike other examples apparent in social welfare legislation (see for example, s.2 Chronically Sick and Disabled Persons Act 1970, which refers to services being provided under the powers in s.29 NAA but accessed via s.2 itself).
3. There is no express authority to charge for s.117 services and thus charges may not be made.
4. The duty under s.21 NAA only arises when accommodation required 'is not otherwise available' (s.21(1) NAA). As it is 'otherwise available' under s.117, there is no duty under s.21 NAA. It is not s.21 accommodation, but 's.117 accommodation'.
5. If the positions were in doubt, the inclusion of s.21(8) NAA is determinative of the fact that accommodation provided under s.117 is just that - it is not accommodation provided under s.21 NAA. S.21(18) confirms the 'last resort' nature of s.21 NAA accommodation in that it prohibits the provisions of accommodation under s.21 where there is a power (or duty) to provide accommodation 'by or under any other enactment'.
6. The fact that aftercare services under s.117 are not defined results from the wide range of needs and services that may be required for this uniquely vulnerable client group - the precise services provided to meet the identified needs are determined via a multidisciplinary assessment of the individual needs of the service user.
7. S.46(3) NHS and Community Care Act 1990 defines 'community care services' for which the local authority must assess a person's needs and reach a service provision decision. S.117 is defined as a subset, which an authority may provide. It cannot, therefore be a gateway section.
8. There is no absurdity or inequality created in the provision of services under s.117 free of charge - any 'windfall benefits' can be avoided by a simply amendment to the social security regulations. Indeed, there is a positive benefit to the provision of aftercare services being free of charge in that there are reduced barriers to persuading those in need of services to access those services, without the disincentive of a financial penalty.

The judgment of the Court of Appeal upheld the decision of Mr Justice Sullivan in the High Court and determined that:

1. The wording of S.117 MHA itself is unambiguous in imposing a free-standing duty to provide aftercare services on health and local authorities. It would be artificial and contrary to the plain meaning of the section to interpret the section as a 'gateway' provision.
2. The reference to services 'provided under s.117' to be found in s.25 A-J MHA (inserted by the Mental Health (Patients in the Community) Act 1995) would not have been phrased as such if s.117 was a 'gateway' section.
3. S.21(1) and S.21(8) NAA are supportive of the argument that s.117 is not a gateway section, as the duty under s.21 is specifically disengaged where the authority has the power/duty to provide accommodation by or under any other enactment.
4. S.46(3) NHSCCA makes it clear that s.117 is concerned with the direct provision of services and not merely a gateway section to the provision of services under other enactments.
5. The concept of 'windfall' was unconvincing in the context of the provision of services for those who have been compulsorily detained in hospital and who may be amongst the most seriously ill and needy in society.
6. The 'perverse incentive' argument was unattractive. This was a slur on the members of the medical profession who are responsible for taking a decision as to whether a person should be detained under the compulsory provisions of the Mental Health Act 1983.
7. The imposition of a joint duty under s.117 on both health and local authorities is consistent with a 'seamless provision' of services, and it would be inequitable for the local authority to charge for services where the health authority had no such power to charge.
8. There was no benefit in resorting to reference to Hansard. There was no ambiguity in s.117, and therefore the application of the principle in *Pepper v. Hart*[3] was not appropriate. In any event, there was nothing in Hansard that supported the authorities' case.
9. Permission to appeal was refused.

The local authorities have now lodged a petition with the House of Lords in respect of a renewed application for permission. The outcome of the application is awaited, but may not be determined for several weeks or months.

Comment

A case involving the issue of charging under s.117 MHA has been long awaited. It is now clear (subject to the outcome of any appeal to the House of Lords) that s.117 is a free-standing duty and that no charges may be made for any aftercare services (including accommodation) which are needed by virtue of a person's mental disorder. The High Court judgment also provides a welcome insight into the circumstances in which the duty under s.117 may lawfully be terminated.

Local authorities and Health Authorities will need to consider carefully their criteria and any policies relating to service provision for this client group. In particular, those authorities who have

3 *[1993] 1 All ER 42. The principle determined by the House of Lords in this case, was that where the precise meaning of legislation is uncertain or ambiguous or where the literal meaning would lead to a manifest absurdity, the Courts can access Hansard (in particular, statements of the government minister, or other sponsor, responsible for the legislation) as an aid in construing the meaning of the legislation.*

policies in place that seek to 'discharge a patient from s.117' after a particular period and elect to continue provision under other community legislation while there is still a continuing need for services will lay themselves open to challenge.

There will be a need to review joint working arrangements and any eligibility criteria agreed between the agencies, given the effect of this judgment and that given in *ex parte Coughlan* (eligibility for health services). Authorities will not only need to revisit those patients who are currently 'subject to s.117', but those who are in receipt of continuing services having 'been discharged from s.117', and there are likely to be a considerable number of claims for restitution in respect of charges already levied.

The judgments of both the High Court and the Court of Appeal confirm in the clearest possible terms that the policy underlying the absence of express authority to charge users of services under s.117 is directly related to the fact that such persons are extremely vulnerable individuals for whom there should be no barriers to access to health or community care services. Such an approach is to be welcomed in a climate where resource implications feature highly in decisions regarding service provision to those in need.

A Consideration of the Approach the Mental Health Review Tribunal Should Adopt When Considering the Discharge of the Asymptomatic Patient

*David Mylan**

Regina v London South and South West Region Mental Health Review Tribunal ex parte Stephen Moyle

High Court (Queen's Bench Division)

Latham J

Judgment Given 21st December 1999

TLR 10th February 2000

The Facts

The Applicant Stephen Moyle was a Patient detained under section 37/41 of the Mental Health Act 1983 ("the Act") having pleaded guilty on the 21st November 1990 to an offence of unlawful wounding. His legal categorisation[1] had originally been one of mental illness, which had been amended to mental illness and psychopathic disorder for a time and had reverted to mental illness in 1995.

He applied for a Mental Health Review Tribunal ("MHRT") on 23rd June 1998 and was at that date and throughout the time up to his MHRT asymptomatic as a consequence of medication.

The medical evidence before the MHRT was that:-

"his condition was such as would not make it appropriate for him to be liable to be detained were he in the community[2]. However .....were he to stop taking the medication , he would quickly relapse, and that after any relapse, it would be more difficult to produce satisfactory control of his symptoms with drugs."[3]

The Psychiatrists giving evidence were all agreed that:

"were he to relapse he would pose a danger to himself and others".

It was submitted to the Tribunal on behalf of the applicant that the admission and discharge criteria should mirror each other so that if it was not appropriate for him to be admitted to detention from the community in his present condition, then he must be discharged. The applicant himself gave an

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1 *Section 1(2) Mental Health Act 1983.*

2 *The question of whether a "condition" is such as to warrant detention is a legal question that should be answered following receipt of medical evidence. Had the Psychiatrists who gave the evidence had the benefit of the Moyle Judgment when making their assessment, the assessment of detainability might have been different.*

3 *Paragraph 2 of the Judgment.*

assurance to the MHRT that were he to be discharged he would continue with the medication. The MHRT rejected the legal submission and did not accept the patient's assurance, as:-

"they could not be satisfied that his mental illness was not of a nature which made it appropriate for him to be liable to be detained in a hospital for medical treatment, nor that he would not be a danger to himself or others were he to be discharged".

The applicant sought judicial review of the MHRT's decision on the basis that it was unlawful because the MHRT had misdirected itself as to the law to be applied to an application for discharge, and irrational, in that the medical evidence was only capable of supporting the conclusion that he should be discharged.

The Law

When a MHRT considers an application from a patient or a reference of a patient detained under either an order for admission for treatment[4] or a hospital order[5] with or without a restriction order[6] it **must** order the discharge of the patient if satisfied that either:-

"he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment"[7]

or

""that it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment".[8]

The MHRT also has a general discretion (other than in the case of restricted patients) to discharge the patient when it considers it appropriate and the statutory criteria are not met.

There are separate discharge criteria[9] in respect of patients detained under an order for admission for assessment[10]; subject to Guardianship[11] [12] or subject to Aftercare under Supervision.[13] [14]

The words "nature or degree" must be construed disjunctively.[15] The double negative requires a patient seeking to obtain discharge on the first statutory ground to satisfy the MHRT that his mental disorder is not of a nature warranting detention **and** is not of a degree warranting detention.

The wording of sections 3 and 37 of the Act relating to the criteria for admission to hospital under a treatment order or hospital order respectively are unambiguous as is the wording of section 72 in relation to the criteria to be applied when considering discharge of detention. The criteria for both detention and discharge include tests that have been termed "appropriateness" and "necessity" (or "safety") tests, and the wording of the "tests" approximate to each other.

4 *Section 3*
5 *Section 37*
6 *Section 41*
7 *Section 72(1)(b)(i)*
8 *Section 72(1)(b)(ii)*
9 *Section 72 (1)(a)(i)&(ii)*
10 *Section 2*
11 *Section 7*
12 *The discharge criteria are in Section 72(4)(a)&(b)*
13 *Section 25A*
14 *The discharge criteria are in section 72[(4A)(a)&(b)]*
15 *Regina v Mental Health Review Tribunal for South Thames Region ex parte Smith [TLR 9th. December 1998]*

There is however a third test that must be satisfied before a treatment order or hospital order can be made in respect of a person suffering from either psychopathic disorder or mental impairment namely that "such treatment is likely to alleviate or prevent a deterioration in his treatment".[16] This has become known as the "treatability" test and is not expressly mirrored in the Section 72 discharge criteria.

The consequence appears to be that the untreatable psychopath (or person suffering from mental impairment) cannot be detained under the Act but if detained cannot thereafter secure their discharge through a MHRT under the mandatory criteria for discharge by showing that their condition is not treatable.

Whether this is a correct statement of the law received judicial consideration in the case of:-

R v Canons Park Mental Health Review Tribunal ex parte A[17]

In a majority decision in the Court of Appeal Kennedy LJ with whom Nourse LJ agreed considered that Parliament had deliberately omitted the "treatability" test, so that section 72 was not to be read as if it provided criteria for discharge which in some way referred back to or mirrored the criteria for admission.

Roch LJ gave a dissenting judgment and the case did not receive consideration in the House of Lords as it had become academic as a consequence of "A" being re-classified as mentally ill.

The same issue arose in Scotland some five years later in the case of:-

Reid v Secretary of State for Scotland[18]

This case was considered by the House of Lords on the construction of the Scottish statute which was accepted to be to all intents and purposes identical to the English legislation.

Although *Reid* does not expressly overrule *Canons Park* such a conclusion is inevitable and in *Moyle* Latham J states:-

"Although, at page 42H [of the judgment in *Reid*] Lord Hope expressly stated that he would not wish to go so far as to say *Canons Park* had been wrongly decided, it is in my judgment inevitable that in agreeing with Roch LJ on the issue of statutory construction, he was disagreeing with Kennedy LJ and Nourse L J."

The ratio of *Reid* is:-

"By referring to a mental disorder of a nature or degree which made it "appropriate for him to be liable to be detained", section 64 of the 1984 Act referred back to section 17 with the result that the issues which the Sheriff or Tribunal were required to address when considering an application for discharge under section 64 of a patient who was subject to a restriction order without limit of time were the same as those which had to be considered when an application was made under section 17(1) for admission to hospital."[19]

Applied to the English legislation the ratio of the House of Lords judgment is that the section 72 criteria to be applied when considering discharge should be the same as those that had to be considered for detention when making an application under section 3 (or imposing a hospital order under section 37).

16 *Section 3(2)(b) and 37(2)(a)(i)*

17 *[1994] 2All ER 659; [1995] QB 60*

18 *[1999] 2 WLR 28; [1999] 1 All ER 481*

19 *At page 482 paragraphs a - b [1999] 1 All ER*

The Decision

The court in *Moyle* applied the *Reid* principle to the case of a patient with a mental illness, who as a result of taking medication was asymptomatic. The MHRT's decision was quashed, and Stephen Moyle's case was remitted to the MHRT for reconsideration. The application for judicial review was successful as the MHRT had failed to ask themselves the correct question when considering the appropriateness of detention.

"By expressly disavowing the relevance of the admission criteria, I consider that they were wrong in law."[20]

The Tribunal concluded that Stephen Moyle's illness could not be considered to be of a degree making detention appropriate. The key issue was whether the nature of the illness made it appropriate to detain or discharge.

Mr Justice Latham stated:-

"The correct analysis, in my judgment, is that the nature of the illness of a patient such as the applicant is that it is an illness which will relapse in the absence of medication. The question that then has to be asked is whether the nature of that illness is such as to make it appropriate for him to be liable to be detained in hospital for medical treatment. Whether it is appropriate or not will depend upon an assessment of the probability that he will relapse in the near future if he were free in the community".[21]

Comment

The Test for Discharge

The case has caused some consternation amongst practitioners partly because they may have had difficulty in appreciating its significance, as they have always regarded the non-sectionable patient as a dischargeable patient and partly because the headnotes of the law reports fail to highlight the way in which the case analyses the meaning of "nature" within section 72 and in consequence re-enforces the judgment in *Smith*.[22]

The headnote in The Times Law Report of *Moyle* states:-

"On an application for discharge by a restricted patient, section 72 of the Mental Health Act 1983 was to be construed by reference to the statutory criteria for hospital detention set out in section 3 of that Act."[23]

The headnote in Lawtel states:-

"The same criteria had to be applied by a mental health review tribunal in relation to admission and discharge of a patient subject to a hospital order with restrictions unlimited in time, but the burden of proof was reversed for the purposes of consideration of discharge. Whether it was appropriate or not for the patient to be detained in hospital for medical treatment depended upon an assessment of the probability that the applicant would relapse in the near future if he was free in the community, and that value judgment had to be exercised in the context of the reverse burden of proof."[24]

20 *At page 22 of the Moyle judgment.*

21 *At pages 19 -20 of the Moyle judgment.*

22 *Supra*

23 *TLR 10/02/2000*

24 *LTL 14/01/2000 Document No: C7800683*

The case should not however be confined to restricted patients and must have a general applicability to any person[25] subject to the Act who has the right to make an application or be the subject of a reference to a MHRT.

