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Notes for contributors

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Foreword

In the Foreword to the last issue (May 2006 – there was no 'November' issue last year) I gave an assurance that the proposed amendments to the Mental Health Act 1983 would be considered in 'the next issue'. I am delighted that that assurance is being honoured within the following pages. Throughout, readers will encounter numerous reflections on, and considerations of, the contents of the Mental Health Bill 2006 ('the Bill') published in November 2006.

However as readers will be well aware, the Bill has had a torrid time as it makes its way through the parliamentary process. Numerous amendments were proposed and passed in the Lords (where the Bill commenced its passage), only to face determined Government resistance[1] once it came to the Commons. As this issue goes to press, it seems probable that parliamentary 'ping-pong' between the two chambers will continue during the remainder of the parliamentary session, and the final form of the Bill is far from clear. As I've bemoaned in previous Forewords, the uncertainty and the forever-changing picture causes problems for contributors, not to mention considerable stress for the editor. The worrying question faced is 'Will the article contain out-of-date material by the time the issue is published?'. As in previous issues, we have tried to pre-empt (and indeed prevent) confusion for the reader. We have tried to be as up-to-date as possible, and we have made every effort to ensure the reader knows the date the article was written, alternatively accepted for publication.

We start off this issue with the question posed by Brenda Hale when she gave the keynote address at the third North East Mental Health Law Conference[2] held in Newcastle upon Tyne on 16th June 2006 – '**The Human Rights Act and Mental Health Law: has it helped?**'. Those who heard, or have read, Lady Hale's widely acclaimed Paul Sieghart Memorial Lecture delivered in the summer of 2004 for the British Institute of Human Rights ('What can the Human Rights Act do for my mental health?'[3]), will be very interested to read and consider her subsequent thoughts. We are extremely grateful to Lady Hale for finding the time to amend the text of her address in the light of the provisions of the Bill.

Another speaker at the June 2006 Conference was Gordon Ashton, Deputy Master of the Court of Protection. He too asked a question – '**Will the new Court of Protection damage your mental health?**'. Professor Ashton is of course eminently qualified to consider the question posed – after all for many years he has been at the forefront of the debate about the appropriate legal framework for decision-making in respect of those unable to make decisions for themselves – but as he himself acknowledges in the text which he has revised for this issue of the JMHL, it is a question which cannot yet be confidently answered. Professor Ashton poses a number of questions about the revamped Court, which will be operational from 1st October 2007, the delayed implementation date of most of the provisions of the Mental Capacity Act 2005 ('MCA 2005').[4]

Considerable interest and debate has been generated by the provisions of Clause 38 of the Bill. It is this clause which will amend the MCA 2005 to provide for 'authorisation procedures' in respect of the 'Bournewood' patient. As solicitor for Mr. L throughout the lengthy journey from High Court to Strasbourg[5], Robert Robinson is of course ideally placed to reflect on how the Government aims to plug the 'Bournewood' gap. In his article '**Amending the Mental Capacity Act 2005 to provide for**

1 *For evidence of the extent of Government opposition to the amendments passed in the House of Lords, one need look no further than the speech delivered by Ms. Rosie Winterton, Minister of State for Health Services, to the Local Government Association Conference, Mental Health Bill, 1st March 2007.*

2 *The fourth N.E. M.H. Law Conference is to be held in Newcastle on 16th November 2007.*

3 *Reproduced in JMHL May 2005 pp 7 – 16.*

4 *'The Mental Capacity Act 2005'. Gateway reference 7890. Department of Health (22/2/07).*

5 *HL v United Kingdom (2005) 40 EHRR case no. 32*

deprivation of liberty', Mr. Robinson is critical of what is intended. He fears that 'an unnecessarily complex and costly detention regime' is in danger of being created 'with little discernible benefit to the people whose interest it is intended to protect'.

In the next article, Chris Heginbotham and Mat Kinton (the Chief Executive and the Senior Policy Analyst of the Mental Health Act Commission respectively) take the opportunity of reconsidering '**Developing a capacity test for compulsion in mental health law**'. In view of the fate of the Richardson Committee's Report of 1999[6] – in which 'capacity' sat at the heart of the Committee's proposals for reform of mental health law – it is reasonable to ask why. The answer lies in the first paragraph of their article – "For England and Wales, the proposal to introduce a threshold requirement of 'impaired decision-making' into the criteria for detention under sections 2 and 3 of the Mental Health Act 1983 was the first amendment to be voted upon in the House of Lords' reading of the Mental Health Bill ... Government lost the vote by a wide margin…"'. The issue of 'capacity' as a threshold test for compulsion continues to be attractive to some – and the fresh look by Professor Heginbotham and Mr. Kinton is therefore to be welcomed.

Another issue which has been central to the whole debate about mental health law reform (much too much so in the eyes of many) has been the 'Michael Stone question'[7]. Robert Francis QC chaired the Inquiry established to consider the events surrounding the killing in July 1996 of Lin Russell and her daughter, Megan, and the assault on her other daughter, Josie. Last summer Michael Stone, the man convicted of these horrific crimes, finally failed in his attempt to stop the Inquiry Report being published[8]. Earlier this year Mr. Francis kindly accepted the invitation extended to him, and has submitted '**The Michael Stone Inquiry – a Reflection**'. He provides an interesting insight into what occurred, and helpfully reflects on the respective roles of the criminal justice system and mental health services.

We then come to three articles which focus clearly on the Bill. Lord Patel has played a significant role in the House of Lords debate on the Bill. He asks '**A Nasty Act?**'. As Chairman of the Mental Health Act Commission, his views warrant particularly careful consideration. His support for the Lords amendments, his view that the amended Mental Health Act should be 'principled legislation' and his commitment to 'the least restrictive option' are all explained within his article. David Hewitt, Visiting Fellow at Northumbria University, also considers the Bill. In his typically meticulous way, Dr. Hewitt in '**Reconsidering the Mental Health Bill: the view of the Parliamentary Human Rights Committee**' analyses the scrutiny devoted to the Bill by the Parliamentary Joint Committee on Human Rights in their report published in February 2007[9]. Given that (in Dr. Hewitt's words) the report "is not the easiest of reads", he has done us a valuable service. His conclusions on the possible effects of the Committee's work should perhaps be considered when answering the question posed by Lady Hale in the opening article of this issue. The third article which focuses exclusively on the Bill, concerns the role (and the name) of the Approved Social Worker. Roger Hargreaves, a former ASW and the 'lead' on the Bill for the British Association of Social Workers, considers '**The Mental Health Bill 2006 – [from a] social work perspective**'. In his wide-ranging article, Mr. Hargreaves makes abundantly clear the primary concerns of his profession. He urges that the Government address these concerns, and concludes that "ultimately it has no choice but [to do so] if it wishes to ensure that the civil procedures of the amended Act will continue to be administered as effectively by AMHPs [Approved Mental Health Professionals] as they have been by ASWs for the past 24 years".

