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The International Journal of Mental Health and Capacity Law is a peer reviewed open access journal devoted to the intersection between law, mental health and mental capacity. It builds on the well-reputed Journal of Mental Health Law, with a revised name to reflect its wider focus. It also follows the desire of its predecessor to combine academic articles and commentary with material that is designed to be used by practitioners – lawyers, and medical or social work professionals – in these nuanced areas.

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Submissions must be original, properly reference any third party material and comply with any copyright limitations. Any possible conflicts of interest must be identified. If an article reflects original research involving human participants, a statement is required that relevant ethical requirements have been met, including an indication as to which body gave ethical approval for the research and the relevant reference number.

All submissions will be peer-reviewed by a double blind peer review process before being accepted for publication; naturally, there will be a process whereby an article may be accepted subject to minor or more major amendments being made. We will endeavour to provide feedback as to why any rejected submission has been rejected.

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Articles and pieces in this issue have been edited by:
Kris Gledhill, Piers Gooding, Giles Newton-Howes, Kevin Stone, Penny Weller and Darius Whelan

EDITORIAL

This latest issue of the International Journal of Mental Health and Capacity Law has a commentary, two articles and a book review, but reflects a wide range of topics and jurisdictions. We open with a commentary in the form of advocacy by a number of authors, led by Lisa Brophy, calling for a review of the use of Community Treatment Orders in Australia. They outline their concern that the current position reflects a breach of the UN Convention on the Rights of Persons with Disabilities. We close with a book review by Eimear Muir-Cochrane of an edited collection on the use of restrictive practices in health care, which also includes a focus on the CRPD. This illustrates how the Convention provides a central framework for rights-compliance in the context of mental health and mental capacity law.

The first article, by Peter Beazley and Charlotte Emmett, seeks to provide a review of the approach adopted in various legal settings to the issue of malingering, the feigning of mental disorder. It appears that this is a somewhat under-researched area, and we would be happy to receive further articles that supplement what the authors have set out, which has a focus on England and Wales. The second article has a focus on another important practical area, namely the control of access to the courts by those against whom compulsory powers have been used in the form of a requirement to obtain leave: this provides a catch for lawyers, but also a hurdle for litigants. Urania Chiu examines this in the context of the legal system in Hong Kong, examining whether it can be justified.

All these pieces provide food for thought, and we are grateful to the authors, editors and peer reviewers. One thing I would like to add is that two members of our editorial team are co-authors of the commentary piece: naturally, they were not involved in the editorial and peer reviewing process for that piece. Thanks are also due to the staff at Northumbria University Newcastle who take the final steps in the open access publishing process.

Kris Gledhill
(for the editorial team for this issue: Kris Gledhill, Piers Gooding, Giles Newton-Howes, Kevin Stone, Penny Weller and Darius Whelan have worked on at least one of the items published)

THE URGENT NEED TO REVIEW THE USE OF CTOS AND COMPLIANCE WITH THE UNCRPD ACROSS AUSTRALIAN JURISDICTIONS

Lisa Brophy, Vrinda Edan, Steve Kisely, Sharon Lawn, Edwina Light, Chris Maylea, Giles Newton-Howes, Christopher James Ryan, Penelope June Weller, Tessa-May Zirnsak*

In every Australian jurisdiction, legislation permits mental health service providers and/or mental health tribunals to force people with mental illness to engage in treatment, under Community Treatment Orders (CTOs). Despite considerable efforts made by every Australian state and territory to meet human rights obligations under the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (2008; Maylea & Hirsch, 2017), Australia has rates of CTO usage that are very high by world standards (Light, 2019). Even within Australia, rates of CTO usage vary considerably between and within jurisdictions in spite of the legislation being very similar (Light, 2019; Adult mental health quarterly KPI report, 2019). This occurs in the context of mixed evidence about the efficacy of CTOs and a lack of clear understanding of their purpose (Segal et al., 2017; Kisely et al., 2017). The use of CTOs remains one of the most contentious issues in mental health service delivery. Not only is their efficacy unresolved, they also raise serious ethical and human rights concerns. The current debates, and attempts at reform, must be informed by valid and reliable data. This brief commentary will make the case for a research agenda that addresses the minimal research that has been undertaken to address the variations of CTO use across Australian jurisdictions.

The use of coercion in psychiatric treatment is controversial especially when it extends to people deemed well enough to be living in the community where it becomes much more difficult to justify the adverse effects on human rights (Newton-Howes & Ryan, 2017). Many of these human rights are set out by the CRPD. The introduction of the CRPD marked a radical shift in the international human rights landscape (Maylea & Hirsch, 2017). The CRPD provided the first legally binding international framework setting out the rights of people with disabilities, challenging the mental health field, in Australia and internationally, to engage in a more robust examination of forced treatment (Szmukler, Daw, & Callard, 2014). Under the CRPD, forced treatment of mental illness jeopardises several human rights, such as the right to equality before the law (Article 12); the right to liberty (Article 14) and the right not to be subjected to medical treatment without consent (Article 15). With Australia having ratified the CRPD, Australian State and Territory governments ought to respond to the obligations

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of the Convention to promote and uphold the rights of persons with disabilities, including those with 'mental impairments' (McSherry, 2014; McSherry & Waddington, 2017). Debates about the use of forced treatment of people well enough to live in the community are complex, encompassing clinical, social, policy-based, legal, philosophical and ethical concerns (Brophy & McDermott, 2003; O'Reilly, 2004; Dawson, 2005; Pridham et al., 2018; Brophy et al., 2018). While most human rights are not considered absolute, any limitations must be reasonable and justifiable.

If human rights are to be limited in providing mental health care, one would hope it is a) to apply an intervention underpinned by reliable evidence of efficacy and b) as a last resort. The evidence on forced community treatment is at best mixed. Segal and colleagues analysed data from the Australian state of Victoria and found that for individuals at risk of long-term psychiatric hospitalisation, the use of CTOs appeared to prevent additional hospitalisation and they therefore argue that CTOs provide a less restrictive alternative to hospitalisation (Segal & Burgess, 2009; Segal et al., 2017). By contrast, a Cochrane review (a systematic review of primary research in health care and health policy) by Kisely and colleagues found no evidence from randomised controlled trials (RCTs) that CTOs reduced health service use or improved social functioning, mental state, quality of life or satisfaction with care (Kisely et al., 2017). Although RCTs in relation to CTOs have been both criticised (Segal, 2017) and defended (Swartz & Swanson, 2017; Burns et al., 2017), non-randomised studies from outside of Victoria also by Kisely, found similar non-significant results when compared with appropriately matched controls (Kisely et al., 2005; Kisely et al., 2004; Kisely et al., 2020a). These findings have been confirmed in meta-analyses of other controlled non-randomised studies from Australia (Kisely et al., 2020a) and elsewhere (Barnett et al., 2018).

Work conducted by Kisely and colleagues highlights the possibility that forced community treatment may be applied to minority populations in an inequitable and possibly discriminatory manner. Recent research in the Australian states of Western Australia and Queensland indicated that the likelihood of forced treatment was increased by cultural and linguistically diverse (CALD) status (Kisely et al, 2018; 2020a). This was confirmed in a subsequent meta-analysis (Kisely et al 2020b). The likelihood of forced treatment in Queensland nearly tripled in cases where an interpreter was required (Moss et al, 2019). There is also evidence that forced community treatment disproportionately affects Indigenous Australians in Queensland (Kisely et al, 2020a), though not in Western Australia or the state of Victoria (Kisely et al, 2020b), and evidence from other jurisdictions is lacking.

Even if CTOs do provide some benefit, it may be because they act as an 'administrative mechanism which signals to community health services that these patients should have priority access to their care' (Newton-Howes & Ryan, 2017, p. 312) so that individuals on CTOs gain better access to, and engagement with, services (Kisely et al., 2017; Light et al 2016). Limiting human rights to remedy service system failures has been called 'Kafkaesque' (Newton-Howes & Ryan, 2017, p. 312), but this insurance policy approach to the use of CTOs persists.

The CRPD (Article 1) sets out general obligations placed upon all States Parties, including: 'to adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention'. Having high quality data on who is subjected to forced treatment, and on what grounds, is essential to ensure the nation is progressing towards fulfilling the 'administrative and other measures' component of its human rights obligations. Australia lacks this knowledge, despite having rates of CTO usage that are very high by world standards (Light, 2019) and rising (Rains et al 2019).

Echoing other sources (Burns & Dawson, 2009; Lawton-Smith, 2005; Light et al., 2012; O'Brien, 2014) data from the Australian Institute of Health and Welfare (2016) indicate that there are significant differences in how forced treatment is applied to people with mental health conditions between Australian jurisdictions. In 2014-15, rates per 100,000 ranged from 3.0 per cent in Western Australia to 14.6 per cent in Victoria, and 23.7 per cent in Queensland. Considerable variations within jurisdictions have also been reported (Adult mental health quarterly KPI report, 2019). For example, in Victoria, it is estimated that more than 25% of consumers of community mental health services are on CTOs at any given time (Light et al., 2012b), but this can vary depending on the service. A recent report (Adult mental health quarterly KPI report 2018-19) found that across Melbourne (Victoria's capital city) CTO rates can vary between 27% of mental health consumers at one service and 11% at another nearby service. The same report also presents the large differences in the use of CTOs between urban and rural services, where rates can be as low as 5%. The driving factors underpinning this variance remain unclear. The variance suggests that the implementation of CTOs is complex with multiple factors–including law, policy, practice, service culture and stigma–all playing a role.

Light and colleagues (2012) point out that CTOs are an 'invisible' element of mental health policy and thus the economic, social and human rights costs of forced community treatment are largely unknown. People subject to such orders are potentially marginalised and the transparency and accountability of the system for making and overseeing CTOs may be limited. People subject to CTOs are likely to miss out on essential safeguards, such as access to independent advocates (Weller et al. 2019). Despite recent revisions of mental health acts in Australian jurisdictions, Lawn and colleagues (2015, p. 14) declare that '[c]urrent Australian mental health legislation appears to focus on the process of imposing CTOs, with little accountability for what workers, services and patients do during the CTO period'.

It is essential to uncover whether the differences in justifications for CTO use are related to variations in laws, practices, or system funding and organisation. Gathering and analysing the demographic data as to who is placed on CTOs and gathering feedback from those with severe mental health conditions, their families, carers and supporters and mental health practitioners will help explain why such discrepancies exist. The National Mental Health Commission (2015) conducted a National Review of Mental Health Programmes and Services that found mental health services in Australia were fragmented and delivered within a complex system, with some confusion of responsibilities between state and federal health systems. For example, there are youth mental health agencies that provide similar services in Victoria, resulting in

confusion for professionals when making a referral. It is therefore unclear whether CTOs are being used to ensure access to services that would otherwise be unavailable to those with severe mental health conditions. There is a need for research to remedy this lack of knowledge and provide an understanding of the needs of those currently being placed on CTOs. Having high quality data on who is subjected to forced community treatment, and on what grounds, is a national and international health and human rights priority. It is knowledge that is likely to be of significant value to mental health service providers and may be used in the future to improve models of health care targeting people with severe mental illness. It will also benefit ongoing reforms to the mental health system and assist Australia to meet its obligations under the United Nations CRPD.

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MALINGERED MENTAL HEALTH: LEGAL REVIEW AND CLINICAL CHALLENGES IN ENGLISH AND WELSH LAW

PETER BEAZLEY AND CHARLOTTE EMMETT*

ABSTRACT

Malingering – the feigning of mental or physical health symptoms for external gain – is a significant problem for clinicians, the courts, and society. For clinicians working in mental health settings, it is a complex task to differentiate malingered presentations from genuine ones, with a range of potential legal and ethical questions facing the clinician who conducts this task. Yet, the malingering of mental health problems has a range of potential impacts. For the courts, malingering presents a significant threat to their basic function by acting as a significant impediment to truth. For society, malingering wastes clinical time, leaves the potential for injustice to occur in response to criminal acts, and has a significant financial burden in unwarranted civil payments. The focus of the present review is therefore to review the issue of malingering from a legal perspective, leading to a consideration of recommendations for a clinician faced with assessing a client suspected of malingering behaviour.

OVERVIEW AND STRUCTURE

The review intends to consider the legal challenges and difficulties for practitioners, including clinicians, who may be faced with the task of working with clients who may be malingering.

Part I addresses the wider clinical and legal context of malingering. To contextualise the basic problem, and the challenges that practitioners might be faced with, the article begins with a summary of two case examples, one drawn from criminal law and one from civil law (Sections B and C). The first, Mr Jones, is a fictitious example within the context of criminal law; the second, Mr A, is a real-world example demonstrating some of the issues that may occur in civil law. After considering these case examples, the article will go on to consider the realities of the assessment of malingering in clinical practice (Section D), as well as summarising the literature that addresses the question of how often malingering might be expected to be observed in various settings (Section E).

Part II then goes on to consider how malingering has been dealt with in relevant law. This review is primarily located in English and Welsh law. This section opens with a review of malingering in military law (Sections A-D), where the only specific offences of malingering in English and Welsh law can be found. Section E then begins to consider the issue of malingering in civil law, with Section F

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considering the more general issue of falsity in civil courts. Section G then begins the review of malingering in relation to criminal law, which includes consideration of key areas where malingering may be relevant in criminal cases. This includes fitness to plead (Section H), the insanity defence (Section I), diminished responsibility (Section J) and sentencing (Section K). A summary is provided in Section L.

Finally, Part III comes full circle, and having reviewed the position in law, considers again the case example of Mr Jones introduced in Part I. The review considers a range of ethical and legal questions that a practitioner working with a potentially malingering client might face, particularly one subject to detention. These include issues around provision of treatment (Section A), informed consent (Section B), the point at which remittal to prison might occur (Section C), how a practitioner might assess capacity (Section D), and to what extent the practitioner is obliged and/or permitted to share professional reports with a court expressing a view about a client who they believe to be malingering (Section E).

Finally, Part IV concludes with an overall review and considerations for the future.

I. INTRODUCTION

A. The problem of malingering

Malingering is by no means a new social, legal or healthcare problem. Indeed, the Bible records the example of the as-yet unanointed King David who, escaping from Saul, 'went to Achisch king of Gath'. Afraid of Achisch's retribution after finding out David was responsible for the deaths of many of his men, David 'pretended to be insane in their presence; and while he was in their hands he acted like a madman, making marks on the doors of the gate and letting saliva run down his beard'.[1] Numerous other examples of malingering have been recorded within history, particularly within the military.[2]

The presentation of malingering, and so the legal challenges it poses, will differ depending on the context in which it is observed and the associated 'external incentive' (see definition, below). One can imagine a range of potential external incentives in the breadth of clinical practice; in forensic psychiatric services, for example, it may present as acute mental health symptoms with a function of avoiding punitive legal sanctions (see case example of Mr Jones; Box 1). In neuropsychiatric services, malingering might present as memory loss or cognitive impairment following a road-traffic accident, where the person seeks to claim compensation from an insurance company. In community health services, malingering might occur in a number of different ways, driven by a

[1] 1 Samuel 21:13 (New International Version).

[2] Ian Palmer, 'Malingering, shirking, and self-inflicted injuries in the military' in Peter Halligan, Christopher Bass, David Oakley (eds), *Malingering and illness Deception* (OUP 2003).

wide variety of external incentives: presentation of feigned psychiatric symptoms in order to obtain admission to hospital and so avoid retribution from a drugs-debt owed; presentation of anxiety or insomnia to obtain medication with potential street value, particularly hypnotics or benzodiazepines; presentation of exaggerated symptoms of trauma to obtain compensation or gain welfare benefit payments.

Clearly, the clinical presentation of malingering is as varied as clinical practice itself, and it must be noted that although the present article is primarily interested in the problem of malingering of mental health problems, it draws upon case law concerning malingering of physical illness also to inform this. It must also be noted that within clinical practice, malingering is just one example of false, exaggerated or distorted responding behaviour more generally (a topic that is itself of much interest, but beyond the specific focus of the present article), and there are many other explanations for distorted or inaccurate clinical responses that are not explained through malingering. To summarise briefly, this can include (but is not limited to) problems such as Factitious Disorder or Factitious Disorder by Proxy (previously known as Munchausen's syndrome and differentiated from malingering primarily through a core 'internal' rather than external incentive); acquiescence, social desirability and other psychological biases; suggestibility; different personality presentations (eg Histrionic personality disorder); effort (which might in turn have another cause such as low mood); other aspects of mental health problems, or even simple practical problems such as uncorrected eyesight or poor hearing. Thus, in defining the behaviour of malingering as the specific focus of the present article, the article uses the American Psychiatric Association's DSM-5 definition:

> [The] intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.[3]

B. Mr Jones

The example of Mr Jones (Box 1) illustrates some of the issues that may be involved in assessment of a client in a clinical forensic context. Although the case is a fictitious one (and so any resemblance to a real-world case coincidental), the issues and questions raised by the case would be familiar to any clinician working in forensic settings. Clinical questions that might arise for the team in reference to this case are detailed in Box 2. These are important to consider, since legal determination of Mr Jones' case will depend heavily on the clinical understanding of his presentation. Prominently, the legal context to the question of malingering in such a case is primarily that in England and Wales a s.37 Mental Health Act 1983 (MHA) disposal puts patients on a discharge pathway that is detached from the Criminal Justice System and means a determinate sentence is not imposed (A s.37 "hospital order" allows a patient,

[3] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, DSM-5* (5th Edition, American Psychiatric Association, 2013).

at the point of sentencing, and following appropriate medical opinion (s.37(2)(a)), to be directed to a specialist mental health hospital instead of serving a custodial sentence. The patient then follows a separate release regime). For a person who has committed a serious violent offence – including manslaughter – this may be an attractive outcome, since there is the potential to be 'released' within a much shorter period – possibly a handful of years - and be detained in the more pleasant surroundings of a psychiatric hospital. In Mr Jones' case, the fact he is charged with murder may lead to other potential incentives during the trial (in particular, the partial defence of diminished responsibility) as well as those open to other defendants (eg the insanity defence). Both of these defences are considered in more detail later in this document.

Box 1: The fictitious case example of Mr Jones

Mr Jones is a 34 year-old man who has just been admitted to Woodvines Medium Secure Unit. Ten weeks ago, he was arrested for the murder of his girlfriend, who was found dead at their home after neighbours reported hearing an argument and distressed noises in Mr Jones' flat. Mr Jones was arrested shortly afterwards after police officers broke down the door to the flat. He was reported to be very angry and agitated and was shouting at police officers when arrested. His girlfriend's body had over 40 stab wounds to various parts of the body and the flat was described as 'carnage'. When in police custody there were no overt signs of mental illness although he had been noted to sometimes appear quite emotionally withdrawn.

He gave a 'no comment' interview to police on the advice of his solicitor except for one point when he clearly became angry or upset and shouted 'I just wanted to teach her a lesson... I never meant to kill her'. Mr Jones was noted to have 'broken down' after this point, and his solicitor quickly requested a break in proceedings.

He was remanded to HMP Ravens Hill and remained there until admission to the secure unit. No concerns regarding his mental health were picked up during the reception interview, but it was noted that he had a history of problematic drug use, although did not require treatment for dependency upon reception. A history of depression was noted but he was not assessed as a suicide risk and was placed in an ordinary location. No unusual behavioural observations were noted by prison officers. Three weeks after his arrival at the prison, however, he requested to see a prison doctor and reported for the first time that at night time he heard a loud voice in the evenings which shouted his name and commanded him to kill. He told the doctor he had been hearing the same voice for over a year but had not told anybody. The doctor arranged for an admission to the healthcare wing of the prison. Upon admission to the healthcare wing, Mr Jones was observed to be frequently shouting (apparently to other people) in his cell and was noted as being aggressive towards nursing staff. Nursing staff describe him as paranoid and suspicious. He is prescribed medication but refuses to take it, shouting at the doctor that he is trying to kill him. Ultimately, he is assessed by psychiatrists and transferred to Brookvale Medium Secure unit under s.48/49 of the MHA.

Box 2: Questions that the clinical team will need to consider following the admission of Mr Jones to their unit

- What accounts for Mr Jones' apparent behavioural disturbance?
- Did Mr Jones have a latent or undetected psychotic presentation prior to the alleged offence?
- If he did, could this have been a partial or complete explanatory factor for his alleged actions in the offence?

- Are the presenting psychotic features genuine? (Or: are they all genuine? If malingering is detected and accounted for, is there any element of genuine mental health problem present?)
- What treatment should be given, potentially against the person's will? How will the response to that treatment be evaluated?
- Does Mr Jones have capacity to make decisions about his healthcare and treatment? (not just those issues of treatment determined under the MHA)
- How can important historical elements of the narrative be verified? (eg behavioural observations from those who knew him prior to the alleged offence)

C. Mr A

The example of Mr A (a real-world case, identified and publicised in the press, but with name removed for the present publication) is perhaps more common and less complex than that of Mr Jones, but would still pose a challenging assessment for any practitioner. The case also illustrates the potential relevance of malingering within civil law. The issues in Mr A's case are by no means unique: one could draw upon many similar stories from the pages of the tabloid press.

Most cases like that of Mr A are dealt with by the lower courts and are not appealed, thus one must rely on journalistic reporting to gain an understanding of events. In Mr A's case the outcomes were published in the Telegraph,[4] Daily Mail,[5] and Daily Star.[6] The reporting details how he claimed £15,000 in Employment Support Allowance and Housing Benefit, reportedly claiming he could not work because he was suffering from a 'split personality disorder'[7] as well as anxiety and depression. He was convicted after pleading guilty to 'four charges of making a false statement to obtain housing benefit and employment support allowance'. The specific statute under which he is convicted is not detailed.

Notably, whilst the journalistic reporting focused on the discrepancy between his claimed illness and photographic evidence reporting him skiing, scuba-diving, and on holiday in front of the Eiffel Tower, the case made by the Department for Work and Pensions seemed to focus on evidence that he had been working in dealing with scrap metal whilst at the same time claiming benefits that required him to be unable to work. This introduces some of the

[4] Ceila Walden, 'Our sympathy for anxiety sufferers is being exploited by the cynical' *Daily Telegraph* (London, 22nd March 2017) <https://www.telegraph.co.uk/women/life/sympathy-anxiety-sufferers-exploited-cynical/> accessed 10th March 2021.

[5] Martin Robinson, 'Around the World… on the taxpayer!' *Daily Mail* (London, 20th March 2017) <http://www.dailymail.co.uk/news/article-4330670/Holiday-snaps-shameless-father-32-benefits.html> accessed 10th March 2021.

[6] Andrew Jameson, 'Benefits cheat who sponged 15k of taxpayers' cash gets caught by posting pics on Facebook' *Daily Star* (London, 20th March 2017) <https://www.dailystar.co.uk/news/latest-news/598458/benefits-cheat-taxpayers-cash-travelling> accessed 10th March 2021.

[7] On this one must point out that 'split personality disorder' is not a recognised or established disorder in any contemporary nosology or classification of mental illness. Whether this was indeed the term used by any clinicians who may have assessed Mr A is of course unknown.

difficulties in other civil cases where demonstrating malingering, particularly of apparent mental health impairment, is legally difficult: impairment that might prevent someone working may not prevent someone from taking a holiday; a demonstration that somebody has been working whilst claiming not to be able to is a much easier contradiction to prove.

