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Articles and Comment

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Contents

Foreword

In the third week of June, the Law Society and the Royal College of Psychiatrists jointly hosted a very well attended two-day conference on reform of mental health law (day one) and the law relating to mental incapacity (day two), entitled '*Make up your mind*'. What emerged both from the presentations and from questions and comments 'from the floor', was widespread and strong opposition to many of the mental health legislative reform proposals set out in the White Paper of December 2000, and equally widespread and strong support for long-awaited legislation in the field of mental incapacity. The following week the *Draft Mental Health Bill* was published. However a Mental Incapacity Bill would still appear to be some way off. According to the Minister who attended the conference, the Government is committed to reform, and will legislate 'when Parliamentary time allows' – which, if nothing else, is consistent with what the Lord Chancellor himself said in his speech at the November 1999 conference, '*Mental Incapacity; New Millennium – New law?*' hosted by the same two bodies (together with the Mental Health Act Commission).

One week after the *Draft Mental Health Bill* was published, this issue of the Journal went to the printers. As a consequence we have not been able to include within it (with one exception) any detailed comment on the Bill's contents. We aim to make amends in the next issue, due for publication in December 2002. By then of course the twelve week consultation period allowed for by the Government will have passed, but at least at that stage we should have a clearer idea firstly if Parliamentary time is to be found for the Bill's introduction[1] and secondly what the final version of the Bill will contain.

The 'exception' referred to in the previous paragraph is the first article published in this issue. Margaret Clayton, Chairman of the Mental Health Act Commission, has considered the Draft Bill and the Durham University Report on Independent Specialist Advocacy, also published at the end of June. Whilst making it clear that it would be premature to express any views on behalf of the Commission until there has been a proper opportunity to digest the documents' contents and to consult fully with Commissioners, her intention (against the background of the Government's intention to dispense with the MHAC in its present format) is to highlight issues which surround the relationship between the concept of independent specialist advocacy services (as described in the Durham report), the statutory functions of mental health advocates as described in the Draft Bill and what is involved in the Commission's current visiting functions. Her contribution to this issue of the Journal is clearly timely.

Our next article revisits the issue of capacity and treatment. Dr. Gwen Adshead and Dr. Sameer Sarkar contrast the ways that ethics and law address involuntary treatment for physical and mental disorders. They identify different approaches to understanding the capacity to make autonomous decisions. They make reference to a wide range of sources as well as judicial decisions which have emanated from both English and American courts.

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[1] *Paragraph 1.5 of the Consultation Document published with the Draft Bill states: "The analysis of all the responses we receive will help us to move towards a Bill ready for introduction* when Parliamentary time allows *[emphasis added]"*

'Compulsory' community care has been the focus of much debate for many years. Conditionally discharged patients are a group who are subject to one form of such care. Sharon Riordan, Dr Helen Smith and Dr. Martin Humphreys have carried out a study in the West Midlands of perceptions of this statutory after-care held firstly by a number of patients subject to it, and secondly by the doctors responsible for their supervision. In their description of the study which we publish in this issue, they break down their findings into good things about supervision, bad things, and recommendations for change. They conclude by suggesting that their findings might assist in the planning and delivery of psychiatric services to other groups of severely mentally ill people.

Those defendants who are charged with murder and are found to have done the act charged, but who are deemed to be unfit to plead or insane at the time of the offence, must be sentenced to a hospital order with an indefinite restriction order attached. In our fourth article, Kevin Kerrigan considers the legal position of such defendants, and concludes that the requirement on the Court to impose such a sentence is likely to violate Article 5 of the European Convention on Human Rights.

In recent years we have seen many changes in the way in which mental health services are organised, delivered and regulated. Professor Anselm Eldergill has provided a descriptive (rather than analytical) guide to the complex legal structure which is now in place. The article is lengthy but for this we make no apology. To understand the structure, we need to be informed about the components of the NHS, the ways in which social care and independent healthcare are provided, and the bodies charged with maintaining quality standards, all of which are covered within the article. Future changes are of course planned, and no doubt future issues of the Journal will need to keep apace with them.

The practice of 're-sectioning' shortly after a Mental Health Review Tribunal decision to discharge, is not common, but it does occur. In our last issue, we included a review by David Hewitt of the Court of Appeal decision in *R v East London & the City Mental Health NHS Trust and Snazell ex parte Von Brandenburg (2001)*[2], a case which required judicial consideration of the practice. In this issue, Kristina Stern joins David Hewitt to re-visit *Von Brandenburg* in the light of the very recent (28th June 2002) Court of Appeal decision in *R v Ashworth Hospital Authority and others ex parte H*. The authors seek to "place both cases in their true context and to attempt to distil some definitive guidance". It should be noted that in due course there are to be further judicial pronouncements on this issue which poses such dilemmas for medical, social work and legal practitioners. *Von Brandenburg* is likely to come before the House of Lords early in 2003.

We are delighted to include four contributions arising from day two of the conference referred to in the first paragraph on this Foreword. We are grateful to the Law Society and the Royal College of Psychiatrists for their agreement to their inclusion. Peter Kinderman argues that "clinical psychologists have much to offer mental health care and mental health law". Gordon Ashton provides an overview of the limited jurisdiction presently available for the resolution of problems involving those who lack mental incapacity, and makes a plea for the new legislation which has been pending for so long. Dr. Donald Lyons reminds us that legislation has been introduced in Scotland, and summarises the main provisions of the *Adults with Incapacity (Scotland) Act 2000*. Denzil Lush, the Master of the Court of Protection, informs us that in the linked cases of *Masterman-Lister v Jewell and Home Counties Dairies* and *Masterman-Lister v Brutton & Co.* (2002), Mr. Justice Wright has "handed down…..the most important decision so far in English law on the meaning of the word 'patient'".

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[2] *'Detention of a recently-discharged psychiatric patient' David Hewitt, JMHL February 2002 pp 50 – 58.*

As has become our practice, we end this issue with some case reviews.

David Mylan has considered the Court of Appeal's judgments in *R (on the application of IH) v The Secretary of State for the Home Department (1) and The Secretary of State for Health (2)* (2002), a decision which is certain to prove to be highly significant for restricted patients potentially eligible for a conditional discharge, for those charged with their care, and for those Mental Health Review Tribunals contemplating a conditional discharge direction.

Nicolette Priaulx recognises that it is the *Human Rights Act 1998* which has enabled the Administrative Court in *R (on the application of KB) v Mental Health Review Tribunal and others* (2002) to voice strong criticism of the delays faced by too many applicants to the Mental Health Review Tribunal. She concludes her article by considering the *Draft Mental Health Bill*'s proposals for a new tribunal, the Mental Health Tribunal, and expresses her doubts that they will be able to manage effectively the increased workload which they will face.

Finally Simon Foster considers the Court of Appeal's decision in *R (on the application of Ann S) v Plymouth City Council and C (interested party)* (2002). This case was concerned with finding the right balance between an incapacitated patient's right to confidentiality and the right of his nearest relative to information to enable her to play her role effectively. The review considers the lead judgment of Hale L.J. in some detail, and welcomes firstly her exploration of the interrelationship between common law and the European Convention, and secondly her recognition of the importance which should be attached to the interest of those with learning disabilities in preserving confidentiality.

As always, we are very grateful to all those who have generously contributed to this issue of the Journal. They have responded with good humour and without complaint to our request that their contributions be as 'up-to-date' as our printing deadline has allowed, and to the tight schedule that we have therefore imposed on them.

John Horne

(Acting Editor)

The Separation of the Mental Health Act Commission's Functions: Inspectors, Visitors and Advocacy.

*Margaret Clayton**

Introduction

This article is written in the week in which both the draft Mental Health Bill[1] and the Durham University Report on Independent Specialist Advocacy[2] have been published for consultation. All Commissioners are being consulted about both documents and it would clearly be premature to express any Commission views until we have all been able to digest their contents. We shall naturally have strong views on a number of issues, particularly the expressed intention to replace the White Paper's proposed Commission for Mental Health[3] by a division of the new Commission for Health Inspection and Audit which will be responsible for scrutinising the proper application of the new Mental Health Act[4].

My intention here is not to attempt to anticipate our considered response but instead to put the spotlight on a critical strategic issue which is not raised in either document and may otherwise be overlooked. This is the relationship between the concept of independent specialist advocacy services as set out in the Durham papers, the statutory functions of mental health advocates as described in the draft bill, and the amalgam of functions involved in the current visiting functions of the Mental Health Act Commission (MHAC). There is no intention of suggesting answers to

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* *Chairman of the Mental Health Act Commission (December 1999 to present)*

[1] *Department of Health (2002) Draft Mental Health Bill Cm 5538-1. London Stationery Office www.doh.gov.uk/mentalhealth*

[2] *Barnes et al (2002) Independent Specialist Advocacy in England and Wales: Recommendations for Good Practice. Executive Summary and Consultation Questions. University of Durham, available from www.doh.gov.uk/mentalhealth/advocacy*

[3] *Department of Health (2000) Reforming the Mental Health Act. Cm 50161. London, Stationery Office. p52–6.*

[4] *See paragraphs 3.1 to 3.4 of Mental Health Bill – Consultation Document Cm 5538 – 111 Department of Health (2002). London Stationery Office.*

the questions raised. These will depend on consultation and consideration over time. The first part of the article, which is my sole responsibility, raises the general question. The second part describes, on behalf of the MHAC, how it has evolved since 1983 in a way which highlights the need for a close relationship between personal meetings with patients and a high level monitoring function. This combination may not be wholly compatible with an advocacy role.

Current Proposals

As the draft bill stands at present, there is no mention of how the current functions of the Mental Health Act Commission (MHAC) will be carried out under the new arrangements. The accompanying consultation document announces that the proper application of the Mental Health Act will become the responsibility of a specially established division of the new inspectorial commission and sets out some of its proposed scrutiny functions[5]. These accord well with many of the proposals the MHAC made in its submission on a successor body[6], providing in particular a power for the new organisation to visit patients where there is cause for concern. The implication both in the consultation document and the Durham papers is that this power would be exercised through the independent advocacy service. Both sets of documents are, however, silent on the question of how the other functions encompassed in the current regular visiting role of the MHAC is to be covered.

The White Paper said that the role which Commissioners currently fulfil in alerting patients to their rights and responding to the many matters of concern raised by them would be taken over by a special advocacy service[7]. No comment was made at that stage on how the equally important function of using the concerns and experiences of all the individual patients to highlight general shortcomings in compliance with the Act would be carried forward. Similarly, there was no mention of the role which MHAC's current Commissioners play in feeding particular or general concerns back to local managers immediately so that remedial action can be taken without delay. Although MHAC visits are periodic and not all detained patients are visited, where they do take place staff as well as patients consistently stress their value. This role should therefore be built on rather than supplanted.

The draft bill makes provision for the approval (subject to regulations) of mental health advocates who will have statutory powers of access to patients and their records and a responsibility for providing the following help to patients:

> "s.159 (2). The help available under the arrangements must include–
>
> (a) help in obtaining information about and understanding–
>
> (i) what medical treatment is being provided to the patient,
>
> (ii) why it is being provided,
>
> (iii) under what authority it is being provided,
>
> (iv) what requirements of this Act apply in connection with the patient's treatment and what rights can be exercised by or in respect of him under this Act, and
>
> (b) help (by way of representation or otherwise) in exercising those rights".

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[5] *Ibid*

[6] *MHAC (2000) A Successor to the Mental Health Act Commission. Available from www.mhac.trent.nhs.uk/successorbody.pdf*

[7] *Department of Health (2000) Reforming the Mental Health Act. Cm 50161. London, Stationery Office. para 7.9.*

These powers and this responsibility could enable the advocates to carry out a large part of the core visiting function of current Mental Health Act Commissioners, provided that they are adequately resourced and properly regulated. They do not, however, include the responsibility mentioned above of bringing together in a generalised way the material relating to the impact of the legislation on individuals so that this can inform wider scrutiny of how the new Act is being implemented. There is similarly no indication that feedback and advice to local managers, which could be seen as compromising the advocacy role, would be one of the expected functions. There is therefore no indication that the whole range of functions of the existing visiting Commissioners will be covered.

The consultation document on Independent Specialist Advocacy in England and Wales is concerned with good practice for mental health advocacy, stressing that advocates are primarily listeners whose ultimate goal should be to enable service users to grow towards advocating for themselves wherever possible. The same document suggests that, if there were a good working relationship between the specialist advocacy services and the inspectorate, "the inspectorate could hear from specialist advocacy services that are alerted to concerns about care, treatment or the operations of mental health legislation". Although this role is not part of the conventional understanding of advocacy, it does not seem incompatible with the suggested model for special advocacy services, provided that the information given is either anonymised or given with the consent of the patient. This would reflect the current relationship between the MHAC and the Commission for Health Improvement and the National Care Standards Commission. The key point is that the advocacy would feed into the monitoring, just as the current visiting functions of the MHAC feed into both its own management and external inspectorial bodies.

The advocacy document also suggests, among other things, that the inspectorate might use the specialist advocacy service:

- to be the first line of independent advice and support for service users who approach the inspectorate direct with concerns, with the advocates only passing matters back to the inspectorate if they cannot deal with the issue,
- to contact service users who make complaints to the inspectorate, possibly offering support through the complaints process but not investigating the complaint.

These suggestions are included in a section of the Advocacy consultation documentation which is headed "Monitoring Body". The only consultation question on this subject included in the Executive Summary (Q.16) is how specialist advocacy services should be independently monitored and who should be responsible for the monitoring. It would therefore be very easy indeed for people who, quite reasonably, read one or other of the consultation documents in isolation from the other not to recognise that there are important questions to be examined here.

The fundamental question is perhaps whether any specific responsibility for approaching patients or undertaking any other activity on behalf of a third party is really compatible with the broader concept of advocacy set out in the Independent Special Advocacy document. Similarly, is a right of access to documentation, irrespective of the wishes of the patient, or a duty to provide information on statutory rights, compatible with advocacy? Should there perhaps instead be a distinction between:

- mental health advocacy services on the lines described more generally in that document, which are offered to all but provided individually only at the request of the patient, i.e. on behalf of the patient;

- people (referred to here as mental health visitors for the sake of a different title) who have specific statutory functions and rights of access which would not necessarily be compatible with speaking on behalf of the patient, but which include visiting every patient within a given time after detention/compulsion and ensuring access to mental health advocacy services, i.e. in the interests of the patient; and
- an inspectorate which has the right to ask statutorily approved mental health visitors to carry out certain functions on its behalf?

Put another way, there seems no difficulty in advocacy feeding, in general terms, into a monitoring/inspection function the qualitative material which enriches the quantitative evaluation. Similarly, it seems right that the monitoring/inspection function should have a right to request an individual approach to particular patients for specific purposes. The crucial issue is whether the latter right involves an imposition of power, with however beneficial a motive, which is incompatible with the whole concept of advocacy.

These questions are stated in a very open way because, as I have said, the Commission has not yet examined in detail or consulted its Commissioners on the two documents. The answers depend on details which are not explored at the present stage of consultation because they will presumably be handled in regulations or Codes of Practice. During the period in which implementation of the legislation needs to be worked out, much could be gained from examining other models, such as the Dutch one mentioned in the Durham papers, or the work which is being done on introducing advocacy at HM Prison, Forest Bank, Salford and how this will link with HM Inspectorate of Prisons and the prison Board of Visitors. What I am anxious to ensure is that those whose concern is with people who may be made subject to compulsion under the new legislation look carefully at the inter-relationship between the draft bill's reference to mental health advocates, the contents of the advocacy consultation documents, and the way in which the MHAC visiting functions enhance quantitative evaluation with qualitative information. To quote the MHAC's own Policy and Communications Manager:

> "It would be a terrible irony if legislation providing a long overdue legal right of access to mental health advocacy also establishes a framework for advocacy and monitoring services which blurs the very real distinction between their roles with deleterious effects on the safeguards provided to patients"[8].

Evolution of the Mental Health Act Commission

The remainder of this article gives a fairly simplistic overview of the evolution of the MHAC to try to show how the visiting function has gradually evolved to encompass functions which may be seen as inspectorial, but which we see as essentially rooted in individual visiting. The purpose is not to demonstrate that all the current functions cannot be carried out in any other way but to provide an understanding of how the quasi-inspectorial role has evolved from individual visiting and the value of the interplay between the two.

The White Paper which preceded the 1983 Act stated that: " the proposed functions of the Commission will be separate to other inspectorial bodies; the Commission will not inspect and

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[8] *Mat Kinton (2002) Providing Mental Health Advocacy in a Patient-Centred NHS. The Mental Health Review 7:2, Pavilion.*

report on services and mental handicap in hospitals and units….[its] concern will be the particular problems which arise from detention of specific individuals in hospital rather than the general services which affect all mentally-ill and handicapped patients"[9].

Meetings between individual patients and Commissioners have been the focus of the Commission's work from the outset and continue to be so. In 1999–2001, Commissioners met over 22,000 patients. The meetings have resulted in numerous specific improvements in compliance with the Act in locations visited. But also from the outset it was clear that it is impossible to meet several thousands of patients each year without drawing conclusions about the general delivery of services. The Commission's Biennial Reports have therefore always highlighted general service issues as well as providing more detailed cameos of the effect on individuals of compliance – or non-compliance – with the Mental Health Act. As the 1990s saw an increasing emphasis on the need for more effective management of health services in general, it became steadily more apparent that, in spite of the primary visiting/meeting function, mental health hospitals and related facilities were tending to rely on Mental Health Act Commission reports to feed back to them short-comings in their own service delivery in much the same way as a school, prison, or police service would look to reports from OFSTED or HM Inspectorates of Prisons or the Police to do so. The key differences have been, of course, that the Commission has had neither the powers nor the resources of a public inspectorate and there has been no health inspectorate to which its findings could be relayed.

This blurring of the distinction between a visiting and an inspectorial body was beginning to emerge even before 1990, when the Commission centralised its original regional structure in Nottingham, thus increasing central direction and control. In 1995/6 the visiting process was formalised by the introduction of policies and documentation which enabled particular experiences to be synthesised in a systematic way. Open recruitment and selection procedures were introduced, leading to a much enlarged body of Commissioners and more emphasis on consistent reporting back to local managers. At the same time, commissioning bodies and other quality assurance interests were included in the reporting back process. The core function on which all the reports are based has nevertheless continued to be meetings with individual patients to ensure that the Mental Health Act requirements are being properly complied with in relation to each person and to provide validation of the generalisations made in reports.

Since 1996, the Commission has continued to evolve in response to the needs of detained patients and those tasked to deliver services to them. A further major internal review in 1998/1999 and the recent creation of a number of new inspectorial or semi-inspectorial bodies led directly to the focus in the Commission's 9th Biennial Report on the need to improve management performance and to related changes in the Commission's visiting programme. The change in the focus of the Report and the developments in the visiting programme, which are briefly described below, were designed primarily to meet the problem that the same broad failures in compliance had been identified year after year without apparent improvement, but they also enhance the value of individual meetings with patients and provide a better basis for highlighting failures in compliance at all levels of management.

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[9] *Department of Health and Social Security (1981) Reform of Mental Health Legislation. Cm 8405. London, Stationery Office. para 34.*

Current and continuing position

What are these changes and developments? Put very simply, the 9th Biennial Report[10] said that no matter how many patients are visited and how much new legislation is enacted, nothing much will change unless:

- there is a robust, properly funded infrastructure to provide the diverse, skilled and dedicated people needed to deliver proper services, and
- management at all levels takes responsibility for ensuring that legislative requirements and related policies are effectively implemented in relation to each individual patient.

The Commission has little influence over the first of these criteria. The recommendations in the Biennial Report and the changes in the visiting programme are, however, both aimed at the second.

In February/March this year, the Commission hosted a series of ten travelling seminars at which we presented the Biennial Report and the changes in our visiting programme to over 300 Chairmen, Chief Executives and senior managers from Health Authorities, NHS Trusts and related private organisations. The essence of these changes (expressed here in a greatly over-simplified way) is that:

- the core focus continues to be on meeting with individual patients;
- whilst a general monitoring focus will be maintained on key areas of concern determined by the MHAC (e.g. in 2002–03, control and restraint, seclusion, and consent to treatment arrangements), additional local monitoring priorities will be targeted during the two year cycle of visits to every mental health hospital, depending on weaknesses identified by local management through its own self-assessment processes or in previous Commission reports;
- there will continue to be feed back to local managers at the end of each visit with action plans required for all identified areas of concern;
- the sum of these visits, together with the outcomes of individual patient visits, will be used to provide commissioning bodies and each NHS Trust or private equivalent with an overview of their effectiveness in compliance with the requirements of the 1983 Act;
- these overviews will provide relevant inspectorial bodies with evidentially-based and validated information to underpin and supplement their own work, while the consolidated results of all the work and the national monitoring of the specific issues identified as priorities by the MHAC itself will sharpen the focus on areas for national review or action.

In general, our new approach has been seen as a positive and helpful enhancement of what the MHAC already does. We have stressed that while our main aim is to help the patient by ensuring that managers "get it right first time", this will also have the considerable benefit to local and other managers of enabling them to demonstrate to all the various bodies concerned that they have in hand effective arrangements to secure ongoing compliance with the legislative requirements. We are making all our monitoring forms available to managers on request to encourage them to check essential safeguards for themselves.

We know that many managers are already using the recommendations in the Biennial Report as a check-list to see how far they are addressing the key weaknesses identified in that Report. At the request of those who attended our seminars, we have also recently issued a checklist and reporting

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[10] *MHAC (2001) Ninth Biennial Report. London, Stationery Office.*

tool for optional use as an aide to help establish good arrangements locally. This may also help managers to respond to the Key Performance Indicator now introduced into the National Service Framework process by the Department of Health as a result of the Commission's urging in the 9th Biennial Report that compliance with the Act is an important ongoing duty which must be positively managed alongside other current priorities.

The main focus of all Commissioners is still on meeting with individual patients to hear their account of their experiences of service receipt, while also checking that their care and treatment is in accordance with the 1983 Act and that their clinicians and local management are aware of any shortcomings and concerns in relation to that particular patient. The new documentation enhances our ability to ensure that the lessons learnt from the experiences of individual patients can be brought together in a standard form which enables the Commission to provide a validated and comprehensive report for local management and commissioning bodies. This not only draws attention to particular cases where action is needed but also highlights whether those particular cases demonstrate or suggest wider failures in compliance with the Act.

The function of meeting patients is seen as essential to provide practical evidence as to whether the Act is being implemented in relation to individual patients in the way implied by more general monitoring tools. Only the patients themselves have the unique knowledge and understanding of what it is like to be compelled to remain in a particular situation and experience the feeling of others being in control of their lives. Such meetings are also vital to the well-being of individual patients, who often have no other independent person to whom they can turn for informed advice and help.

In spite of this emphasis on the importance of patient meetings, the change of style in the 9th Biennial Report, the subsequent emphasis on the need for management to make a more positive effort to ensure compliance with mental health legislation, and the clarification of the respective functions of meetings with patients and reporting/monitoring has led some commentators to assume that the Commission has abandoned its key role of keeping under review the operation of the Act as it relates to the detention of patients, or to patients liable to detention, under the Act[11]. This is far from the truth. We see the situation rather as the continuation of a gradual evolution which recognises the need to ensure that the experiences of individuals continue to have a real impact on the technologically-based and quantitative approach to quality assurance which seems to characterise the beginning of the 21st century. There must continue to be a qualitative input to the quantitative monitoring. Nevertheless, the greater emphasis on general reporting can be seen as the beginning of a separation between the visiting and monitoring functions which requires careful consideration to be given to how the benefits of regarding them as two parts of one whole can be retained.

If this is to be achieved, personal experiences must be recorded and synthesised to focus on the specific action needed to remedy the more general defects in the service revealed by the failure to deliver in individual cases. And this identification of required action in turn needs greater powers to make sure that targeted action plans are produced and fulfilled. It may therefore be that the wheel has now come full circle and the time has come to separate the visiting functions yet again from the wider monitoring and inspectorial ones. Input to the new inspectorate from advocacy

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11 *For example see Anselm Eldergill's review of the 8th Biennial Report, Journal of Mental Health Law, February 2002, pages 85–92.*

services, PALS, and Community Health Councils could provide the qualitative flesh to the quantitative bones. The inspectorial function could be the key to ensuring the positive follow-up which the MHAC has had no power to achieve. But, as stressed in the first half of this article, the greater ability to monitor and enforce and the greater access by patients to advocacy services must not be allowed to undermine each other's integrity – there may still need to be a third element of statutorily based meetings with patients which provides the necessary link between them. How this might best be achieved remains to be seen.

Treatment over objection: minds, bodies and beneficence

Sameer P. Sarkar and Gwen Adshead***

> *"The only freedom which deserves the name is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily or mental and spiritual"*
>
> John Stuart Mill – On Liberty[1]

Introduction

This quote from Mill highlights an important distinction for medical ethics: a distinction between bodily and mental health. In this paper, we want to look at the ways that ethics and law have addressed this distinction, especially in relation to involuntary treatment. We will claim that both philosophy and case law appear to address involuntary treatment for physical disorders in very different ways to involuntary treatment for mental disorders; and will relate these differences in analysis to different approaches to understanding the capacity to make autonomous decisions.

Voluntary and involuntary treatment.

The bioethics literature generally has privileged the place of patient autonomy in medical decision making: a position perhaps best summed up by Judge Cardozo in *Schloendorff*: [2]

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."

There are two key issues here; first, that the privileging of autonomy rests on a finding of 'soundness of mind'; second, that any intervention by the doctor that does not reflect the patient's autonomous agreement is an assault. By extension, where there is 'unsoundness of mind', the patient's right to choose for himself may be undermined, and therapeutic interventions may (a) be performed without consent, and (b) will not then constitute an assault in legal terms.

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* *Specialist Registrar in Forensic Psychiatry, The Institute of Psychiatry, De Crespigny Park, London.*

** *Consultant Psychotherapist, Broadmoor Hospital, Berks.*

[1] *John Stuart Mill, On Liberty . London: Pelican Books . 1974 at page 72*

[2] *Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129–30, 105 N.E. 92, 93 (1914).*

This extended argument is bourn out by existing legal approaches. Any non-consensual treatment, unless legally sanctioned. will be liable to damages as per existing Tort laws. Changes to the legal concept of 'consent' have led to shifts in the application of judicial sanctions[3]; including notions such as "informed" consent, proxy consent, best interest, and substituted decision making. Consent is defence to assault; where there has been consent, there can be no injury[4].

Underpinning the concept of consent lies the concept of capacity or competence. Confusingly these terms may reflect either the legal or the clinical concept, depending on which side of the Atlantic it is being discussed; in this paper we use the term *competence* to refer to the *psychological* construct underpinning a *legal* concept of *capacity*. As suggested above, lack of capacity has been understood as justifying involuntary treatment, or at least undermining a right to consent before treatment. The question of involuntary treatment has been most widely explored in relation to people with mental illness, whose competence to make autonomous decisions may be impaired by that illness. Most countries have legislation that provides a legal measure setting out the conditions under which it is lawful to impose involuntary assessment, detention or treatment for a mental illness.

Such measures frequently cause controversy among jurists, clinicians and academics in mental health law. Most jurisdictions proscribe any prolonged deprivation of liberty of citizens; so that (for example) in the US and Europe, involuntary detention and treatment may contravene both the 14th Constitutional amendment in the USA, and the European Convention on Human Rights.

Some have argued that such involuntary treatment constitutes a paternalistic intervention in the lives of those who are merely socially deviant ([5,6]cf Kittrie, 1971; Szasz, 1960); or even, that involuntary treatment for mental disorder represents the most severe intrusion by the state into individual civil liberties, short of criminal charge and conviction. Such a view points out the similarities between responses to deviance as a consequence of illness, and criminal deviance, in that both deprive the individual of his or her liberty, usually involve forced residence in an impersonal institution, and subjection to control by others which may entail loss of dignity ([7]Goffman, 1961).

In the case of forced treatment, a person may also be subjected to physical coercion and even intrusion; both of which may be experienced by the individual as humiliation or even punishment. The tremendous power differential between the recipients and providers of mental health care makes freedom to choose an illusion, even when it is ostensibly voluntary[8]. Finally, it has been argued that (a) it is difficult to make mental health diagnoses which would justify any intervention, and (b) that distressing mental experiences do not constitute a health 'disorder' at all; (we will not explore this argument further in this paper, referring the interested reader to Fulford, 1989 for a review[9]).

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[3] *Paul S. Appelbaum. Almost a Revolution–Mental Health Law and Limits of Change, Oxford University Press. 1994.*

[4] *Feinberg,J. Harm to others. Oxford OUP. 1984*

[5] *Kittrie,N. Right to be different. Viking Press 1971.*

[6] *Szasz,T. (1960) The myth of mental illness. American Psychologist; 15: 113–118*

[7] *Goffman,E . Asylums. London, Penguin . 1961*

[8] *McCubbin M., & Cohen D. (1996) Extremely Unbalanced: Interest divergence and power disparities between clients and psychiatry. Int J. of Law and Psychiatry , 19, 1–25*

[9] *Fulford,K.W. Moral theory and medical practice. Cambridge, CUP. 1989*

The counterarguments in support of involuntary treatment for mental disorder are briefly:

(a) that mental competence can be lost for health reasons, and

(b) that an individual's lack of mental competence to make decisions for himself is a justification for benevolent intervention by others, and

(c), further, that loss of competence, being a harm in itself, should not result in further harms or the prevention of benefits[10].

Such paternalistic arguments assume that where there is absent or diminished capacity to make decisions, a duty to benefit others takes precedence over autonomy, and that there is only limited over-riding of autonomy. Thus, both the wrong and the harm done to the individual are minor. Further, involuntary treatment is almost always used as a last resort, when there is not only a demonstrated need but also when there is the potential for *harm* without it. Although such weak paternalism does limit autonomy on the grounds of beneficence, the harm or wrong done by denying autonomy is offset by the harm that would have been if the choices of an incompetent person were honoured, or if no choice were made at all. For these reasons, competence underpins legal capacity to consent to health care decisions; absence of competence/capacity is a justification for state intervention on the grounds of *parens patriae*, a legal notion whereby power is exerted by the state on behalf of its citizens.

Perhaps what is most striking about these arguments are the underlying assumptions that mental disorders uniformly render patients incompetent to consent, and that physical disorders do not. Factors that might limit competence have not been explored in the same detail, other than mental illness. Nor has there been the same attention paid to those situations where individuals refuse treatment for *physical* disorders. As a result, there have been several legal cases which have pushed the theoretical debate, in both the USA and England. Before, reviewing those cases, we consider in more detail the legal and philosophical aspects of capacity.

Autonomy, Competence and Capacity

Competence and capacity are legal and psychological concepts, which in turn are closely conceptually related to the philosophical concept of autonomy, which entails (arguably) both a psychological competence to choose for oneself, and the experience of a self that chooses. One requires a competence to be autonomous; to achieve what Berlin describes as 'positive liberty'[11].

Autonomy may not have a single coherent meaning; Feinberg[12] suggests that there are four:

(i) the capacity to govern oneself;

(ii) the actual condition of self-government;

(iii) an ideal of autonomy, derived from (ii); and

(iv) the authority to govern oneself.

Within medical ethics, this fourth aspect arguably underlies both the principle of respect for autonomy and the privileging of that principle[13]. Gillon[14] has suggested that it may be helpful

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[10] *Buchanan,A & Brock,D Deciding for others: the ethics of surrogate decision making. Cambridge, CUP. 1989*

[11] *Berlin,I Four essays on Liberty. Oxford OUP 1971*

[12] *Feinberg,J Harm to self. Oxford OUP 1986*

[13] *Beauchamp, T & Childress,J Principles of biomedical ethics. Oxford OUP 1994.*

[14] *Gillon,R. Biomedical ethics. BMA books. London, 1985*

(certainly in the medical domain) to consider autonomy of will, thought and action as separate capacities. Christman[15] distinguishes the psychological capacity for autonomy (P–C autonomy) from the right against actions which undermine P–C autonomy (R autonomy).

Christman's distinction may be a helpful way to think about the distinction between consent to treatment for physical disorders, and consent to treatment for mental disorders. Respect for autonomy in relation to treatment for physical disorders seems to privilege R–autonomy, whereas in relation to mental disorder, it is assumed that P–C autonomy is so compromised that R– autonomy is not a consideration. We will return to discuss this further.

Autonomy and others

Respect for autonomy is reflection of the respect for individual freedom, which Mill believed would produce the greatest happiness for individuals. But Mill's emphasis on liberty is arguably only relevant in isolation and not in the company of others[16]. It has been argued that the traditional concept of autonomy is too individualistic and does not take into account normal human experiences of dependence and need for others.[17] Similarly, autonomy is likely to be a developmental capacity that has a lifespan trajectory, and may change over time; there may be different types of autonomy at different stages of the life span. This shifting nature of autonomy is most obvious in relation to children and adolescents where the developing child's autonomy is located in a network of relationships with carers, and only emerges over time[18,19]. This notion of a nested or located autonomy is similar to that described by Agich as 'interstitial autonomy'. Such N (or network) autonomy is located in the psychological spaces between people in relationships with each other, where their experience of themselves is profoundly affected by those relationships.

A more complex account of autonomy could have significant implications for the ways we look at ethical and legal dilemmas in mental health practice. One of us has argued elsewhere that an approach to ethical reasoning, which locates the actor in a relational context rather than a rights based approach, may offer different and more complex solutions[20]. In contrast, the law in AngloSaxon jurisdictions such as the US and the UK tends to reflect a traditional individualistic approach to autonomy, as exemplified by the legal notion of capacity to make choices. Such legal capacity is individually based, and is a categorical decision (either one has capacity or one does not[21]). There is some acknowledgement that different decisions require different capacities; e.g. the legal test of competence to make a will (which is a criteria based test) is different from the legal test of competence to get married (which is a status based test).

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[15] *Christman,J(1988) Constructing the inner citadel: recent work on the concept of autonomy. Ethics, 109–124.*

[16] *" We are not isolated free choosers, monarchs of all we survey, but benighted creatures sunk in a reality whose nature we are constantly and overwhelmingly tempted to deform by fantasy"– Murdoch, "Against dryness", in S. Hauerwas and A. Macintyre (eds.) Revisions: Changing perspectives in Moral Philosophy . University of Notre Dame Press 1983 at p. 49.*

[17] *Agich,George A . Autonomy and longterm care. Oxford OUP. 1993*

[18] *Josselson,R-E. The space between us. Josse-Bass. 1992*

[19] *Sutton,A. (1997) Autonomy in adolescents. Journal of Medical Ethics. 23: 26–31*

[20] *Adshead,G. A different voice in psychiatric ethics. In Parker,M & Dickeson,D (eds.) The Cambridge medical ethics work book. Cambridge, CUP. 2000. pp 185–190.*

[21] *Kennedy,I & Grubb,A. Textbook of Medical Law. London, Butterworths. 1994.*

Autonomy and rationality

Mill's account of autonomy also presupposes rationality, where rationality means the privileging of reason over emotion. Although the descriptive splitting of thinking and feeling as separate psychological functions has a long conceptual history, there is less evidence to support such a split than may be supposed. Affects generate thoughts, and thoughts generate affects; thinking and feeling are processes which need to operate as a psychological matched pair. If either are out of kilter, then the other will be affected; the relationship is symbiotic rather than hierarchical. Rationality therefore presupposes a functioning capacity for both affects and cognitions; it will not be possible to be rational where there is dysfunction of either process.[22]

Rationality and autonomy have been closely linked conceptually; hence the general and traditional assumption that the mentally ill lack autonomy, because they lack rationality. Rationality includes the logical capacity to make judgements and decisions, and it is generally assumed that the presence of a mental illness compromises the ability to make decisions of any kind. In fact, it might be argued that one of the symptoms of mental illness is an inability to make decisions for oneself; a loss of an ability to govern oneself is a diagnostic criterion in its own right.

It is however not so clear that all types of mental illness do compromise all types of autonomy, or diminish all capacity to make any decisions[23]. There is increasing evidence that people with mental illnesses do retain capacity to make all sorts of decisions, including consent to treatment and research. The problem remains that others may not like their decisions, and this subjective reaction may lead to a questioning of capacity[24]. What this suggests is that the test of rationality applied is one that relates to the supposed motivations behind the decision[25] or the comprehension and acceptance of the reasons given for the decision[26].

Many important life decisions for people involve a low threshold for decision making competence. In English law, for example, one need only be 16 to choose to have heterosexual intercourse, or to get married. One has to be aged 18 to vote; this decision, one might argue, is a less complex decision than either of the previous two, which involve judgements about complex interpersonal relationships over time. One need be only 16 to make decisions about health care; later legal modifications to this are discussed below. Given that tests of competence for these decisions are generally set very low, it seems anomalous to set them higher on the basis of an individual's history of mental disorder. It might be argued that the consequences may be potentially very serious, if the wrong decision is made; but this argument would apply also to individuals with physical disorders also.

It could be argued that any type of disorder, physical or mental, compromises autonomy to some degree. Although the distinction between will, thought and action looks attractive, psychologically these are likely to be overlapping domains; and someone with what might be thought to be a purely physical disorder may well find that their sense of themselves as autonomous has been altered or compromised[27]. Something of this difficulty can be seen in relation to patients' experience of

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[22] *Charland, L. (1998) Is Mr Spock mentally competent? Philosophy, Psychology & Psychiatry, 5:67–81.*

[23] *Grisso,T & Appelbaum,P . Assessment of competence. CUP 1998*

[24] *Roth,L et al. (1982) The Dilemma of denial in the assessment of competency to refuse treatment. American Journal of Psychiatry 139: 910–913*

[25] *Matthews,E . Mental and physical illness: an unsustainable separation? In Eastman,N & Peay,J (eds.) Law without Enforcement. Hart Publishing, Oxford. 1999 pp 47–59.*

[26] *Culver,CM & Gert,B. Cited in Buchanan and Brock (supra). p 66.*

[27] *Sacks, O. A leg to stand on. Simon & Schuster, New York, 1998*

giving informed consent in general medical practice, where it is clear that although the procedure of informing patients has taken place, patients do not retain information, and may be hazy about the implications of the consent procedure. Similarly, a study by Appelbaum[28] found that a significant proportion of apparently competent people could not distinguish between participation in research and therapy.

Legal approaches to capacity: English and US law

Consent to treatment

We have suggested that both mental and physical disorders may have an impact on the capacity to make good quality decisions about health care. We have emphasised this issue because it appears that the legal approaches to capacity differ in relation to physical and mental disorder. We turn now to review some relevant legal cases.

Consent is defined as the voluntary and continuing permission of patient to receive a particular medical treatment. It is based on knowledge of the nature, purpose, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Consent should be freely given (i.e. in the absence of duress or inducements) and includes the right to refuse treatment.

Valid consent is that which is given by a person with the capacity to make a treatment choice. Right to self-determination in adults with capacity generally prevails over any countervailing state interest[29]. In relation to the consent of children, a majority decision in the case of *Gillick*[30] held that age alone did not make one incapacitated to consent; and parental authority has to give way when capacity is established, based on the maturity of the individual child.

American law has utilised a concept of ‘informed consent’, which entails competence, disclosure, understanding, voluntariness and consent[31], all of which must be present for consent to be legally binding. We concentrate here on the legal criteria of competence and understanding, and relate these to more general accounts of tests of capacity to consent. Broadly, these are–

(a) the ability to make and express a decision

(b) to actually understand the information presented and alternatives

(c) to rationally manipulate the information and appreciate the implications of alternative choices and

(d) to make a reasonable decision.

US and British tests are fairly similar; English law criteria include the ability to understand, retain and believe information.[32,33] English common law allows a competent individual to decline treatment under the same broad general principles as in the US; the test for capacity to refuse treatment appears to be same as consenting to treatment.

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[28] *Appelbaum PS et al (1987) False hopes and best data: Consent to research and therapeutic misconception. Hastings Center Report. Apr.: 20–24*

[29] *Home Secretary v. Robb [1995] 1 All ER 677*

[30] *Gillick v. West Norfolk and Wisbech Area Health Authority and another [1985] 3 All ER 402*

[31] *Beauchamp and Childress goes further to add recommendation of a plan in the information part. Authorisation of the chosen plan then becomes similar to expression of consent. Similarly, refusal of consent has to be read as decision against a plan. – Principles of Biomedical Ethics – 4th Ed. Oxford University Press. 1994*

[32] *Re C (Adult) (Refusal of Medical Treatment) [1994] 1 WLR 290, sub nom C (Refusal of Medical Treatment) [1994] 1 FLR 31*

[33] *Clauses 1 to 5 of a draft of a Bill annexed to the Law Commission report No 231 on Mental Incapacity. 1995.*

Absence of consent: who decides?

Previous cases have highlighted the need to make clear the role of third parties or the state in giving consent to treatment for those who cannot give consent for themselves, either permanently or temporarily. In *re B*,[34] the House of Lords found that medical treatment in the absence of consent was not an assault if the treatment were in the patient's best medical interests (as defined with reference to a professional medical standard). However, they noted that there might be some treatments that had such social significance (such as sterilisation) that the treatment decision could not be left to the medical profession, but a court opinion should be sought. Several subsequent cases have further defined 'socially significant' treatments, and the role of the court.

The English courts have therefore favoured a medical justification for proceeding in the absence of consent. In contrast, the American courts have tended to favour the notion of 'substituted judgement' i.e. others make a judgement for the incompetent individual. Yet this is not straightforward. In *Saikewicz*,[35] the Massachusetts Supreme Court reviews the concept of substituted judgement; and argues that it involves ascertaining the incompetent person's actual wishes and preferences. However, they also suggest that the decision should be:

> 'that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would….be part of the decision making process'.

In the case of *Quinlan*[36] however, the New Jersey Supreme Court indicated that the views of others close to the individual could substitute for the views of the incompetent patient; which seems to support a less atomistic view of a person's choices.

Various legal measures have been proposed for dealing with cases where there is lack of capacity. A process of substituted decision making was supported by the Law Commission[37] and the Expert Committee recently reviewing English mental health legislation[38]. The Law Commission has also supported advance directives and 'living wills', which express previously given consent as if it were given now, even if currently incapacitated. Lord Goff in *Bland*[39], and British medical codes of practice, have clearly stated that advance refusals (directives) are as valid[40] as the advance statements.[41] Once established as authentic, due respect must be given to such an advance directive. However, such directives are not binding on the professional nor are they effective in the case of treatment refusal for mental disorder if the patient is detained under the Mental Health Act 1983 and is subject to the provisions of Part IV of that Act.