The Mental Health (Patients in the Community) Act 1995 ("the 1995 Act") introduced the "Supervision Application" and required three "grounds"[26] to be satisfied before such an application can be made and three "conditions"[27] to be satisfied before a renewal can take place. The 1995 Act also amended section 72 of the 1983 Act by introducing section72 (4A) which sets out the criteria to be applied by a MHRT when considering an application by a patient subject to after-care under supervision.

Parliament appears to have shown prescience in anticipating the *Reid/Moyle* issue by drafting the 1995 Act in such a way that the admission and discharge criteria co-incide exactly whether the patient has or has not left hospital at the time of the hearing. It does this by referring the MHRT back to the admission/renewal criteria (which in any event only differ to reflect the fact that on admission to section 25A the patient has not yet started to receive section 117 services whereas on renewal he is receiving them).

Rather than re-iterating the admission "grounds" 72(4A) states that the MHRT shall direct that the patient shall cease to be subject to s25A if satisfied that the "conditions set out in section 25A(4) [in the case of a patient still in hospital] [section 25G(4) in any other case] are not complied with."

Section 72(4) sets out the criteria for the discharge of a Guardianship Order and mirrors the admission criteria set out in section 7(2) [and section 37(2)(a)(ii)] of the Act.

The Burden of Proof

Richard Gordon QC counsel for Stephen Moyle (who was also counsel for "A" in the *Canons Park* case) submitted "that by its very nature, the Tribunal was a reviewing body". This was emphatically rejected by Mr. Justice Latham in the following terms:-

"In my judgment, for the reasons that I have already indicated, this submission is based on a misunderstanding of the nature of the Tribunal's jurisdiction in relation to restricted patients. They have an original jurisdiction, in which they have to exercise their own judgment, based on the evidence before them."

There is no authority for suggesting that the jurisdiction of the MHRT should differ in respect of restricted and non-restricted patients although the power in relation to discharge differs. It therefore appears that *Moyle* is authority for the proposition that a MHRT is a judicial body with original jurisdiction and not an appellate or reviewing body.

In the *Canons Park* case Kennedy LJ stated[28]:-

"The first thing to be noted about section 72(1)(b) is that the tribunal is only required to direct discharge if it is satisfied of a negative - first, that the patient is not then suffering from [a specific form of mental disorder].If he may be, the obligation does not arise".

This supports the generally held view that the burden of proof is placed on the patient and this view is reinforced in the judgment of Mr Justice Latham.[29]

25 *That is subject to Section 2, Section 3, Section 7, Section 37 or Section 25A.*

26 *Section 25A(4) (a) (b) and(c).*

27 *Section 25G(4) (a) (b) and(c).*

28 *[1994] 2 All ER at 683*

29 *Page 20 of the judgment.*

That value judgment [referring to the probability of relapse as a factor in determining the nature of a mental illness] has to be exercised in the context of the reverse burden of proof".

Moyle was however dealing with an application by the patient and it may be that in the case of a reference to the MHRT[30] a distinction can be drawn and that in such cases the burden of proof rests with the party seeking to detain. This submission is made because a requirement for the patient to prove he does not possess a mental disorder before the judicial body with original jurisdiction to determine the question would appear to be contrary to the decision of the European Court of Human Rights (ECHR) in:-

X v United Kingdom[31]

Paragraph 40 of the judgment of the ECHR in *X v UK* quoted with approval the judgment of the ECHR in :-

Winterwerp v The Nederlands[32]

Paragraph 40 states:-

"In its *Winterwerp* judgment of 24 October 1979, the Court stated three minimum conditions which have to be satisfied in order for there to be "the lawful detention of a person of unsound mind" within the meaning of Article 5 par. 1 (e) [of the European Convention of Human Rights ("the Convention")]: except in emergency cases, the individual concerned must be reliably shown to be of unsound mind, that is to say, a true mental disorder must be established before a competent authority on the basis of objective medical expertise; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such disorder".

A periodic reference to a judicial body is required in order to comply with the requirement that the lawfulness of the detention be reviewed at reasonable intervals.

Paragraph 52 of the *X v UK* judgment states:-

"....it would be contrary to the object and purpose of Article 5 to interpret paragraph 4 as making this category of confinement immune from subsequent review of lawfulness merely provided that the initial decision issued from a court. The very nature of the deprivation of liberty under consideration would appear to require a review of lawfulness to be available at reasonable intervals."

If it is a correct statement of the law that the balance of the burden of proof is on the patient then it follows that there is no requirement for the detaining authority to adduce any evidence to support the lawfulness of continuing the detention. In circumstances when the patient elects not to participate in the proceedings either as a consequence of a mental disorder or for other reasons; or in circumstances when the patient lacks capacity to give instructions, (notwithstanding the incapacity may not satisfy the MHA detention criteria) the MHRT would in consequence be required to uphold the lawfulness of the detention despite the absence of any evidence of the persistence of the disorder. Such an approach appears to be contrary to the requirement of the MHRT to make its decision on the basis of "objective medical expertise", and would lead to the judicial body with original jurisdiction to determine whether a person has a mental disorder of a nature or degree such as to make detention appropriate, making a decision to detain in the absence of any evidence.

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30 Section 67(1), Section 68(1), Section 68(2), Section 71(1), Section 71(2), Section 71(5) and Section 75(1)(a).

31 (1981) 4 E.H.R.R. 181; 1 B.M.L.R. 98

32 (1979) 4 E.H.R.R. 387

It follows that there is an argument that those seeking to justify detention must adduce the necessary evidence, that is the burden of proof should lie with them, in order to comply with Article 5 of the Convention.

When a MHRT is seized with an application by a patient detained under a hospital order the patient is in effect requesting the MHRT not to wait until the statutorily prescribed time for reconsideration that would arise as a consequence of a reference, and to reconsider whether the circumstances that pertained at the time of the imposition of the order by the Court still pertain. In these circumstances there is a logic in placing the burden of proof on the applicant.

Where the application is made by a patient detained under Part II of the Act there is no original judicial authority for the detention and the situation would appear to be closer to that of a reference than to that of a hospital order.

The Criteria for Discharge are Mirror Images of the Criteria for Admission

At page 17 of the *Moyle* judgment Mr Justice Latham states:-

"I accept Mr Gordon's submission that the decision in Reid requires the question of discharge to be approached on the basis that the criteria for discharge are meant to be matching or mirror images of the admission criteria."

It is this part of the decision that has received prominence in the headnotes of the reports and has attracted most interest from practitioners. It is a clear statement of the law but is as Mr Justice Latham makes clear only a reiteration of the ratio of the House of Lords judgment in *Reid*. The significance of the statement may prove to be not in respect of discharge but in respect of admission.

If the criteria for discharge mirror the admission criteria then it is inescapable that the criteria for admission mirror the discharge criteria.

When consideration is being given as to whether an asymptomatic person diagnosed as schizophrenic or with a bi-polar affective disorder should be detained when the illness can not considered to have any ascertainable "degree", but the "nature" is well known as a consequence of the history, it would appear appropriate to ask whether in the light of the person's comments about medication, they would on that day be successful in securing their discharge before a MHRT had they been detained in hospital.

If the person is ambivalent about continuing with medication and the history shows that their health or safety or the safety of others is at risk when symptomatic, a MHRT applying the "nature" test proposed by Mr Justice Latham (supra) would be likely to decide that they do not meet the "appropriateness" test for discharge. If this is the case it follows as a consequence of the mirror criteria that if the nature of the illness is such as to justify detention they could be admitted for treatment under section 3. Such a conclusion appears to be a natural consequence of the *Smith* decision referred to earlier.

Conclusion

Although Moyle is already being used by practitioners[33] to support a submission before a MHRT that as the health of the patient on the day of the hearing is such that he could not be "sectioned" he should therefore be discharged, the use of the case in this way is both superficial and fails to appreciate the true significance. The importance of the case rests on the lucid exposition of the meaning of the word "nature" within the Act and the importance for the asymptomatic patient of appreciating the role of medication in his treatment and the significance of demonstrating to the Tribunal his commitment to continuing with it when not subject to the compulsion that follows from detention.

33 *Personal knowledge of the writer gained in his capacity as MHRT legal member.*

Treatment for Mental Disorder - another step backwards?

*Simon Foster**

R v Collins and Ashworth Hospital Authority ex parte Brady

Maurice Kay J Liverpool District Registry

(Judgment given 10th March 2000 - at time of going to print the decision is unreported.)

Appearances: Mr Nigel Pleming QC and Ms Eleanor Grey (Reid Minty) for the Respondent; Mr Benet Hytner QC, Ms Philippa Kaufmann and Mr Robin Makin, solicitor advocate (E Rex Makin and Co) for the Applicant.

Introduction

The case concerns the right of a psychiatric patient to choose to die by refusing intervention from the hospital. The Court considered the treatment provisions of Part IV of the Mental Health Act, capacity at common law and the legitimate interests of society in preserving life. However the notoriety of Mr Brady, and his own personality, meant that underlying the judgment were considerations of public policy as much as legal analysis.

The facts

The Applicant, Ian Brady, was 62 years old at the date of the hearing. In 1966 he was sentenced to three concurrent terms of life imprisonment, for which the Secretary of State fixed a whole life tariff. Mr Brady accepts that he will never be released. In November 1985 he was transferred to the then Park Lane Hospital (now incorporated into Ashworth) under section 47 Mental Health Act 1983. In 1995 he was moved to Jade Ward, and restrictions were put on his freedom. By way of compensation he was granted the use of a personal computer and special visiting arrangements. However, following the publication of the Fallon Report[1] the computer was withdrawn and security for visitors was increased. In addition the Applicant began to fear a return to the prison system. On 18th June 1999 an automatic tribunal review confirmed that the Applicant was correctly detained in hospital.

In September 1999 the Acting Medical Director arranged a meeting to review security on Jade Ward. It was agreed that the Applicant should be moved as soon as possible to a more secure environment. On 30th September, while the Applicant was writing in his room, a six-person team entered in full riot gear without explanation, strip searched him and took him to a waiting van which transferred him to Lawrence Ward. The Applicant was under restraint for about fifty minutes, during which time he offered little or no resistance. His arm was injured, possibly

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1 *The Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital. Cm 4194 (1999) The Stationary Office.*

fractured, during the process. No-one told him why he had been moved; he feared he was being transferred to prison. The Applicant has never assaulted or offered physical resistance to staff, either in hospital or before that in prison.

The Applicant's response was to refuse food or sweetened drinks. He was on hunger strike continuously until the date of judgment. It is clear from his records that his initial purpose was to protest, not to starve himself to death; he had used hunger strikes as a tactic some years previously.

At the end of October his new Responsible Medical Officer, Dr Collins, expressed the view that the clinical team should intervene to prevent deterioration in the Applicant's condition. On 29th October force-feeding commenced, by way of a naso-gastric tube. The Applicant did not consent to this but offered no resistance either. Dr Rix, a consultant forensic psychiatrist, offered a second opinion, but the Applicant refused to see him.

Professor Sines, who was appointed by Ashworth to consider the Applicant's complaints, reported on 30th November 1999. He was strongly critical of the move but decided that it had been correct to commence force feeding.

On 19th October and 3rd December 1999 and 17th February 2000 the Applicant was interviewed by Professor Maden, who had seen him several times before at the request of his solicitors. Following the 3rd December interview Professor Maden reported that the Applicant had thoughts of suicide, based on a rational argument that the regime to which he was subjected made his life intolerable. He could not say under what circumstances he would be prepared to end his protest.

The Applicant's application for judicial review sought to challenge "the continuing decision... to force feed the Applicant,... apparently made pursuant to section 63 of the Mental Health Act 1983." Permission to apply for judicial review was granted on 2nd February 2000 by Forbes J, who also directed that the psychiatrists should attend for cross-examination. The present judgment was given in open court.

The law

Section 63 Mental Health Act 1983 (MHA): "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 under section 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer."

Section 145 MHA: 'medical treatment' includes "nursing, and also includes care, habilitation and rehabilitation under medical supervision."

Medical treatment has been given a particularly wide interpretation in cases of psychopathic (personality) disorder: *Reid v Secretary of State for Scotland*[2]. In *B v Croydon Health Authority*[3] Hoffman LJ stated: "Nursing and care concurrent with the core treatment or as a necessary prerequisite to such treatment or to prevent the patient from causing harm to himself or to alleviate the consequences of the disorder are, in my view, all capable of being ancillary to a treatment calculated to alleviate or prevent a deterioration of the psychopathic disorder. It would seem strange if a hospital could, without the patient's consent, give him treatment directed to alleviating a psychopathic disorder showing itself in suicidal tendencies, but not without such consent be able to treat the consequences of a suicide attempt."