D. How is malingering assessed in Clinical Practice?

Although the present article is primarily concerned with the legal aspects of malingering, it is important to summarise at the outset the context of malingering from the position of a clinician potentially dealing with the issue. The clinical context is important as it will inevitably influence the way such evidence might be brought to bear in the courtroom.

In most cases of healthcare provision there is a common fundamental aim: identify the problem (clinicians might use frameworks such as 'diagnosis' or 'formulation' to achieve this), and provide appropriate treatment or intervention.[8] Typically, the treatment that follows rests on the way in which the underlying problem is understood. The medical law that has built up over the years assumes that medicine, and clinical practice more generally, follows this same basic pattern. Malingering violates this fundamental assumption: the person seeking help aims to emulate the symptoms of a problem; not to gain treatment or intervention for a disorder, but for some other external reason. This fundamental shift changes the legal landscape in which the clinician operates, turning the clinician's task from that of identifying the nature of a genuine complaint, to that of identifying whether or not the complaint is itself genuine.

Regardless of whether the law requires the presence of malingering to be demonstrated on the balance of probabilities, or to the criminal standard (which will depend on the nature of the proceedings themselves), the consideration or acceptance of malingering by a court requires evidence of its presence. To accuse somebody of malingering is to accuse them of lying. Whilst clinical assessment can incorporate a number of strategies to assess malingering (or indeed other forms of false responding), conclusions about this complex behaviour are rarely given in black and white terms. As will be seen, the assessment of malingering raises ethical and potentially legal questions for the clinician. This is highlighted by considering the regulations that govern the more concrete use of video surveillance (which as will be seen, is commonly used within the civil courts). Here, there is a requirement on professional investigators to be registered with the SIA (Security Industry Authority),[9] and

[8] Academy of Medical Royal Colleges, 'Common Competencies Framework for Doctors' (2010) <https://www.aomrc.org.uk/reports-guidance/common-competences-framework-doctors/> (accessed 10th March 2021); British Psychological Society, 'Good Practice Guidelines on the Use of Psychological Formulation' (2011) <https://shop.bps.org.uk/good-practice-guidelines-on-the-use-of-psychological-formulation> (accessed 10th March 2021).
[9] Private Security Industry Act 2001, s.3, Schedule 2.

the Association of British Insurers publishes guidance[10] to insurance companies to ensure their activities do not lead to legal challenge (eg by contravening the Data Protection Act,[11] or coming within the scope of the Regulation of Investigatory Powers Act).[12] Accusing somebody of lying in a legal context is never done lightly.

In this regard, one must note the process of clinical assessment in a case of potential malingering. Malingering is a 'diagnosis of exclusion', thus other clinical considerations and explanations must be considered first, and a clinician would be much more likely to focus an assessment in understanding a problem more widely, than asking, from the outset, whether a presentation is malingered or not. The process of clinical assessment of a client who may be suspected of malingering typically requires a full clinical assessment including taking a full clinical and developmental history, review of relevant records, and extensive discussions about the nature of the person's beliefs, reasoning and view of the world. If unreliable reporting is identified, the clinician may use strategies to try to understand the nature of the unreliability further, for instance by changing the order or nature of questions asked and repeating these questions at different times, asking about unlikely, unusual or extreme patterns of symptoms,[13] exploring inconsistencies within and between self-report, the report of others, and the person's behaviour, and looking for mismatches between the apparent patient's reported symptoms and those that might more typically occur.[14] In addition, clinical psychologists may well administer specific psychological tests which are either designed in their methodology to identify

[10] Association of British Insurers, 'Guidelines on the instruction and use of Private Investigators' (2014) <https://www.abi.org.uk/globalassets/sitecore/files/documents/publications/public/2014/crime/guidelines-on-the-instruction-and-use-of-private-investigators-and-tracing-agents.pdf> (accessed 10th March 2021).

[11] Data Protection Act 1998, s.55.

[12] Regulation of Investigatory Powers Act 2000, s.26-27.

[13] For instance, it is known that most people who experience visual hallucinations typically do so in colour; asking somebody who is malingering but reporting visual hallucinations whether their experience is in colour or black and white will force the person to make a choice that may reveal an unlikely pattern of experience (Philip Resnick and James Knoll, 'Faking It: How to Detect Malingered Psychosis' (2005) 4 Current Psychiatry 11). A response indicating visual hallucinations were in black and white would be unusual in genuine psychosis. However, in this case, an experienced clinician would also be aware that black and white hallucinations might occur in some cases of more organically driven psychosis (eg Charles Bonnet Syndrome, where apparent psychotic symptoms are linked to ocular impairment).

[14] Richard Rogers, *The Clinical Assessment of Malingering and Deception* (3rd Edition, The Guildford Press, 2008); Grant Iverson and Laurence Binder, 'Detecting Exaggeration and Malingering in Neuropsychological Assessment' (2000) 15 Journal of Head Trauma Rehabilitation 2; Anne Mason, Rebecca Cardell and Merry Armstrong, 'Malingering Psychosis: Guidelines for Assessment and Management' (2013) 50 Perspectives in Psychiatric Care 1; L Paul Chesterman, S Terbeck and F Vaughan, 'Malingered Psychosis' (2008) 19 The Journal of Forensic Psychiatry and Psychology 3.

malingered and other factitious presentations,[15] or which have within them scales that identify distortion, inconsistency or over-reporting of symptoms (alongside other scales that may help identify the presence of different types of mental health problems or personality types).[16] Although most clinicians would likely resist such a definition on the grounds that such tests can never assess the incentive behind detected patterns of exaggeration or distortion, these assessments are probably the closest thing to a 'malingering test'; but they are by no means infallible, and must be interpreted by a skilled clinician in the context of all the available assessment data. A particular ethical issue for clinicians who use such instruments, not directly considered in the present paper, is the challenge of protecting the validity and methodology of such assessments from being exposed in the face of requirements from courts to explain methods of assessment and, of course, the internet. This is an increasing challenge as test materials and methodologies are increasingly published, cited or reprinted in some form in publicly accessible journals.

There is very little, however, to ensure that clinicians do follow all these lines of enquiry, and very little research to suggest how successful clinicians are, in practice, in detecting malingered presentations. One risk in this regard is the fact there is surprisingly little evidence of structured quality appraisal of any clinical assessments (regardless of whether malingering is considered) that are presented to the courts.[17] Clearly, however, the situation does cause problems. One might look to the case of *BN v Secretary of State for the Home Department*[18] for an example where a psychiatrist, who did not address directly concerns that that the appellant was malingering, was subject to some judicial criticism (although this was significantly tempered from the criticism provided in the original judgment):

> [I]t was Professor Prasher who pointed out that there were three possible explanations, alone or in combination for the symptoms described and seen: medication, malingering, and genuine illness. He took steps to eliminate the first. But he never returned to the second in either report, whether to say that no view could be formed or that he had concluded, and if so why, that the symptoms were or might be genuine or not. That is

[15] For example: HA Miller, *Miller Assessment of Symptoms Test: M-FAST; Professional Manual* (PAR, 2001); Richard Rogers, K Sewell and N Gillard, *SIRS-2: Structured Interview of Reported Symptoms* (PAR, 2010); T Tombaugh, *Test of Memory Malingering: TOMM* (Pearson Clinical, 1996).

[16] For example: Theodore Millon, C Millon, R Davis and Seth Grossman, *Millon Clinical Multiaxial Inventory (MCMI-III) Manual* (Pearson/Psychcorp, 2009); L C Morey, *Personality Assessment Inventory* (PAR, 1996); J Butcher, W Dahlstrom, J Graham, A Tellegen and B Kaemmer, *Minnesota Multiphasic Personality Inventory (MMPI-II) Manual for administration and Scoring* (Minnesota University Press, 1989).

[17] One might remark that this is a much wider problem relating to all clinical assessments conducted for the courts (see for example Cathryn Rodway, Victoria Norrington-Moore, Louis Appelby and Jenny Shaw 'An examination of the quality of psychiatric reports for juvenile perpetrators of homicide' (2011) 22 The Journal of Forensic Psychiatry and Psychology 895, or EP Larkin and PJ Collins, 'Fitness to Plead and Psychiatric Reports' (1989) 29 Medicine, Science and the Law 26.

[18] *BN v Secretary of State for the Home Department* [2010] UKUT 279 (IAC).

not satisfactory.[19]

Psychologists, too, have been subject to such criticism. Simon McCarthy-Jones and Philip Resnick's 2014 article[20] raises serious concerns about practice in relation to assessment of auditory hallucinations. The article is a substantive review of the phenomenology of auditory hallucinations as expressed by people with genuine psychosis and those who are malingering. Worryingly, it cites as an example the US case of *People v Jefferson*[21] in which a court-appointed psychologist doubted the validity of the defendant's symptoms on the basis that 'schizophrenics typically described voices 'as coming from inside their head and being of either famous people or strangers or groups of people'', which was inconsistent with the defendant's reported experience. The paper points out that the assumption on which this assessment rested is countered by evidence that people with genuine psychosis do not always report the symptoms coming from inside their head, and clearly people with psychosis do hear voices of people who are known to them. Clearly there is a significant risk to justice if clinicians themselves do not have adequate knowledge of the apparent disorder they are assessing.

As can be seen, malingering is a challenging focus of any clinical assessment. However, clinical assessment is often the only option for detecting malingering in the case of fabricated mental health symptoms. Clinical assessment, too, is much more able to speak to the wider context of, and motivations behind the malingering act than other techniques such as video surveillance, which can by definition only provide an account of behaviour. This might lead to a reasonable expectation that in different court settings, where different clinical-legal questions were asked of mental health experts, there was a rigorous process of quality assurance for clinical assessments presented to the court, and perhaps some process outlining minimum standards and expectations for a clinical assessment. However, this is in general the exception rather than the norm, and clinicians typically have latitude to determine the way in which a clinical assessment should answer a legal set of instructions.

E. How common is malingering?

This is undoubtedly a difficult question to answer. In addition to the usual issues in determining the frequency of any particular index behaviour (for instance, it will depend on how the behaviour is defined and measured, and on the population considered), malingering presents the additional problem that it is logically impossible to know how many people are 'successful' in any given context.

Nonetheless, various pieces of clinical research indicate that malingering – or at

[19] ibid [44].

[20] Simon McCarthy-Jones and Philip Resnick, 'Listening to Voices: The use of phenomenology to differentiate malingered from genuine auditory verbal hallucinations' (2014) 37 International Journal of Law and Psychiatry 183.

[21] *People v Jefferson* (2004) 119 Cal App 4th, 508.

least the broader concepts of false or distorted symptom responding – is more common in clinical practice than would commonly be assumed. A brief review of some of the primary authorities in the clinical literature is summarised in Table 1, though it is acknowledged that a fuller systematic review of these authorities would be warranted. Nonetheless, if these estimates are even close to representing the true frequency of malingering within people presenting with clinical problems in the English and Welsh court system, it can clearly be concluded that the problem is under-recognised and given insufficient attention. This conclusion seems to stand in contrast with a conclusion from Jill Peay's[22] recent review of 'legal malingering' that 'the fear of legal malingering may be more powerful than its occurrence'.

Despite this, there is evidence to suggest that clinicians instructed in cases, even in settings where rates of malingering may be elevated, may only infrequently address the issue directly within their clinical assessment. Matthew Large and Olav Nielssen,[23] for instance, conducted an audit of medico-legal reports in Australian personal injury cases. The extent to which 'veracity and corroboration' was considered within each report varied depending on the position of the clinician: treating clinicians only considered the issue 21% of the time; clinicians instructed by the plaintiff considered the issue 35% of the time; clinicians instructed by the defendant considered the issue 55% of the time. Perhaps of more concern, Tess Neal and Thomas Grisso,[24] although not addressing the issue of malingering directly, asked a large sample of clinicians who had completed the court reports to provide details on specific structured assessments used in their two most recently submitted court reports. Whilst a specific assessment of memory malingering and a specific assessment of malingered mental health symptoms did feature in the 'top 10' most frequently used assessments, they were only used, on average in 3.2% and 2.8% of reports respectively.

Table 1: Summary of studies aiming to estimate prevalence of malingering or false symptom responding in various clinical samples

Author and reference	**Sample**	**Conclusions**
W Mittenberg and others 2002[25]	33,531 cases referred for neuropsychological evaluation: 6371 personal injury; 3688 disability; 1341 criminal; 22,131 medical cases	'Diagnostic impressions of probable malingering' in: 29% personal injury; 30% disability; 19% criminal; 8% medical cases

[22] Jill Peay 'Legal Malingering: a vortex of uncertainty' (2019) LSE Law, Society and Economy Working Papers 10/2019, <http://ssrn.com/abstract=3406572> accessed 11th March 2021.

[23] Matthew Large and Olav Nielsen 'An Audit of medico-legal reports prepared for claims of psychiatric injury following motor vehicle accidents' (2001) 35 Australian and New Zealand Journal of Psychiatry 535.

[24] Tess Neal and Thomas Grisso, 'Assessment Practices and Expert Judgement Methods in Forensic Psychology and Psychiatry' (2014) 41 Criminal Justice and Behaviour 12.

[25] Wiley Mittenberg and others, 'Base rates of malingering and symptom exaggeration' (2002) 24 Journal of Clinical and Experimental Neuropsychology 1094.

B Ardolf, R Denney and C Houston, 2007[26]	105 criminal defendants for neuropsychological assessment	'The combined rate of probable and definite MND was 54.3%'
D Clifford, M Byrne and C Allan, 2011[27]	154 referrals to forensic psychologists, involved in litigation.	31% of scores above cut-off on psychometric test (MMPI-II) known to be associated with malingered presentations
JL Lewis, AM Simcox and D Berry, 2002[28]	55 men undergoing pre-trial evaluations for competency to stand trial/criminal responsibility	44% scored above cut-off on measures designed to detect malingered symptoms
P Gold and C Freuh, 1999[29]	119 veterans referred for assessment of PTSD	14-22% classified as 'extreme exaggerators'
KW Greve, JS Ord, KJ Bianchini and KL Curtis, 2009[30]	508 patients referred for evaluations of chronic pain (where financial incentive is present)	20-50% depending on definition and assessments used
J Denning and R Shura, 2017[31]	74 veterans assessed for compensation in relation to mild Traumatic Brain Injury (mTBI)	33-52% of sample found to be malingering. Estimated national costs to US treasury based on malingering of mTBI symptoms of $136-$235 million/year.

Worryingly, there is evidence that the judiciary may also underestimate the frequency of malingering, and further, may overestimate the degree to which clinicians can successfully identify malingering without specific assessment.[32] One struggles to find English or Welsh authorities that have given an indication as to the judiciary's beliefs on this matter, but the Canadian authority of *Chaulk and another v R*[33] highlights this problem. Part of this judgment reviews

[26] Barry Ardolf, Robert Denney and Christi Houston, 'Base Rates of Negative Response Bias and Malingered Neurocognitive Dysfunction among Criminal Defendants Referred for Neuropsychological Evaluation' (2007) 21 The Clinical Neuropsychologist 899.

[27] Danielle Clifford, Mitchell Byrne and Chris Allan, 'Getting Caught in Court: Base Rates for Malingering in Australian Litigants' (2011) 11 Psychiatry, Psychology and Law 197.

[28] J L Lewis, A M Simcox and D T Berry, 'Screening for feigned psychiatric symptoms in a forensic sample by using the MMPI-2 and the Structured Inventory of Malingered Symptomatology' (2002) 14 Psychological Assessment 170.

[29] Paul Gold and Christoper Freuh, 'Compensation-Seeking and Extreme Exaggeration of Psychopathology Among Combat Veterans Evaluated for Posttraumatic Stress Disorder' (1999) 187 Journal of Nervous and Mental Disease 680.

[30] K W Greve, J S Ord, K J Bianchini and K L Curtis, 'Prevalence of Malingering in Patients With Chronic Pain Referred for Psychological Evaluation in a Medico-Legal Context' (2009) 90 Archives of Physical Medicine and Rehabilitation 1117.

[31] John Dennins and Robert Shura, 'Cost of malingering mild traumatic brain injury-related cognitive deficits during compensation and pension evaluations in the veterans benefits administration' (2017) 15 Applied Neuropsychology 1.

[32] Malingering is not necessarily the only area where this is so. See for instance, Joseph Cocozza and Henry Steadman 'Prediction in Psychiatry: An Example of Misplaced Confidence in Experts' (1978) 25 Social Problems 265, for a review of the issues in regards to assessment of 'dangerousness'.

[33] *Chaulk and Another v R* [1991] LRC (Crim) 485.

specifically the likelihood of somebody feigning mental illness gaining an insanity verdict. Drawing from other case law including *Davis v United States,*[34] the judgment of Wilson J concludes that:

> The argument is sometimes advanced that feigning insanity is easy but in fact it appears that nothing is further from the truth. As the body of scientific and diagnostic knowledge about mental illness develops and is consolidated by interdisciplinary research, the disease becomes more and more clearly defined.

From a clinical perspective, one might reasonably argue that the very opposite is true. Increasing knowledge about the complexity of mental health problems has meant, for instance, that the diagnostic frameworks which developed out of biomedical psychiatry in the 1960s are now seen as increasingly limited.[35] They may also, themselves, be a source of stigma.[36] The idea that mental health problems can be understood through a 'disease' paradigm is considered outdated.[37] The recognition of a complex interplay of biological, social and psychological factors in causation and maintenance of mental health problems is recognised in the 'biopsychosocial' paradigm. Yet, the scientific understanding of the complex web of interactions between biological factors such as genetics and life experiences (particularly early and developmental experiences) remains embryonic.[38]

In sum, the picture of malingering as being a not infrequent behaviour, particularly in groups of people who have 'something to gain', combined with the lack of explicit attention given to the issue within both legal judgments and clinical assessment, and the potential over-estimation by the judiciary and clinicians themselves of the ability to reliably detect malingering, is a toxic combination of factors, and provides impetus for the present review.

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[34] *Davis v United States*, 160 US 469 (1895).

[35] Steven Hyman, 'The Diagnosis of Mental Disorders: The Problem of Reification' (2010) 6 Annual Review of Clinical Psychology 155; S Guloksuz and J Van Os, 'The slow death of the concept of schizophrenia and the painful birth of the psychosis spectrum' (2017) 48 Psychological Medicine 229; Lee Anna Clark, W John Livesley and Leslie Morey, 'Special Feature: Personality Disorder Assessment: The Challenge of Construct Validity' (2011) 11 Journal of Personality Disorders.

[36] John Read, N Haslam, L Sayce and E Davies, 'Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach' 114 Acta Psychiatrica Scandinavica 303.

[37] Donald J Kiesley, *Beyond the Disease Model of Mental Disorders* (Praeger 1999); British Psychological Society, 'Division of Clinical Psychology Position Statement on the Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnoses: Time for a Paradigm Shift' (Division of Clinical Psychology 2013) <https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Classification%20of%20behaviour%20and%20experience%20in%20relation%20to%20functional%20psychiatric%20diagnoses.pdf> accessed 11th March 2021.

[38] Michael Rutter, 'The Interplay of Nature, Nurture, and Developmental Influences - The Challenge Ahead for Mental Health' (2002) 59 Archives of General Psychiatry 996; Kathryn A Becker-Blease, 'As the world becomes trauma–informed, work to do' (2018) 18 Journal of Trauma and Dissociation 131.

II. MALINGERING: A LEGAL REVIEW

A. Malingering as a specific Military Offence

Perhaps the most straightforward examples of malingering in law relate to the Acts of Parliament concerning members of the Armed Forces. The reasons are obvious: a government requires an effective military force to enter dangerous situations which their human instincts will drive them to avoid. Injuries which render a soldier unfit for service may in desperate times be seen as a logical option to avoid combat.

B. Historical context of Malingering in the Armed Forces

The Mutiny Acts were annually reviewed Acts first implemented in 1689, and provide some of the earliest examples in which malingering received legal attention. L White & W Hussey state the primary purpose of the Mutiny Acts 'was to legalise the existence of a standing army and the enforcement of military law by court martial with appropriate punishments for mutiny, sedition and desertion, but no other offences'.[39] However, by the time of the Marine Mutiny Act of 1830, their scope had widened, and there is a concrete example of the term 'malingering' being used in statute in the United Kingdom, perhaps for the first time. This provides that a court martial may place a custodial sentence 'with or without hard Labour... or to Corporal Punishment, not extending to life and limb' for

> [D]isgraceful Conduct in wilfully maiming or injuring himself, or any other Marine at the Instance of such Marine, with Intent to render himself or such other Marine unfit for the Service; in tampering with his Eyes; in malingering, feigning Disease, absenting himself from Hospital while under Medical Care, or other gross Violation of the Rules of any Hospital, thereby wilfully producing or aggravating Disease or Infirmity, or wilfully protracting his Cure.[40]

The context of these legal developments is noteworthy as, rather than stemming primarily from the specific need of the military to act as an effective defensive force, the need to focus on malingering actually bears striking similarity to contemporary concerns about the use of malingering within wider society in claims of fraudulent welfare payments,[41] in the form of disability pensions.[42]

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[39] L W White and W D Hussey, *Government in Great Britain, The Empire and the Commonwealth* (Cambridge University Press, 1958) 146.

[40] Marine Mutiny Act 1830, s.XI.

[41] (n 4-6).

[42] Roger Cooter, 'War and Modern Medicine' in WF Bynum and Roy Porter (eds), Companion Encyclopaedia of The History of Medicine (Volume 2, Routledge, 1993) 1536. 'During the Napoleonic Wars, it became apparent that alarming numbers of soldiers and sailors were obtaining disability pensions; indeed, in the aftermath of those wars, to the horror of the treasury, it was claimed that there were nearly as many men on such pensions as there were *in* the armed forces... Partly in response to the treasury's concerns, and partly from an interest in improving job prospects in an overcrowded profession, civilian practitioners in Britain staked

The methods used by these medical practitioners to detect malingering are worth a brief detour to consider, if only to highlight that some of the most obvious methods of detection of malingering would be highly problematic from a legal and ethical perspective today. Samuel Gross' 1861 'Manual of Military Surgery' for instance, highlights that:

> contraction of the joints, a not unfrequent source of imposition, is easily detected by the use of anaesthetics, or simply by pricking the parts suddenly with a needle, when the patient is off his guard.[43]

Similarly, the text suggests crude methodologies for detecting malingering:

> paralysis is frequently imitated, but is generally easily detected, simply by watching the patient, tickling his feet when he is asleep, or threatening him with the hot iron.[44]

The manual, unsurprisingly, does not make reference to the potential of malingering to encompass mental health problems, arguably reflecting the fact that malingered presentations will necessarily reflect the contemporary nosology of 'accepted' illness.

C. The contemporary legal position of malingering in the Armed Forces

The prohibition in military law against malingering has persisted since this time, up until the most recent Armed Forces Act 2006[45] (AFA 2006) as well as its precursor legislation (Army Act 1955,[46] Air Force Act 1955[47] and Naval Discipline Act 1957).[48] This specific statue is a broad one regulating most aspects of British military law in the Armed Forces, of which the consideration of malingering forms only a small part; the inclusion of malingering is one small part of the much bigger legislation.