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[34] *Re B (a minor) (wardship:sterilization) [1987] 2 All ER 206*

[35] *Superintendent of Belchertown State school v. Saikewicz. Supreme Judicial Court of Massachusetts, 1977. 373 Mass.728, 370 N.E.2d 417.*

[36] *In Re Quinlan. Supreme Court of New Jersey, 1976. 70 N.J. 10, 355 A.2d 647.*

[37] *Law Commission– Report on Mental Health Incapacity 1995*

[38] *Department of Health (1999) Review of the Mental Health Act 1983: Final Report of the Expert Committee . Department of Health, London.*

[39] *Airedale NHS Trust v Bland [1993] 1 All ER 821.*

[40] *For an advanced directive to be valid and enforceable, the following has to be satisfied (BMA Code of Practice, infra note 41):*

(a) advance instructions are clear and unambiguous as to what is to be done (or not done) and under what circumstances

(b) at that time he is legally competent to do so

(c) the document should be witnessed

(d) been made fully aware of the risks, alternatives etc.

(e) circumstances are exactly similar, verified by independent health carer(s)

Also see Richard Jones Mental Health Act Manual (2001) (Sweet and Maxwell – 7th edition) Para I–630.

[41] *BMA Code of Practice on Advance Statements about Medical Treatment – Report of the British Medical Association – BMA 1995*

The capacity to refuse treatment: physical disorders

In most jurisdictions, a competent treatment refusal must be respected by health care teams. This stance reflects not only the respect for autonomy described above, and the privileging of autonomous decisions, it also recognises that there are decisions that are more important than medical ones. Such an approach has been reflected in legal decisions on both sides of the Atlantic. The cases are often tragic ones; for example, the case of AK, a 19 year man with 'locked in syndrome' who refused further treatment, knowing this would result in his death.[42] Some cases have involved refusal of treatment on religious grounds.[43]

However, the key issue here is that of how to conceptualise the competence to make such a decision, especially where the foreseeable consequences are risky to the individual concerned. It has been argued that the more serious the consequences, the greater the degree of capacity which needs to be demonstrated. Counterarguments have emphasised the right to make decisions that are unpopular with others, especially in the domain of quality of life and living. Such debates have naturally found most relevance in relation to refusal of treatment that leads to death. Interestingly, the American courts have suggested that the right to privacy includes the right to die.

When treatment refusals have been contested by third parties, the courts have paid close attention to the competence of the patient, and generally assumed that the capacity to consent is the same as the capacity to refuse. In *Yetter*,[44] the court found that if the refusing patient was aware of the possible consequences of her refusal of treatment then this should be respected, even though it might be considered 'unwise, foolish or ridiculous'. In both *re C* and *re B*, the Courts found that a patient detained in a mental hospital, suffering from a mental disorder, could still make a competent treatment refusal, which must be respected; and in *re T*,[45] Butler-Sloss LJ stated (at 664),

> 'the decision to refuse medical treatment by a patient *capable* of making the decision does not have to be sensible, rational or well considered' (emphasis added).

However, this approach has not been consistently supported in relation to one group of competent patients: pregnant women who refuse Caesarean section. Even where the competence of the patient is not in doubt, women have been legally compelled to have surgery in order to save the life of their unborn child.[46] In *St George's Healthcare NHS Trust v S*,[47] the mother was compelled to have the surgery; at appeal, Judge LJ said this:

> 'the autonomy of each individual requires continuing protection even, perhaps particularly when the motive for interfering with it is readily understandable, and indeed to many would appear commendable'.

But as Wicks suggests, it is hard to know if this principle would still have been respected if the patient had not been coerced, and subsequently died. In these cases, one must conclude that the clinicians and the courts have been more influenced by the perceived risky consequences than the principles of respect for autonomy. However, the extent to which professional anxiety may

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[42] *re AK [2000] 58 British Medical Law Review 151*

[43] *In re Osborne District Court of Columbia Ct of Appeals, 1972. 294 A.2d 372*

[44] *In re Yetter Court of Common Pleas of Northampton County, Pennsylvania, Orphans Court Division, 1973. 62 Pa.D.& C.2nd 619.*

[45] *Re T (Adult refusal of medical treatment) [1992] 4 All ER 649*

[46] *Wicks, E (2001) The right to refuse medical treatment under the European Convention on human rights. Medical Law Review, 9: 17–40.*

[47] *St George's Healthcare NHS Trust v S. [1998] 3 All ER 688*

compromise good quality decision making is not anywhere discussed; just as AK's feelings about his terminal illness are also not discussed. There appears to be a distinction operating about the experience of psychological distress: In relation to a physical condition, it is rational, understandable and does not compromise competence, but in relation to a mental condition, psychological distress is neither rational nor understandable, and does compromise competence.

The capacity to refuse treatment: mental disorders

The situation with regard to treatment refusal is very different if this is in the context of mental disorder. Under current English law, a detained patient may not be legally able to refuse treatment for a mental disorder under certain conditions. There is no requirement to show that the patient lacks capacity to make a treatment decision, (unlike the approach taken above where a determination of capacity is essential); only that they suffer from a 'mental disorder' (a status test).

'Medical treatment' is defined in the English Mental Health Act 1983 as including 'nursing and also includes care, habilitation and rehabilitation under medical supervision'[48], broadly the range of activities aimed at alleviating or preventing deterioration of the patient's mental disorder. It also includes physical treatment such as Electro-convulsive Therapy (ECT) and the administration of drugs and also Psychotherapy.

Two sections limit the administration of involuntary treatment. There are treatments of a particular kind, administration of which needs special safeguards because of their very nature or effects (such as psychosurgery or hormone implants). Section 57 of the English Mental Health Act requires for these types of treatment both the patient's expressed consent and a second opinion. For ECT or prolonged drug treatment, either consent or a second opinion is required under Section 58.

All other treatment not specifically falling under sections 57 and 58, can be given without the patient's consent, even when capacity is retained. This would include a variety of therapeutic activities with a variety of staff, psychological and social therapies. Only involuntary treatment for mental disorder therefore covers such a wide range of interventions; no such treatments can be given involuntarily for physical disorders.

However, new advances in medicine highlight some of the difficulties there may be in making such a distinct separation between mental and physical disorders. Certain drugs, used for both physical conditions and mental conditions, can have different status under consent provisions. An example would be Propranolol. Originally a drug for heart conditions; it is used for treatment of anxiety. When used as such, it falls under Section 58. When the same drug, in similar dosage is administered for Lithium[49] induced tremor or akathisia[50], it is not legally necessary to obtain consent or subject it to Section 58 because the treatment will be for a neurological condition, not a mental illness.

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[48] *Mental Health Act 1983 Section 145*

[49] *a mood stabilizer – used in treatment of manic depressive illness among others*

[50] *a condition of motor and psychic restlessness, usually but not exclusively a side effect of certain anti-psychotic medications*

New and controversial interventions have been added to the list of treatments for mental disorder, which can therefore be given in the face of a flat refusal. These include restraint[51,52], involuntary Caesarian section[53] and tube feeding[54]; all of which have been deemed by courts to be treatment for mental disorder. Treatment has even been extended to include assessment[55].

Such decisions reveal striking anomalies in the way that the English courts have dealt with treatment refusal in relation to mental disorder and physical disorder. Consider tube feeding as an example. An ordinary person who decides to starve themselves to death (for example, a prisoner), or a terminally ill person who is not eating during the final stages of life, cannot be force fed against their will. It may be that if they become incompetent to take a treatment decision (e.g. when they become unconscious) that treatment may be given in the absence of their consent as described above.

If, however, food-refusing individuals can be deemed to be suffering from a mental disorder, then they can be force fed, even if they are deemed to be competent. The 'not eating' is understood as a symptom, which is secondary to the mental disorder, and forced feeding is the appropriate treatment for that symptom. This was the case in *B v. Croydon Health Authority* where, although B's treatment refusal was deemed to be competent, she could be force fed in the face of her refusal because she was detained for treatment of a mental disorder. Compare this with the stopping of feeding of those with terminal illnesses, where the loss of appetite is secondary to the physical disorder, but a previously expressed wish to forego treatment for the physical disorder can be accepted.

In the case of suspected mental disorder, the judiciary appears to abandon autonomy as the overriding value in relation to consent, and instead favour beneficence, in the form of treatment intervention. In these cases, English courts seem to have favoured a medical 'best-interest' model; consistent with the courts approach to consent in children, where, even if *Gillick* competent, best interests was once again held to be all prevailing[56].

Mental and physical disorder : autonomy and risk

As described above, courts seem to take a wide definition of treatment for mental disorder, which includes treatment for the physical symptoms of that disorder. The courts have reasoned that to take any treatment interventions out of context will be 'too atomistic a view'[57]. They appear to have taken the view that involuntary treatment may be given for *any* physical condition which is *'integral'* to the mental disorder of the patient.

What is then not clear is what 'integral' means in this context. The courts seem to be arguing that where the physical symptoms can be understood as related to the mental disorder, even indirectly, then treatment for the symptoms will be treatment for mental disorder, and thus can be given under current law. However, this position is not consistent with the view (held in both *C* and *B*) that the

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[51] *Tameside and Glossop Acute Services Trust v CH [1996] 1 FLR 762, (1996) BMLR 93*

[52] *Herczegfavly v Austria [1992] 15 EHRR 437*

[53] *Tameside supra note 51*

[54] *B v. Croydon Health Authority [1995] Fam 133. [1995] 2 WLR 294, [1995] 1 All ER 683, [1995] FLR 470, CA*

[55] *B v. Barking Havering and Brentwood Community Healthcare NHS Trust, Court of Appeal [1999] 1 FLR, 106 Lord Woolf MR at 114 E*

[56] *Re. W (A Minor) (Court Jurisdiction) [1992] 3 WLR 758 at 769*

[57] *Tameside supra note 51*

presence of a mental disorder does not necessarily compromise all an individual's decisions. People can apparently split off different aspects of their experience, especially decision making capacity, and possess full competence, even where there is serious physical and/or mental disorder.

The distinction which is being made here seems to rest on the assumption that the presence of any mental disorder globally affects all decision making, so all decisions are rationally suspect and do not reflect a 'true' decision of that person. In addition, physical symptoms arising from treatment refusal in cases of mental disorder are therefore also symptoms of mental disorder; psyche and soma are 'integral' to each other. In contrast, physical disorders are not assumed to affect mental processes in a global way, or indeed in any way. No matter how physically symptomatic the patient is, nor however risky the consequences, his mental capacity to make a treatment refusal can be reliably separated from the effects of his physical disorder; psyche and soma are dis-integrated.

Does it make sense to distinguish mental and physical disorders as different entities in relation to capacity? It might be argued that the chronicity of some mental disorders does affect autonomy in ways that differ from physical disorders which often occur in discrete episodes. As Agich has argued[58], the ethical issues raised by the delivery of long term care are different from acute care. Agich has argued that "chronic illness involves suffering as a mode of existence" and the definition fits most models of mental illness and certainly personality disorders. Chronic illness is not treated, it is *managed*. Chronic illness thus has to be discussed along a different axis, one which is complementary to liberal theory, not inimical to it[59]. Agich's argument is that, there are differing levels of autonomy, there must be different levels of capacity. But there is no reason why this argument should not also apply to chronic physical disorders. As autonomy shrinks in any sort of chronic illness (mental or physical), so competence to make treatment decisions may be restricted. By implication, legal capacity may also be reduced and parens patriae powers become more prominent.

As Winick[60] suggests, a strong distinction between mental and physical illness in terms of capacity, not only treats those with mental illnesses as lesser citizens in terms of autonomy and consent, but can also have a stigmatising effect on therapeutic relationships for both patients and mental health staff. Research by the MacArthur foundation has found out perceived coercion is common in all forms of psychiatric hospitalisation, and treatment and legal status is not an accurate indicator of perception of coercion.[61]. This perception of coercion itself interferes with competence. Valid consent, by most moral and legal definitions has to be free, so that consent obtained under any form of duress is not true consent, but assent. Arguably, a patient who has just been made subject to 'compulsion'[62] has had a large part of his voluntariness eroded; which in turn must undermine

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[58] *Agich, George A. Chronic Illness and Freedom. In Carson R, Barnard D, Toombs K, eds. Chronic Illness and the Humanities. Indiana University Press. Indiana. 1992*

[59] *Agich , George A. Autonomy and Long-term Care. New York: Oxford University Press. 1993*

[60] *Winick,B The Right to Refuse Mental Health Treatment American Psychological Association, Wash. DC 1994*

[61] *Monahan, J., Lidz, C., Hoge, S., Mulvey, E., Eisenberg, M., Roth, L., Gardner, W., & Bennett, N. (1999). Coercion in the provision of mental health services: The MacArthur studies. In J.Morrissey, and J. Monahan (Eds), Research in Community and Mental Health, Vol. 10: Coercion in Mental Health Services — International Perspectives. Stamford, Connecticut: JAI Press (pp. 13–30). " Legal status is only a blunt index of whether a patient experienced coercion in being admitted to a mental hospital. A significant minority of legally "voluntary" patients experience coercion, and a significant minority of legally "involuntary" patients believe that they freely chose to be hospitalized".*

[62] *preferred term of the Committee – preferred over detention as it will/can extend to treatment in the community*

his competence to make decisions. The very coercive nature of detention[63] or compulsion makes any discussion of voluntariness in consent theoretically redundant. If autonomy is all or none, then 'Choice' is all and 'Compulsion', none. Any further negotiation based on capacity merely reinforces Agich's point that autonomy is graded and negotiable.

Legal reasoning

Perhaps legal approaches to capacity reflect a traditional split in Western cultures, which since the 17th century have seen reason as a property of mind, which is distinct from passions or emotions, which are the property of the body[64]. If the mind is disturbed everything is disturbed; if the body alone is disturbed, reason can still prevail over physical sensation and feeling. Unfortunately, there is not much evidence for this traditional view. Instead, there is increasing evidence that physical and mental disorders have similar, but limited effects on capacity in different ways for different people.

It might be argued that if any physical disorder could compromise autonomy and competence, then it might be justifiable to over-ride refusal on paternalistic grounds in the traditional way. Bartlett and Sandland[65] have expressed legal concerns in relation to overturning treatment refusal, fearing a 'post-modern world where the limits are constantly receding as one approaches it'. Montgomery has gone so far as to suggest that the way is paved by *Tameside* to treat physical disorders without consent as long as they are related to the mental disorder. Such alarm is probably unfounded as there is existing case law[66,67] preventing medical treatment for physical disorders when capacity is retained, and Montgomery's *related*[68] is not the same as Goff LJ's *integral*[69]. Nevertheless, the frequency with which these matters appear before the courts suggest that health care professionals are concerned about the extent they will be responsible for the 'risky' decisions of others. This concern reflects a more general question about the responsibility of health care professionals to abolish all medical risks. In relation to mental health, the concept of 'medical risk' appears to have been expanded to include risks to third parties, not just risk to self.

Scotland has recently passed an Incapacity Act[70] that will provide measures for treatment and care of all those who lack capacity to consent to treatment, whether as a result of physical or mental disorder; it remains to be seen whether English law will follow suit. A similar approach to consent based on capacity was recommended by the Richardson Committee in relation to the treatment of mental disorders. The Committee accepted the need for compulsory treatment but only where there was demonstrated incapacity. Loss of autonomy would be balanced with increased claims to care through the principle of reciprocity[71].

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[63] *American case – Sex offender in prison consents to trial of anti androgens. Kaimowitz v. Michigan DMH, 1 MDLR 147 (1976)*

[64] *Matthews, supra Note 25*

[65] *Bartlett and Sandland: Mental Health Law: Policy and Practice. Blackstone Press Ltd. 2000.*

[66] *Re. C (Adult) (Refusal of treatment) supra note 32*

[67] *Re JT (Adult: Refusal of Medical treatment) [1998] 1FLR 48*

[68] *" …in a wide range of circumstances. Provided that the physical problems are related to the mental disorder, either in their origin or their effects, consent will not be strictly necessary"– Montgomery J. Health Care Law . Oxford University Press. Oxford. 1998.*

[69] *Goff LJ– " Section 63…may apply to the treatment of any condition which is integral to the mental disorder" St George's Healthcare NHS Trust v S; R v Collins and Others ex parte S [1998] 2 FLR 728*

[70] *Adults with Incapacity (Scotland) Act 2001. See Lyons Medical Treatment using the Scottish Incapacity Act: Will it work? pp197–202 of this issue of the Journal of Mental Health Law.*

[71] *Eastman,N & Hope,RA (1988) The ethics of enforced treatments: the balance model. Journal of Applied Philosophy,5: 49–59*

However, this proposal was rejected by the current English government[72]. In contrast, the Government's proposal was that loss of autonomy for the mentally disordered was justified with reference not to lack of capacity but *risk* (to self or others). Similarly, American outpatient and inpatient commitment procedures (for compulsory treatment for mental disorder) are judicially determined and dangerousness based. The American system of judicial determination for commitment has at least three models; Exceedingly non-interventionist[73,74], minimal intervention[75] and maximum protection, all dealing with question of risk. In the state of Massachusetts, where the *Rogers*[76] case was heard, state law has been changed to reflect maximum intervention although as Appelbaum has shown, the theoretical possibility of maximum protection has not matched with the practical outcomes, which still remains deferential to medical advice[77].

Arguably, the judiciary has been increasingly inclined towards granting the very paternalism which the state seeks[78]. The pendulum has swung back from extreme liberalism to a parens patriae model. If that is the case, the liberty interest can be seen in a different light as arguably a type of negative liberty (pace Berlin): the freedom from psychosis[79] including any risk arising from that illness. It seems that freedom from exposure to any kind of risk is perceived as a medical benefit, which could and should trump claims to autonomy by the mentally ill; an argument which is not applied to the physically ill.

Conclusion

It appears that people with a mental illness diagnosis are still regarded as having limited or no capacity to refuse treatment for mental disorder, (including the physical consequences of that mental disorder) on the grounds of risk. Patients with severe physical disorders are however seen generally as being competent to refuse treatment for their physical condition, even where the outcome is highly risky for them.

Current societal attitudes are towards transparency and respect for persons. In the UK, this has been reflected in the adoption of the Human Rights Act 1998, almost 50 years after the signing of the European Convention on Human Rights. Achieving a delicate balance between the State's

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[72] *Peay,J . Reform of the Mental Health Act: squandering an opportunity? Journal of Mental Health Law. 2000. 5–15*

[73] *Youngberg v. Romeo 457 US 307, 102 S. Ct. 2452 (1982) A decision made by Professionals would be "presumptively valid". Liability may be imposed only when a decision is "such a substantial departure from accepted professional judgement…..as to demonstrate that the person responsible actually did not base the decision on such a judgement"– Justice Powell of Supreme Court.*

[74] *Rennie v. Klein 720 F. 2d. 266 (3d Cir. 1983) Treatment driven model. It stands for a second physician decision-maker in contrast to Rogers. See below*

[75] *Washington v. Harper 494 US 210 (1990) The policies and administrative hearing procedures comported with adequate procedural due process. Due process did not require a judicial hearing. State has a legitimate interest in treating inmates for the purpose of reducing danger. Dissent stated that a "mock trial before an institutionally biased tribunal did not provide due process of law".*

[76] *Rogers v. Commissioners 390 Mass. 489 , 458 NE 2d. 308 (1983) Also known as the "Rights Driven model" . A committed patient is competent until judicially found incompetent. A judge, using full adversarial hearing, determines, using the substituted judgement model, what the incompetent patient (ward) would have wanted if competent. No other state interest supersedes this right save in an emergency, narrowly defined as an "immediate, substantial, and irreversible deterioration of a serious mental illness" or likely harm to self or others. The guardian's role is not as the ward's decision maker, but as a monitor of the treatment plan and the patient's continuing incompetence.*

[77] *Appelbaum PS-Almost a Revolution supra note 3*

[78] *Appelbaum PS supra*

[79] *anonymous -Quoted in-Appelbaum PS Almost a Revolution supra note 3*

legitimate interest in preserving life, and the individual's claim to autonomy even in risky situations, is a process which may be best left to the courts. Most of our current legal trends have flown from the other side of Atlantic, albeit very slowly. Only time will tell if Appelbaum's observation on the pendulum swinging back will continue in that tradition.

Perhaps we need a better analysis of what it is to be a person in the company of others. We also need a better conceptual grasp of risk: how it is socially perceived and tolerated, and the management of risk when social anxiety increases. If as a society we are becoming increasingly intolerant of risk, we are likely to be particularly so in relation to mental disorder, where there is a perception that risk can be measured and controlled. However, what this may mean is that patients with mental disorders are not allowed to make the same sort of risky decisions that people without mental disorders are allowed to make: either in relation to their own health or the health of others.

Alternative Perceptions of Statutory Community Aftercare: Patient and Responsible Medical Officer Views

Sharon Riordan, Helen Smith** and Martin Humphreys****

ABSTRACT

The need for more effective means of caring for mentally disordered individuals in the community has been given a prominent place by the Department of Health. The inclusion of user perspectives in mental health care research, to inform and improve the development of services, has also been given a high priority and the necessity of incorporating patients' and carers' views has been recognised by the Department of Health in the National Service Framework for Mental Health published in 1999. Studies incorporating both the service user and professional viewpoints of statutory community care have been relatively sparse. This study, looking at the process of conditional discharge of restricted hospital order patients sought the views on the benefits, deficits and recommendations for change from those people providing and receiving statutory community aftercare. The findings may assist in any future review of the Mental Health Act, policy development and in the planning and delivery of psychiatric services to other groups of severely mentally ill people.

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* *Research Associate, The University of Birmingham*

** *Consultant Forensic Psychiatrist, South Birmingham Mental Health NHS Trust*

*** *Senior Lecturer and Honorary Consultant Forensic Psychiatrist, The University of Birmingham and South Birmingham Mental Health NHS Trust*

INTRODUCTION

The Department of Health and NHS Executive have placed great emphasis on the importance of effective supervision of mentally disordered individuals in the community, in particular, in the context of issuing guidance on the supervision of such individuals in the community[1], the introduction of supervision registers[2] and the power of supervised discharge under Sections 25A Mental Health Act 1983.

The process of statutory community aftercare for patients conditionally discharged from a restricted hospital order (Section 37/41 MHA 1983) is known to be successful[3]. Supervision is comprehensive, potentially long lasting and resource intensive in terms of professional time. The purpose of formal supervision is essentially to protect the public from further serious harm by assisting the patients' successful reintegration into the community after what may have been an extended period of hospitalisation in conditions of varying levels of security. It allows close observation of the patients' mental condition and also is beneficial in identifying any perceived change in the risk of danger to the public in order that measures can be taken to support the patient and provide public protection. The conditional discharge process enables professionals involved in the supervision a period of time to assess the patients' progress in the community before any decision is made to abolish the controls affected by the imposition of the restriction order by way of an absolute discharge.

What is not known is why exactly the process of conditional discharge works. It may be that legal constraints force both patients and clinicians to comply with Home Office regulations. But it could be that legal enforcement provides the framework within which individuals have the opportunity to form good relationships with each other, allowing for successful supervision and rehabilitation.

One of the principal objectives of the White Paper, *Caring for People* (1989) was to emphasise the importance of user and carer involvement in the planning and development of services. It anticipated that users would have a greater individual say in how they live their lives and the services needed to help them do so. This subsequently translated into the NHS and Community Care Act (1990) that required local authorities to produce community care plans and to actively involve users and carers in the development of services. To what extent this has been realised is debateable.

A sample of 92 psychiatric service users in the City of Westminster were interviewed regarding their experiences and levels of satisfaction with community care services provided. The findings highlighted the vulnerability of service users, the high regard most had for their helpers, the benefits of day centres and 'drop-in' facilities, which were perceived as lifelines by the majority of those that used them, and the difficulties caused by the loose co-ordination between health and social services. Service users provided a rich source of information on how services might be improved[4].

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[1] *Department of Health (1994a) The guidance on the discharge of mentally disordered people and their continuing care in the community. NHS Executive Health Service Guidelines. HSG(94)27. London; Dept of Health.*

[2] *Department of Health (1994b) Introduction of supervision registers for mentally ill people from 1st April 1994. HS Management Executive HSG (94)5 London; Department of Health.*

[3] *Dell, S and Grounds, A. (1995) The discharge and supervision of restricted patients. London. Home Office.*

[4] *MacDonald, G and Sheldon, B. (1997) Community Care Services for the Mentally Ill. International Journal Of Social Psychiatry Vol.43 No 1 35–55.*

In another study, 94 psychiatric outpatients were individually interviewed about their views on the characteristics of ideal outpatient treatment. Fifty-seven statements were generated concerning characteristics of ideal outpatient treatment. A second sample of 84 psychiatric outpatients were asked to rate the importance of the 57 statements generated in the first part of the study. Patients put great emphasis on the ability of staff to display empathic qualities in taking patients seriously, being caring and understanding and exhibiting respectful behaviour towards the patient. The next most important theme to patients concerned matters of the quality of information given to them about their mental illness and medication by their care team[5].

The aim of the present study was to address the paucity of research evaluating statutory community aftercare from the dual perspectives of service users and responsible medical officers, and to provide a basis for future comparison with other groups of patients with severe mental illness under other statutory community supervisions, as well as those managed in the community with no statutory framework or requirements.

METHOD

A semi-structured questionnaire was administered to 14 Responsible Medical Officers involved in the care of 38 conditionally discharged restricted hospital order patients in the West Midlands. Of those 38 patients, 24 agreed to participate in the study. Each participant was asked about:

- The quality of the relationship between the responsible medical officer and the patient.
- The good things about supervision from each individual's point of view.
- The bad things about supervision from each individual's point of view.
- Any recommendations for change from each individual's point of view.

Responses were analysed using a qualitative approach.

RESULTS

Patient Perceptions

Sixteen patients (67%) said there were good and bad things about statutory supervision. Seven (29%) said there were only good things, and in one case a patient said there were only bad things. Overall the perception of the quality of the relationship between the patient and their clinical team was positive. Thirteen patients (54%) said they got on well with their RMO; their RMO agreed on 12 occasions, and in the remaining case the RMO said the relationship was okay. Eight patients (33%) said the relationship was okay; however the RMO thought the quality of the relationship was good in six cases and okay in the remaining two. Three patients (13%) said the relationship was bad, in contrast to the RMO who thought they got on well with their patient in one case and okay for the remaining two.

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[5] *Bjorkman, T; Hansson, L; Svensson, B and Berglund, I. (1996) What is Important in Psychiatric Outpatient Care? Quality of Care from the Patient's Perspective. International Journal for quality in Health Care. Vol.7.No.4. Pp355–362.*

Good things about supervision

Relationships/support

The best thing about supervision from the patients' perspective was the general support given in all aspects of their lives. In the main they felt confident enough to approach their clinical teams if they needed help with anything. Patients confirmed that they received help with practical issues such as money matters and housing. They felt that they could trust their supervisors and in many instances described them as 'friends'.

> *'The community aftercare is supportive. I respect my nurse and social supervisor, they're there to sort things out. My social supervisor is more like a friend than a social worker.'*

The theme of loneliness felt by patients emerged on a number of occasions. Clinical teams were acknowledged for their willingness to listen, discuss and provide help.

> *'If I need someone to talk to they are good at listening and I can take or leave their advice. I can talk to them about anything that bothers me. A lot of people like me have their bad days and the first people I think of is the team.'*

Patients on the whole made positive comments about their consultant psychiatrists and medical supervision overall. There was recognition that the clinical team would, wherever possible, keep the patient out of hospital.

> *'The clinic is the only place that has really understood me and looks after me on a one to one basis… the best aftercare anyone could wish for.'*

It was also clear that relationships between patients and their clinical teams took time to develop.

> *'When I first went into the community I wouldn't be inclined to tell the team first if I was unwell or relapsing. I would now as I've got to know the team well…The more my Social Supervisor knows about me the less chance there is that things will go wrong…consistency is important.'*

Outside agency involvement

Patients often mentioned the help of other outside agencies involved in their care. The extra assistance from them added to the sense of security and confidence patients felt.

> *'I'm given lots of different support and this lets you know you're not on your own. I get support from a MIND support worker.'*

Some patients had the offer of support from outside agencies seven days a week. A number did, however, acknowledge that not all people would necessarily welcome this sort of input and that it was an issue of personal preference and choice.

> *'Some people would be dubious about having a support worker, they might be seen as interfering in people's lives …I have an outreach worker who is very helpful and understands me. It improves my life, I know people will do what they can as soon as they can.'*

Legal framework

The legal framework of the conditional discharge process was considered beneficial by a third of all those interviewed. Patients emphasised their own vulnerability once out in the community after a long period of hospitalisation and said they felt a sense of extra security knowing that a hospital bed was available should they need it. Patients also felt that being subject to a restricted hospital order gave them a choice of going into hospital as a voluntary patient rather than being admitted compulsorily. As a consequence they felt that this meant they could get out of hospital more rapidly once recovered. Patients recognised that without statutory aftercare they could face difficulties in all areas of their lives.

> *'If I get stressed its good to know that there's a bed always there for me…Before, I've had to commit silly crimes to get attention for my illness. As I see it, it's the only way forward. Without the supervision a lot of conditionally discharged people would get into problems…'*

Bad things about supervision

Legal framework–control/coercion

The most common thing patients thought was bad about statutory supervision was the feeling that the supervision disempowered them in terms of personal autonomy and privacy. Patients particularly mentioned the frustration of having to ask permission from the Home Office to go on holiday.

> *'I don't really like the restrictions on my travel. …I did get a bit annoyed when the Home Office refused me a holiday abroad fairly soon after conditional discharge, but I do realise why they did now.'*

There were a number of comments about the protracted length of supervision and the perceived lack of negotiation and communication between the clinical team and the patient.

> *'Sometimes I feel like a dog on a leash. The authorities will have to release me sometime - why not now?…I don't think there's a need for coercion, you should negotiate with the patient.'*

Clinical team meetings

The practice of calling patients to clinical team meetings at the hospital where they had previously been detained was particularly unnerving for many. These places were seen as the focus of bad memories.

> *'I don't like to go up to the clinic for CPA meetings and out patients appointments because it brings back bad memories…I get nervous and my thoughts race.'*

Many patients wanted the venue for clinical meetings to be changed to a neutral location because the hospital setting unnerved them. Two (8%) patients felt they had been treated discourteously in team meetings.

> *'Perhaps they don't think we deserve respect and courtesy… It's my life, I don't like to be stared at and people asking me about my past.'*

Medication issues

Nine (38%) patients said that having to have depot injections was one of the worst things about statutory care. Some expressed their distress about the side effects. Those people who experienced tremors as a side effect of medication said they felt that this made them stand out as different. This affected their social confidence and in their view increased the likelihood of stigmatisation of the individual by others. In the main patients said that having to have medication by injection was painful.

Eight patients (33%) said they would like to change from having injected depot medication to oral antipsychotics. In four cases (17%) the request for change was directly related to the pain of the injections.

Some patients equated the use of injected depot medication by their consultant psychiatrist with punishment.

Recommendations for change

Most patients were generally happy with supervision and recognised the value of support given to them. Some said they would like to be absolutely discharged but stay under the care of their clinical team. One commented.

> *'I'd rather look after myself but I might need a bit of help though.'*

Accommodation

Eight patients (33%) said they would change their accommodation if they could. In two cases (8%) patients said they would like to move so that they were not so lonely.

Responsible Medical Officer Perceptions

Patients were in the main seen by their consultant in out patients or in a minority of cases were seen by the consultant in the patient's own home. Where data were available, evidence suggested that most RMOs saw their patients on a monthly basis. The frequency of contact between the RMO and patient depended upon how long the patient had been conditionally discharged, whether there had been any recent cause for concern about the patient's mental health, behaviour, or non-compliance with treatment or supervision. Where the consultant saw the patient at home this was to gain a clearer view of the patient's mental state and social circumstances in the context of the patient's daily environment.

Responsible medical officers said they got on well with 26 (68%) of their patients and okay with 12 (32%). The data showed that of the 14 patients that declined to take part in the study, in nine cases the RMO said they got on well with their patient and in the remaining five cases said they got on okay. Comments were made, however, to support the contention that sometimes the relationship between the RMO and the patient was only superficially good because of the legal framework surrounding the relationship.

In some cases the RMO perceived the quality of the relationship to be based on enforced tolerance of the supervision process on the part of the patient.

> *'I get on well with my patient due to the compulsory nature of the relationship. Superficially we get on very well, he's welcoming etc. But it's a tolerance on his part'*

In 20 cases (53%) the RMO said there were both good and bad things about supervision and in 18 cases (47%) the RMOs said there were only good aspects of supervision for those specific patients.

Good things about supervision

The benefits of supervision from the perspective of the RMOs are discussed in the order of the frequency in which they were reported.

Legal framework

The benefit of the legal framework towards the development and continuity of a successful community aftercare package for the patient was clearly expressed by RMOs.

Compliance

The conditional discharge arrangement was seen as particularly useful in cases where there was evidence of previous aftercare breakdown and consequent disengagement with services. Many patients were described as having a previous history of non-compliance and therefore the legal framework served to ensure continued treatment and follow-up.

> *'We offer him support that he finds useful…he hasn't been compliant in the past.'*

Statutory supervision was used on some occasions as a lever with which to maintain compliance.

> *'The order provides a structure that means he takes medication and lives in appropriate accommodation.'*
>
> *'He doesn't have enough insight to take medication without it.'*

Risk

Comments about the benefit of supervision from the point of view of risk reduction figured commonly in the RMO responses. The degree of control over where the patient lived, the intensive multi-disciplinary supervision and the use of compulsory drug screening was seen as helpful.

> *'His offence was drug related in part and after conditional discharge he started to smoke cannabis. The restriction order assisted us in giving him regular urine screening. It helps minimize the risk'*

Repeated interagency collaboration between the psychiatric services, the police and social services was considered a benefit of statutory supervision and an important aspect in reducing potential risk of harm to others.

Relationships

Many comments were made about the benefits of the legal framework in assisting the development of good relationships between the clinical team, the patient and the patients' family. The assistance and support of the family were perceived as key factors of successful supervision.

> *'His parents are also very supportive and that has been key. They have been able to keep me informed about his mental health.'*

Bad things about supervision

Legal Framework

Although the RMOs saw the legal framework as being a major factor of successful statutory supervision, paradoxically the legal framework was mentioned most commonly as a bad feature of supervision. The restriction order was seen as too inflexible and long lasting in some cases.

> *'The potential downside of statutory supervision is that patients become frustrated with the length of time they are on conditional discharge, especially if they have been stable for a long time.'*

Recommendations for change

In more than half (53%) of the cases of patients currently under supervision the RMOs said that they were happy with the supervision and could not make any recommendations for change. In a number of cases the consultants said that they would support an application for absolute discharge for their patient and were convinced that the patients would keep in contact with psychiatric services after absolute discharge.

Accommodation

There were a large number of comments referring to the lack of appropriate housing for these patients. Consultants said that they would like access to more supported housing particularly for the more vulnerable patients who were subject to exploitation from various sectors of society. There was also recognition that some individuals were suffering from the negative effects of the stigmatisation of being an offender-patient in the community.

> *'We would like to accommodate him in another area because he's attracted a lot of vigilante type attention.'*

Staffing issues

Due to the high numbers of black people in secure psychiatric provision there was recognition by the consultants for the need for more black staff on clinical teams. In some cases it was also suggested that it would be preferable to have some more male CPNs, particularly for those patients with a history of violence towards women.

The problems caused by intensive statutory follow-up in terms of the financial cost and professional time involved led to some consultants suggesting that the amount of professional input time be reduced for some patients. In some cases the reduction in staff input was linked to the consultant wanting to facilitate the rehabilitation process and improve patient autonomy.

> *'Reduce the amount of time he gets from others so that he can deal with his own problems and increase his independence.'*

Drug misuse

Psychiatrists indicated a need for more effective means of drug misuse prevention. Some said they would welcome the imposition of more stringent conditions that could be enforced to stop patients using illicit drugs. They highlighted the difficulties caused by patients abusing drugs.

> *'He was no management problem before he started using. He may have been vulnerable and targeted.'*

DISCUSSION

The benefit of a restricted hospital order has long been recognised[6], not because of the constraint it involves on movements through the hospital and rehabilitation process, but because of the intensive community aftercare that is required.[7]

The National Service Framework published by the government in 1999 sets out new standards that health and social services will be obliged to meet in the delivery of mental health and social care to people experiencing mental health problems. It requires that mental health services must be planned and put into practice in partnership with local communities and involve service users and carers. There have been a number of reasons suggested for the inclusion of service user perspectives. One is that any evaluation without service user participation is unsatisfactory and will be biased towards the providers.[8] In addition, psychiatric patients, particularly offenders, are a particularly socially marginalized and disadvantaged group with little or no bargaining power and no alternative to public health service programmes[9]. Without service user evaluation the sufficiency and quality of care is left solely to service providers. It might be argued that where legal requirements are involved in addition to clinical considerations, user opinion and involvement is even more important, hence the value of the work presented here.

The uptake rate by patients was 63%. It could be argued that patients who agreed to take part in this study were more likely to be content with their supervision and therefore represent a biased sample. Nevertheless they did, in most cases, identify areas of supervision that they were not happy about and were prepared to make recommendations for change in respect of supervision.

Those that declined to take part in the study included all of the women in the sample. Refusal did not appear to be linked to unsuccessful community aftercare for this group as they were all maintaining good mental health and were viewed by their clinical team as progressing well in the community. In addition none had a history of poor compliance with treatment or supervision. The reasons why these women did not wish to participate are therefore unclear. The men that declined to take part did have a background of non-compliance and previous recall to hospital and therefore may not have been so happy with their statutory community aftercare arrangements. This is obviously a potential limiting factor in interpreting the results of the present study.

As might have been anticipated, the benefits and deficits of statutory community aftercare from the perspectives of patients and Responsible Medical Officers differed in their focus. Patients valued the practical support it gave and the human relationships it fostered. Doctors emphasised the strength of the legal framework in keeping the patient well through compliance with treatment and supervision.

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[6] *Walker, N and McCabe, S. (1973) Crime and Insanity in England Vol 2. Edinburgh. Edinburgh University Press.*

[7] *Humphreys, M,Kenney-Herbert, J and Gray, C. (1998) Restricted hospital orders: a survey of forensic psychiatrists' practice and attitudes to their use. The Journal of Forensic Psychiatry.Vol 9 No 1 May 1998 173–180.*

[8] *Bjorkman, T; Hansson, L; Svensson, B and Berglund, I. (1996) What is Important in Psychiatric Outpatient Care? Quality of Care from the Patient's Perspective. International Journal for Quality in Health Care. Vol.7.No.4. pp355–362.*

[9] *Ibid*

Comparisons between our study and an earlier review[10] showed that overall, interpersonal aspects of psychiatric care are rated consistently as more important by patients than impersonal dimensions. One service user study found that individuals felt left on their own after discharge from hospital. In addition, negative attitudes of the public towards mentally disordered people translated into damaging experiences for users.[11] However, although the issue of isolation was mentioned by some in the present study, overall, patients felt less isolated under statutory provision than they had in the past under non-statutory care. This may be explained at least partially, by the intensive nature of the care required by restricted patients who may have had a long period of hospitalisation and the added Home Office requirement for more regular supervision than those people in the community who are not subject to any legal control.

Both patients and responsible medical officers made some mention of the problems of stigmatisation and vulnerabilities of the mentally ill within the community. The public may not always be sympathetic or understanding of the mentally ill, a problem exacerbated by a criminal background. Some restricted patients are likely to have committed the sort of offence that makes their acceptance back into the community particularly problematic.

Both parties did, to varying degrees, acknowledge the benefit of the legal framework in assisting the development of good relationships between all those involved in the process. However, both groups agreed that in certain cases statutory supervision was continued for too long, paradoxically causing damage to the therapeutic relationship.

Both the patients and responsible medical officers recognised the value of multi disciplinary clinical team and family support in the conditional discharge process. Patients felt their teams and families gave them extra security whilst doctors recognised that families could be a vital source of support and information regarding patients' mental health. This is very much in keeping with the guidelines for supervising psychiatrists which state that '…the two most important elements in effective supervision are the development of a close working relationship with the patient and the maintenance of a good liaison with the social supervisor'.[12] Teamwork and close communication have previously been highlighted as key factors in any work with offender patients.[13]

In line with other research[14], the patients in the present study agreed that using the facilities of outside agencies and befrienders was beneficial. Staff allied to these services were seen as knowledgeable about the specific problems encountered by individuals and were able to provide a cushion between the individual and the pressures of everyday life in the community.

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10 *Ruggeri, M. Patients and relatives' satisfaction with psychiatric services: the state of art of its measurements. Soc Psychiatry Psychiatr Epidemiol 29:212,1994.*

11 *Rose, D. (1996) Living in the Community.London, The Sainsbury Centre for Mental Health.*

12 *Mental Health Act 1983 Supervision and After-Care of Conditionally Discharged Restricted Patients – Notes For The Guidance of Supervising Psychiatrists. Home Office and Department of Health and Social Security 1987.*

13 *Prins, H (1983) The care of the psychiatric prisoner-discharge into the community and its implications. Medicine, Science and the Law,Vol. 23, No.2, 79–86.*

14 *MacDonald, G and Sheldon, B (1997) Community Care Services for the Mentally Ill: Consumers' Views International Journal of Social Psychiatry (1997) Vol.43 No1 35–55.*

A key factor in community care policy is that patients should have a greater say in determining the services they receive and have the opportunity to influence their quality. Almost half of the respondents in an earlier study[15] felt they had no choice at all in the services they used. In our study participating patients and responsible medical officers generally felt that needs were met by the services offered. This was particularly true where services were tailored to the individual concerned. There were, however, recommendations for change put forward from both groups. These were mainly to do with specific needs on the part of patients and more general changes to do with staffing and lack of appropriate accommodation from the responsible medical officers.

Restricted hospital order patients have in the past been asked for their opinions of statutory supervision[16] but have not explicitly been asked to make recommendations for change. This research indicates that by and large conditionally discharged patients were content to be supported in the community within the confines of statutory provision and responsible medical officers were satisfied with its value and effectiveness. The Mental Health Act 1983 introduced aftercare planning for certain categories of detained patients. The more recent introduction of Section 25A Supervised Discharge provides a way of formalising aftercare within a legal framework for those patients who meet specified criteria. On the basis of the results described here the long established process of conditional discharge might, in some ways, be viewed as a template for a model of psychiatric community aftercare that is, for a substantial group of patients and their supervising psychiatrists, successful from two seemingly contrasting perspectives.

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[15] *Ibid*

[16] *Dell, S and Grounds, A. (1995) The discharge and supervision of restricted patients. London. Home Office.*

Psychiatric evidence and mandatory disposal: Article 5 compliance?

*Kevin Kerrigan**

Abstract

This Article considers the position of defendants charged with murder who are found to be unfit to plead or insane at the time of the offence. If the court is satisfied that the defendant did the act charged as murder then the judge has no option but to impose a hospital order with restrictions. This Article examines the statutory requirements for medical evidence prior to a finding of unfitness or insanity and asks whether this satisfies the requirements of Article 5 of the European Convention on Human Rights. It concludes that there is no obvious justification for requiring defendants to be sent to hospital in the absence of a conviction where the medical evidence does not indicate that such a disposal is necessary. It follows that the current practice is likely to violate the Convention.