6 *The Report of Expert Committee, 'Review of the Mental Health Act 1983' was published by the Department of Health in November 1999. The Government's Green Paper 'Reform of the Mental Health Act 1983' was published at the same time, and made clear its rejection of the Committee's capacity-based approach.*

7 *The expression adopted by Lord Carlile of Berriew in the House of Lords debate of 12th June 2006. See footnote 8 in Robert Francis's article.*

8 *R (on the application of Stone) v South East Coast Strategic Health Authority and others [2006] EWHC 1668 (Admin)*

9 *HL Paper 40, HC 288, 4th February 2007*

In October 2005, the Law School at Northumbria University hosted a 'Comparative Mental Health Law Seminar'. Professor Warren Brookbanks from the Law School at the University of Auckland, New Zealand was one of the speakers. Since then he has revised the paper delivered at that event. '**Sexual predators, extended supervision and preventive social control: Risk management under the spotlight**' takes as its starting-point recent New Zealand legislation, the Parole (Extended Supervision) Amendment Act 2004. He proceeds to a critical analysis of "the legitimacy of this model of preventive detention in the light of the legislative response to sex offenders in other jurisdictions, notably the United States and England". It is a statement of the obvious, but surely needs to be constantly re-stated – much can be learned by looking across to other jurisdictions[10].

We end the issue as usual with some case reviews and book reviews.

The consideration given by Mr. Justice Munby to the question as to whether or not someone is 'deprived of [their] liberty' is referred to both by Robert Robinson and David Hewitt in their articles. The case in which the question was asked is *JE v DE (by his litigation friend the official Solicitor) (1) Surrey County Council (2) EW (3)*[11], heard in the Family Division of the High Court on 29/12/06. In '**Two steps forward, one step back**' Lucy Scott-Moncrieff (solicitor) welcomes the approach taken by the Judge, before proceeding to express her concerns about the problems she foresees as arising from the proposed amendments to the MCA 2005[12]. She suggests that the case "displays the problems …. in all their grisly inadequacy".

The other case reviewed is the 2007 Court of Appeal decision in *Mersey Care NHS Trust v Ackroyd*[13]. John Anderson (solicitor) provides a critical review of this decision, the latest (and presumably the last) in the long-running saga involving the leaking of confidential information to the Press from Ashworth High Security Hospital. The review's title ' **'Sunlight [as] the best of disinfectants'?** ' will no doubt intrigue and entice readers – as is intended.

We draw readers' attention to two books. Michael Konstam (barrister) welcomes '**Mental Disability and the European Convention on Human Rights**'[14] by Peter Bartlett, Oliver Lewis and Oliver Thorold, whilst Simon Foster (solicitor) considers '**The Approved Social Worker's Guide to Mental Health Law**'[15] by Robert Brown.

There are two clear omissions from the contents of this issue, one or both of which may have been spotted by the eagle-eyed reader. Firstly Part 2 of Kay Wheat's consideration of 'Mental Health in the Workplace' is not included despite being flagged up in the last issue (when Part 1 was published[16]). Secondly there is no article focussing closely on the controversial provisions within the Bill for supervised community treatment/community treatment orders, despite one being intended (by Kris Gledhill (barrister)). Their absence is not the fault of either author, but simply because of an editorial decision to hold them over to the November issue. An assurance is given that both will appear then.

As ever, sincere thanks must go to those who have so generously contributed to this issue of the JMHL. I also take the opportunity of (a) welcoming Dr. George Szmukler (Institute of Psychiatry) to the Editorial Board, and (b) thanking David Hewitt (solicitor, Hempsons) and Mat Kinton (Mental Health Act Commission) for sharing editorial responsibility for this issue (and hopefully, for many issues in the future).

John Horne

Editor

10 *It is hoped that the November 2007 issue will contain a number of articles which consider jurisdictions other than that of England and Wales.*

11 *[2006] EWHC Fam 3459*

12 *See Clause 38 Mental Health Bill 2006*

13 *[2007] EWCA Civ 101*

14 *Martinus Nijhoff (2006)*

15 *Learning Matters (2006)*

16 *JMHL May 2006 pp 53–65*

The Human Rights Act and Mental Health Law: Has it Helped?[1]

Brenda Hale[2]

The short and gloomy answer must be – not very much. But that all depends upon how one thinks about human rights and what one hoped for from the Act. Lawyers – perhaps especially the English lawyers who helped draft the European Convention and who practise in the administrative court today – tend to think of human rights in terms of civil liberties and political freedoms and only to a limited extent in terms of economic and social rights.[3] But there is a much broader conception of human rights which can be found in the Universal Declaration of Human Rights of 1948 and its daughter Covenants of 1966, the International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights. It can also be found in the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.[4]

I think these principles can be summed up in five basic propositions:

(1) People with mental disorders and disabilities should be enabled to receive the treatment and care which they need.

(2) This applies to all people, without discrimination on grounds such as sex, racial or ethnic origin, sexual orientation, religion, membership of a particular social group, or the nature of their disorder or disability.

(3) Enabling does not mean enforcing. Everyone should be assumed to have the ability to decide for themselves whether to accept the treatment or care that others think they need. A person's right to choose what may be done with his body or his mind should only be taken away in accordance with due process of law.

(4) That process should not discriminate unjustifiably between the mentally and the physically ill or disabled. It should involve, as a minimum:

  (i) Logical and defensible grounds for compulsion;

  (ii) A fair process which enables both sides of the case to be put and heard; and

  (iii) The appropriate treatment and care in return.