The definition used in the AFA 2006 to determine whether an offence of malingering has occurred does not fully overlap with the clinical definition of malingering in DSM-5.[49] This would be an important point to note for any clinician faced with assessing malingering in the context of military law. Table 2 shows some of the main differences.[50]

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claims to expertise in the detection of malingering. Ever after, suspected malingers ('skulkers' in navy talk) were required to pit their wits against medical officers intent on their unmasking.'

[43] Samuel D Gross, *A Manual of Military Surgery* (first published 1861, Norman Publishing 1988) 162.

[44] ibid, 160.

[45] Armed Forces Act 2006, s.16 & s.345. The former section provides for an offence for the act of Malingering itself. The latter section provides for an offence of 'aiding and abetting malingering'.

[46] Army Act 1955, s.42.

[47] Air Force Act 1955, s.42.

[48] Naval Discipline Act 1957, s.27.

[49] (n 3).

[50] In addition to these differences, the definition in AFA 2006 also includes the concept of the person causing themselves an injury leading to genuine physical symptoms (Armed Forces Act

It is noteworthy, however, that the AFA 2006 explicitly includes mental health problems within the scope of potential malingered behaviour, with s.16(3) defining the scope as 'any impairment of a person's physical or mental condition'. The term 'mental condition' is not defined further, but does not appear to be the same definition of Mental Disorder as used in either the MHA,[51] or the definition of Mental Impairment used in the Mental Capacity Act.[52] Rather, the phrase echoes that used within other earlier legislation, for instance in the Law Reform (Personal Injuries) Act 1948[53] and the County Courts Act 1984.[54]

Table 2: Comparison of clinical definition of malingering in DSM-5 with that found in AFA 2006

DSM-5 definition component	**Offence in Armed Forces Act 2006, s.16**
intentional production	No mention of intentionality
false or grossly exaggerated	'False' – 'Pretends to have an injury' (s.16(1)(a)) 'Grossly Exaggerated' – not considered
Physical or psychological symptoms	s.16(3): 'any impairment of a person's physical or mental condition'
motivated by external incentives	Must be motivated by a desire 'to avoid service' (s.16(1))

D. Convictions for Malingering under the AFA 2006

A review of cases of offences of malingering under the AFA 2006 suggests that such behaviour has been rare, with three offences of malingering mentioned in

2006, s.1(b)) which is not considered within DSM-5 (at face value this might be covered within the DSM-5 concept of factitious disorder, but this requires the incentive for the malingering to be 'internal'), prolonging an injury through an 'act or omission', (Armed Forces Act 2006, s.1(c)) and 'causing another person to injure him'. (Armed Forces Act 2006, s.1(d)) All of these points seem to be relevant to feigned or induced physical illnesses/injuries, but fall outside a literal interpretation of DSM-5.

[51] Mental Health Act 1983, s.1(2).

[52] Mental Capacity Act 2005, s.2(1).

[53] Law Reform (Personal Injuries) Act 1948, s.3(1).

[54] County Courts Act 1984, s.51(5). Interestingly, but perhaps somewhat divergently to the main issue at hand, when this phrase has been interpreted within the instance of personal injury law, case-law has interpreted this phrase as seemingly requiring there to be a formal diagnostic threshold to be crossed, for instance in *Cartledge v E Jopling & Sons Ltd* [1963] AC 758, the damage had to reach a threshold 'beyond the minimal', and in *Johnston vs NEI International Combustion Limited* [2007] UKHL 39, [2008] PIQR P6, the judge, referencing *Lynch v Knight* [1861] 9 HLC 577, 598, held that 'it is accepted that a state of anxiety produced by some negligent act or omission but falling short of a clinically recognisable psychiatric illness does not constitute damage sufficient to complete a tortious cause of action'. This potentially leaves open a rather circular argument as to how attempts to identify malingered mental illness that didn't cross the artificial diagnostic threshold might be defined using this phrase, since, clearly, malingering must require the active lack of diagnosis of a genuine mental illness (or at least the lack of diagnosis of the mental illness supposedly being presented).

the court martial records of military courts between 2010-2018.[55] The first two of these cases appear to have been appealed (the most recent case, in 2018, does not, at least at the time of writing), with the appeal judgments indicating that both cases concerned acts of physical malingering (asking a friend to run over his leg;[56] asking contemporaries to break the person's arm[57]) to avoid returning to combat. In the second case, it is noted that the defendant would not have been returned to active service anyway as she 'needed to be downgraded on grounds of emotional pressure'.

Both cases brought to appeal highlight the difficulties that the courts face in dealing with malingering behaviour which is itself connected to emotional vulnerability. The second case in particular highlights the possibility that existing emotional vulnerabilities may well mean it is more likely that those in the military will look for viable options to escape military service, and hence consider malingering; or perhaps it simply highlights that more desperate attempts to avoid service are associated with less convincing attempts to malinger.

It is probable that these cases are an underestimation of the extent of malingering as a wider problem in the military. There is of course no way of determining how many people might successfully avoid combat because of malingering, but data from military healthcare records in America seems to suggest that this is a relatively common problem.[58] This might be for several reasons, but perhaps significantly because attempts to malinger are unlikely to always be dealt with by court martial in the first instance; the Commanding Officer has significant powers to deal with most aspects of military discipline, including malingering, as the need arises.

In sum, whilst the military law provides the only example of a specific offence of malingering, the contemporary application of this law provides very little in the way of guidance as to how the issue might be addressed by both legal professionals and clinicians dealing with criminal or civil cases. It does, perhaps, raise the prospect that mental health problems, or at least emotional vulnerability, may be at times causally related to somebody's decision to carry out, at least, an act of physical malingering. A wider potential overlap between genuine mental health symptoms and malingering is extraordinarily complex and under-researched. At one level one might imagine that experiential knowledge of mental health problems might in some cases provide a template

[55] HM Government (Military Court Service), 'Guidance: Court martial results from the military court centres' (*Ministry of Defence*, 8.7.2020) <https://www.gov.uk/government/publications/court-martial-results-from-the-military-court-centres> accessed 10th March 2021. The review published by the Ministry of Defence covers the period January 2010-December 2019. The relevance provisions of the Armed Forces Act 2006 came into force on 28th March 2009 (The Armed Forces Act 2006 (Commencement No. 4) Order 2009) so any cases that occurred in the latter part of 2009 would not be recorded.

[56] *R v Danny Cross* [2010] EWCA Crim 3273.

[57] *R v Kirsty Louise Capill* [2011] EWCA Crim 1472.

[58] R. Gregory Lande and Lisa Banks Williams, 'Prevalence and Characteristics of Military Malingering' [2013] 178 Military Medicine 50.

on which a client may base later malingered behaviour (though this would imply, at least some post-hoc 'insight' into the original mental health problem, since presumably one could only do this if one accepted and understood one's original experiences as being caused by a mental health difficulty). Alternatively, one might imagine a range of other potential functional links; for instance, a person with post-traumatic stress symptoms (PTSD) malingering psychotic symptoms to avoid military service, or a person with paranoia malingering hallucinations to avoid feared individuals.

E. Malingering in Civil Law: Why does it matter?

Unlike military law, the civil courts do not deal with malingering as a specific offence or legal issue. Rather, malingering in this context is primarily of concern because of its potential impact on the veracity of evidence relevant to a civil claim. In considering the seriousness by which the law views malingering, one might take as a starting point the judgment given by Moses J in *South Wales Fire and Rescue Service v Smith:*[59]

> Our system of adversarial justice depends upon openness, upon transparency and above all upon honesty. The system is seriously damaged by lying claims. It is in those circumstances that the courts have on numerous occasions sought to emphasise how serious it is for someone to make a false claim… Those who make such false claims if caught should expect to go to prison. There is no other way to underline the gravity of the conduct.[60]

A similar stance was taken by Laws LJ in the 2001 case of *Molloy v Shell UK.*[61] In agreeing to a 100% costs order against the claimant (instead of 75% allowed in the prior judgment) Laws LJ hinted he might well have liked to have gone further:

> I entertain considerable qualms as to whether, faced with manipulation of the civil justice system on so grand a scale, the court should once it knows the facts entertain the case at all save to make the dishonest claimant pay the defendant's costs.[62]

One might further this point by reflecting on the various processes of the court which aim to guard more generally against falsity. Even given the adversarial rather than inquisitorial nature of the English and Welsh legal system, truth is vital to the process of seeking 'justice' (or perhaps, more accurately, falsity is an impediment to seeking justice). For instance, one need only to consider the processes of cross-examination, taking the oath and the need for signed statements of truth in documents and statements, all of which are intended to ensure the veracity of the information presented. Malingering, where it forms part of the legal issue at hand, is therefore a direct threat to the task of any court.

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[59] *South Wales Fire and Rescue Service v Smith* [2011] EWHC 1749 (Admin), [2011] All ER (D) 39 (Oct).
[60] ibid [4]-[5].
[61] *Molloy v Shell UK Limited* [2001] EWCA Civ 1272, [2002] PIQR P7.
[62] ibid [18].

However, as will be demonstrated, a relatively uncompromising stance to malingering does not always occur in practice. For instance, one might look to the authority of *Painting v University of Oxford,*[63] in which a slightly softer stance was taken by the judge:

> Here, Mr Farmer was constrained to accept that Mrs Painting had been deliberately misleading in the course of the claim, and the fact that the exaggeration is intended and fraudulent is, to my mind, a very important element which needs to be addressed in any assessment of costs.[64]

F. Dealing with falsity, and malingering, in the civil courts

In theory, civil courts could deal with false claims, including malingering, in two broad ways: dismissal of the proceedings in part or entirety; or committal to prison for contempt of court. Furthermore, a person who malingers in any court setting in England and Wales potentially risks prosecution for perjury.[65] However, it is arguably the case that the reality of the civil court process is that very few people receive any legal sanction following malingering being detected; that claimants who do present with symptoms where malingering is questioned are generally given the benefit of the doubt; and that, in reality, there is little in law to discourage claimants from pursuing claims based on malingered symptoms. The following discussion will draw out this argument based on a review of relevant case law.

In regard to the process for striking out a case, whilst a judge in a civil case has jurisdiction to decide to strike out a case or a statement of a case either through the Civil Procedure Rules[66] or the court's inherent jurisdiction, this position was heavily restricted through the Supreme Court judgment in *Summers v Fairclough Homes Ltd.*[67] The original case, as outlined in the appeal judgment,[68] had seen the claimant bring a claim for damages of over £800,000, subsequently reduced to approximately £90,000 because undercover surveillance had demonstrated incompatibility between his claimed injury and observed physical abilities. These were separated by the original judge from some limited psychiatric injury which was felt to be genuine, and some physical injury which was accepted as genuine. Those acting for the employer claimed that the fact that the claimant had lied so significantly, demonstrated that the

[63] *Painting v University of Oxford* [2005] EWCA Civ 161, [2005] PIQR Q5.

[64] It is noted that even in this case, which solely concerned an appeal as to costs (previously the employer had been ordered to bear all of the employee's costs), and where an element of exaggeration was agreed, the judgment made an order splitting costs between the employer and employee – supporting the idea that the courts tend to prioritise evidence of any genuine component of the presentation over evidence of at least partial exaggeration of fabrication. (see also Andrew Gillett, '*Lying for Free*' (2010) 2 Fraud Intelligence 8 and Jonathan Upton, '*Lying litigants beware!*' (2010)160 New Law Journal 418).

[65] Perjury Act 1911.

[66] CPR 3A.

[67] *Summers v Fairclough Homes Ltd* [2012] UKSC 26, [2012] 1 WLR 2004.

[68] *Summers v Fairclough Homes Ltd* [2010] EWCA Civ 1300.

claim was an abuse of process, and the claim should have been struck out in its entirety. The Supreme Court agreed with the original judge and appeal judge, stating that whilst the court did have power under the Civil Procedure Rules to strike out a claim for abuse of process, this was something that should only be done in exceptional circumstances, which did not apply in the present case. This leaves a situation where on one hand, the law suggests that those who are 'caught' malingering should expect a custodial sentence, but on the other, could still receive at least partial compensation in a claim, at least in all but the most exceptional circumstances.[69]

Not all jurisdictions have taken the same approach. For instance, the Irish legislators have introduced much stricter measures in s.26(1) of the Civil Liability and Courts Act 2004.[70] This provides that a case will be dismissed if a 'plaintiff in a personal injuries action gives or adduces... evidence that (a) is false or misleading in any respect, and (b) he or she knows to be false or misleading'. Note that the wording implies an imperative to strike out a case if this test is met, with an exception being made only if 'the dismissal of the action would result in injustice being done'. This seems a reverse of the English and Welsh situation where the exception created is for striking out. Whilst a full analysis of the Irish legal situation in regard to this issue is outwith the scope of this the present article, it is important to note that this statutory provision does seem to have resulted in a practical legal position that is much less friendly to the part-malingering claimant. *Salako v O'Carroll,*[71] a case in the Irish Court of Appeal, is one instance in which the judge summarises the position at law that:

> [w]hile the defendant has pointed to a great number of occasions on which it is alleged that a false or exaggerated account and presentation of symptoms and complaints was given to consultants, it suffices in my view for her to be shown to have done so even once, since even that one occasion is sufficient to trigger the section and mandate a dismissal of the entire case.[72]

Arguably, the English and Welsh approach leads to a situation where anything less than a definitive view that all features of the apparent disorder are false leads to a judgment that gives the claimant the benefit of the doubt. This is problematic because the task of identifying malingering, or even false responding, is complicated *per se* and clinicians are unlikely to draw definitive conclusions in all but the most clear-cut cases (which, of course, are unlikely to progress far in the court system anyway).

Two cases illustrate the complexity of such issues, particularly in regard to the question of determining whether false responding is motivated by external gain (as required to demonstrate malingering). First, *Fletcher v Keatley*[73] considered

[69] David Sawtell, 'My Big Fat Fraudulent Claim' [2011] 7463 New Law Journal. This article provides a similar perspective including reviewing the *Summers v Fairclough Homes* judgment within the context of other contemporary case-law.
[70] Civil Liability and Courts Act 2004, s.26(1) (Republic of Ireland).
[71] *Salako v O'Carroll* [2013] IEHC 17.
[72] ibid [2].
[73] *Fletcher v Keatley* [2017] EWCA Civ 1540.

the problems in identifying differences between a person who presents with deliberate and unconscious reasons for exaggerated or distorted symptoms. In this case there was a difference in expert views. The appeal concerned the question of whether the original judge had been correct to only apply a partial reduction in damages (of 50%) to reflect the respondent's deliberate behaviour. The appeal was dismissed (with the appeal judges agreeing that the original decision to apply a partial reduction in damages had indeed properly accounted for the uncertainty in determining which elements of the presentation were genuine and which were exaggerated), leaving the respondent with a successful 50% claim for damages.

Second, one might consider *Ford v GKR Construction,*[74] which concerns an appeal brought against damages. This case illustrates how the introduction of an 'internal' explanation for the person's false reporting can lead to a somewhat tautological argument that becomes virtually unfalsifiable. Specifically, the original judge had been careful not to conclude that the person was malingering but that observed discrepancies between the claimant's stated injuries and her observed performance on video surveillance arranged by the defendants were due to 'by implication at least… a manifestation of the mental state to which she had been reduced as a result of her injuries'. The appeal judge considered that had the first judge concluded otherwise:

> I have little doubt that he would have taken the view that… the claimant should not be permitted to escape the consequences of the revelation… of her attempted fraud.

Courts that reason that a claimant's decision to feign or exaggerate symptoms was itself caused by the person's own vulnerability are essentially forced to find in favour of the claimant. This is problematic. Whilst one can conceptually see a clear link between malingering and underlying vulnerability in the cases of malingering in the armed forces[75] (the person is motivated by an external incentive of avoiding harm to themselves, potentially influenced by their own feelings of vulnerability or inability to cope with such potential harm), there may be a less direct or obvious relationship between vulnerability and a motive to seek financial compensation.

However, this tendency of the court to resolve a dispute in favour of the claimant where there is anything less than a unanimous and definitive view that malingering is present, is not just limited to situations where external/internal motives are in doubt. The issue arises also where an external motive may be present alongside an internal one, as well as situations where fabrication of symptoms is at least a partial explanation for the person's presentation. Three cases, which seem to highlight a potential specific difficulty in cases involving potentially malingered mental health symptoms, are highlighted presently:

First, *AXD v The Home Office.*[76] This was a case considering a claim for damages

[74] *Ford v GKR Construction* [1999] EWCA Civ 3030, [2000] 1 WLR 1397.
[75] See paragraph 9.2 onwards.
[76] *AXD v The Home Office* [2016] EWHC 1133 (QB).

as a result of unlawful detention and breach of Article 3 and Article 8 ECHR rights. A significant component of the case rested on whether or not the claimant should have been diagnosed with paranoid schizophrenia, or whether the symptoms were malingered. On this point psychiatrists gave divergent opinions. In considering a claim for breach of ECHR rights, the judge had to apply the criminal burden of proof, and concluded that he could not be satisfied beyond reasonable doubt that the client had paranoid schizophrenia. However, in considering the claim for unlawful detention at common law, the judge considered the same question on the balance of probabilities, concluding that the claimant probably did have paranoid schizophrenia, and allowing a subsequent claim to be made for substantial damages.[77] Five psychiatrists completed assessments of the claimant, with the judge's difficulty in being able to reach a definitive conclusion about the presence of mental health difficulties highlighting the difficulty in resolving such differences of opinion in practice. Notably, in this case, the psychiatric opinion was not supplemented by any psychological testing which might have provided greater clarity as to the validity of symptoms expressed.

Second, *Ali v Catton*[78] is a complex case in which the issue of quantum of compensation, following brain injuries received in a motor vehicle accident, is considered. The case considers evidence from a number of experts in relation to the injuries suffered and, for instance, the client's need for support with self-care. Concerns were expressed that the client's father had assisted the client in presenting a more exaggerated level of impairment than was the case. Alongside this evidence was the evidence of two neuropsychologists, who both conducted symptom validity tests as well as tests of cognitive impairment. There was a divergence in views as to whether the impairment observed was genuine. The judge preferred the evidence of the neuropsychologist who thought the impairment was genuine, making some criticism of the other expert witness for sticking doggedly to views that did not change in light of new evidence. However, the judge did find examples where both the claimant and the father had exaggerated disability.[79] The claimant received substantial damages. The judgment was appealed and upheld.[80]

Third, as a demonstration of a similar approach taken within the lower courts, *Maguire v Carillion Services Ltd*[81] is a noteworthy case. The claimant had experienced an occupational injury whilst at work, sustained whilst riding a glass lift. The judgment notes that a steel-framed window had somehow been opened into the inside of the lift-shaft. As the lift moved it pushed against this window causing the glass to shatter. The claimant had not suffered any gross physical injury but was ultimately admitted to the local hospital with 'shock' and diagnosed with soft-tissue injury. However, over subsequent months she gained

[77] *AXD v The Home Office* [2016] EWHC 1617 (QB).
[78] *Ali v Catton* [2013] EWHC 1730 (QB).
[79] ibid [246].
[80] *Ali v Catton* [2014] EWCA Civ 1313, [2015] PIQR Q1.
[81] *Maguire v Carillion Services Limited* (Manchester County Court, 31st March 2017).

additional diagnoses of Post-Traumatic Stress Disorder (PTSD) and Fibromyalgia. The insurance company demonstrated some apparent incompatibility between her claimed illness and her behaviour in video evidence. Expert evidence suggested that stated memory impairments (often a feature of PTSD) were exaggerated. The judge concluded that there had been 'an element of conscious subjective exaggeration', but chose not to strike out the case, citing specifically the judgment of *Fairclough Homes.*[82] An award of £133,000 was made (the original claim for damages had been for £560,000).

The one case that seems to provide an exception to this approach is the more recent case of *Pinkus v Direct Line*[83] which considered a claim for loss of earnings, and other damages, after claimed Post-Traumatic Stress Disorder following a road traffic accident. Despite there being some disagreement amongst the expert witnesses, the judge preferred the evidence of the majority view of the experts, finding that the claimant did not have Post-Traumatic Disorder, and dismissing the entire claim, including the small element of the claim that the judge noted had merit, because of fundamental dishonesty.[84] Whilst this dishonesty was significantly about the account of mental health symptoms, the judge noted a much wider pattern of dishonesty which presumably assisted in forming this view.

It must be stated that it does not seem to be the case that the courts are unable or unwilling to deliver robust judgments in responding to false reporting; as will be shown shortly, the position taken in *South Wales Fire and Rescue Service*[85] has been used in several subsequent cases as the basis for a committal proceeding to succeed. Indeed, an analysis of relevant case-law finds plenty of examples where committal to prison (or a suspended sentence) has occurred in relation to factitious *physical* health problems, typically after video evidence or objective evidence demonstrating a clear inconsistency is presented (eg. evidence the person is working when they claimed they were unable to work). These include the cases of *Homes for Haringey v Fari,*[86] *Nield v Loveday,*[87] *Kirk v Walton,*[88] *Calderdale and Huddersfield NHS Trust v Sandip Singh Atwal,*[89] and *Ajaj v Metroline West Limited.*[90]

In addition to these cases, one might note as well a number of cases where the actual accident is contrived. In such cases there is also usually feigned physical injury, which provides a basis for a fraudulent claim. These cases include *Aviva*

[82] (n 67).
[83] *Pinkus v Direct Line* [2018] EWHC 1671 (QB), [2018] PIQR P20.
[84] Criminal Justice and Courts Act 2015, s.57.
[85] (n 59).
[86] *Homes for Haringey v Fari [*2013] EWHC 757 (QB).
[87] *Nield v Loveday* [2011] EWHC 2324 (Admin), [2012] 123 BMLR 132.
[88] *Kirk v Walton* [2008] EWHC 1780 (QB), [2009] 1 All ER 257.
[89] *Calderdale and Huddersfield NHS Trust v Sandip Singh Atwal* [2018] EWHC 961 (QB).
[90] *Ajaj v Metroline West Limited* [2015] (UKEAT, 3rd December 2015).

Insurance Ltd v Ahmed,[91] *Liverpool Victoria Insurance Co v Bashir,*[92] *AIG Europe Limited v Parmar,*[93] *Amlin Insurance Ltd v Kapoor, EUI Limited v Damian Hawkins & Samantha Presedee-Hughes*[94] and *Havering Borough Council v Bowyer, Jones & Bowyer.*[95]

This brief review emphasises the seriousness with which the law treats false statements in the courtroom. Malingering of mental health problems is no different in its toxicity to the justice system than malingering of physical symptoms, or false claims entirely, but is clearly harder to prove. The types of evidence to do so are also limited; for instance, compared to claimed physical impairments, video evidence is inherently less *able* to demonstrate a conflict between claimed disability and observed behaviour in the case of claimed mental health impairments; one cannot demonstrate that somebody is not depressed by showing one – or several – examples of them appearing cheerful. Further, in several cases, evidence given by clinicians often seems to be in conflict. Apart from this, one might also note that in regard to contempt of court proceedings, the burden of proof is to the criminal – not the civil – standard,[96] and the proceedings must be shown to be in the public interest (for instance see *Royal & Sun Alliance v Kosky*[97] and related commentary by West[98]). Given this high bar, and the potential consequences of a judge incorrectly accusing a claimant of malingering, it is perhaps unsurprising that they shy away from doing so.