Introduction

Disposal of cases in unfitness and insanity cases

The passing of the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 (the 1991 Act) introduced a significantly more enlightened framework for dealing with defendants who were unfit to plead or insane. First, it implemented a trial of the facts procedure to ensure that unfit accused could be acquitted outright if it could not be proved that they had done the act charged as the offence. Secondly, it gave the judge a much broader discretion in respect of disposal options.[1] Whereas previously an unfit or insane accused faced a mandatory admission to hospital order with restrictions,[2] the 1991 Act permits the judge to impose a range of additional disposals, namely an admission order without restrictions, a guardianship order, a supervision and treatment order or, if appropriate, an order for absolute discharge.[3]

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* *Solicitor and Principal Lecturer in Law, Northumbria University. I would like to thank Professor Don Grubin for his helpful comments on an earlier draft of this paper. I am responsible for any remaining errors.*

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

[2] *Criminal Procedure (Insanity) Act 1964 (The 1964 Act) prior to 1991 permitted only one disposal – an admission order with restrictions without limit of time.*

[3] *1991 Act section 3 – this introduced the range of disposals into the 1964 Act section 5(2)(b).*

Statutory requirements for medical evidence in unfitness and insanity cases

A jury is not permitted to find that a person is unfit to plead except on the oral or written evidence of two doctors at least one of whom is approved under section 12 of the Mental Health Act 1983.[4] The same requirement applies to a finding of insanity.[5] The role of the psychiatrist in cases where offenders may be unfit or insane involves an assessment of whether the tests for unfitness[6] or insanity[7] are met in view of the state of the accused. In cases other than murder, the psychiatrist may often be asked for an opinion regarding disposal, which is dependent to a significant degree on the type of mental disorder the accused is found to suffer from.

Residual mandatory disposal for murder cases

Section 5(3) of the Criminal Procedure (Insanity) Act 1964 (the 1964 Act) provides that the range of disposals outlined above "shall not apply where the offence to which the special verdict or findings relate is an offence the sentence for which is fixed by law". In such cases the only disposal available is an admission order with a restriction order without limit of time.[8] The only offence for which the sentence is fixed by law is murder. This provision thus represents a mandatory disposal for those found unfit to plead to the indictment or those acquitted by way of the special verdict of not guilty by reason of insanity because they were insane at the time of the commission of the offence.

Triggering Article 5 of the European Convention

Article 5 of the European Convention on Human Rights protects the right to liberty and security of the person. The right is not absolute but is subject to interference where the deprivation is "lawful", "in accordance with a procedure prescribed by law" and for a permitted reason. These reasons include detention as a consequence of conviction for a criminal offence under Article 5(1)(a) and detention of those who are of "unsound mind" under Article 5(1)(e). It is important to note that defendants who are found unfit to plead or insane are not convicted of a criminal offence.[9] It follows that Article 5(1)(a) cannot justify their detention. If detention is to be justified, then, it must comply with the requirements of Article 5(1)(e). The leading case of *Winterwerp v Netherlands*[10] considered a challenge to detention under Dutch mental health legislation. The European Court of Human Rights made the following important ruling regarding detention for mental disorder:

> "The next issue to be examined is the 'lawfulness' of the detention for the purposes of Article 5 (1) (e). Such 'lawfulness' presupposes conformity with the domestic law in the first place and also … conformity with the purpose of the restrictions permitted by Article 5 (1) (e); it is required in respect of both the ordering and the execution of the measures involving

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[4] 1964 Act section 4(6).

[5] 1991 Act section 1(1). Additionally, section 1(2) provides that for insanity cases the provisions of section 54(2) and (3) of the Mental Health Act apply so as to permit a medical report without it being proved in evidence subject to certain safeguards. This does not appear to apply to unfitness cases.

[6] R v Pritchard (1836) 7 C & P 303. See Blackstones Criminal Practice 2002 D11.17. The jury direction in this case has since become firmly embodied in the law and has bee approved on numerous occasions – see R v Friend [1997] 2 All ER 1011.

[7] McNaughtens's Case (1843) 10 Cl & F 200, [1843–60] All ER Rep 229. See Blackstones 2002 A3.12–3.18.

[8] 1991 Act Schedule 1 para 2(2).

[9] 1964 Act section 4A(2); 1964 Act section 1.

[10] (1979) 2 EHRR 387.

> deprivation of liberty. … in a democratic society subscribing to the rule of law, no detention that is arbitrary can ever be regarded as ' lawful'. … In the Court's opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be established before the competent national authority – that is, a true mental disorder – calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder."[11]

For present purposes the essential requirements for detention under Article 5(1)(e) are thus:

(i) the defendant is reliably shown on the basis of objective medical expertise to have a true mental disorder;

(ii) the disorder is of a kind or degree warranting compulsory confinement; and

(iii) the disorder must persist throughout the detention. This in turn requires periodic access to an authority with the characteristics of a court in order to review the lawfulness of the continued detention under Article 5(4).

In *Verbanov v Bulgaria*[12] the European court confirmed the *Winterwerp* criteria and also emphasized the need to avoid arbitrary decision-making:

> "The Court further reiterates that a necessary element of the "lawfulness" of the detention within the meaning of Article 5(1)(e) is the absence of arbitrariness. The detention of an individual is such a serious measure that it is only justified where other, less severe measures, have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained. The deprivation of liberty must be shown to have been necessary in the circumstances."[13]

The principles in *Winterwerp* have recently been followed in the domestic courts in *R (H) v Mental Health Review Tribunal for North and East London Region*.[14] The Court of Appeal considered the Mental Health Act 1983 requirements for discharge of restricted patients.[15] Lord Woolf said of the Article 5(1)(e) requirements as follows:

> "… the test is whether it can 'reliably be shown' that he or she suffers from a mental disorder sufficiently serious to warrant detention."[16]

The Court found that the statutory provisions effectively reversed the burden of proof required by the Convention. The provisions could not be interpreted compatibly with the Convention right so the Court granted a declaration of incompatibility under section 4 of the Human Rights Act 1998.[17]

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[11] *Ibid. at paragraph 39.*

[12] *Application no. 31365/96, European Court of Human Rights, judgment 5 October 2000.*

[13] *Ibid. at paragraph 46.*

[14] *[2001] EWCA Civ 415 [2002] Q.B. 1.*

[15] *See sections 72 and 73.*

[16] *Ibid. at paragraph 29.*

[17] *The government subsequently made a remedial order under section 10 of the Human Rights Act to make the law compatible with Article 5 – Mental Health Act 1983 (Remedial) Order 2001, 2001/3712.*

Is Article 5 breached by compulsory admission to hospital?

Central to the justification for detention under Article 5(1)(e) is the medical evidence. It must reliably show that the person has a true mental disorder which requires confinement. The potential problem with the tests for unfitness and insanity is that they do not mirror the requirements of the Convention for lawful detention.[18] Moreover, the legislation does not require the judge to consider whether the person suffers from a "true mental disorder" before imposing an admission order.[19] It follows that a person could be admitted to hospital without any evidence that they are currently suffering from a mental disorder, or even with contrary evidence. Such a situation would be in clear conflict with the Article 5 principles outlined above. As will be seen, the Human Rights Act 1998 provides a remedy for this defect in respect of most cases but not where the charge is murder.

The medical evidence in unfitness cases goes to the question of ability to participate in the proceedings. This has been interpreted as meaning that the accused can, "understand and reply rationally to the indictment … exercise his right to challenge jurors, understand the details of the evidence … instruct his legal advisers and give evidence himself…"[20]. It follows that an accused can be unfit to plead without having a recognised mental disorder, let alone one requiring detention. Indeed, courts have upheld findings that accused are unfit in cases where no mental health problem at all was identified but rather a physical communication problem.[21] Such cases are rare[22] but the overriding point is that the medical evidence is used to ascertain a different issue (fitness) from that required by the Convention (mental disorder).

The medical evidence in an insanity case goes to the question of whether an accused was insane under the test in *McNaughten's Case*:

> "… it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of 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 what he was doing was wrong."[23]

The courts have made clear on a number of occasions that this test does not necessarily conform to medical conceptions of mental disorder. In *R v Sullivan*[24] Lord Diplock rejected medical evidence that an epileptic seizure should not be a disease of the mind where it is only transitory:

> "The nomenclature adopted by the medical profession may change from time to time … But the meaning of the expression 'disease of the mind' as the cause of a 'defect of reason' remains

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[18] *See generally Emmerson and Ashworth, Human Rights and Criminal Justice Sweet and Maxwell, 2001, pages 296 et. seq.*

[19] *The legislation in fact imposes no express limits on the judge's ability to impose an admission order. Section 5(2)(b) of the 1964 Act as amended imposes a suitability test in respect of community-based disposals but this does not apply to the hospital disposal.*

[20] *R v Friend op. cit.*

[21] *See Pritchard op. cit. where the accused was deaf and speech impaired, and R v Governor of Stafford Prison ex parte Emery [1909] 2 KB 81 where the accused was deaf and could not read or communicate through sign language. Darling J said at page 87–88: 'It is contended that the prisoner has not been found to be insane, and that therefore there is no jurisdiction to order him to be detained in custody. It seems to me that the finding of the jury amounts to a finding that the prisoner is non-sane so as to give the court jurisdiction to act under s.2 of the Criminal Lunatics Act, 1800. It is not merely a finding that he stands mute by the visitation of God … but it is a distinct finding that he is incapable of understanding and following the proceedings and of making his own view, if any, known.'*

[22] *But they are not unknown. There were at least 2 such findings in the first 5 years of the operation of the 1991 Act. See McKay and Kearns An Upturn in Unfitness to Plead? Disability in Relation to the Trial under the 1991 Act [2000] Crim LR 535.*

[23] *(1843) 10 Cl & F 200 at page 210 per Tyndal CJ.*

[24] *[1984] AC 156.*

> unchanged for the purposes of the application of the M'Naughten rules … it matters not whether the aetiology of the impairment is organic, as in epilepsy, or functional, or whether the impairment itself is permanent or is transient and intermittent, provided that it subsisted at the time of commission of the act."[25]

This built on earlier dictum to similar effect in *R v Kemp*[26] where the medical evidence differed as to whether lack of mens rea due to arteriosclerosis was caused by a disease of the mind. Devlin J ruled that it did not matter which medical evidence was accepted:

> "In my judgment the words … are not to be construed as if they were put in for the purpose of distinguishing between diseases which have a mental origin and diseases which have a physical origin … Hardening of the arteries is a disease which is shown on the evidence to be capable of affecting the mind in such a way as to cause a defect, temporarily or permanently, of its reasoning, understanding and so on … and so is a disease of the mind … within the meaning of the Rules."[27]

This case, along with others where insanity has been found such as *R v Hennessey*[28] (hyperglycaemia) and *R v Burgess*[29] (sleepwalking) clearly show that insanity does not necessarily entail a mental disorder requiring detention.

There is an additional difficulty in respect of insanity. It should be recalled that the special verdict is returned only if the accused was insane *at the time of the offence*. It follows that the medical evidence must look back in time rather than considering the position of the accused when he or she appears before the court. There could be a long delay between the offence being committed and the trial taking place. Even if the accused was suffering from a mental disorder requiring detention at the time of the offence this does not mean that the same must hold true at the time of the trial. Treatment received in the interim or changed circumstances may mean that the disorder has abated. The European Court has ruled that the Convention requires that:

> "… no deprivation of liberty of a person considered as being of unsound mind may be deemed in conformity with Article 5(1)(e) of the Convention if it has been ordered without seeking the opinion of a medical expert. Any other approach falls short of the required protection against arbitrariness, inherent in Article 5 of the Convention. … Furthermore, the medical assessment must be based on the actual state of mental health of the person concerned and not solely on past events. *A medical opinion cannot be seen as sufficient to justify deprivation of liberty if a significant period of time has elapsed*.[30]

The upshot for both unfitness and insanity cases is that hospital detention under the 1964 Act may often not meet the criteria in Article 5 and will therefore violate the Convention.

The impact of the Human Rights Act 1998 on compulsory hospital disposal

It is submitted that the Human Rights Act can and should be used to avoid breaches of Article 5 in the disposal process. Judges ought to have in mind that they are a public authority under the Act[31] and must therefore act compatibly with the Convention rights unless prevented from doing so by primary legislation.[32] The Act permits defendants to rely on the Convention rights in any

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[25] *Ibid. at page 172.*

[26] *[1957] 1 QB 399.*

[27] *Ibid. at page 408.*

[28] *[1989] 1 WLR 287.*

[29] *[1991] 1 QB 92.*

[30] *Verbanov v Bulgaria op. cit., emphasis added.*

[31] *Human Rights Act section 6(3).*

[32] *Ibid. section 6(1).*

legal proceedings[33], which clearly includes the criminal trial and the disposal process. Moreover, section 3 of the Human Rights Act requires the courts to interpret all legislation, including the 1964 Act, compatibly with the Convention rights unless it is impossible to do so.[34]

It follows that despite the legislation apparently *permitting* the judge to detain a person in breach of Article 5, it does not *require* such an approach. The 1991 Act introduced the range of "non-detention" disposals outlined earlier. The courts must therefore draw a distinction between a *finding* of unfitness or insanity and the appropriate *disposal* of a defendant who has been found to be unfit or insane. In this way the legal tests for unfitness and insanity can remain as they are[35] but detention will not be ordered unless there is clear medical evidence that the accused currently suffers from a true mental disorder. If this evidence has not emerged from the psychiatric reports leading to the finding of unfitness or insanity then separate medical evidence will be required. In those cases where the evidence does not show there is a mental disorder the accused must be dealt with by way of a community-based disposal.

The insuperable problem of mandatory disposal

As has been seen, where the accused was charged with murder then the trial judge has no choice but to impose an admission order with a restriction order. This mandatory disposal seems on the face of it to violate Article 5 as in those cases where the evidence does not show the accused has a mental disorder the accused will nonetheless be sent to hospital. The Human Rights Act cannot lead to a different conclusion as it preserves the validity and enforceability of legislation that cannot be interpreted compatibly with the Convention – sometimes referred to as "irredeemable incompatibility".[36] Moreover, a judge does not act unlawfully under the Human Rights Act if s/he is compelled to so act by legislation that is incompatible with the Convention.[37]

The Court of Appeal recognised the apparent impasse in *R v Heather Grant*[38]. The main issue in the case was whether the defence of provocation could be relied upon in the trial of the facts, the Court of Appeal ruling that it could not.[39] The Court also rejected an Article 6 submission that the decision of the prosecution to charge murder amounted to pre-determination by a body that was not independent and impartial.[40] However, their Lordships identified one important point of concern:

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[33] *Ibid. section 7(1)(b).*

[34] *Ibid. section 3(1).*

[35] *Note that there has been substantial criticism of the current tests. It is not here suggested that the tests are faultless, only that the Convention does not require the alteration of the substantive tests, but a change in the approach towards disposal.*

[36] *Per Lord Hobhouse in R v DPP ex parte Kebilene [2000] 2 A.C. 326. In Poplar v Donoghue [2001] 3 WLR 183 the Court of Appeal recognised the limits of the section 3 interpretative duty: "… if it is necessary in order to obtain compliance to radically alter the effect of the legislation this will be an indication that more than interpretation is involved … In this case [counsel] contends that all that is required is to insert the words 'it is reasonable to do so' into the opening words of [the provision]. The amendment may appear modest but its effect would be very wide indeed. It … would defeat Parliament's original objective … It would involve legislating." (Per Lord Woolf at paragraphs 76–7.) See also Re. S (Children) (Care Order: Implementation of Care Plan [2002] UKHL 10; [2002] 2 All E.R. 192.*

[37] *Section 6(2)(a).*

[38] *[2001] EWCA Crim 2611, 22 November 2001.*

[39] *The issue had been left open by the House of Lords in R v Antoine [2001] 1 AC 340. See Kerrigan, Unfitness to Plead, Insanity and the Mental Element in Crime [2000] Journal of Mental Health Law 121.*

[40] *Their Lordships noted that Article 6 did not apply to pre-charge decisions, or, following R v Moore, Kerr and Haroon [2001] EWCA Crim 2024, to the trial of the facts. Moreover, there could be no criticism of the CPS charging decision, which had fully complied with the Code for Crown Prosecutors – see paragraph 49 of the judgment.*

> "… whether the procedures give proper effect to the second of the conditions laid down for detention under Article 5(1)(e). To adopt the formulation in *R (H) v London North and East Mental Health Review Tribunal*, 'the test is whether it can be reliably shown that the [person] suffers from a mental disorder sufficiently serious to warrant detention'. The procedures under the 1964 Act are not directed specifically to that question. The issue under section 4 is whether the defendant has sufficient intellect to instruct his legal team, to plead to the indictment, to challenge jurors, to understand the evidence and to give evidence. Those criteria do not correspond directly to the criteria for a mental disorder sufficiently serious to warrant detention and it may be possible for a person to be found unfit to be tried without his suffering from a mental disorder sufficiently serious to warrant detention. Yet once a person facing a charge of murder has been found to be unfit to be tried, there is no further consideration of his mental condition under the statutory procedures prior to admission to hospital. … This feature of the procedure does raise the question of whether detention is 'arbitrary' in the sense explained by the European Court of Human Rights in *Winterwerp* and *Johnson*.[41]

Although these comments relate to the unfitness procedure they are equally applicable to insanity cases. If the detention is arbitrary then the only domestic remedy is a declaration of incompatibility under section 4 of the Human Rights Act. A trial judge does not have jurisdiction to make such an order so defendants will have to appeal in order to seek an order.[42] The government would then have to consider whether to introduce a remedial order. It should be noted that despite the potential for a breach of Article 5, the medical evidence might be sufficient for the judge to find a mental disorder requiring detention. In such cases then, although the judge has no discretion over the disposal, the detention will not in fact violate Article 5. Indeed, the Court of Appeal in *Heather Grant* found that "the conditions for detention, albeit not considered in terms under the statutory procedure, were in fact met." All of the medical evidence stated that the appellant suffered from mental impairment, albeit one expert said that guardianship could have been considered had the statute not precluded it.

Deference to Parliament?

The Court of Appeal did not therefore have to resolve the issue of compatibility in the instant case. Their Lordships thought that the apparent breach might be avoided by taking a wide view of the discretion of Parliament within Article 5:

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[41] *R v Heather Grant op. cit. paragraph 52.*

[42] *There is no right of appeal to the Court of Appeal against the disposal under section 5 of the 1964 Act as it is not a sentence. However, as the Heather Grant case makes clear, the appellant can appeal by way of case stated to the Divisional Court. The prohibition on such appeals in relation to matters on indictment (Supreme Court Act 1981 section 28(2)) does not apply as once the accused is found unfit, the trial ends. There is a problem in relation to a section 5 disposal following a special verdict in that the Divisional Court in R v Snaresbrook Crown Court ex parte Damaar 16 June 2000 found the disposal related to a trial on indictment so as to prevent a judicial review: "For my part, I have every sympathy with the proposition that an order made affecting the liberty of an acquitted defendant ought to be subject to review. That it is not presently subject to review is, to my mind, the clear consequence of the provisions of the Criminal Appeal Act on the one hand, and section 29(3) of the Supreme Court Act on the other. Regrettably it is not a matter which is capable of being addressed, as it seems to me, by this Court." Per Rose LJ. The same would apply to a case stated appeal. There is thus no apparent mechanism by which a declaration of incompatibility can be sought. The answer could lie in a revisiting of the decision in Damaar. If not, then the only remedy is an application to the Strasbourg Court.*

> "The answer to it may lie, but does not necessarily do so, in Mr Eadie's submission that this is a difficult and complex area where Parliament has carried out the requisite balancing exercise and has concluded that, where it has been found by a jury that a person is unfit to be tried and has done the act charged as murder, the automatic consequence ought to be admission to hospital as prescribed in s.5 (subject to the person's right to make an immediate application to the MHRT and to the other protections afforded to a person subject to detention under these provisions); that the court should afford a measure of deference to Parliament in such a field; and that in all the circumstances the procedure is not to be stigmatised as arbitrary for the purposes of Article 5."[43]

This appears to be a type of "discretionary area of judgment" approach. The courts have developed this doctrine as a domestic version of the Convention concept of margin of appreciation. It recognises the respective roles of Parliament and the courts and affords a degree of deference to the executive and legislative branches of government on the basis of their democratic mandate, particularly in areas of social, economic or political policy.[44]

The Court of Appeal obviously did not consider the matter in detail and it is submitted that had it done so, it would have rejected the notion that the court should defer to Parliament in this field. First, the issue concerned relates not so much to matters of social, economic or political judgment but to a matter of high constitutional importance – the right to liberty of the person. Secondly, even if it is accepted that this is an area of social policy, it is not clear what the justification for the policy is. Unless deference is equated with unquestioning acceptance, the court must be able to address the reason for a particular policy.[45] Bland assertions that this is a difficult and complex area are insufficient, particularly at a time when even the mandatory sentence for murder is subject to heightened scrutiny.[46] Thirdly, drawing upon Canadian jurisprudence, it can be seen that the margin of discretion ought to be drawn more narrowly where, as in criminal proceedings, the state is pitted against the individual:

> "[T]he courts will judge the legislature's choice more harshly in areas where the government plays the role of the 'singular antagonist of the individual' …"[47]

Fourthly, the discretionary area of judgment should be narrower in areas where the courts are particularly well suited to deciding the issues. It is suggested that this holds true in respect of requirements for evidence of mental disorder and the need for detention.[48] The idea that Parliament is better placed to balance the respective interests of the public and the individual in cases where people are detained on the basis of unsound mind is unsustainable. Fifthly, it should

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[43] *Ibid. at paragraph 53.*

[44] *See Lester and Pannick, Human Rights Law and Practice, Butterworths 1999, paragraph 3.26, followed by Lord Hope in R v DPP ex parte Kebilene op. cit.*

[45] *Wilson v First County Trust Ltd (No.2). [2001] EWCA Civ 633, [2001] 2 WLR 42.*

[46] *Stafford v United Kingdom, Application no. 46295/99, European Court of Human Rights judgment 28 May 2002. The Court ruled that the mandatory life sentence for murder ought to be treated in the same manner as discretionary life sentences in terms of release procedures.*

[47] *Per McLachlin J in RJR McDonald Inc v Canada (A–G) (1995) 127 DLR 4th 1.*

[48] *Some support for this can be drawn from the House of Lords judgment in R v A [2001] UKHL 25; [2001] 2 WLR 1546 which related to legislative inroads into the right to cross-examine witnesses in sexual offence trials. Lord Steyn accepted that some deference may need to be recognised but went on: "… when the question arises whether in the criminal statute in question Parliament adopted a legislative scheme which makes an excessive inroad into the right to a fair trial the court is qualified to make its own judgment and must do so" (paragraph 36). The same holds true, it is argued, for the right to liberty.*

be recalled that the European Court has been emphatic in its requirement for medical evidence prior to detention. The only exception identified has been emergency situations.[49] Mandatory disposal for those charged with murder is not a permissible extension of this principle. Finally, the rule against arbitrary detention requires an assessment of the circumstances of the individual case and a consideration of other less intrusive measures.[50] This is clearly not possible if the balance is struck by Parliament; the very essence of the right is undermined.

The right to make an immediate application to the tribunal[51] and the Home Secretary's duty to refer the case after 6 months if there has been no application,[52] although important safeguards, cannot render the detention lawful in Convention terms. The right to liberty in Article 5(1) and the right of access to a court in Article 5(4) are separate rights. Unlawful detention remains unlawful notwithstanding the ability to apply for review of its lawfulness.

In conclusion, it is submitted that the provisions of the 1964 Act for the mandatory admission to hospital of unfit or insane defendants who were charged with murder is irredeemably incompatible with the Convention. If the provisions remain in place there is bound to arise a case where the medical evidence is insufficient to justify detention. A declaration of incompatibility or a successful application to the European Court in Strasbourg is the likely consequence.

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[49] *Winterwerp op. cit. paragraph 39.*

[50] *Verbanov v Bulgaria op. cit. paragraph 46.*

[51] *Mental Health Act 1983 section 69(2)(a).*

[52] *Ibid. section 71(5).*

The Legal Structure of Mental Health Services

*Anselm Eldergill**

INTRODUCTION

The way in which mental health services are organised, delivered and regulated has been reorganised many times in recent years. The purpose of this article is to summarise the present position, and it is informative, rather than analytical. The service changes are dealt with in the following order:

A The National Health Service

B The Provision of Social Care

C The Provision of Independent Healthcare

D Maintaining Quality Standards

A. THE NATIONAL HEALTH SERVICE

In essence, the NHS has four components:

- The Department of Health (including its executive agencies and regional offices/directors).
- NHS bodies and individuals which commission or provide services, or do both (e.g., Health Authorities, Primary Care Trusts, NHS trusts and general practitioners). They are part of the National Health Service, but not part of the Department of Health. However, the Secretary of State controls their activities through the giving of directions, the making of appointments, the issue of health service circulars, and so forth.
- Independent organisations and institutions that provide services to the NHS through arrangements entered into with NHS bodies (e.g., 'private hospitals and clinics').
- Quasi-autonomous, non-departmental public bodies such as the Commission for Health Improvement ('quangos'), that fulfill advisory or executive functions, and are accountable to the Department of Health.

The Health Act 1999 created a new duty of co-operation within the NHS, and NHS bodies are expected to work together to deliver the NHS Plan.

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* *Solicitor, Visiting Professor, School of Law, University of Northumbria; Former Mental Health Act Commissioner; Author 'Mental Health Review Tribunals – Law and Practice' (Sweet and Maxwell 1997)*

The Department of Health

The Secretary of State has overall responsibility for the Department of Health, and he is accountable to Parliament for the National Health Service in England. He is supported by two Ministers of State and by three Parliamentary Under Secretaries of State.

The Department's funding is negotiated annually with the Treasury, through the public expenditure survey. The sum available for hospital and community health services current spending in 2000/01 was £35,716m.

Section 1 of the National Health Service Act 1977 imposes a broad duty on the Secretary of State to ensure the provision of a health service.

So far as mental health services are concerned, it is the Secretary of State's duty to continue to promote a comprehensive health service designed to secure improvement in the mental health of the people of England and Wales; and, for that purpose, to provide or secure the effective provision of services in accordance with the 1977 Act.

More specifically, the Secretary of State has a duty to provide hospital accommodation and such facilities for the prevention of illness, the care of persons suffering from illness, and the after-care of persons who have suffered from illness, as he considers are appropriate as part of the health service, and to such extent as he considers necessary to meet all reasonable requirements.

Although responsibility for securing that these services are provided to patients rests with the Secretary of State, he has delegated most of his functions to local Health Authorities.

NHS Executive

The NHS Executive is headed by a Chief Executive and has a departmental board. The most senior civil servant in the department combines the roles of Permanent Secretary to the Department of Health and Chief Executive of the NHS Executive. He reports directly to the Secretary of State.

The NHS Executive works with ministers to develop health policies, and is responsible for giving hospital chief executives, staff and health service agencies information and guidance concerning their implementation.

The board is supported by directors, each of whom has responsibility for leading work on certain departmental priorities. There is a Directorate of Public Involvement, Nursing, Mental Health, Disability and Allied Health Professions.

Functions of Department of Health

The Government paper, '*Shifting the Balance of Power within the NHS: Securing Delivery*', published in 2001, set out a long-term programme aimed at changing the culture and practices of the NHS, by moving power away from central government. NHS bodies will be expected to devolve more decision-making power to frontline staff, patients and the local community.

According to '*Shifting the Balance of Power*', the Department of Health will change its working pattern, by withdrawing from aspects of performance management, and focusing on the delivery of the NHS Plan and the development of the NHS. Its key functions will include:

- Responsibility for overseeing the development of the NHS and social care.
- Managing the appointment and development of senior management staff.
- Supporting Ministers.
- 'Troubleshooting'.

NHS regional offices

The size and complexity of the NHS means that the NHS Executive operates through a regional structure. However, the NHS Executive's regional offices will be abolished in April 2003. From then onwards, four regional directors of health and social care will oversee the development of the NHS, and provide a link with the centre.

The four new regional directors will cover London, the South, the Midlands and the North, with the outer boundaries of each region being coterminous with the Government Offices of the Regions.

It is not intended that the new regional directors will simply replace the regional offices. They will be more clearly part of the Department of Health, and take a more strategic role, as performance management is devolved to the new Strategic Health Authorities (see below). The key functions of the new directors will include:

- Responsibility for overseeing the development of the NHS and social care. This includes ensuring the integration of health and social care planning, and the implementation of the flexible arrangements allowed for by the Health Act 1999, and supporting the development of care trusts.
- Supporting the Chief Executive, the Chief Operating Officer, and the Chief Inspector of Social Services in assessing performance. This includes ensuring that NHS and social services are integrated, and overseeing the targets in local authorities' Local Public Service Agreements.
- Managing the appointment, development and succession planning of senior management staff.
- Supporting Ministers through casework, Ministerial visits and local intelligence.
- Troubleshooting.

Executive agencies

Executive agencies are self-contained units established to improve management in government. They carry out specific executive functions on behalf of the parent department within an operational framework agreed by Ministers. Although they have discrete responsibility for particular business areas, they are still part of the Department, and accountable to it.

The Department of Health has six executive agencies:

EXECUTIVE AGENCIES	
Health Development Agency	Previously the Health Education Authority. It provides the evidence for health improvement, sets standards for public health practice, and advises on the capacity and capability of the public health workforce.
Medicine Devices Agency	Oversees the safety, quality and performance of medical devices.
Medicines Control Agency	Safeguards public health by ensuring that all medicines on the UK market meet appropriate standards of safety, quality and performance.
NHS Estates	Supports the provision of high-quality NHS buildings and facilities
NHS Pensions Agency	Looks after the pension needs of NHS staff.
NHS Purchasing & Supply Agency	Provides expertise in purchasing and supply matters for the NHS.

Non-departmental public bodies (‘quangos’)

Non-departmental public bodies are set up when ministers feel that particular work needs to be done without the direct influence of government departments.

Various terms are used when naming these public bodies, although the terminology is inexact. They may be described as an inspectorate (if services are inspected); as a commission (if a body of persons is authorised to inquire into certain facts or services); as an agency (if it is not independent, and acts as a department’s agent); as a regulatory body (if it regulates the conduct of a profession or business); as a council (if it is intended to be representative); or as an advisory body (if it has no powers). The powers conferred on them vary considerably, and depend on the body’s functions. For example, advisory bodies need no powers.

Non-departmental public bodies and non-provider special health authorities employed 14,780 staff in 1999/2000, and received almost £715m in public funding. The Mental Health Act Commission employed 32 of the 14,780 staff, and received just over £3m of the £715m of public funding.

The NHS Plan

In July 2000, the Government published ‘*The NHS Plan: A plan for investment, A plan for reform*’, in which was set out a ten-year plan for the reform of the health service in England. The NHS Plan is the Government’s blueprint for the National Health Service.

Action has since been taken to implement many elements of the plan. Many of the proposals requiring legislation were included in the Health and Social Care Act 2001, and others form part of the National Health Service Reform and Health Care Professions Bill introduced in November 2001.

The clinical priorities set out in the plan include the following:

- 1,000 graduate primary care mental health workers to be employed to help GPs manage and treat common mental health problems.
- 500 more community mental health staff to be employed to work with GPs and primary care teams, NHS Direct, and in A&E departments.
- 50 early intervention teams to be established to provide treatment and active support in the community to young people and their families.
- 335 crisis resolution teams to be established within three years.

By 2004:

- all young people who experience a first episode of psychosis to receive the early and intensive support they need.
- all people in contact with specialist mental health services to be able to access crisis resolution services.
- women-only day centres in every health authority.

NHS Trusts

Section 5 of the National Health Service & Community Care Act 1990 Act provided for the establishment of semi-autonomous bodies known as NHS trusts. These bodies were created to assume responsibility for the ownership and management of hospitals and other facilities previously managed by local Health Authorities. Health Authorities and Primary Care Trusts sign service agreements with NHS trusts for the provision of hospital and community health services.

As amended by section 13 of the Health Act 1999, section 5(1) now provides that NHS trusts are established to provide goods and services for the purposes of the health service. Furthermore, the order establishing the trust may impose on it a duty to provide particular goods or services at or from particular hospitals, establishments or facilities. The Secretary of State may therefore specify that a trust must provide a particular service, such as an ambulance service, from a particular site or sites.

NHS trusts are established by statutory instrument, and the establishment order specifies the trust’s functions. These functions will include any statutory functions under the Mental Health Act 1983. Trusts should appoint a committee to undertake the hospital managers’ statutory duties under the Mental Health Act 1983.

The 1999 Act gave the Secretary of State a general power to give directions in respect of an NHS trust’s full range of statutory functions. Previously, NHS trusts enjoyed a substantial degree of autonomy. Trusts are required to carry out their functions ‘effectively, efficiently and economically,’ and to comply with directions given to them by the Secretary of State.

Every NHS trust is a body corporate, having a board of directors which consists of a chairman appointed by the Secretary of State and executive and non-executive directors (that is to say, directors who respectively are and are not employees of the trust). All of the trust’s directors are full and equal members of the Board, and jointly responsible for carrying out the functions of the trust.

NHS trusts continue to provide most secondary care and specialist services in hospitals. Nearly all the hospitals in England are now vested in NHS trusts, although smaller community hospitals are increasingly being run by Primary Care Trusts.

At the beginning of 2000, there were 373 NHS trusts in England responsible for managing the provision of hospitals, community health and ambulance services.

Health Authorities

The entire area of England is covered by Health Authorities. On 1 April 2002, the pre-existing 95 health authorities were merged to form 28 larger Strategic Health Authorities.

The new authorities cover an average population of around 1.5 million, and are funded in a similar way to Special Health Authorities (such as the Mental Health Act Commission and NICE).

The function of the new 'Strategic Health Authorities' is different from that performed by their predecessor bodies. Under the new arrangements:

- Primary Care Trusts (see below) are the lead NHS organisations. Revenue allocations will be made directly to them, and incentives will reward devolution to frontline teams. They will assess need, plan and secure all health services, improve health in their localities, provide most community services and develop primary care services. NHS trusts will continue to provide most secondary care and specialist services in hospitals.
- The Strategic Health Authorities will provide strategic leadership and seek to ensure that NHS organisations work together to deliver the NHS Plan and the devolution agenda. They will be expected to foster trust autonomy, to encourage trusts to empower clinical teams, and to develop a culture of decision-making as close to communities and patients as possible.
- PCTs and NHS trusts will be accountable to the Strategic Health Authorities, and performance managed by them through performance agreements that focus on the areas with greatest clinical priority, including mental health.
- Strategic Health Authorities will, in turn, account to the Secretary of State for the performance of the NHS in their area. Annual delivery agreements between them and the Department of Health will set out the progress expected against the NHS Plan. These will build on the performance agreements with individual PCTs and NHS Trusts.

Special Health Authorities

Under the National Health Service Act 1997, the Secretary of State may establish special health authorities for the purpose of performing any functions which he may direct the body to perform on his behalf.

Some NHS services are administered by special health authorities, which are accountable directly to the Health Secretary. Examples include the Mental Health Act Commission and the National Institute for Clinical Excellence (NICE).

Primary Care Trusts

The Health Act 1999 provided for the establishment of new bodies called Primary Care Trusts, which constitute a new tier of administrative body below Health Authorities.

On 1 April 2002, local primary care trusts (PCTs) effectively took over the responsibility of commissioning most hospital and community health services from the old Health Authorities.

This increased role for PCTs is intended to deliver improvements for patients by focusing on supporting frontline staff and empowering them to make decisions locally.

Primary Care Trusts are now the lead NHS organisations. They will assess need, plan and secure all health services, improve health in their localities, provide most community services and develop primary care services. NHS trusts will continue to provide most secondary care and specialist services in hospitals.

Once enacted, the National Health Service Reform and Health Care Professions Bill introduced in November 2001 will impose a legal duty on the Secretary of State to establish Primary Care Trusts across all of England.

PRIMARY CARE TRUSTS — THE STATUTORY FRAMEWORK

1. Primary Care Trusts are established by the Secretary of State with a view to:

   (a) providing, or arranging for the provision of, hospital and community health services under Part I of the 1977 Act;

   (b) exercising Health Authority functions in relation to the provision of general medical services under Part II of the Act, and

   (c) providing services in accordance with arrangements made for the provision of personal (i.e., general) medical services under a pilot scheme.
2. Each Primary Care Trust serves the area specified in its establishment order, each area being wholly contained within the area of a Health Authority.
3. The trusts are corporate bodies with their own budget for local health care. Typically, an English trust is likely to serve a population of at least 100,000, and have a budget of around £60m or more.
4. A substantial number of PCT members must be GPs, local nurses and other health care professionals involved in providing services under the National Health Service Act. The Chairman and the lay members are, however, appointed by the Secretary of State.
5. Once a proposal to establish a Primary Care Trust has been selected or initiated by a Health Authority, it is the subject of a consultation conducted in accordance with regulations.
6. Trusts are subject to directions given by the Secretary of State. In particular, the Secretary of State may determine which functions may or may not be delegated to Primary Care Trusts, and the extent to which they may be delegated.
7. Subject to any directions of the Secretary of State, a PCT's particular functions are mainly conferred by directions of the local Health Authority, to which it is accountable. The Health Authority may also direct it as to the exercise of delegated functions, although it is not intended that they should seek to control detailed day-to-day operational matters.
8. Although the Health Act did not specify what services Primary Care Trusts will or will not commission, the intention was that responsibility for commissioning most hospital and community health services would be delegated to them.
9. In some cases, a Primary Care Trust may also provide hospital and community health services for their local population (in practice, usually community health services), a function currently performed by NHS trusts. In this respect, a Primary Care Trust is something of a 'hybrid' between a Health Authority and an NHS trust.

10. Progression from a commissioning-only trust to a commissioning-and-providing trust is subject to consultation and approval by the Secretary of State.
11. Although mainly concerned with the Part I system relating to hospital and community health services, Primary Care Trusts may exercise certain Health Authority functions relating to general medical services. Subject to regulations and directions, Health Authorities may direct them to exercise the authority's functions in relation to general medical services.
12. Functions relating to high security psychiatric services, and family health service functions other than general medical services, cannot be delegated to PCTs.
13. Primary Care Trusts are funded by Health Authorities under section 97C of the 1977 Act. They are subject to a set of financial duties similar to those for Health Authorities, and the same distinction is drawn between cash-limited and non-cash-limited funding.

14 The trusts have considerable flexibility when it comes to arranging for the performance of their functions. For example, it is possible for them to pool administrative support services such as IT, estate and payroll management with other NHS bodies.

15. Trusts must prepare and provide reports and information on their activities to the relevant Health Authority and the Secretary of State. This enables Health Authorities to monitor their performance. They must publicise their accounts, an annual report, any auditor's report given under section 8 of the Audit Commission Act 1998, and any other documents specified in regulations.

Functions

According to '*Shifting the Balance of Power*', a PCT's key functions include:

- Improving the health of the community through community development, service planning, health promotion, health education, commissioning, occupational health and performance management. PCTs will identify the health needs of their local populations, develop plans for health improvement, lead the development of the local health strategy, and deliver it by providing and commissioning services from primary care practitioners and NHS Trusts.
- Securing the provision of:
    a) primary care, community health, mental health and acute secondary care services;
    b) personal medical services including out-of-hours and walk-in centres;
    c) medical, dental, pharmaceutical and optical services;
    d) emergency ambulance and patient transport services;
    e) the health contribution to child protection services;
    f) all primary care development.
- Regulating the contracts of all family health services providers.
- Managing clinical performance in the PCT.
- Developing a coherent modern nursing service.
- Implementing population screening.

- Ensuring the involvement of patients, public, voluntary sector and local communities in plans.
- Integrating local health and social care through the use of recent legislation. Where the local agencies agree, care trusts 'will be important vehicles for modernising both social and health care, helping to ensure that integrated services are focused on the needs of patients and users'.

Funding

PCTs will control 75 per cent of total NHS funds by 2004. They will be directly funded by the Secretary of State, rather than by Health Authorities, and the funding arrangements mirror those by which the Secretary of State previously allocated monies to Health Authorities. Providing funds directly to PCTs is intended to help 'empower' frontline staff and patients in the planning, modernisation and delivery of services.

Block capital will be given directly to PCTs, using a national formula that measures the need for investment.

The Secretary of State may increase the allotments made to a Primary Care Trust if it has satisfied preset objectives over a defined period, or performed well against criteria relevant to their satisfactory performance of functions. These additional sums may be subject to conditions.

Designation as a Care Trust

The Health & Social Care Act 2001 provided for designating Primary Care Trusts *and* NHS trusts as care trusts, which are intended to integrate health and local authority services. In particular, care trusts will be able to commission and/or provide integrated services covering health, social services and other health-related local authority functions. A number of care trusts were established in April 2002.

The basic care trust framework is as follows:

- Care trusts are NHS bodies that combine a PCT(s) or NHS Trust(s) with local authority services. Their establishment is intended to help to ensure that health and local authority services are coordinated and integrated locally.
- Care trusts may be established either by dissolving an existing PCT or NHS trust or by amending their establishment order. More particularly, an existing PCT or NHS trust may be designated as a care trust where they have local authority health-related functions delegated to them by agreement.
- The two basic care trust models are therefore, firstly, incorporating social care within (specialist mental health) NHS trusts; and, secondly, PCTs taking on mental health and social care (the 'PCT+ model'). Here, a PCT would take on certain specialist mental health and social care services and commission the remainder.

- Applications to the Secretary of State for care trust status are made jointly by the NHS bodies and local authorities involved. The proposal must have been subject to local consultation; and the Secretary of State must be of the opinion that care trust status is likely to promote the effective exercise by the trust of any delegated local authority health-related functions alongside the trust's existing NHS functions. This reflects the main aim that such a trust will improve services through effective integration of NHS and local authority services.
- Designation as a care trust will lead to a change in governance arrangements, so that local authority interests are duly represented within the governance structures of the trust. According to the regulations, the non-officer members of a PCT designated as a care trust must include at least one member of the relevant local authority (appointed by the Secretary of State following nomination by the relevant local authority), and at least one person who is representative of users of services of the trust.
- Where an NHS body is to exercise social services functions as a care trust, it must act in accordance with directions and guidance from the Secretary of State in relation to its acquired social services functions.
- It is possible for a care trust to be imposed by the Secretary of State following failures in joint working.