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1 *This was the title of the lecture delivered by Lady Hale at the North East Mental Health Law Conference on 16 June 2006. Lady Hale has kindly updated the text of that lecture for this issue of the Journal of Mental Health Law. It was accepted for publication on 3 April 2007.*

2 *Baroness Hale of Richmond.*

3 *For a discussion of the as yet unexplored potential of the Human Rights Act in this difficult area, see E Palmer, Judicial Review, Socio-economic Rights and the Human Rights Act (Hart Publishing, forthcoming).*

4 *General Assembly Resolution 46/119 of 19 December 1991.*

(5) Underlying and overriding all of these principles is respect for the dignity and humanity of all people, however disabled or disordered in body or in mind or both.

I want to concentrate on (3) and (4) – the right to choose and the process of compulsion – because that is where the debates in our case law and legislation have mainly been.

The Presumption of Capacity and the Right to Choose

Section 1 of the Mental Capacity Act 2005 is quite clear about this. A person must be assumed to have the capacity to make his own decisions unless it is established that he does not. He is not to be treated as unable to take a decision unless all practicable steps to help him do so have been taken without success. But the Mental Capacity Act deliberately retained the common law concept of necessity from the case of *Re F*:[5] that if a person is indeed unable to take a decision for himself, those looking after him may do whatever it is reasonable in the circumstances for them to do for him, provided that they act in his best interests.[6] The original framers of the 2005 Act (which began its life in the Law Commission during my time as a Commissioner) did not think it practicable or desirable for there to have to be some formal process to enable family and carers to look after people who were unable to look after themselves.[7] Formalities are cumbersome and can be both expensive and stigmatising. The better approach is to provide proper machinery for resolving disputes about treatment or care and to enact limits to what may be done without formal approval.

The limits we proposed were of two kinds: extra formalities for certain forms of medical treatment, such as ECT, and general prohibitions of coercion and confinement.[8] We were concerned that if the *Re F* doctrine could be used to authorise major surgery it might well be used to authorise detention.[9] The former kinds of limit did not find their way into the Act but the latter did. The Act limits the use of restraint. It also tries to make it clear that it does not allow anyone to go beyond restraint and deprive a person of his liberty within the meaning of article 5.1 of the European Convention on Human Rights.[10]

Article 5.1 says this:

> '*Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:*'

It then lists six cases (a) to (f) where deprivation of liberty may be allowed, (e) being:

> '*the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.*'

Little attention has so far been paid to the 'security of person' aspect of article 5. It is all about deprivation of liberty. So what does that mean?

No doubt everyone is familiar with the *Bournewood* saga. Section 131(1) of the Mental Health Act 1983 (repeating section 5(1) of the Mental Health Act 1959) was undoubtedly intended to allow both actively consenting and passively non-dissenting patients to be admitted to hospital and cared for there without any legal formalities. It was all part of the 1959 Act's normalisation of psychiatric care. No legal formalities are required for admission to hospital for treatment for physical disorders, so why should any be required for admission for treatment (or care) for mental disorders? Why should the thousands of

5 *Re F (mental patient: sterilisation) [1990] 2 AC 1.*

6 *2005 Act, s 5.*

7 *Law Com No 231, Mental Incapacity (1995), paras 4.1 – 4.5.*

8 *Paras 6.3 – 6.15; 4.30 – 4.33*

9 *Para 4.31. The Bournewood cases, discussed below, were to prove us right about this.*

10 *Section 6(5).*

elderly demented or mentally disabled people then in long term hospital care be subject to formalities designed to compel the seriously mentally disturbed to accept treatment when no compulsion was needed in their case? Why should hospitals be any different from nursing and residential care homes in this respect? That was the thinking then and many would be sympathetic to it now.

Mr L did not quite fit the picture of a passive patient. An autistic, profoundly disabled man in his forties, he became agitated at his day centre, was sedated and taken to A & E. A psychiatrist there assessed him as needing in-patient treatment but it was not thought necessary to section him as by then he appeared fully compliant and unresisting. He was admitted to an unlocked ward. But he was sedated there and would have been sectioned had he tried to leave. His foster carers were prohibited from visiting him in case he wanted to leave with them. They wanted him home but the hospital was not prepared to release him until they thought he was ready.

The Court of Appeal held that section 131(1) applied only to positively consenting patients. They regretted that 'authoritative textbooks', such as those by Hoggett (now Hale) and Jones, had misinterpreted the effect of the Act.[11] They awarded Mr L £1 in damages for false imprisonment. The day that the Court of Appeal announced its decision, Mr L was formally detained under section 5(2) of the Act and then sectioned under section 3. The House of Lords unanimously allowed the hospital's appeal.[12] Their lordships were given much more information about the background to section 131(1) than the Court of Appeal had been. Three of them decided that Mr L had not been imprisoned at all. Two decided that he had indeed been detained. Lord Steyn described the suggestion that he was free to leave as 'a fairy tale'. But the minority agreed that his detention had been justified under the *Re F* doctrine of necessity. Indeed, Lord Steyn pointed out that it might even on occasions justify the detention of a non-compliant, actively dissenting patient. There are certainly common law decisions to this effect (which were quoted in Hoggett[13]) which had not been cited to the Court of Appeal.

So the case went to Strasbourg. The European Court of Human Rights[14] agreed that Mr L had been deprived of his liberty. To do this they had to distinguish the case of *HM v Switzerland.*[15] This was a typical case of an old lady being taken to a nursing home for her own good. The Court said that it had not been established that she was incapable of expressing a view; she had often said previously that she was willing to go there and within a short time of admission she was willing to stay (are they not always?); the regime in the nursing home was entirely different from that in hospital; it was an open institution allowing freedom of movement and encouraging links with the outside world.