2 *(1999) 2 WLR 28 at 44*

3 *(1995) 1 All ER 683 at 687*

Precedent facts and 'super-*Wednesbury*'

Mr Hytner QC, for the Applicant, submitted that the court had first to decide whether force feeding was **in fact** treatment 'for the mental disorder from which he is suffering'. The fact that Dr Collins, the RMO, had reasonably believed it to be so was not the point, as this was a 'precedent fact' without which the treatment could not be covered by section 63: see *Khawaja v Secretary of State for the Home Department*[4]. The words 'in the opinion of' the RMO did not appear in the section and should not be implied into it. Any derogation from fundamental human rights should be construed strictly in favour of the Applicant: *Khawaja* (above) and *R v Secretary of State for the Home Department ex parte Simms and O'Brien*[5]. Moreover, the so-called 'super-**Wednesbury** test' in human rights cases applied as set out in *R v Ministry of Defence ex parte Smith*[6] (per Sir Thomas Bingham MR): 'The more substantial the interference with human rights, the more the court will require by way of justification before it is satisfied that the decision is reasonable in the sense outlined above.'

Mr Pleming QC, for the Respondent Authority, submitted that section 63 should be read in the context of Part IV of the Act as a whole. No question of precedent fact arose; the court's role was limited to supervising the RMO on **Wednesbury** principles. In the same way section 62 spoke of treatment which 'is immediately necessary to save the patient's life'. If the court approached section 62 on a precedent fact basis it would seriously undermine the ability of healthcare professionals to take immediate, emergency steps to save life. Likewise, in *R v Mental Health Act Commission, ex parte X*[7] the court had held that a challenge under section 57 should be considered according to **Wednesbury** principles. In the present case, therefore, the court should not interfere with Dr Collins' judgement unless it was irrational.

The judgment

(i) Section 63

Maurice Kay J said that the psychiatrists agreed that the Applicant had a psychopathic or personality disorder. However, Professor Maden approached the matter on the basis that a person without the disorder could have made the same decision on rational grounds, while Dr Collins concluded that the decision to refuse food was caused by the personality disorder. The Applicant's response to the move had been wholly disproportionate and it was "ridiculous not to look to the personality disorder for the explanation". Dr Rix had come to a similar conclusion.

His Lordship had no doubt that the opinions of Dr Collins and Dr Rix were correct as to the part the personality disorder played in the hunger strike. He was therefore satisfied that Dr Collins' approach to section 63 satisfied both the 'precedent fact' test and the 'super-Wednesbury' test. Section 63 was triggered because what arose was the need for medical treatment for the mental disorder from which the Applicant was suffering. The fact that a person without mental disorder could reach the same decision on a rational basis in similar circumstances did not avail the Applicant because he reached and persisted in his decision because of his personality disorder. At the commencement of the hunger strike his Lordship was satisfied that the Applicant's intention was not to starve himself to death. While he could not reach a certain conclusion about the Applicant's present intention, the likelihood was that he was playing the system.

4 *(1984) 1 AC 74*
5 *(1999) 3 WLR 328 at 341*
6 *(1996) QB 517 at 514*
7 *(1988) 9 BMLR 77*

Mr Hytner had submitted that Dr Collins and his team had failed to take into account the quality of the particular life that was being preserved. That argument did not get off the ground, because the Applicant had not to this day told Dr Collins that his intention was to starve himself to death. Moreover, the Applicant was physically healthy and a significant amount of his 'impoverished' life resulted from his extremism in dealing with his circumstances and his uncompromising relationship with Ashworth. There was therefore no element of irrationality in Dr Collins' decision to force feed.

(ii) Capacity

The parties had also asked the judge to rule on the Defendants' second argument, that the Applicant lacked capacity to consent and that they had a duty at common law to act in his best interests. It was common ground that a mentally disordered patient might nevertheless have capacity, and that the test in *Re C*[8] applied. Dr Collins had reported that the Applicant had the intellectual ability to appreciate the risk of refusing food but that his ability to weigh the information was impaired by the emotions and perceptions he had at the time, which were related to his personality disorder. Dr Rix had agreed. Neither Dr Collins nor Dr Rix saw total incapacity, but rather incapacity in the area relating to his battle with the Ashworth authorities. Professor Maden, however, did not accept that the Applicant lacked capacity. Mr Hytner submitted that far more disordered minds had been held to retain capacity, for example in *Re C* (above).

His Lordship was satisfied on a balance of probabilities that, although he was a man of well above average intelligence, the Applicant had been incapacitated in relation to decisions about food refusal since 25th October. His doctors had therefore been empowered to supply medical treatment in his best interests. This was a matter of clinical judgement and subject to the test in *Bolam v Friern Hospital Management Committee*[9].

(iii) A duty to prevent suicide?

Mr Pleming submitted that even if he retained capacity the Applicant's right of self-determination was not absolute. There was a public interest in preserving life, preventing suicide and maintaining the integrity of the medical profession. In *Secretary of State for the Home Department v Robb*[10], which concerned a prisoner on hunger strike, Thorpe J had put forward the following principle: "...if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes even though they do not consider it to be in his best interest to do so". He had cited *Re T*[11], *Airedale NHS Trust v Bland*[12] and the American case of *Thor v Superior Court*[13]. However, Mr Pleming submitted that Robb simply established that there was no duty to intervene and did not address the question of whether there was a **power** to do so. More recent cases had established that police and prison officers owed a prisoner a common law duty to take care to prevent him from committing suicide or causing himself harm (see for example *Reeves v Commissioner of Police*[14]).

8 *(1994) 1 WLR 290*
9 *(1957) 1 WLR 582*
10 *(1995) 1 All ER 677*
11 *(1992) 4 All ER 649*
12 *(1993) AC 789*
13 *(1993) 5 Cal. 4th 725*
14 *(1999) 3 WLR 363*

The judge said that it would be somewhat odd if there was a duty to prevent suicide by an act, but not even a power to intervene to prevent self-destruction by starvation. He did not consider that, as a first instance judge, he had enough evidence to make a finding in this complex issue, but he did not believe that he would be constrained by authority from finding for the Respondents.

(iv) Conclusion

His Lordship was entirely satisfied that the decision to commence and continue force feeding was justified by reference to section 63 and that it was in all respects lawful, rational and fair. Even if section 63 had not applied it would still have been lawful because the Applicant had at all material times lacked capacity by reason of his disorder and the steps taken by the doctors were reasonably perceived to be in his best interests. The application was therefore dismissed.

Costs

Ms Grey, for the Respondent, asked for an order that the Applicant pay the Respondents' costs. As he was legally aided this should be in the form that determination of his liability should be postponed for such period as the Court saw fit. As Mr Brady used litigation as a tool, such an order would keep an eye on the possibility of settling for liability to costs orders.

Ms Kaufmann, for the Applicant, said that the Respondents had themselves welcomed the opportunity to have a Court determine the issue. She conceded that the proceedings were adversarial, but maintained that a public interest had been served by bringing the matter to Court. Mr Brady would have to seek the permission of the Court to commence proceedings which might result in a monetary award and obtain positive advice from his legal advisers before any such proceedings would be funded by the Legal Aid Board. It would be an improper denial of access to the Court to impose a costs order as a disincentive; the Court had mechanisms for dealing with frivolous applications.

Maurice Kay J said he would make the order for costs in the form sought by Ms Grey because it was the normal consequence of adversarial proceedings, and not for collateral purposes. He granted Legal Aid taxation and refused leave to appeal.

Comment:

It was predictable that Mr Brady would not succeed in this application. Even if he had not been the subject of such intense public interest, it is hard to imagine any judge permitting a healthy patient to take his own life by a positive act of will. Moreover, Mr Brady's approach to his detention made it likely that his hunger strike was a weapon against the hospital rather than a considered decision to kill himself. It is not therefore surprising that the judge took the view that his choice arose from his personality disorder and could therefore be overridden, both under section 63 and on the 'best interests' test at common law.

Nevertheless, there are worrying features of the judgment. Once again, Hoffman LJ's controversial dictum in *B v Croydon* is cited to justify **any** sort of medical intervention which doctors believe benefits the patient, whether physically or mentally. This goes far beyond what would be regarded, on an ordinary construction of section 63, as 'treatment for mental disorder'. Given the increased emphasis on self-determination by those with mental health problems and the prospect of human

rights challenges under Article 8, it is high time that the appellate courts looked at *B v Croydon* again.

In any event, Maurice Kay J seems to have omitted a crucial link in his judgment; the 'precedent fact' discussion does not address the point. Even if the hunger strike arose from Mr Brady's personality disorder, how can force feeding be regarded as treatment **for that condition**? If section 63 has any remaining meaning- other than 'the RMO can treat as he or she wishes'- there must surely be some connection between the treatment and alleviation of the condition. At least in *B v Croydon* the saving of life was an integral part of the treatment plan. It is not apparent from the judgment how Mr Brady's condition can be treated- but surely keeping someone alive, without more, cannot reasonably be construed as 'treatment for the mental disorder'? If it is, then *Re C* itself would have to be reconsidered.

There can be less argument with the judge's logic with regard to the incapacity issue. If Mr Brady was determined to risk his life to make a point he could reasonably be said to have not 'weighed' the treatment information. It might have been fairer if the case had been decided on this ground, rather than section 63.

The judge was probably wise to avoid ruling on the 'suicide' issue, since he did not need to do so. However, he went a considerable distance towards disagreeing with *Robb*. The fact that he did not comment upon *B v Croydon*, whether it was binding upon him or not, suggests that he was instinctively more sympathetic to intervention than self-determination- again, a public policy approach rather than a strictly legal one.

Finally, it is disappointing to see that the judge was prepared to make a costs order in a case so manifestly of public interest. This application did not simply challenge a particular decision; it raised fundamental issues of life and death upon which there was no directly applicable authority. At least he did not make the order as a deterrent to future court action, which he was invited to do. As Ms Kaufmann made clear, this would have impugned a fundamental human and Convention right of access to the Courts.

Mental Health Act Guardianship and the Protection of Children

*Ralph Sandland**

Re F (Mental Health Act: Guardianship) [2000] 1 FLR 192, CA

Court of Appeal (30th September 1999). Evans, Thorpe, and Mummery LJJ. Judgment of the Court given by Thorpe LJ.

Introduction

This case arose as a spin-off from what on the face of it was a relatively straightforward application for care orders, made by the Social Services Department of the London Borough of Hackney ('LBH'), in respect of eight siblings. The case is of interest to mental health lawyers by reason of the attempt of LBH to use creatively elements of the Mental Health Act 1983 ('the 1983 Act') regime to plug apparent gaps in the powers available to local authorities and the courts in the Children Act 1989. This entailed the court's consideration of various provisions of the 1983 Act, as they relate to persons with learning difficulties. This case will also be of interest to family lawyers, as the boundary between family law and mental health law, such as it is, was also considered by the Court of Appeal. Moreover, it is worth remembering that the backdrop to all judicial activity in the field of mental health law at present is the on-going root-and-branch reform of this area of law. As will be discussed below, this case adds to a growing number that highlight deficiencies in the operation of the current regime as it applies to adults with learning difficulties. Finally, although there is little direct discussion to be found in the law report of the judgment of the Court of Appeal, this case raises broader issues of human rights; a topic that none can afford to ignore in light of the Human Rights Act 1998.

The Facts

The appeal concerned the plans proposed by LBH in respect of T, the eldest of eight children born to the F family between 1981 and 1992. All eight had been the subject of Emergency Protection Orders (EPOs) made on 11 November 1998. The F children were taken from their home and placed in various local authority accommodation. T, along with two of her sisters, was placed in a specialist children's home. This was intended by LBH as a first step to the seeking of full care orders. The basis for the intervention of LBH was claimed neglect of the F children by their parents, and the particular claim that the F children were exposed by their parents to adults 'prone to sexual abuse or exploitation of children' in the words of Thorpe LJ[1]. The care order hearing was pending at the time of the instant case. The Court of Appeal was therefore confronted with allegations rather than proof of inadequate parenting.

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1 *[2000] 1 FLR 192 at 193 D-E. All subsequent references will be to this report unless specified.*

An EPO lasts for a maximum of eight days in the first instance[2], renewable for one further period of seven days[3]. Eight days after the EPOs had first been made, interim care orders were made in respect of the seven youngest children of the family. However, in the intervening period T had passed her seventeenth birthday and so could not be made subject to a care order[4]. In her case, therefore, the EPO was renewed for a further seven days. Thereafter, the order lapsed, although T remained in local authority accommodation on a voluntary basis. During that time she was examined by a consultant paediatrician, who formed the view that she had experienced sexual intercourse. Some two months later, T's parents announced that they wished for T to return home. As T was being 'voluntarily accommodated' by LBH, s.20(8) Children Act 1989 provides that persons with parental responsibility 'may at any time remove the child'. There is no requirement that notice be given.

T also wished to return to live in the family home. LBH was concerned that T would again be exposed to the risks that had prompted their initial intervention. As T could not be made subject to a care order, LBH felt that it had to seek another mechanism to ensure her protection. Of the options open to it (discussed further below), it chose to seek a Guardianship Order under s.7 of the 1983 Act, on the grounds that T was 'mentally impaired' within the meaning of that Act, having a 'mental age' assessed at between five and eight years of age, and that it was necessary for her welfare and protection.