Some of the possible advantages and disadvantages of care trusts are summarised in the following table:

CARE TRUSTS

Possible advantages

- Integration of the purchase and provision of health and social care at every level (no gaps, delays, duplication or boundary disputes; improved care integration and communications).
- Better crisis management (multidisciplinary intervention and crisis teams; hospital at home; joint management of emergency admissions; shorter hospital stays, less bed blocking).
- Financial advantages (cost effectiveness, removing perverse incentives across health and social care).
- Opportunity to re-organise badly managed services.

Possible problems

- Less partnership (care trusts are NHS bodies, and care trusts are a type of takeover, not a true partnership)
- Loss of social care aims (because care trusts are NHS bodies, healthcare and medical/clinical model will be dominant, and local authority services and the social care model become an adjunct to health).
- Disinvestment (most social services authorities spend above SSA, and this priority might not be maintained by local government in care trusts).
- Conflict (inter-professional rivalry and stereotyping, resentment, suspicion, uneasiness).

- Complexity (harmonizing 'best value' and 'value for money' duties; setting eligibility criteria; managing charging for services; different accountability and scrutiny schemes; harmonizing the terms and conditions of health and social care staff).
- Loss of accountability (the NHS is not as accountable as local government).
- Less effective co-ordination of social services and other local authority services, such as housing and education (at present, social services is the bridge between health services and wide local government services).
- Defensive medicine due to litigation spilling over into defensive social care.

Requirements

- A coherent strategy with regard to health and social care accountability systems, internal governance and professional accountability.
- Good attitudes, e.g. with regard to cultural differences between the medical and the social model, and the need to change behaviour and challenge stereotypes.
- One set of values, not two (both services working together in the same buildings; joint needs assessment and service commissioning; shared ownership; joint inspections; equal consultation).
- Governance and management arrangements that enable local councils to maintain democratic accountability.
- Power sharing and working arrangements that are joined at the frontline, and not just senior management level.
- Information sharing arrangements.
- Clear measurements of success.

B. THE PROVISION OF SOCIAL CARE

Local Authorities are responsible for performing community care functions and other social services functions, such as housing and education.

The gross expenditure of English local authorities on personal social services in 1998–99 amounted to £10,847m. This included £564m on mental health services and £1,495m on learning disability services. About half of the gross expenditure was on provision for older persons (a quarter of which was recouped through sales, fees and charges), and nearly a quarter on provision for children. Central and strategic costs (including regulation and inspection) accounted for only 1% of gross expenditure.

According to Department of Health data, the number of adults in staffed residential care being supported by English local authorities increased from 144,312 on 31 March 1994 to 249,438 on 31 March 1998. Of the latter:

- 202,722 were people aged 65 or over.
- 9,277 were categorised as people with mental health problems (compared with 4,432 on 31 March 1994), and 26,029 as people with learning disabilities (1994: 17,648).
- 54,611 were in local authority staffed residential care; 121,923 in independent residential care; and the remaining 72,904 in independent nursing care.

Social services functions

A local authority's 'social services functions' include providing residential accommodation for adults suffering from mental disorder; promoting the welfare of adults who suffer from mental disorder; temporarily protecting the property of persons in hospital or Part III accommodation; providing facilities for enabling disabled persons to be employed or work under special conditions; promoting the welfare of old people; providing certain welfare services; preparing plans for community care services; assessing people's needs for community care service; and various functions under the Mental Health Act 1983.

Exercise of social services functions

The Local Authority Social Services Act 1970 imposed a requirement on local authorities to establish a social services committee to deal with matters relating to the discharge by it of its statutory social services functions. However, the Local Government Act 2000 provides that this requirement no longer applies where the authority adopts one of the forms of local authority executive provided for by that Act.

Local authority executives

The Local Government Act 2000 received Royal Assent on 28 July 2000. The Act provides for local authority executives and executive arrangements. Section 11 specifies three particular forms of executive: A directly-elected mayor who appoints between two and 10 councillors to the executive ('a mayor and cabinet executive'). An executive leader, elected by the full council, plus between two and 10 councillors appointed by the leader or the council ('a leader and cabinet executive'). A directly-elected mayor, with an officer of the authority appointed by the council as a council manager ('a mayor and council manager executive').

Overview and scrutiny committees

Under executive arrangements, social services and other council functions are no longer carried out by committees that reflect the political balance of the council, and new ways of scrutinising the conduct of council business are necessary.

Section 21 of the Local Government Act 2000 requires authorities operating executive arrangements to set up overview and scrutiny committees in order to hold the executive to account. Any member of such a committee may ensure that any relevant matter is put on the agenda and discussed at its meetings.

Committees may make reports and recommendations, either to the executive or to the authority, on any aspect of council business. They may also make reports and recommendations on other matters which affect the authority's area or its inhabitants.

An overview and scrutiny committee may require officers and members of the executive to appear before it, and may invite any other person to appear before it. It may review and scrutinise executive decisions, and recommend that they are reconsidered or arrange for the authority to review them.

A mixed economy of care

The National Health Service & Community Care Act 1990 fundamentally changed the way in which social care is provided to people suffering from mental disorder.

The underlying philosophy of the legislation was to separate out the functions of purchasing and providing such care, so as to create an 'internal market' in the health service and a 'mixed economy of care' in relation to social services.

Just as the role of Health Authorities became one of purchasing health services provided by NHS trusts, so local authorities were developed as 'enabling authorities' and 'commissioning agencies', seeking out and purchasing community care services from a range of public and non-public providers.

The enabling and commissioning roles of a local authority involve it:

- identifying the need for care among the population it serves;
- planning how best to meet those needs;
- setting an overall strategy in terms of priorities and targets;
- seeking out, and purchasing, the required services from a range of providers in the voluntary, private and public sectors (that is developing a mixed economy of care); and
- monitoring the quality of the services which it has purchased.

The general position today is that any community care services that can be provided by a local authority may also be provided by an agency from the independent sector.

Community care functions

The term 'community care services' is defined in section 46 of the National Health and Community Care Act 1990. Community care services are services that a local authority may provide or arrange under:

- Part 3 of the National Assistance Act 1948,
- Section 45 of the Health Services and Public Health Act (promotion by local authorities of the welfare of old people),
- Section 21 of and Schedule 8 to the National Health Service Act 1977; and
- Section 117 of the Mental Health Act 1983 (after-care).

The practical importance of the definition is that local Authorities have a duty, under section 47 of the 1990 Act, to assess a person's need for community care services. This is undertaken through what is called the care management process.

The care management process begins with a local authority 'care manager' undertaking an assessment of an individual's need for services. If the person is assessed to need a community care service, a care plan is then drawn up. This plan should ensure, as far as possible, that normal living is preserved or restored, primarily by providing the services within the user's home, including (where necessary) day and domiciliary care, respite care, and the provision of disability equipment and adaptations to the home. Care managers therefore act as brokers for services across the statutory and independent sectors.

Partnership arrangements

The Health Act 1999 extended the duty of co-operation between NHS bodies and local authorities in England and Wales. In addition, section 2 of the Local Government Act 1999 empowers local authorities to take any steps which they consider are likely to promote or improve the economic, social or environmental well-being of their local community. This power enables them to work in partnership with other bodies, for example by assisting other statutory bodies to discharge their functions, or by exercising functions on their behalf.

Under the new NHS partnership legislation, NHS trusts may provide social care, and likewise local authorities may provide health care. Furthermore, health and local authorities may pool budgets or nominate a lead commissioner for specific client groups. These measures are intended to allow the authorities to agree jointly who is best placed to carry out their functions, and how resources may be used more efficiently.

Where NHS services or social services are failing, section 46 enables the Secretary of State to direct an NHS body and local authority to enter into partnership arrangements and/or pooled funding arrangements. The exercise of the power is limited to situations where a local authority or NHS body is failing to deliver its functions adequately, and the Secretary of State is of the opinion that a delegation or pooled fund arrangement would be likely to improve the delivery of the failing function.

'Best value'

The Local Government Act 1999 repealed those laws that required authorities to submit activities to compulsory competitive tendering; and imposed a new statutory duty on them to arrange for delivering 'best value' in the way in which their functions are performed. 'Best value' means securing continuous improvement in the exercise of the authority's functions, having regard to economy, efficiency and effectiveness.

The 1999 Act empowers the Secretary of State to prescribe performance indicators against which best value authorities will be measured; and to set national standards which authorities must meet in order to discharge the duty. The Audit Commission may carry out inspections aimed at assessing the degree to which authorities are complying with the requirements of the best value legal framework; and the Secretary of State is given a wide range of intervention powers in response to failures.

Under the Act, authorities were required to carry out an initial assessment of whether to perform functions they may perform, how, by whom, and to what standard. They are also required to prepare and publish annual Local Performance Plans (LPPs). These plans are scrutinised by auditors, who must comply with any code of practice produced by the Audit Commission. The authority must publish the auditor's report. If it contains recommendations about follow-up action, the authority is required to publish a statement of the action it proposes to take, and its timetable for doing so.

C. INDEPENDENT HEALTHCARE

In accordance with the NHS plan, the NHS has agreed a new national framework with the Independent Healthcare Association that enables NHS patients to be treated free in the private and voluntary health care sector. According to this 'concordat', there should be no organisational or ideological barriers to the delivery of high quality healthcare free at the point of delivery to those who need it, when they need it.

Prior to 1 April 2002, independent mental health establishments were regulated as mental nursing homes (including those larger establishments often referred to as 'private hospitals'). Statistical data published by the Department of Health shows that:

- The number of registered mental nursing homes rose by 8% to 1073 during the year to 31 March 2000; and the number of beds in such homes by 4% to 31,828.
- 28,709 of these beds were intended for mental health use, of which only 6392 were occupied by people aged 64 or under.
- 182 of the 1073 registered mental nursing homes were registered to receive detained patients under the 1983 Act (17%), and these homes provided 1,465 beds.
- The number of formal admissions to mental nursing homes under the 1983 Act increased from 400 in 1990–91 to 1400 in 2000–01. 1200, or 86%, of these admissions were under Part II (compared with 95% for NHS hospitals).
- At 31 March 2001, 1,700 of the 13,800 patients detained in hospital under the 1983 Act were in private mental nursing homes (one in eight).
- Mental nursing homes now receive the majority of people detained under the Act on the grounds of mental impairment or severe mental impairment.
- 96 of the 1073 registered mental nursing homes had a resident medical practitioner, and 96 a registered pharmacy.
- 51,200 qualified whole time equivalent nursing staff were working in all private nursing homes, hospitals and clinics, of whom 69% were registered general nurses, 15% registered nurses, and 12% registered mental nurses.

Care Standards Act 2000

The Care Standards Act 2000 repealed the Registered Homes Act 1984. The Act, which came into force on 1 April 2002, defines independent healthcare services in three categories: independent hospitals; independent clinics; and independent medical agencies (agencies that provide doctors to visit private patients). Under the new scheme, some existing 'mental nursing homes' constitute 'independent hospitals' and others 'care homes'.

Independent hospitals

Section 2(3) of the Care Standards Act defines an independent hospital as any establishment which has *as its main purpose* the provision of psychiatric or medical treatment for illness or mental disorder (including palliative care), or which provides a 'listed service'; and any other establishment that provides treatment for people liable to be detained under the Mental Health Act 1983. The definition of 'people liable to be detained' does not include those on section 17 leave.

‘Listed services’ are services which, due to the potential risk to the patient, can only be provided by an independent hospital, and regulated accordingly. The listed services include medical treatment under anaesthesia or sedation.

The definition of an independent hospital includes clinics that treat people for alcohol and drug misuse and eating disorders if their main purpose is to provide psychiatric treatment for illness or mental disorder. According to guidelines, an establishment that provides care for elderly people with dementia will be a care home, as its main purpose is not the provision of mental health treatment.

Care homes

A ‘care home’ is defined, by section 3, as a home that provides accommodation together with nursing or personal care for any person who is or has been ill (including mental disorder), is disabled or infirm, or who has a past or present dependence on drugs or alcohol. The definition is intended to include residential care homes and nursing homes as defined in the 1984 Act. The Commission will be able to impose conditions on care homes as to the categories of person they can accommodate.

Residential care homes run by NHS bodies must be registered under this definition, as the provision of residential homes is not a core NHS function. Local authority homes provided under Part III of the National Assistance Act 1948 must also register.

‘Personal care’ in this context includes assistance with bathing, dressing and eating for people who are unable to do these things without help. This means that an establishment is not ‘a care home’ unless this type of assistance is provided where required.

Homes that provide personal care and accommodation for disabled children are treated as children’s homes.

Some establishments must be separately registered, both as an independent hospital and a care home. This is because an establishment may have a number of premises on the same grounds, and in one provide psychiatric treatment for people with eating disorders and on another provide care to elderly people with dementia. These establishments must be registered separately and regulated to different standards, to ensure that the care provided meets the needs of the patients.

Independent clinics

In essence, an independent clinic is an establishment other than a hospital within which medical practitioners provide services to private patients only. In 1999, it was estimated that there were 95 psychiatric clinics, providing 468 beds. However, it is thought that as many as 3,000 specialist doctors may operate significant private practices, many from home.

Public-private partnerships

As amended, section 96C of the National Health Service Act 1977 enables the Secretary of State to participate in public-private partnerships with companies that provide facilities or services to persons or bodies carrying out NHS functions. The new powers can be delegated to Health Authorities, and through them to Primary Care Trusts and Special Health Authorities. The intended first use of this new power is the establishment of NHS LIFT (NHS Local Improvement Finance Trust), which invests in primary care premises.

Private Finance Initiatives

Private Finance Initiatives (PFI) involve the use of private finance in capital projects, particularly in relation to the design, construction and operation of buildings and support services. Such initiatives are the most common form of financing new capital projects in the NHS, and the majority of schemes relate to the provision of hospital facilities.

Major PFI schemes are usually on a 'design, build, finance and operate' (DBFO) basis, where the contractor takes on a facilities management role for the duration of the contract. These contracts generally range from 25 to 35 years.

The estimated total capital value of major schemes (those with individual capital values of over £25 million) closed by 31 March 2000 was nearly £1.4 billion.

During 2000–2001, a further 29 major schemes with a capital value of over £3.1 billion were submitted for assessment to the Capital Prioritisation Advisory Group. In February 2001, Ministers approved all 29 schemes.

Although no major PFI schemes were operational by 31 March 2000, four became operational during 2000–2001.

D. MAINTAINING QUALITY STANDARDS

The attention of public bodies that oversee service standards focuses on one of two things:

- Quality standards (setting, monitoring and enforcing quality standards; patient safety; implementing service reforms designed to improve quality).
- Legal standards (including the maintenance of ethical standards that may not be legally enforceable).

As one would expect, the vast majority of the public bodies that come under the umbrella of the Department of Health exist in order to ensure or improve the safety and quality of health and social care.

SETTING QUALITY STANDARDS

In December 1998, the Government promised to modernise mental health services by providing safe, sound and supportive services ('*Modernising Mental Health Services*', Department of Health, December 1998).

Before 1999, there was no statutory duty on NHS bodies in respect of the quality of care provided to patients (although they owed a duty at common law to exercise reasonable care and skill when providing treatment and other services). Section 18 of the Health Act 1999 changed this, by imposing a 'duty of quality' on Health Authorities, Primary Care Trusts and NHS trusts.

According to the NHS Plan, the Department of Health will set national standards, in conjunction with leading clinicians, managers and staff. Some of the main standards set for mental health services are listed in the following table.

QUALITY STANDARDS FOR MENTAL HEALTH SERVICES

Universal standards

The national service framework for mental health

The care programme approach

NHS standards	Local authority standards	Local Authority & Independent care standards
Guidance published by the National Institute for Clinical Excellence (NICE)	National inspection standards (Social Services Inspectorate)	National minimum standards for care homes & independent healthcare
Patient's Charter	Social services performance assessment framework	General Social Care Council Codes of Practice
Performance assessment framework	Best value duty	Guidance published by the Social Care Institute for Excellence
Value for money duty		

National Service Framework (November 1999)

National Service Frameworks are detailed documents setting out the standards expected of the NHS in meeting the needs of specific patient groups. The framework for mental health sets seven key standards in five areas:

Standard 1	● Mental health promotion
Standards 2 & 3	● Primary care and access to services
Standards 4 & 5	● Effective services for people with severe mental illness
Standard 6	● Caring about carers
Standard 7	● Preventing suicide

Each standard is supported by a rationale, by a narrative that addresses service models, and by an indication of performance assessment methods. Each standard indicates the lead organisation and key partners. Performance is assessed at a national level by measures that include factors such as the national psychiatric morbidity survey; reduction in suicide rates, etc. The outcome indicators for cases of severe mental illness include the prevalence of severe illness; the proportion of CPA plans signed by service users; the incidence of serious physical injury; and the prevalence of side effects from anti-psychotics.

Care programme approach

The requirements of the care programme approach form part of the national service framework for mental health. 'Modernising the care programme approach', published in October 1999, set out important changes to the approach, which took account of available evidence and experience. Some of the key developments were the integration of CPA and care management; the appointment of lead officers within each trust and local social services authority; the introduction of two CPA levels (standard and enhanced); the removal of the previous requirement to maintain a supervision register; and the use of the term 'care co-ordinator' in place of 'key worker'. Adherence to the care programme approach is one of the guiding principles set out in the Code of Practice on the Mental Health Act.

National Institute for Clinical Excellence

The National Institute for Clinical Excellence was established by the Secretary of State as a Special Health Authority on 1 April 1999. It produces formal advice on the clinical and cost effectiveness of new and existing technologies, including drugs, diagnostic tests and surgical procedures, and guidance on how clinicians can compare their current standards with best current practice (clinical audit). It sets clinical guidelines and a clinical audit framework. The institute has an executive board consisting of four executive members (Chief Executive, Director of Resources and Planning, Communications Director and Clinical Director) and seven non-executive members. NICE completed 16 technology appraisals between 1 December 1999 and 31 December 2000, and it published a patient-friendly version of each appraisal.

National Performance Assessment Framework

The National Performance Assessment Framework sets out various indicators and standards by which NHS Trusts are to be measured, for example waiting times for patients and the outcomes of specific medical interventions.

Social Services Inspectorate standards

The SSI sets standards for each of its national inspections, and evaluates services against these standards. There are currently 29 standards.

Minimum care standards

The Care Standards Act 2000 authorises the Secretary of State to publish national minimum standards for care homes and independent healthcare providers, with which they are expected to comply. The National Care Standards Commission (see below) may give advice about changes to the standards, with a view to securing improvement in the quality of services.

General Social Care Council Codes

Although approximately one million people work in social care, the large majority have no recognised qualifications or training, and there are no nationally agreed standards of practice or conduct. Section 62 of the Care Standards Act 2000 now requires the new General Social Care Council to produce codes of good practice for social care workers and the employers of such staff.

Social Care Institute for Excellence (SCIE)

A Social Care Institute for Excellence was established at the end of 2001, to develop and promote a knowledge base of what works in social care. It is intended to play an important role in creating a culture in social services that prioritises quality, evidence based knowledge and a commitment to continuous improvement. In developing its knowledge base, it will draw on the views and experience of service users, research evidence, inspection findings and the experience of managers and practitioners.

The Patients' Charter

The Patient's Charter sets out the rights and responsibilities of patients, including the standards that they can expect from different levels of the Health Service.

Professional codes and standards

Professional bodies issue codes of practice and regulations, setting standards of practice and conduct. Revalidation is a process being introduced by the General Medical Council. Under it, all doctors will have to prove their continuing fitness to practice on a regular basis.

DELIVERING QUALITY STANDARDS

The way in which quality standards are monitored and delivered varies by sector. Some of the main mechanisms are summarized in the following table.

ENSURING THE QUALITY OF MENTAL HEALTH SERVICES

Method	Mechanisms
Supporting services	● Modernisation Agency
Establishing clinical and service networks	● National Institute for Mental Health in England
Regulating professional practice	● A Council for the Regulation of Health Care Professionals
	● General Social Care Council
	● Protection of vulnerable adults scheme
Reviewing competence to practice	● The National Clinical Assessment Authority
Improving patient safety	● The National Patient Safety Agency
Public and patient involvement	● A statutory duty to involve patients and the public.
	● Local authority overview and scrutiny committees.
	● An independent reconfiguration panel.
	● An independent complaints advocacy service.
	● NHS complaints procedures. Reinforced by:
	● Health Service Commissioner
	● Parliamentary Commissioner
	● Social services complaints procedures, e.g. re community care services. Reinforced by:
	● Local Authority Commissioner

	• Patients Forums.
	• A Commission for Patient and Public Involvement in Health
	• Patient and user surveys.
Clinical governance	• Clinical governance guidance.
External monitoring — NHS	• The Commission for Health Improvement
— Care homes, independent healthcare	• National Care Standards Commission
— Social services	• Social Services Inspectorate
— Value, efficiency	• Audit Commission
Intervention	• Inquiry and intervention powers (Secretary of State)

Brief notes follow on those organizations created by the present Government since it came to power in 1997. It will be seen that four public bodies are now responsible for inspecting health and social care authorities and agencies, and for reviewing the quality of their services: The Commission for Health Improvement; The National Care Standards Commission; The Social Services Inspectorate (which is part of the Department of Health); and The Audit Commission.

Modernisation Agency

The Modernisation Agency was set up to support the improvement of services. It aims to help professionals and managers redesign and improve local health services around the needs and convenience of patients. Various organisations make up the agency. They include the Social Care Institute for Excellence and the NHS Clinical Governance Support Team (CGST). The new National Institute for Mental Health in England is located within it.

National Institute for Mental Health in England (NIMHE)

A National Institute for Mental Health was established in Autumn 2001, led by Professor Louis Appleby, the National Director for Mental Health. The overall aim of the Institute is to drive forward the implementation of the National Service Framework for Mental Health and the changes for mental health services set out in the NHS Plan. The Institute will initiate the development of regional clinical and service development networks. These will bring together best current practice with new developments in mental health, so as to ensure that high quality care is consistently provided. The Institute’s first task will be to develop a national research plan, and to set up a network of leading institutions to work collaboratively.

Professional regulatory bodies

Parliament has created statutory frameworks for many healthcare professions, within which the professions regulate themselves. Each of the groups has its own regulatory body operating within its own legal framework:

Doctors	General Medical Council	Medical Act 1983
Dentists	General Dental Council	Dentists Act 1984
Nurses, midwives and health visitors	Nursing and Midwifery Council	Nurses, Midwives and Health Visitors Act 1997/Health Act 1999
Opticians	General Optical Council	Opticians Act 1989
Pharmacists	Royal Pharmaceutical Society of Great Britain	Pharmacy Act 1954; Medicines Act 1968
Osteopaths	General Osteopaths Council	Osteopaths Act 1993
Chiropractors	General Chiropractic Council	Chiropractors Act 1994
Professions supplementary to medicine (12)	The Health Professions Council	Professions Supplementary to Medicine Act 1960/Health Act 1999

Council for the Regulation of Health Care Professionals

Clause 23 of the National Health Service Reform and Health Care Professions Bill provides for the establishment of a Council for the Regulation of Health Care Professionals. The Bill gives the Council the functions of promoting the interests of patients and the public in the way that statutory regulatory bodies carry out their work, and promoting co-operation between them. The Council is to be a non-ministerial government department financed out of money provided by Parliament, and paid to it by the Secretary of State.

General Social Care Council

Section 70 of the Care Standards Act 2000 abolished CCETSW in relation to England and Wales, and established a General Social Care Council. The Council is a non-departmental public body sponsored by the Department of Health. It will operate according to rules approved by the Secretary of State.

Section 56 of the 2000 Act provides for the Council to establish and maintain a register of social care workers. Section 61 enables the title of 'social worker' to be protected, by making it an offence to describe oneself as a social worker, with intent to deceive, if not registered as a social worker. Sections 63 to 66 of the Act set out the new Council's functions with regard to the education and training of social workers. The Council is given wide powers to make rules about the approval of courses, with the intention of ensuring the consistency and quality of the education to be provided at pre- and post-qualifying levels.

Protection of vulnerable adults scheme

Section 81 of the Act places a duty on the Secretary of State to keep a list of care workers who are considered unsuitable to work with vulnerable adults. Providers of care services to vulnerable adults are required to refer individuals for inclusion in the list in certain circumstances. In addition, the Secretary of State may consider for inclusion individuals named in the findings of certain inquiries. The provisions only apply to healthcare establishments where individuals are employed in prescribed services (for example, wards for older people).

National Clinical Assessment Authority (NCAA)

'*Building a Safer NHS for Patients*' (Department of Health, April 2001) set out the Government's plans for patient safety in the context of the NHS quality programme. Where there is evidence of poor clinical performance, and the problem cannot be evaluated or resolved locally, or is particularly serious, the medical practitioner concerned will be referred to the new National Clinical Assessment Authority. This authority will make a thorough assessment, and give advice to the trust or health authority. Educational and training solutions will be used where possible, but serious problems will be referred to the General Medical Council. The NCAA will notify the Commission for Health Improvement if there may be wider service problems that need to be investigated.

The National Patient Safety Agency

The new National Patient Safety Agency will collect and analyse information on adverse events from local NHS organizations and staff, patients and carers; assimilate other safety-related information from a variety of existing reporting systems and other sources in England and abroad; learn lessons and ensure that they are fed back into practice, service organisation and delivery; produce solutions to identified risks, to prevent harm; and specify national goals and establish mechanisms to track progress.

In future, there will be only two ways of responding to a failure of a whole service, a seriously dysfunctional service, or major systems weaknesses: an independent inquiry commissioned by the Department of Health or an investigation by the Commission for Health Improvement (the approach to be agreed between the Department and the Commission in each case). Inquiries into mental health services will be brought within this integrated approach. There will be no ad hoc external investigations or inquiries commissioned by trusts or health authorities; nor will comprehensive internal inquiries be carried out. Internal reviews will be limited to scoping investigations designed to inform a decision as to whether an independent investigation is required.

Risks to patients that arise from the poor performance of an individual practitioner will be dealt with by the new National Clinical Assessment Authority. Patient complaints will be dealt with under NHS complaints procedures, and staff concerns about care standards will be addressed by the new adverse event reporting system, or as part of clinical governance.

Public and patient involvement

Section 11 of the Health & Social Care Act 2001 imposes on each Health Authority, Primary Care Trust and NHS trust a new statutory duty to make arrangements for involving patients and the public in their planning and decision making processes, insofar as they affect the operation of the health services for which the body is responsible. In relation to Health Authorities, this covers both hospital and community health services and the family health services provided in their area.

Local authority overview and scrutiny committees

Sections 7 to 10 of the 2001 Act provide for local authority overview and scrutiny committees to scrutinise the NHS, and to represent local views as to the development of health services.

The Local Government Act 2000 gave these committees power to scrutinise local authority social services functions. The 2001 Act then conferred on them the function of reviewing and scrutinising health service matters, and making reports and recommendations to NHS bodies about such matters. In this respect, they can also oversee and scrutinise social care services provided or commissioned by an NHS body that exercises local authority functions (under partnership arrangements).

Health Authorities must consult the local committee on major service changes, and the Chief Executives of local NHS bodies are required to attend overview and scrutiny committee meetings at least twice a year.

Independent Reconfiguration Panel

The functions of overview and scrutiny committees include referring contested proposals for major service changes to the Secretary of State on the grounds of process and merit. A new Independent Reconfiguration Panel will advise the Secretary of State on proposals referred to him in this way; and its membership will include clinicians, patient representatives and NHS managers.

Independent complaints advocacy service

Section 12 of Health & Social Care Act 2001 imposes a duty on the Secretary of State to arrange independent advocacy services for people who wish to complain about the service that they, or someone whom they care for, has received from the NHS. The arrangements for discharging this duty centre on new, non-statutory, Patient Advocacy and Liaison Services (PALS). These trust-based services will be situated in or near the main reception areas of hospitals, and 'act as a welcoming point for patients and carers.' They will provide information, help to resolve problems and difficulties, and advise patients on how to access independent advocacy to support complaints.

Patients' Forums

The National Health Service Reform and Health Care Professions Bill introduced in November 2001 provides for the establishment of Patients' Forums. Their membership is to be drawn from voluntary sector organisations representing patients and/or carers and from individual patients.

Clause 15 of the Bill requires the Secretary of State to establish a Patients' Forum for each Primary Care Trust and NHS trust in England, and sets out their functions. These include monitoring and reviewing the services for which the trust is responsible, obtaining and reporting to the trust the views of patients and their carers, and making available to patients advice and information about the trust's services. Where a trust exercises local authority functions, for example social care services, the forum will also monitor these services.

In accordance with regulations, the forum may assume responsibility for arranging or providing services to assist patients. This could include Patient Advocacy and Liaison Services (PALS), where the trust PALS service is not performing satisfactorily.

Clause 16 of the Bill gives the Secretary of State power to make regulations requiring Strategic Health Authorities, trusts or providers of family health services (e.g. GPs and pharmacists) to allow authorised members of Patients' Forums to inspect premises owned or controlled by them.

Commission for Patient and Public Involvement in Health

The National Health Service Reform and Health Care Professions Bill, introduced in November 2001, also establishes a new independent corporate body called The Commission for Patient and Public Involvement in Health.

The Secretary of State may direct the Commission to perform his duty of making arrangements for independent advocacy for people wishing to complain against the NHS. This aside, the Commission's other functions are to:

- advise the Secretary of State about the arrangements that are in place across England for the involvement and consultation of patients and the public in matters relating to the NHS.
- promote public involvement in decisions and consultations on matters affecting the health of the population. It will be able to do this at a local and national level.
- advise the Secretary of State on arrangements for independent advocacy services.
- report to the Secretary of State the views of locally based patient and public involvement bodies (including Patients' Forums) on such arrangements, e.g. as to how effectively they are operating.
- facilitate the co-ordination of Patients' Forums and to provide assistance to them. It is intended that the Commission's local arrangements will provide them with administrative support.
- give advice and assistance to providers of independent advocacy services. This could be in the form of guidance or training.
- set quality standards for the activities of Patients' Forums and the provision of independent advocacy services. It will also monitor how effectively these standards are met.
- make reports of the public's views on matters affecting their health to any local body that has an influence over the health of the public; in particular, Local Authority Overview and Scrutiny Committees.

Clinical Governance

The Health Act 1999 imposed a statutory duty of quality on Health Authorities, Primary Care Trusts and NHS trusts; and these bodies are now required to have in place arrangements for monitoring and improving the quality of the health care they provide. Clinical governance is the name given to these arrangements.

The first clinical governance guidance was published in March 1999, under Health Service Circular HSC 1999/065.

The main components of clinical governance are clear lines of responsibility and accountability for the overall quality of clinical care; a comprehensive programme of quality improvement (including clinical audit, supporting and applying evidence-based practice, implementing clinical standards and guidelines, workforce planning and development); clear policies aimed at managing risk; and procedures for all professional groups to identify and remedy poor performance.

Commission for Health Improvement

The Health Act 1999 established new arrangements for improving the quality of the care provided to NHS patients. In particular, it imposed a statutory duty of quality on health service bodies, and established a commission to monitor and help improve quality.

The Commission for Health Improvement is responsible for monitoring the quality of care for which NHS bodies are responsible through a variety of reviews and investigations. It carries out regular inspections every three to four years, and has the power to look at adverse incidents.

The Commission's establishment was accompanied by the dissolution of the Clinical Standards Advisory Group (CSAG). Since 1990, its function had been to advise on standards of clinical care in the NHS, and on access to, and the availability of, services to NHS patients.

Section 20(1) of the 1999 Act, reproduced below, sets out the Commission's core functions.

CORE FUNCTIONS OF THE COMMISSION FOR HEALTH IMPROVEMENT

Health Act 1999

20.–(1) The Commission has the following functions:

(a) providing advice or information with respect to arrangements by Primary Care Trusts or NHS trusts for the purpose of monitoring and improving the quality of health care for which they have responsibility,

(b) conducting reviews of, and making reports on, arrangements by Primary Care Trusts or NHS trusts for the purpose of monitoring and improving the quality of health care for which they have responsibility,

(c) carrying out investigations into, and making reports on, the management, provision or quality of health care for which Health Authorities, Primary Care Trusts or NHS trusts have responsibility,

(d) conducting reviews of, and making reports on, the management, provision or quality of, or access to or availability of, particular types of health care for which NHS bodies or service providers have responsibility, and

(e) such functions as may be prescribed relating to the management, provision or quality of, or access to or availability of, health care for which prescribed NHS bodies or prescribed service providers have responsibility.

It is the duty of the Commission to carry out its functions effectively, efficiently and economically; and the Secretary of State may issue directions to the Commission as to the exercise of its functions.

Additional functions imposed by regulations

The Commission for Health Improvement (Functions) Regulations 2000 (S.I. 2000 No. 662) came into force on 1 April 2000. Clause 2, which is reproduced below, sets out various additional functions which the Commission is to perform.

ADDITIONAL FUNCTIONS PRESCRIBED BY REGULATIONS

The Commission for Health Improvement (Functions) Regulations 2000

(S.I. 2000 No. 662)

- 2.–(1) providing advice or information with respect to the arrangements by Health Authorities, Special Health Authorities or service providers for the purpose of monitoring and improving the quality of health care for which they have responsibility;
- providing advice or information with respect to the arrangements by Primary Care Trusts for the purpose of monitoring and improving the quality of health care provided by their relevant service providers;
- conducting reviews of, and making reports on, arrangements by Health Authorities, or Special Health Authorities to which the duty in section 18 of the Act has been extended, for the purpose of monitoring and improving the quality of health care for which they have responsibility;
- conducting reviews of, and making reports on, arrangements by Primary Care Trusts for the purpose of monitoring and improving the quality of health care provided by their relevant service providers;
- carrying out investigations into, and making reports on, the management, provision or quality of health care for which Special Health Authorities have responsibility;
- (with the Secretary of State’s consent) providing advice with respect to the establishment and conduct of particular or proposed health service inquiries, such advice to take into account any guidance relating to health service inquiries given to NHS bodies by the Secretary of State.
- 4.–(1) providing advice or information on clinical governance arrangements to the Secretary of State, NHS bodies, and service providers (taking into account any guidance relating to clinical governance arrangements given by the Secretary of State, the National Institute for Clinical Excellence, or a body responsible for the regulation of a health care profession)

Powers

The Commission possesses extensive powers in connection with the performance of its statutory functions. The statutory authority for these powers derives from section 23 of the 1999 Act.

POWERS OF THE COMMISSION FOR HEALTH IMPROVEMENT

Health Act 1999, s.23

Section 23(1) of the 1999 Act provides that regulations may:

- confer on persons authorised by the Commission a right to enter premises owned or controlled by a health authority, PCT or NHS trust, in order that they may inspect the premises or inspect and take copies of documents (including electronic documents/information);
- require the production of documents, information to persons authorised by the Commission, and require relevant persons to make reports and/or to provide an explanation to the Commission in relation to matters within its remit.

Restrictions on the Commission’s powers

The regulations may not authorise the disclosure of information that another Act states may not be disclosed, unless the other Act only prohibits disclosure because the information is capable of identifying an individual, in which case the regulations may authorise its disclosure in an anonymised form.

Furthermore, the regulations may only authorise the disclosure of information in health records which relate to and identify a living individual, or other information subject to a duty of confidence, if:

- the information is disclosed in an anonymised form; or
- the individual consents to the information being disclosed; or
- the individual cannot be traced despite the taking of all reasonable steps; or
- where the Commission is carrying out an investigation into, or reporting on, the management, provision or quality of health care by a health service body [under section 23(1)(c)], it is impracticable to disclose the information in an anonymised form; the Commission considers that there is a serious risk to the health or safety of patients arising out of the matters under investigation; and the risk and urgency of the situation are such that the Commission considers that the information should be disclosed without the individual's consent.

Such powers have been conferred by regulations on the Commission and persons authorised by it. See, The Commission for Health Improvement (Functions) Regulations 2000 (S.I. 2000 No. 662).

Sanctions

It is a criminal offence to obstruct a person authorised by the Commission who seeks to enter NHS premises. It is also an offence to fail to comply with a lawful request for documents or information or a request to provide an explanation made under the regulations under this section.

Future Developments

In April 2002, the Secretary of State for Health announced the Government's intention to establish a new Commission for Healthcare Audit and Inspection (CHAI). This new 'super-commission' will take over the work of the Commission for Health Improvement, the Audit Commission's work on value for money (see below), and the National Care Standards Commission's remit to inspect private hospitals (see below). It will be responsible for inspecting NHS hospitals, the Government's star rating system, the imposition of special measures for failing organisations, the licensing of private hospitals, the conduct of NHS value for money audits, the independent scrutiny of patient complaints, and (it seems) certain legal functions of a kind similar to those presently performed by the Mental Health Act Commission. New legislation will be required, and it is unlikely that the new body will be operational before 2004.

A second new commission, the Commission for Social Care Inspection, will inherit the National Care Standard Commission's care homes work, as well as the Social Services Inspectorate's remit to inspect and publish star rating for social services departments.

National Care Standards Commission

The Care Standards Act 2000 established a new regulatory system for the private and voluntary health care sector. Under this scheme, the National Care Standards Commission is established as the registration authority for England. The Commission is a non-departmental public body which must act under the general guidance of the Secretary of State, who may regulate its procedures, and give directions. The Commission began its registration functions on 1 April 2002, at which time inspectors and support staff were transferred to it from health and local authorities.

Establishments & agencies regulated by the Commission

Healthcare	Social care
● Independent hospitals (e.g., mental nursing homes)	● Children's homes
● Independent clinics (e.g., private primary care premises where prescribed)	● Care homes
● Independent medical agencies (e.g., wholly private GP call-out services)	● Residential family centres
● Nurses agencies	● Domiciliary care agencies
	● Fostering agencies
	● Voluntary adoption agencies

Establishments and agencies that are required to register with the Commission must have a registered owner or proprietor — the person who carries on the business — and, if that person is not in day-to-day control of it, a registered manager also. The Commission must register an applicant if it is satisfied that the applicant has demonstrated that an establishment or agency has complied with, or will comply with, all the requirements of relevant legislation and regulations. The burden of proof is on the applicant. Applications may be granted subject to such conditions as the Commission thinks fit. Any such conditions may be generic or specific. For example, conditions may be imposed that specify the categories of patients and the number of residents that may be accommodated.

Commission inspectors must regulate independent healthcare providers against national minimum standards. Inspectors and other authorised persons are given a range of powers to enable them to fulfil their statutory functions. For example, they may enter and inspect premises at any time if they are used (or believed to be used) as an establishment or agency; and they may require that they are given any information necessary to enable them to discharge their functions.

Social Services Inspectorate

The Social Services Inspectorate was established in 1985, as a professional division within the Department of Health. The Chief Inspector is the principal professional social services adviser to Ministers, and oversees the development of social care policy.

Social Services Inspectorate Functions

- Providing policy advice within the Department of Health
- Managing the Department of Health's links with social services departments and other social care agencies
- Inspecting the quality of social care services
- Assessing the performance of local councils with social services responsibilities (including 'best value')

Joint reviews are carried out with the Audit Commission. The SSI Inspection Division also undertakes a programme of national inspections in England, with the aim of evaluating the quality of social services and improving their efficiency and effectiveness. The inspectorate sets standards for each national inspection, and evaluates the quality of services against those standards. There are currently 29 standards. Each local council with social services responsibilities receives three inspections during the five year period between SSI-Audit Commission joint reviews. One of these inspections concerns adult care services and another focuses on an area of high priority. There are also inspections of local authority inspection units, and targeted inspections in poorly performing councils.

Audit Commission

The Audit Commission was established in 1983, to perform the function of appointing and regulating the external auditors of local authorities in England and Wales. It is a non-departmental public body, sponsored by the Department of the Environment, Transport and the Regions (with the Department of Health and the National Assembly for Wales). The Commission is self-financing, and most of its income derives from the fees charged to audited bodies.

In 1990, the Audit Commission's role was extended to include the NHS. In April 2000, it was given the responsibility of carrying out best value inspections of local authority services. The Commission's remit now covers more than 13,000 bodies, which between them spend nearly £100 billion of public money each year. This amounts to around 15% of the nation's gross domestic product.

Audit Commission Functions

- To carry out best value inspections of local authority services.
- To appoint auditors to all local government and NHS bodies in England and Wales, either from its arms-length agency (District Audit) or from a pool of private firms.
- To set standards for those auditors, through the Code of Audit Practice.
- To carry out national studies designed to promote economy, efficiency and effectiveness in the provision of local authority and NHS services.
- To define indicators of local authority performance and to secure a review by auditors of each authority's arrangements for producing performance indicators.

In accordance with the NHS Plan, from 2003 onwards the Audit Commission will work with the Commission for Health Improvement (and, where appropriate, the Social Services Inspectorate) in local inspections of the implementation of national service frameworks.

Intervention by the Secretary of State

The Secretary of State has power to initiate formal and informal inquiries, and he also possesses powers of intervention in relation to health service bodies. Management of the NHS is moving to a system of 'earned autonomy', and section 13 of the Health & Social Care Act 2001 allows the Secretary of State to intervene in poorly performing NHS organisations. He can, for example, temporarily replace the board of an NHS trust. The purpose of the section is to enable him to intervene in an NHS body if he has concerns about its management, its ability to perform its functions to the required standard, or there has been a one-off catastrophe.

Re-admission under the Mental Health Act following discharge by a Mental Health Review Tribunal

Kristina Stern and David Hewitt***

Introduction

There is continuing confusion over the precise effect and force of Mental Health Review Tribunal ('MHRT') decisions and the extent to which they may be lawfully overborne. That confusion has not been alleviated by the Court of Appeal judgment in the *Von Brandenburg* case,[1] and it may even have been exacerbated by the case of *H v Ashworth Hospital*.[2] Now that the latter decision has been considered by the Court of Appeal, and before the former decision comes before the House of Lords, this may be an opportune moment to place both cases in their true context and to attempt to distil some definitive guidance on this troublesome point.

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* *Kristina Stern is a barrister practising from chambers at 39 Essex Street, London, WC2R 3AT. She appeared both at first instance and in the Court of Appeal in Von Brandenburg, and at first instance in H v Ashworth, both of which cases are considered here. This paper is based upon a lecture delivered by Dr Stern at the Hempsons Mental Health Law Seminars in Manchester on 26 June 2002 and London on 2 July 2002*

** *David Hewitt is a partner with Hempsons, Solicitors, a member of the Mental Health Act Commission and Associate Lecturer in the Faculty of Health at the University of Central Lancashire*

[1] *R v East London & the City Mental Health NHS Trust and David Stuart Snazell, Approved Social Worker ex parte Count Franz Von Brandenburg (aka Nicholas Hanley) [2001] EWCA Civ 239; see: David Hewitt, Detention of a recently discharged psychiatric patient, Journal of Mental Health Law, February 2002, pp50–58*

[2] *R v Mental Health Review Tribunal for West Midlands & North West Region, ex parte Ashworth Hospital Authority and (1) H (a patient) (2) Hammersmith & Fulham London Borough Council (3) Ealing, Hammersmith & Hounslow Health Authority (Interested Parties) : R v (1) Ashworth Hospital Authority (2) Lorraine Berry (3) Edward Silva (4) Melanie Frances Croy, ex parte H (a patient) and Ealing, Hammersmith & Hounslow Health Authority (Interested Parties) [2001] EWHC Admin 901; See: David Hewitt, Challenging MHRT decisions, Solicitors Journal, vol 146, no 14, 12 April 2002, pp 338–339; R v Ashworth Health Authority and others, ex parte H : R v (1) Mental Health Review Tribunal for West Midlands and North West Region (2) London Borough of Hammersmith and Fulham (3) Ealing, Hounslow and Hammersmith Health Authority, ex parte Ashworth Hospital Authority [2002] EWCA Civ 923*

A cruel mirage?