G. Malingering and Criminal Law

As noted, the act of malingering requires a specific external incentive, which in the context of criminal law is likely to relate broadly to the potential to avoid a conviction (or gain a lesser conviction) for an alleged offence, or indeed to gain a lesser or more favourable sentence post-conviction. Of course, any act of malingering is likely to be targeted to specific legal issues only as far as the malingerer is aware of those legal issues, and it is quite likely that malingering may be pursued by a defendant with a general aim of 'getting off' or 'getting a better sentence' without specific knowledge of the most effective way to go about achieving this. Nonetheless, one might broadly observe that some of the most obvious legal issues which may give rise to an 'external incentive' may include the following legal questions:

- Whether a defendant is unfit to plead

[91] *Aviva Insurance Ltd v Ahmed* [2017] EWHC 3276 (QB).
[92] *Liverpool Victoria Insurance Co v Bashir* [2012] EWHC 895 (Admin), [2012] ACD 69.
[93] *AIG Europe v Bernard Parmar* [2016] EWHC B23 (QB).
[94] *EUI Limited v Damian Hawkins & Samantha Presedee-Hughes* [2015] (Cardiff County Court, 16th June 2015).
[95] *Havering Borough Council v Bowyer, Jones & Bowyer* [2012] EWHC 2237 (Admin).
[96] *Dean v Dean* [1987] 1 FLR 517 (EWCA); *Re Bramblevale* [1970] 3 WLR 699 (EWCA).
[97] *Royal and Sun Alliance Insurance Plc vs Shirley Kosky,* [2013] EWHC 835 (QB).
[98] Richard West, 'Royal & Sun Alliance Insurance Plc v Kosky: personal injury - road traffic - civil procedure' (2013) 3 Journal of Personal Injury Law C171.

- Whether a defendant has access to the insanity defence
- Whether a defendant has access to the special partial defence of diminished responsibility in response to a charge of Murder
- When a defendant is convicted of an offence and a potential alternative sentence route is available that is more appealing to the defendant (eg a s.37/41 disposal under the MHA as opposed to a custodial sentence). Presumably this would also include situations where a community sentence (eg with a Mental Health Treatment Requirement) was considered in preference to a custodial sentence.

Of course, there are many other possibilities; malingering may be an issue that raises itself during an initial trial, or indeed it may 'develop' after the trial, potentially leading to the basis for an appeal (ie that the symptoms which the person is supposed to experience were in fact present, but not detected, during the original trial). Malingering of course may even be an issue prior to the trial, in that apparent mental health symptoms may lead a prosecutor to decide the case is not in the public interest (eg by reducing culpability).[99]

In order to consider relevant case-law, the present discussion will briefly lay out the main points of law relevant to each of these potential issues, considering the ways in which this is relevant for a malingered presentation, and will then summarise relevant cases and discuss how these issues have been resolved in practice in the courts.

H. Criminal Law: Fitness to Plead and Malingering

The current law in regard to fitness to plead has undergone review by the Law Commission,[100] which still awaits the government's response in relation to its findings.[101] This is important as any changes to the process, particularly if they lead to a claim of unfitness to plead that is easier to access, may increase the potential for malingered presentations to appear in this context.

The case law underpinning the determination of fitness to plead is found in *R v Pritchard*[102], emphasised in *R v Walls*[103] and revised in *R v M (John).*[104] At first blush, fitness to plead may appear an attractive option for a potentially malingering defendant, particularly since the outcome of this process means by default that a custodial sentence is avoided (a finding of unfitness to plead means that the defendant is subject to a 'trial of the facts',[105] with the *mens rea*

[99] Crown Prosecution Service, 'The Code for Crown Prosecutors' (CPS, October 2018), <https://www.cps.gov.uk/publication/code-crown-prosecutors)> accessed 10th March 2021, 4.14b.
[100] Law Commission, *Unfitness to Plead* (Law Com No 364).
[101] Law Commission, 'Unfitness to Plead' (Law Commission, 30th June 2016). <https://www.lawcom.gov.uk/project/unfitness-to-plead/> accessed 10th March 2021.
[102] *R v Pritchard* [1836] 7 C & P 303.
[103] *R v Walls* [2011] EWCA Crim 443, [2011] 2 Cr App R 61.
[104] *R v M (John)* [2003] EWCA Crim 3452, [2003] All ER (D) 199.
[105] Criminal Procedure (Insanity) Act (1964), s.4A.

component of the offence not being tried.[106] The only possible options following a conviction are a hospital order (with or without restrictions), a supervision order, or an absolute discharge).[107] In practice, however, it is so infrequently successfully made out[108] that it is unlikely to be a successful avenue for *any* defendant (recent estimates are that about 30 defendants are found unfit per year[109] – a tiny fraction of criminal cases where mental illness is a prominent issue).

Despite this, questions of factitious presentations, including potentially malingering, have made several appearances within case law. In all cases identified, doubt was resolved against a finding of unfitness to plead. In *R v Marcantonio*[110] the doubt related to divergence in professional views about the nature and extent of cognitive impairment. There had been some suggestion by one psychiatrist that exaggeration had occurred. In *R (Boujetiff) v Public Prosecutor's Office of Court of Appeal, Brussels, Belgium*,[111] the doubt again revolved around professional differences of opinion, with the judge preferring evidence suggesting a defendant was faking psychiatric symptoms, concluding there had been no unfitness to plead at the original trial, and dismissing the appeal. Finally, in *R v Borkan*,[112] malingering is not explicitly considered but a judge accepted psychiatric evidence 'that Mr B. was emphasising his psychological problems in the hope that he might be transferred to a psychiatric hospital'. The judge dismissed the appeal.

Given it seems unlikely that malingering behaviour will often interact with the question of fitness to plead, this therefore may be a particular subject that needs to be given explicit attention if the Law Commission's recommendations for change are adopted. Three considerations seem relevant in the context of the present discussion. First, the question of whether the test for determining fitness should be applied to the criminal or civil standard, and under which circumstances, is of relevance given the experience within the civil courts of judges giving malingering claimants the benefit of the doubt. Second, a doctoral dissertation appears to cast doubt on the validity of one of the Law Commission's published tools for assessing fitness to plead when applied to

[106] *R v M (John)* [2003] EWCA Crim 3452, [2003] All ER (D) 199; *R v Wells* [2015] EWCA Crim 2, [2015] 1 WLR 2797.

[107] Criminal Procedure (Insanity) Act, (1964), s.5(2).

[108] Indeed, rather than being an 'open target' for malingers, it is noteworthy that the current narrative around these criteria is that they lead to a situation where too few people with genuine mental illness are able to access the defence; indeed this has provided impetus for the Law Commission's review of the law (n 98), 2.60.

[109] Law Commission, 'Insanity and Automatism' (23rd July 2013) <https://www.lawcom.gov.uk/project/insanity-and-automatism/> accessed 10th March 2021; note also that this view is supported by Jill Peay in her recent article (n 22).

[110] *R v Marcantonio* [2016] EWCA Crim 14, [2016] MHLO 9.

[111] *The Queen on the Application of Boujetiff v Public Prosecutor's Office of Court of Appeal, Brussels, Belgium* [2014] EWHC 2658(Admin).

[112] *R v Borkan* [2004] EWCA Crim 1642, [2004] MHLR 216.

cases of simulated malingering.[113] Third, the case of *R v Omara*[114] provides some authority that once unfitness has been found, even if the defendant is subsequently found to be fit, there is no process by which the trial of facts and subsequent process may be avoided. Given the 'high stakes' involved in fitness to plead cases, this needs careful consideration bearing in mind the inherent fallibility within the clinical assessment process.

I. The Insanity Defence and Malingering

If a person is fit to plead and the case proceeds to trial, an insanity defence may be the next possibility for a malingering defendant to attempt to gain a more favourable outcome. The insanity defence would have particular appeal in this regard as it provides a complete defence in regard to the alleged offence. The court's disposal options are the same as for a finding of unfitness to plead.[115] The relevant two-part test drawn from the case of Daniel M'Naughten,[116] is well known, as is the more contemporary version found in *R v Sullivan.*[117]

Of relevance to the present discussion, the first part of this test focuses not on whether there is mental illness from a broad clinical perspective (though of course may be informed by this), but whether the defendant was suffering from a 'disease of the mind'. This has led to cases where a clear clinical impression of mental illness has not been viewed as meeting this limb of the test,[118] and cases where a physical disorder only, which psychiatrists have viewed as not being a mental disorder, has been viewed as meeting this limb of the test.[119] This problem has long been recognised.[120]

The second part of the test means the defendant must either not know 'the nature and quality of the act' or 'not know what he was doing was wrong'. In regard to the latter, this is to be interpreted in terms of whether the defendant was aware the act was legally wrong.[121] This part of the test may or may not be a problem for a malingering defendant, depending on the nature of presentation they feign. A person feigning a psychotic-type presentation may, for instance, make an argument that they knew the act was wrong, but believed

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[113] Maeve Wallis 'Establishing the Accuracy of the 'FTP' tool in identifying malingering' (Doctorate in Clinical Psychology Thesis, Royal Holloway, University of London, June 2016).
[114] *R v Omara* [2004] EWCA Crim 431, [2004] All ER (D) 31.
[115] Criminal Procedure (Insanity) Act 1964, s.5(2).
[116] *R v M'Naghten* [1843] 8 ER 718 (HL).
[117] *R v Sullivan* [1984] AC 156 (HL).
[118] *R v C* [2001] EWCA Crim 1251, [2001] MHLR 91; *R v MAB* [2013] EWCA Crim 3, [2013] 1 Cr App R 36; *R v Johnson* [2007] EWCA Crim 1978, [2008] Crim LR 132.
[119] *R v Hennessey* [1989] 1 WLR 287 (CA); *R v Burgess* [1991] 2 QB 92 (CA); *R v Kemp* [1957] 1 QB 399, [1956] 3 WLR 724; *Bratty v Attorney General of Northern Ireland* [1963] AC 386, [1961] 3 WLR 965.
[120] W Lindesay Neustatter, 'Psychiatric Aspects of Diminished Responsibility in Murder' (1960) 28 Medico-Legal Journal 92.
[121] *R v Windle* [1952] 2 QB 826; *R v Johnson* [2007] EWCA Crim 1978, [2008] Crim LR 132.

it was justified because of some misplaced expectation of harm.

Given its ability to provide a complete defence, the insanity defence as it stands in England and Wales may seem an attractive opportunity for a would-be malingerer; the concept of impairment as a 'disease of the mind' may well allow a more confusing or 'less perfect' picture of mental disorder to 'pass' for this part of the test. Further, although the question of insanity is determined by a judge, it must be proven only on the balance of probabilities.[122] However, in practice it seems unlikely to be a frequent opportunity for malingering, at least in its current form. The defence is rarely used, even in cases where mental illness is present,[123] and judgments have tended to take quite black and white approaches to the second limb of the test where any evidence of knowing right from wrong, or awareness of what the person was doing, means the test fails (*R v Windle*[124]; *R v Codere*[125]).

Given this, it is noted that it has not been possible to identify any cases concerning the insanity defence where malingering or exaggeration of impairment has been an explicit concern. However, again, this may become more of an issue if access to the insanity defence is widened, and may need to be balanced alongside the real potential benefits for people with mental health problems that might be obtained through widening access

J. Diminished Responsibility and Malingering

The law around diminished responsibility is a complex area outside the scope of discussion in the present text. Its relevance to the topic at hand is in the fact that somebody convicted of murder must be given a life sentence.[126]. Diminished responsibility is a special partial defence to murder, and if pleaded successfully, allows the courts the same sentencing options as if the defendant had been convicted of manslaughter. It only applies in cases where the defendant is charged with murder, however in such cases can be seen as being a potential attractive 'external incentive' for a defendant

The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness[127] provides relevant data as to how often the diminished responsibility defence is successfully argued. This suggests that of 662 'patient

[122] *Woolmington v DPP* [1935] AC 462, 481.

[123] Janet Meehan and others, 'Perpetrators of Homicide with Schizophrenia: A national Criminal Survey in England and Wales' (2006) 57 Psychiatric Services 1648. This paper reviews all homicides committed within a three-year period between April 1996 and April 1996 in England and Wales. Of the 1,594 perpetrators of homicide, 85 were reported to have schizophrenia. Of this sample 13 were found unfit to plead or not guilty by reason of insanity.

[124] *R v Windle* [1952] 2 QB 826.

[125] *R v Codere* [1916] 12 Cr App R 21.

[126] Murder (Abolition of Death Penalty) Act 1965, s.1(1).

[127] University of Manchester, 'The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20-year Review' (University of Manchester, October 2016).

homicides'[128] committed in England over a ten-year period (2004-2014), 16% ended with a disposal of manslaughter by diminished responsibility. This is in the context of 6,241 total homicide convictions (murder, manslaughter, infanticide) over the same period. Thus, perhaps 1-2% of homicides end in a disposal of manslaughter by diminished responsibility. Clearly, a lot of people with mental illness will not get access to the diminished responsibility defence. Could people without mental illness do so?

The test for diminished responsibility is laid out in s.2 of the Homicide Act 1957. This is a three-part test, requiring the defendant to suffer from an:

> [A]bnormality of mental functioning which (a) arose from a recognised medical condition; (b) substantially impaired D's ability to either understand the nature of D's conduct, form a rational judgment, or to exercise self-control; (c) provides an explanation for D's acts and omissions in doing so or being a party to the killing[129]

R v Golds[130] is important recent case-law from the Supreme Court clarifying that 'substantial impairment' means substantial in the sense 'impairment of some importance'.

A review of appeal cases concerning diminished responsibility and malingering suggests that where the issue of false reporting is raised, even equivocally, at trial, the courts tend to dismiss claims for diminished responsibility made out on appeal. To illustrate this, one might briefly reference the appeal cases of *R v Fathi,*[131] *R v Shetty,*[132] *R v Clemens,*[133] *R v Sharp,*[134] *and Yazdanparast v HM Advocate*[135] – all were rejected appeal cases where a query of false reporting had been made at the original trial.

R v Shetty[136] is worthy of specific comment to highlight somewhat curious reasoning within one of the psychiatric opinions that 'what was diagnosed as the claimant's malingering 'could well be a harbinger of future genuine mental illness".[137] This statement seems hard to understand, but perhaps was a way of conveying a concern about mental illness whilst also stressing exaggerated or theatrical components of the defendant's presentation. This may highlight, again, either the aversion of clinicians in reaching black and white conclusions about malingering, or their inability to do so based on a limited approach to the clinical assessment taken.

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[128] A patient here is defined as somebody who has had contact with Mental Health services in the preceding 12 months.
[129] Homicide Act 1957, s.2(1-1A).
[130] *R v Golds* [2016] UKSC 61, [2016] 1 WLR 5231.
[131] *R v Fathi* [2001] EWCA Crim 1028.
[132] *R v Shetty (Responsible Medical Officer) and another* [2003] EWHC 3152 (Admin), [2004] MHLR 131.
[133] *R v Clemens* [2003] EWCA Crim 2385.
[134] *R v Sharp* [2003] EWCA Crim 3870, [2004] All ER (D) 119 (Feb).
[135] *Yazdanparast v HM Advocate* [2015] HCJAC 82.
[136] (n 127).
[137] ibid [3].

Whilst appeal cases are useful in giving a flavour of how the courts deal with issues of diminished responsibility in the face of questionable mental illness, to give the issue proper discussion one has to consider first instance decisions. As an example, one might highlight one case reported in the press; *R v Kalejaiye.*[138] Initially, local journalistic reporting highlighted that the defendant had successfully convinced a jury that he had killed his mother by reason of diminished responsibility.[139] However, on sentencing almost a year later, reports from mental health professionals who had assessed the defendant in hospital, were conflicted about the validity of the symptoms being expressed.[140] The judge sentenced for manslaughter,[141] passing a custodial sentence (for life) and 'Hybrid Order' under s.45A of the MHA, noting the possibility of long-term hospital treatment being beneficial.[142] As with insanity findings, the case highlights a potential difficulty of 'undoing' a finding of diminished responsibility if subsequent evidence comes to light questioning the veracity of a defendant's presentation.[143]

On the other hand, the unreported case of *R v Fraser*[144] is notable. Reporting in the national media[145] highlighted that the defendant, who killed a sex worker, was able to successfully access a defence of diminished responsibility at trial based on clear evidence of psychosis. However, the report highlights that prior to this, he had not received psychiatric help because the local psychiatric hospital had believed he was malingering to gain accommodation. Clearly, 'getting it wrong' has the potential for serious implications, whichever way the error occurs.

K. Malingering and sentencing

Out of all of the ways in which malingering may be of use to a defendant in a criminal trial, the sentencing process is perhaps the most obvious and most likely to be successful. s.157 of the Criminal Justice Act 2003 requires that 'in

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[138] *R v Kelajaiye* (Chelmsford Crown Court, 15th April 2015).

[139] Basildon Echo, 'Man Found Guilty of Killing his Mum' *Basildon Echo* (Essex, 18th April 2014) <http://www.echo-news.co.uk/news/11157637.Man_found_guilty_of_killing_his_mum/> accessed 10th March 2021.

[140] Basildon Echo, 'Conflicting Views of Mental State of Son who killed his mum' (Essex, 15 April 2015) <http://www.echo-news.co.uk/news/12889108.Conflicting_views_on_mental_state_of_son_who_killed_his_mum/> accessed 10th March 2021.

[141] Basildon Echo, 'Wickford Man Starts Life Sentence for Killing His Mum' (Essex, 19th June 2015) <http://www.echo-news.co.uk/news/13343629.Wickford_man_starts_life_sentence_for_killing_his_mum/> accessed 10th March 2021.

[142] Mental Health Act 1983, s.45A.

[143] Although in this case at least there was little practical difference in outcome following the successful diminished responsibility finding; the defendant still received a life sentence.

[144] *R v Fraser* (Central Criminal Court, 19th December 2014).

[145] BBC News, `*Robert Fraser Detained over Sex Workers Death'* <http://www.bbc.co.uk/news/uk-england-london-30553670> accessed 10th March 2021.

any case where the offender is or appears to be mentally disordered, the court must obtain and consider a medical report before passing a custodial sentence other than one fixed by law'.[146] The court is then required to consider the contents of such a report including 'the likely effect of such a sentence on that condition and on any treatment that may be available for it'.[147] This process provides a significant opportunity for a malingering defendant.

As noted earlier, one of the most obvious 'external incentives' for malingering might be to gain a Hospital Order disposal[148] instead of a custodial sentence. The ability to gain a Hospital Order, has, however, been reduced somewhat by the judgment in *R v Vowles*[149] which has required clinicians and judges to take a more rigorous approach to assessing the links between the mental disorder and offending behaviour.[150] Nonetheless, several cases can be drawn upon to illustrate the issues the courts have faced when considering the issue of malingering in this context:

R v Ahmed[151] was an appeal against sentence following claims that the defendant had been suffering from schizophrenia at the time of sentencing, and so should have received a Hospital Order disposal rather than an indeterminate custodial sentence. Psychiatric opinion from the hospital which had treated him under s.47 of the MHA broadly supported the appropriateness of a Hospital Order, suggesting the Mental Illness was genuine. An independent psychiatrist, however, provided evidence suggesting the defendant was malingering. The results of psychological testing, conducted by the hospital, and which supported this conclusion, were relied upon both by the psychiatrist, and by the judge in their rejection of the appeal.

R v Hussain[152] is a first-instance judgment following conviction for terrorism offences. The judge's sentencing remarks make clear he had deep suspicions about the validity of the defendant's claimed mental health experiences. In terms of the psychiatric evidence, the judge noted that during the commissioning of the offences the defendant had written to his GP claiming to suffer from a range of mental health issues including social anxiety and paranoia. The defendant had been referred to a psychiatrist but did not attend the appointments. After being arrested, the defendant revealed wide-ranging symptoms of apparent psychosis including paranoid beliefs and a need for protection through bomb-making. The defendant was admitted to hospital on remand. Whilst there he was assessed by three hospital psychiatrists and one

[146] Criminal Justice Act 2003, s.157(1).
[147] Criminal Justice Act 2003, s.157(3)(b).
[148] Mental Health Act 1983, s.37.
[149] *R v Vowles* [2015] EWCA Crim 45, [2015] WLR(D) 52.
[150] Andrew Ashworth and Ronnie Mackay, 'Case Comment - R. v Vowles (Lucinda); R. v Barnes (Carl); R. v Coleman (Danielle); R. v Odiowei (Justin Obuza); R. v Irving (David Stuart); R. v McDougall (Gordon): sentencing - guidance where an element of mental disorder exists' (2015) 7 Criminal Law Review 542.
[151] *R v Ahmed* [2013] EWCA Crim 1393, [2014] MHLR 58.
[152] *R v Zahid Hussain* (Winchester Crown Court, 9th October 2017).

independent psychiatrist. The hospital psychiatrists concluded the defendant was psychotic and recommended a hospital order. The concerns about the potential for making the wrong decision (ie providing a Hospital Order disposal to somebody malingering mental illness) are illuminated in the following excerpt summarising the position of the independent psychiatrist, Dr Joseph:

> Dr Joseph invited consideration of the fact that you were considering who to talk to on the basis that you would only engage with psychiatrists who you considered would support a hospital disposal, and that you were likely to be manipulating Dr Cumming. He expressed concern that three psychiatrists were recommending a s.37/41 disposal in the face of what may well be a malingered mental illness, but concluded that if the court is satisfied that you are currently suffering from a mental disorder the appropriate disposal is by a Direction under s.45A as the risk is too great that if you are made the subject of a s.37/41 disposal you will make a swift "recovery" so that a First Tier Tribunal has no option but to conditionally discharge you.

Ultimately, the judge, who also expressed his doubts about the genuineness of the defendant's mental health symptoms, imposed a sentence of life imprisonment (minimum term of 15 years) and concurrently a Hospital Order direction under s.45A of the MHA.

Outside of hospital orders, malingering may be an issue for sentencing in other ways. Two cases are highlighted. *R v Ali*[153] is a particularly interesting judgment, with a potential unusual function of malingering. Here, the defendant had failed to comply with an enforcement notice made under the Town and Country Planning Act 1990,[154] following his decision to partition – without permission – a single dwelling house into 12 distinct flats. A confiscation order had been made in the absence of the defendant. The defendant was in hospital at the time of the confiscation hearing, reporting that he had suffered from mental health problems. The court had unsuccessfully tried to obtain information from the hospital as to the basis of the patient's admission. The judge attached significance, however, to the fact that they had ascertained it was a voluntary readmission, not one under the MHA, and concluded that 'this was not a case where the appellant was involuntarily absent so as to make it just for the court to step in and stop proceedings'. Two of the three psychiatrists involved, including the treating psychiatrist, had felt there was an element of malingering. The appeal found the judge had not erred in the decision to make the confiscation order.