An order under s.7 of the 1983 Act cannot be made without the consent of the 'Nearest Relative' of the person to be made subject to the order[5]. In the present case that person was Mr. F, T's father, who would not give his consent. However, there is provision[6] for the substitution of the Nearest Relative on grounds, *inter alia*, that that person 'objects unreasonably' to the guardianship application or has objected 'without regard to the welfare of the patient'. Shoreditch county court had, on the application of LBH, made an order under s.29 of the 1983 Act, by which Mr. F had been replaced by a LBH social services department officer as Nearest Relative. A Guardianship Order had then been made by LBH.

Mr. F appealed, challenging the decision of the county court to displace him as Nearest Relative. A narrow reading of the case, therefore, would deem the issues to be the interpretation of the powers given to the county court by s.29 of the 1983 Act and, tangentially, the circumstances in which an order under s.7 of the Act is appropriately made. However, as Thorpe LJ noted, 'the real issues in the case surround the neglect, abuse and protection of children'[7]; and the desire to attend to these issues drew the Court of Appeal into a consideration of a broader legal terrain than might have been the case had a narrower construction of the case been adopted.

Judgment

The Court of Appeal allowed the appeal, holding that Mr. F could not be said to have been objecting unreasonably to the making of the guardianship order as this was not a suitable case for the making of such an order.

The court reached that relatively straightforward conclusion by a rather less straightforward reasoning process. The issues in this case are strung together like a daisychain: whether Mr. F could

2 *Children Act, 1989, s.45(1).*
3 *Children Act, 1989, s.45(5).*
4 *Children Act, 1989, s.31(3).*
5 *Mental Health Act 1983, s.11(4).*
6 *In s.29 of the 1983 Act.*
7 *At 193 C.*

be said to have objected unreasonably to the guardianship application depended on whether it could be said that the guardianship order had been appropriately sought and made. This in turn depended not only on whether the requirements for the making of such an order had been satisfied, but also on whether there was a more appropriate alternative course of action open to LBH.

The Construction of 'Mental Impairment'

The court dealt first with the construction of the relevant words of the 1983 Act. 'Mental impairment' for the purposes of the 1983 Act, including its provisions relating to guardianship orders, is defined in s.1(2) as

> A state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned

As Thorpe LJ discussed at some length, the reason for the association of the fact of mental impairment with abnormally aggressive or seriously irresponsible behaviour that s.1(2) makes, is to exclude from the ambit of the legislation all but 'the small group to whom we wished it to apply'[8], that is, mentally impaired persons 'for whom detention in prison should be avoided,[9].

Applying this approach, the court decided that T's desire to return home should not be construed as 'seriously irresponsible', notwithstanding that LBH had concerns that this would expose T to risk. In the view of the court, this was a judgment that to a considerable extent turned on the facts of the case. The court decided that LBH's concerns related to a household of ten, rather than one of three, and that there was considerably less risk of neglect if T were the only child of the family living at home[10]. It also noted that the vast majority of children who are received into local authority care return home by the age of eighteen, so that it could not be said that T's desire was seriously irresponsible by comparison with that of other young people in her situation. Indeed, it was 'natural'[11]. Finally it was pointed out that two of the four incidents cited by LHB as evidence of risk to T occurred at school, which she continued to attend whilst living in the children's home[12]. Preventing her from returning home would not reduce her exposure to these risks.

The Choice between Guardianship and Wardship

Having decided that T's desire to return home could not be labelled as 'seriously irresponsible' and so did not fall within the scope of Part II of the 1983 Act, the court then turned to consider the alternative course of action in this situation. It was held that, rather than looking to the Mental Health Act, those in the position of LBH should invite the court to give leave to invoke the inherent jurisdiction of the High Court, under the procedure found in s.100(3) Children Act 1989. This would have the effect of making T a ward of court. The court noted a number of advantages that this mechanism has over the use of guardianship.

8 *Lord Elton, introducing these words into the Mental Health (Amendment) Bill, the forerunner of the 1983 Act, on 19th January 1982.*

9 *Ibid.*

10 *At 198 D-E.*

11 *At 198 C.*

12 *At 198 G-H.*

First, a court operating under the inherent jurisdiction 'would have ensured [T's] continuing protection in the exercise of its almost unlimited powers'[13]. The Guardianship regime, by contrast, has since the coming into force of the Mental Health (Amendment) Act 1982[14], operated a circumscribed 'essential powers' approach, which had been introduced purposefully to reform the extremely wide and vaguely defined powers which a guardian enjoyed under the Mental Health Act 1959. Under the existing law, a guardian has three powers: to specify where the person subject to the order shall live; to require that person to attend specified places for the receipt of medical treatment, occupation, education or training; and to require that access to the person subject to the order be given be given to any doctor, approved social worker or other specified person[15]. In the view of the court these powers are simply not designed to be flexible enough to deal with all the welfare and protection issues that may arise in the case of a young person like T.

Secondly, by extension, the court pointed out that the guardianship regime is not a child-centred jurisdiction[16]. Indeed, guardianship is only available for persons aged sixteen and over[17]. Wardship by contrast is exclusively concerned with the protection and furtherance of the best interests of the child. Had T been made a ward of court, she would have been represented by the Official Solicitor, who would have carried out an independent inquiry into the situation, and have provided the court with a report of that inquiry[18]. The Official Solicitor could also have provided independent legal representation for T in court[19]. In the Guardianship regime, by contrast, r 12(3)(b), Civil Procedure Rules 1998 specifically provides that the person to be made subject to a guardianship order shall not be made a respondent in a disputed s.29 application. The court held that 'T would have been advantaged by that aspect of the wardship jurisdiction', whilst the situation under the Mental Health Act 'seems a comparatively impoverished alternative'[20].

Finally, the court noted, had wardship been invoked it would have been possible for one judge to consider the interests of all eight children together in consolidated proceedings, whereas the choice of guardianship had channeled T away from her siblings[21]. Taking all these points together, the court concluded that guardianship was in any case less suitable than wardship as a mechanism to best protect the interests of a young person such as T.

Commentary

On one view, seemingly the view of the Court of Appeal, this is a case that turned on its own facts. On the question of the preferability of wardship over guardianship, the court underscored the fact that 'Clearly each case must depend on its particular facts and we would not wish to be taken as offering any general guideline'[22]. And by way of conclusion, the court again stated that 'we wish to emphasise that we have reached our conclusions on the special facts of a difficult and unusual case'[23]. Yet the fact is that this judgment does impact at the level of 'policy', and does so in a number of ways.

13 *At 193 H.*
14 *Later consolidated into the Mental Health Act 1983.*
15 *Mental Health Act 1983, s.8(1).*
16 *At 199 G.*
17 *Mental Health Act 1983, s.7(1).*
18 *At 193 H.*
19 *At 199 D.*
20 *At 199 F.*
21 *At 199 F-G.*
22 *At 198 E.*
23 *At 200 D-E.*

First, the judgment does make clear that an important element of the distinction between wardship and guardianship is that between a child-centred and an adult-centred regime. Guardianship is posited on the policy of minimum interference with the rights of the individual. Wardship is based on the much broader concept of the welfare of the child. It will be rare indeed that, when there is a choice between the two (that is when the person who is to be the subject of the order is aged sixteen or seventeen), guardianship will be the preferable option. It is not surprising that the Court of Appeal, when presented with a choice, expressed such a preference, as in this it follows earlier decisions of the court, which also have preferred to construct older children as children rather than as adults[24]. Of course, wardship was only invoked in this case because of the limitation placed on the availability of care orders by s.31(3) Children Act. But although the powers of a court exercising the wardship jurisdiction are greater than those available to a local authority over a child in care[25], nothing turns on this in the present context, since a care order shares many of the advantages of wardship by comparison with guardianship.

Secondly, it provides confirmation that 'abnormally aggressive or seriously irresponsible conduct', which features in the definition not just of 'mental impairment', but also of 'severe mental impairment' and 'psychopathic disorder' in s.1(2) of the 1983 Act, is to be construed narrowly. It is interesting to note, first, that the court emphasised that those found to be seriously irresponsible became liable not only to guardianship but also to civil confinement[26]; and, second, that in arriving at its conclusion the court focused not on the words themselves, but on the intention behind them. For the fact is that, although this form of words was selected, according to Lord Elton 'after a long dictionary search and a good deal of discussion'[27], their meaning is not transparent. This is because 'abnormal aggression' and 'serious irresponsibility' are more moral-political than medical concepts, and so their meaning will always contain a considerable subjective element. They are in fact words upon which meaning is *imposed* by the reader.

The real significance of the decision of the court on this point, then, is that by turning to the, highly contextualised, intention of the framers in 'giving meaning' to this phrase, the court reaffirmed civil libertarianism over paternalism in the use of guardianship, turning its back on the opportunity to start a process which may have extended the scope of guardianship considerably. It would not have involved any particular corruption of the English language to hold that T was exhibiting 'seriously irresponsible conduct' in returning to live in a home at which she was at real risk of sexual abuse and neglect. It would, however, have involved a muddying of the ethos behind the scheme. And who could say where, if T's conduct fell on the 'seriously irresponsible' side of the line, that line would be drawn in future cases?

We know, from the case of *R v Hall* (1988) 86 Cr App R 159 (CA) that both 'severe mental impairment' and 'mental impairment' are to be assessed in the context of the Sexual Offences Act 1956 by reference to normally developed persons. Although there is some uncertainty regarding the transferability of this decision into the context of the interpretation of the 1983 Act[28], *Hall* nevertheless seems to suggest that 'abnormally aggressive or seriously irresponsible conduct'

24 *Re R (A Minor) (Wardship: Consent To Treatment) [1991] 3 WLR 592; Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1992] 3 WLR 758.*

25 *For example, s.34, Children Act 1989 limits the restrictions that a local authority can place on contact between a child in care and his or her parents and other defined carers. An authority can, however, seek the permission of a court to prevent contact.*

26 *At 198 B-C.*

27 *Lord Elton, op cit, cited by Thorpe LJ at 197 C-D*

28 *See P.Bartlett and R. Sandland, (1999) Mental Health Law Policy and Practice, London: Blackstones Press, pp 27-29.*

should be defined in the same way. And on one level this is what the Court of Appeal proceeds to do, holding essentially that T's desire to return home is 'natural'; that is, normal; that is, not sufficiently distinct from normally developed young persons. But for the court, it was in any case 'simply inapt'[29] to construe T's conduct as falling within the s.1(2) definition; and this is a statement about the underlying policy of the 1983 Act, rather than about the particular facts of the case. In the sense that this view is not dictated or governed by legal rules, it is an extra-legal judgment: the judge as citizen or as politician but not as lawyer.

This should not be taken to imply, however, an argument that the Court of Appeal adopted the 'wrong' policy. It seems unarguable that the 'essential powers' approach is unsuitable to meet the needs of a person such as T. For instance, the court noted in passing that LBH had placed restrictions on contact between T and her parents, purportedly under the powers given by the guardianship order, which in the court's view were of doubtful legality[30]. The point was incidental to the appeal and so perhaps understated by the court. But it is clear: there is no provision in the powers given by s.8(1) of the 1983 Act to place limitations on those with whom the person subject to the order may have contact. On the other hand, it may be suggested that the Court of Appeal was so closely focused on the intention behind the guardianship scheme that it failed to consider how a guardian is actually able in practice to control contact between the person subject to the order and others. In *Cambridgeshire County Council v R (An Adult)* [1995] 1 FLR 50 (FD), which involved a situation broadly comparable to that of T in the instant case[31], Hale J. took the view that 'Guardianship would ... give the [local] authority the greater part of what they seek'[32]. In Hale J.'s view this would allow the authority to dictate where R would live and this, combined with the general right to control access to private property, could in practice regulate contact between R and her family. This view may be problematic for other reasons[33], but it does make the point that the Court of Appeal's explanation of guardianship as nothing more than the three powers specified in s.8(1) of the 1983 Act may capture the technical position but is rather further away from what will often be the realities of the situation.

That the Court of Appeal took a rigorously civil libertarian approach to the interpretation of the 1983 Act does not of course mean that it was indifferent to the arguments in favour of paternalism or protectionism. Rather, for the court it was an issue concerning appropriate mechanisms. As far as children are concerned, the regime established under the Children Act 1989 and related legislation, supplemented by the inherent jurisdiction, is the appropriate forum for the implementation of protectionist concerns. For adults these mechanisms are not available. Instead, at present, all that exists is the inherent jurisdiction of the High Court to issue declarations as to the best interests of an adult lacking competency to take his or her own decisions. This was of course a live issue in this case as T, having passed her seventeenth birthday shortly after the making of the initial EPOs, was rapidly approaching her eighteenth birthday by the time of the appeal, at which time the wardship jurisdiction would no longer be available.