The Mental Health Act 1983 ('MHA 1983') provides a scheme by which those who require medical treatment for mental disorder may be admitted to hospital against their will. Because that scheme is founded primarily upon the clinical judgment of doctors and social workers, it may occasionally come into conflict with the Mental Health Review Tribunal ('MHRT') process. The MHRT is, of course, the court-like body to which statute[3] has entrusted the responsibility of ensuring that detained psychiatric patients receive the protections contained in Article 5(4) of the European Convention on Human Rights ('ECHR'). Those protections provide that:

> "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."

However, there may be a divergence of opinion between psychiatrists and social workers on the one hand and the MHRT on the other. For example, although a MHRT may direct that a patient be discharged, the clinical team may take the view that s/he should in fact be detained in hospital under MHA 1983, section 3[4]. This may be so either where the patient's discharge is to be immediate or where it has been deferred to enable satisfactory arrangements to be made for his/her aftercare. In such circumstances there is an apparent conflict between the statutory schemes for admission *to*, and for discharge *from* hospital. The first relies solely upon clinical judgment. Although the second may do the same – for example, where discharge is granted[5] by the patient's Responsible Medical Officer ('RMO') or the managers of the hospital in which s/he is detained – it may also be contingent upon the judgment of the MHRT. That more complex judgment will be reached only after the patient has been examined by the MHRT (through its medical member), and after the Tribunal has heard all of the evidence and considered any legal submissions.

The scheme provided by the 1983 Act gives no clue as to when – or, indeed, if – a previous MHRT discharge will restrict the power to admit a patient to hospital under MHA 1983, section 3 in future. However, if there is no such restriction, and if a discharge from detention in fact counts for nothing once it has taken effect, it is at least arguable that the ECHR, Article 5(4) protection that the MHRT is required to provide is nothing more than a cruel mirage. Of course, few people would suggest that a MHRT direction for discharge counts for *nothing*, and the real question is one of degree: when a new admission is proposed under MHA 1983, section 3, what weight should – or may – be given to an earlier discharge from detention? In cases such as these, the courts must also grapple with a question of degree: to what extent do public law principles in general – and the Human Rights Act 1998 in particular – provide a solution to the problem?

The statutory scheme

(a) Admission

The extent to which the scheme for detaining patients depends upon the professional judgement of various clinicians is evident from a consideration of MHA 1983. Section 3(3) of the Act provides that:

> "An application for admission for treatment shall be *founded* on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a

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[3] MHA 1983, ss 65–79

[4] Although, for convenience, this paper refers only to MHA 1983, s 3, its analysis may be applied equally to detentions effected under MHA 1983, ss 2 or 5

[5] Under MHA 1983, s 23

> statement that in the opinion of the practitioner the conditions set out in subsection (2) above[6] are complied with."[7]

The clinical recommendations, which are provided in statutory Form 11,[8] are focused upon the condition of the patient and the necessity for compulsion, and the medical practitioners who provide them must set out their own clinical opinions. However, they are not required to state whether it is appropriate for a patient to be detained under MHA 1983, nor to consider any prior decision of a MHRT. Indeed, it would appear that their obligation is simply to deal with the here-and-now – in other words, to consider whether the statutory criteria for detention are satisfied at that point in time, in the patient who appears before them. This point is illustrated by MHA 1983, section 3(2), which states that an admission application may be made in respect of a patient on the grounds that:

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

It is difficult to see how a recent MHRT direction for discharge can directly impinge upon the doctor's clinical opinion as to the fulfilment of each of these three criteria.

Whilst it must be *founded* upon the opinions of medical practitioners, an application for admission to hospital may be made only by an Approved Social Worker ('ASW') or the patient's nearest relative.[9] The Act would appear to offer an unconstrained power in this regard, for it provides that:

> "Each of the applications[10] shall be sufficient if the recommendations on which it is founded are given either as separate recommendations, each signed by a registered medical practitioner, or as a joint recommendation signed by two practitioners."[11]

Furthermore, an ASW will be under a *duty* to make an application for admission:

> "… in any case where he is satisfied that such an application ought to be made and is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him."[12]

At first blush, this provision appears to constrain the power of an ASW, for it requires him/her to consider both whether an application "ought to be made" and whether it is "necessary or proper". However, the possibility that this might require – or permit – an ASW to take into account such matters as an earlier MHRT discharge would appear to be removed by MHA 1983, section 13(5), which states that:

> "Nothing in this section shall be construed as … restricting the power of an approved social worker to make any application under this Act."

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[6] *Namely mental illness/disorder/impairment, treatability, appropriateness of receiving medical treatment in hospital and necessity for health or safety of patient or others that treatment be provided in hospital under compulsion [see later]*

[7] *Emphasis added*

[8] *Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, regulation 4(1)(f)(ii)*

[9] *MHA 1983, s 11(1)*

[10] *That is, by the nearest relative or an ASW*

[11] *MHA 1983, s 11(7)*

[12] *MHA 1983, s 13(1)*

The admission process should culminate in a formal application by an ASW. MHA 1983, section 6 provides that the application will be sufficient authority for the patient to be conveyed to hospital within 14 days, and for the managers of the hospital to detain him/her there. Moreover, MHA 1983, section 6(3) provides that:

> "Any application for the admission of a patient … which appears to be duly made and to be founded on the necessary medical recommendations may be acted upon without further proof of the signature or qualification of the person by whom the application or any such medical recommendation is made or given or of any matter of fact or opinion stated in it."

The consequence of this provision is that the managers will be entitled to detain a patient upon the authority of an application that appears to be duly made. However, if the application was not in fact duly made, the patient will have been detained unlawfully and will be entitled to seek his/her release by means of an application for a writ of *habeas corpus*.[13] Therefore, a patient may be lawfully detained provided the ASW or nearest relative presents a valid application and supports it with medical recommendations that focus upon his/her current condition.

In summary, therefore: within this statutory scheme:

- there is nothing that expressly requires the doctors to consider the appropriateness of making an application for admission, or to focus in any way upon a recent MHRT decision;
- the ASW or nearest relative is not in way constrained as to the circumstances in which s/he may make an application for admission; and
- the role of the statutory managers is unclear, save that they must ensure that an application is – or at least, that it *appears to be* – duly completed.

(b) Discharge

The statutory criteria for discharge of un-restricted patients are set out in MHA 1983, section 72. However, with effect from 26 November 2001, they were amended by the Mental Health Act 1983 (Remedial) Order,[14] which placed the burden of justifying a patient's continued detention upon the authority – usually, a NHS Trust – that sought to continue detaining him/her.

In *Reid v Secretary of State for Scotland*,[15] the House of Lords held that the criteria for discharge mirror those for admission. Therefore, in order to justify a patient's continued detention the detaining authority will have to satisfy a MHRT that the admission criteria are satisfied as at the date of the hearing. It is, of course, the case that a MHRT may direct a patient's discharge even if it is satisfied that the admission criteria still obtain.[16] That rarely invoked discretion apart, a MHRT direction for discharge is in fact a decision that, as at the date of the hearing, the MHA 1983 admission criteria are no longer satisfied. This creates real confusion as to the question of when, if at all, an earlier MHRT decision should be taken into consideration as part of the decision-making process that precedes a subsequent admission under MHA 1983, section 3.

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[13] *Re S–C (Mental Patient: Habeas Corpus) [1996] 1 All ER 532 (CA)*

[14] *SI 2001 No 3712*

[15] *[1999] 2 AC 512*

[16] *MHA 1983, s 72(1)*

Difficult situations

There are many situations in which doubt may arise as to whether it is appropriate to apply for a patient to be detained in hospital under MHA 1983, section 3. For example:

- although the MHRT rejected their view that discharge was inappropriate, members of the clinical team may still believe that the patient should be detained;
- a patient's psychiatric condition may have deteriorated since the MHRT decision was made;
- it may not be known how the patient presented at the hearing or why the MHRT decided to direct discharge (the RMO may not have been present for the whole of the hearing and the MHRT's reasoning may be brief);
- the clinicians now considering the possibility of admission may simply have no knowledge of what went on before the MHRT (the patient may have moved to a different geographical area since s/he was discharged);
- it may be believed that the MHRT erred in its decision, which is – or may be – susceptible to judicial review;
- a further psychiatric opinion may be received, which provides information or raises issues that were not before the MHRT;
- information may become available – for example, from family members – which was not considered by the MHRT;
- a patient may break a promise to comply with medication. In such circumstances, it may not be clear whether, in reaching its decision, the earlier MHRT accepted the patient's assurance, or whether, in fact, it concluded that even if s/he did not comply, the patient did not need to be detained.

There are likely to be many more situations in which clinicians are faced with real difficulty in reconciling a clinical opinion that the statutory criteria for detention are satisfied with an earlier MHRT direction for discharge.

The issue as considered by the Court of Appeal in ***R (Von Brandenburg) v East London and The City Mental Health NHS Trust and another***

Last year, in the *Von Brandenburg* case,[17] the Court of Appeal was told that if the statutory admission criteria were to be reconciled with an earlier MHRT discharge, a subsequent detention would usually have to have been precipitated by a change of circumstances.

The issue arose in this case because, although the clinical team had argued for Count Von Brandenburg's continued detention, a MHRT had discharged him, holding that he was not suffering from mental illness of a nature or degree which justified detention, and that his detention was not necessary in the interests of his own safety or for the protection of others. His discharge was deferred for several days to enable accommodation to be arranged and a care plan to be drawn up. In the interim, and before he had in fact left hospital, the Count was detained again under MHA 1983, section 3. He argued that this subsequent detention was unlawful, because:

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[17] [2001] EWCA Civ 239. The issue had been previously considered directly by Laws J in R v. Managers of South Western Hospital ex parte M [1993] QB 683, and in passing by David Pannick, QC in In re Whitbread (Unreported, 5 January 1999)

(a) there had not been a change in his circumstances, as there would need to have been in order to justify re-detention; and

(b) neither the medical recommendations nor the application that was based upon them addressed the question of a change of circumstances.

The NHS Trust, which was the Defendant in the claim, contended that:

(a) on the facts, there had in fact been a change of circumstances between the patient's discharge and his subsequent re-detention; and

(b) in any event, a change of circumstances was not necessary (although it conceded that public law principles would apply to the second admission, such that it must be *bona fide* and rational).

It is important to understand the scope of the issue that arose in *Von Brandenburg*. In particular, the Claimant did not argue that his second admission was irrational or that it fell foul of accepted public law principles. Rather, he said that it would only be lawful if there had been a demonstrable change of circumstances since the MHRT granted his discharge. Alternatively, and in a refinement of the test proposed at first instance, the Claimant argued that it was impracticable for the MHRT decision to be followed. The Court of Appeal found that no requirement for a change of circumstances was contained in MHA 1983, whether as a matter of domestic law or by virtue of the special duty of construction imposed by the Human Rights Act 1998. However, applying traditional public law principles, the Court held that the earlier discharge *was* a relevant factor in the later decision, and that the subsequent admission would only be lawful if those who precipitated it had given proper regard to the MHRT's decision.

The Court of Appeal did not, however, resolve all the issues. For example, it was not clear from the judgments to what extent each of the various agencies involved in the subsequent admission – the doctors, the ASW and the statutory hospital managers – must (a) be aware of, and (b) reason by reference to, the earlier MHRT decision. Furthermore, whilst it is clear that the Court of Appeal was simply applying traditional public law principles, its decision at times appears to imply a "test" for determining how those principles should apply to this situation. For these reasons, the judgments of the Master of the Rolls (with whom Buxton LJ agreed) and Sedley LJ merit close examination.

The Master of the Rolls found that "normally a sensible period is likely to elapse between discharge and readmission."[18] In those circumstances, he felt that a change of circumstances test would be neither necessary nor sensible. Readmission was likely to be prompted by consideration of how the patient had behaved in the community and, he said, that of itself would almost certainly constitute a change of circumstances. Moreover, to require such a change to be investigated by the professionals involved would be neither helpful nor meaningful.

However, according to the Master of the Rolls:

> "The position is very different where an application for readmission is made within days of a tribunal's decision to discharge, which carries the necessary implication that the criteria for admission are not present – the more so if the patient has remained under the hospital regime because discharge has been deferred, so that there has been no change in the patient's environmental circumstances. In such a situation there is likely to have been … a difference of

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[18] *At paragraph 30*

> view between the patient's RMO and the Tribunal as to whether or not the criteria justifying detention were established. Under the statutory scheme, where such a conflict exists, it is the opinion of the tribunal that is to prevail.
>
> "In such circumstances I do not see how an Approved Social Worker can properly be satisfied, as required by section 13, that 'an application ought to be made' unless aware of circumstances not known to the tribunal which invalidate the decision of the Tribunal. In the absence of such circumstances an application by the Approved Social Worker should, on an application for judicial review, be held unlawful on the ground of irrationality".[19]

The Master of the Rolls concluded by finding that:

> "[…] I do not consider that the statutory scheme leaves it open to professionals effectively to overrule a decision to discharge taken by a Tribunal."[20]

Thus, although in the body of his judgment the Master of the Rolls appeared to place the obligation to consider the earlier MHRT decision firmly upon the ASW, his conclusion referred more generally to the professionals involved.

In essence, Sedley LJ held that that the lawfulness of admission following a MHRT decision to discharge would be determined according to a set of private and public law controls. Where admission comes hard on the heels of discharge:

> "Any decision made in the exercise of statutory powers and affecting a person's liberty must not only be made in good faith but must, among other things, have proper regard to any relevant facts".[21]

More specifically, a recent MHRT decision:

> " … must be accorded very great weight if the second decision is not to be perceived as an illicit overruling of the first. Put another way, there will have to be a convincing reason, in such a case, for readmission".[22]

Counsel for the ASW had conceded that his client's subsequent admission application would be unlawful if he believed that a MHRT would respond by ordering the patient's discharge. Sedley LJ pronounced this view "correct" and, perhaps more significantly, he ruled that the same stricture would apply to the recommending doctors. In other words, a medical recommendation certifying that the statutory criteria were satisfied would not be lawful if the recommending doctor believed when he gave it that a MHRT would order the patient's discharge.[23]

Of equal significance was Sedley LJ's ruling that a recent – and often, a not-so-recent – MHRT discharge will always be a relevant factor, so that a failure by a subsequent decision-maker to take it into account – *albeit through ignorance* – will vitiate a decision to seek admission.[24]

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[19] *At paragraphs 31–32*

[20] *At paragraph 35*

[21] *At paragraphs 38–39*

[22] *At paragraph 41*

[23] *At paragraph 40*

[24] *At paragraph 41*

H v Ashworth at first instance

The issues that had exercised the Court in *Von Brandenburg* arose again in the case of *H v Ashworth* – albeit, from a somewhat different perspective. In that case, the patient, Mr H, had been detained at Ashworth Hospital for approximately six-and-a-half years. However, on 22 March 2001, a MHRT ordered his immediate discharge. It had heard that no aftercare arrangements had been made for Mr H, and regarded this as significant because the failure of previous arrangements had led to him becoming violent and, ultimately, to his re-admission to hospital. Although H agreed to remain in hospital voluntarily, there was doubt as to whether he would do so. Therefore, on 26 March 2001, he was detained under MHA 1983, section 5(2), and on 29 March 2001, under MHA 1983, section 3.

Upon hearing the MHRT's decision, the hospital immediately took legal advice and subsequently sought judicial review of Mr H's discharge. Its claim was issued on 29 March 2001, when Stanley Burnton J granted interim relief in the form of an order staying the decision and an injunction prohibiting H's release from hospital.

A further complication was that, following his detention under MHA 1983, section 3 on 29 March 2001, H himself instituted proceedings for judicial review. He claimed that his readmission was unlawful because the recommending doctors and the ASW had failed to take sufficient account of the MHRT discharge; and that it had been unnecessary in the light of the stay and the injunction ordered by Stanley Burnton J.

For the purposes of this paper, the case of *H* raised the following issues of relevance:

(a) the extent to which a MHRT's obligation to give reasons for its decision had been heightened by the judgment in *Von Brandenburg*;

(b) the proper course to be taken when it is felt that a MHRT decision is – or may be – improper or unlawful;

(c) the proper interpretation of *Von Brandenburg*; and

(d) the extent to which a prior MHRT decision should be taken into account where those involved are advised by lawyers that it may be flawed.

Stanley Burnton J held that the decision of the MHRT was unlawful because it did not include any consideration of the issue of after-care, which was essential to ensure H's safe reintegration into the community. Accordingly, he ruled that the decision to direct an immediate discharge was "*Wednesbury* unreasonable", and he quashed it. Moreover, he held that the Tribunal's reasoning was defective because it did not explain why it disagreed with the well-reasoned preponderance of medical opinion that opposed discharge. The judge also found that the existing precept that reasons "must sufficiently inform both the patient and the hospital as to the findings of the Tribunal" had been given added significance by the decision in *Von Brandenburg*. He said that the MHRT "must also bear in mind that its decision may have to be considered by those who were not present at or parties to the hearing".[25]

As to the correct procedure in circumstances where a MHRT decision is thought to be unlawful, Stanley Burnton J held that his earlier order granting interim relief had been ineffective because:

(a) a stay of proceedings may defer the legal consequences of a decision but it may not "turn back the clock". Thus, as the MHRT ordered the patient's immediate discharge on 22 March, the stay of 29 March could have no legal effect;

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[25] *at para 77(h)*

(b) whilst the Administrative Court clearly enjoyed the power to do so, the judge could think of no circumstances in which it would be appropriate for it to grant an injunction that prohibited a patient from leaving hospital and required him to submit to treatment.

Accordingly, Stanley Burnton J held that, other than in the most exceptional cases, the court would have no power to grant effective interim relief where judicial review was sought of a MHRT decision for immediate discharge. Therefore, he stated that the recommending doctors and the ASW would act lawfully if "they are advised on substantial grounds that the decision [of the MHRT] is unlawful and that proceedings for judicial review have been commenced or that such proceedings are imminent".[26] In such a case, the professionals would not be required to afford the MHRT decision the authority that it might subsequently be held not to have; and they would be entitled to take into account the alleged unlawfulness of that decision.

The judgment of Stanley Burnton is also interesting for its more general application of *Von Brandenburg*. He held that even if the MHRT decision had been assumed to be lawful and valid, the professionals involved would have had sufficient reason to detain H again. This was because they believed that he would discharge himself from hospital without any after-care plan having been put in place. Accordingly, as the recommending doctor could not have thought that the MHRT had reasonably envisaged this situation, her MHA 1983, section 3 recommendation had been lawful, notwithstanding the earlier MHRT decision to discharge. This suggestion stretches by some way the judgments of the Court of Appeal in *Von Brandenburg*, and it seeks to justify a MHA 1983, section 3 detention where there may be circumstances that the MHRT did not have envisaged. In fact, the possibility cannot be ruled out that the Tribunal did envisage those circumstances and simply chose not to regard them as sufficient to prohibit discharge. On the facts of this case, even where the MHRT had in fact ordered an immediate discharge, Stanley Burnton J was prepared to assume that the latter explanation was the more likely.

The judge did not resolve any of the issues outstanding after *Von Brandenburg*. In particular, he did not clarify the extent to which the obligations on the ASW also apply to hospital managers and/or recommending doctors. However, his analysis suggests that it is incumbent upon each of them to consider the impact of a MHRT decision when taking steps to facilitate a further MHA 1983, section 3 admission. Furthermore, Stanley Burnton J held that once a situation arose which had not been considered by the MHRT, the recommending doctors and the ASW were under a duty to bring their professional judgement to bear once again.

Von Brandenburg re-visited: ***H v Ashworth*** in the Court of Appeal

On 27th June 2002, the Court of Appeal gave judgment in *H v. Ashworth*[27]. In his leading speech, Dyson LJ disagreed with many of the findings at first instance. In particular, he held that when professionals believe a MHRT decision to be flawed, they should not proceed on the basis of the *Von Brandenburg* principles. Were they to heed those principles, he said, the decision to "sideline" the effect of the MHRT decision would be taken away from the Courts altogether. He held that the only appropriate course open to the professionals would be to seek permission to apply for judicial

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[26] *at paragraph 104*

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

review and at the same time to apply for a stay of the MHRT decision. In a sharp reversal of the decision at first instance, Dyson and Mummery LJJ held that a stay would be effective to "turn back the clock", even where the patient had already been discharged by the MHRT. Simon Brown LJ doubted this analysis only in its application to a patient who had left the hospital before the stay could be made. In those circumstances, he held, a stay could not authorise the patient's forcible re-detention, and he suggested that attention should be focussed upon bringing a substantive hearing of the application for judicial review before the court as quickly as possible.

As to the circumstances in which it would be appropriate for the court to grant a stay, the Court of Appeal held that the criterion should not be mere 'arguability'. Rather, strong grounds for interfering with the MHRT decision must be shown to exist. In such circumstances, a stay would be an appropriate means of holding the ring pending the outcome of the substantive judicial review application, which should in any event proceed with all possible expedition.

The Court of Appeal also gave useful guidance as to how its decision in *Von Brandenburg* should be interpreted. Dyson LJ held that:

> "[…] when considering whether to resection a patient who has only recently been discharged by a tribunal, the question that the professionals must ask themselves is whether the sole or principal ground on which they rely is one which in substance has been rejected by the Tribunal. If it is, then in my view, they should not resection. In deciding whether the grounds on which they rely are ones which have been very recently rejected by the tribunal, they should not be too zealous in seeking to find new circumstances".[28]

Thus, where the patient has not yet left the hospital, it may be difficult to justify an application for his/her re-detention solely on the basis of circumstances of which the MHRT was unaware.

Applying that test to the facts of *H v. Ashworth*, Dyson LJ held that, even though the professionals believed that the patient would leave hospital if no aftercare was in place, the decision to re-section him was made upon grounds that had been rejected by the MHRT. Accordingly, he disagreed with the finding at first instance that once there was a relevant change of circumstances the professionals must apply their professional judgment, even if the Tribunal had already rejected it

Conclusion

The appeal in *Von Brandenburg* is likely to come before the House of Lords in early-2003. However, in its re-consideration of *H v Ashworth*, the Court of Appeal has provided a very helpful gloss to that earlier, troublesome decision. In particular, it has confirmed that in deciding whether to re-section a patient who has been recently discharged by a MHRT, the professionals involved must consider whether the principal grounds upon which they rely have been already rejected by the Tribunal. In addition, the Court has indicated that any subsequent application for admission must be founded upon circumstances not known to the first MHRT. These rulings will be of considerable assistance to those who are entrusted with the vital, sensitive task of balancing individual liberty and public safety; and who must continue to exercise their professional judgment even though the Mental Health Review Tribunal has already rejected it.

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[28] *At paragraph 59*

Mental health law and incapacity: The role of the Clinical Psychologist

*Peter Kinderman**

[This article is based upon a paper given by the author at the two day conference entitled 'Reform of Mental Health Law and Mental Incapacity' held in London on 21st and 22nd June 2002 and hosted by the Law Society and the Royal College of Psychiatrists. We are grateful to both organisations for their permission to publish this article]

Abstract

From an academic clinical psychological perspective, mental health problems are seen as existing on a number of continua with normal functioning, rather than being explicable in terms of categorical diagnoses. Clinical Psychologists use clinical case formulations in their professional practice and are critical of the validity and utility of diagnosis. Psychologists also see mental health problems as stemming from disturbances in psychological processes. In turn, these processes may be disrupted by a variety of causes – biological, social and psychological. Nevertheless, we see disturbance or impairment of such psychological processes as the central issue in mental ill health.

Mental health legislation should therefore reflect these perspectives in terms of the criteria for compulsory treatment and in terms of the procedures and practices governing care.

To an extent this is welcome in the Government's current proposals for mental health legislative reform. A basis of compulsion based on criteria rather than diagnosis is proposed, as are care plans rather than diagnosis and treatment. Clinical psychology, however, would go further. Since there seem to be differences between 'well' and 'ill' in terms only of the degree and nature of the disturbance of psychological process and the impact on functioning, this speaks to the nature of 'unsoundness of mind'. Clinical psychologists contend that it follows that mental health legislation is appropriate and necessary only if people are impaired in their judgement to the extent of being unable to make valid decisions for themselves.

It has been proposed that Clinical Psychologists could act as 'clinical supervisors' (the term which is to replace 'responsible medical officers'). If, indeed, mental ill health is the disturbance of complex, inter-related psychological processes, it makes perfect sense to employ psychologists to coordinate care and decision-making. Clinical psychologists are ready to take their place as partners with lawyers and psychiatrists.

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* *Reader in Clinical Psychology, University of Liverpool*

Clinical psychologists

Clinical psychologists are scientist-practitioners. We act as theoreticians, academics and researchers. We are also therapists and care managers. When working as therapists, we act as applied scientists – building on our research expertise and knowledge of the scientific literature to develop psychotherapeutic and other solutions through the systematic application of this analysis.

The core skills of a clinical psychologist are: assessment, formulation, intervention and evaluation[1]. Assessment of psychological processes and behaviour is different from diagnosis, partly in the way in which the results of these assessments are placed within the context of the historical and developmental processes that will have shaped an individual.

Formulation is the summation and integration of the knowledge that is acquired by this assessment process[2]. Psychological formulations attempt to explain why people are experiencing difficulties. They usually consist of a list of problems and possible psychological reasons for these[3]. Typically, a formulation will examine what events have happened in a person's life, and how they have interpreted and reacted to these. Formulations tend to change as the psychologists and their clients learn more about the problems. Formulations are designed to be hypotheses about the problems, which are tested out over time[4]. For example, a clinical psychologist might tentatively hypothesise that childhood sexual abuse may be important in the development of a client's problems. This would be explored, sensitively, in therapy in order to confirm or disconfirm the possibility and, if confirmed, to develop a therapeutic response. Psychological case formulations are complex. Psychologists are trained to link theory with practice, and therefore a formulation may comprise a number of provisional hypotheses, based on a large variety of psychological theories, each drawing on scientific research.

Intervention, if appropriate, is based on the formulation. This may involve one of the psychological therapies, but may involve training, supervision or the supply of expert evidence.

The nature of the phenomenon

Continua

Psychologists recognise that each individual's experiences are unique[5]. Diagnoses such as 'schizophrenia', 'manic depression' and 'personality disorders' have limited utility, validity and reliability. If a diagnosis is valid, it should predict prognosis. However, for example, the outcome for people with a diagnosis of schizophrenia is extremely variable[6]. Diagnoses should also have 'prognostic validity'. They should indicate what treatments will be effective. Again, however, responses to medication appear to follow from the individual problems a person is experiencing, rather than the diagnosis they receive. In one notable study, for example, people were randomly

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[1] *British Psychological Society Division of Clinical Psychology (2001) The Core Purpose and Philosophy of the Profession. British Psychological Society, Leicester.*

[2] *Hawton, K., Salkovskis, P. M., Kirk, J., & Clark, D. M. (Eds.). (1989). Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide. Oxford: Oxford University Press.*

[3] *Persons, J. B. (1989). Cognitive therapy in practice: A case formulation approach (Vol. 41). London: W. Norton & Company.*

[4] *Brewin, C.R. (1988). Cognitive foundations of clinical psychology. London: Lawrence Erlbaum.*

[5] *British Psychological Society Division of Clinical Psychology (2000) Understanding Mental Illness and Psychotic Experiences: A Report by the British Psychological Society Division of Clinical Psychology. Leicester: British Psychological Society*

[6] *Boyle, M. (1990) Schizophrenia: A Scientific Delusion? London: Routledge.*

assigned to receive different medication. Delusions and hallucinations responded to antipsychotic medication and mood swings responded to lithium, irrespective of diagnosis[7].

Statistical analysis, too, has revealed that the ‘symptoms’ of ‘illnesses’ do not, in reality, cluster together in the way predicted by the diagnostic approach. For example[8] the correlation amongst psychotic symptoms has been found to be no greater than chance, and cluster analysis does not reveal patterns recognisable as diagnostic categories[9].

The central issue in diagnosis is one of classification – the idea that particular psychological problems cluster together and can therefore be considered together. Plato referred to this as “carving nature at the joints”[10]. If diagnosis ‘carves nature at the joints’, it is assumed that the problems called ‘schizophrenia’ are different from the problems called ‘bipolar disorder’ in the same way that the breast of a chicken is different from the leg. On the basis of the evidence reviewed above, many psychologists believe that these distinctions are invalid, that diagnostic approaches to psychological problems do not reflect real ‘joints’ in nature.

This can (hopefully memorably) be summarised as suggesting that mental health is a sausage, not a chicken. You can identify the ends of a sausage, and distinguish them from the middle. You can even choose to cut out a burnt bit. But there are no joints at which to carve, just decisions to be made. With respect to mental health legislation, an important practical conclusion follows. We cannot separate humanity into ‘mentally ill’ and ‘healthy’. The distinctions between those ‘of unsound mind’ and those of us lucky enough to avoid the Mental Health Act are subtle. They are also judgements about where to draw lines on continua. Similar continua exist in law and medicine that may be informative in comparison. Obesity is a useful and important term. But the spread of ‘fatness’ in the community is continuous. It makes sense on practical and clinical grounds to draw a line at a particular point on that continuum to distinguish the ‘obese’ from the rest. Or, in law, it makes sense to draw a line between adults and minors. But nobody believes that there is a developmental discontinuity on the stroke of midnight of an adolescent’s 18th birthday. ‘Adulthood’ is determined pragmatically. And it differs and is flexible. Laws related to sexual consent, voting, standing for parliament, driving etc, use (for eminently reasonable reasons) different cut-off points. And rulings like *Gillick*[11] suggest that the ‘fuzziness’ of these distinctions is recognised by the judiciary. Yet, at present the law, like medicine, relies heavily on dichotomous distinctions – guilty vs not guilty, negligent vs not liable, competent vs incompetent, well vs ill. Adherence to a continuum model would imply the need for a psycho-legal enquiry into this interface.

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[7] *Moncrieff, J. (1997) Lithium: evidence reconsidered. British Journal of Psychiatry 171 113–119.*

[8] *Slade, P.D. and Cooper, R. (1979) Some conceptual difficulties with the term “schizophrenia”: an alternative model. British Journal of Social and Clinical Psychology. 18: 309–317.*

[9] *Everitt, B.S., Gourlay, A.J. and Kendell, R.E. (1971) An attempt at validation of traditional psychiatric syndromes by cluster analysis. British Journal of Psychiatry 119: 399–412.*

[10] *Hamilton, E. & Huntington, C. (1961) The Collected Dialogues of Plato. Princeton University Press. Princeton, N.J. p. 511.*

[11] *Gillick v. West Norfolk and Wisbeach AHA (1985) All ER 373*

Psychological processes

The continua of dysfunction in mental health are related to the disturbance of normal psychological processes. People who experience anxiety to the extent of receiving a diagnosis of an anxiety disorder show extreme versions of relatively normal processes. We all pay attention to threats, frightening things absorb our attention (we'd be in some danger if we ignored threats). Anxious people seem to take this tendency further, overemphasising danger, catastrophically misinterpreting signs of danger and ignoring material that signals safety. They may also excessively engage in normal processes such as performing reassuring rituals. People who are depressed tend to interpret information in a negative way. For example, they see the glass as half-empty, not half-full[12].

Such distortions of normal processes occur for explicable reasons. Traumatic, abusive or unpleasant events during a person's childhood can affect the way that the person interprets information and reacts to events later in life. People with mental health problems commonly report having had highly distressing or traumatic life experiences such as bereavements, abuse and assault[13]. Because everybody interprets new events and challenges in the light of previous experience, such experiences affect the ways people respond to life's challenges and in the ways new experiences are understood.

One early theory of 'schizophrenia' was that it reflected a 'loosening of connections' in the brain[14]. (That idea is reflected in the term 'schizophrenia' meaning 'fragmented mind'). Psychotic experiences such as hearing voices, unusual beliefs and 'thought disorder' appear to involve making unusual connections between apparently unrelated events. This is not in itself either good or bad. Sometimes making unusual connections between things is valuable, when it is termed 'lateral thinking' or 'creativity'. In fact, people who score highly on measures of 'schizotypy' also score highly on measures of creativity[15]. It is even possible to imagine how the ability to make creative connections could be a genetically inheritable trait. Many studies have shown that people who have unusual or delusional beliefs tend to 'jump to conclusions' when faced with limited or contradictory information[16].

Psychologists believe that many mental health difficulties result from a combination of these normal, but distorted, processes. For example, if you are feeling confused and experiencing overwhelming emotions, you may find it particularly hard to interpret other people's actions and intentions accurately. This might mean that interactions with other people are very anxiety provoking and ambiguous. If the events in your life have led you to believe that people tend to abuse and hurt you at every opportunity, and you also have a tendency (again exaggerated in a state of stress) to jump to conclusions, it is understandable that you might occasionally feel paranoid.

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[12] *Brewin, C. (1988). Cognitive foundations of clinical psychology. London: Lawrence Erlbaum.*

[13] *Romme, M.A.J. (1998) Understanding Voices: coping with auditory hallucinations and confusing realities. Runcorn, Cheshire: Handsell Publishing.*

[14] *Bleuler, E. (1911/1950). Dementia praecox or the group of schizophrenias (Zinkin, E., Trans.). New York: International Universities Press*

[15] *Schuldberg, D., French, C., Stone, B.L. & Heberle, J. (1988) Creativity and schizotypal traits. Creativity test scores and perceptual aberration, magical ideation, and impulsive nonconformity. Journal of Nervous and Mental Diseases. 176(11): 648–657.*

[16] *Huq, S. F., Garety, P. A., & Hemsley, D. R. (1988). Probabilistic judgements in deluded and nondeluded subjects. Quarterly Journal of Experimental Psychology, 40A, 801–812.*

Centrality of psychology

Such an analysis places psychology at the centre of mental health. While psychologists universally acknowledge that biological factors and the social environment, together with psychosocial experiences and learning, contribute to mental health, their perspective is that illustrated in Figure 1. Psychologists do not believe that there are ‘genes for schizophrenia’ or even that ‘schizophrenia is a brain disease’. Within a psychological perspective, a variety of factors must be considered to have an impact on mental health, but not directly. Psychologists view biological, social, environmental and psychological causes as having impacts on underlying or mediating psychological processes. It is dysfunction of these processes that results in mental ill health.

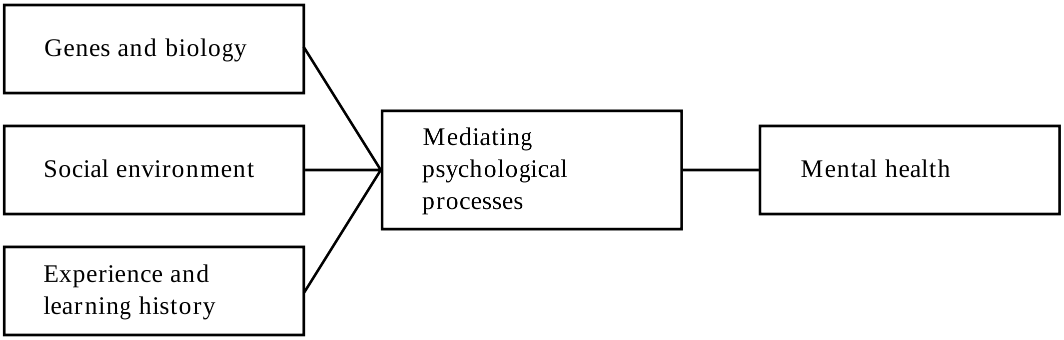

Figure 1. The relationship between causes, psychological processes and mental health.

Capacity

Within such a framework then, there are few valid places to ‘carve nature at the joints’ when it comes to mental health. The central issue in mental ill health is the disturbance or impairment of psychological processes. Such disturbances lie on continua. There are many such continua, because there are many psychological processes that contribute to mental ill health.

In the context of mental health legislation, the most important continuum is impairment of judgement. Many psychological dysfunctions impact on the ability to make sound and consensual judgements. Impairment of judgement, or incapacity, also relates most appropriately to ‘being of unsound mind’,

The European Convention on Human Rights, enshrined in the Human Rights Act 1998 of course applies to mental health legislation, and includes the fundamental human right to liberty and security of person (Article 5). It explicitly allows for exemptions in the case of persons ‘of unsound mind’. This term is not defined in either the Convention or the Act, but case law some 23 years old has referred to people with “real illnesses” (*Winterwerp v The Netherlands*, 1979)[17]. Clearly, people cannot be considered to be unsound of mind warranting compulsory detention and treatment, merely by virtue of having a diagnosable mental illness, since one person in four[18] is likely to meet such a criterion and this would imply that one can pass such a threshold if one has, for example, a phobia of snakes.

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17 Winterwerp v The Netherlands (1979) EHRR 387

18 Kaplan,H & Sadock,B Comprehensive Textbook of Psychiatry. Williams and Wilkins. Baltimore (1989).

And both the Mental Health Act 1983 and the present proposals for reform of that Act make reference to mental disorder 'of such a nature or degree' as to warrant compulsory treatment. The 'nature or kind' of disturbance of psychological functioning that relates sensibly to 'unsound mind' is the extent to which individuals are capable or incapable of making relevant decisions for themselves.

The obvious implication is that people are of 'unsound mind' if they lack the capacity for making valid consensual decisions. This is relatively straightforwardly tested by assessing a person's ability "to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision" and their ability "to make a decision based on that information" in respect to a particular decision[19].

Impairment of judgment, continua and personality disorder

An important aspect of present proposals to reform the Mental Heath Act is the focus on public protection from people who are thought to pose a significant risk of serious harm to others. The present proposals have been widely discussed and essentially permit presumptive and preventative detention of people whom a professional believes might commit an offence. There is a definition of a new group of high risk patients – people who are considered "high risk as a result of Dangerous and Severe Personality Disorders". This uses a broad, vague and circular definition of 'dangerous and severe personality disorder', a definition yet to be subjected to empirical test. It is circular because people are identified as having a personality disorder by virtue of certain behaviours (including committing violent crimes), which are then seen as "arising from [the] underlying disorder" to quote the White Paper.[20]

From a psychological perspective, there are serious scientific flaws in this stance. First, labels are not causal explanations. One cannot have behaviours 'arising from' what is a socially-constructed label describing those very behaviours. As with other psychological problems, continua clearly best describe the true sate of affairs. To distinguish 'Dangerous and Severe Personality Disorder' from normal behaviour may solve practical and political problems, but it is an arbitrary decision on a rather vague continuum.

Many (but by no means all) people with a diagnosis of 'personality disorder' can be seen as having legal 'capacity'. The needs and risks of such people should be managed through consensual services and criminal justice mechanisms respectively. Because such a legal framework does not exist, there have not been legal, or psychological, tests of impaired judgement in personality disorder. But it is relatively easy to see people who would meet the DSM-IV criteria for antisocial personality disorder who retain capacity and also people with this label who would fail a test of capacity based on impaired judgement. I have in mind a sexual predator who fails, or is unable, to appreciate the seriously damaging consequences of his behaviour on his victims and their families. In the decisions surrounding consensual sexual behaviour, such considerations appear vital to making valid decisions. Depending on the case, of course, I could consider such vital failings in what is termed 'theory-of-mind' – appreciating the perspective of another – would render that person's judgement impaired to the point of being incapacitated with respect to that particular decision.

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19 *London. The Law Commission (1995) Report on Mental Incapacity. The Stationery Office. London.)*

20 *Reforming the Mental Health Act. Part II. High Risk Patients (Department of Health; the Home Office) (2000) Cm 5016 – II.*

As well as being scientifically flawed, then, the present proposals are dangerous. People who have committed no crimes, and who retain the capacity validly to decide their own lives will be subject to compulsory detention and treatment under a mental health aegis because they are believed to be potentially dangerous. People's future dangerousness cannot reliably be predicted from their mental health history.[21] It can be predicted on the basis of past violent or criminal behaviour. The public could be better protected from dangerous individuals with a straightforward amendment to sentencing policy – a change recommended by at least three government enquiries or commissions.[22] Unlike a spuriously medicalising mental health approach, such an approach would be compatible with the Human Rights Act.

A variable threshold of impairment

Finally, impairments of judgement themselves are best thought of as lying on a continuum – or a series of criteria, individual to the different judgments. Legal criteria should, logically, differ for different situations. The legal tests of unfitness to plead, not guilty by reason of insanity, and diminished responsibility all imply capacity and impairment of judgement. It is not unreasonable to suggest that the legal thresholds necessary for judging capacity in respect to decisions involving no risk, risk to self and risk to others may be different. We do, of course, have different criteria for assessing the competence of judgement-making capacity necessary to sanction allowing people to decide how to organise their own personal relationships and the judgement-making competence considered sufficient to license a person as a barrister – capable of representing one's clients in a court of law – or a psychologist – capable of assessing competence!

The role of the Clinical Psychologist

The government is proposing that the current 'Responsible Medical Officer' role should be replaced by that of 'Clinical Supervisor', and that Clinical Psychologists could fill this role.[23] If, indeed, mental ill health is the disturbance of complex, inter-related psychological processes, it makes perfect sense to employ psychologists to coordinate care and decision-making. This paper should be interpreted, in part, as a call for psychological understanding to be placed centre-stage in mental health legislation.

Some psychologists welcome this development, seeing it as a means of introducing psychological perspectives into decisions about compulsory treatment, whilst others fear that it might compromise our professional values. In a recent survey, however, 70% of clinical psychologists responding stated that the profession of psychology should be open to this development, and 51% stated that they would be willing to be a clinical supervisor if offered appropriate training.[24]

Such responses should not be taken to imply approval of other plans for reform. Eighty-two percent of respondents agreed that people should only be subject to mental health legislation if their judgement is (permanently or temporarily) impaired to the extent that they are incapable of

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[21] *Bonta J, Law M, Hanson K. (1998) The prediction of criminal and violent recidivism among mentally disordered offenders: a meta-analysis. Psychological Bulletin. 123: 123–142.*

[22] *For example, the Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital (1999) Cm 4194 – II. The Stationery Office.*

[23] *See Paragraph 29 of Draft Mental Health Bill Explanatory Notes, Department of Health (2002) Cm 5538 – II. The Stationery Office.*

[24] *Cooke, A, Kinderman, P. & Harper, D. (2002) Criticisms and concerns: Results of a survey of DCP members opinions about proposed reforms to the 1983 Mental Health Act. Clinical Psychology. 13: 43–47.*

making the relevant decisions for themselves, and 84% agreed that to call someone who is habitually violent "personality disordered" is circular and adds nothing to our understanding of the causes of, or likely remedy for, such behaviour.