Owda v Greece[155] was a case in which the defendant appealed a decision to extradite him to Greece on charges of people trafficking. The appeal was based in part on a claim that his mental condition 'is such that it would be oppressive to extradite him within the meaning of section 25 of the 2003 Act'.[156] The judge held that although there was evidence of mental health problems (referring to

[153] *R v Ali* [2014] EWCA Crim 1658, [2015] MHLR 446.
[154] Town and Country Planning Act 1990.
[155] *Owda v Greece* [2017] EWHC 1174 (Admin).
[156] ibid [1].

depression and personality disorder as 'relatively mild') there was also evidence of malingering. The judgment indicates that this rested on the fact that the defendant had 'admitted lying to doctors which resulted in a withdrawal of a possible diagnosis of Post-Traumatic Stress Disorder'. The judge ruled the appeal failed because the problems fell 'far short of the establishing that it would be oppressive to extradite him'.[157]

Finally, whilst considering the issue of sentencing, it is worth citing the American case of *US v Geer*[158] and associated commentary.[159] The case highlights the American system which, to act as a deterrent to attempts to malinger, allows a judge to increase a sentence to account for the malingering.

L. Summary of Malingering in Criminal Law

The review of cases of malingering in the criminal courts perhaps most prominently highlights how unusual it is for a judgment to turn on the issue of malingering. Certainly, it is an important issue in some cases, but the issue is far less prominent than might be anticipated given the expected frequency of malingering in these contexts.[160] This leads one to question just how many people are 'successful' at malingering in the criminal courts. It is of course impossible to know the true answer to this question, but one suspects that courts, and clinicians, are perhaps fooled more often than they would like to think. Certainly, journalistic reports exist of people who have 'confessed' to having previously malingered.[161] Such 'admissions' might happen occasionally when the 'external incentive' no longer applies, although of course it is impossible to rule out the 'confession' is itself simply another manifestation of a person's mental illness or challenging personality.

How could the courts improve their chances of detecting malingered presentations? A few suggestions may be made. First, guidance could be produced requiring further structure of clinical assessment to address specifically the issue of malingering in all cases where mental health problems are considered. Directing clinicians to provide opinion on whether malingering or false reporting was likely in a specific case would at least force the issue to be considered by the courts. Second, whilst courts require psychiatric/medical

[157] ibid [14].

[158] *US v Greer*, 158 F 3d 228 (5th Cir 1998).

[159] James Knoll and Philip Resnick, '*US v Geer: Longer Sentences for Malingerers'* (1999) 27 Journal of American Academy of Psychiatry and the Law 621.

[160] see Table 1.

[161] Associated Press, 'Mental Patient Surprised by his Own Escape' (VC Star, November 17th 2017); Les Zaitz, 'He wasn't insane, he says – he faked it to avoid prison' (Pacific Northwest News, March 29th 2017); Anthony DeStefano, 'NY Crime Boss admits he faked mental illness' (The Baltimore Sun, 8th April 2003); Katherine Sayre, 'Mobile judge to consider release of a man accused of Capital murder from mental hospital' (The Times-Picayune, January 15th 2012); Kevin Krause, 'Family Admits to faking mental illness to steal Social Security benefits' (Dallas News, July 3rd 2017); Rha Hae-Sung, ''Schizophrenic' draft-dodger gets caught by IQ test score' (The Korea Times, 9th November 2017).

evidence in all of the above cases, there is no legal requirement for evidence from psychologists, who could provide assessments of claimants using aforementioned psychometric tests. Whilst such assessments might be unlikely to give a 'black and white' conclusion, they may significantly assist the court in reaching a better-informed decision. These changes may be of particular importance if access to any of the partial defences is widened following the Law Commission's recommendations.

Of course, these recommendations need to be seen in the context as being specific to malingering, and it may well be that wider improvement to the quality assurance of expert evidence in mental health cases would, overall, be more valuable. The issues with malingering may be symptomatic of wider issues in the use of clinical assessment and expert evidence in mental health cases. Jill Peay's recent review[162] makes the important point that the relationship between mental health problems and offending is, generally, a very complex one. From a clinician's perspective, the courts could develop a more sophisticated understanding of the relationship between mental health presentations and offending by moving away from a primary interest in the presence or absence of a diagnosis or 'medical condition', and towards a more nuanced focus on the specific symptoms, experiences and psychological characteristics of the defendant, particularly before and during the alleged offence. Some of the suggestions made above in relation to malingering may thus be relevant here also, and could therefore potentially lead to wider improvements in court processes for people who do indeed have very genuine mental health problems.

III. WHAT NEXT FOR MR JONES: HOW SHOULD CLINICIANS RESPOND TO LEGAL AND ETHICAL DILEMMAS IDENTIFIED?

The complexities of the clinician's assessment, and the potential legal issues facing the clinician, are best illustrated by returning to the case of Mr Jones. This is presented as an unfolding narrative with the specific legal questions described at each stage. Although a criminal case, many of the issues would be common to any assessment of malingering.

Upon admission to hospital, Mr Jones presents with acute behavioural disturbance, and is placed within a seclusion facility on the ward. After calming down, Mr Jones describes how he continues to feel worried about the staff on the unit, although feels better than he did in prison. He explains how he came to believe that two prison officers were actually sent by MI5 to spy on him and feed information back to the government about his movements. He gives a vague description of auditory hallucinations experienced in prison. Suddenly, during the interview, Mr Jones shouts 'shut up' and looks to the ceiling, then tells the clinicians he heard the voice again. Mr Jones explains he believes the medication in prison was poisoned intentionally by MI5 with the intent of controlling him.

[162] (n 22).

Legal issue 1: **What next for Mr Jones' treatment?** *At this point a medical decision will be necessary to decide whether to continue prescribing antipsychotic medication. As the patient is subject to Part IV of the MHA, the Responsible Clinician (RC) can do this without the patient's consent for the first three months (if the patient lacks capacity or the other parts in the relevant section apply).*[163] *However, we may imagine the RC has concerns about the validity of Mr Jones' presenting symptoms but has not yet reached a clear opinion. If Mr Jones is malingering, the prescribing clinician risks Mr Jones experiencing serious unnecessary side effects from medication, as well as potentially complicating the subsequent assessment process (medication withdrawal can paradoxically induce a genuine psychotic episode,*[164] *which would risk leading the psychiatrist to falsely conclude that the patient had indeed always had genuine psychosis). If medication is withheld, and the presentation is genuine, there is a risk of deterioration in the person's psychosis. What legal principles should the prescribing clinician draw on in deciding whether or not to prescribe the medication?*

During the same meeting, a psychologist on the ward explains to Mr Jones that they offer all patients a psychological assessment. They explain that the assessment may be used to help the Responsible Clinician understand his clinical needs better. The psychologist explains that they wish to conduct a number of psychometric tests as part of this assessment.

Legal issue 2: Informed Consent in Assessment of Malingering. *In reality, the psychologist shares the Responsible Clinician's doubts about the validity of the patient's symptoms. They do not share these doubts with the patient. Specific symptom validity testing alongside appropriate clinical assessment may help form the clinical opinion. The psychologist decides they cannot expand on the explanation of the purpose of the test beyond the general explanation already given for fear that the patient will alter his presentation to defeat the purposes of the test. How can the psychologist gain informed consent to take the test under these circumstances? Does the psychologist have to do so?*

After three and a half months of assessment, both clinicians have formed the opinion that the patient is malingering psychosis and does not have a genuine mental health condition. Both clinicians have prepared a report to this end, justifying their opinion. Amongst other observations, they highlight behaviours which show significant inconsistencies in his presentation at different time points (apparently depending on whether or not he believed he was being observed), emotional presentations that were incompatible or inconsistent with stated beliefs (eg reporting highly distressing auditory hallucinations but showing no

[163] Mental Health Act 1983, s.58(1)(b).

[164] Joanna Moncrieff, 'Does antipsychotic withdrawal provoke psychosis? Review of the literature on rapid onset psychosis (supersensitivity psychosis) and withdrawal-related relapse' (2006) 114 Acta Psychiatric Scandanavica 3.

signs of distress), and high scores on various measures designed to assess symptom validity.

Legal Issue 3: At what point should the RC transfer Mr Jones back to prison? *Do these conclusions have any implications for Mr Jones' continued status under the MHA? Are the clinicians now duty-bound to initiate a transfer back to prison now that they have formed the opinion that he is malingering?*

Legal Issue 4: How to assess capacity? *At the three-month stage, the Responsible Clinician has to make a decision whether the patient has capacity to consent to their medical treatment. If he does have capacity to consent, the RC is required to certify this. How should the RC assess the patient's capacity to consent to medical treatment given doubts about the veracity of his presentation?*

Legal Issue 5: What considerations should the clinicians have when disclosing their reports to the courts? *Should the clinicians share their reports with Mr Jones? If Mr Jones objects to the contents, can he prevent the reports from being shared with the court?*

A. Legal Issue 1: What next for Mr Jones' treatment?

One might start to answer this question by reviewing the nature of 'medical treatment' as defined in the MHA.[165] This requires that medical treatment must have a 'purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations'. This suggests that if (or in this case, once) the clinician has concluded that there is no 'disorder', it would not be possible to provide 'medical treatment'. This has a potential wider implication in terms of the third question (whether the patient should be remitted to prison) since without medical treatment, presumably there can be no detention (though the wide scope of 'medical treatment' is emphasised). Further, providing treatment to somebody judged to have no genuine disorder may also open the clinician to a range of problematic legal outcomes or challenges, which could become more serious as the risks or side effects of the treatment increased. From a criminal perspective, this might include a criminal assault charge if there is evidence of harm or injury, allegations of professional misconduct, liability for negligence, and potentially other civil charges. Ultimately, it might even be conceived that a claim under the Human Rights Act 1998 for a violation of Article 3 of the European Convention on Human Rights (ECHR),[166] concerned with the prohibition of torture, could be made, as the absence of a genuine mental health problem would make it hard to justify the 'medical necessity' of the proposed treatment.[167] Similarly, it could lead to a violation of Article 15 of the Convention on the Rights of Persons with Disabilities

[165] Mental Health Act 1983, s.145(4)

[166] Council of Europe, 'European Convention on Human Rights' (1950).

[167] *Herczegfalvy v Austria* [1992] 15 EHRR 437; *B v S* [2005] EWHC 1936 (Admin), [2005] HRLR 40.

(CRPD)[168] which prohibits 'medical or scientific experimentation' in the absence of consent. This range of adverse legal outcomes leaves the potential for a very problematic situation for a clinician who continues treatment after concluding that there was no disorder to treat, and potentially even works to lead clinicians to avoid concluding a presentation was malingered (even in the face of near clinical certainty). This leads to a more general question about 'clinician avoidance' of malingering, which is certainly a worthwhile future research topic.

How would a clinician be guided in a situation where their view on the nature of the disorder was uncertain? A fuller answer would depend on a lengthy analysis of medical ethics and decision making more generally. However, this is certainly more familiar clinical territory; clinicians have to make treatment decisions about uncertain presentations in all areas of clinical practice. One might start by exploring the general expectations placed on clinicians in guidance in dealing with clinical uncertainty. For medical doctors, guidance from the General Medical Council suggests this is ultimately a matter of clinical judgement for the doctor:

> The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options.[169]

To do this effectively would likely require the clinician to carry out a balancing act between the advantages and risks of the treatment, considering all the potential explanations for the person's apparent presentation. The response may well be different, also, depending on the level of doubt the clinician has about the veracity of the person's presentation. However, given the serious implications involved in making an incorrect judgment, the clinician would also be well advised to make clear records of their decision-making process, and to remain actively aware of the potential legal consequences of medicating somebody who may not have a relevant underlying medical condition.

There is a wider question, mostly unanswered here, about the *expectation* placed on clinicians to 'investigate', or follow up their doubts, following questions about the validity of a patient's self-reported statements. Likely, this requirement will differ significantly with context and with the potential risks of the treatment being considered. Clinicians seeing psychotic clients in forensic settings, therefore, may be expected to take much more active attempts to understand this than, for example, a General Practitioner dealing with a presentation of low mood.

B. Legal Issue 2: Informed Consent in Assessment of Malingering.

The question here is specifically whether a clinician should or must seek informed consent to conduct a clinical assessment, if the process of doing so risks potentially defeating the purpose of that assessment or test.

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[168] United Nations, 'Convention on the Rights of Persons with Disabilities (CRPD)' (2007).
[169] General Medical Council, 'Good Medical Practice (GMC, 2013) [57].

Professional guidance has tried to solve this problem by two broad approaches. Firstly, by presenting tests of 'effort' as a routine part of testing more generally, it may be argued that a clinician is not doing anything 'different' when they assess a patient they suspect of deliberately distorting their performance on a test. Secondly, by advising clinicians to warn patients that their effort may be tested, for instance by 'a general statement along the lines that the tester will assess how hard the testee is trying on the tests'.[170] However, there are problems with both of these approaches. In terms of the first, there is plenty of evidence that clinicians, in practice, do not use effort tests routinely.[171] Thus, most clinicians cannot truthfully rely on this explanation. In terms of the second, a 'general statement' that effort testing may be carried out does not specifically inform a patient that such testing would be carried out in their case, nor allow them any choice as to whether to take part in that part of the assessment. This hardly feels like informed consent in the contemporary use of the term.

The most straightforward situation for the clinician would be for a patient detained under the MHA falling under the scope of s.63. The broad definition of treatment used by the MHA[172] would clearly include any such assessment by a clinician. This would suggest that consent would not be required for such an assessment. Though the MHA Code of Practice at 24.37 indicates that consent should still be sought if practicable, the language here allows some scope for limitation. Similarly, professional practice guidelines (including recently updated guidelines for psychologists[173]) would seem to allow scope for delivery of psychological interventions, in some circumstances, if it was not possible to obtain informed consent. Further, the provisions of s.139[174] would seem to protect clinicians from any civil or criminal claim made on the basis of having conducted such an assessment to a patient detained under the Act (unless it was conducted 'in bad faith or without reasonable care'; and there is perhaps some uncertainty as to whether the decision *not* to gain consent would be considered an 'act purporting to be done' (as opposed to an omission)). However, overall, it would seem reasonable to advise the clinicians working with Mr Jones that they could proceed with the assessment without gaining informed

[170] British Psychological Society, *Assessment Of Effort in Clinical Testing of Cognitive Functioning for adults* (BPS, 2009) 12; Grant Iverson, 'Ethical Issues Associated with the Assessment of Exaggeration, Poor Effort and Malingering' (2006) 13 Applied Neuropsychology 77 similarly recommends that 'Neuropsychologists should emphasize the importance of honesty and best effort. Patients should be informed that there are methods to detect invalidity within the evaluation'.

[171] Renee McCarter, 'Effort Testing in Contemporary UK Neuropsychological Practice' (2009) 23 The Clinical Neuropsychologist 1050, states that whilst 59% of a large sample of neuropsychologists reported commonly using effort tests in legal cases, only 15% routinely used them in clinical assessments. Similar results were obtained in a New Zealand study (Suzanne Barker-Collo & Kris Fernando, 'A survey of New Zealand psychologists' practices with respect to the assessment of performance validity' (2015) 44 New Zealand Journal of Psychology 35).

[172] Mental Health Act 1983, s.145.

[173] British Psychological Society, *Practice Guidelines* (3rd Edition, BPS, August 2017).

[174] Mental Health Act 1983, s.139.

consent.

For patients who are not subject to the relevant provisions of the MHA, however, the issue becomes trickier. Broadly, the issue of informed consent for clinical practice generally is now informed by the seminal ruling of *Montgomery*[175] in the UK Supreme Court, which rejected the previous doctrines of *Bolam*[176] and *Sidaway*[177] as applying to the need to obtain consent. The ruling of *Montgomery* seems to leave the starting point that clinicians should seek informed consent for all their acts.

However, *Montgomery's* focus was primarily around the obligation to disclose *risks* of treatment to patients, and so allow the patient to make an informed decision between one treatment or another, or indeed between one treatment and no treatment. The context of the case in regard to warning of the risk of shoulder dystocia during labour is quite different to the present issue. What 'risks' apply in the current example? If the assessment goes ahead, the primary risk from the patient's perspective are the potential implications of being 'found out'.[178] However, if the assessment does not proceed, there may be other risks such as those associated with the prescription of unnecessary psychoactive medication with significant potential side effects;[179] however, of course, the clinician cannot warn of these risks without revealing to the client their concerns about the veracity of their presentation. The apparent patient, for their part, may well be unaware of the risks also.

In conclusion, the position from *Montgomery*, as well as that taken by professional practice guidelines (General Medical Council (GMC)[180] and Health and Care Professions Council[181] (HCPC)), of informed consent being a positive obligation on the practitioner may require clinicians to develop a standard form of wording which at least explains the possibility that effort, response styles and validity may be tested, and that the clinician will not be able to reveal their full clinical opinion until after completion of the assessment.

C. Legal Issue 3: At what point should the RC transfer Mr Jones back to prison?

Section 50 of the MHA deals with the remission of detained prisoners to prison. This provides for remittal if the Responsible Clinician, 'any other Approved

[175] Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 11.
[176] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
[177] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871.
[178] Presumably, the 'reasonable patient' in Montgomery would not be a 'reasonable patient who was malingering', however.
[179] (n 164).
[180] General Medical Council, 'Consent: Patients and doctors making decisions together: Good Medical Practice' (General Medical Council, 2008).
[181] Health and Care Professions Council, 'Standards of Conduct, Performance and Ethics' (HCPC, 2018).

Clinician',[182] or an 'appropriate tribunal' notify the secretary of state that the 'person no longer requires treatment in hospital for mental disorder or that no effective treatment for his disorder can be given in the hospital to which he has been removed'.[183] This would certainly seem to allow the RC to make an application to the secretary of state in the case of Mr Jones. However, would the RC be obliged to do so?

The only guidance in case law in regard to the operation of s.50 confirms that the Secretary of State is able to direct remission to prison even if mental health symptoms *are* present (the key issues being 'in hospital', 'requires' and 'effective treatment') (*R v RW,*[184] *R v Larkin*[185]).

Further guidance is available through the Department of Health's 'Good Practice Procedure Guide'[186] in relation to remission of patients under s.47 and 48. This states that:

> Once the clinical team providing treatment agrees that the criteria for detention under the Mental Health Act is no longer met or that no more treatment can be given and, where allowed under the legislative framework, remission to prison should be achieved with the minimum of delay.

Again, however, this is a guideline and does not specifically address the obligation on the practitioner. Regardless, even if no obligation exists, a failure to do so may cause wider consequences if detention continues past the point of a conclusion that the person is malingering. Specifically, a violation of Article 5 of ECHR,[187] or of Article 14 of CRPD,[188] seems a possible concern. The ECHR Article 5 Right to Liberty and Security is a qualified right allowing for the lawful detention of 'persons of unsound mind', so provided this is conducted 'in accordance with a procedure prescribed by law'. Of course, once a person is found to not be 'of unsound mind' this qualification would seemingly no longer apply. This may be less of a concern for a prisoner such as Mr Jones (another qualification allows detention of offenders) but may be a significant risk in the case of somebody detained under one of the civil sections of the MHA.

Thus, appropriate guidance to Mr Jones' RC would be that Mr Jones should be referred back to the Secretary of State for remittal to prison at the point of making a determination of malingering. In practice, if a court date was

[182] As a somewhat divergent point, this presumably leaves the position that if an Approved Clinician working alongside another patient's Responsible Clinician has cause to assess the patient and believes they are malingering, they could in theory notify the Home Office and request remittal. How a disagreement here would be dealt with is unknown.
[183] Mental Health Act 1983, s.50.
[184] *R v RW* [2012] EWHC 2082 (Admin), [2012] MHLR 288.
[185] *R v Larkin* [2012] EWHC 556 (Admin), [2012] MHLR 161.
[186] Department of Health, 'Good Practice Procedure Guide: The Transfer and Remission of Adult Prisoners under s.47 and s.48 of the Mental Health Act' (Secure Services Policy Team, DH, 2011).
[187] (n 166).
[188] (n 168).

imminent, the team may well wait until legal proceedings had concluded.

D. Legal Issue 4: How to assess capacity?

The question here fundamentally concerns the clinician's application of the diagnostic test contained within the Mental Capacity Act. If the RC believes the client's presentation is accounted for by malingering they would not meet the test for '*impairment of or disturbance in functioning of the mind or brain'.*[189]

Fortunately, this seems one of the more straightforward situations on which to give guidance. Whilst the Mental Capacity Act places obligations on the practitioner, these are generally imperatives couched in language that allows wide limitation ('duty to consider'; 'take into account'; 'so far as reasonably practical'). The test for capacity is made on the balance of probabilities.[190] Thus, whilst the clinician cannot avoid consideration of capacity, they do not have to have reached clinical certainty to draw conclusions about capacity.

This is the one question on which opinion appears more established, with the process of assessment of capacity in a case of malingering being detailed within an article by Nick Airey.[191] This paper outlines how an assessment of a bizarre clinical presentation initially concluded that the apparent patient lacked capacity, but as more evidence came to light demonstrating a fabricated presentation of symptoms, the assessment was changed. Such a process would likely occur in the case of Mr Jones.

E. Legal Issue 5: What considerations should the clinicians have when disclosing their reports to the court?

The primary issue here is whether or not the clinicians are obliged, or even permitted, to pass on their report to the courts if Mr Jones objects to disclosure. In the present case, the issue is more fundamentally about the circumstances under which a clinician can disclose any unfavourable report. Case law provides some guidance here.

R v Crozier[192] involved a case of attempted murder. The defendant had been seen by two psychiatrists prior to sentencing, both of whom had prepared reports. The psychiatrists had been instructed by the defence. The first psychiatrist indicated he did not believe the defendant to fall within the scope of the MHA. The second psychiatrist concluded that the defendant did fall within the scope of the MHA (under the previous category of Psychopathic disorder). However, the second psychiatrist arrived late at court, shortly after the judge had passed a custodial sentence. The counsel for the prosecution was made

[189] Mental Capacity Act 2005, s.2(1); presuming of course there was no other disorder or the clinician was not reasoning that the malingering was in some way caused by a disorder.
[190] Mental Capacity Act 2005, s.2(4).
[191] Nick Airey, 'Physically ill, mentally ill, or malingering? A case of impaired capacity (or probably not!)' [2017] Family Law Journal 435.
[192] *R v Crozier* [1988] 8 BMLR 128.

aware of the contents of his report. After the first doctor confirmed he now agreed with the second, the crown invited the court to vary the sentence to a s.37/41 Hospital Order with Restrictions.

The appeal was based on an argument that the second psychiatrist breached confidentiality by sharing the report with counsel for the prosecution. The judgment drew on an earlier appeal case, *W v Edgell*[193] in which a doctor had been instructed to assess a client detained at Broadmoor, with the prospect of the client being transferred to a Regional Secure Unit. Here, the report had been highly unfavourable to the client. Consequently, the solicitors chose not to use the report as evidence in a forthcoming Mental Health Review Tribunal. The client's solicitors informed the psychiatrist that they opposed him releasing the report to the Tribunal. The psychiatrist did so anyway, concerned that the report might not be put before the tribunal. The patient made a claim for damages against the psychiatrist.

This case was resolved very clearly in favour of the doctor with Bingham J writing that:

> Where a prison doctor examines a remand prisoner to determine his fitness to plead … the professional man's duty of confidence towards the subject of his examination plainly does not bar disclosure of his findings to the party at whose instance he was appointed to make his examination.