So the first question is 'what amounts to a deprivation of liberty?' As is its custom, the Court repeats the same test in case after case, for example in *Storck v Germany*:[16]

> *'The Court reiterates that, in order to determine whether there has been a deprivation of liberty, the starting point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case, such as the type, duration, effects and manner of implementation of the measure in question.'*

The *Storck* case is also important for holding that the first sentence of article 5.1 lays down a positive

11 *R v Bournewood Mental Health NHS Trust, ex parte L [1999] AC 458, at 474, referring to Hoggett, Mental Health Law, 4th ed 1996, p 9 and Jones, Mental Health Act Manual, 5th ed 1996, p 340.*

12 *Ibid.*

13 *Op cit, pp 78 – 79.*

14 *HL v United Kingdom, Applic No 45509/99; (2005) 40 EHRR Case No 32.*

15 *Applic No 39187/98; [2002] MHLR 209.*

16 *Applic No 61603/00, Judgment of 16 June 2005, para 71; (2006) 43 EHRR 96.*

obligation upon the State to protect the liberty of its citizens (in this case a young woman detained in a private psychiatric clinic) and that *ex post facto* sanctions, in the shape of criminal and civil liability for wrongful detention, do not provide effective protection for people in such a vulnerable position.[17]

So the second question is, 'what measures may be needed to safeguard the liberty of people such as Mr L?' In Mr L's case, the Court accepted that the deprivation of liberty was capable of being justified under article 5.1(e). Mr L had been shown to be of unsound mind during the whole period that he was in hospital. However, they decided that his detention had not been 'lawful'. It is not enough that the detention is lawful under domestic law, as this was. It must also meet the Convention standard of legality. This requires the law to be sufficiently clear and precise to allow the citizen to foresee the consequences of a given action. But it also requires the law to comply with the essential objective of article 5 'which is to prevent individuals being deprived of their liberty in an arbitrary fashion'.[18] If there are no procedural rules, no criteria, no statement of purpose, no limits of time or treatment, and no requirement of continuing clinical assessment, there is nothing in the law to protect the citizen against the arbitrary deprivation of liberty on grounds of necessity. There was also no process whereby the legality of the detention could be speedily determined by a court, as required by article 5.4.

One might also have thought that some remedy was urgent. In the olden days, the Government might have reflected in tranquillity about what to do next. But section 6(1) of the Human Rights Act 1998 makes it unlawful for a public authority to act in a way which is incompatible with a Convention right. Even so, the Government took its time. It produced its *Bournewood Consultation* in March 2005[19] and in June 2006 it announced that the proposed Bill to amend the Mental Health Act would also amend the Mental Capacity Act 'to introduce safeguards for patients with a mental disorder who are deprived of their liberty but are not subject to mental health legislation'.[20] It would also clarify when detention under the Mental Health Act should be used rather than the Mental Capacity Act or the proposed new Bournewood procedure: where there is a choice, 'the Government's intention is that the Mental Health Act will be used where people object to being detained or treated'.[21] The new safeguards will put 'these people in broadly the same position as people who have capacity but refuse to consent to treatment'.

The Mental Health Bill introduced in the House of Lords on 16 November 2006[22] makes elaborate provision to this effect.[23] In brief (and necessarily inadequate) summary,[24] the supervisory body responsible for a resident in a hospital or care home will be able to authorise detention for the purposes of care or treatment if certain qualifying conditions are met. The resident must be suffering from mental disorder (including learning disability), lack the capacity to decide for himself whether he should be accommodated in the hospital or care home, and not be ineligible, in effect because the authorisation would be inconsistent with the Mental Health Act regime to which he is already subject or because he meets the criteria for detention in hospital under the 1983 Act and objects to his detention or treatment. Crucially,

17 *Ibid, paras 102 and 105.*

18 *HL v United Kingdom, para 115.*

19 *Department of Health, Bournewood Consultation: The approach to be taken in response to the judgment of the European Court of Human Rights in the 'Bournewood' case, Gateway Ref 4706, 23 March 2005.*

20 *Department of Health, The Mental Health Bill – Plans to amend the Mental Health Act 1983, Briefing sheet on Implementing Government Policies on Mental Health Law, June 2006, p 1.*

21 *Department of Health, The Mental Health Bill – Plans to amend the Mental Health Act 1093, Briefing sheet on The criteria for detention, April 2006, p 4.*

22 *The Bill is still going through Parliament, and many of its provisions are controversial, so reference will be made only to the version introduced on 16 November 2006.*

23 *Clause 38, introducing new sections 4A, 4B, 16A, 21A, 39A, 39B and 39C, and new schedules A1 and 1A and making numerous other amendments to the 2005 Act.*

24 *The Explanatory Notes to the Bill devote paragraphs 155 to 195 to the subject!*

the detention must be in his best interests, necessary in order to prevent harm to him, and a 'proportionate response' to the likelihood and seriousness of that harm. The Court of Protection will also be able to authorise detention, and in places other than hospitals or care homes, provided that the resident is not ineligible. The object is to maintain a strict separation between the Mental Health Act and Mental Capacity Act procedures: but it seems strange that, if the case is already before the Court of Protection and the criteria are met, the Court should not be able to authorise the use of Mental Health Act powers.[25]

So the main effect of the Human Rights Act in mental health law will soon be to make substantial inroads into the whole concept of informal admission, which was so central to the thinking underlying the 1959 Act. Do we think that that is a good thing or a bad thing? And how far will it go? What will be the effect on nursing and residential homes caring for elderly mentally infirm or younger mentally disabled people? How confident are we that we know the difference between unacceptable deprivation of liberty and acceptable limitations on freedom? And there is another question lurking in the future: what about other invasions of bodily integrity and autonomy? The Bournewood amendments deal only with safeguards against arbitrary deprivation of liberty. They do not introduce safeguards against unjustified medical treatment. There may well come a time when the *Re F* principle will be challenged as giving insufficient protection to the right to respect for a person's private life under article 8. For some treatments at least, as the Law Commission originally proposed, *ex post facto* remedies may not be enough. The Parliamentary Joint Committee on Human Rights, relying heavily upon *Storck v Germany*, has already suggested as much.[26]

Logical and defensible grounds for compulsion

I am not sure that the Human Rights Act is much help here either. The leading Strasbourg case on what is required to demonstrate that a person is 'of unsound mind' within the meaning of article 5.1(e) is *Winterwerp v The Netherlands*.[27] The Court deliberately declined to define what this meant:

> *'. . . because its meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitudes to mental illness changes, in particular so that a greater understanding of the problem of mental patients is becoming more widespread.'*

Does this mean that more and more people may be drawn into the net? Or does it on the contrary mean that as understanding grows, fewer and fewer people will be thought to be of such unsound mind that they may lawfully be deprived of their liberty? I hope the latter but am not at all sure that this is what Strasbourg meant.