Summary

Mental ill-health is, essentially and centrally, a psychological issue. Mental ill-health should be seen as the consequence of dysfunctional or impaired psychological processes, These processes may be impaired by biological, social, environmental or psychological factors, but such factors impact on mental health through psychological factors. Both mental health legislation and mental health care should reflect this reality. Individual multidisciplinary case formulations should be the basis of care. Incapacity – impairment of decision-making ability – should be the basis of mental health legislation.

With respect to the present Government proposals, the British Psychological Society welcomes the use of specific functional criteria under a broad remit of 'mental disorder'. Psychologists, however, echo the concerns of the Health Select Committee, the Royal College of Psychiatrists and others that the current criteria remain over-broad, and likewise recommend the use of further limiting criteria.

The British Psychological Society therefore calls for the inclusion of a further specific criterion before compulsory care is legitimised. This would entail that the "the mental disorder is of a nature or severity so as to impair the individuals' judgement to the extent that the individual is incapable of giving or withholding valid consent with regard to a particular issue or issues addressed by the care plan".

Psychologists believe that such a criterion, coupled with the existing proposals, will ensure that vulnerable people are able to receive the care they need and that the public is protected from the few people whose mental disorder renders them dangerous. However, we recognise that this would not permit compulsion under a Mental Health Act for dangerous people whose judgements are unimpaired. The BPS does not believe that mental health legislation is an appropriate vehicle in such circumstances. Instead, psychologists recommend the use of further legal sanctions under the criminal justice aegis (entirely separate from mental health legislation). These may include the use of reviewable or indeterminate sentences and of the use of specific treatment orders and community supervision orders for people identified as being likely to reoffend. Psychologists will be willing to assist fully in developing these suggestions.

Clinical psychologists have much to offer mental health care and mental health law. They are ready to take their place as partners with lawyers and psychiatrists. Apologies will have to be given for the fact that our profession is some 4000 years younger than either law or medicine.

Mental Incapacity: An Overview

*Gordon Ashton**

[This paper was given by the author at the two day conference entitled 'Reform of Mental Health Law and Mental Incapacity' held in London on 21st and 22nd June 2002 and hosted by the Law Society and the Royal College of Psychiatrists. We are grateful to both organisations for their permission to publish this article]

Our legal system is still much admired by those who can gain access to it, but what about those who can't? Our courts present physical barriers to people in wheelchairs, but today I am not talking about the logistical problems of people with physical disabilities – I am concerned about the jurisdictional problems of individuals who lack mental capacity.

Background

The problem

In May 1989 the *Mental Health Sub-Committee* of the Law Society (as it then was) held a Conference here in London. One of the speakers was a new Law Commissioner, Professor Brenda Hoggett (as she then was). I was present and captivated because I was in the midst of writing my first book *Mental Handicap and the Law*. That Conference highlighted the vacuum in our law and procedures in regard to decision-making for adults who lack mental capacity. Those present recognised that the handicap that these people encountered in society should not be reinforced by the legal system and agreed that we should all have a say in our own future. I spent the next 10 years on that Committee and the next 6 years heavily involved in the Law Commission consultation which was provoked by that far-sighted Conference. Since then I have been an unashamed advocate for the reform of our law and procedures. Before I became a judge I encountered the vacuum in our law as an 'elderly client practitioner' but the problems came much closer to home than that. As many of you know, my son Paul who is now 27 years old has severe learning disabilities. So what has happened since then?

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* *District Judge at Preston County Court; Deputy Master of the Court of Protection; Author of 'Mental Handicap and the Law' (Sweet and Maxwell – 1992) and 'Elderly People and the Law' (Butterworths – 1995); Contributor to numerous legal publications.*

Law Commission recommendations

Law Commission Report No. 231 *Mental Incapacity* was published in February 1995 after extensive consultation. The architect was Brenda Hoggett. It contained comprehensive proposals with a draft Bill. I have been selling the proposals as follows:

> "The individual with capacity will be able to appoint someone to make his personal, financial and medical decisions in the event that he loses capacity. For those who do not take advantage of this facility or are unable to do so the court will be able to make decisions or appoint someone to do so but carers will be authorised to make everyday decisions which need to be made. The courts at appropriate levels will be able to deal with any vacuum or dispute, with specially trained judges and an appeal system that allows this area of law to develop."

Of equal importance, guidance is given as to how capacity should be determined and how decision-making for other people should be tackled with '*best interests*' defined to take account of: ascertainable past and present wishes, the need to participate, views of connected persons and conflicts of interest. In other words it is not simply what the decision-maker thinks best, which may be based on self interest.

There was widespread support but for reasons that I still do not understand one section of the media saw this as an attack on family values. My family felt potentially empowered, not attacked.

The Government's response

After a period of uncertainty the Government responded in December 1997 with the consultation paper *Who Decides?*[1] We were all busy again on that consultation. This was followed by the report *Making Decisions*[2] in October 1999.

The Lord Chancellor has stated that we can expect legislation 'when Parliamentary time allows'. Scotland had its own simultaneous Law Commission report and there was legislation in the first Scottish Parliament. In England and Wales there has been time to tackle the evils of dangerous dogs and fox-hunting – is society less concerned about the legal status of all those grannies with Alzheimers? Legislative time has been found for racial discrimination following the Stephen Lawrence Report yet disability discrimination is apparently seen as less insidious. It already seems that medical treatment will be omitted due to an alleged link with euthanasia and protection of vulnerable adults has been side-tracked.

If we have the new legal jurisdiction will it be accessible to those who need it? That would require a regionalised *Court of Protection* with supporting services and suitable people to fill the new roles. What an exciting prospect!

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[1] *Who Decides? Making Decisions on behalf of Mentally Incapacitated Adults (Lord Chancellor's Department) (December 1997) Cm 3803.*

[2] *Making Decisions (Lord Chancellor's Department) (October 1999) Cm 4465.*

Changing times

The social perspective

Society is changing. More people lack mental capacity because the population is living longer and more brain damaged babies survive. More money is involved due to greater home ownership and savings for the confused elderly, and larger damages awards in the courts. There is now a new social perspective: the old paternalistic approach is no longer acceptable and we increasingly recognise personal autonomy. The need for a new jurisdiction has become even more compelling.

A new legal climate

There is also a new legal climate. The *Law Commission recommendations* are influencing how the courts tackle issues arising from a lack of mental capacity, with the architect playing a key role in her new identity as Lady Justice Hale. Examples are assessment of capacity, interpretation of best interests and the extension of declarations to personal welfare decisions. The problems identified at our 1989 Conference are now reaching the judiciary with increasing frequency, and part-solutions are emerging from the back door of the courts instead of the front doors of Parliament.

Under *Community Care policies* introduced in April 1993 we now assess and provide for the needs of people with disabilities instead of expecting them to cope with whatever services happen to be available. There is as a result an increased expectation that the needs of those who lack mental capacity will be fairly addressed. For some years we have had legislation that outlaws discrimination on account of race and sex, but discrimination in any form is now disapproved of and this has resulted in the *Disability Discrimination Act 1995*. It does not cover everything but the *Human Rights Act 1998* helps to fill the gaps and obliges lawyers to look at situations from the individual’s point of view. The person who lacks mental capacity is recognised as an individual rather than just a patient to be cared for – and overlooked.

The courts are not excluded from the provisions in the Disability Discrimination Act which relate to the delivery of services, and if we judges do not modify our approach we could find ourselves in breach of this legislation. To the disabled individual it does not matter whether the problem is physical access to the court building, understanding what is going on or actually being heard and understood by the judge. All would be seen as discrimination. Could it not be argued that the absence of legal procedures for decision-making discriminates against people who cannot make their own decisions?

Judicial training

The Judicial Studies Board is responsible for the training of judges. Discrimination was first addressed by the JSB in the context of people from ethnic minorities. But surely people with other disadvantages should be considered in a similar manner? EMAC (the Ethnic Minorities Advisory Committee of the JSB) has become ETAC – the *Equal Treatment Advisory Committee* – and its remit now extends to discrimination on account of race, gender, sexual orientation and disability.

This Committee, of which I am proud to be a member, has produced an *Equal Treatment Bench Book*. The ‘Disability’ section to which I contributed has almost been given the status of law by the Court of Appeal (see the judgment of Brooke LJ in *R v Isleworth Crown Court*).[3] I think we got it

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[3] *R (on th application of King) v Isleworth Crown Court [2001] EHLR14*

wrong when we began by highlighting people from ethnic minorities – that was seen as teaching judges to be ‘politically correct’ and became a turn-off to many. There are underlying issues which are of general application. I made such a fuss about this that I was asked to re-structure the Bench Book to include an introductory section dealing with *Judgecraft* which means creating a *level playing field* for all litigants – or in Human Rights speak ensure *Equality of Arms*.

I regularly lecture to judges at residential seminars on disability issues and have been pointing out that for people with physical and mental disabilities it is not simply a question of avoiding discrimination but also addressing *special needs*. This involves ensuring that all parties and witnesses are properly listened to. It is, after all, the strongest case that should win – not the strongest litigant. Because some people have special needs the phrase ‘equal treatment’ seems inadequate to me – we should be ensuring *equal opportunity*.

The legal vacuum

The problem

We do not have proper legal decision-making procedures at present, because the Court of Protection only deals with financial issues. It is unacceptable that ‘he who holds the purse controls the person’ but this is what happens in practice. What happens when family or carers cannot agree about arrangements for care and attempts at conciliation fail? Or when there is uncertainty about what can legally be done and an authoritative decision is needed? Some examples are given in the Appendix to these Notes.

The High Court has attempted to fill the legal vacuum by assuming jurisdiction to make ‘declarations of best interests’ for incapacitated adults – it started with *Re F* (sterilisation case)[4] and then Tony Bland[5] (switching off life preserving equipment). More recently this has been extended (by Mrs Justice Hale, as she then was) to personal welfare decisions such as where to live.[6] I have used this approach to tackle adult contact disputes, but the procedures are slow and incredibly expensive when compared with those for resolving such issues in respect of children. This is not an accessible dispute resolution procedure.

What is the problem about legislation?

At a joint Law Society/BMA conference in 1996 I said that:

> “‘we need a government with the foresight and courage to lead society rather than follow the ill-informed wishes of the unconcerned masses who only wake up to the real problem when it hits their families”.

A government that has given us the Civil Justice Reforms and the Human Rights Act would appear to be suitably qualified so, in 1999 at a *Disability Law Conference* organised by the Bar, I asked the Lord Chancellor this question:

> “The absence of legal procedures for decisions to be taken on behalf of mentally incapacitated adults is the worst form of discrimination against people with disabilities. What is the Government doing about this?”.

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[4] *Re F (Mental Patient: Sterilisation) [1990] 2 A.C. 1.*

[5] *Airedale NHS Trust v Bland [1993] 1 All ER 821.*

[6] *Re S (Hospital Patient: Court’s Jurisdiction) [1995] 1 All ER 449. Affirmed in Court of Appeal [1995] 3 All ER 290. Also see Ref (Adult: Court’s juristiction) 2 F.L.R. 512*

His response was that the matter was then 'before cabinet'. At a further Law Society Conference in November 1999 to mark the New Millennium I expressed doubts as to whether funding concerns were dominating the Government's thinking and enquired: 'What is the cost of not having adequate procedures?' The cost of the uncertainty and abuse is unquantifiable but undoubtedly exists although it does not come out of the Lord Chancellor's budget. What about the adult contact dispute that I case managed, which cost £150,000 and many months to reach a hearing where it collapsed? If the learning disabled son had been a few years younger I could have resolved the dispute in as many months for less than £8,000.

What are my concerns about the legislation?

I do have concerns about the proposed reforms but only because they don't go far enough. They provide a new jurisdiction to assess capacity and make or delegate decision-making, but what about *vulnerability*? We all need advice, whether in making investments or tuning the new video. There is an ill-defined line between accepting help and being taken over. We are all liable to be influenced by others, and in our private relationships these influences can be profound. When does this become undue influence?

Undue influence

How do we tackle undue influence for those who, perhaps by reason of advancing years, have reached the stage where they are of questionable capacity? Do we look at outcomes – the influence is not undue if it is in the best interests of the individual? The civil courts scrutinise the nature of the relationship and the case law has developed independently of incapacity issues but these issues may be inter-linked. This crops up in so many of the cases in the Court of Protection where capacity is disputed. I imagine you will say this is a matter for the Courts, not the legislation – well, thank you very much!

Abuse

How do we prevent abuse, especially by those to whom decision-making has been delegated? There are indications that empowerment may lead to an unacceptable level of abuse. Supervision is expensive, intrusive, demeaning and the cause of delay. I favour an open jurisdiction with people in authority who will hear the whistle blowers and respond. That brings me to the next topic.

The legal system

The Public Trust Office

I dream of a new incapacity jurisdiction exercised by a reconstituted Court of Protection with a regional presence. The Court will need a strong administrative arm and there had been much criticism of the antiquated *Public Trust Office* (PTO) which was performing that role. But I was horrified by the terms of an administrative *Quinquennial Review*[7] by Ann Chant in November 1999. This proposed the break-up of the PTO and questioned the need for some of its services.

After 10 years of working with the Law Society for a new mental incapacity jurisdiction it seemed to me that the administrative means of achieving this was to be destroyed and valuable expertise dissipated. Proposals to delegate functions to the Inland Revenue, social services and the Benefits

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[7] *The Public Trust Office of the Lord Chancellor's Department: A Quinquennial Review (November 1999).*

Agency overlooked conflicts of interest. This would have been big-brother protection rather than independent best interests empowerment. We wanted something better but instead what we had was to be destroyed.

The Public Guardianship Office

Those of us who realised what was happening were quite vocal and after the *Making Changes*[8] consultation the Government acknowledged in *The Way Forward*[9] the need for a 'centre of excellence' for adults who lack mental capacity. In April 2001 the *Public Guardianship Office* was born and now it must grow up and mature. Those of us who work within the system are familiar with the process of change – the setting up of committees and working groups, great activity, new names and logos, different job titles, published standards and policy documents. *Plus ca change mais ces la meme chose* – everything changes but it is always the same thing!

There are in fact some promising signs following an injection of new management and funding. One initiative is the *Consultative Forum*, a representative body which meets regularly and advises on the *Change Programme*. I am a member and, I suspect, something of a nuisance because I keep asking for items to be put on the Agenda. There is a new focus on the needs of the client with an early needs assessment. The office is to be more accessible and properly organised, though as a result of the changes and move to Archway Tower there has been a serious deterioration – hopefully short-lived. Visiting services are extended to receivers as well as patients with more visits. A new *Website*[10] provides information and after being the poor relation for so long the office is to be the envy of the Court Service by having computerised, paperless files – I just hope that being the guinea pig does not prove too painful!

The Court of Protection – and Human Rights!

Having battled over the administrative body, I then compared the procedures of the civil courts with those of the Court of Protection in the context of Human Rights. The official view appears to be that only the decision that an individual is a patient engages Article 6 (the right to a fair trial) and once this status – of lack of it – is achieved there are no further human rights implications. The reality is that the rights of other members of the family are affected by decisions about control of money. Anyone who has dealt with a dispute between son and daughter as to how mother should be cared for knows that. Unless there is an expensive High Court action for a declaration the issue will be determined by the appointment of a receiver or attorney. Article 8 provides a right to respect for family life and if this is alleged to be infringed there must be a right to a fair trial under Article 6. That would happen if the matter arose in the High Court so why not if it is dealt with on step removed by the Court of Protection?

I pointed out that the Assistant Masters are not judges (this is a courtesy title) and hearings in London may not be accessible to those involved. I questioned existing procedures because the distinction between judicial and administrative decisions is unclear, there are no procedures in the Rules for advance disclosure of evidence and judgments are not made public. These factors may provide a useful disincentive to litigation but do they achieve justice to the families involved?

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[8] *Making Changes: The Future of the Public Trust Office (April 2000).*

[9] *Making Changes: The Future of the Public Trust Office, the way forward and an analysis of the consultation (December 2000).*

[10] *http://www.guardianship.gov.uk.*

My short-term solution was simple, inexpensive and did not require legislation. Appoint a handful of part-time Deputy Masters from the body of District Judges in the provinces who could hear disputed cases near where the parties live and apply parts of the Civil Procedure Rules 1998 by reference. But then I would say this, wouldn't I!

A regionalised Court of Protection

To my surprise the Lord Chancellor took up my suggestion and I was appointed a Deputy Master for a six month Pilot to handle disputed cases arising in the North from my court at Preston. Master Lush and I have worked together for many years, so with the co-operation of the senior managers at the Public Guardianship Office we soon set up a procedure based on email communication. The pilot was deemed a success and I have now been appointed for a five year period – so we have a Northern Court of Protection. But please do not try to come to me direct – the administration is done in London and hearings are referred to me when this is more convenient to the parties. I am just a satellite trying not to go – or be pushed – out of orbit. It has been a steep learning curve.

But there are additional benefits. I am trying to introduce case management and dispute resolution techniques based on experience of the civil and family courts, and local practitioners who would not have ventured to London are getting involved. There may also be the potential for one judge to sit in a dual jurisdiction.

The future

What next? Could there be a Court of Protection for Wales? That would be politically attractive, and welcomed by the lawyers too! Would other areas benefit from regionalisation? I am confident that we are in the process of re-building the Court of Protection in a form that is ready for the new jurisdiction – when it comes. All we need now is the legislation?

APPENDIX

Cases under the new Jurisdiction

The following are examples of situations that may need to be dealt with under the new jurisdiction but are not encountered by the existing Court of Protection. They illustrate the need for local dispute resolution by a District Judge appointed as a Deputy Master of the Court of Protection. An appeal would go before a nominated Circuit Judge or High Court Judge also appointed to sit on Circuit in the Court of Protection.

Care dispute

Dispute between a son and daughter who live some distance apart as to which residential care or nursing home their mother should move to. She has Alzheimer's disease and is incapable of participating in the decision but has adequate funds to meet the fees. Her solicitor has an enduring power of attorney so is able to make financial decisions but unwilling to become involved in this family dispute. Some method is required of resolving this dispute which is becoming increasingly acrimonious but does not address mother's best interests. It could readily be resolved by a Deputy Master sitting in a local court under the new jurisdiction.

Contact disputes

(a) A daughter from an Asian background has married outside her ethnic origins and adopted a way of life that results in her being cut off by her family. She still wishes to visit her learning disabled brother but the family prevent this.

(b) Older parents with a learning disabled son became involved in a bitter divorce which results in father being excluded from the matrimonial home where mother continues to care for this son. A daughter who has sided with father is then denied access to her brother.

At present expensive applications must be made in the High Court for declarations with the intervention of the Official Solicitor. Although the individuals concerned are 'patients' there is a preliminary issue as to whether they have capacity to decide whom they wish to have contact with. Directions hearings take place before a District Judge followed by at least one hearing before a High Court Judge sitting in the Family Division. The existing procedure is disproportionate in its use of legal resources and a Deputy Master could resolve the issue under the new jurisdiction.

(**Note**: I encountered both these cases whilst sitting as a District Judge in the Preston District Registry of the High Court of Justice).

Activities

A charity providing outdoor adventure holidays for adults with learning disabilities wishes to take an individual on a mountaineering course but mother (who may be over-protective) thinks it is too dangerous and objects. Care workers and a personal advocate wish to support this opportunity for personal development. The charity seeks reassurance that they would not be vulnerable to legal proceedings irrespective of fault. A Deputy Master could resolve this dispute under the new jurisdiction in a local court according to the best interests of the incapacitated individual.

(**Note**: I have been asked about this when speaking to care providers at conferences).

Education

Father wants the 19 year old son with severe learning disabilities to attend a residential training college and has arranged funding. Mother prefers him to live with her but has made no arrangements for his daytime activities. The local authority has offered a place at the local training centre and is very concerned that mother will not allow him to attend. She will not discuss the matter further and the son's future is in doubt. An application could be made under the new jurisdiction for a declaration as to his best interests and be dealt with in a local court by a Deputy Master who would see the parties, consider welfare reports and make a decision (if an attempt at mediation did not result in the deadlock being resolved).

(**Note**: these situations arise in practice without an opportunity for judicial intervention).

Minor medical decisions

Parents wish to arrange for their 23 year old daughter with Downs Syndrome to have some dental treatment which will improve her appearance but is not otherwise necessary. She appears to want this treatment but there is doubt as to whether she can legally consent so the dentist is unwilling to proceed perhaps because there is some element of risk. An application to a Deputy Master in a local court could resolve the matter.

(Note: this is not an uncommon scenario for such families).

Dispute over medical intervention

Parents are concerned that it is proposed to remove the teeth of their incapacitated son who presents challenging behaviour and is biting everything and everyone in the local authority home where he is cared for. They wish to oppose this decision before it is implemented and encourage other methods of behaviour control but receive no support from those responsible for his care. A Deputy Master could provide the necessary intervention and ensure that all relevant options are taken into account before a decision is reached.

(Note: this question was raised at a previous Conference by a distinguished lawyer).

Sexual relationships

Care workers are concerned as to whether a resident with severe learning disabilities being supported in a group living arrangement is competent to enter into a sexual relationship with another resident. They seek a declaration from the Court. Such an application might be referred to a Deputy Master who arranges to sit locally to take evidence from a consultant psychiatrist and others who have experience of the conduct and level of understanding of the individual.

(Note: these problems arise in practice but there is no adequate way that they can be brought before a court).

Cases under a dual jurisdiction

The following further examples (all of which have been encountered at Preston County Court!) illustrate the need for an overlap with the existing role of the civil and family courts. The Court of Protection when exercising the new jurisdiction cannot be seen as a separate court, but needs to function in part through judges working on a regional basis within the existing court system exercising a dual jurisdiction.

Residence dispute

Following a divorce there is a dispute as to which parent is to continue to care for an adult mentally disabled child. The future of the matrimonial home may depend on this. A Deputy Master sitting concurrently as a District Judge could deal with the residence issue under the new jurisdiction and also the ancillary relief claims. (The Master of the Court of Protection would have no such dual jurisdiction).

(Note: I have encountered this problem at Preston County Court).

Possession action

A landlord or mortgagee brings a possession claim and the tenant or mortgagor attends the hearing but appears confused and unable to cope. Doubts arise as to mental capacity and the District Judge finds himself in difficulty knowing how to proceed. If this defendant is a *patient* a litigation friend must be appointed but a separate application may then have to be made to the Court of Protection for the appointment of a Receiver. That may be a disproportionate response if the tenant or mortgagor has no savings and is simply failing to cope with state benefits. Under the new jurisdiction the claim could be transferred to a Deputy Master who could deal locally with the capacity issue, exercise powers of the Court of Protection over personal financial affairs and resolve the possession claim (possibly all in the same series of hearings).

(**Note**: this is not an unusual scenario at possession hearings).

Action for 'necessaries'

A local shopkeeper sues a customer with learning disabilities who has been placed 'in the community' for non-payment of bills for normal provisions. Support from social services (who set up this living arrangement) has evaporated with everyone passing the buck. A District Judge dealing with the matter as a 'small claim' will be in great difficulty, but under the new jurisdiction he could pass the case to a Deputy Master who would have the powers (under a dual jurisdiction if necessary) and experience to deal with it.

(**Note**: I have encountered this problem whilst sitting in the 'small claims track').

Ancillary relief claim

Following a divorce between an elderly couple financial claims are made which include the future of the former matrimonial home. At an FDR ('financial dispute resolution hearing') the husband makes proposals under which she may remain in the home for life. The lawyers involved agree that these proposals are more beneficial to the wife than she is likely to achieve at a contested hearing. She cannot grasp the implications and refuses to accept. The District Judge is in a dilemma because if she persists in refusing the offer she is in danger of paying all the costs and losing the home. He questions whether she lacks mental capacity and should be treated as a 'patient' with a 'next friend' appointed to conduct the proceedings on her behalf, but she refuses to be medically examined. If this case was transferred to a local Deputy Master he could tackle all the issues and resolve them locally with minimum delay and expense.

(**Note**: I am facing this problem at the moment and wondering how progressive to be!).

Medical Treatment Using the Scottish Incapacity Act: Will it Work?

*Donald Lyons**

[This paper was given by the author at the two day conference entitled 'Reform of Mental Health Law and Mental Incapacity' held in London on 21st and 22nd June 2002 and hosted by the Law Society and the Royal College of Psychiatrists. We are grateful to both organisations for their permission to publish this article]

INTRODUCTION

The *Adults with Incapacity (Scotland) Act 2000* was one of the first pieces of legislation passed by the Scottish Parliament. It is a major and significant Act that repeals and replaces many outdated pieces of legislation and brings the broad spectrum of incapacity issues under one single legislative framework. It is being implemented on a phased basis and can be viewed on the internet at *http://www.scotland.gov.uk/justice/incapacity*. This paper examines the major provisions of the Act, focusing on some of the difficult issues surrounding treatment and research.

HISTORY

Around 100,000 people in Scotland suffer from some degree of incapacity. It has long been recognised that the law in Scotland was fragmented and unsatisfactory and did not offer significant protection for people nor offer a framework for intervention. The Scottish Law Commission[1] reported on the unsatisfactory state of existing law in 1991 and, following a four year consultation process, issued their *Report on Incapable Adults*[2] in 1995. This report laid out the framework for the future Bill. It was well received by professional and voluntary agencies and led to the setting up of an alliance to promote the introduction of the Adults with Incapacity Bill. The alliance was spearheaded by ENABLE and Alzheimer's Scotland – Action on Dementia (both Scottish voluntary organisations) and won over considerable political support in Scotland. However, the Westminster Parliament was unable to find time to introduce the Bill.

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* *Consultant Psychiatrist in Old Age Psychiatry, Greater Glasgow Primary Care Trust; Member of the National Implementation Steering Group for the Adults with Incapacity (Scotland) Act 2000*

[1] *Scottish Law Commission (1991) Mentally Disabled Adults; Legal Arrangements for Managing their Welfare and Finances. Edinburgh: SLC, 1991 (SLC Discussion Paper 94).*

[2] *Scottish Law Commission. Report on Incapable Adults, Edinburgh: SLC, 1995 (SLC Report 151)*

In 1999, the Scottish Parliament was established. Scottish Ministers took this area of law seriously and issued a Consultation Paper, *Making the Right Moves*[3]. This adopted most but not all of the recommendations of the Scottish Law Commission and formed the framework for the *Adults with Incapacity Bill*, which was introduced to the Scottish Parliament in September 1999. After a process of debate within the Scottish Parliament and consultation with interested bodies, the *Adults with Incapacity (Scotland) Act 2000*[4] was passed by the Scottish Parliament on 29 March 2000 and received its Royal Assent in May 2000.

REPEAL OF EXISTING LAW

Many ancient (and some not so ancient) pieces of legislation are repealed by this Act. A "Curator Bonis" appointed to manage the financial affairs of an adult with incapacity is a procedure that dates from 1585 and is repealed by the 2000 Act. The Office of Tutor Dative (appointed by the Court of Session, usually to manage welfare issues) will no longer exist and Guardianship under the Mental Health (Scotland) Act 1984 is repealed. Several other Acts are significantly amended. Existing Curators, Tutors and Guardians will continue but will have titles and powers consistent with the new Act.

GENERAL PROVISIONS

The Act specifies principles and definitions and lays down the role of statutory bodies. The five key principles governing all interventions are:

1. Any intervention under the Act must benefit the adult. The Act states that "there shall be no intervention ….. unless that intervention will benefit the adult and unless that benefit can be obtained without the intervention".
2. The intervention must be the least restrictive in relation to the adult's freedom. The Act reflects this in its layout.
3. In deciding on any intervention, account must be taken of the adults past and present wishes.
4. Account shall also be taken of the wishes of relevant others (including nearest relative and primary carer) where it is reasonable and practical to do so.
5. People holding certain powers under the Act e.g. attorneys and guardians must encourage the adult to use existing skills and to develop new skills.

Incapacity, in relation to this Act, is defined as being "incapable of acting or making decisions or communicating decisions or understanding decisions or retaining the memory of decisions by reason of mental disorder or inability to communicate". The Act is very clear that assessment of capacity relates to specific decisions and is not an "all or nothing" assessment. The Codes of Practice give some guidance to people assessing capacity but the interpretation of the above definition is very much one for individual practitioners. In particular, it is not clear what "retaining the memory of decisions" means in relation to this Act. It would be unreasonably paternalistic to remove decision-making authority from people who make decisions clearly and consistently but may not necessarily be able to spontaneously recall them.

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[3] *Scottish Executive (1999). Making the Right Moves; Rights and Protection for Adults with Incapacity. Edinburgh: The Stationery Office, 1999*

[4] *Adults with Incapacity (Scotland) Act 2000 Edinburgh: The Stationery Office, 2000*

For the purposes of this Act, mental disorder is very much as defined by the Mental Health Act and is relatively broad. It excludes misuse of alcohol and drugs and provides a new exclusion that a person shall not be deemed incapable merely by “acting as no prudent person would act”! The Act also specifies that any inability to communicate must be one that cannot be overcome by translation, interpretation or mechanical means.

The general provisions of the Act also lay out the roles of statutory bodies. It introduces a new body, the Office of the Public Guardian, that has a duty to keep a register of various interventions under the Act and also oversee, inspect and investigate financial interventions under the Act. Local authorities and the Mental Welfare Commission for Scotland have similar powers, notably with regard to welfare issues. The Act specifies that the Sheriff Court will be the main route for legal proceedings under the Act and gives a right of appeal against a decision on incapacity.

OUTLINE OF INTERVENTIONS

Part 2.

This deals with powers of attorney. In Scots law, powers of attorney have been assumed to persist into incapacity if taken out after 1990. There was no requirement to register these powers, no mechanism for inspecting the use of a power of attorney and no clear use of welfare powers. Under the 2000 Act, powers of attorney can be continuing powers for financial matters. It is now possible to appoint a welfare power of attorney with the authority to consent to treatment and make other welfare decisions on behalf of an adult with incapacity. The grantor must be certified capable of granting the power. A doctor, lawyer or member of the Faculty of Advocates can give the certificate. The Public Guardian keeps a register of all such powers and can investigate, at the request of any party, the use of a power of attorney for financial issues. The local authority has a duty to investigate welfare powers. This part of the Act was implemented in April 2001 and approximately 5,000 new style powers of attorney were taken out during the first year.

Part 3.

This deals with accounts and funds and provides a simple mechanism for withdrawing money from the account of an adult with incapacity to pay for essential goods, services etc. This is authorised by the Public Guardian and requires a certificate of incapacity and also a counter signatory to testify to the character of the withdrawer. Only a relative or friend can do this, a professional cannot act in this capacity for one of his/her clients. This is quite a new legal procedure and, following its implementation in April 2001, the Public Guardian approved about 90 applications of this type.

Part 4.

This deals with the management of finances of residents of care homes or hospitals. It gives authority to the managers of such establishments to manage the funds of their residents within limitations as to their use and as to the amount of money they can hold on a persons behalf. The new Scottish Commission on the regulation of care will provide much of the regulatory framework for this part of the Act. Because this is a new body, the implementation of this part has been delayed until April 2003.

Part 5.

This deals with medical treatment and research. This will be covered in greater detail below. Briefly, Part 5 provides a framework for medical interventions where an adult is incapable of giving consent to treatment or research. This part of the Act proved very difficult to implement and much thought had to be given to the Code of Practice. It was implemented on 1 July 2002, roughly a year after the original scheduled implementation date.

Part 6.

This deals with intervention orders and guardianship. An intervention order is a single order covering one financial, property or welfare issue. It could be used for selling a house, signing a lease or giving up a tenancy. A guardianship order covers ongoing interventions in the areas of finance, property or welfare and, unlike Mental Health Act guardianship, the diet of powers is not laid down by law and is up to the Sheriff to decide. Any person may apply for either of these orders to the Sheriff. The application must be accompanied by two medical certificates and a report from either a social worker or, for financial issues, a suitably qualified person.

IMPLICATIONS FOR MEDICAL TREATMENT

Prior to this Act, there was no legal framework for medical treatment where an adult was not able to consent with the exception of persons detained under the Mental Health Act (but then only for treatment for mental disorder) and the appointment of a Tutor Dative by the Court of Session (a lengthy and complex procedure!). Much has been written about the issues of provision of health care to people who are incapable[5]. There was a pressing need for legislation in this area. The dilemma of autonomy of the individual versus professional duty of care is brought into sharp focus by this part of the Act.

Part 5 defines medical treatment as "any health care intervention designed to safeguard or promote the physical or mental health of the adult". This is very broad and can cover medical, dental, nursing, ophthalmic and other health care procedures. Section 47 of the Act introduces a general authority to provide reasonable treatment under a certificate of incapacity given by the medical practitioner primarily responsible for the adult's care. However, the general philosophy of the Act demands that decisions on capacity are specific to the interventions and it would be against the spirit of the Act to issue a blank certificate covering all health care interventions. The Act imposes limitations on the general authority to treat by excluding the use of force and detention except where immediately necessary and by disallowing any treatment prohibited by court order or subject to court proceedings unless authorised by law. It is not expected that this part of the Act will be used in medical emergencies.

The general authority to treat is limited by regulations. The Scottish ministers have decided that neuro-surgery for mental disorder cannot be administered to a person who is not able to consent to the procedure. Other treatments require special safeguards e.g. Court of Session authorisation for sterilisation. An independent second opinion is needed for Electroconvulsive Therapy or hormonal drugs to alter sexual drive. As a result of these regulations, it will be possible in Scotland

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[5] *Not least because of the publicity generated by the well-known case of R v Bournewood Community and Mental Health NHS Trust ex parte L [1998] 3 AER 289*

to treat a mentally ill person with Electroconvulsive Therapy when that person is not able to consent to the procedure (but presumably not resisting) using the Adults with Incapacity Act as opposed to the Mental Health Act. The Act also specifies that the general authority to treat shall not apply where there is a welfare attorney or guardian with the authority to consent to treatment or where someone holds an intervention order in relation to that treatment. Unfortunately, the Act was not specific about the need for certification of incapacity in these cases. The Code of Practice has laid down that a certificate of incapacity will be given but there may be further debate on that point.

This part of the Act also lays down procedures for challenging medical decisions. Where there is not a proxy decision-maker as outlined above (i.e. a welfare attorney or guardian), the medical practitioner will obey the general principles of the Act in deciding on treatment. This treatment will then proceed unless any person claiming an interest in the adult's welfare appeals that treatment to the Sheriff and the Sheriff grants an interdict preventing the treatment. If a proxy exists, the medical practitioner will consult the proxy where it is reasonable and practical to do so and may only proceed with the proxy's agreement. If the proxy disagrees, the medical practitioner will seek an independent opinion given by a nominated medical practitioner. This person will be appointed by the Mental Welfare Commission for Scotland and will be a practitioner skilled in the procedure being suggested but independent of the prescribing doctor. The nominated practitioner will examine the adult, consult with the parties involved and make a decision. Following this decision, treatment will proceed unless appealed to the Court of Session. The timescale involved has provoked some anxiety and the Act specifies that, in the meantime, the practitioner has a duty to provide treatment to safe life or prevent a serious deterioration in the adult's condition.

Perhaps the most difficult area highlighted by this change in the law is decision making for people with major degrees of incapacity and a need for complex, multiple and not easily foreseen health care interventions. An adult could have multiple certificates of incapacity ranging from basic feeding through the whole range of health care interventions to major surgery. The Code of Practice introduced the idea of a treatment plan to deal with this situation. A treatment plan would include a broad "catch all" category of fundamental health care procedures for basic nutrition, hydration, skin care etc and a list, in broad terms, of the areas of intervention the adult requires. The treatment plan will not include single special procedures such as invasive surgery or investigations. These will need separate consultation and certification. The medical practitioner will make a decision on capacity in relation to each area of intervention and agree a whole package with interested parties including relatives and other professionals. Because a certificate of incapacity can only last for a year, this treatment plan would be subject to an annual review. This would reinforce good practice in continuing hospital and nursing home care.

It is too early to say whether this part of the Act will be a success in achieving its objectives of providing a workable legal framework for medical decision making for adults with incapacity. Unlike other parts of the Act, it is not subject to registration and inspection although the Mental Welfare Commission will take a keen interest in the use of the Act.

RESEARCH

Research is also covered by *Part 5* of the Act and is implemented on 1 July 2002. The Act specifies that research can be undertaken where an adult is incapable of giving consent but that the outcome of the research must provide real and direct benefit to the adult. This might appear to misunderstand the nature of research but it is consistent with the general principles of the Act. However, a further clause states that, if the adult will not benefit directly from the research, then the outcome must be likely to provide real and direct benefit to others with the same incapacity through greater scientific understanding of the condition. Research can only be undertaken into the incapacity for which the adult suffers and must involve no or minimal foreseeable risk or discomfort. Consent is obtained from a welfare attorney or guardian or, if no such person exists, from the nearest relative. A special ethics committee will consider all such research for ethical approval.

OMISSIONS FROM THE ACT

Two areas relating to medical treatment proposed by the Scottish Law Commission were omitted from the Bill and subsequently the Act.

Withdrawing and withholding medical treatment.

The Scottish Law Commission proposed a framework for making decisions to withdraw or withhold life-sustaining treatment. This gave rise to anxieties about “euthanasia” although the Commission’s proposals were very much in line with good practice guidance from the British Medical Association[6] and reflect what doctors are doing at present. This area is, to some extent, covered by the general principles of the Act. The Act prohibits any intervention that will not benefit the adult and this could be taken to include a futile attempt to prolong life where the adult has no hope of recovery.

Advanced Statements.

Again, the Scottish Law Commission recommended that the status of advanced statements should be solidified in Scots Law. This is not an explicit part of the Act but, again, the general principles insist that the past wishes of the adult must be taking into account in determining any intervention. Guidance from the British Medical Association[7] states that practitioners should regard an advance refusal of treatment as being as valid as a contemporaneous refusal of treatment. It is perhaps unfortunate that this “common law” stance has not been solidified by the Act.

IMPLEMENTATION.

A national steering group oversees the phased implementation of this Act and advises the Scottish Executive on any difficulties that occur. Early data suggests that the Act is working well but the potentially major impact of the changes to the law on medical treatment have yet to be assessed. Time will tell whether this Act provides a sound protective legal framework for adults with incapacity and for those trying to provide healthcare without being restrictively cumbersome and bureaucratic.

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[6] *Withdrawing and Withholding Life Prolonging Medical Treatment; Guidance for Decision Making (Second Edition) British Medical Association 2001*

[7] *Advanced Statements about Medical Treatment The British Medical Association 1995*

Masterman-Lister and the Capacity to Manage One's Property and Affairs

*Denzil Lush**

[This paper was given by the author at the two day conference entitled 'Reform of Mental Health Law and Mental Incapacity' held in London on 21st and 22nd June 2002 and hosted by the Law Society and the Royal College of Psychiatrists. We are grateful to both organisations for their permission to publish this article]

Inrtoduction

The judgment of Mr. Justice Wright in *Masterman-Lister v Jewell and Home Counties Dairies and Masterman-Lister v Brutton & Co.*, [2002] EWHC 417 (QB), which was handed down on 15 March 2002, is the most important decision so far in English law on the meaning of the term 'patient'. This, of course, is one of the two disabilities recognized in CPR Part 21. It is also the cornerstone of the Court of Protection's jurisdiction under the Mental Health Act 1983.

Section 94(2) of that Act defines a 'patient' as someone who is 'incapable, by reason of mental disorder, of managing and administering his property and affairs.' There are two prerequisites. A person must (a) have a mental disorder, and (b) as a consequence, be incapable of managing and administering his property and affairs.

'Mental disorder' is defined in the legislation, but the incapacity to manage one's property and affairs is not, and this is where Sir Michael Wright's decision has filled a void, and possibly opened a debate. In fact, he said nothing startlingly new, but the significance of his judgment is that it will be widely reported, whereas previous decisions on the meaning of incapacity to manage one's property and affairs have been inaccessible, either because they were unreported, or because they emanated from other common law jurisdictions, whose reports are only available in a few very specialist libraries.

The background

Martin Masterman-Lister was born in 1963. In 1980, while he was on his way to work on a motorbike, he collided with a milk float driven by Mr. Jewell, and sustained various orthopaedic injuries and a severe head injury. Brutton & Co., Solicitors, Fareham, acted for him in the personal

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* *Master of the Court of Protection*

injury litigation, and in 1987, on counsel's advice, the claim was settled for £76,000 – half its value on full liability on account of contributory negligence.

A few years later, Martin felt aggrieved that the claim had been settled at an undervalue, and sought to re-open it. His solicitors, Stewarts, obtained a medical report from an expert in head injuries, Dr. Martyn Rose of St Andrew's Hospital, Northampton, who was of the opinion that Martin was a patient, and that he had been ever since the accident in 1980. Dr Rose was the first of the many doctors who had seen Martin to have expressed this view, and it was shared by Dr. Graham Powell, a leading clinical neuro-psychologist. The defendants, however, obtained reports from some equally eminent doctors and psychologists to support their contention that Martin was not a patient.

Essentially, if he were a patient, time would not have run against him under the Limitation Act 1980, and the original settlement would have been a nullity because it had not been approved by the court. In March 2000 Master Murray ordered that the question be tried as a preliminary issue. The trial began before Mr. Justice Wright on 28th January 2002, and lasted fifteen days. Laura Cox QC appeared for Martin, Robin De Wilde QC for Brutton & Co., and Richard Methuen QC for the driver and the dairy.

Sir Michael Wright decided that Martin may have been a patient for the first three years after the accident; but that he had not been a patient since 1983; that he had survived for the last twenty years without any major or even minor catastrophe, and that his affairs had, in fact, been perfectly adequately managed. Accordingly, the claim was statute-barred.

The fundamental issue, as far as Martin's counsel was concerned, was his vulnerability. Mr. Justice Wright was of the view that, even if he accepted such an approach (which he did not), he would not have felt able to hold that Martin was sufficiently vulnerable to the risks of unwise decisions, bad advice, or self-interested and manipulative persons, to justify the inroads on his personal freedom and autonomy that are implicit in declaring him a patient.

Earlier authorities

The meaning of the term 'incapable of managing and administering his property and affairs' had previously been considered in four cases. *Re CAF* (1962) (unreported), was a decision of Mr. Justice Wilberforce, of which there is no surviving transcript. However, it was referred to in a footnote in *Heywood & Massey's Court of Protection Practice* as authority for the statement that "the question of the degree of incapacity of managing and administering a patient's property and affairs must be related to all the circumstances, including the state in which the patient lives and the complexity and importance of the property and affairs which he has to manage and administer."