The judgment notes that in the case at hand, and indeed in the case of *Crozier*, the psychiatrist was instructed by a party other than the court. Nonetheless, in both cases it was agreed that the public interest in disclosure outweighed the patient's duty to confidentiality; in both cases the severity of the offending and associated risk was highlighted as a justification for taking this stance.

In the case of Mr Jones, therefore, both clinicians could arguably rely on this case-law to disclose the report to the court, regardless of Mr Jones' views. However, a medical doctor, under direct instruction from the court – for example in the context of the Criminal Justice Act s.157(1), may be in a slightly stronger position than a clinician who has not received such direct instructions but has completed an assessment on the patient for other purposes. A medical doctor, in the context of Mr Jones, would also often have access to a range of other multidisciplinary opinions which could also contribute towards developing their views, although a doctor in such cases may be best advised to include any reports verbatim, to avoid any potential risk of providing hearsay evidence.[194] However, s.157(3) is noteworthy here, since this does provide recognition that courts may have before them other information which relates to the defendant's mental health, which they are also obliged to consider.

[193] *W v Edgell* [1990] 1 All ER 835 (Ch).

[194] Lionel Haward, 'Hearsay and Psychological Reports' [1965] Bulletin of the British Psychological Society, 18, 21-26.

IV. SUMMARY AND CONCLUSIONS

Undoubtedly, the present review has highlighted that malingering is a thorny issue for clinicians and lawyers alike. There appears much scope for improvement in the many ways in which clinicians' skillsets are best harnessed for the courtroom environment. However, to achieve this requires change. Firstly, it requires there to be a much wider acceptance of the problem of malingering in courts and in the clinic room. Clinicians need to avoid the delusion that they will always and obviously 'catch' a malinger; courts need to avoid fuelling this belief through misplaced expectations and expect to see clinicians considering the validity of symptom presentations more routinely within clinical assessment. Courts should question clinicians generally who present clinical opinions that do not have 'sound workings' beneath them. Secondly, it requires a development of processes, and a much better reciprocal understanding between lawyers and clinicians as to what the other profession does. In particular, clinical psychologists, who arguably have in many cases the most obvious skill-set to conduct formal assessments of malingering, need to work harder to understand how they can contribute to the problems faced in the court-room; lawyers and judges might benefit from understanding how such assessments take place and for what sorts of questions they can be useful. These better working relationships need to lead to development of agreed models by which psychological assessments would be conducted and commissioned, and look at the most efficient and effective ways to make use of the clinical resource.

In terms of the law, too, there are opportunities for change. Whatever other merits it may or may not have, the Irish approach to false reporting in the civil court setting, if accepted in England and Wales, would lead to radically different outcomes to any cases where evidence of malingering had been clearly established, but some partial valid element to the claim was also made out. Arguably, claimants would be much less likely to risk malingering in a civil claim if they believed it may prejudice a valid claim; currently, there seem to be very few risks to a claimant malingering mental health difficulties.

In criminal law, whilst it is likely that there are issues with malingering particularly during the sentencing stage, these are hard to capture and measure; as noted, it is impossible to know how many 'successful' malingerers there are. As things stand, there is little evidence of malingering in regard to the defences of insanity and diminished responsibility, but this is largely because of the general inaccessibility of these defences, and this may change if access to these defences is widened. Many opportunities for clinical-legal research present themselves.

For the practitioner carrying out an assessment of a client who is potentially malingering, this remains a delicate task. The guidance previously noted addresses some of the major questions, but many of these issues have not been tested in law. Professionals working with clients who may be malingering where they are not being seen in the context of a court-ordered assessment, or

detained under the provisions of the MHA, may need to take particular care. Professional guidance in these issues needs to be developed with close advice from professionals with significant legal, as well as clinical, experience.

The article, of course, says little about those who have real mental health problems. Jill Peay[195] has rightly emphasised that one should not let a fear of malingering come before the need to help people with genuine problems, and this, indeed, is a very real concern. Certainly, the authors would not wish to advocate for a focus on malingering that neglected the much greater need for statutory services to attend to people who present to services with mental distress. On the other hand, the scarcity and cost of mental health treatment for offenders (a single secure hospital bed may be in the order of £200,000 per year[196]) serves as a very real limitation to those who do have genuine mental health problems, and the extent of resource that could be better used because of the problem of malingering is unknown, though unlikely to be negligible.

To conclude? We need to do better. Clinicians who are concerned about an over-stretched health service cannot ignore the impact of potential malingering on the provision of care. Society cannot ignore the cost of potential unwarranted welfare payments or financial settlements from insurance companies. And in the legal system, justice is not done when a person malingering mental health difficulties gets a disposal meant for somebody with a genuine mental health need. Malingerers, particularly convincing ones, will happily ignore both clinicians and lawyers, and we ignore the problem at our peril. Yet, the legal landscape in assessing a potentially malingering client risks creating a context that leads clinicians to shy away from this important task, perhaps risking the production of conclusions that are more tentative than their actual view. Whilst this may be understandable, even desirable, in situations where there is significant doubt, it certainly becomes problematic for a clinician that has developed serious and well-founded concerns about the veracity of a client's presentation.

Yet, fundamentally, we would caution against knee-jerk reactions exclusively focused on getting better at 'catching' malingering. The issues here may be symptoms of a bigger problem that deserves wider attention: the process of clinical governance and quality assurance of expert evidence in the court room, and the reciprocal understanding of clinicians and lawyers of each other's skillsets. As currently configured, there is significant latitude afforded to clinicians to offer and structure expert opinion, so long as they address the primary issues of instruction. But there are many variables that differentiate clinicians in their approach to assessment and that may be determinants of the quality of outcome; for instance, the length of time spent with a client (and period over which assessment is completed); the nature and focus of the

[195] (n 22).

[196] Centre for Mental Health, 'Briefing Note – Secure Care Services' (2013) <https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/securecare.pdf> accessed 11th March 2021.

questions asked of the client; the type of measures of clinical symptomatology adopted, and even the skillset of the clinician in non-verbal communication in enabling engagement with a client. Clinicians, too, have quite different areas of expertise, the breadth of which might well be under-appreciated by the courts, with even job titles potentially becoming a source of confusion (psychiatrists, psychologists and psychotherapists each have highly different training routes and different skillsets, but may be readily confused). Further confusion can occur since clinicians *within* a profession might align themselves to particular 'schools of thought' or theoretical orientations that influence both approach and opinion, but of which legal practitioners may well be unaware. In the courtroom, the confusing picture is mirrored by a 'black and white' approach of legal philosophy, and taken together with the basic complexities of mental health problems, may lead to a 'pull' towards clinical evidence that reflects a more reductionistic view of classification and causation than is warranted. This much wider issue might well account for some of the issues for courts in grappling with malingering.

A wider solution, thus, is to consider the broader question of how clinical evidence and expertise is best used to help the courts make decisions about people presenting with mental health problems. This may be informed by research enterprises to support joined-up discussions between both clinicians and lawyers. As well as stimulating thought about the challenge of malingering, the authors hope the present paper provides impetus to these objectives more broadly.

OVERPROTECTING PROFESSIONALS FROM 'VEXATIOUS' CLAIMS UNDER THE HONG KONG MENTAL HEALTH ORDINANCE: THE QUESTION OF ACCESS TO JUSTICE FOR PERSONS WITH MENTAL ILLNESS

URANIA CHIU*

ABSTRACT

Using Hong Kong's mental health legislation as a case study, this article asks whether provisions in domestic mental health legal frameworks which seek to restrict the institution of legal proceedings against those working under such legislation may be justified, given the implications they have on the fundamental right to access to justice. Under section 69 of the Hong Kong Mental Health Ordinance, legal proceedings cannot be brought against anyone acting in pursuance of the Ordinance unless leave has been given by a court, and such leave shall not be given unless the court is satisfied there is a 'reasonably arguable' case of bad faith or negligence. Limited case law on section 69 and Hong Kong mental health jurisprudence in general indicate that this test is likely to be applied by judges stringently, with the result that mental health patients face a virtually insurmountable hurdle should they wish to bring actions against professionals for wrongful or negligent treatment under the Ordinance. The author argues that provisions such as section 69 are rooted in discriminatory stereotypes of persons with mental illness as particularly 'vexatious' litigants and constitute unjustified barriers to their right to equal access to the courts. In Hong Kong's case, in particular, section 69 operates within and reinforces a broader legislative framework that is systemically discriminatory against those who fall under the compulsory mental health regime. As such, such provisions must be seriously reconsidered and reformed.

I. INTRODUCTION

Since the UN Convention on the Rights of Persons with Disabilities ('CRPD') was opened for signature in 2007, there has been much academic commentary on what this 'paradigm-shifting' treaty means for the conceptualisation of equality and justice for persons with disabilities, given its specific focus on the 're-articulation of rights found in other treaties in ways that will make those rights meaningful to people with disabilities'.[1] Articles 12 and 13 in particular go to the heart of this aspiration, requiring states to ensure persons with disabilities enjoy legal capacity *and* effective access to justice on an equal basis with others, as they have historically and routinely been excluded from making decisions for themselves in relation to their person and property and from participating in legal proceedings, usually by the law's denial of their legal capacity or the lack of reasonable accommodation for them to meaningfully participate in the courtroom.

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[1] Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 Modern Law Review 752.

Much of the literature[2] and a considerable number of individual communications filed with the Committee on the Rights of Persons with Disabilities[3] have focused on these two particular aspects of domestic legal systems' treatment of persons with disabilities. However, short of being deprived of their legal capacity and apart from the issue of whether they are provided with the accommodation they need to participate in legal proceedings, there exists a different kind of barrier which certain persons with mental disabilities face in accessing the courts which has not been much explored in relation to the right to access to justice, especially in view of the CRPD: in many jurisdictions, mental health legislation contains provisions which expressly limit the liability of those working under the legislation to situations where they have acted in negligence and/or bad faith;[4] in other jurisdictions, there are further provisions which restrict or even prohibit the commencement of legal proceedings against such personnel.[5]

Hong Kong is one of the jurisdictions which restrict *both* professional liability and the institution of legal proceedings under its mental health legislation. Under section 69(2) of the Hong Kong Mental Health Ordinance ('MHO'), legal proceedings cannot be brought against anyone acting in pursuance of the Ordinance, for example in making an application to compulsorily detain a patient with mental disorder, unless leave has been given by a court; such leave is not to be given unless the court is satisfied there is a 'reasonably arguable' case of bad faith or negligence.[6] A recent decision by the Court of First Instance, *Bhatti Bhupinder Singh v Hospital Authority* ('*Singh v HA*'),[7] is one of the first reported cases which shed light on a judge's application of the test in detail, and it seems to suggest that the threshold is, in practice, applied in such a way as to be virtually insurmountable. The effect of this legally instituted hurdle, which is clearly intended to discourage individuals from initiating proceedings against medical professionals for their conduct under the MHO, in turn raises the question of whether patients' right to access to justice has been unjustifiably restricted by this rule. This

[2] See eg Eilionóir Flynn and Anna Lawson, 'Disability and Access to Justice in the European Union: Implications of the United Nations Convention on the Rights of Persons with Disabilities' (2013) 4 European Yearbook of Disability Law 7, 9; Lucy Series, 'Legal capacity and participation in litigation: Recent development in the European Court of Human Rights' (2015) 5 European Yearbook of Disability Law 103; Anna Lawson, 'Disabled People and Access to Justice: From disablement to enablement?' in Peter Blanck and Eilionóir Flynn, *Routledge Handbook of Disability Law and Human Rights* (Routledge 2017) 91, 95; Penelope Weller, 'Legal Capacity and Access to Justice: The Right to Participation in the CRPD' (2016) 5 Laws 13. Flynn and Lawson (2013) and Lawson (2017) give comprehensive accounts of different types of barriers faced by persons with disabilities in accessing justice, but the denial of legal capacity and lack of reasonable accommodation remain the two main strands discussed in detail.

[3] See eg a series of individual communications submitted by deaf individuals against Australia for failing to fulfil its obligations under, *inter alia*, article 13, by not providing reasonable accommodation for them to perform their jury duties: UN Committee on the Rights of Persons with Disabilities, 'Views adopted by the Committee under article 5 of the Optional Protocol, concerning communication No. 11/2013' (25 May 2016) UN Doc CRPD/C/15/D/11/2013, 'Views adopted by the Committee under article 5 of the Optional Protocol, concerning communication No. 13/2013' (30 May 2016) UN Doc CRPD/C/15/D/13/2013, and 'Views adopted by the Committee under article 5 of the Optional Protocol, concerning communication No. 35/2016 (20 December 2018) UN Doc CRPD/C/20/D/35/2016.

[4] See eg s 231 of the Victorian Mental Health Act 2014, s 797 of the Queensland Mental Health Act 2016, s 218 of the Tasmanian Mental Health Act 2013, and s 33.6 of the Ontario Mental Health Act 1990.

[5] See eg s 119 of the Indian Mental Healthcare Act 2017: 'No suit, prosecution or other legal proceeding shall lie against the appropriate Government or against the chairperson or any other member of the Authority or the Board, as the case may be, for anything which is in good faith done or intended to be done in pursuance of this Act or any rule or regulation made thereunder in the discharge of official duties.' See also s 139 of the English Mental Health Act 1983, which will be further discussed below.

[6] *Chan Shek Him v Hospital Authority* [2014] CHKEC 980.

[7] [2020] HKCFI 530.

issue, however, has not been examined in the literature, despite renewed academic interest in the need to reform the MHO.[8]

Given this gap, this article therefore sets out to explore the implications of legal rules which impose restrictions upon the commencement of legal proceedings against those working under mental health legislation on the right of persons with mental illness to access to justice, using section 69 of Hong Kong's MHO as a case study. It argues that such restrictions are rooted in discriminatory stereotypes of persons with mental illness as particularly 'vexatious' litigants and, even where it may otherwise be said to pursue a legitimate aim, the threshold, as applied, represents a disproportionate interference with their right to equal access to the courts. The next section gives a brief overview and history of section 69 and its counterparts in English mental health legislation, while section III examines how the law has been applied in practice. Section IV explores the content and limits of the right to access to justice in relation to the issue of gatekeeping litigation against professionals working under legislation such as the MHO, especially in light of the CRPD and in the context of broader mental health jurisprudence in Hong Kong. Finally, section V concludes with suggestions for reconsidering and reforming the provision so that those with mental illness or who are otherwise subject to the MHO may truly be able to access justice on an equal basis with others.

II. A BRIEF OVERVIEW OF SECTION 69: 'PROTECTION OF PERSONS CARRYING OUT THE PROVISIONS OF THIS ORDINANCE'

A. The English Mental Treatment Act 1930 and Mental Health Acts 1959 and 1983

Hong Kong mental health law today, as with other legislation in the land, has historically been developed from English law because of the city's history as a British colony.[9] While Hong Kong courts are no longer bound by English statutory and case law after the handover in 1997, they nevertheless refer to English jurisprudence for guidance at times as the common law system has remained in place,[10] and especially when it comes to provisions that have roots in English law.[11] It is therefore useful to examine the historical origins of section 69 and how Hong Kong and English courts have interpreted and applied this section and its English counterparts over the years.

[8] See eg The Law Reform Commission of Hong Kong, *Substitute Decision-Making and Advance Directives in Relation to Medical Treatment* (LRC, August 2006) <https://www.hkreform.gov.hk/en/publications/rdecision.htm> accessed 17 August 2021; HK Cheung, 'What We Should Consider When We Next Amend the Mental Health Ordinance of Hong Kong' (2009) 19 Hong Kong Journal of Psychiatry 53; Sherlynn G Chan, 'The Way Forward' in *A Practical Guide to Mental Health Law in Hong Kong* (HKU Press 2019) 138; Daisy Cheung and others, 'Articulating future directions of law reform for compulsory mental health admission and treatment in Hong Kong' (2020) 68 International Journal of Law and Psychiatry 101513; 'Workshop: "Living Will, Living Well? Advance Directives Across Asia" by the Centre for Medical Ethics and Law' (*Hong Kong Lawyer*, November 2020) <http://hk-lawyer.org/content/workshop-%E2%80%98living-will-living-well-advance-directives-across-asia%E2%80%99-centre-medical-ethics-and> accessed 17 August 2021.

[9] See Daisy Cheung, 'Mental Health Law in Hong Kong: The Civil Context' (2018) 48 Hong Kong Law Journal 461 for an overview of the historical development of civil mental health law in Hong Kong.

[10] The Basic Law of the Hong Kong Special Administrative Region of the People's Republic of China, art 8.

[11] Anthony Mason, 'The Place of Comparative Law in Developing the Jurisprudence on the Rule of Law and Human Rights in Hong Kong' (2007) 37 Hong Kong Law Journal 299, 307.

The statutory text of section 69 has remained unchanged since the original MHO was enacted in 1960. It was directly modelled upon section 16 of the English Mental Treatment Act 1930, which provided that:

> (1) Where a person has presented a petition for a reception order, or signed or carried out, or done any act with a view to signing or carrying out, an order purporting to be a reception order or any report, application, recommendation, or certificate purporting to be a report, application, recommendation, or certificate under this Act, or any Act amending this Act, or has done anything in pursuance of this Act, or any Act amending this Act, he shall not be liable to any civil or criminal proceedings whether on the ground of want of jurisdiction or on any other ground unless he has acted in bad faith or without reasonable care.
>
> (2) No proceedings, civil or criminal, shall be brought against any person in any court in respect of any such matter as is mentioned in the last preceding subsection, without the leave of the High Court, and leave shall not be given unless the court is satisfied that there is substantial ground for the contention that the person, against whom it is sought to bring the proceedings, has acted in bad faith or without reasonable care.

This section was largely preserved in section 141 of the Mental Health Act ('MHA') 1959, albeit in less cumbersome language. The protection afforded by the 'substantial ground' requirement to professionals and public authorities acting under the 1930 and 1959 Acts was intended to be construed broadly, covering cases where these actors 'may have misconstrued the Act' and 'may have done things which there was no jurisdiction to do', as long as 'they acted in good faith and in a reasonable manner'.[12] It was also meant to provide greater protection than its predecessor in the Lunacy Act 1890 and Mental Deficiency Act 1913, as Denning LJ explained in *Richard v London City Council* in relation to section 16 of the 1930 Act:

> [Section 16 of the 1930 Act] puts the burden of proof the other way round. It puts the burden of proof on the man who seeks to bring such an action. It goes further. It says that not only must there be reasonable grounds [as in the Mental Deficiency Act 1913], but there must be substantial grounds for the contention.[13]

Case law indicates that the 'substantial ground' threshold was, if a little ambiguous, certainly an onerous one. In the same case, it was held that, while it was not possible to define 'substantial grounds', it sufficed to say that 'there must be solid grounds for thinking that there was want of reasonable care or bad faith'.[14] In *Carter v Commissioner of Police of the Metropolis*,[15] this standard was confirmed by the Court of Appeal to be applicable to section 141 of the MHA 1959.

However, in section 139 of the MHA 1983, while the civil and criminal liability for individuals acting in pursuance of the Act continues to be limited to cases of bad faith or negligence, some notable changes were made to the rule regarding the commencement of proceedings. Under subsection (2), criminal proceedings may only be brought in respect of such acts by or with the consent of the Director of Public Prosecutions; civil proceedings remain subject to the requirement of leave of the High Court, but the threshold for granting such leave is no longer specified in the text.

[12] *Richardson v London City Council and Others* [1957] 1 WLR 751, 760 (Denning LJ).
[13] ibid.
[14] ibid.
[15] [1975] 1 WLR 507.

Subsection (3) states that the section no longer applies to the Secretary of State or public authorities, such as the National Health Service Commissioning Board or Local Health Boards.

The question of which test to be applied under section 139(2), since the 'substantial ground' threshold had been scrapped from the statute, was considered in the case of *Winch v Jones*,[16] an appeal against a High Court decision to not grant such leave. Sir John Donaldson first acknowledged that the change in law was one 'of substance and not merely an improvement in the drafting', before considering a few possible approaches the court might take: whether the plaintiff has established a 'prima facie case' of negligence or bad faith, as the High Court judge had asked; whether there is a 'serious issue to be tried' or a 'real prospect of succeeding', as submitted by the plaintiff and taken from a line of cases on granting interlocutory injunctions; and whether there is an 'arguable case', as used in granting leave in the context of judicial review. [17] Sir John Donaldson concluded that 'none of these approaches is directly applicable to the jurisdiction under section 139' and decided to opt for an approach that was analogous to the one adopted in the context of judicial review but also *sui generis*:

> The issue is whether, on the materials immediately available to the court […], the applicant's complaint appears to be such that it deserves the fuller investigation which will be possible if the intended applicant is allowed to proceed.[18]

Parker LJ concurred in the same case, framing the threshold as 'there is a reasonable suspicion that [the potential defendant] has committed some wrong'.[19] Section 139(2) of the MHA 1983 thus represents a considerable departure from the 'substantial ground' approach taken under section 16 of the Mental Treatment Act 1930 and section 141 of the MHA 1959, providing claimants with 'increased access to the courts'.[20] Later judgments on section 139(2) remain faithful to the approach adopted in *Winch v Jones*. For example, in *David Johnson v The Chief Constable of Merseyside Police*, the claimant's application for leave was granted, with Coulson J concluding that the claim was 'not frivolous, vexatious, or an abuse of process' and 'although far from straightforward, has a real prospect of success'. [21] In *DD v Durham County Council*, the Court of Appeal overturned a High Court decision to refuse leave, as the claimant's case was 'at least arguable' and had met 'the very low threshold' under section 139.[22]

B. Section 69 of the Mental Health Ordinance

As mentioned above, the text of section 69 of the MHO was modelled upon the 1930 English legislation and has not been amended since, even whilst other parts of the Ordinance were updated, often taking reference from developments in other

[16] [1986] 1 QB 296.
[17] ibid 303–304 (Sir John Donaldson MR).
[18] ibid 304–305 (Sir John Donaldson MR).
[19] ibid 306 (Parker LJ).
[20] Peter Bartlett and Ralph Sandland, *Mental Health Law: Policy and Practice* (4th edn, OUP 2013) 577.
[21] *David Johnson v The Chief Constable of Merseyside* [2009] EWHC 2969 (QB) [24].
[22] *DD v Durham County Council and Another* [2013] EWHC Civ 96 [24].

commonwealth jurisdictions, especially England and Wales.[23] Section 69(2) uses the exact same threshold as provided for in pre-MHO 1983 English law, that 'leave shall not be given unless the Court is satisfied that there is substantial ground for the contention that the person […] has acted in bad faith or without reasonable care'.

In 2014, however, the requirement of 'substantial ground' was read down in a remedial interpretation in *Chan Shek Him v Hospital Authority*.[24] *Chan Shek Him* concerned a challenge of the constitutionality of section 69 by the applicant, whose earlier claim for damages against a psychiatric hospital for wrongful detention in the High Court was struck out as he had not obtained leave under section 69(2) before initiating the proceedings.