29 *At 198 E.*

30 *At 198 G-H.*

31 *like T, R, a young woman of twenty-one, having mild learning difficulties, lived away from her family in local authority accommodation having been taken into care. Also like T she had expressed a wish to return to live in the family home, whereas the local authority wished to prevent contact between R and members of her family, including her father who had been convicted of a serious sexual offence against her.*

32 *[1995] 1 FLR 50 at 55E.*

33 *Namely that there may well have been no 'seriously irresponsible conduct' on the part of R, as that phrase was explained by the Court of Appeal in the present case, thus excluding her, like T, from the ambit of guardianship.*

The court declined to embark on a comparison between the powers available under guardianship and that which is possible by way of the issuance of a best interests declaration[34]. It did, however, express a 'wish to see the Family Division judge given wider powers to deal with the welfare of adult patients where that cannot be fully achievable under the provisions of the Mental Health Act 1983'[35]. Family Division judges have in fact proven fairly ready to develop the use of the mechanism of the declaration since the landmark decision of the House of Lords in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (sub.nom. *F v West Berkshire HA* [1989] 2 All ER 545). In that case, as is well known, the House held that a Family Division judge might properly issue a declaration that a proposed course of action, in respect of the medical treatment of an adult patient who lacks the capacity to take his or her own decisions and protect his or her own best interests, is lawful. In explaining the concept of 'best interests', Lord Goff with the concurrence of other member of the House, used the seemingly broad phrase 'life, health or well-being'[36]. But it has generally been assumed that the jurisdiction is of limited effect. The Court of Appeal in the present case referred to two High Court decisions, *Re C (Mental Patient: Contact)* [1993] 1 FLR 940 (FD) and *Cambridgeshire County Council v R (An Adult)* (above). In the former of these, it was held that where an adult child with learning difficulties lived with one parent, and that parent was refusing access to the absent parent, the High Court could, in the best interests of the young person in question, grant access by way of declaration. This was on the basis that access to one's parents is a common law right and hence infringement is unlawful and therefore properly the subject of a declaration. But in the latter case, as discussed above, the issue was not access but the prevention of contact between an adult woman with learning difficulties and members of her family. Re C was distinguished as the prevention of contact is not the protection of a common law right but the infringement of one, namely the right to freedom of association. Hale J. took the view that the power to issue declarations was in effect only a power to state the strict legal position[37], which did not extend to permitting the infringement of common law rights. As such, as the Court of Appeal seemed to accept, the mechanism of the best interests declaration would not be able to prevent contact between T and her parents, or prevent T returning home, in the instant case. If this is correct, then on her attaining adulthood, the law would be able to offer T no protection in this regard.

There are three points that can be made here. First, in lamenting the limitations of the mechanism of the best interests declaration, the Court of Appeal in this case adds its voice to what has become a virtual collective mantra for all those with an interest in this area of law and social policy. As is well known, the process to reform this area of law began in the late 1980s following the decision in *F v West Berks*. It has threatened to produce legislation on a couple of occasions in the 1990s. The situation at present, likely to continue until after the next general election at the earliest, is that the government accepts the need for reform but is unable to pledge the necessary parliamentary time[38]. Until legislation is forthcoming - the courts have stated on numerous occasions from the F case onwards that the changes required are beyond their jurisdiction to deliver - they will no doubt continue to identify gaps in the coverage of the protection offered to persons like T.

The second point, however, is that perhaps in the meantime more creative use could be made of the existing law. Little was said in this regard by the Court of Appeal in the present case. But it

34 *At 199G-200A.*

35 *At 200 D-E.*

36 *[1990] 2 A.C. 1 at 76.*

37 *[1995] 1 FLR 50 at 52 F-G.*

38 *Lord Chancellor's Department (1999) Making Decisions: The Government's proposals for making decisions on behalf of mentally incapacitated adults, London: Lord Chancellor's Department. www.open.gov.uk/lcd/family/mdecisions*

would also have been interesting to see how the court would have responded, for example, to an argument that the common law right of access between parent and child was never absolute at common law[39], and therefore it is possible to **declare**, in an appropriate fact situation, that the common law position is that the right is not exercisable[40], on the basis that its exercise is contrary to the best interests of the person concerned[41].

In *Cambridgeshire* Hale J. also discussed the relevance of the law relating to harassment. At that time, it was at least arguable that there was no tort of harassment, the latest decision at that time being that of the Court of Appeal in *Khorasandjian v Bush* [1993] QB 727 (CA). But since *Cambridgeshire* was decided the Court of Appeal in *Burris v Azadani* has stated that there is a tort of harassment; or at least that the High Court should be prepared to invoke its inherent jurisdiction to issue an injunction to prevent an activity that is not tortious if, on balancing the needs and interests of those concerned 'the court recognises a need to protect the legitimate interests of those who have invoked the jurisdiction'[42]. Perhaps this element of the inherent jurisdiction - to issue injunctions - could usefully be developed in the area of mental health as it seemingly has been in the area of family law[43]. It is worth noting that in *Cambridgeshire* Hale J. did not hold that the law of harassment is inapplicable, she merely noted that 'no one has sought to persuade'[44] her that it was applicable. But even if *Burris* turns out to be a questionable authority, there are still the mechanisms to regulate contact between adults that are contained in the Family Law Act 1996 and the Protection from Harassment Act 1997. This is not to deny that these statutes are aimed at a fairly narrow set of issues, but this does not mean that they could not usefully be employed in appropriate circumstances.

Moreover, this being the third point, if the Court of Appeal has shown itself willing to abandon the requirement that there need be an identifiable legal right that has been infringed before a Family Division judge acting under the authority of the inherent jurisdiction might properly issue an injunction placing limits on the rights of another party[45], then perhaps it is arguable that this might also enable the judge to issue a declaration as to best interests that does not defend an identifiable common law right, but which rather declares that a particular course of action is lawful as in the best interests of the person concerned, even where that infringes in some way the legal rights of

39 *As would be possible, for example, on the basis what was said by the House of Lords in Gillick v West Norfolk and Wisbech AHA [1986] AC 112 per Lord Scarman at 183: 'Parental rights clearly do exist, and they do not wholly disappear until the age of majority... But the common law has never treated such rights as sovereign or beyond review and control case.'*

40 *This argument was rejected by Hale J. in the Cambridgeshire case, [1995] 1 FLR 50 at 52 E-53 C.*

41 *In point of fact, T's situation continued to be litigated after her eighteenth birthday, with LBH seeking declarations from the High Court, that it would be lawful to keep T in LBH accommodation, and to prevent contact with her mother (her father having died shortly after the present appeal was heard). On the preliminary question, of whether the High Court has jurisdiction to grant declarations in regard to such matters, the Court of Appeal (In re F (adult patient), CA, case no. 2000/0094) answered in the affirmative, taking a very broad view of the legitimate scope of declaratory relief. This important decision is the subject of a case note in this Journal at p196.*

42 *Per Lord Bingham, M.R., [1995] 4 ALL ER 802 at 807.*

43 *J. Conaghan [1996] 'Gendered Harms and the Law of Tort: Remedying (Sexual) Harassment' 16(3) OJLS 407 has argued that reliance on Burris should be cautious, because the decision goes so clearly against the accepted wisdom that the inherent jurisdiction can only operate by way of an injunction to prevent the infringement of an identifiable legal right.*

44 *[1995] 1 FLR 50 at 52 H.*

45 *In Burris, the defendant had been made subject to an injunction preventing him from approaching within a specified distance from the complainant's home, thus limiting his legal right to use a public road. The defendant was found to have breached the terms of the injunction and imprisoned for contempt of court. On appeal, the Court of Appeal upheld the terms of the injunction.*

that person or some third party. After all, no legal right is absolute, and the power to issue declarations and to issue injunctions are both merely part of a broad raft of powers that comprise the inherent jurisdiction[46]. Perhaps a greater willingness to issue injunctions under the authority of *Burris*[47] would be a useful development in the protection of persons lacking capacity. The inherent jurisdiction seems to operate with a very broad definition of 'harassment', similar to that of 'molestation' in the Family Law Act 1996, which is 'any conduct which could be properly regarded as such a degree of harassment as to call for the intervention of the court'[48]. This may not be the strongest argument in legal terms, but I for one would like to have seen it put to the Court of Appeal in this case.

Finally, it is worth pointing out that the court chose to 'express no view'[49] in respect of the submission of council for Mr.F, that the situation whereby a person in T's position is prevented from representation before a court hearing an application to displace her Nearest Relative amounts to a breach of her human rights. The law report does not disclose which particular right or rights were mentioned. It may well have been Art 6.1 of the Convention[50], which provides that 'In determination of his civil rights and obligations... everyone is entitled to a fair and public hearing'. Art 6 is one of those convention rights incorporated into domestic law by s.1 Human Rights Act, 1998. It is not, however, clear that it would be able to assist a person in T's position. Art 6.3 gives those charged with a criminal offence with rights, **inter alia**, to defend him- or herself and to examine witnesses. Although there is no corresponding positive right in relation to civil proceedings, it is likely that a similar right of audience is inherent in the generally applicable requirement for 'a fair and public hearing'. The attitude of the European Court of Human Rights has been that Art 6.1 should not be construed restrictively[51], but it is not clear whether this means that the protection offered by Art 6 extends to those who are not a party to the proceedings in question. Technically, s.29 proceedings do not determine the civil rights of the person subject to, or intended to be subject to, the order under the 1983 Act. There is scope for arguing that in practice this may be the case, but even so there are of course mechanisms - at present the mental health review tribunal system - that are available to a person detained under the 1983 Act which clearly are designed to be determinative of the extent of civil freedom enjoyed by the person subject to the order, and at which representation is a right. On the other hand, the decision of the county court in this case, to make the s.29 order, did have, as an immediate consequence, the making of an order under s.7, In reality, therefore, T's interests were all but directly before the court, and it does seem at least arguable on the basis of *Moreira de Azevedo* that that is enough to bring a person in her position within Art.6. In future, of course, it will not be so easy for the courts to avoid addressing such arguments.

46 *Again, readers are referred to the decision of the Court of Appeal in the sequel to the case presently under discussion, see fn.41, above, which addresses directly arguments along these lines and see p196 of the Journal.*

47 *In fact, as it is most often contact with family members that is at issue, the powers in Family Law Act to issue 'non-molestation orders' would often be available, and here it is clear that there need be no infringement of an identifiable legal right.*

48 *Horner v Horner [1982] 4 F.L.R. 50 at 51 Ormrod L.J., but see also C v C (Non-Molestation Order: Jurisdiction] [1998] 1 FLR 554 (CA).*

49 *At 199 F.*

50 *Arts 5 and 8 of the Convention (concerning the rights to security of the person and regard for family life), were to be discussed by Sedley LJ in the later proceedings relating to F (see fn. 41, above) in the context of declaratory relief.*

51 *Moreira de Azevedo v Portugal (1990) 13 EHRR 721.*

Concluding Comments

In one sense, the Court of Appeal was quite right to say that this is an unusual case, which turns on its own facts. The choice between guardianship and wardship can only arise in respect of young people who are 'mentally disordered' in one of the four ways required by s.7(1) of the 1983 Act, and who are of seventeen years of age. For those younger than seventeen, a care order rather than wardship is the appropriate option, and for those younger than sixteen guardianship is not available. For those older than seventeen, neither wardship nor a care order is possible.

So it is fair to say that this is a factually unusual case which has forced us to look at familiar legal provisions from an unfamiliar angle. But in so doing, as this note has shown, the facts of this case have acted so as to provide an insight into various broader policy questions, allowing the Court of Appeal to specify in some detail why it is that wardship should have been preferred to guardianship on these facts. The message is that the Court of Appeal is not prepared to allow the extension of the guardianship regime on grounds of beneficence, any further than was, in the court's view, intended by the framers of the legislation. But as this note has also shown, this case leaves questions unanswered and options unexplored. For now, whether there could be an increased role for the law of harassment in this area; whether the inherent declaratory powers of the High Court have been developed to the fullest extent possible; and whether human rights law is set to make a marked impact on mental health law and policy, are questions that still await an answer.

Widening the 'Bournewood Gap'?

*David Hewitt**

In re F (Adult: Court's Jurisdiction)
Court of Appeal, 26 June 2000

The rights of a compliant, incapacitated adult could best be preserved by subjecting her to greater compulsion

Introduction

These proceedings were a sequel to the case reported as *Re F (Mental Health Act: Guardianship)*,[1] in which the Court of Appeal held that wardship proceedings were preferable to guardianship proceedings under section 7 of the Mental Health Act 1983 where there were concerns for the well-being of a seventeen-year-old girl who had a mental age of between five and eight years.[2]

Facts

The young woman who had been the subject of the previous case, Miss T, was now eighteen years-of-age, and the wardship jurisdiction had therefore become unavailable. Her parents had withdrawn their consent for her to reside in local authority accommodation and, following her father's death, her mother had continued to seek T's return home. Invoking the inherent jurisdiction of the High Court, the local authority had sought declarations, the effect of which would be to keep her in residential accommodation and to restrict contact with her mother and other members of her family. At first instance, Johnson J held on a preliminary issue that the High Court *did* enjoy the requisite jurisdiction, pursuant to RSC Order 15, rule 16, and gave the mother permission to appeal.

The Appeal

For the purposes only of the Appeal, and despite her mother's contrary view, it was agreed that T lacked capacity to decide where her future home should be. Her mother sought to set aside the order of Johnson J and to strike out the claim of the local authority as disclosing no reasonable cause of action. The Official Solicitor appeared as guardian of T and sought an investigation of her best interests.