The additional criteria set by the Court were scarcely demanding:

> *'The very nature of what has to be established before the competent national authority – that is a true mental disorder – calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder.'*

There is little hint here of the debates about the moral justification for compulsory detention and treatment which have been troubling mental health lawyers for decades. The Percy Commission[28] which

25 *As the Law Commission had recommended: Law Com No 231, paras 8.27 to 8.30.*

26 *House of Lords, House of Commons, Joint Committee on Human Rights, Legislative Scrutiny: Mental Health Bill, Fourth Report of Session 2006-07, HL Paper 40, HC 288, 2007, paras 93 to 101. For a detailed consideration of this report, see David Hewitt's article in this issue of the JMHL.*

27 *(1979) 2 EHRR 387.*

28 *Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency 1954-1957, Cmnd 169, 1957.*

led to the 1959 Act drew careful distinctions between the major mental disorders – mental illness (by which they undoubtedly meant what had previously been called lunacy or madness) and severe mental subnormality – which would justify long term detention and treatment, the minor disorders – psychopathic disorder and subnormality – which would only justify long term compulsion while the person was young or when he had committed a criminal offence, and the 'catch-all' concept of mental disorder - which would only justify emergency intervention and short term assessment. These distinctions were eroded by the 1983 Act, which did away with the age limits upon the long term compulsion of psychopathic and mentally impaired patients in return for a treatability test. When the current review of that Act began, the Richardson Committee of experts[29] likewise devoted a lot of thought to the justifications for compulsion. The desire to promote the principle of non-discrimination on grounds of mental health was fundamental to their approach. They saw much of the answer in a rigorous definition of incapacity: why should society force treatment upon a person who is capable of making the decision for himself? But they also acknowledged that there might be people who retained capacity, in that their cognitive and choice-making powers enabled them to understand what was proposed and to make a considered choice about whether or not to accept it, but who nevertheless constituted such a risk to others that it was justifiable to compel them to accept treatment.

But the Government did not accept any of that. The Mental Health Bill amends the definition of mental disorder to remove all distinctions between the different types of disorder (although the use of long term compulsion for mentally disabled patients will be restricted to those whose disorder is associated with abnormally aggressive or seriously irresponsible conduct).[30] This is 'to further simplify the Act and to help ensure that nobody who needs compulsion is arbitrarily excluded on the basis of a legal classification.' The present distinctions '[encourage] some patients and their lawyers to argue about legal classifications in the hope of securing inappropriate discharge. Detention ought to be based on the needs of patients and the degree of risk posed by their disorder, not on their diagnostic label'.[31]

This is surely discriminatory as between people with mental disorders and people with physical disorders. People with physical disorders are entitled to refuse treatment which they undoubtedly need, at whatever risk to themselves. Nor can they be locked up before they have done anything wrong, no matter how likely it is that they will cause harm to others in the future. We have to ask what it is about mental disorder that makes a difference. What is the rational justification for subjecting people with mental disorders to compulsion when people with other disorders are not so subject? But there is little or nothing in the Strasbourg jurisprudence to encourage a more rigorous approach to this question.

Winterwerp does require that the disorder be of a type or severity to justify detention. This is reflected in the 'nature or degree' requirement in the current Act and the Bill does not change this. The main change will be to replace the current 'treatability' test in admission for treatment (but only for psychopathic and mentally impaired patients) with one which requires that appropriate medical treatment actually be available to the patient (whatever his disorder). This means 'medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all the other circumstances of his case'.[32] The definition of medical treatment is also to be amended, to include 'nursing, psychological

29 *Department of Health, Report of the Expert Committee: Review of the Mental Health Act, November 1999.*

30 *Mental Health Bill [HL], clauses 1 and 2, amending section 1 of the 1983 Act.*

31 *Department of Health, The Mental Health Bill, Plans to amend the Mental Health Act 1983, Briefing sheet, The definition of mental disorder, April 2006, p 2.*

32 *Clauses 4 and 5, amending the criteria for admission for treatment under section 3, remands to hospital for treatment under section 36, hospital orders (including restriction orders) under section 37, hospital and limitation directions under section 45A, and transfers to hospital under section 47 and 48. The criteria for renewal under section 20 and discharge by a tribunal under sections 72 and 73 are also amended.*

intervention, and specialist mental health habilitation, rehabilitation and care'.[33] The Government believes that the appropriate treatment test will be better 'because it calls for a holistic assessment of whether appropriate treatment is available, not focused only on the likely outcome of treatment'. [34] I think it may very well be right about this, and it could be a great improvement, but I doubt whether it has much to do with Strasbourg.

One of the main difficulties faced by people trying to secure their discharge from hospital is that they would be able to cope in the community if only the appropriate treatment and care were available to them there. One might have thought that it would be a breach of article 5.1 to detain someone in hospital if he did not need to be there. But in *R (H) v Secretary of State for the Home Department*,[35] the House of Lords held that there was no violation, even though a tribunal had granted a conditional discharge, when the community agencies would not make the arrangements necessary to meet the conditions. It seems that a patient's condition may be of a nature or degree justifying detention if there is no other treatment available for him even though it could quite properly be treated without the need to detain him. Once again, Strasbourg was no help because the *Winterwerp* criteria were met. Nor, of course, is it any help to those patients detained in secure hospitals who are ready to move on but who for one reason or another are prevented from doing so. In *Ashingdane v United Kingdom*,[36] the Court held that as long as their condition meets the *Winterwerp* criteria, and the place where they are detained is a psychiatric hospital, they cannot complain.