In considering whether section 69 was unconstitutional, the Court of Appeal began from the position that the section 69(2) requirement of leave presented a prima facie limitation on 'the right to litigate' under article 35 of the Basic Law, which states that Hong Kong residents shall have the right to, *inter alia*, access to the courts and to judicial remedies, and article 10 of the Hong Kong Bill of Rights, which guarantees equality before the courts and tribunals. It then referred to English jurisprudence on the issue over the years, deciding that, first of all, the limitation pursued and was rationally connected to a legitimate aim. The Court cited Lord Simon's judgment in *Pountney v Griffiths*, a 1976 case on section 141 of the MHA 1959, that the justification for the provision was that 'unless such classes of potential litigant enjoy something less than ready and unconditional access to the courts, there is a real risk that their fellow-citizens would be, on substantial balance, unfairly harassed by litigation'.[25] This was supported by the Secretary for Justice's submission to the Court, whose position was that

> In Hong Kong, the most common form of severe mental illness is schizophrenia and such patients tend to be unaware of their illness. There is also a tendency for such patients to develop persecutory delusion and distorted appreciation of personal experience which make some of them litigious, particularly when they are subject to detention against their will […]
>
> It is in the public interest that people involved in the process of involuntary removal or detention under the MHO should not be deterred by the cost and annoyance of unmeritorious potential court actions because otherwise those suffering from mental illness may not receive the necessary treatment which may require custody and detention.[26]

Having established that section 69(2) was able to meet the requirements of the first two stages of the proportionality test, the Court went on to consider whether it was proportionate, meaning that it did not impose a restriction which was more than necessary for the pursuit of the purported legitimate aim,[27] specifically in terms of the 'substantial ground' threshold and the fact that the onus of meeting it rested entirely on the claimant. In doing so, the Court turned to *Winch v Jones* and a subsequent

[23] See Cheung (n 9). Despite these reforms, other parts of the MHO have often been criticised as lagging behind other jurisdictions in terms of compliance with international human rights standards as well: see section IV(C) below.
[24] *Chan Shek Him v HA* (n 6).
[25] *Pountney v Griffiths* [1975] 3 AC 314, 329 (Lord Simon).
[26] *Chan Shek Him v HA* (n 6) [53].
[27] Note that the test applied here was the three-stage test as set out in *Leung Kwok Hung v Secretary for Justice* (2005) 8 HKCFAR 229, which has since been replaced by the four-stage test in *Hysan Development Co Ltd v Town Planning Board* [2016] HKCFA 66.

House of Lords judgment on section 139 of the MHA 1983, *Seal v Chief Constable of South Wales Police*,[28] noting that section 69(2)'s English counterpart has been revised since the 1930 and 1959 Acts to require claimants to meet only a very low threshold.[29]

Acknowledging that the 'substantial ground' threshold was 'a high threshold' which could 'be a hurdle which a claimant cannot meet when he has not even had the chance to get discovery and the other side has put forward contradictory evidence from professional personnel treating him', the Court ultimately found that the current threshold of 'substantial ground' constituted a disproportionate interference with the fundamental right of access to the courts.[30] In a remedial interpretation, the Court decided to adopt the standard 'reasonably arguable ground' currently used in the context of granting leave for judicial review, as set out in *Po Fun Chan v Winnie Cheung*,[31] which means that section 69(2) should now read:

> No proceedings, civil or criminal, shall be brought against any person in any Court in respect of any such matter as is mentioned in subsection (1), without the leave of the Court, and leave shall not be given unless the Court is satisfied that there is *reasonably arguable ground* for the contention that the person, against whom it is sought to bring the proceedings, has acted in bad faith or without reasonable care.

This was notably contrary to Sir John Donaldson's decision in *Winch v Jones* to *not* directly adopt the threshold used in the context of judicial review, his reasoning being that those subject to section 139 were not necessarily 'vexatious litigants' by nature, as those whom the leave requirement for judicial review was meant to deter were, and therefore required a different, presumably less demanding test.[32] The Court of Appeal in *Chan Shek Him*, however, held that the judicial review standard was directly applicable, as 'the purpose for having a leave requirement for judicial review is similar [to section 69(2)]: to filter out unmeritorious claims and to protect public process and public officers or authorities against disruption and harassment occasioned by such claims'.[33]

A 'reasonably arguable case', according to *Po Fun Chan*, is one which 'enjoys realistic prospects of success'.[34] How this threshold is applied in practice and its effects on potential claimants is discussed in the following section.

III. THE 'REASONABLY ARGUABLE GROUND' THRESHOLD IN ACTION: MEDICAL NEGLIGENCE AND 'PROFESSIONAL JUDGMENT'

Applications made under section 69(2) of the MHO since *Chan Shek Him* have been few and far between, but the very limited case law available, when seen in the broader context of general mental health jurisprudence in Hong Kong, raises serious concerns about the likely impact it has on the right to access to the courts of those subject to the MHO, namely individuals who have, or are perceived to have, a (history of) mental

[28] [2007] UKHL 31.
[29] *Chan Shek Him v HA* (n 6) [60].
[30] *Chan Shek Him v HA* (n 6) [63].
[31] (2007) 10 HKCFAR 676.
[32] *Winch v Jones* (n 16) 304 (Sir John Donaldson MR).
[33] *Chan Shek Him v HA* (n 6) [62].
[34] *Po Fun Chan* (n 31) [15].

illness and who thereby find themselves caught up in the compulsory mental health regime.

Bhatti Bhupinder Singh v Hospital Authority is a recently decided case on an application for leave to bring an action against the Hospital Authority for wrongful detention. Singh was a man who, in the midst of a two-year ordeal with his estate management over his complaints about a noise problem that had been consistently ignored, was escorted to an Accident and Emergency department by the police after he had thrown a stapler onto the floor and a letter at a member of staff at the management office on two separate occasions. After being assessed by a nurse and a doctor, he was admitted to and detained in a psychiatric hospital for observation for seven days under section 31 of the MHO based on his suspected psychotic symptoms (as evidenced by his complaints about apparently non-existent noises) and also his 'uncontrollable violent behaviour with potential to cause bodily harm to others when he felt that he had not been fairly treated'.[35] Although during Singh's seven-day detention, the hospital was able to obtain confirmation from his family that the noises did in fact exist, his detention was extended for 21 days under section 32 of the MHO on the basis of a delusional disorder diagnosis. He was discharged after this period, with a principal diagnosis of paranoid personality disorder. Singh sought to commence a case against the medical professionals responsible for his diagnosis and detention, but leave was refused.

As the author and Daisy Cheung have argued elsewhere, the Judge's reasoning in the judgment appears to be highly flawed in many respects.[36] The main case to be considered here was the contention that the professionals had acted without reasonable care, which meant that the *Bolam* test was to be applied:

> [a doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art […] a man is not negligent, if he is acting in accordance with such practice, merely because there is a body of opinion that takes a contrary view.[37]

The question the Judge had to decide, therefore, was whether Singh was able to present a reasonably arguable case that the professionals had acted in a way that would not be accepted as proper by any responsible body of medical personnel skilled in psychiatry. Despite the fact that the nurse and doctors involved in Singh's admission to and detention in hospital seemed to have based their decisions on less than solid grounds — relying only on Singh's estate management, a party with its own clear interests in the case and no expertise in the medical matters at hand, for reports of his supposed auditory hallucinations and violent behaviour in admitting him and extending his stay even after having confirmed that his 'hallucinations' were in fact real — the Judge did not scrutinise these decisions at all, instead starting and stopping at the point of acknowledging that the nurse and doctors had exercised their 'professional judgment'.[38] The *Bolitho* principle that 'if, in a rare case, it can be

[35] *Singh v HA* (n 7) [22].
[36] Urania Chiu and Daisy Cheung, 'Claiming wrongful diagnosis under the Mental Health Ordinance: The impossibility of building a reasonably arguable case' (2020) 50 Hong Kong Law Journal 837.
[37] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587.
[38] *Singh v HA* (n 7), [30]–[32]. See also Chiu and Cheung (n 36).

demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that body of opinion is not reasonable or responsible'[39] was not mentioned at all, and there was no evidence that the Judge had put each of these decisions to logical analysis in relation to the requirements under the MHO. For example, under section 31(1), an application may only be made for the detention of a patient if the patient is suffering from a mental disorder of a nature or degree which warrants such detention *and* if they ought to be so detained for their own health or safety or for the protection of others. Without referring to these criteria, the Judge seemed to have simply accepted that the diagnosis and reported incidents were a reasonable basis on which the medical professionals could come to the decision of applying for Singh's detention.

As advised by a lawyer at the time he intended to bring his case to court (which was more than two years after his detention), Singh obtained and submitted a report on his mental condition. The report stated that, at the time of the assessment, the psychiatrist was unable to find any evidence of mental disorder or substantive ground to support a diagnosis of paranoid personality or delusional disorder.[40] This was rejected outright by the Judge as irrelevant.[41] However, although this psychiatric assessment made more than two years after the detention could not, indeed, have been used as a retrospective evaluation of Singh's state of mind at the relevant time, it should have been considered in assessing the reasonableness of the original diagnoses and in light of the possibility that Singh's 'hallucinations', as observed by the nurse and doctors at his admission, were 'putative' and a result of the conflicting versions of events with which they were confronted.[42] The reasonableness of the professionals' decision to act, to make use of the compulsory provisions under the MHO in such difficult circumstances, was precisely what the question of whether there is a reasonably arguable case hinged on, but the Judge stopped short of examining it. While the Judge could not (and should not) have gone into such an examination in detail at this stage, it would be impossible for him to assess whether the case enjoyed any 'realistic prospects of success' if he simply deemed the professionals' actions 'reasonable' or accepted them as having a logical basis as long as they were 'professional' in the sense of being within the ambit of their job descriptions.

Having acknowledged the facts, the Judge came to the conclusion that he was not satisfied that 'the applicant manages to establish that he has reasonably arguable grounds for saying that the nurse or any of the doctors, and thus HA, had acted in bad faith or without reasonable care'.[43] *Singh v HA* is one of the very few available judgments concerning an application under section 69(2), and by far the most detailed one — although as a standalone Court of First Instance judgment it has no binding force on other applications, it still raises serious concerns about the effect of section 69 on the ability of those subject to the MHO to bring cases against professional

[39] *Bolitho v City and Hackney Health Authority* [1998] AC 232, 243 (Lord Browne-Wilkinson). The *Bolitho* principle is widely accepted in Hong Kong medical negligence jurisprudence to have qualified the original *Bolam* test. See *Kong Wai Tsang v Hospital Authority* [2004] HKEC 1333 [10] (Rogers VP) and *Dr Chan Po Sum v Medical Council of Hong Kong* [2015] 1 HKLRD 330 [43]–[45] (Kwan JA).
[40] *Singh v HA* (n 7) [38]–[39].
[41] *Singh v HA* (n 7) [42].
[42] *Singh v HA* (n 7) [40].
[43] *Singh v HA* (n 7) [47].

misconduct. Given the troubling trend towards excessive deference to medical professionals in mental health jurisprudence in general in Hong Kong, it is very likely that the tone set in *Singh* will be one followed by future section 69(2) cases. As the author and Cheung note, the refusal of the Judge in *Singh v HA* to go into the substance of the medical reasoning echoes Hartmann J's judgment in *The Hospital Authority v A District Judge* (*HA v A District Judge*), a case in relation to judges' power to scrutinise applications under the MHO:[44]

> The judge or magistrate is, of course, much more than a rubber stamp. But that does not mean that he is entitled to question the medical validity of opinions expressed if those opinions comply, on their face, with the relevant section of the Ordinance.[45]

In that case, the original District Court judge's refusal to countersign an application for detaining a patient under section 36 of the MHO, as he was not satisfied that the doctors' opinion that it was necessary for the patient to be detained was based upon sound evidence,[46] was sternly criticised and eventually set aside by Hartmann J. However, if judges are not allowed to ask whether the criteria set out under the section have truly been met in ascertaining that the application certificate is 'in order and there are no grounds for rejecting it',[47] they are essentially performing only the function of a rubber stamp to confer legitimacy upon unchallengeable medical decisions. Although medical professionals are often protected by law from becoming liable for every decision that happens to result in a negative outcome (as under the *Bolam* test for medical negligence), they are still required to have made these decisions with reasonable care, as judges are tasked with ascertaining under the *Bolitho* principle. Hartmann J's statement therefore has troubling implications for the role of the judiciary in safeguarding individuals from arbitrary compulsory detention or treatment under the MHO.[48]

The Judge in *Singh v HA* has, in effect, applied the section 69(2) test in a way that makes it extremely difficult for a case to be considered 'reasonably arguable'. This is because the Judge, by refusing to question the doctors' and nurse's actions beyond whether they have acted within the bounds of their official duties, has essentially failed to consider the question of whether there are *reasonably arguable grounds* for the contention that they have acted without reasonable care or in bad faith. If a case like Singh's, which evidently exhibited many points of doubt about the reasonableness of the professionals' decision-making, is not granted leave, it is difficult to imagine what kind of cases may pass the section 69 hurdle to be heard in full.

[44] Chiu and Cheung (n 36).
[45] *The Hospital Authority v A District Judge* [2001] HKEC 1657 [27].
[46] *Re Patient O* [2001] HKEC 509.
[47] Mental Health Ordinance Cap 136, s 36(2).
[48] Daisy Cheung, 'The compulsory psychiatric regime in Hong Kong: Constitutional and ethical perspectives' (2017) 50 International Journal of Law and Psychiatry 24.

IV. OVERPROTECTING PROFESSIONALS FROM 'VEXATIOUS' CLAIMS: WHAT ABOUT ACCESS TO JUSTICE FOR PERSONS WITH MENTAL ILLNESS?

A. The rights to access to justice and equality before the courts

The introduction of the CRPD, by framing injustices historically faced by persons with disabilities in terms of universal rights, brought international attention to previously underexplored ways that human rights instruments and discourse may be utilised to achieve equality and justice for all. As noted in section I, the deprivation of legal capacity and lack of reasonable accommodation have been the main focal points around which academic discussions about the exclusion of persons with disabilities from meaningful participation in legal proceedings have revolved in recent years.[49]

Under article 12 of the CRPD, states are asked to recognise that persons with disabilities 'enjoy legal capacity on an equal basis with others in all aspects of life'; under article 13, states are tasked with ensuring 'effective access to justice for persons with disabilities on an equal basis with others'. These provisions correspond to article 14 of the International Covenant on Civil and Political Rights, which guarantees that all persons shall be equal before the courts and tribunals. In the Hong Kong local human rights framework, the same is guaranteed under articles 25 (equality before the law) and 35 (the right to confidential legal advice and access to the courts) of the Basic Law. Although case law on the MHA and MHO provisions has in the past alluded to the right to access to the courts and evaluated the relevant threshold for granting leave to bring cases against medical professionals in relation to its interference with such a right,[50] what the right means, especially to those with mental disabilities, is never explicated in detail.

The term 'access to justice', in academic literature, has been used generally to refer to the legal system's two basic purposes of 'be[ing] equally accessible to all' and 'lead[ing] to results that are individually and socially just'.[51] It has also been used in a more aspirational sense, 'as a focus of campaigns and other calls for justice to be made available to all', a 'political claim for an inclusive, affordable and impartial justice system' fundamental to a functioning and fair democracy and the rule of law.[52] In law specifically, 'access to justice' is used to describe 'the bundle of rights relating to the justice system which are recognised in human rights law'.[53] The right to access to justice, as set out under article 13 of the CRPD, falls within this latter usage of the term and may be viewed, at a basic level, as simply 'an extension of the existing universal rights to an effective remedy and to a fair hearing'.[54] At the same time, given the CRPD's overall focus on the effective enjoyment and exercise of universal rights by persons with disabilities 'on an equal basis with others', it may be understood to mean, more specifically, that 'disabled people should have the same opportunities as

[49] See nn 2, 3 above.
[50] See, most notably, *Pountney v Griffiths* (n 25), *Winch v Jones* (n 16), and *Chan Shek Him v HA* (n 6).
[51] Mauro Cappalletti and Bryant Garth, 'Access to Justice: The Newest Wave in the Worldwide Movement to Make Rights Effective' (1978) 27 Buffalo Law Review 181.
[52] Lawson (n 2) 89, 90.
[53] Lawson (n 2) 90.
[54] Eilionóir Flynn, 'Access to Justice' in Ilias Bantekas, Michael Ashley Stein and Dimitris Anastasiou, *The UN Convention on the Rights of Persons with Disabilities: A Commentary* (OUP 2018) 384.

non-disabled people to access justice'; Eilionóir Flynn therefore suggests that the relevant test for discrimination should be 'whether a non-disabled person would have been able to access justice in the same circumstances where a disabled person has been prevented from accessing justice'.[55] This is supported by the view of the Committee on the Rights of Persons with Disabilities that legal regimes which separate patients with mental illness from other patients and allow them to be subject to compulsory treatment are non-compliant with CRPD norms:

> Persons with disabilities are frequently denied equal protection under these laws by being diverted to a separate track of law, including through mental health laws. These laws and procedures commonly have a lower standard when it comes to human rights protection, particularly the right to due process and fair trial, and are incompatible with article 13 in conjunction with article 14 of the Convention.[56]

Access to justice may be further conceptualised in terms of four elements: substantive, procedural, symbolic, and participatory.[57] The substantive focuses on 'the content of the legal rules and principles which shape the decisions made about those who make a "justice claim"',[58] while the procedural involves the familiar requirement of removing barriers and providing support for individuals to be able to effectively participate in legal proceedings.[59] The symbolic element expands the current understanding of access to justice to express an aspiration towards 'a society in which, due in part at least to its laws and justice system, individuals from marginalised communities are fully included and empowered to participate as equal citizens'.[60] The participatory element focuses on the overall attainment of equal citizenship for persons with disabilities in all aspects of life.[61] Given these different dimensions to the right to access to justice and the crucial fact that individuals' ability to exercise or otherwise assert other relevant rights under compulsory mental health regimes such as the right to liberty and security of the person (article 14 of the CRPD), equality and non-discrimination (article 5), and the right to protection of the integrity of the person (article 17) hinges on this very right, access to justice is clearly a fundamental issue that needs to be critically examined in detail by courts and academic literature in this area.

Section 69 of the MHO, in restricting the type of proceedings (conduct involving negligence or bad faith) that those subject to the compulsory mental health regime—who would, except in the rare case of *Singh v HA*, most likely be people with mental illness and/or other disabilities—can institute against professionals and putting in place an extra obstacle of having 'a reasonably arguable case' which they need to overcome in order to bring a case, clearly contravenes the substantive element of access to justice, as those in other medical settings do not have to face the same barriers in making a justice claim. It is moreover argued here that, in evaluating the rights-

[55] ibid 392.
[56] UN Committee on the Rights of Persons with Disabilities, 'Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities' (September 2015) [14].
[57] Eilionóir Flynn, 'Access to Justice and its Relevance for People with Disabilities' in *Disabled Justice? Access to Justice and the UN Convention on the Rights of Persons with Disabilities* (Routledge 2016).
[58] ibid 13.
[59] ibid 15.
[60] ibid 16.
[61] ibid 18.

compliance of a rule which seeks to exclude a minority group from accessing systems of law and justice, it is necessary to look to broader conceptions of equality and justice as set out above, given the rule not only affects potential claimants who have already brought their application for leave to court but also those who intend or would have intended to do so. The symbolic element of access to justice must therefore also be considered here: the legal rule and how courts interpret it send a powerful message to this group as a whole and the community at large about who are and are not deserving of having their cases heard fully in a court of law without additional barriers. By setting down a rule that explicitly excludes a group which overwhelmingly consists of people with mental disabilities from unhindered access to justice, the current law not only falls foul of the substantive dimension of the right to access to justice but also the symbolic—those subject to the MHO are, undoubtedly, not being included or empowered to participate in the justice system on an equal basis with others by the current law.

B. Persons with mental illness as 'vexatious' litigants

The justification for provisions which limit not only the liability of those working under mental health legislation, but also the possibility of having cases brought against them at all, is essentially based on a view that those who find themselves subject to such legislation, i.e., people who have or appear to have a mental illness, are particularly 'vexatious' litigants. Lord Simon in *Pountney v Griffiths*, for example, wrote,

> Patients under the Mental Health Act may generally be inherently likely to harass those concerned with them by groundless charges and litigation, and may therefore have to suffer modification of the general right of free access to the courts.[62]

In *Winch v Jones*, although a relatively low threshold was set down for section 139 of the MHA 1983 and the judicial language used was seemingly more sympathetic, the justification for the continued existence of the threshold remained the same: 'mental patients are liable, through no fault of their own, to have a distorted recollection of facts which can, on occasion, become pure fantasy',[63] which meant that it was necessary to protect those working under the MHA from being 'harassed by clearly hopeless actions'.[64] It is notable that, despite these strongly worded proclamations to the effect that those subject to the compulsory mental health regime are somehow inherently prone to initiating undesirable (characterised as 'groundless' 'clearly hopeless', 'frivolous', or 'vexatious') litigation, none of these judgments relied on actual empirical evidence, whether psychiatric or statistical, to support these claims.[65]

The concept of 'vexatious litigants' has long been used in general civil procedural law: under Rule 3.4 of the English Civil Procedural Rules 1998, a court may strike out the statement of a case if it appears to the court that it discloses 'no reasonable grounds for bringing or defending the claim' or that it is 'an abuse of the court's process' or

[62] *Pountney v Griffiths* (n 25) 329 (Lord Simon).
[63] *Winch v Jones* (n 16) 302 (Sir John Donaldson MR).
[64] *Winch v Jones* (n 16) 305 (Parker LJ).
[65] Baroness Hale specifically criticised section 139(2) of the MHA for making the 'empirically unproven' assumption that 'everyone who has ever been subject to Mental Health Act compulsion is automatically suspect': *Seal v Chief Constable of South Wales Police* (n 28) [57].

otherwise 'likely to obstruct the just disposal of the proceedings'. Despite the existence of Rule 3.4, those who carry out their duties under the MHA are seen as needing additional protection, in the form of section 139, from vexatious litigation.