* *Solicitor, Hempsons Solicitors; Mental Health Act Commissioner.*

1 *[2000] 1 FLR 192.*

2 *A review of this case can be found elsewhere in this issue of the JMHL at p186.*

Argument

The mother's counsel, Mr Richard Gordon, QC, argued that none of the three routes by which the local authority might obtain relief was applicable to this case. First, there was no statutory justification for granting what was in effect an immunity against liability: the extensive guardianship powers contained in the 1959 Mental Health Act had been circumscribed by the 1983 Act, and an order under the 1983 Act had in any case already been refused; the only other analogous powers - in section 135 of the 1983 Act or section 47 of the National Assistance Act 1948 - were of severely limited effect. Second, there was no possibility of wardship proceedings as T was now over 18 years-of-age. And third, the doctrine of necessity could not apply. It was this last submission that was to take up most of the Court's time.

Mr Gordon argued that the 1959 Act had ousted the High Court's former *parens patriae* jurisdiction, which had not been revived when the 1983 Act restricted the guardianship regime. Consequently, the Court's inherent jurisdiction was now severely limited in scope, and could only be used to make 'advisory declarations' such as those relating to medical issues such as sterilisation, caesarian section or hysterectomy. It would no longer cover 'coercive declarations', such as those sought in this case, which concerned long-term intervention without limit of time and without a clear view of the subject's future requirements.

For the local authority, Mr Nigel Pleming, QC argued that the doctrine of necessity would operate whenever decisions were made about the care and protection of an incapable adult, no matter that those decisions might be extremely trivial. As was demonstrated by the case of *R v Bournewood Community and Mental Health NHS Trust, ex parte L*,[3] most such decisions were made by family members, or by medical or care staff, without recourse to the courts.

The Official Solicitor was represented by Mr Roger McCarthy, QC, who submitted that the Court was not constrained by the terms of the local authority's application, and might make a declaration in terms more suited to the facts as they emerged. Such a declaration need not, therefore, have a coercive effect. He sought an investigation, not only of T's capacity but also, should it prove appropriate, of her true wishes, and argued that it would be helpful if, whatever its decision on the merits of the appeal, the Court were to make findings of fact as to where her best interests would lie. There were other issues, such as T's right to association with her family, which might more appropriately be resolved at a substantive hearing.

Decision

The President of the Family Court, Dame Elizabeth Butler-Sloss, agreed with Mr Gordon both that there was no statutory authority for intervention by the local authority and that the possibility of wardship had now disappeared. She pointed out that without the doctrine of necessity, the court would be unable to regulate the future arrangements for T.

As far as necessity was concerned, she said that three questions must be answered:

1. ***Do the present facts demonstrate a situation in which the doctrine of necessity might arise - that is to say a serious justiciable issue that requires resolution in the best interests of an adult without the mental capacity to decide for herself?***

T did not have the capacity to decide where she should live, and the respective views of her mother

3 *[1999] AC 458*

and the local authority on this point were irreconcilable. T's welfare was in dispute, and she was at such risk that if she were under 17 years-of-age she would probably have been made the subject of a care order. The President cited the judgment of Sir Thomas Bingham, MR in *Re S (Hospital Patient: Court's Jurisdiction)*,[4] in which he reviewed the declaratory jurisdiction in respect of those persons who lacked the capacity to make decisions in their best interests. He said:

> "The consequence of this inability is not that the treatment of patients is regarded by the courts as a matter of indifference, nor that patients are regarded as having no best interests. Instead, in cases of controversy and cases involving momentous and irrevocable decisions, the courts have treated as justiciable any genuine question as to what the best interests of a patient require or justify. In making these decisions the courts have recognised the desirability of informing those involved whether a proposed course of conduct will render them criminally or civilly liable; they have acknowledged their duty to act as a safeguard against malpractice, abuse and unjustified action; and they have recognised the desirability, in the last resort, of decisions being made by an impartial, independent tribunal."[5]

The President had no doubt that in this case there was a serious, justiciable issue which required a decision by the courts.

2. Has recourse to the inherent jurisdiction been excluded by the statutory framework of the mental health legislation?

As far as the guardianship provisions of the 1959 Mental Health Act were concerned, the President noted that they were:

> " ... neither comprehensive nor exhaustive and did not cover a multitude of every day activities in which decisions are made on behalf of a person unable to decide for him/herself."

The amendments introduced by the legislation of 1982 and 1983 - principally, the 1983 Mental Health Act - had done nothing to alter this position. Although the House of Lords had held that the common law could not be used to fill a vacuum in the statutory regime,[6] the regime in question - which provided powers of detention - was intended to be exhaustive. However:

> " ... the English mental health legislation does not cover the day-to-day affairs of the mentally incapable adult and the doctrine of necessity may properly be invoked side by side with the statutory regime."

The President noted that in the *Bournewood* case, the House of Lords had held that in relation to informal patients, the doctrine of necessity was preserved by section 131 of the 1983 Act. She cited the following words of Lord Goff of Chieveley:

> "It was plainly the statutory intention that [patients who are admitted as informal patients under section 131(1) but lack the capacity to consent to such treatment or care] would indeed be cared for, and receive such treatment for their condition as might be prescribed for them in their best interests. Moreover the doctors in charge would, of course, owe a duty of care to such a patient in their care. Such treatment and care can, in my opinion, be justified on the basis of the common law doctrine of necessity, as to which see the decision of your Lordship's House

4 *[1996] Fam 1*

5 *Ibid.,at page 18*

6 *Black v Forsey [1988] SC (HL) 28; the statutory regime in question was that created by the Mental Health (Scotland) Act 1984*

in *Re F (Mental Patient: Sterilisation)*. It is not therefore necessary to find such justification in the statute itself, which is silent on the subject. It might, I imagine, be possible to discover an implication in the statute providing similar justification, but even assuming that to be right, it is difficult to imagine any different result would flow from such a statutory implication. For present purposes, therefore, I think it appropriate to base justification for treatment and care of such patients on the common law doctrine."[7]

T's mother had invested a faith in *Black v Forsey* that in the light of *Bournewood* was misplaced. The inherent jurisdiction of the High Court to grant declaratory relief had not been ousted by the 1983 Mental Health Act.

3. *If the doctrine of necessity is not excluded, does the problem arising on this appeal come within the established principles so as to give the court jurisdiction to hear the issue of T's best interests and to grant declarations?*

The President noted that there was "an obvious gap in the framework of care for mentally incapacitated adults", and that if the Court could not intervene, T "would be left at serious risk with no recourse to protection, other than the future possibility of the criminal law". This, she felt, would represent "a serious injustice to T, who has rights which she is unable, herself, to protect". The President then considered dicta in several authorities.

In *Re F (Mental Patient: Sterilisation)*,[8] Lord Donaldson, MR had said:

"... the common law is the great safety net which lies behind all statute law and is capable of filling gaps left by that law, if and in so far as those gaps have to be filled in the interests of society as a whole. This process of using the common law to fill gaps is one of the most important duties of the judges."

In *Re S*,[9] the court had once again considered the patient's best interests, and, according to the President, in *Bournewood*, Lord Goff himself had:

" ... recognised ... that the concept of necessity had a role to play in all branches of the law where obligations existed and was therefore a concept of great importance."

In *Re C (Mental Patient: Contact)*,[10] which Bingham, MR had cited, the parents of an adult mentally incapacitated girl could not agree on contact with her mother. Eastham J held:

" ... in an appropriate case, if the evidence bears out the proposition that access is for the benefit of the patient ... I see no reason at all why the court should not grant access by way of a declaration."[11]

These authorities were analogous to the present disagreement and, the President said, it was clear that if declarations were required to determine where T should live,

" ... there is nothing in principle to inhibit a declaration that it was in her best interests that she should live in a local authority home and should not live anywhere else, nor, while she was in the home to regulate the arrangements for her care and as to with whom she might have contact ... I am clear that it is essential that T's best interests should be considered by the High Court and that there is no impediment to the judge hearing the substantive issues involved in this case."

7 *[1999] AC 458, at page 485*

8 *[1990] 2 A.C. 1*

9 *See footnote 4 above*

10 *[1993] 1 FLR. 940*

11 *Ibid., at page 945*

However:

> "The assumption of jurisdiction by the High Court on a case by case basis does not ... detract from the obvious need expressed by the Law Commission and by the Government for a well-structured and clearly defined framework of protection of vulnerable, mentally incapacitated adults ... Until Parliament puts in place that defined framework, the High Court will still be required to help out where there is no other practicable alternative."

The President therefore indicated that she would dismiss the appeal.

Lord Justice Thorpe had delivered a judgment in the earlier appeal in this case. Citing the decisions in *Re A*[12] and *Re S (Adult Patient: Sterilisation)*,[13] he argued that although they

> " ... establish the function of the court where jurisdiction is conceded, they offer no guide as to the extent of the jurisdiction when it is disputed."

He suggested that it was with the case of *Re F (Mental Patient: Sterilisation)*[14] that "the determination of the ambit of the jurisdiction commences". There, Lord Goff had hinted that the Court's inherent powers might be applied to wider purposes. He had said:

> "When the state of affairs is permanent, or semi-permanent, action properly taken to preserve the life, health or well-being of the assisted person may well transcend such measures as surgical operation or substantial medical treatment and may extend to include such humdrum matters as routine medical or dental treatment, even simply care such as dressing and undressing and putting to bed."[15]

In *Bournewood*, said Thorpe LJ, Lord Goff had acknowledged that the doctrine of necessity did not originate in *Re F*, but in various decisions from the eighteenth and nineteenth centuries.[16] These and the more recent authorities showed that the common law doctrine was "not necessarily" ousted in the way the appellant had suggested. Thorpe LJ therefore concluded:

> "It would in my opinion be a sad failure were the law to determine that Johnson J has no jurisdiction to investigate, and if necessary, to make declarations as to T's best interests to ensure that the protection that she has received belatedly in her minority is not summarily withdrawn simply because she has attained the age of 18."

It was precisely because guardianship regimes, whether statutory or inherent, might restrict the liberty of the individual that the 1983 Mental Health Act had reduced their scope, but:

> " ... it cannot follow that that reduction intended to benefit patients must operate consequentially to deny patients the protective aspects of guardianship which the common law is able to furnish through the application and, if necessary, the extension of declaratory relief justified by the common law doctrine of necessity."

Thorpe LJ conceded that, taken at its most liberal extent, such a line of argument might be seen to restore the old *parens patriae* jurisdiction. However, he added: "I would not wish this judgment to be so understood."

Because he felt that "we are breaking new ground on terrain which is partly constitutional", Sedley LJ chose to add a few words of his own. For him, the "critical question" was whether the gap

12 *[2000] 1 FCR 193*

13 *CA, 18 May 2000*

14 *See footnote 8 above*

15 *[1990] 2 A.C. 1, at p 76G*

16 *Rex v Coate (1772) Lofft. 73, per Lord Mansfield at p75; Scott v Wakem (1862) 3 F & F 328, per Bramwell B at p333; Symm v Fraser (1863) 3 F & F 859, 883 per Cockburn CJ*

created when the 1983 Act limited the powers of guardians, "represents a legislative policy which the courts must respect or a lacuna which they may fill". That it had been the intention of parliament to cut back the power of the state could be the appellant's only case, for this would otherwise be "a strong case of necessity", and further, if the alleged dangers were real, it would certainly be open to the court to

> " ... sanction not only the provision of local authority accommodation (which in any case needs no special permission) but the use of such moral or physical restriction as may be needed to keep T there and out of harm's way."

This last was apparent from *R v Bournewood Mental Health Trust, ex parte L*,[17] in which Lord Goff had said:

> "The concept of necessity has its role to play in all branches of our law of obligations - in contract ..., in tort ... in restitution ... and in our criminal law. It is therefore a concept of great importance."[18]

And so, Sedley LJ concluded:

> "I would accordingly not think it right to set prior limits to the applicability of the doctrine."

Had this case come before the courts in the 1980s, shortly after parliament had circumscribed the guardianship role, the local authority would have faced a more difficult task. But times had changed. The 1981 White Paper had said:

> "The guardian ... is given the powers that a father has over a child of 14. These powers are therefore very wide, as well as somewhat ill-defined, and out of keeping, in their paternalistic approach, with modern attitudes to the care of the mentally disordered."[19]

However, this thinking had subsequently been revised: the Law Commission had remarked that post-1959 reforms had overlooked "the benign side of guardianship", and that statute law had come to reflect "a single-minded view of personal guardianship as a method of restricting civil liberties rather than as a method of enhancing them";[20] in consequence, ministers had now published a green paper which proposed legislation to give a court powers which include deciding where a person who lacks capacity is to live and what contact he or she should have with particular individuals.[21] It was plain, Sedley LJ concluded:

> " ... that the legislative will which produced the very elements of 1983 Act with which we are concerned is no longer there ... What was once an eloquent silence has with the passage of time and events acquired the character of an uncovenanted gap in provision for the incapacitated."

Sedley LJ took the view that it was essential also to consider the effect of the European Convention on Human Rights, because the right to liberty in Article 5 was engaged by the stance both of T's mother and of the local authority. Article 5 (1) (e) would permit the state to restrict the personal freedom of persons of unsound mind, and the fact that it might only do so in accordance with a procedure prescribed by law:

> " ... does not mean that the common law cannot grow or shape itself to changing social conditions and perceptions: see *SW and CR v UK* (1996) 21 EHRR 363. It means that any such

17 *See footnote 3 above*
18 *[1999] AC 458, at p490*
19 *Cmnd. 8405*
20 *1995, Report no. 231*
21 *Cm 4465*

change must be principled and predictable. For the reasons set out in the two preceding judgments I consider that the development of the law which our decision represents passes both limbs of this test."