In *PY v RJS* [1982] 2 NSWLR 700, Mr. Justice Powell, a specialist judge who headed the Protection Division of the Supreme Court of New South Wales, drawing partly on a decision of the great American jurist Benjamin Cardozo, defined a patient as someone who is "incapable of dealing, in a reasonably competent fashion, with the ordinary routine affairs of man, as a consequence of which there is a real risk that he may be disadvantaged in the conduct of such affairs, or that such money or property which he may possess may be dissipated or lost." However, in another Australian case, *Re MacGregor* [1985] VR 861, Mr. Justice Starke chose not to follow Powell's definition, and preferred *Re CAF*, because the legislation itself refers to "his property and affairs" rather than the "ordinary routine affairs of man."

Finally, in *White v Fell* (1987) (unreported), a case in which the facts were very similar to those in *Masterman-Lister*, Mr. Justice Boreham said that the meaning of the expression "incapable of managing his property and affairs" should be construed in a commonsense way as a whole. Few people have the capacity to manage all their affairs unaided, and whether they are capable of managing their property and affairs depends on whether they are capable of taking, considering, and acting upon appropriate advice.

In addition to these judicial authorities, Mr. Justice Wright also considered the checklist in *Assessment of Mental Capacity: Guidelines for Doctors and Lawyers*, published jointly by the British Medical Association and the Law Society in 1995. Following *Re CAF*, the checklist suggests that, when assessing an individual's capacity to manage his financial affairs, one needs to consider their extent, importance and complexity. This might include, for example, considering:

- the value of his income and capital (including savings and the value of the home)
- financial needs and responsibilities
- likely changes in his financial circumstances in the foreseeable future
- the skill, specialized knowledge and time it takes to manage his affairs properly
- whether he would be likely to seek, understand, and act on appropriate advice where needed, in view of the complexity of his affairs.

The checklist goes on to recommend that a number of personal factors should be taken into account, such as:

- age
- life expectancy
- psychiatric history
- prospects of recovery or deterioration
- the extent to which the incapacity could fluctuate
- the condition in which he lives
- family background
- family and social responsibilities; and
- the degree of back-up and support he receives or could expect to receive from others.

It finally proffers three further questions that should be considered:

- could his inability to manage his property and affairs lead to him making rash or irresponsible decisions?
- could his inability to manage lead to exploitation by others – perhaps even members of his family?
- could his inability to manage lead to other people being compromised or jeopardized.

These further questions, of course, raise the issue of vulnerability, and, In *Masterman-Lister* Mr. Justice Wright held that "while they are plainly proper and appropriate questions to ask, they have to be answered, in my view, in the light of the other guidance set out in the checklist."

He concluded his masterly review of the existing authorities by discussing the Law Commission's report on *Mental Incapacity* (Law Com No. 231), published in 1995. He approved its 'functional approach' to capacity, namely that a person should not be regarded as unable to make a decision unless he is unable to understand an explanation – in broad terms and simple language – of the information relevant to that decision, and that he should not be regarded as unable to make a decision merely because he makes a decision which would not be made by a person of ordinary prudence.

Comment

In *Masterman-Lister* Sir Michael Wright upheld all the existing authorities on the question whether a person is a patient, except the decision of Mr. Justice Powell in New South Wales. He approved and applied *Re CAF, Re MacGregor, White v Fell*, the BMA/Law Society guidelines, and the Law Commission's report on Mental Incapacity. The problem is that each of these authorities approaches the question in a slightly different way, and each arrives at a rather different conclusion. I shall try and explain why.

It is an anomaly – particularly after the Woolf reforms – that the definition of a patient in CPR Part 21 should still be linked to the criteria under which the Court of Protection is entitled to assume control over the management of someone's property and finances. There really ought to be a discrete capacity to litigate, but what constitutes the capacity to litigate?

- Does it depend on the proposed litigant's ability to take, understand, and act upon appropriate advice (following *White v Fell*)?
- Is it the ability to understand an explanation in broad terms and simple language of the information relevant to making the decision (following the Law Commission's proposals in its report on *Mental Incapacity*)?
- Does it depend on the extent, complexity, and importance of the litigation involved (following *Re CAF*)? or
- Is it a combination of all three (*semble*, following *Masterman-Lister*)?

The Law Commission's functional approach to capacity is ideally suited for one-off transactions, such as entering into a contract, making a will, or signing a power of attorney. Such decisions are largely based on understanding the nature and effect of that particular transaction, but it is less obvious whether this approach is suitable for the wider, more generic range of activities involved in managing one's property and affairs, and maybe even litigation.

The BMA/Law Society guidelines suggest that a person may not need to be declared a patient if they have adequate back-up and support mechanisms at home which enable them to cope with the management of their finances. Many demented elderly women come into the Court of Protection's jurisdiction shortly after the death of their husband, because – until then – the husband has been looking after their financial affairs and there has been no need for the court to intervene. The availability of a support network was particularly important in *Masterman-Lister*. Martin had been readily able to draw upon the support of his parents, and, when eventually they are no longer around, he will be able to enlist advice and assistance from his sister and brother-in-law. In *White v Fell* Mr. Justice Boreham recognized the importance of similar help given to Susan White. But what happens if someone comes from a dysfunctional family, or from an environment in which the support is not disinterested?

In theory, the decision in *Masterman-Lister* should make the assessment of capacity more arduous for doctors, who have traditionally been gatekeepers of an individual's status as a patient. They will need to consider a broader range of social, domestic and economic factors. While acknowledging that "the opinions of skilled and experienced medical practitioners are a very important element in the evidence to be considered by the court," Mr. Justice Wright added that, "that element has to be considered in conjunction with any other evidence that there may be about the manner in which the subject of the inquiry actually has conducted his everyday life and affairs." In practice, however, it is unlikely that the decision will have much impact on the way in which doctors and clinical psychologists assess capacity, unless challenges to their professional opinion of the kind mounted in *Masterman-Lister* become more commonplace. Until now they have been extremely rare.

Mr. Justice Wright was, I am sure, perfectly entitled to reach the conclusion he did on the facts, but I do have some sympathy for Martin and his advisers. There is a growing body of opinion, particularly among those involved in the rehabilitation and case management of head injury victims, that the law (public and private, criminal and civil) provides inadequate safeguards for their clients, and that the proposed reform of the mental incapacity legislation will bring little or no further remedy. The Law Commission's report on *Mental Incapacity* addressed a single issue – capacity, in which understanding an explanation in broad terms and simple language seems to be all that is required. It did not consider undue influence, or that vast grey area between undue influence and incapacity (known in Scots law as 'facility and circumvention'), which is inhabited by people who have a mild or moderate cognitive impairment that does not amount to actual incapacity, but nevertheless leaves them easy prey to predators. The main problem is that capacity is relatively easy to define, assess and prove, whereas vulnerability is more elusive.

Because these are important issues, not only in England and Wales but elsewhere in the common law world, Mr. Justice Wright gave leave to appeal. Funding has been granted, and the Court of Appeal will consider the case on either 11 or 12 November 2002.

Casenotes

Deferred Conditional Discharges – The New Regime

*David Mylan**

R (on the application of IH) v Secretary of State for the Home Department (1)

Secretary of State for Health (2)

-and-

Mental Health Review Tribunal (1) Nottinghamshire Healthcare NHS Trust (2) Appellant C (3) (Interested Parties)

[2002] EWCA Civ 646

Court of Appeal (15th May 2002) Lord Phillips MR, Dyson LJ, and Jonathan Parker LJ

The Facts

On the 21st. July 1995 IH was found not guilty by reason of insanity of a serious assault on his young son, and the Court made an order under Section 5 of the Criminal Procedure (Insanity) Act 1964 [as substituted by section 3 of the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991] ("CPIA"). The effect of this disposal is for all relevant purposes to confer the same status as a patient detained under Section 37 of the Mental Health Act 1983 ("the Act") together with a restriction without limit of time under Section 41.[1]

He was detained at Rampton High Security Hospital, and because his detention was pursuant to Section 5 CPIA, his case was referred by the Secretary of State[2] to the Mental Health Review Tribunal ("MHRT") (the first tribunal) after the first six months of his detention. This Tribunal met on the 18th. July 1996, and although requested to support a move to IH's local Regional Secure Unit (RSU), it declined to do so stating:

> "In the tribunal's view, the resources at Rampton Hospital may well make it preferable that he remain there. No doubt this is ultimately a clinical decision, but we do not think we should make a recommendation either way."

IH's case was next considered by the MHRT following his application on the 11th. September 1998. At this time he was asymptomatic. During his detention he had never been treated with medication at a therapeutic level although he had been provided with trial doses of medication to which he experienced severe side effects.

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* *Solicitor, Saxmundham, Suffolk; MHRT Legal Member; Solicitor for the patient in the case under review*

[1] *Section 79(1)(b) of the Act.*

[2] *Section 71(5) of the Act.*

At the second tribunal, IH's Responsible Medical Officer ("RMO") opined that IH no longer suffered from a mental illness but he considered that he should be transferred to a RSU for rehabilitation. The Tribunal decision was not to grant a discharge but it stated:

> "The Tribunal endorse the view that the Patient should be transferred to a suitable RSU for further observation and treatment."

IH was subsequently assessed by the clinical team at the appropriate RSU, and was granted leave by the Secretary of State to visit the RSU for an orientation visit which was subsequently successfully undertaken. IH was assessed by the RSU as suitable for transfer, and since 1998 both his clinical team at Rampton Hospital and the relevant psychiatrist from the RSU have consistently stated their views that IH does not require the special security of Rampton Hospital but does require ongoing treatment which should take place within the setting of the RSU.

The transfer of a restricted patient from one hospital to another cannot take place without the permission of the Secretary of State[3]. Since 1998 the Secretary of State has refused to grant permission for the transfer.

On the 7th. June 1999 a third Tribunal considered IH's detention. It adjourned the hearing on the following terms:–

> "Having considered all the medical evidence we have come to the conclusion that IH is not now suffering from mental illness of a nature or degree which necessitates his detention in hospital for medical treatment but having regard to the serious nature of the condition he suffered and the possibility of recurrence we do consider it appropriate for the patient to remain liable to be recalled to hospital for treatment. We adjourn the hearing until 1st. December 1999 at the latest for a full Care Plan to be drawn up. The terms which we consider should probably be attached to the Conditional Discharge are
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> 1. Supervision by a named social worker.
> 2. Supervision by a named forensic psychiatrist; Mr. IH to be subject to the directions of the psychiatrist including any relating to drug monitoring.
> 3. Residence at a suitable hostel preferably staffed 24 hours a day.
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> If it is considered that he should be excluded from any area because of the presence there of the victim we should be given full details of the area proposed.
>
> We require [X] Council to provide full details of a suitable plan at the adjourned hearing."

In the event the third Tribunal did not resume until the 3rd. February 2000 and, although it had the benefit of further reports, it was not presented with the name of a psychiatrist who would supervise in the community, the address of a suitable hostel or a care plan. The Tribunal was **positively** satisfied that IH was **not** suffering from a mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in hospital and was also **positively** satisfied that it was **not** necessary for his health, safety or for the protection of other persons that he should receive such treatment.[4] A deferred conditional discharge was directed in accordance with the Tribunal's statutory power under section 73(7) MHA 1983.

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[3] *Section 41(3)(c)(ii) MHA.*

[4] *The hearing took place prior to The Mental Health Act 1983 (Remedial) Order of 18th. November 2001 and in consequence the onus was on IH to prove on a balance of probabilities that he did not possess a disorder of the necessary nature or degree and that his treatment within hospital was not necessary for his health, safety or the protection other persons.*

The reasons for the decision were:

> "Having considered the reports and correspondence from [X] Social Services and the [Y] Health Authority, and having heard the evidence of Miss M of the [X] Social Services we are very concerned that no supervising psychiatrist has yet been identified and as a result no care plan has been put in place. For the reasons given on the 7th. June 1999, we make a Conditional Discharge order in the following terms:
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> 1. There shall be supervision by a named social worker;
> 2. There shall be supervision by a named psychiatrist, preferably by a Forensic Psychiatrist;
> 3. IH shall be subject to the directions of the psychiatrist including any relating to drug monitoring;
> 4. IH shall reside at a suitable hostel, preferably a hostel staffed 24 hours a day;
> 5. IH shall be excluded from [Z] save for the purpose only of visiting his relatives in their homes. In the event that his psychiatrist or supervising social worker wishes to vary the exclusion zone for the purpose of implementing the conditions of this order as to treatment and/or residence application may be made for that purpose.
>
> IH's discharge shall be deferred until the arrangements listed have been made."

The crucial factor in arranging the aftercare plan was the identification of a psychiatrist willing to supervise IH in the community. The psychiatrists at the catchment area RSU were willing to offer a bed and supervise within the RSU, but were not willing to provide supervision in the community as they disagreed with the decision of the Tribunal and considered it clinically inappropriate.

The Health Authority used its best endeavours to secure a psychiatrist outside the catchment area without success. The Secretary of State maintained his refusal to consent to a transfer to the RSU.

In order to seek to ameliorate IH's position, a request was made to his RMO to seek the consent of the Secretary of State[5] to the grant of unescorted leave on the basis that IH's detention after a reasonable time from the decision of the Tribunal of the 3rd. February 2000 was unlawful. The request was refused on the basis that the RMO did not consider it clinically appropriate. IH sought leave to seek judicial review;–

> a) Against the RMO's decision not to seek the consent of the Secretary of State for Section 17 leave;
>
> b) Against the Secretary of State for not consenting to the request (in the event that the RMO subsequently made such a request);
>
> c) Damages;
>
> d) A declaration of incompatibility, namely between sections 73(2) and/or (7) MHA 1983 and Articles 5(1)(e) and/or (4) of the European Convention on Human Rights.

The paper application was refused by Mr. Justice Silber on the 1st. March 2001 and, after hearing oral argument, by Mr. Justice Ouseley on the 25th. April 2001.

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[5] *Section 41(3)(c)(i) MHA.*

Leave was sought from the Court of Appeal, and on the 3rd. July 2001 Lord Justice Sedley on a paper application ordered the application to be renewed as soon as possible in open court. His reasons were:

> "I agree at present with Ouseley J that it is not possible to extract from the MHRT's order an obligation to grant unescorted day leave.
>
> But this itself has major implications for the operation of the Human Rights Act 1998. Either MHA s.73(7) is incompatible with the Convention rights , in which case government needs to address the conflict ; or – what seems likelier to me – there is a lacuna for which the UK may be answerable in Strasbourg because the State (its courts included) is unable to secure the implementation of the MHRT's order.
>
> In either event it may be necessary for this court to say – if it be the case – that the end of the domestic legal road has been reached and why."

On the 23rd. July 2001 the application for leave was renewed before Lord Justice Simon Brown (Vice President of the Court of Appeal, Civil Division), Lord Justice Tuckey and Lord Justice Laws. Leave was refused against the RMO, and granted against the Secretary of State for the Home Department. It was further ordered that the Secretary of State for Health, and Nottingham Healthcare NHS Trust (Rampton Hospital) be joined as Respondents and that the MHRT be joined as an interested party.

The Judicial Review application was heard in the Administrative Court before Mr. Justice Bell, and Judgment was delivered on the 5th. December 2001. The claim had been refined by abandoning the damages claim, and the only matter before the Court was the request for the declaration of incompatibility.

Mr. Justice Bell found that:

> "It is at least arguable that the claimant has been detained unlawfully from a period a few months after February 2000"[6]

He went on to say:–

> "In summary, I cannot therefore conclude that in this case where there was a clear medical issue as to whether the claimant suffered from mental illness at all, the effect of the Tribunal's February 2000 order was that they found that Mr. H would continue to be lawfully detained in compliance with the 1983 Act and the Convention until such time as conditions including psychiatric supervision could be satisfied."[7]
>
> "I am more confident that in breach of Article 5(1)(e) and (4), the claimant has been left in limbo, as Mr. Owen put it, for some twenty-one months."[8]

Mr. Justice Bell went on to find that there was no incompatibility, as it was possible to interpret Section 73(7) of the Act in a way that produced compatibility. He did however grant leave to appeal on the basis that the question of incompatibility was at least arguable.

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[6] *Paragraph 52 of the Judgment of the Administrative Court.*

[7] *Paragraph 53 ibid.*

[8] *Paragraph 54 ibid.*

The Issue before the Court of Appeal

The central issue before the Court of Appeal was whether in circumstances such as those pertaining to IH (i.e. where a Restricted Patient applies to the MHRT and is successful in obtaining an order that he should be discharged subject to conditions, but where it has not proved possible to assemble the resources that will enable him to comply with the conditions, and in consequence he remains detained), it is possible to interpret the Act in such a way that it does not infringe the patient's rights under Article 5(1)(e) or 5(4) of the Convention.

Article 5(1)(e) states:

> "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
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> the lawful detention .... of persons of unsound mind."

Article 5(4) states:

> "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 speedily decided by a court and his release ordered if the detention is not lawful."

IH's case was that it was not possible to interpret the present legislation in a way that produced compatibility. It was the Respondents' case (with which the Court subsequently agreed) that compatibility could be produced by revisiting the decision in the case of *Campbell*[9] (for details of which see below).

The Decision

The Court of Appeal's approach to the problem is to introduce a clear distinction between a patient who:–

> "is suffering from a mental disorder of a nature or degree which makes it essential for his safety or that of others that he be detained in hospital for treatment"[10]

and other patients who may be one of three types:–

> "i) The patient is clearly no longer suffering from mental disorder and there is no risk of a relapse or renewed outbreak of illness such as to make it appropriate for him to be subject to any further treatment or supervision.
>
> ii) The patient is probably no longer suffering from mental disorder, but there is a risk that this diagnosis may be wrong and that the patient is merely in remission. Supervision or treatment is appropriate to guard against this risk.
>
> iii) The patient is still suffering from mental disorder which requires treatment or supervision for his own health and safety or the protection of others. This can be provided satisfactorily either in hospital or in the community."[11]

Having introduced these three categories of patients who do not fall within the category of the clearly detainable, the Judgment goes on to reverse the House of Lords decision in *Campbell*.

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[9] *Campbell -v- Secretary of State for the Home Department [1988] 1 AC 120*

[10] *Paragraph 76 of the Judgment*

[11] *Paragraph 76 of the Judgment.*

Campbell was clear authority that the decision of a Tribunal that a patient should be conditionally discharged, and that the discharge should be deferred[12], was a final and not a provisional decision[13]. The sole judgment in *Campbell* was given by Lord Bridge. It is summarised in IH as follows:

> "Section 73 provides for a two stage process in relation to a conditional discharge. At the first stage the Tribunal decides that it will direct the patient's discharge subject to conditions, but defers giving the direction so that arrangements may be made to enable the patient to comply with the conditions. The second stage is reached if and when the Tribunal is satisfied that those arrangements have been made, whereupon it directs the conditional discharge. The Tribunal is not obliged, or even entitled, to reconsider its earlier decision in order to accommodate any new facts that might cause it to alter that decision."[14]

The Court of Appeal in the light of the Human Rights Act 1998 has now reversed the *Campbell* situation,[15] and the Judgment has highlighted this by including a cross heading:–

> "The New Regime
>
> Tribunals should no longer proceed on the basis that they cannot reconsider a decision to direct a conditional discharge on specified conditions where, after deferral and before directing discharge, there is a material change of circumstances. Such a change may be demonstrated by fresh material placed before or obtained by the Tribunal. Such material may, for instance, show that the patient's condition has relapsed. It may show that the patient's condition has improved. It may demonstrate that it is not possible to put in place the arrangements necessary to enable the conditions that the Tribunal proposed to impose on the patient to be satisfied. The original decision should be treated as a provisional decision, and the Tribunal should monitor progress towards implementing it so as to ensure that the patient is not left "in limbo" for an unreasonable length of time."

The Critical Impasse

The Judgment proceeds to offer a way in which the "critical impasse" can be resolved. The critical impasse arises when the MHRT considers that it is reasonable for the patient to continue treatment in the community rather than in hospital and that the treatment is necessary but the psychiatrists who have to provide such treatment refuse because they disagree with the MHRT's view.[16]

The way in which the Court of Appeal summarises the position of a MHRT considering a conditional discharge accords with the submissions made on behalf of the Secretaries of State as follows:–

> "i) The Tribunal can at the outset, adjourn the hearing to investigate the possibility of imposing conditions.

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[12] *Pursuant to the power under Section 73(7) MHA.*

[13] *This was despite the fact that rule 2 of the Mental Health Review Tribunal Rules 1983 (S.I. 1983 No. 942) states that "provisional decision" includes a deferred direction for conditional discharge in accordance with section 73(7) of the Act and a notification to the Secretary of State in accordance with section 74(1) of the Act."*

[14] *Paragraph 53 of the Judgment.*

[15] *It may seem surprising that the Court of Appeal can reverse a House of Lords decision in a precedent-based system. However this is due to the interaction of sections 2 and 3 of the Human Rights Act 1998, and the consequent duty on the Courts to interpret legislation compatibly with the ECHR.*

[16] *Paragraph 92 of the Judgment.*

> ii) The Tribunal can make a provisional decision to make a conditional discharge on specified conditions, including submitting to psychiatric supervision, but defer directing a conditional discharge while the authorities responsible for after-care under s. 117 of the Act make the necessary arrangements to enable the patient to meet those conditions.
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> iii) The Tribunal should meet after an appropriate interval to monitor progress in making these arrangements if they have not by then been put in place.
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> iv) Once the arrangements have been made, the Tribunal can direct a conditional discharge without holding a further hearing.
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> v) If problems arise with making arrangements to meet the conditions, the Tribunal has a number of options, depending upon the circumstances.
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> a) It can defer for a further period, perhaps with suggestions as to how any problems can be overcome.
>
> b) It can amend or vary the proposed conditions to seek to overcome the difficulties that have been encountered.
>
> c) It can order a conditional discharge without specific conditions, thereby making the patient subject to recall.
>
> d) It can decide that the patient must remain detained in hospital for treatment.
>
> vi) It will not normally be appropriate for a Tribunal to direct a conditional discharge on conditions with which the patient will be unable to comply because it has not proved possible to make the necessary arrangements."[17]

Was IH unlawfully detained?

The Judgment makes it clear that the Court considered that after a reasonable period from the decision of the MHRT to discharge him, IH was unlawfully detained:–

> " ……….. under the Convention and the principles to be derived from *Johnson*[18] this uncertainty could not justify the continued detention of IH for more than a reasonable period to enable arrangements to be put in place for his discharge. His prolonged detention in these circumstances, was in violation of Article 5(1)."[19]

Discussion

The case establishes a totally new framework for the MHRT when considering the case of a restricted patient. It is impossible to predict exactly how the changes will operate in practice and the resource implications.

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[17] *Paragraph 98 of the Judgment.*

[18] *Stanley Johnson -v- United Kingdom [1997] 27 EHRR 296.*

[19] *Paragraph 100 of the Judgment.*

Consideration of the Discharge Criteria under the New Regime

The first issue that the MHRT should address when considering an application or reference concerning a restricted patient is whether both the criteria for continuation of the detention are satisfied.[20] Before the clarification provided in *IH*, the first task of the MHRT was to direct itself to answering yes or no to each of the tests set out in Section 72(1)(b)(i) and (ii) of the Act. Following *IH*, the MHRT should consider into which of the four types of 'mental state' set out at paragraph 76 of the Judgment, the patient falls. These are set out above and may be paraphrased as:

1. A mental state such that it is essential for the patient's safety or that of others that s/he be detained in hospital for treatment.
2. A mental state that is asymptomatic and there is no risk of relapse.
3. A mental state that is asymptomatic where there may or may not be a risk of relapse.
4. A mental state that continues to require treatment that can be provided satisfactorily in the community provided clinicians to provide the treatment can be found, and, in the absence of such clinical resources in the community, can be provided in hospital.

Type 1 will contain patients whose presentation whether as a consequence of active psychosis or severe personality disorder makes them easy to identify as requiring hospital treatment.

It is unlikely there will be many, and possibly no, patients who fall into type 2. The use of the term "*no risk of relapse*" is rarely heard in forensic psychiatry. Should any patient be considered to fall into this category they would be prime candidates for an absolute discharge, and indeed it would be difficult to justify how a MHRT could find that a patient did fall into this category and then make them liable to recall by granting a conditional discharge.

The MHRT will be need to be astute to differentiate between types 3 and 4 but that is what it must do in order to know how to proceed, if it is necessary to reconsider the case following the granting of a deferred conditional discharge (DCD), should the resources required to meet the proposed conditions not have been identified within a reasonable time.

In deciding *IH*, the Court had to resolve what was referred to as "*the critical impasse*". This is the position that can arise when the MHRT decides that the patient no longer satisfies the criteria for continued detention, and the clinicians with community responsibility disagree. The clinicians rely on the concept of clinical judgment to refuse to treat the patient when they consider that the treatment cannot be safely provided in the community. Quite simply they disagree with the finding of the MHRT, and in consequence they refuse to co-operate in the implementation of the decision. On behalf of IH, it was argued that unless the MHRT had the necessary power to ensure implementation of its own decision it lacked an essential requirement of an Article 5 judicial body.

In order to resolve this impasse, the Court of Appeal devised the types set out above. There can be little doubt that the impasse has been resolved for a patient falling into type 4. The MHRT when considering such a patient will have satisfied itself firstly that the risks can be safely managed in the community provided there is sufficient support, and secondly that in the absence of sufficient support, such risks cannot be safely managed. In consequence it can grant a DCD, and in the event that the resources are not available, can rescind at a future hearing the original decision, which was both provisional and contingent on resource provision.

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[20] *Section 72(1)(b)(i) and (ii) as applied by section 73(1)(a) and 73(2) MHA.*

The possible effect of the introduction of this type of situation is that advocates could find it easier to obtain a DCD firstly because the MHRT would be aware that it is not a final decision, and secondly because the balancing factor in deciding the detainability of many patients is the availability or otherwise of risk minimisation resources in the community. The granting of the DCD would be a way for the MHRT to explore this availability.

The court in identifying the type four situation makes it explicit that the treatment or supervision the patient requires " ..... *can be provided satisfactorily either in hospital or in the community.*"

The apparent distinction between type 4 and type 3 is that for type 3, the MHRT must in any event discharge the patient following the grant of the DCD even if the resources necessary to meet the original proposed conditions have not been assembled. That is not to say that at the following hearing it must discharge, for there are no restrictions on the number of subsequent hearings that the MHRT may have, subject only to determining the application within a reasonable time. The position is clearly set out in the judgment:

> " ..... In order to comply with *Winterwerp* and *Johnson* a conditional discharge must not be deferred under section 73(7) beyond a reasonable limited period. After that the tribunal must discharge the patient whether or not it has proved possible to put in place arrangements to accommodate the conditions that the Tribunal wished to impose. If it has not, the Tribunal should make appropriate modification to the conditions so that it will be possible for the patient to comply with them…"
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> " ..... If, however, the preferred arrangements prove impossible, the Tribunal must make appropriate modifications to the conditions and direct the discharge of the patient. Such a course is necessary because in this situation the second and third requirement in *Winterwerp* will not be satisfied."[21]

There is in consequence a fundamental distinction between a type 3 and a type 4 patient. Should a MHRT when granting a DCD fail to indicate either expressly or implicitly in the reasons for their decision into which category the patient falls, the MHRT may be vulnerable to subsequent judicial challenge not only because of inadequacy of reasons but also in respect of any further decision they may take. The type 4 patient should be aware that if it is not possible to find the resources to meet the conditions, he or she will remain in hospital, whereas the type 3 patient should be aware that if the resources to meet the conditions cannot be found, the MHRT is required to either modify the conditions so that they can be met or impose no conditions in order that discharge can be implemented. He or she will then be granted a conditional discharge, free of conditions other than the statutory provision that he or she remains liable to be recalled to hospital.

Although the introduction of the distinctions between different types of DCD situations will undoubtedly resolve many cases where otherwise the impasse might arise, it is difficult to conclude that there is under the new regime no possibility of an impasse.

For example, a MHRT may conclude that a patient clearly falls within type 3 but requires a supported hostel, and it indicates such when setting proposed conditions on a DCD. If it then

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[21] *Paragraphs 90 and 91 of the judgment. In Winterwerp v Netherlands [1979] 3 EHRR 387, the European Court ruled that the essential requirements for detention on grounds of 'unsoundness of mind' to be compliant with Article 5(1)(e) ECHR are that (i) the patient is shown on reliable objective medical expertise to have a true mental disorder; (ii) the disorder is of a nature or degree warranting compulsory confinement; and (iii) the disorder must be persistent throughout the period of detention.*

reconvenes and no such hostel is available, it may be unwilling to withdraw the condition and is precluded from deciding that the patient should remain in hospital.

The MHRT has the power to direct the attendance of witnesses[22] by the use of summonses if necessary. The attendance of the Chief Officers of service providers may resolve some problems. The theoretical chance of an impasse appears possible and only time will tell whether in practice an impasse will occur.

Hearings following the making of a Provisional Decision to Discharge

There is within the judgment nothing to indicate the procedure for ensuring that the case returns to the MHRT for a final decision. Following the making of the provisional decision to make a DCD, the MHRT may fix a new date when it will review the case if it has not previously been notified that the resources necessary to meet the conditions have been assembled. It may simultaneously give directions to the authorities with section 117 responsibility to provide reports, and to request or direct the attendance at the resumed hearing of those individuals within those authorities with the responsibility for the service provision[23].

Alternatively the MHRT may elect not to fix a new date. Should it adopt this course then presumably any party or the Secretary of State may request a new hearing in the event that there has been a material change in circumstance or there has been an unreasonable delay. The Court of Appeal do not set out any timetable and presumably it depends on the particular circumstances of the case. Although a delay in assembling resources is permissible[24] the delays must be reasonable if the detention is not to become unlawful.

Resource Implications

The MHRT was an interested party in IH, and adduced evidence to show that the new regime would be unlikely to have major resource implications in view of the relatively small number of DCDs that are made. This view may be optimistic.

The resources of the MHRT are currently stretched to meet the current caseload. Although DCDs are a relatively small proportion of the total workload, under the new regime they may create a disproportionate amount of additional work as they are more likely than other cases to require the MHRT secretariat to ensure the attendance of witnesses who are not parties to the case, and to follow up the directions of the MHRT when making a DCD.

Practical difficulties may arise in ensuring the attendance of the legal member who will usually be a circuit judge. He or she is allocated by the circuit to sit on MHRTs for one or more periods a year, but will not necessarily be available when it becomes appropriate and necessary to re-consider the provisional decision.

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[22] *Rule 14(1) op.cit.*

[23] *ibid. Rules 14 & 15.*

[24] *Johnson op. cit.*

Conclusion

IH failed to obtain the declaration under section 4(2) of the Human Rights Act 1998 which he sought. It was submitted on his behalf that sections 73(2) and/or (7) of the Mental Health Act 1983 are incompatible with Articles 5(1)(e) and/or (4) of the Convention, in that MHRTs lack the power to guarantee that such conditions as they may attach to a deferred conditional discharge will be implemented within a reasonable period from the making of the order. The Court of Appeal did however accept that the existing regime was incompatible, and only by reversing the decision of the House of Lords in *Campbell* and setting out a new regime, was it able to interpret section 73(2) and (7) in a Convention-compliant way.

The effect of the new regime will have a major impact on the way in which MHRTs consider applications and references of restricted patients, both in respect of the initial finding of the detainability of the patient and, in the event that discharge could be appropriate, in the way in which the MHRT proceeds to its final decision.

A likely consequence of the *IH* case is that for some patients there may be several hearings as the MHRT attempts to influence the authorities with responsibility for providing necessary community resources to fulfill their obligations. Ultimately some patients may not then be discharged because it has proved impossible to assemble the resources, and others will be discharged with less stringent conditions than might otherwise have been the case.

It remains to be seen how easily the MHRT will be able to cope with this new regime and whether it will require further resources. Most significantly it remains to be seen whether the impasse has truly been resolved or whether there will be cases in which a MHRT refuses to alter its provisional decision that a patient should be discharged subject to the provision of the resources necessary to enable him to comply with the conditions it considers appropriate, and the service providers remain unable or unwilling to provide the resources that will enable the patient to comply.

So far as IH is concerned, the Court of Appeal was satisfied that he had been unlawfully detained for a lengthy period of time. The consequence of such a detention is an entitlement to damages under Article 5(5)[25] of the Convention. It remains to be determined which public authority is liable for such damages.

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[25] *Article 5(5) ECHR states: 'Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation'.*

Mental Health Review Tribunals – Just how 'Speedily'?

*Nicolette Priaulx**

R (on the application of KB and others) v (1) Mental Health Review Tribunal (2) Secretary of State for Health [2002] EWHC 639 (Admin)

Administrative Court (23rd April 2002) Stanley Burnton J.

Introduction

Numerous legal commentators have noted the tension between current mental health legislation and the Human Rights Act 1998, contending that a modest review across the provisions of the Mental Health Act 1983 ('the Act') suggests the potential for numerous challenges[1]. In the light of recent decisions, which have exposed the susceptibility of mental health legislation, it is hard to disagree. This Administrative Court decision exemplifies the positive approach that domestic courts have adopted in this area of law, and closely follows the jurisprudence of the European Court of Human Rights ('European Court') in its assertion that the vulnerability of patients compulsorily detained calls for "increased vigilance in reviewing whether the Convention has been complied with".[2]

In *R (On the Application of KB and Others) v Mental Health Review Tribunal*[3] Stanley Burnton J ruled that the State has breached the fundamental rights of such patients in failing to take effective steps to provide *speedy* reviews as to the lawfulness of their detention. This case note will examine the content of the judgment and the future implications of this decision, having regard to the fact that such delays are commonplace and of concern, are increasing through an established shortage of medical tribunal members[4].

Facts

Seven claimants detained under the provisions of the Act made applications to the Mental Health Review Tribunal ('the tribunal/MHRTs') for a review of their detention. Four of the applicants were subject to detention under section 3, one detained under section 2, a further subject to detention under section 37 and the final applicant subject to detention under section 37 and to a restriction order under section 41 of the Act. Each claimant had been subject to delays in their hearings due to repeated adjournments. The claimants issued proceedings for judicial review,

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* *Tutor-at-Law, Kent Law School, University of Kent at Canterbury*

[1] *For a discussion of the provisions of the MHA 1983 and practices potentially susceptible to future challenge, see Davidson, L. 'The Impact of the Human Rights Act 1998 on Mental Health Law: Part II' in Garwood-Gowers, A., Tingle, J. and Lewis, T. (Eds.) (2001) Healthcare Law: The Impact of the Human Rights Act 1998, London: Cavendish, 181–200.*

[2] *Herczegfalvy v Austria (1992) 15 EHRR 437*

[3] *[2002] EWHC 639 (Admin)*

[4] *This commentary will not consider the individual circumstances of each application in that each was subject to delays in the hearing of their application for very similar reasons.*

contending that their rights under Article 5(4) of the European Convention on Human Rights (‘ECHR’) to a speedy determination of the lawfulness of their detentions were infringed, by virtue of the delays between their application to the tribunal and the date of an effective hearing. They claimed that these delays potentially resulted in the unjustified detention of patients, who, had their cases been considered earlier, would have been discharged. Furthermore, they claimed that these delays were not isolated, but were typical and unjustified, representing the overall systemic inadequacies in the administration of the tribunal. The respondents stated that they were taking all reasonable steps to remedy the situation.

Decision

Allowing the applications, Stanley Burnton J stated that the fact that a patient’s case was unmeritorious would not deprive him or her of the right to a speedy hearing. Second, although questions relating to financial policy would normally fall within the remit of the executive rather than the courts, when such issues were raised in relation to Articles 5 or 6 ECHR, the Court may then be required to assess the adequacy of resources and effectiveness of administration. The correct approach is to consider whether such delays are inconsistent with the requirement of a speedy hearing. If so, then the onus is upon the State to excuse such delay, for example that the delay had been caused by a sudden and unpredictable increase in the workload of the tribunal, and that it has taken effective and sufficient measures to remedy the problem.

If the State fails to satisfy that onus, the claimant will have established a breach of his right under Article 5(4). In the present cases the Secretary of State could not have been taken by surprise by these delays, and measures taken by the government had predictably added to the workload of the tribunals, such as moves to smaller hospitals and to care in the community. The extent to which failures to provide speedy hearings were due to shortages in medical members of the tribunal and the shortage and lack of training of staff, or the pressure of the work upon them, the responsibility for the delays experienced by patients was that of central government.

The seven claimants will now be lodging their claims for damages.

Relevant Legal Provisions

MHRTs

MHRTs are established under section 65 of the Act, forming one of the statutory safeguards for those compulsorily detained in psychiatric institutions. There is one Tribunal for each region of England and one Tribunal for Wales. In England there are four regions: North London; Trent and Northern and Yorkshire; South London; and West Midlands and Northwest. The Lord Chancellor appoints tribunal members including the five Regional Chairmen. Each panel consists of a legally qualified member, a medical member[5] and a third member (usually referred to as the ‘lay member’) appointed from persons having experience in administration, knowledge of social services or other qualifications that are considered suitable by the Lord Chancellor. Remuneration and conditions of service of Tribunal members are determined by the Department of Health, upon whom responsibility falls for the funding of their payment and for the provision of the staff and accommodation of the Tribunal.

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[5] *In practice medical members are consultant psychiatrists.*

The MHRT Rules 1983 (‘the Rules’) made under section 78 of the Act apply to all applications and references to tribunals and to the proceedings of those tribunals. The Rules set out a sequence of actions following the receipt of an application/reference, which will obviously affect the timing of a tribunal hearing. These include the requirement that the tribunal sends notice of the application/reference to the managers’ of the hospital[6], that the responsible authority sends a statement[7] to the tribunal containing prescribed information, either within three weeks of the application or, in the case of assessment (i.e. section 2) applications, “as can reasonably be provided in the time available”. Where the case involves a restricted patient, the Secretary of State must be sent the prescribed information, and he/she must then send to the Tribunal his/her statement within the next three weeks[8]. In addition, the medical member of the tribunal must examine the patient some time prior to the hearing[9]. The tribunal has a limited power of postponement if it is in the interests of the patient[10] and holds the power to give directions to ensure the speedy and just determination of the application[11]. There is a general power for the tribunal to adjourn and before adjourning it may give directions as it thinks fit to ensure the prompt consideration of an application at an adjourned hearing[12]. In all cases other than assessment applications, at least fourteen days’ notice is required of the time, date and place fixed for the hearing[13].

The Right to Apply for a Review of Detention

All patients that are admitted to hospital compulsorily under sections 2 and 3 of the Act have the right to apply for an MHRT hearing for a review of their detention[14]. A patient liable to detention under section 3 has a right to apply to the tribunal when admitted to hospital under section 3 (at any time during the first six-month period of detention). If the liability to detention is renewed for a further six months after the initial period, the patient then has a further right to apply during the second six-month period. If liability to detention is further renewed under section 3, the patient has the right to make an application in each period of twelve-month renewal.

Patients detained under section 37 do not have the right to make an application to the tribunal in their first six-month period of detention following the imposition of the order by a court. They do have the right to apply in the second six-month period of their detention and at annual intervals thereafter. By section 70 of the Act, a patient subject to a restriction order may apply to the tribunal in the period between the expiration of six months and the expiration of twelve months beginning with the date of the relevant hospital order. The Home Secretary may refer the case of any restricted patient to the tribunal at any time[15]. The Home Secretary is required to refer: (a) the

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[6] *Rules 4 and 31(c) MHRT Rules*

[7] *This is required to contain: an up-to-date medical report, including the relevant medical history and a full report of the patient’s condition (Rules 6 and 32(1) MHRT Rules).*

[8] *Rules 6 and 32(1) MHRT Rules. Note that in all cases other than assessment applications other background reports are required and the production of these is required within three weeks, subject to it being reasonably practicable to produce them (Rule 6 MHRT Rules).*

[9] *Rule 11 MHRT Rules*

[10] *Rule 9 MHRT Rules*

[11] *Rule 13 MHRT Rules*

[12] *Rule 16 MHRT Rules*

[13] *Or such shorter time as all the parties may consent to (Rule 20 MHRT Rules).*

[14] *Section 66(1) MHA*

[15] *Section 71(1) MHA*

case of any patient whose case has not been considered by a tribunal for three years[16] and (b) the case of any patient treated as subject to a hospital order and restriction order[17] who has not applied to a tribunal in the six months beginning with the date of the order[18].

Time Limits

There are only two instances where the Rules prescribe times limits within which the case must be heard:

1. In the case of a section 2 patient (who may be detained for no longer than twenty-eight days under that section), the tribunal is required to fix a hearing to take place within seven days of receipt of an application[19].
2. In the case of the restricted patient who has been conditionally discharged and who is then subsequently recalled, his or her case must be referred to the tribunal by the Secretary of State within a month of his or her return to hospital under section 75(1) of the Act. Rule 29 (cc) of the Rules provides that the tribunal must fix a date for the hearing of the reference, neither later than eight weeks, nor earlier than five weeks, from the date of the receipt of the reference.

Neither the Act nor the Rules lay down a specific time period within which the hearing of any other application or reference must be heard. However, a policy has been in force in recent years whereby cases involving unrestricted patients are heard within eight weeks and those involving restricted patients are heard within twenty weeks[20].

The European Convention on Human Rights

The incorporation of the ECHR through the enactment of the Human Rights Act 1998 (‘HRA’) means for those alleging a breach of their Convention Rights, they may seek a remedy in domestic courts. In interpreting whether rights have been violated or not, courts shall have regard, where appropriate, to previous Convention jurisprudence[21]. In the context of the instant case, Convention rights are of central importance, as neither the Act nor the Rules provide a mechanism to challenge delays, although it is certainly open to a patient to seek judicial review on the grounds of unreasonableness. The most effective option is to challenge the legality of their detention by reference to Article 5(4) ECHR, which gives the detained patient the right to have the lawfulness of his or her detention decided *speedily* by a court[22].

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[16] *Section 71(2) MHA*

[17] *Under section 5(1) of the Criminal Procedure (Insanity) Act 1964*

[18] *Section 71(5) MHA*

[19] *Rule 31 MHRT Rules*

[20] *These target time-limits were agreed between the Council on Tribunals and the Department of Health.*

[21] *Section 2 of the Human Rights Act 1998*

[22] *Article 5 permits detention on the grounds of unsoundness of mind, provided that it is carried out in accordance with a procedure prescribed by law and that the detained patient has access to a court where the lawfulness of his detention can be periodically reviewed. The criteria for lawful detention are laid out in Winterwerp v Netherlands (1979) 2 EHRR 387.*

The purpose of this paragraph has been stated to "assure to persons who are arrested or detained the right to judicial supervision of the lawfulness of the measure to which they are thereby subject"[23] and to ensure that no one is "arbitrarily dispossessed of his liberty."[24] Therefore the rights granted under Article 5(4) not only entail that such individuals are entitled to take proceedings at reasonable intervals before a court to put in issue the lawfulness of their detention25 but that the authorities must make a patient's right to a speedy review "practical and effective"[26].