Similarly, in Hong Kong's case, the judiciary readily accepts the argument that instituting a legal hurdle to dissuade potential claimants from pursuing cases under the MHO is necessary and in the public interest, endorsing the government's submission in *Chan Shek Him* that there is a tendency for patients with mental illness, especially those with schizophrenia, to be particularly 'litigious'.[66] The Court further cited statistics in relation to involuntary removal and detention in Hong Kong which showed that there was a 'not insignificant' number of cases where such compulsory powers had to be exercised by frontline officers, which supposedly implied that they could be exposed to much unwarranted litigation if the section 69(2) hurdle was removed.[67]

The Court never made clear why, given the low count of applications under section 69(2) that make it to the courts, the fact that there is a significant number of individuals subject to compulsory powers under the MHO should indicate a tendency to initiate unnecessary litigation rather than the opposite, that this group of individuals are in fact disinclined to bring lawsuits against those involved in their care or treatment. To demand them to satisfy the onerous test under section 69(2) before they could have their case fully heard would be to further discourage them from making claims for their rights, when they should instead be provided with more information on and assistance in exercising them, given that their present disinclination to do so likely stems from their vulnerable and disempowered position in clinical settings and in broader society.[68] Ultimately, it seems that these assumptions are reflective of the age-old stereotype that those with mental illness are troublesome, difficult, and simply 'crazy', someone from whom 'normal' people, especially those whose jobs involve caring for (or rather, 'dealing with') them, have to be protected. Although the concept of 'querulous behaviour' has been raised in some psychiatric literature before (and not without controversy) as a syndrome which 'may occur as part of other psychiatric illnesses such as paranoid personality disorder, organic and schizophrenic psychoses' and which entails 'an overvalued idea of having been wronged' that 'results in behaviour directed to the attainment of justice',[69] there is no evidence that this is the case with most people who have a mental illness or who are otherwise subject to the MHO,[70] especially in light of cases such as *Singh v HA*, where the very claim put forward is that the individual in question did *not* have a mental illness and had been negligently or wrongfully detained. In such cases, the professed rationale for putting an extra barrier in place to deter those under the compulsory mental health regime from bringing legal actions against professionals—to counteract the 'litigious'

[66] *Chan Shek Him v HA* (n 6) [53].
[67] *Chan Shek Him v HA* (n 6) [54].
[68] See text accompanying n 72 below.
[69] GS Ungvari, AHT Pang and CK Wong, 'Querulous Behaviour' (1997) 37 Medical, Science and the Law 265, 266.
[70] See eg Alfred H T Pang and others, 'Querulous Paranoia in Chinese Patients: A Cultural Paradox' (1996) 30 Australian & New Zealand Journal of Psychiatry 463. Pang and others found that, out of more than 1,500 new referrals to a psychiatric outpatient clinic in Hong Kong in one year, only three were diagnosed with querulous paranoia. There has been little to no research on this in more recent years, for better or worse, mainly because the very question of 'vexatious litigants' is prone to being misused to stigmatise those with mental illness.

tendencies that are assumed to be inherent to people with mental illness—completely disappears. Again, what the evidence shows is that patients are in fact very much disinclined to initiate legal proceedings in relation to their detention or treatment under the MHO, contrary to what is usually alleged; this is certainly the case in Hong Kong, as may be gleaned from the fact that there have only been three reported cases on section 69(2) to date, all of which have been dismissed.[71] Literature on professional-patient relationships in the mental health context shows that patients occupy a systemically disadvantaged position in relation to psychiatrists, due to their passive role in the therapeutic encounter, the stigma attached to mental illness, and psychological distress stemming from their conditions and treatment.[72] Moreover, individuals who (are perceived to) have a mental illness often feel, and are, discredited and disbelieved in clinical settings,[73] and it is likely that these issues of power disparity and epistemic injustice[74] spill over into a feeling of powerlessness in general which makes them hesitant to bring complaints for perceived negligent or wrongful treatment; further barriers to their access to court such as section 69(2) only exacerbate this.[75]

At any rate, it is impossible to tell how many 'clearly hopeless', 'vexatious', or 'frivolous' cases there would be without the 'reasonably arguable' threshold, if individuals are deterred from making applications at all by the current rule. This was rightly recognised by Baroness Hale in her dissenting judgment in *Seal*, where she suggested 'the best solution would be to remove the procedural requirement [under section 139 of the MHA] altogether'.[76] With such a dearth of evidence on what exactly professionals are supposed to be protected from, it is indeed disconcerting that the threshold exists at all. On the substantive level of equality and access to justice, section 69 is clearly discriminatory, imposing an almost impassable obstacle for persons with mental disabilities to overcome which those without such disabilities, who may well make claims that are deemed vexatious, are not subject to. On the symbolic level of equality and justice, this is even more alarming. The main reason used by courts to justify the rule, which is simply taken for granted in all the aforementioned cases and never corroborated by any empirical evidence, perpetuates the stereotype of persons with mental illness as inherently untrustworthy and unreliable, which in turn contributes to the stigma they face both in the community

[71] *Chan Shek Him v Hospital Authority* CAMP 61/2017; *Jacqueline Francis v Chan Yi San* [2020] HKCFI 238; *Singh v HA* (n 7).
[72] Michael McCubbin and David Cohen, 'Extremely Unbalanced: Interest Divergence and Power Diversities Between Clients and Psychiatry' (1996) 19 International Journal of Law and Psychiatry 1, 12–15.
[73] Rena Kurs and Alexander Grinshpoon, 'Vulnerability of Individuals with Mental Disorders to Epistemic Injustice in both Clinical and Social Domains' (2018) 28 Ethics & Behavior 336.
[74] Epistemic injustice is a kind of injustice that consists 'in a wrong done to someone specifically in their capacity as a knower'. Those diagnosed with or perceived to have a mental illness or other mental health problems often face *testimonial* injustice in particular, which is when 'prejudice causes a hearer to give a deflated level of credibility to a speaker's word': Miranda Fricker, *Epistemic Injustice: Power & the Ethics of Knowing* (OUP 2007) 1. See also Paul Crichton, Havi Carel and Ian James Kidd, 'Epistemic injustice in psychiatry' (2017) 41 BJPsych Bulletin 65.
[75] In the case of *Singh v HA*, although Singh himself did not raise this issue, it is possible that his minority ethnic background also played a part in his complaints being disbelieved and his actions construed as unduly aggressive by his estate management, the police, the medical professionals, and ultimately the Court. The vulnerability of those who (are perceived to) have a mental illness may thus intersect with other vulnerable characteristics to further marginalise certain groups in clinical and judicial settings.
[76] *Seal v Chief Constable of South Wales Police* (n 28) [57], [61]. Baroness Hale was referring to clause 298 of the Draft Mental Health Bill proposed in 2004 (Cm 6305-1), which never came to fruition.

and in clinical settings.[77] *Singh v HA* demonstrates this perfectly: after having his noise complaints discounted by his estate management for two years, Singh continued to be disbelieved by medical professionals when he was presented at the hospital, with his expressions of frustration and agitation readily construed as the basis for a delusional disorder diagnosis despite him not even having a psychiatric history. When the Judge relied upon the discharge summary which recorded his 'improvement' as evidence that the doctors had exercised reasonable care in relation to his detention, one cannot help but think that, had Singh instead shown signs of growing distress, which would have been quite understandable in the circumstances, they would probably have been equally construed as evidence that he was severely ill and therefore in need of treatment.

C. Compulsory powers, vulnerability, and the lack of protection for the rights of mental health patients in Hong Kong

One might argue that, the 'vexatious litigant' argument aside, section 69 may still be justified by the fact that psychiatric diagnostic processes are largely dependent upon professionals' evaluation of symptoms, which is inherently prone to controversy and often has to be done under huge time pressure.[78] However, professionals must also understand that they are wielding extremely broad powers, notably to impose compulsory detention and/or treatment, over those who come into contact with the mental health system, who are vulnerable both because of their mental state and because of the fact that they have essentially no power to object to these compulsory measures once they are deemed to have a mental illness that places them within the MHO's remit. Here, the effects of section 69 need to be examined in the broader context of the compulsory mental health regime in Hong Kong. First of all, according to current mental health jurisprudence, it is very unlikely for judges to question medical professional opinion at the stage of the compulsory order being made: the effect of *HA v A District Judge* is such that doctors' medical opinions are essentially not subject to any real scrutiny beyond having to conform to the required legal form when applying to detain a patient under sections 31, 32, or 36 of the MHO.[79] Technically, once compulsorily detained, individuals may apply to the Mental Health Review Tribunal ('MHRT') to have their cases reviewed—but for those detained under sections 31 (seven days) and 32 (21 days), launching such an application will inevitably take more time than the detention period, and limited research shows that the success rate for such applications is extremely low.[80] In an application for leave to commence judicial review concerning a conditional discharge order made under section 42B of the MHO, the judge, with some irony, suggested that the applicant

[77] See, for the Hong Kong context, Sing Lee and others, 'Stigmatizing experience and structural discrimination associated with the treatment of schizophrenia in Hong Kong' (2006) 62 Social Science & Medicine 1685 and K F Chung and M C Wong, 'Experience of stigma among Chinese mental health patients in Hong Kong' (2004) 28 Psychiatric Bulletin 451.

[78] *Chan Shek Him v HA* (n 6) [53].

[79] *HA v A District Judge* (n 45); Cheung (n 48).

[80] According to limited information obtained by an Access to Information request to the Food and Health Bureau by Daisy Cheung, the average wait time between the date of application to the MHRT and the date of hearing, in the period from July 2017 to January 2020, was more than 120 days. 33 applications related to section 36 were recorded in this period, only three of which were successful. There was no record of how many section 31 or 32 applications were made, since the patients concerned had all been discharged before the MHRT even started to properly categorise them in their case files.

resort to section 69(2) of the MHO or bring his case to the MHRT.[81] Again, the prospects of success at the MHRT for these cases are dishearteningly low, to say the least.[82] Given this lack of an effective review mechanism during the period of the individual's compulsory detention and/or treatment, professionals cannot expect to be immune from being called upon to answer cases where their exercise of these extensive compulsory powers are in doubt after the event.[83] Indeed, given the existing power disparity between professionals and patients and the immense difficulty at every stage of their compulsory detention and/or treatment for individuals to have their cases reviewed, it is arguable that *more* protection and avenues for effective remedy for patients need to be put in place to ensure professionals are held accountable for their decisions under the MHO.

Taking a step back from section 69(2) of the MHO, one can see that medical professionals are, in fact, already very much protected by the current law from unmeritorious claims. On top of section 69(1), which limits the liability of professionals acting in pursuance of the MHO to cases of negligence or bad faith, medical negligence law also presents a more onerous test for claimants to meet than in general negligence cases, which has the explicit purpose of protecting doctors from liability from any unintended consequences of decisions that may otherwise be deemed reasonable by standards of accepted practice. Under more general civil procedural law, cases which are clearly unmeritorious, i.e., which disclose 'no reasonable cause of action or defence', are 'frivolous or vexatious', or are 'otherwise an abuse of the process of the court', may also be struck out by the High Court under Order 18, Rule 19 of the Rules of the High Court. In more extreme cases, the Court of First Instance may even make an order that a person who has 'habitually and persistently and without any reasonable ground instituted vexatious legal proceedings' may not institute any legal proceedings without leave.[84]

Despite these laws that are already in place to protect medical professionals from various unwanted claims and the fact that those subject to the MHO have hardly any effective avenue in earlier stages of their compulsory detention and/or treatment to raise objections, section 69(2) continues to operate as an additional barrier to bringing cases against professionals under the MHO. The 'reasonably arguable' threshold, as set out in the statute and applied in the stringent manner seen in *Singh v HA*, thus effectively seals the final gateway that those subject to the MHO have to any access to the courts, to have their cases heard in full, and ultimately to the opportunity of attaining justice and asserting their fundamental rights in a court of law. As discussed above, it is in fact very unlikely for those subject to the MHO to be inclined or able to initiate proceedings against those involved in their care and treatment. Even if they do make an application for leave under section 69(2), they are confronted with a test

[81] *Ho Man Kon Natalis v Pamela Youde Nethersole Eastern Hospital* [2013] HKEC 1069 [6].
[82] Information obtained by Daisy Cheung shows that, in the period from July 2017 to January 2020, 51 such applications were made; only one succeeded. See also Urania Chiu, 'Compulsory treatment in the community in Hong Kong: Implications of the current law and practice on the rights of persons with mental illnesses' (2019) 20 Asia-Pacific Journal on Human Rights and the Law 60.
[83] See Baroness Hale's judgment in *Seal v Chief Constable of South Wales Police* (n 28) [49]: 'The purpose [of section 139 of the Mental Health Act 1983] was and remains the protection of staff. But protection from what? It cannot have been intended or expected that staff would be protected from all knowledge of possible claims […] What staff are protected from is having to defend a baseless action.'
[84] High Court Ordinance Cap 4, s 27.

that seems practically impossible to satisfy and a constant sense that because they had, for whatever reason, found themselves caught up in the mental health system, they had to jump through extra hoops in order to make justice claims that those in other medical settings do not have to—a result of the existing inequality in accessing justice, in both the substantive and symbolic senses. It is lamentable that the Court of Appeal in *Chan Shek Him* has chosen to retain such a high threshold on paper and that lower court judges, guided and perhaps even constrained by the general judicial deference to medical judgment, will likely apply it in a way that will allow only the most egregious cases through the gap. The rule therefore has deeply discriminatory effects on those who have or are seen to have a mental illness and sends a dangerous message to this community, frontline workers, and society at large that persons with mental illness are not to be trusted and are only seeking to make trouble when they make claims for their rights. Given the deep-seated prejudice and stigma those who regularly come into contact with the mental health system already face in society, this is a state of affairs that needs to be addressed as a matter of priority.

V. CONCLUDING REMARKS

This article, by highlighting the statutory provision preventing individuals from initiating proceedings under the main piece of mental health legislation in Hong Kong and how it is applied in practice in the context of broader mental health jurisprudence, hopes to bring the discussion about this discriminatory and very real obstacle to access to justice for persons with mental illness to the fore, especially in light of the CRPD's focus on achieving substantive equality for persons with disabilities.

Given section 69(2)'s discriminatory roots, the need for it and its content must be seriously reconsidered. This is so for similar rules in other jurisdictions as well, such as section 139 of the English MHA 1983: regardless of the threshold set by judges, the justification for the rule itself ought to be re-evaluated in view of renewed international standards for the rights of persons with disabilities. In Hong Kong's case, since it will probably require a legislative overhaul and overcoming considerable resistance from the social work and medical sectors in order to even come close to abolishing the threshold altogether, the best courts can do for now may be to reconsider the content of the threshold and, instead of merely applying the proportionality test at the point of access, take into account the fundamental importance of equality before the courts and access to justice and keep in mind the wider impact such a rule would have on a community that is vulnerable and much maligned by society. The current adoption of the threshold originally used in leave applications for judicial review is plainly untenable. In the case referred to by the Court of Appeal in *Chan Shek Him*, Bokhary PJ explained the rationale behind adopting a relatively high threshold in deciding whether to grant leave for judicial review:

> Rarely and exceptionally, the public interest in having a particular point of law decided can be so great as to warrant leave to pursue an application or appeal even though the case has become academic as between the immediate parties save perhaps as to costs […] This broad approach avoids further costs. It represents practical justice.[85]

[85] *Po Fun Chan* (n 31) [18] (Bokhary PJ).

This rationale clearly does not apply to the case of a potential claimant under the MHO, whose rights to liberty and security, to equality and non-discrimination, to dignity, and to remedy for negligent or wrongful treatment are neither academic nor a mere matter of cost-effective 'practical justice'. They concern a historically marginalised group who have long struggled to have their voices heard in the community, in their own care and treatment decisions, and in the legal system and who deserve an equal opportunity to have their claims considered carefully and thoroughly in a court of law as those without mental disabilities currently do. Section 69(2) as it currently stands exacerbates the discriminatory treatment persons with mental disabilities already experience in the Hong Kong mental health legal system, which are in many ways unsatisfactory by international human rights standards.[86]

In the longer term, a fundamental cultural change in courts' approach to mental health law, in particular to the judiciary's role in scrutinising medical decisions and guarding against unjustified interferences with patients' rights, is needed for any legislative reform to be effective. As observed in the previous sections, mental health law in Hong Kong gives far-reaching compulsory powers to frontline professionals without any equivalent safeguards that can be deemed adequate in protecting individuals from unwarranted detention or treatment at the time of its occurrence or providing them with effective remedy or redress after it has occurred. A large part of it is due to how legal rules are applied in practice by judges, whose views inevitably reflect, to some extent at least, prevalent societal attitudes toward mental illness and those associated with it. At the same time, any progressive development in upholding rights in the court will also hopefully trickle down to public attitudes and discourses. To achieve true access to justice, including the symbolic and participatory elements of inclusion, empowerment, and ultimately overall attainment of equal citizenship for persons with disabilities in all aspects of life,[87] much more has to be done in terms of destigmatising mental illness both in the community and in the courtroom. Abandoning outmoded legal rules and recognising the important role judges themselves have to play in redressing the power imbalance between professionals and those subject to the compulsory mental health regime are the first steps courts can take in addressing the historical exclusion of persons with mental disabilities from accessing justice, and they must be taken promptly to prevent further harm to this community.

[86] See Cheung and others (n 8).
[87] Flynn (n 57).

BOOK REVIEW: RESTRICTIVE PRACTICES IN HEALTH CARE AND DISABILITY SETTINGS, EDITED BY BERNADETTE MCSHERRY & YVETTE MAKER (ROUTLEDGE, 2021)

EIMEAR MUIR-COCHRANE*

The use of restrictive practices in the treatment of people with mental illness and disability has a very long and chequered history and is recognised as a global concern. There is significant evidence that restrictive practices have no therapeutic value, have deleterious effects on people exposed to these practices and that the experience of individuals is largely negative. Nevertheless, some health professionals view restrictive practices as beneficial and necessary whilst others view such practices as an embarrassing reality and as a failure of treatment. In the light of such controversy, this new text, 'Restrictive practices in health care and disability settings', is a welcome addition to the published literature on this topic.

This is a solid tome of almost three hundred pages bringing together international experts in mental health and disability from disciplines including law, social work, psychiatry, pharmacy, mental health nursing, consumer academics and those with a lived experience of mental illness. These authors are all influential players in the discourse of restrictive practices and their writings reflects the current state of play in Australia and internationally regarding the quest to reduce and eliminate control mechanisms in health and disability care. The text examines the latest evidence in relation to restrictive practices in mental health and disability. Differing approaches to the legislative, policy and practices of restrictive practices are provided from England, New Zealand, Germany, the Netherlands and Australia. This text will be a valuable resource to both undergraduate and postgraduate students in health professions and legal studies, as it brings together new understandings on control issues in care. Further, the text firmly bears witness to the paradigm shift required in the treatment of people with mental illness and disability in order to potentially eliminate or at least vastly reduce restrictive practices.

The text is divided into five parts with individual chapters within each part. There is some repetition across the text in relation to the historical, human rights, legal and clinical practice of restrictive practices, but this is to be expected when a large number of international authors are considering these issues from different perspectives. A great strength of the text is the coherent weaving and interweaving of common ground in various contexts.

Part One is background with Chapter One setting the scene regarding the scope of the text, the legislative and human rights context, i.e. the United Nations Human Rights Convention on the Rights of Persons with Disabilities (2007) and definitional issues in terms used to describe restraint. The definitional issues are described in general terms, but more could be made of the use of terms such as 'restraint practices' and 'restrictive practices' as they are often used interchangeably in legislative, policy

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and research papers, which can be confusing for those working, researching or studying in this area. Later chapters use these and other terms such as rapid tranquilisation, chemical restraint variously and inconsistently, reflecting the ongoing problems with definitional clarity and the difficulties in establishing good quality evidence, as well as making meaningful international comparisons in research.

Chapter Two is the strongest and most courageous chapter in this impressive text, bearing witness to the discrimination of people with mental illness and disability and presenting a bold vision beyond reducing restrictive practices to complete elimination. These authors, with lived experience of restrictive practices, discuss the social 'othering' of people with a mental illness, as well as providing strong examples of the trauma and re-traumatisation consumers have experienced. Definitions of restraint defined in Australian are tabled but without further discussion about the jurisdictional differences in mental health acts and policies. Such discussion would have been a useful addition, particularly since an elimination of restrictive practices would require changes to mental health acts nationally.

They also identify that 'any legal system operating only on the category of people labelled mentally ill is discriminatory' (p.17) and is in fact a form of lawful violence. This paradigm shift is examined usefully in Chapter Two providing a sociologically based theoretical model describing the intersectionality of restraint from a micro- to macro-systems perspective. This insider view foregrounds the negative and ongoing trauma to people experiencing forms of restraint. This chapter also has an engaging and laudable section in what care could look like in 2050 with an elimination of restraint practices. However, detail about how to care for people who are a danger to themselves or others, who are suicidal or psychotic, is not provided beyond the suggestion that systematic community based holistic care can provide care that respects individuals' human rights.

Chapters in Part Two explore a diverse range of issues: rapid tranquilisation, restrictive practices on people with intellectual impairment and gender in regard to designing legislation to facilitate real change. Chapters Three, Four and Five are very dense and heavy going in places, but certainly provide a great resource for psychiatrists and those in the legal profession regarding the legal complexities involved in effecting policy change. Chapter Five is a valuable and timely examination of the need for a lens on gender in relation to restrictive practices and the need for a trauma-informed approach to care. Quotes provided by women are harrowing examples of the harms caused by experiences of restraint. Chapter Six chronicles tragic fatalities of people exposed to restraint and explores a range of practices which can facilitate a reduction in restraint from an English perspective.

Part Three discusses issues relating to the implementation and monitoring of reforms using data from Australia, the Netherlands and Germany. The content is somewhat uneven across chapters but provides a breadth of detail across an international context of attempted reforms. The use of data and associated limitations about restrictive practices is clearly a fundamental factor in monitoring the effect of change as described in Chapter Nine, whilst Chapters Seven and Ten focus on legislation and human rights issues. Chapter Eight provides an Australian context from the state of

Queensland, detailing the lessons learned from the implementation of the state mental Health Act of 2010, yet does not overcome the predominance of the risk and safety discourse continuing to justify restrictive practices.

The risk discourse is further problematised in Part Four exploring societal, psychiatric and mental health culture as a key influencing factor in the continuing justification for the use of restrictive practices. Chapter Eleven takes the reader through the appalling clinical practices as detailed in the 'Oakden report' from South Australia (concerning abuse and violence against residents of the Oakden Older Persons Mental Health Service) and calls for strategies that can lead to organisational change through leadership but, in conclusion, warns that without respectful workplace cultures, systemic reforms cannot be realised. Chapter Twelve focusses usefully on recovery-oriented care and associated challenges but is generally silent on the burning questions, 'What does care look like when no restrictive practices are used at all?' and 'How are health professionals and carers to be protected from aggression and violence in the workplace?'. Nevertheless, this chapter synthesises the limited quality of evidence about how to improve care and consumers' experience of care in acute psychiatric institutions and other health settings and this 'pulling together' of themes and challenges makes a substantial contribution to ongoing discussions in the literature. Chapter Thirteen reports on the state of play with specific examples of research in aged care settings, regarding the use and overuse of psychotropics and has prescience in the context of another Australian development, the Final Report of the Royal Commission into Aged Care Quality and Safety, released earlier this year. The final chapter of the book takes the reader on an often-neglected exploration of the need for the engagement of doctors to reduce restraint by changing medical behaviour.

In summary, this weighty text enhances awareness as well as the knowledge base about the ongoing complexity and controversy regarding the use of restrictive practices with the most vulnerable in society, those with mental illness and disability. The logical progression of chapters from current reforms to transformative, recovery-oriented care provides the reader with an engaging narrative building on previous knowledge in each chapter. The collective impact of various forms of restrictive practices need to be recognised and understood as greater than the sum of individual restraint and seclusion practices which frequently have a profound and enduring negative impact on consumers. The paradox of providing care in the context of the use of controlling practices remains both a perennial issue and a wicked problem facing health professionals working in the care of people with an acute mental illness and in disability settings. This text addresses these core issues in a systematic and comprehensive way which I have not encountered in any collection of literature to date. I thoroughly recommend this text to those working, studying and researching in legal, social work, psychiatry, mental health nursing and disability fields.