Secondly, of course, any restriction must not breach the Article 8 right, which, as Sedley LJ reminded the Court, was to *respect* for family life, and not to the absolute enjoyment of such life. Furthermore, rather than being vested in either parent or child, such a right:

" ... is as much an interest of society as of individual family members, and its principal purpose, at least where there are children, must be the safety and welfare of the child ... The purpose, in my view, is to assure within proper limits the entitlement of individuals to the benefit of what is benign and positive in family life. It is not to allow other individuals, however closely related and well-intentioned, to create or perpetuate situations which jeopardise their welfare."

Sedley concluded:

" One of the advantages of a declaratory remedy, and in particular of an interim declaration, is that the court itself can do much to close the so-called Bournewood gap in the protection of those without capacity."

Accordingly, the appeal was dismissed and leave to appeal to House of Lords refused.

Discussion

1. Widening the doctrine of necessity

Although plainly aware that it was supplementing the existing law, the Court was at pains to stress that in so doing, it was merely working an existing seam within the common law doctrine of necessity, a seam that had already found expression, for example, in the case of *Re C (Mental Patient: Contact)*.[22] However, both the doctrine itself and the range of remedial options it carries are surely now much wider. And it is likely that the range of practitioners who might avail themselves of those options - which previously would have been restricted to various types of clinician - is also much wider: the judgment will endow upon social workers both fresh solutions and new responsibilities.

The boundaries of the new, expanded doctrine may perhaps be discerned from the words of Sedley LJ, who spoke of sanctioning "not only the provision of local authority accommodation ... but the use of such moral or physical restriction as may be needed to keep T there and out of harm's way"; and also from the judgment in *Re F (Mental Patient: Sterilisation)*,[23] which Sedley LJ cited, in which Lord Goff spoke of interventions transcending the merely medical, and extending "to include such humdrum matters as routine medical or dental treatment, even simply care such as dressing and undressing and putting to bed". These boundaries are capable of being very widely set, and may come to confound Lord Justice Thorpe's insistence that his judgment should not be read as advocating the restoration of the old *parens patriae* jurisdiction.

2. Closing the Bournewood gap?

As we have seen, Lord Justice Sedley advocated the use of declaratory relief to plug the so-called 'Bournewood gap'. Although it is unclear whether he saw this as the purpose of his judgment, such was certainly not its result. It was Lord Steyn who first located this particular gap. In giving far

22 *See footnote 10 above*

23 *See footnote 8 above*

from unconditional support to their Lordships' judgment, he said:

> "The general effect of the decision of the House is to leave compliant incapacitated patients without the safeguards enshrined in the 1983 Act. This is an unfortunate result ... 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 healthcare professionals ... [N]either *habeas corpus* nor judicial review are sufficient safeguards against misjudgements and professional lapses in the case of compliant, incapacitated patients."[24]

Earlier, speaking of what might become "an indefensible gap in our mental health law", Lord Steyn had made the object of his concern very clear. He said that Parliament had:

> " ... devised the protective scheme of the 1983 Act as being necessary in order to guard amongst other things against misjudgement and lapses by the professionals involved in health care;"[25]

and he added:

> "If protection is necessary to guard against misjudgement and professional lapses, the confident contrary views of professionals ought not to prevail."[26]

In Steyn's conception, the '*Bournewood* gap' revealed the need for incapable, compliant patients to be protected *from*, not *by*, the professionals. Other judgments in *In re F (Adult: Court's Jurisdiction)* took the contrary view. When Lord Justice Thorpe mentioned *Bournewood*, it was to claim that,

> " ... in expressing his concerns, Lord Steyn recognised the width of the common law doctrine of necessity to which provision in the Code of Practice would have to yield."

Although the President clearly imagined that she was plugging a gap of some kind, it was not that of the *Bournewood* ilk. It seems, in fact, that what she had in mind was the void left - it may be said, deliberately so - when the guardianship provisions of the 1959 Act were reduced in size. Yet, despite many references to the judgment of the House of Lords in the *Bournewood* case, neither the President nor her brothers considered whether it might itself offer a complete solution to T's unfortunate situation. If *Bournewood* was insufficient, that could only be because of the local authority's desire to augment its power to confine Miss T with the power to restrict her social contacts. Yet, the Court of Appeal did not attempt either to distinguish the two powers or to consider whether the latter might be unprecedented within the doctrine of necessity and its use excessive.

As we have seen, the President spoke of "an obvious gap in the framework of care for mentally incapacitated people" which might leave T "at risk with no recourse to protection", despite the fact that "she has rights which she is herself unable to protect". It is clear, however, that the President did not believe that *all* of those rights were deserving of intervention by the Court, for one of the effects of her judgment would be to deprive T of her liberty and of the ability to associate with whomsoever she chose. Having identified this void in the statutory framework, she sought to plug it with the common law, the very medium in *Bournewood* in which that gap had first been located. Likewise, those to whom she chose to entrust the common law weapon were precisely those whose use of it Lord Steyn had tried to restrain.

Although this judgment will relate to persons who resemble the unfortunate Mr L, its principal effect will not be to give them greater rights, or even enhanced protections: rather, it will be to add to the stock of compulsions that might be brought to bear upon them; extending those compulsions beyond the hospital ward or day centre so as to control every facet of their contact with the modern world. As a result of *In re F (Adult: Court's Jurisdiction)*, the '*Bournewood* gap' now yawns even wider.

24 *[1999] AC 458, [ref]*

25 *Ibid., [ref]*

26 *Ibid., [ref]*

3. The European Convention on Human Rights[27]

Lord Justice Sedley expressed his confidence that the expansion of the doctrine of necessity in which he was complicit *would* comply with Article 5 of the ECHR. In so doing, he confirmed that he viewed the doctrine so expanded as a potential deprivation of the liberty of those to whom it was applied. However, his comments were confined to sub-section (1)(e) of the Article, and he made no reference to the requirement of Article 5(4), that:

> "Everyone who is deprived of [her] liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of [her] detention shall be decided speedily by a court and [her] release ordered if the detention is not lawful".

As has been already pointed out, this judgment creates no new rights: there are no new restraints upon the use of compulsion and no new tribunal to police them. Presumably, therefore, it was assumed that in cases falling within the expanded doctrine of necessity, the 'Court' that will satisfy Article 5(4) is the High Court. However, the inherent jurisdiction of the court may be - in fact, is most likely to be - invoked *before* there has been a deprivation of liberty. Will such a state of affairs be sufficient to satisfy Article 5(4)?

Likewise, it is surely conceivable that some future local authority will decide to forego an application to the Court and instead subject a compliant, incapable patient to compulsion without a prophylactic declaration. In those circumstances, the patient's only remedy would presumably be an application for judicial review. Given the narrow scope of such proceedings, could the Administrative Court really be said in such circumstances to be determining "the lawfulness of [the patient's] detention", and not simply its bureaucratic compliance?

It is a further requirement of Article 5 - as interpreted by the *Winterwerp* decision - that a detention of the kind that Sedley LJ has implicitly conceded will occur under the expanded doctrine will only persist as long as the 'unsoundness of mind' by which it is purportedly justified.[28] If the subject of the new powers of compulsion wishes to assert that he is no longer labouring under such an unsoundness of mind, how might he do so? If only by means of an application for *habeas corpus* or judicial review, again, will the requirements of Article 5 be met? The existing authorities suggest that they will not.[29]

Conclusion

The judgment in *In re F (Adult: Court's Jurisdiction)* does not justify the claims that have been made for it. It does not widen the protections available for compliant, incapacitated patients, rather, it reduces them. In extending the use of compulsion away from the medical sphere and into areas of social and personal life, it widens even further the so-called '*Bournewood* gap' and creates the possibility of successful challenge under the European Convention on Human Rights.

27 *See also: John Hodgson, Detention, Necessity, Common Law and the European Convention: Some Further Aspects of the Bournewood Case [1999] 1 Journal of Mental Health Law, pp23-32 as to the general question of whether a purely common law construct such as the doctrine of necessity can ever be consistent with the ECHR*

28 *Winterwerp v Netherlands (1979) 2 EHRR 387*

29 *X v United Kingdom (1981) 4 EHRR 181, (1981) 1 BMLR 98 [habeas corpus]; Kay v United Kingdom, Application number 17821/91, Report of Commission, adopted 1 March 1994 [judicial review]*

Book Reviews

Mental Health Law Policy and Practice, by Peter Bartlett and Ralph Sandland

Published by Blackstone Press Ltd. (2000) £24.95

This is a long, complex and demanding book that repays many times over those with persistence who read all of its 447 pages. Alternatively, it is set out in such a way that the rather more selective dip into a discrete subject area is made easy and rewarding.

Bartlett and Sandland take the view that mental health law cannot be studied in a vacuum: indeed they suggest that perhaps more than any other area of law "it would be almost immoral to divorce the study of mental health law from the social situation of the people directly involved". Mental Health Law Policy and Practice at the conceptual stage started life as a text book for the authors' students at the University of Nottingham. In realising that objective, they have provided a book that will take its place alongside those of Brenda Hoggett, Anselm Eldergill and Richard Jones as an essential part of the armamentarium of anybody seriously interested in this important and riveting subject.

The first three chapters discuss some of the "big issues" that lie at the core of mental health law and commences with a recent review of what the authors identify as a central paradox at the heart of the study of mental health and illness: the centrality of the medical model and its imposition of "a scientific order onto the profoundly un-ordered world of the mad". "All this" they go onto assert "is a construction of the reasoned, and reflects the world of the reasoned; to the insane person, it is an alien landscape". Similarly, mental health law, like psychiatry is also a language "of reason about madness" and whilst at times law and psychiatry are uneasy bedfellows they are both "paradigms of rationality in their way, and thus each is faced with the same problem: how to impose order onto madness; a realm which would seem ex hypothesi to be lacking order, to be irrational". Foucault speaks loudly in these debates and whether or not you are a fully signed up member of his fan club, his insights (briefly and not uncritically referred to by the authors in the opening chapter) provide an important part of the foundation for the approach they take.

Conceptualising mental health law, the problem of definition of mental disorder and the contemporary mental health system provide the gist of the opening three chapters. In focusing on what some might see to be the essentially non-legal (in the strict rather formalistic meaning of the word) content of the opening section of Mental Health Law Policy and Practice, it is important to emphasise that this is a book for lawyers and the law is entwined at every point into these rather more discursive chapters that clearly set out the context of social issues and professional practice.

At the outset, the authors engage with the alleged beneficiaries of all this effort with a discussion entitled "Who are the insane?". Quoting from published accounts of the reality of mental illness by those who have experienced it, the significance of the view of mental illness as intrinsic to self (for many the alternative to the disorder is "a void, a nullity") is highlighted and follows through to the judicial acknowledgement this received in *B v Croydon District Health Authority* (1994) 22

BMLR 13 (the High Court hearing). Thorpe J referred to the relationship between the individual and their personality. Citing an expert witness he asked "Have we the right to remove the only mechanism that remains to her without the prospect of being able to help her to cope in other ways?". The man-must-be-mad test referred to by Lord Justice Lawton in *W v L* [1974] QB 711 receives rather more positive analysis than that provided by Brenda Hoggett, in a discussion about the challenges posed to lawyers and others by the failure to define mental illness in the Mental Health Act. The authors then go on to very clearly identify the fundamental problem attached to using medical terms as a basis for determining the application of legal intervention. Whilst sympathetic to the medical and professional objectives of classifications such as DSM-IV and ICD10, they lucidly debate whether "a medical model can formulate what is in the end, a social choice both as to what constitutes an illness or disorder and as to when intervention or differential treatment is warranted". Devoting perhaps excessive attention to the opening three chapters can only be justified if, in doing so, it highlights (and in the case of this reviewer, applauds) the powerful policy, social and administrative context which the authors set for the discussion of the relevant legal rules themselves. As they convincingly argue "the intellectual appeal of mental health law lies not merely in the legal rules, but in the tensions between the rules, psychiatric practice, social administration, and the ways in which mental illness is characterised and understood by professional and lay people alike".

Chapters four to eight deal with admission to hospital, civil confinement, mental disorder and criminal justice, treatment in hospital and leaving hospital respectively. Extensive legal analysis is firmly rooted in the political and organisational reality. The chapter on mental disorder and criminal justice starts with the depressing finding by the Health Education Authority that mental disorder and criminality are often viewed by the general public and the media as natural bedfellows. A critical review of the policy of diversion follows and it is in that context that the relevant legal provisions are explained, examined and evaluated. Similarly, the chapter on leaving hospital takes a particular theme - the limitations on the ability of the law to act as an independent constraint on the exercise of medical discretion - and presents an analysis of the law within that framework.

Chapter nine deals with care, control and community and in its initial examination of the underlying tensions between welfareism and managerialism and, more topically, between treatment and control as well as the law itself, provides a useful basis for the critical appraisal of the implementation of the government's current policy objective of "breaking the automatic link between compulsory care and treatment and detention in hospital" (Reform of the Mental Health Act 1983 - Proposals for Consultation; CM4480; (1999)). Similarly the position of mental capacity has recently achieved a higher profile as a professional and legal issue by way of the proposals of the expert group examining the Mental Health Act (Review of the Mental Health Act; Report of the Expert Committee; DOH; (1999)) that it should be a part of any criteria for admission to compulsion in any new mental health law. In chapters ten and eleven, the authors offer an exhaustive analysis of the concept and in doing so give full recognition to the fact that "investigation of the concept ..... overlays mental illness with a new set of criteria" and that it can be raised in a "multitude of legal contexts". Perhaps for this reason the policy context is more lightly applied in these chapters, although the discussion culminates in a review and endorsement of the proposals of the Law Commission (Mental Incapacity; Law Commission (1995); Law. Com, No 231; London: HMSO).