Comment

In the present case, none of the applicants had an effective hearing within the time limits required by Statute or those set by the MHRT service itself. One applicant had waited twenty-six weeks for a hearing that had been cancelled three times, and the application concerning the section 2 patient did not come before the MHRT for 3 weeks when it should have been heard within seven days. While the judge found that in all instances there had been a breach of Convention rights, if similar delays should occur in other cases, will it not become abundantly clear that the rights of a patient have been breached under Article 5(4)?

Just how 'Speedily'?

Setting out to achieve a 'speedy' decision does not mean that a decision should be made with undue haste. As the judge noted, the issues before the MHRTs were probably the most important issues decided by any tribunals, in that they involve decisions as to the liberty of the individual. A wrong decision could lead to the unnecessary detention of a patient, and at the other extreme to the release of a patient who may pose a danger to himself and/or the public. Other than in cases involving section 2 patients, the decision of the tribunal may determine the patient's fate for several months ahead. Therefore the concern for the MHRT is to provide a speedy, fair and effective means by which detained patients may challenge the need for restrictions upon their liberty. Indeed, the circumstances of some cases may necessitate a longer period in order to prepare for a hearing[27].

Despite expressly declining to provide a definition of 'speedily', the European Court has stated that its meaning should be determined in the light of the circumstances of individual cases[28]. In this respect, observance of Strasbourg jurisprudence provides an indication as to what may *not* constitute 'speedily'. In *E v Norway*[29], a newly detained patient had to wait fifty-five days from the date of application to a decision on the legality of his detention, owing partly to the unavailability of the judge who was on holiday. This was held to constitute a breach of Article 5(4). Similarly, in the case of *Van der Leer v The Netherlands*[30] the Court held that a delay of five months in obtaining a hearing was unacceptable[31], in particular focusing on the fact that there had been a one-month

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[23] *De Wilde, Ooms and Verp v Belgium (1971) 1 EHRR 373 at para 76*

[24] *Shiesser v Switzerland [1979] 2 EHRR 417 at 425*

[25] *Megyeri v Germany (1993) 15 EHRR 584 at para 22*

[26] *Luberti v Italy (1982) app. no. 9019/80 at para 69*

[27] *R (On the Application of C) v MHRT, London South and South West Region [2001] EWCA Civ 1110*

[28] *Sanchez-Reisse v Switzerland (1987) 9 EHRR 71, at para 55*

[29] *(1990) 17 EHRR 30*

[30] *(1990) EHRR 567*

[31] *See also Koendjiharie v Netherlands (1990) 13 EHRR 820 EctHR.*

period of adjournment without good reason. However, as illustrated by the case of *Cottingham v UK*[32], where delay is caused through requests for an adjournment, this will not constitute a breach of Article 5(4).

Although not concerned with delay, the routine practice of listing *all* section 3 hearings eight weeks after the date of application was successfully challenged as constituting an infringement of the right to a 'speedy' hearing under Article 5(4). The Court of Appeal in *R (On the Application of C) v MHRT London South and South West Region*[33] held that this practice was unlawful, was bred of administrative convenience and failed to conform with the requirement that individual applications are heard as soon as is reasonably practicable. Their Lordships confirmed that whether there has been a breach of Article 5(4) is to be determined with regard to the particular circumstances of the individual case, although it should be practicable, in the ordinary case, for such hearings to take place *within* eight weeks of the application[34].

It is abundantly clear that Article 5(4) will not be breached by *isolated* cases in which reviews are heard after the date upon which they could in practice have been accommodated. This point was emphasised by Burnton J, who stated that in any sensibly managed judicial system there are bound to be adjournments and cancelled hearings for a number of reasons, for example, the illness of a judge, witness unavailability or earlier hearings over-running. Also, the need to accommodate urgent hearings of section 2 applications in preference to section 3 applications/references, listing difficulties caused by withdrawn applications and the fact that hearings are held at the patient's place of detention (rather than in a central location), provide relevant considerations as to why hearings need to be delayed or cancelled.

But as the present case demonstrates, by no means are these delays isolated, but sadly are typical of the situation of MHRTs. As the judge found, the cancellation of section 3 hearings in order to accommodate section 2 hearings is commonplace, principally because of a lack of sufficient tribunals, rendering a lack of flexibility in the system to accommodate urgent cases without disrupting the hearings of less urgent cases. Nevertheless, despite being given priority, nor has it always been possible to hear section 2 cases within the statutory limit.

Therefore, the question of whether the incidence of delay might constitute a breach of Article 5(4) pivots on several issues. As Trowler notes, the tendency of the European Court has been to find that there has been a breach of Convention rights where there is no good reason for a delay, particularly when owing to administrative failings[35]. Furthermore, from the jurisprudence of the European Court, it appears that had the backlog of cases been both recent and exceptional, combined with prompt remedial action by the State, this would possibly have been sufficient in the circumstances to avoid a breach of Article 5(4)[36].

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[32] *[1999] EHRLR 530 EctHR*

[33] *See note 27 above.*

[34] *See further, Trowler, R. (2001) 'MHRT Target Hearing Times and the ECHR' Journal of Mental Health Law, pp. 93–100.*

[35] *Ibid, pp. 96 and 100 (Rebecca Trowler's casenote provides a detailed consideration of the case law relating to this area).*

[36] *In the context of an Article 5(4) case, see note 31 above.*

But delay (and under-funding) has *long* been a feature of the operation of the MHRT as evident from the following passage:

> “There is a clear and urgent need for substantially increased resources to be put into the operation of the tribunal system if the issue of delay is to be tackled effectively and the general quality of the service to patients is not to be significantly compromised. This is not a novel observation, having been made by the MHAC as long ago as its Report for 1985–87.”[37]

Scrutinising Causes of Delay

At the heart of the problem lies a history of under-funding, large workloads and recruitment difficulties. But questions relating to the level of public expenditure have traditionally been approached as being a matter of political opinion[38], reserved for policy makers rather than judges[39]. Therefore, the central question is, to what extent is the court able to scrutinise the way the government organises the MHRT system?

Reference was made to the cases of *Buchholz v Federal Republic of Germany*[40] and *Zimmermann and Steiner v Switzerland*[41], both involving the allocation of resources to a court system. Undoubtedly this is an area in which a judge would be regarded as competent to hold a view as to appropriate allocation. Although MHRTs are distinctive from the ordinary court system, in that not only are legal experts involved but also medical personnel, Burnton J noted that when issues are raised under either Articles 5 or 6 (guarantee of a speedy hearing or a hearing within a reasonable time) the Court may be required to assess both the adequacy of resources, as well as the effectiveness of administration. Nevertheless, the judge noted that within the confines of a two-day hearing, the court was “ill-equipped” to determine general questions concerning the efficiency of administration, the sufficiency of staff levels and the adequacy of resources. He therefore adopted the approach taken by the European Court, ostensibly, that where such delays are, on the face of it, inconsistent with the requirement of a speedy hearing, the onus is on the State to excuse the delay. A failure to excuse the delay will establish a breach of article 5(4).[42]

The judge was quite clear that the principal cause of cancellation and delay was the shortage of tribunal members, in particular, medical members, accounting for 76 per cent of all MHRT cancellations. Where consultant psychiatrists are in short supply and therefore difficult to recruit, combined with unattractive pay for MHRT duties and a reduction of the retirement age from 70 to 65[43], the judge considered that the State had not taken appropriate action to ensure that tribunals were adequately staffed. In addition, the judge identified that delays owing to the staff shortages

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[37] *Barlett, P. and Sandland, R. (2000) Mental Health Law Policy and Practice, London: Blackstone Press, p. 271*

[38] *R v Secretary of State for the Environment, ex parte Hammersmith & Fulham London Borough Council & Ors [1991] 1 AC 521*

[39] *See for example, R v Cambridge Health Authority, ex parte B [1995] 1 WLR 898; X (Minors) v Bedfordshire County Council [1995] 2 AC 633*

[40] *(1980) 3 EHRR 597 – The European Court found that the delays in hearings did not exceed a reasonable time under Article 6(1) as the backlog of cases was found to be both recent and exceptional and the Government had demonstrated that it was fully conscious of their responsibilities.*

[41] *(1983) 6 EHRR 17 – by contrast to the above case, the European Court viewed the measures adopted by the Swiss Government as insufficient, thereby constituting a breach of Article 6(1). Of particular interest, the Swiss Government had relied upon the fact that the applicants’ cases had to be delayed to give priority to more urgent cases.*

[42] *See note 31 above; Musial v Poland (2001) 31 EHRR 29*

[43] *However, it should be noted that in June 2001 the Lord Chancellor reverted to 70 years as the age of retirement.*

and lack of training, were exacerbated by the pressure of large workloads and lack of IT provision. He stated that these shortages were the responsibility of the Secretary of State for Health and that the State must "establish such tribunals or courts, and provide such resources, as will provide speedy hearings."[44]

The judge considered that the proportion of ineffective applications was very high, due to discharge by the RMO prior to the hearing date, a change of mind by the patient, a deterioration in the condition of the patient, a realisation that the application is hopeless, or indeed the making of a fresh application that may hold greater prospect of success. He suggested that while the tribunal system must cope with considerable uncertainty and a large increase in applications, the significant increase has been experienced year on year for some time. The judge was, however, quick to separate responsibility from those in the Tribunal Service, whom he stated, were working under considerable pressure and "doing all they can with the resources available to them"[45]. In this respect, the State was responsible and should have taken the likelihood of continuing increases in applications into account, in deciding on the allocation of resources to Tribunals.

The shortage of medical members is confirmed in the Department of Health's *Mental Health Review Tribunal Report, April 1999 to March 2001*[46], which highlights that the recent retirement, and impending retirement of doctors in the tribunal service presents a significant cause for concern. Limited medical membership, coupled with a national shortage of consultant psychiatrists has unquestionably generated "serious delays" in the Tribunal service[47]; but these ongoing difficulties, exacerbated by a continuing rise in applications, indicate that delay may remain a feature of the MHRT landscape for the foreseeable future. The Report states that these difficulties have led to the Lord Chancellor's agreement to a "special" recruitment exercise which will require newly appointed Medical Members to sit for double the number of days permitted in a normal contract. Despite these measures and an increase in the pay rates for Medical Tribunal Members, the response to the advertised appointment is described in the Report as "poor".[48]

Who will this affect?

The overarching question to be addressed is who will be in a position to challenge delays in their hearings in the future? Of significance, it is now clear that a patient whose case is regarded as unmeritorious cannot be deprived of his right to a speedy review, and nor will it excuse an infringement of his right under Article 5(4).[49]

Some are critical of this apparent "privileging" noting that detained patients are free of any analogous restrictions to those under the Civil Procedure Rules 1998 and that the authorities can hardly be expected to run the system any faster without excluding "a huge number of applications at the outset."[50] This is a relevant consideration, particularly where the MHRTs are under immense pressure and failing to provide the volume of hearings demanded of them. But, as demonstrated by the different wording of Article 5 ("shall be decided speedily") and Article 6 ("within a reasonable time") a clear distinction has been drawn between patients with mental health problems

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[44] *See above note 3, at para 112*

[45] *See above note 3, at para 113*

[46] *Department of Health (2002) Mental Health Review Tribunal Report April 1999 to March 2001, London: DoH*

[47] *Ibid, at p. 5.*

[48] *Ibid, at p. 13.*

[49] *See above note 3, para 31.*

[50] *English, R. (2002) Lawtel Human Rights Bulletin, (16) 30/04/02 – 3/5/02, p. 3*

and other litigants, reflecting the need for increased vigilance (and additional safeguards) when dealing with individuals regarded as particularly vulnerable.

But will this lead to thousands of patients successfully claiming damages as a result of the delay in their hearings as the UK media has suggested?[51] The judge noted that almost 27,000 compulsory admissions were made in 2000/2001. Nevertheless, as Hewitt suggests, the actual number of patients who will be in a position to claim damages will be limited by a number of factors[52]. Firstly, the problems highlighted by this case are fairly concentrated in the London region. Secondly, only patients who have experienced delays in the past twelve months will have an automatic right to make a claim owing to the restrictive limitation period under the HRA 1998. Thirdly, as MHRTs discharge few patients in practice, most of the delayed hearings would not have actually deprived patients of their liberty, but of their opportunity to seek it and therefore the recovery of damages will probably be nominal in many cases.

Conclusion

Undoubtedly, this judgment is to be welcomed, in continuing a process of strengthening the rights of those detained in psychiatric institutions. Considerable pressure has now been placed on the government to confront the issue of funding for MHRTs and in turn, it is hoped that this will lead to the improvement of the quality of service provided to patients. And significantly, in relation to the issue of allocation of resources, nor can the State hope to hide behind the veil of non-justicability in cases involving either Articles 5 or 6[53] or excuse such administrative failures through an alleged constraint of resources[54].

Some might seek to argue that any damages recovered by patients would be better spent on the Tribunal system in order to recruit more Medical Tribunal members and administrative staff. However, as Hewitt asserts, "this cannot hide the fact that many people have been deprived of rights that are held to be fundamental".[55] And for the reviewer, herein lies the substance of this case – in the event that some are being unfairly detained, access to a speedy hearing is obviously necessary to protect their right not to be deprived of their liberty.

Nevertheless, not all patients in the circumstances of repeated cancellation of hearings will be found to have suffered a breach of their rights under Article 5(4) owing both to the fluid meaning of 'speedily' and the lack of reparation available to those who experience 'isolated' delays. However, as highlighted by Trowler, the merits of such a challenge will be "improved in cases where the delay is due to administrative failings"[56]. This point is certainly confirmed by the instant case, and unfortunately, continues to provide an accurate summary of the MHRT system.

And, while for some, damages may be available it is worth considering the wider implications to such delay, which were well accepted by the judge. These might include causing distress and disappointment to the vulnerable patient, a risk of damage to his or her relationship with the psychiatrists and staff of the hospital, a loss of trust in the tribunal system and a waste of scarce resources. Compensation cannot rebuild a therapeutic relationship with clinicians or re-engender

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[51] *For example, The Guardian 'Human Rights for Psychiatric Patients', Tuesday, April 23, 2002*

[52] *Hewitt, D. (2002) 'Delays have dangerous ends: Henry IV, Pt 1 – Act III, scene ii, line 33', 172/7031 N.L.J., 694*

[53] *See earlier discussion.*

[54] *Bezicheri v Italy (1989) 12 EHRR 210*

[55] *See above note 52*

[56] *See above note 34, p 100*

trust in the mental health system. Therefore, these implications should be borne in mind not only in relation to the present operation of the MHRT, but also its future.

The Government has stated that compliance with the Human Rights Act 1998 is a central aim of its proposed reform of the Act[57]. The suggested reforms are outlined in the recently published Draft Mental Health Bill ('Draft Bill')[58], which is intended to supersede the majority of the existing Act[59]. One of the key changes involves the establishment of a new tribunal, the Mental Health Tribunal ('MHT'), which would replace the existing MHRT[60]. The new MHT will possess a wider jurisdiction, holding the power to make care and treatment orders[61] and will be required to scrutinise *all* compulsory treatment beyond twenty-eight days[62]. In addition, patients will be able to apply to the tribunal[63] for a review of the continued application of compulsory powers at any time during the initial period of formal assessment[64]. Although clearly aimed at the requirement that the lawfulness of restrictions on a patient's liberty be decided 'speedily' by a judicial body[65], this clause does not, by contrast to the White Paper, incorporate the notion of an expedited hearing[66]. Instead, the period in which Tribunals must determine such applications is to be specified in the rules made by the Lord Chancellor[67]. Other key changes include the introduction of a Mental Health Appeal Tribunal[68] to which a patient, if given leave[69], may appeal on any point of law arising from a determination made by a MHT[70].

The Draft Bill has attracted widespread concern and has been accused of being "harmful" and constituting a "breach of human rights"[71], owing to the broad criteria for compulsion and the proposals for compulsory detentions and forced treatments. Nor will the Government's plans for the Tribunal service escape criticism. The proposals clearly envisage a greatly increased role for MHTs, which will require an enlarged workforce of psychiatrists, lawyers and other personnel, bearing in mind that the former continue to prove difficult to recruit. In view of the fact that MHRTs are clearly incapable of sustaining the current level of applications, the Draft Bill in its current form raises serious questions as to the future of the Tribunal service. Without a full review of these proposals, the capability of MHTs to provide a significantly increased level of effective hearings 'speedily' is to be doubted.

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[57] *Department of Health/Home Office (2002) Mental Health Bill Consultation Document, Cm 5528–III, London: TSO at para. 2.2*

[58] *Department of Health (2002) Draft Mental Health Bill, Cm 5538-I, London: TSO.*

[59] *Part VII of the existing Act is to remain in force (Department of Health (2002) Draft Mental Health Bill Explanatory Notes Cm 5538-II, London: TSO at para 8).*

[60] *Clause 3 of the Draft Bill*

[61] *Clause 31 of the Draft Bill*

[62] *Clause 30 of the Draft Bill (other than offenders where authorisation is required by the courts, Clause 70, subsections (1) and (2)).*

[63] *Clause 28(1)(a) of the Draft Bill (or a nominated person acting on their behalf (Clause 28(1)(b)).*

[64] *Clause 28 of the Draft Bill*

[65] *DoH (2002) See note 59 above, para. 38.*

[66] *The White Paper proposed a 'fast-track procedure' under which the Tribunal hearing would take place within seven days of receipt of the application (Department of Health/Home Office (2000) Reforming the Mental Health Act, Part I: The New Legal Framework Cm 5016, London: TSO, at para. 3.42).*

[67] *Clause 29(2) of the Draft Bill*

[68] *Clause 4 of the Draft Bill*

[69] *Clause 160(6) of the Draft Mental Health Bill 2002*

[70] *Clause 160(1) of the Draft Mental Health Bill 2002*

[71] *'The Treatment of the Mentally Ill that Shames us All', The Independent on Sunday, 30 June 2002.*

Confidentiality and Patients' Rights

*Simon Foster**

R (on the application of Ann S) v Plymouth City Council and C (Interested party) [2002] EWCA Civ 388

Court of Appeal (26th March 2002) (Kennedy, Clarke and Hale LJJ)

Introduction

In this case the Court of Appeal considered the proper balance between an incapacitated patient's right to confidentiality and the right of his nearest relative (s.26 Mental Health Act 1983) to sufficient information to exercise her role effectively. The court reviewed the common law principles and applied Article 8 of the European Convention. The judgment is to some extent limited to a nearest relative case, but the principles are of much wider application.

The facts

Mrs S was the mother of C, who was born in 1974 and thus was 27 at the date of hearing. She had brought him up alone. C had learning and behavioural difficulties, which received different diagnoses, and he had attended special schools. The diagnoses on record at the relevant time were avoidant personality disorder and learning disability. His mother wanted to look after him at home with appropriate support from health and social services, including periods of respite care and appropriate treatment for his learning and behavioural difficulties. His behaviour presented problems for her, and her neighbours, when he lived at home, but these were less noticeable in other settings. As C got older, the professional view was that it would be better if he were in a stable residential environment away from home.

In February 1998 a case conference concluded that guardianship should be pursued. C's consultant, Dr Morris, reported that he would be better placed in a small caring environment separate from his mother's home, maintaining social contact between C and his mother. This was discussed with his mother, who was also told that if she and C disagreed, social services could apply to court for her to be displaced as nearest relative. She asked for time to consult with Mencap, a major learning disability organisation.

In April 1998 C was admitted to hospital under section 2 MHA 1983. A short-term residential placement was arranged while discussions about guardianship continued. Eventually an application was made to displace C's mother as nearest relative (under section 29 MHA 1983). In July 1998 the mother signed a form to say that she did not object to guardianship, on the understanding that the application to displace her would be withdrawn. C was admitted to guardianship on 14th July 1998. Guardianship was renewed in January 1999, July 1999 and July 2000 (and was renewed again during these proceedings).

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* *Principal Solicitor, Mind, London. A shorter review of this case by the author appears in the June 2002 Mind Legal Network Newsletter.*

Mrs S attended care planning meetings and received the minutes. However, she was shown none of the documentation upon which the guardianship or its renewal was based, other than very brief minutes relating to the first renewal in January 1999. At this time she had asked for access to C's files to assist with pursuing a formal complaint against social services, but this was refused. She made a complaint to the local government ombudsman but decided not to pursue it.

In March 2000 she wrote to the local authority again asking to see C's files. Her letter was countersigned by C himself. On 10th April 2000 the complaints officer replied that they did not regard C's consent as valid as he did not have the mental capacity to understand the implications of what was being asked. Since C could not consent to disclosure, 'I am afraid it is not legally possible for you to see them.'

Mrs S's solicitors wrote in July 2000, asking for access to the recommendations and reports leading to the guardianship and its renewal, and to C's social services files. The local authority solicitor replied: 'I can find no authority for me to disclose this information to Mrs S or to you as her solicitors. I find it illogical, if not ludicrous, that the nearest relative should not be entitled automatically to this information but without authority I do not see how it can be disclosed.' She agreed that the common law rules on confidentiality would apply but that she would have to seek further instructions on whether disclosure was in C's best interests.

Mrs S's solicitors renewed their request in August 2000. They pointed out that much emphasis had been put on C's wishes as to where he should live while denying his capacity to consent to disclosure. The local authority solicitor replied in October 2000 that C's doctor had confirmed that he did not have capacity to give informed consent to disclosure of his files. (The doctor confirmed this opinion in April 2001.) The solicitor agreed that the duty of confidentiality was not absolute and that the public interest in preserving confidences could be outweighed by some other public interest in disclosure. However, she did not think that sufficient reasons for disclosure existed in this case. 'Mrs S has been fully involved in the care planning process for C and is aware of al the professional opinions, the reasons for them and the reasons for all the decisions which have been made. The fact that Mrs S does not like those reasons is not, in my opinion, sufficient to outweigh this Authority's common law obligation not to disclose confidential information.' The mother's solicitors wrote again in October 2000, raising further arguments based on C's best interests and his right to family life, but the response was the same.

Mrs S's application for judicial review was lodged on 5th December 2000. The Official Solicitor was invited to act for C. An independent psychiatrist confirmed in July 2001 that C lacked capacity to consent to disclosure or to apply to a Mental Health Review Tribunal on his own behalf, so the Official Solicitor had not visited C or investigated his wishes and feelings about the present application. Shortly before the hearing the mother's solicitors wrote to clarify that their request was specifically aimed at finding out about the key decisions made by the authority which led to the guardianship and its renewal, and the evidence upon which these were based. The hearing took place in July 2001 before Maurice Kay J, with judgment reserved until September 2001. The judge dismissed Mrs. S's application. Permission to appeal was granted in October 2001.

The mother's solicitors identified two experts, a consultant psychiatrist and an independent social worker, to advise her on whether to exercise her power as nearest relative to discharge C from guardianship. They identified the records they would need to see: their lists were very similar but fell short of requiring access to the complete file.

By the time of the Court of Appeal hearing, the local authority had indicated their willingness to grant the experts such access as they might require. They would also allow the experts to decide what information to disclose to the mother in the course of giving their advice. However, they remained unwilling to disclose the information directly to the mother or her solicitors. This movement meant that the decision of the judge at first instance was not of great relevance to the issue now before the court.

The Law

Guardianship and displacement applications

The court reviewed the provisions of the Mental Health Act 1983 relating to guardianship, in particular the role of the nearest relative in relation to admission (s.11(1) & (4)) and discharge (s.23(2)). The court noted that guardianship under the 1959 Act had conferred 'all such powers as would be exercisable by them or him in relation to the patient if they or he were the father of the patient and the patient were under the age of fourteen years' (s.34(1)). By contrast, the 1983 Act restricted the guardian's powers to those which were essential to achieving its purpose. Giving or refusing consent to the disclosure of information was not among them.

Section 24 provides:

> '(1) For the purpose of advising as to the exercise by the nearest relative of a patient who is… subject to guardianship under this Part of this Act of any power to order his discharge, any registered medical practitioner authorised by or on behalf of the nearest relative of the patient may, at any reasonable time, visit the patient and examine him in private.
>
> (2) Any registered medical practitioner authorised for the purposes of subsection (1) to visit and examine a patient may require the production of and inspect any records relating to the detention or treatment of the patient in any hospital [or to any after-care services provided for the patient under section 117 below].'

Any sensible nearest relative who was unhappy about the decisions made by the professionals would seek such advice rather than rush to discharge the patient. However, funding for such independent advice might be difficult to secure. Moreover, section 24 only provides for a doctor to visit and examine the records, whereas social work judgements about guardianship might be as important if not more so; and it provides only for hospital and statutory after-care records to be seen. C was admitted briefly to hospital but under section 2 rather than section 3 so his care did not fall under section 117.

The county court has power to displace the nearest relative on the application of, among others, an approved social worker (s.29(1)) on four grounds (s.29(3)), of which the two most relevant are:

> '(c) that the nearest relative of the patient unreasonably objects to the making of… a guardianship application in respect of the patient; or
>
> (d) that the nearest relative of the patient has exercised without due regard to the welfare of the patient or the interests of the public his power to discharge the patient from… guardianship under this Part of this Act, or is likely to do so.'

The procedure for a displacement application is governed by County Court Rules, Order 49, rule 12. Rule 12(4) states:

> 'On the hearing of the application the court may accept as evidence of the facts stated therein any report made by a medical practitioner and any report made in the course of his official duties by–
>
> (a) a probation officer; or
>
> (b) an officer of a local authority or of a voluntary organisation exercising statutory functions on behalf of a local authority; or
>
> (c) an officer of a hospital authority,
>
> provided that the respondent shall be told the substance of any part of the report bearing on his fitness or conduct which the judge considers to be material for the fair determination of the application.'

By contrast, section 78(2) of the Mental Health Act 1983 (vires for mental health review tribunals) specifically allows provision to be made:

> '(h) for making available to any applicant, and to any patient in respect of whom an application is made to a tribunal, copies of any documents obtained by or furnished to the tribunal in connection with the application, and a statement of the substance of any oral information so obtained or furnished except where the tribunal considers it undesirable in the interests of the patient or for other special reasons.'

The Data Protection Act 1998

The Data Protection Act did not offer much assistance in this case. All the material requested was 'personal data', and so much of it as related to C's 'physical or mental health or condition' was 'sensitive personal data' within the meaning of section 2(e). The processing of sensitive personal data is permitted where it is necessary in order to protect the vital interests of the data subject or another person in a case where consent cannot be given by, or on behalf of, the data subject (Sch.3, para 3); or for the purpose of, or in connection with, any legal proceedings (including prospective legal proceedings) or for the purpose of obtaining legal advice, or where it is otherwise necessary for the purposes of establishing, exercising or defending legal rights (para 6); or where it is necessary for the administration of justice, or for the exercise of any functions conferred on any person by or under an enactment (para 7). It was common ground that the Data Protection Act did not prevent the local authority from disclosing the information, but that it did not require the authority to do so.

The common law and the European Convention on Human Rights

The answer to the dilemma in this case must therefore turn upon the principles of the common law and the obligations of the local authority and the court under the Human Rights Act 1998. The position of the parties could be simply stated.

Mr Alan Maclean, on behalf of the authority, started from the proposition that this was confidential information which should not be disclosed without a very good reason. However, the authority were now content for the mother to see anything which her experts considered she should see. They justified this by extension of the purpose underlying sections 24(1) & (2) of the 1983 Act.

Mr Murray Hunt, on behalf of the mother, started from the proposition that the relevant interests should be balanced against each other. However, while C's interest in preserving confidentiality was purely theoretical given his lack of capacity, the mother was entitled to the information she required in order to seek legal and professional advice upon the exercise of her functions as nearest relative. This was part and parcel of her right of access to a court both at common law and under Article 6 of the European Convention, because the local authority had made it clear that they would apply to a county court should she seek to discharge her son from guardianship against their wishes. Mr Hunt acknowledged that this right must be qualified where there was a risk that disclosure would be harmful or damaging to C's health or welfare. There was no such suggestion in this case.

Miss Weereratne, on behalf of the Official Solicitor acting for C, was mainly concerned that the court should not endorse an absolute right of any nearest relative to the disclosure of any information about a patient for which she asked. She drew a distinction between the documentation necessary to support the guardianship application and its renewal and the wider disclosure of social services files. She was however content with the disclosure to experts offered by the authority and content for the experts to disclose this material to the mother and her legal advisers.

The simple answer was that, both at common law and under the Human Rights Act, a balance had to be struck between the public and private interests in maintaining the confidentiality of this information, and the public and private interests in permitting, indeed requiring, its disclosure for certain purposes. There was no evidence from correspondence leading up to the first instance hearing that the local authority had made any attempt to strike that balance. They began from the proposition that they had no power to disclose the information at all. They no longer sought to justify that stance. The more difficult question was how that balance was now to be struck.

The judgment

Hale LJ gave the majority judgment of the court.

The common law obligation to keep a confidence was conceptually quite different from the statutory obligation to process data in accordance with the data protection principles and from the right to respect for private life enshrined in Article 8(1) of the European Convention on Human Rights, although there were overlaps. The local authority had assumed that all the material was covered by a common law obligation of confidence. They had not sought to claim any form of public interest immunity for it. Some of the material would indeed be confidential to C, for example medical reports and recommendations. Some might be confidential to other people, for example opinions shared at professionals' meetings. Some might not be confidential at all, such as straightforward descriptions of everyday life. For the sake of argument the court had assumed that most if not all of the information sought was covered by a common law obligation of confidence.

Even where information was covered by an obligation of confidence, the breadth of that obligation depended upon the circumstances: see *W v Egdell* (1990) Ch 359, per Bingham LJ at 419c. If the information had been brought into existence for certain authorised purposes, it could be disclosed for those purposes. For example, the medical reports and recommendations had to be disclosed to the applicant approved social worker and to the local authority in order for them to fulfil their statutory functions. It was scarcely a large step to include the nearest relative within that loop.

Furthermore, as Bingham LJ observed, the decided cases very clearly established that duties of confidence were not absolute but liable to be overridden where there was held to be a stronger public interest in disclosure. The first example he gave was the public interest in the administration of justice. Professional confidence had frequently to be breached in the course of litigation. Hence the basic documents upon which the guardianship was founded, the application, the medical recommendations and the renewal reports, should be placed before a court hearing an application to displace the nearest relative. They would also have to be disclosed to a mental health review tribunal hearing an application made either by C or by his mother, should she be displaced as nearest relative.

In *B (A) v B (L) (Mental Health Patient)* (1980) 1 WLR 116, this court had held it sufficient to comply with CCR Order 49 rule 12(4) if medical reports were shown to the solicitor acting for the nearest relative. However, rule 12(4) clearly imposed a minimum obligation. It might imply that the court had power to withhold other relevant information from a party to the proceedings, but it certainly did not require the court to do so. The court had to comply with the rules of natural justice, which normally required that anything relevant to the court's decision be seen by both sides to the dispute: see *Re D (Adoption Reports: Confidentiality)* (1996) AC 593, per Lord Mustill at 615. The principle might be qualified if there were competing interests sufficient to outweigh it. In particular, where the proceedings concerned the welfare of a child or a patient, it might have to yield to the need to protect that person from harm or the risk of harm. However, that person also had an interest in the fairness of the trial and in having the material properly tested in court.

Those basic principles were reinforced by Article 6 and 8 of the European Convention on Human Rights. Although the right to a fair trial in Article 6 was absolute, the content of that right was not. Hence the right to see all the documents in a case might be outweighed by other considerations, but there must be a clear and proper public objective and the limitation must be proportionate to that objective. There were proper public objectives other than the protection of a child or patient from harm, but no such objective had been put forward in this case. In general, therefore, one would expect the disclosure of all the information put before the court in proceedings under section 29 unless there was a demonstrable risk of harm to the patient or others in so doing.

In principle, the approach of a court in a section 29 application should be no less open than that of a mental health review tribunal. The Mental Health Review Tribunal Rules 1983 permitted non-disclosure of documents to the applicant or patient, but only 'on the ground that its disclosure would adversely affect the health or welfare of the patient or others' (rules 6(4) and 12(2)). If the applicant was represented by a barrister, solicitor, doctor or other suitable person the document must be disclosed to him (rule 12(3)). It would be strange indeed if the practice governing disclosure in the county court were more restrictive than that in mental health review tribunals.

It was, of course, normally for the parties to decide what evidence or information to put before the court or tribunal. Applications under section 29 have to be dealt with quickly; resort to the normal process of disclosure would be impracticable. But where the interests of children or patients were concerned the courts had traditionally taken a more inquisitorial approach. The information sought by the experts instructed by the mother was exactly the sort of information which a court might properly expect to be put before it for the purpose of determining this dispute.

What, then, should be the authority's approach at this stage, before the matter had got to court? Clearly they were right to have gone as far as they had now gone. There was an obvious public and private interest in the mother having access to the best possible expert advice before she decided whether or not to exercise her power of discharge. The professionals would be subject to the same duties of confidence as everyone else. Their advice would assist the mother in carrying out her statutory functions, but would also assist C in enabling decisions he could not make for himself to be properly scrutinised.

But should the mother and her lawyers also have access to the information sought by her experts? Mr Hunt relied on her right of access to a court, and the right of access to legal advice in order to exercise that right, contained in Article 6 of the European Convention on Human Rights and the jurisprudence of the European Court of Human Rights, particularly *Golder v United Kingdom (1975)* 1 EHRR 524. The mother had been told that if she exercised her right to discharge C an application would be made to displace her. The two were part of the same process and it was unrealistic to regard them separately. In effect the mother was placed in a position where she was likely to have to justify her decision before a court.

Against this the local authority argued, first, that the proceedings before the county court were not 'the determination of her civil rights and obligations' (Article 6(1). Her status as nearest relative was given her by statute and not by virtue of her actual relationship with the patient. Second, there was not yet, and might never be, any question of court proceedings. They would only arise if and when she decided to discharge C from guardianship, and even then it would depend on the professional judgements available to her and to the local authority at the time.

As to the first, it was plain that the common law also recognised a right of access to a court and access to legal advice for the purpose of exercising that right: see e.g. *Raymond v Honey* (1983) 1AC 1. The common law would protect the exercise of those rights irrespective of whether or not they would be classed as civil rights for the purpose of Article 6 (see *R v Secretary of State for the Home Department ex parte Saleem* (2001) 1 WLR 443). In any event, Article 6 did not prescribe or presume any particular content for civil rights, which was a matter for domestic law. Disputes between the state and the family about family relationships had long been regarded as falling within the ambit of Article 6 as well as Article 8: see e.g. *W v United Kingdom* (1977) 10 EHRR 29. Furthermore the dispute between the mother and the local authority about where C was to live might well have been resolved by way of a claim for a declaration in the Family Division as to what was in C's best interests (see e.g. *Re S (Hospital Patient: Court's Jurisdiction)* (1995) Fam 27). That would undoubtedly have fallen within Article 6. It was artificial to draw a distinction here.

In the same way it was artificial to draw a distinction between access to legal advice upon discharge and access to legal advice upon a displacement application,. The two went hand in hand. The mother could not lose her dispute with the local authority about whether or not to discharge C without also losing her status as nearest relative, and the statute gave her no power to seek reinstatement. It was also very much in C's interests for her to have that advice at the earlier stage. If she was advised not to discharge him, the litigation might be avoided altogether. If she was advised to do so, then there must at least be a case which was worth putting before a court.

The Human Rights Act 1998 introduced a further dimension in Article 8. Both the mother and C had a right to respect for their family life. Not only was the mother C's closest relative in fact as well as in law, they had lived together all his life until shortly before he was placed under guardianship. It was of course true that replacing the mother as nearest relative would not change their actual relationship. But the right to respect for family life went deeper than that: the state was not permitted to interfere with that right unless it was (1) in accordance with the law, (2) in pursuit of a legitimate aim, and (3) proportionate to that aim. The protection of the health and welfare of a young man who was unable to make decisions for himself must be a legitimate aim for this purpose. But irrespective of Article 6, the parent also had a right under Article 8 to be involved in the decision making process: see *W v United Kingdom*, above; *McMichael v United Kingdom* (1995) 20 EHRR 205; and most recently *TP and KM v United Kingdom* (2001) 2 FCR 289, para 72:

> 'The court further recalls that whilst Article 8 contains no explicit procedural requirements, the decision-making process involved in measures of interference must be fair and such as to afford due respect to the interests safeguarded by Article 8.'

Article 8 also conferred a right to respect for private life. Adults such as C had that right as much as anyone else. Indeed, many would think it more at risk, and therefore more worthy of respect by the authorities, if, because of their mental disabilities, they were unable to protect it for themselves. But both his and his mother's right to respect for their family life under Article 8, and the mother's right to a fair trial under Article 6, would constitute legitimate aims of interference with C's right to respect for his private life, provided as always that the interference was proportionate.

Hence both the common law and the Convention required that a balance be struck between the various interests involved. C's interests in protecting the confidentiality of personal information about himself must not be underestimated. It was all too easy for professionals and parents to regard children and incapacitated adults as having no independent interests of their own: objects rather than subjects. But the court was not concerned with the publication of information to the whole wide world. There was a clear distinction between disclosure to the media with a view to publication to all and sundry and disclosure in confidence to those with a proper interest in having the information in question. The court was concerned only with the latter. It would be different if C had the capacity to give or withhold consent to the disclosure: any objection from him would have to be weighed in the balance against the other interests, though as *W v Egdell* showed it would not be decisive. C also had an interest in being protected from a risk of harm to his health or welfare which would stem from disclosure; but it was important not to confuse a possible risk of harm to his health or welfare from being discharged from guardianship with a possible risk of harm from disclosing the information sought. As *Re D* showed, he also had an interest in decisions about his future being properly informed.

The balance would not lead in every case to the disclosure of all the information a relative might possibly want, still less to a fishing exercise amongst the local authority's files. But in most cases it would lead to the disclosure of the basic statutory guardianship information. In this case it must also lead to the particular disclosure sought.

Her Ladyship therefore granted disclosure of the information required by the experts instructed by the mother to those experts and to the mother and her legal advisers.

Clarke LJ concurred.

Kennedy LJ delivered a minority judgment. Mr Hunt, for the mother, had said that if she exercised her right to discharge C an application would be made to displace her, the two were linked, and she needed to have proper access to legal advice before she set the process in action. It needed to be recognised that in reality any application to displace the mother could only succeed if it could be shown that she had acted irresponsibly; in other words that she had sought his discharge against the advice of her own expert advisers, who were being given access to all of the material they considered to be relevant, which was in fact all of the material she now wanted to see. He did not accept that the mother could not lose her dispute with the local authority without losing her status as nearest relative. It all depended on whether, in the opinion of the court, she had acted irresponsibly in seeking his discharge.

His Lordship accepted and endorsed what Hale LJ had said as to Article 8, respect for family life, and about the need to find legitimate reasons for interfering with the right of a disadvantaged adult to have respect for his family life. It was precisely because he wished to safeguard that right so far as possible and for as long as possible without doing injustice to the mother that he would not at this stage be prepared to order disclosure of the material to anyone other than her expert advisers.

Appeal allowed with costs.

Comment:

This lengthy judgment usefully reviews the common law in relation to disclosure. To some extent it repeats and summarises the analysis in *W v Egdell*. However, it goes beyond *Egdell* in two respects. First, it explores the interrelationship between the common law and the European Convention. (Those who prepare court submissions should note that, once again, the Court of Appeal makes plain its preference to base its decision upon common law principles, using the Convention in support rather than as the lead.)

Second, the court seems to attach far higher importance to the subject's interest in preserving confidentiality than was apparent in *Egdell*. Hale LJ makes it plain that there must be very strong reasons for disclosure without informed consent, and even then it is to be limited to reports which would have been placed before a court; Social Services files are expressly not made available. Moreover, disclosure is expressly for the purpose of seeking legal advice prior to accessing a court, and not for wider circulation: such limited disclosure follows the principles applied in the European Court of Human Rights (see for example *Z v Finland* (1997) 25 EHRR 371).

Kennedy LJ goes further: he would not allow any disclosure to the mother at this stage, nor to her legal team, but only to her medical and social work advisers. It may be said that this implies a mistrust of the mother; on the face of it, however, it is reinforcing the high duty of confidence required on behalf of C himself.

This approach, while no doubt deriving in part from Hale LJ's personal interest in learning disability issues, also demonstrates a shift in attitude over the last ten years towards greater autonomy and self-determination of those with learning disabilities. It is a welcome counterbalance to the Government's deplorable drive towards requiring information-sharing without consent (see for example section 60 of the Health and Social Care Act 2001 and the consultation section of the draft Mental Health Bill). This is ostensibly for the benefit of the subject or the public, but (to this author at least) shows a lack of the respect for vulnerable adults which the court is so determined to uphold in the present case.

It should be remembered, however, that unlike C, the subject in *Egdell* was believed to be dangerous. While we may hope that judicial attitudes have generally become more enlightened since that case, it remains to be seen whether the court will be so keen to preserve confidentiality in a case where the individual lacking capacity is believed to be a risk to others.

Finally, it is interesting that in a judgment 19 pages long, the Data Protection Act 1998 merits a single paragraph. This is because, as Hale LJ explains, the Act added nothing to the argument. It is often assumed that the Data Protection Act has superseded the common law, so that its provisions are all that count. However, as is apparent throughout the guidance issued by the Information Commissioner[1], the Act simply regulates how disclosure should take place, not when. In particular, processing of data must be ‘lawful’ under common law and statutory principles before the Act is engaged. Moreover, it provides a power to disclose, not a duty.

One point in the judgment may need slight correction. Hale LJ refers to the provision permitting disclosure of sensitive personal data ‘in order to protect the *vital interests* of the data subject or another person, in a case where consent cannot be given by or on behalf of the data subject…’ (Schedule 3 of the Act). However, this is misleading. The Information Commissioner ‘considers that reliance on this condition may only be claimed where the processing is necessary for matters of life and death, for example the disclosure of a data subject’s medical history … after a serious road accident’[2]. In other words, it does not permit the routine disclosure of confidential information to family members simply because the patient lacks capacity to consent to it – still less where she or he has capacity but refuses consent, unless there is a risk to others. On the other hand, the Information Commissioner does not make the law; and in the instant case disclosure can still be justified under one of the other grounds in Schedule 3 to the Act.

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[1] *See ‘The Data Protection Act 1998- legal guidance’ (Information Commissioner, December 2001)*

[2] *Op cit, page 13, paragraph 2*