A fair process

It seems that the Human Rights Act may have more to offer on process issues than on the substance. (After all, the early case of *X v United Kingdom*[37] led to the power of mental health review tribunals actually to discharge, rather than to make recommendations to the Home Secretary about the discharge of, restricted patients.) The Mental Health Act relies on the right to challenge an admission *ex post facto* and to seek a review at regular intervals thereafter, rather than on prior authorisation or automatic reviews in every case. This means that many compulsory admissions go unchallenged. In some cases this may be because the patient accepts the situation. In others it may be because the patient is incapable of making an application and may not have a nearest relative who can take action on his behalf. One example is where proceedings are pending in the county court to remove a nearest relative on the ground that she is proposing to exercise her powers to discharge, or to object to long term compulsion, unreasonably. At present, this extends the life of an admission for assessment until the proceedings are completed, which can take years rather than months. The Court of Appeal thought that this provision was incompatible with the Convention but the House of Lords thought otherwise: the provision itself was not incompatible, although the authorities would have to take steps to operate it in a compatible manner.[38]

There is nothing in the Convention jurisprudence to require an automatic review in every case. Article 5.4 guarantees the right of everyone deprived of their liberty 'to take proceedings by which the lawfulness of his detention shall be decided speedily by a court . . .' The onus is therefore placed upon the patient to bring the proceedings. This is in contrast to article 5.3, which requires that people arrested on suspicion

33 *Clause 7, amending section 145(1).*

34 *Department of Health, The Mental Health Bill, Plans to amend the Mental Health Act 1983, Briefing sheet, The criteria for detention, p 2.*

35 *[2003] UKHL 59; [2004] 2 AC 253.*

36 *(1985) 7 EHRR 528.*

37 *(1981) 4 EHRR 181.*

38 *R (H) v Secretary of State for Health [2005] UKHL 60; [2006] 1 AC 441.*

of crime be brought promptly before a judicial officer. Article 6.1 requires a fair trial in the determination of his civil rights or obligations, but this requires a *contestation*. Nevertheless, indefinite detention without review would be contrary to article 5.1, as 'the validity of continued confinement depends upon the persistence of such a disorder'.[39] So the Act should be operated in such a way as to ensure that such cases were referred to a tribunal for review. At present, this can be done by procuring a Secretary of State's reference under section 67 of the Act.[40] A hospital, which continued to detain without procuring such a reference might, therefore, be acting incompatibly.

Nor has the Convention prevented the professionals from invoking compulsory powers soon after a patient has been discharged by a mental health review tribunal. What could be more apparently unjust than for a patient to succeed before a tribunal only to find that the professionals immediately invoke the Act to detain him? But the Human Rights Act may have been influential in refining the circumstances in which this can be done: a social worker can only apply again if he reasonably and in good faith considers that he has information which was unknown to the tribunal and puts a significantly different complexion on the case.[41]

But there have been successful declarations of incompatibility, most notably in *R (H) v London North and East Region Mental Health Review Tribunal (Secretary of State for Health intervening)*.[42] There it was held incompatible to require that the patient prove to the tribunal that he was not detainably ill, rather than that the hospital prove that he was. This led to the first remedial order under section 10 of the Human Rights Act.[43] The standard of proof, however, is still on the balance of probabilities rather than the stricter criminal standard.[44]

The Human Rights Act has also spurred reforms in the process of selection and replacement of the nearest relative. Despite all the historical evidence to the contrary, the Mental Health Act proceeds on the assumption that the patient's nearest relative will always have his best interests at heart. It is much kinder to the relative who wants to admit the patient to hospital or guardianship than it is to the relative who resists this: a relative who unreasonably objects to admission may be replaced, whereas a relative who makes repeated and unnecessary emergency applications cannot. Under the Bill, the patient will be able to apply to replace the nearest relative and to discharge a replacement order. General unsuitability will be added to the grounds for replacement. But relatives displaced for unreasonable resistance to admission or guardianship will still not be able to apply for reinstatement.[45] Civil partners, unaccountably left out of the generally comprehensive assimilation of civil partners and spouses under the Civil Partnership Act 2005, will be added to the list alongside husband or wife, and unmarried same sex partners will be treated in the same way as unmarried opposite sex partners.[46]

The nearest relative can be an important safeguard. So too can the independence of the recommending doctors and the Mental Health Review Tribunal. Article 6 requires that the tribunal be 'independent and

39 *Winterwerp v The Netherlands (1979) 2 EHRR 387.*

40 *Clause 30 of the Bill amends section 68, so that the hospital managers will be under a duty to refer all patients on the expiry of six months from their admission for assessment, even if they have exercised their right to apply within 14 days of their admission.*

41 *R (Von Brandenburg) v East London and The City Mental Health NHS Trust [2003] UKHL 58; [2004] 2 AC 280.*

42 *[2001] EWCA Civ 415; [2002] QB 1.*

43 *Mental Health Act 1983 (Remedial) Order 2001, SI 2001/3712.*

44 *R (N) v Mental Health Tribunal (Northern Region) [2005] EWCA Civ 1605; [2006] QB 468; leave to appeal to the House of Lords has been refused.*

45 *Mental Health Bill [HL], clauses 21 to 24.*

46 *Department of Health, The Mental Health Bill, Plans to amend the Mental Health Act 1983, Briefing sheet, Nearest Relatives, April 2006. The House of Lords' decision in Ghaidan v Godin-Mendoza [2004] UKHL 50; [2004] 2 AC 557 may have been some encouragement.*

impartial'. So what about the medical member? A patient might well think that a psychiatrist employed by the same NHS Trust as his own responsible medical officer, albeit at a different hospital, had at least the appearance of bias. But the test is not what the patient thinks but what a reasonable and fair-minded bystander in possession of the relevant facts might think. So the Court of Appeal dismissed the challenge.[47] This is a dilemma facing all administrative tribunals. The whole object is to have expertise which the ordinary courts do not have, not least so that they can be more user-friendly and effective. An ignorant tribunal is no great safeguard, no matter how objectively independent. A psychiatrist is much better at challenging another psychiatrist than any lawyer. But psychiatry is quite a small profession; the RMO and the medical member may very well know one another, quite apart from their natural professional solidarity. Like the Percy Commission, however, I tend to think that expertise and familiarity with the subject matter is likely to lead to more searching reviews than might happen in an ordinary court.

The appropriate treatment and care

Now I turn to the sensitive matter of what actually goes on in psychiatric hospitals. I mentioned earlier that Bill requires that 'appropriate medical treatment' is actually available for the patient before he can be compulsorily admitted to hospital for treatment. I do not know to what extent this may have been influenced by the Strasbourg case law under article 3. Article 3 prohibits torture and inhuman or degrading treatment or punishment. It is an absolute prohibition so the threshold of severity is high. But in *Keenan v United Kingdom*[48] Strasbourg stressed the special obligations owed to people who are deprived of their liberty:

> '. . . *the authorities are under an obligation to protect the health of persons deprived of liberty*. The lack of appropriate medical treatment may amount to treatment contrary to Article 3. In particular, the assessment of whether the treatment or punishment is incompatible with the standard of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment.
>
> '. . . there are circumstances where proof of the actual effect upon the person may not be a major factor. For example, *in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3.* Similarly, treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be capable of pointing to any specific ill-effects.'