Mental Health Law Policy and Practice concludes with a brief review of the main forms of legal redress and also advocacy for clients and thus comes full circle back to the people who are the central focus of this discourse and activity. They issue a challenge to legal advocates to provide clients with mental health problems with the representation they deserve, and not the sort of approach implicit in Lord Denning's pronouncement in *Richardson v London County Council* [1957] 1 WLR 751 that "..... much as a small child or a dumb animal resents being given medicine for its own good, ... they [the mentally ill] are apt to turn around and claw and scratch the hand that gives it". Amongst many other things, Mental Health Law Policy and Practice should ensure that future generations of mental health lawyers, like most (but possibly not all) of the current generation, will find such an attitude unacceptable.

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Community Care and the Law, by Luke Clements, Second Edition

Published by Legal Action Group 2000, £30

In Luke Clements' Introduction to this revised second edition he describes the state of community care law as a "mess" and a "hotchpotch" of conflicting statutes which have been enacted over a period of 50 years with no unifying principles underlying them. It is, he says, "crying out for codification". That cry for reform seems no closer to being answered than it was four years ago when the first edition was published. However the cries of those trying to study, teach and apply community care law have been responded to with the publication of this book.

The aim is to state the law as of April 2000 though some later developments are also mentioned. The author is to some extent the victim of his own success because the first edition (and other books by Gordon and Mackintosh[1] and Mandelstam[2]) played a vital part in "opening up" community care law and in encouraging service users and their advisers to bring legal challenges. In the four years since the first edition of the book the pace of change in community care law has accelerated enormously making it inevitable that the most recent developments cannot be included. For example in the discussion of the Immigration and Asylum Act 1999 no reference is made to the important case of *ex p.* O[3] in which the Court of Appeal all but refused on policy grounds to give statutory wording its natural and obvious meaning. Neither has it been possible to include a discussion of the Court of Appeal's decision in the second *Re F* case on the inherent jurisdiction of the High Court concerning mentally incapacitated persons[4]. Clements, with good reason, refers to the interface between health and social care as a "minefield". Here again the rapid pace of change has meant that the book does not quite keep up with the very latest developments such as the details of partnership arrangements under the Health Act 1999, the NHS National Plan and proposals for social care trusts.

The basic structure of the work is retained, with introductory chapters on the sources of community care law and the duties to plan and assess, followed by chapters dealing with specific subject areas such as residential accommodation, NHS responsibilities for community care services, charging and the interplay between housing and community care. The last chapter in the book deals with remedies including judicial review and the Human Rights Act. There is a clear account of the grounds for, and the procedures of, judicial review before the coming into force of the Human Rights Act and the introduction of new rules setting up the Administrative Court. However the text does not attempt to discuss to what extent, after the Human Rights Act, the Administrative Court will be prepared to go beyond the "anxious scrutiny" of decisions touching on human rights issues, and review directly the merits of decisions before it. It is also somewhat surprising, given the expertise of the author in the human rights field, that his discussion of human rights issues is largely confined to the remedies chapter rather than more closely integrated into the main body of the text.

1 *Gordon and Mackintosh "Community Care Assessments - A Practical Legal Framework" Sweet and Maxwell 2nd edition 1996*

2 *Mandelstam "Community Care and the Law" Jessica Kingsley Publishers 2nd edition 1999*

3 *"O" v London Borough of Wandsworth, R. v. Leicester City Council ex p. Bhikha, CA Times 18th July 2000*

4 *Re. F (Adult: Court's jurisdiction) CA Times July 25th, [2000] 3 FCR 30*

Turning to the treatment of some specific issues of interest to mental health lawyers the new edition deals with a number of cases dealing with the housing rights of the mentally disordered. These include the decision of the Court of Appeal in *Croydon LBC v. Moody*[5] that in considering the reasonableness of a possession order on the grounds of nuisance, the fact that the tenant had agreed to treatment for his treatable personality disorder should be taken into account, and the important decision of Scott Baker J. in *ex p. Penfold*[6] that "ordinary" accommodation might have to be provided under s.21 of the National Assistance Act 1948 even when a local authority's homelessness duty had been discharged. Also referred to is the Court of Appeal decision in *ex p Kujtim*[7] on the circumstances in which a s.21 duty may treated as discharged by a local authority. That case raises a number of questions about the extent of continuing obligations of health and social services towards clients who are reluctant, or refuse to engage with services offered to them - especially when their reluctance or inability to accept help has itself been identified as a facet of their need.

Section 117 Mental Health Act 1983 duties inevitably loom large, though Clements properly reminds us that the majority of the mentally ill and formerly mentally ill do not qualify under s.117. Curiously, although he draws attention to the backbench origins of other important community care provisions, he does not mention the origin of section 117 as being a backbench amendment to the Mental Health (Amendment) Act 1982 brought by Baroness Masham. Depending on one's point of view, a reading of the relevant Hansard debates demonstrates either the danger that when legislating in this manner a legislative provision will be passed by Parliament which will prove to have far-reaching and completely unintended consequences, or the vital and positive role of the backbencher in effecting social change.

In connection with the perennial problems in securing compliance with s.117 care planning duties, Clements refers to the decisions in the *Hall* case[8] and guidance,[9] though not the National Service Framework.[10] The decision in the case of *ex p. K*[11], in which Burton J. took a robust and controversial view that there was no absolute duty on a health authority to comply with s.117 duties when individual clinicians were unwilling to provide clinical supervision, came too late for inclusion. Clements points out that as s.117 places no restriction on the services that might be provided, s.117 services are virtually unlimited in nature including where appropriate the provision of accommodation. Questions still remains about the extent of the duty - for example would it extend to purchasing a house for an allegedly "difficult" person such as Mr. Hall if there is no other way of meeting his needs? Following the case of *ex p. Watson*[12], Clements now states clearly that s.117 services may not be charged for, and more cautiously suggests there might be a human rights challenge to charges made for accommodation to those subject to guardianship who do not

5 *(1999) 2 CCLR 92*

6 *[1998] 1 CCLR 315, also see R. v. Wigan MBC ex p. Tammage [1998] 1 CCLR 582*

7 *[1999] 2 CCLR 340*

8 *(1999) 2 CCLR 361, (1999) 2 CCLR 383*

9 *In Hall the Court of Appeal said that the wording of the current Code of Practice suggested that a care plan "at least in embryo" should be available .Building Bridges - A Guide to Arrangements for Inter Agency Working for the Care and Protection of Severely Mentally Ill People" (Department of Health 1995), Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach (Department of Health 1999).*

10 *National Service Framework for Mental Health (Department of Health 1999).*

11 *9th June 2000. The Court of Appeal has given leave to appeal.*

12 *In which the Court of Appeal on the 27th July 2000 upheld the decision of Sullivan J (1999) 2 CCLR 402 A petition has been submitted to the House of Lords by the unsuccessful local authorities.*

qualify under s.117. However he does not deal in any detail with the massive problems posed to social services authorities by the possibility that large numbers of service users might now have restitutionary claims to charges already paid, nor with the stark unfairness to those now paying for services because they happen not to qualify under s.117, which others in no greater actual need receive free of charge.

The Legal Action Group are to be congratulated for keeping the price down to such a reasonable level, and for the improvements to the layout of the book. In particular the marginal indexing and flow charts now included, make the book far easier to use. A useful selection of the essential statutory provisions and guidance can be found at the end of the book, and while the coverage of guidance is not extensive, this is a minor quibble given the availability of this material on the internet and the quality of the text. In its first edition, this book established itself as an essential guide to the complex area of community care law. Until the arrival of a third edition (surely sooner than four years from now) it remains an essential purchase for everybody working within this area of law.

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Advising Mentally Disordered Offenders - A Practical Guide by Deborah Postgate and Carolyn Taylor.

Published by Law Society Publishing 2000, £15.95

This book was commissioned by the Law Society, and, according to the Preface, the Legal Aid Board Duty Solicitor Committee will require all duty solicitors to have a copy. It covers law and procedures relating to the mentally disordered offender in police stations and magistrates court only; it does not deal with contested trials in the magistrates court or crown court procedures.

The book starts with a chapter on the appropriate terminology - i.e. definitions of some key legal terms such as presented in Section 1 of the 1983 Mental Health Act. It then examines the legal procedures which cover the offender in the police station, including the use of appropriate adults, the role and duties of the custody officer, the police surgeon etc, followed by a chapter giving advice on how to assist the mentally disordered client in the police station before the relevant interviews. There are then chapters on police interviews, on breaches of the Code of Practice, assistance after the interview and a final chapter on the first appearance of the mentally disordered suspect in the court. There are Appendices which *inter alia* give extracts from the influential Home Office Circular 66/90 and the PACE Codes of Practice.

It is difficult to know how to assess this book. It goes from the simple ("when acting for a client who is mentally disordered you may be required to consider your own personal safety" p.32) to the more complex relating to case law surrounding mental disorder. It covers many of the main points, but nothing in depth, and ignores many of the complexities surrounding say the role of the police surgeon or the appropriate adult. Occasionally the advice given is misleading: for example the authors say "you could agree that the appropriate adult will intervene [on the police interview] on issues related to your client's health and welfare while you will intervene if necessary on legal issues" (p.49). That misunderstands the role of the appropriate adult who should also intervene on both. Also I am puzzled about who would want to buy the book. I can see that trainee lawyers might need it as an introductory guide but experienced lawyers should know all that is contained here. If they don't, then one wonders what they have been doing all this time. As a practical guide it achieves what it set out to do but careful consultation of a good quality text such as Jones R. *Mental Health Act Manua*l, (6th Edition; Sweet & Maxwell) would give a great deal more. Incidentally, the bibliography is weak ignoring many key texts on the subject, but the Appendices are useful.

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Care or Custody? Mentally Disordered Offenders in the Criminal Justice System by Judith M Laing.

Published by Oxford University Press 1999, £45.

This book is divided into two parts, the first part relates to mental health law, - albeit slipping over mental health law over the past 100 years - and the history and general principles about how the criminal justice system deals with mentally disordered offenders. Essentially this section is a review that can be found elsewhere. The second part of the book, and the more interesting, is an empirical study of six court-based diversion schemes operating in West Yorkshire in 1993-95.

I approached this book with much interest and expectation that some light might be shed on why there are still so many mentally disordered offenders in our prisons. However, I was generally disappointed with the study in two respects. First, the findings of this somewhat limited empirical study conducted for a Ph.D failed to find anything new about the depressing process whereby mentally vulnerable people are diverted into either one system or another. Secondly, there are inaccuracies in the text, and a failure by the author to properly understand some key issues.

The author has two explanations for "..the high levels of mental illness still in prison". First it "may be accounted for by the fact that there are significantly more people in prison in the late 1990s". Secondly "the reason could also be that these offenders may not be sufficiently ill to meet the criteria for transfer under the Mental Health Act 1983, which reinforces the urgent need dramatically to improve the health care facilities and support which is provided in the prison system" (p. 318). Such simplistic explanations do not conform with the publisher's description of the book as being "..a comprehensive and scholarly text...".

A further example of a failure by the author to fully comprehend some key issues can be found in her analysis of the use of the appropriate adult for mentally disordered detainees. The use of the appropriate adult for mentally vulnerable people detained in the police station is central to how they are processed through the criminal justice system. The author states: "If the police suspect that a person in police custody is mentally disordered, they must seek a medical opinion to assess if he or she is fit to be interviewed or requires the assistance of an appropriate adult. The police will inevitably call out the FME [Forensic Medical Examiner]..." (p. 97). Although Laing goes onto to criticise the FME (for example, the lack of training most FMEs (commonly known as police surgeons) have regarding mental illness), she fails to grasp or reveal to us the fundamental point about the FME and the use or non-use of the appropriate adult for mentally disordered suspects. Research has shown - indeed the author references these studies - that the FME invariably declares that many mentally vulnerable suspects are 'fit for detention and interview', with the consequence that the use of the appropriate adult is forgotten by the custody officer and/or declared unnecessary by the FME. But the decision to call an appropriate adult is not a medical decision. The presence of the appropriate adult is justified not because the suspect is unfit to be detained or unfit to be questioned. If that were the case there would be no role for them at all, least of all one which took them into the interview room with the suspect[1].

1 *Bean P.T. and Nemitz T. (1993) 'Out of Depth and Out of Sight', London: MENCAP.*

There are other disturbing inaccuracies to be found in the book. For example on page 31 the author asserts that mental health review tribunals were established under the Mental Health Act 1983. And one *faux pas*, although not as worrying as the others, reveals a certain lack of editorial observation. It is found on page 132 (n.315), namely the statement that on 12/11/93 Jim MacKeith gave the Robert Maxwell Memorial Lecture. It was of course the first Memorial Lecture for Bob Baxter!

As stated earlier, the first part of the book can be found elsewhere and much is now out of date. However as most of the evaluations of diversion schemes have taken place in and around London, the fact that the research which underpins the book was conducted elsewhere in itself makes it worthy of consideration.

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