That is all very encouraging, but note the reference to necessity. There are many things which are done in psychiatric hospitals which might be thought inhuman and degrading, in particular forcible medication or ECT and the use of seclusion. The leading case in Strasbourg is *Herczegfalvy v Austria.*[49] The patient, who was obviously not the easiest person to handle and objected violently to his detention, had been force-fed, forcibly given psychotropic drugs, and kept for more than two weeks in handcuffs tied to a security bed. He complained of degrading treatment. The Court started strongly:

> *'The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has*

47 *R (PD) v West Midlands and North West Mental Health Review Tribunal [2004] EWCA Civ 311.*

48 *(2001) 33 EHRR 28.*

49 *(1993) 15 EHRR 437.*

> *been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit of no derogation.'*

But then it weakened:

> *'The established principles of medicine are admittedly decisive in such cases: as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has convincingly been shown to exist.'*

The reference to the 'established principles of medicine' looks very reminiscent of the *Bolam* test for medical negligence (which, you will recall, involved the administration of ECT without an anaesthetic).[50] Sure enough, the Court concluded:

> *'. . .the evidence before the Court is not sufficient to disprove the Government's arguments that, according to the psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue.'*

Forcible treatment would also contravene article 8 unless it could be justified by medical necessity. The European Court of Human Rights has recently reiterated, in *Storck v Germany*,[51]'that even a minor interference with the physical integrity of an individual must be regarded as an interference with the right to respect for private life under Article 8 if it is carried out against the individual's will'. In that case, the treatment was not lawful under domestic law and so the Court did not have to consider whether it was medically necessary.

The requirement that 'medical necessity be convincingly shown' did lead the Court of Appeal to hold, in *R (Wilkinson) v Broadmoor Special Hospital Authority and Others*,[52] that despite the powers to impose treatment given by the Mental Health Act, the court might have itself to examine the facts to decide whether the proposed treatment would be incompatible with the patient's rights under articles 2 (right to life), 3 (prohibition of inhuman or degrading treatment) or 8 (invasion of privacy). That was a judicial review case, where the procedure is not well adapted to the resolution of factual disputes, and the Court of Appeal has since tried strenuously to restrict its impact.[53] But the patient has a freestanding right of action under section 7(1) of the Act, to which the procedural objections should not apply.

At least Broadmoor did not appeal to the House of Lords.[54] The Court of Appeal has fared less well with its attempts to control the use of seclusion in Ashworth. In the case of 'Colonel Munjaz', it held that the statutory Code of Practice under the Mental Health Act was designed, among other things, to protect patients against potential invasions of their human rights in hospital. Hence hospitals should follow what the Code said unless there were good reasons to depart from it in the individual case. They were not entitled to have a completely different policy on seclusion. The House of Lords, by a majority of four to one, disagreed.[55] A particularly disturbing feature of this case was that the Department of Health, having approved the Code and laid it before Parliament, supported Ashworth in its attempts to ignore it.

50 *Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.*

51 *Applic no 61603/00, Judgment of 16 June 2005, para 143; (2006) 43 EHRR 96.*

52 *[2001] EWCA 1545; [2002] 1 WLR 419.*

53 *R (N) v M [2002] EWCA Civ 2335; [2003] 1 WLR 562; R (B) v S [2006] EWCA Civ 28; [2006] 1 WLR 810.*

54 *In fact, the Government relies upon Wilkinson to show how effective judicial review can be in cases where breaches of convention rights are alleged.*

55 *R (Munjaz) v Secretary of State for Health [2005] UKHL 58; [2006] 2 ac 148.*

That case also raised the possibility of using article 8 to challenge such decisions. The Court of Appeal held that seclusion was an interference with the patient's right to respect for his private life. This may be justified if it is 'necessary in a democratic society' in pursuit of legitimate aim. But it must also be 'in accordance with the law', in the sense explained earlier in the *Bournewood* case. The Code of Practice aimed to regulate the use of seclusion so that patients would know where they stood. This was another reason why hospitals should respect it. Lord Brown and Lord Steyn agreed with the Court of Appeal (of which I was a member) but the majority did not.

The stress in recent Strasbourg case law (such as *HL v United Kingdom* and *Storck v Germany*) upon the State's positive obligations to take active steps to protect vulnerable people from breaches of their convention rights, rather than relying upon *ex post facto* sanctions, strengthens my view that the Court of Appeal were right in the Munjaz case. But the extent and limits of medical necessity remain unexplored. Mr Herczegfalvy succeeded under article 8 because the hospital had tampered with his correspondence; bad enough, I agree, but his physical treatment in hospital was much worse. However, there are signs[56] that the Court is beginning to develop article 8 into a right to personal autonomy, which might in time lead to a different approach.

All of this is very negative. It has more to do with *preventing* the authorities giving a person the care and treatment that they think he needs than with *ensuring* that the patient actually gets the care and treatment that he does need. There are some reciprocal obligations owed to those deprived of their liberty and there may be room for developing these. It is less easy to see how the Convention could be used to enforce a positive obligation to provide the treatment and care which a patient needs in the community. The Bill provides for supervised community treatment orders.[57] These would apply to a patient detained in hospital for treatment under section 3 or an ordinary hospital order who meets the criteria. In effect these require that he still needs treatment, that it can be given without his being detained in hospital, and that appropriate medical treatment is available for him in the community. 'An appropriate package of treatment and support will be put in place before a patient leaves hospital on SCT.' [58] Patients who refuse their consent to community treatment will not be treated against their will in the community but may be recalled to hospital where clinically necessary. This is not very different from the present situation, where leave of absence may be used for the same purpose.

The Bill protects people from long term compulsion without the quid pro quo of appropriate treatment. That is undoubtedly an advance and consistent with the *Keenan* principle. It stops far short of a positive duty to provide patients with what they need. I do not hold out much hope that the courts will construct such a duty out of an amended Mental Health Act. The Act does not spell out what the duties of the health and social services are towards people with mental disorders: these have to be found in other legislation which usually creates general duties rather than duties to individuals. Of course, those duties have to be performed in a rational way, so that arbitrary allocation or rationing decisions may be challenged on ordinary administrative law principles. The development of positive obligations under the Convention, for example to safeguard bodily integrity, may bring some further impetus in the future. But the House of Lords has been reluctant to imply obligations into the Convention ahead of the Strasbourg case law: it is an international treaty agreed between sovereign states with widely differing levels of public health care and social services. It is not for the courts tell Parliament that is has got things wrong if

56 *Mainly in Pretty v United Kingdom (2002) 35 EHRR 1.*

57 *Mental Health Bill [HL], clauses 25 to 29, inserting new sections 17A to 17G, 20A and 20B, 56 and 62A, and 64A to 64K into the 1983 Act and repealing sections 25A to 25J.*

58 *Department of Health, The Mental Health Bill, Plans to amend the Mental Health Act 1983, Briefing sheet, Supervised Community Treatment (SCT), April 2006.*

Strasbourg would not do so. That is why, as a practising judge, I am rather sceptical of the help which the Human Rights Act can bring although, as a practising human being, I might wish that it could do more.

Dignity

However, the right to proper treatment and care is one thing; the right to be treated properly is another. Articles 3 and 8 are undoubtedly concerned with the latter. As the Court emphasised in *Pretty v United Kingdom*[59] the very essence of the Convention is respect for human dignity and human freedom. Examples abound in our health and social care settings of a quite unnecessary and unjustified lack of respect for human dignity. No-one should be expected to eat their breakfast while sitting on a commode, or to be exposed to public gaze while having their ablutions and necessary treatment done, or to be expected to wear incontinence pads because no-one is available to help them go to the lavatory.[60] We should not need legal challenges to put these things right – merely the empathy and imagination to see elderly or incapacitated people as people rather than packages. But I certainly hope that, if legal challenges are needed, they will be made and they will succeed in enough cases to make a difference.

59 *(2002) 35 EHRR 1, para 65.*

60 *See Something for Everyone: The Impact of the Human Rights Act and the need for a Human Rights Commission, 2002, British Institute of Human Rights.*

Will the New Court of Protection Damage Your Mental Health?[1]

Gordon Ashton[2]

Introduction

In this short talk I do not propose to consider the entire new jurisdiction established by the Mental Capacity Act 2005. You can read that for yourselves, and I commend to you *Mental Capacity: the new law* published by Jordans (2006), not least because I had a hand in it. Instead I wish to address the challenges faced by the new Court of Protection in four specific areas: care delivery, discrimination, access to justice and human rights. But first . . .

A PERSONAL PERSPECTIVE

The previous climate

In the past, care was generally provided by members of the family who had to cope with whatever support happened to be available. If they could not cope, then the state provided institutional care and people with mental disabilities were generally hidden from society. Discrimination was accepted and acceptable – in fact the norm – and there was a degree of social stigma associated with mental disabilities and little integration into mainstream society.

People with mental disabilities were largely denied access to justice because the culture was that people were expected to cope with the courts rather than the courts with them. Human rights were not identified, let alone recognised for mentally disabled people. So, in effect, a lack of mental capacity resulted in no status or legal rights.

A new social climate

A policy of community care has now been introduced. This means different things to different people, but in essence it promotes care in the community with an assessment of needs and provision to meet those needs. At least that is the theory; the reality is often that due to a lack of funding, community care is reduced to crisis care. Nevertheless, the policy does involve a degree of responsibility moving from the family to the state.

1 *This was the title of the lecture delivered by Professor Ashton at the North East Mental Health Law Conference on 16 June 2006. Professor Ashton has kindly updated the text of that lecture for this issue of the Journal of Mental Health Law.*

2 *Senior District Judge, Deputy Master of the Court of Protection; Visiting Professor in Law at Northumbria University.*

Discrimination laws now include disability discrimination and there is a move from a medical to a social model of disability. In substance this means that one should not concentrate upon the impairment of the individual but on the obstacle imposed within society. So don't blame the individual; blame society for the way it conducts itself and require reasonable adjustments to be made. Human rights have also been 'brought home' by the Human Rights Act 1998 and this is of particular significance to people with disabilities because they have these rights too! It follows from all this that a paternalistic approach to people with impaired mental capacity is no longer acceptable.

It follows that people with disabilities are entitled to expect *equal* access to justice. Attitudes, facilities and procedures must not present an obstacle to the attainment of justice. There is now a recognition of diversity in society and judges and the courts are learning to cope with all manner of people. The Equal Treatment Advisory Committee of the Judicial Studies Board (of which I am a member) has produced an *Equal Treatment Bench Book* which is issued to all judges and available on the web at www.jsboard.co.uk/etac/etbb/index.htm. In reality we should not be talking about equal *access* to justice but equal *opportunity* for justice because in the delivery of justice the special needs of people with disability must be met. A level playing field is not enough because treating disabled people in the same way as everyone else would not be sufficient.

The role of the Law

People without capacity are vulnerable to neglect, abuse and exploitation. The law should tackle these vulnerabilities by regulating the support that is provided by the state, providing protection and facilitating empowerment. It must also cope with the resulting conflicts, because when you seek to protect a vulnerable individual it is almost inevitable that you will disempower that individual.

The conclusion must be that:

> *The absence of legal procedures for decisions to be taken on behalf of mentally incapacitated adults is the worst form of discrimination against people with disabilities and a breach of their human rights*

THE NEW JURISDICTION

Overview

The Mental Capacity Act 2005 is a *SINGLE* piece of legislation with *TWO* fundamental concepts: a definition of **incapacity** and clarification of **best interests**. There are *THREE* areas of decision-making: personal welfare, health care and property and affairs. There are *FOUR* levels of decision-making: a person acting under *general authority to act*, an *attorney* under a *lasting power of attorney*, the Court of Protection making decisions and a *Deputy* appointed by the Court. There are *FIVE* general principles:

- a decision-specific approach to capacity based on understanding and the ability to make and communicate a decision;
- adults are presumed to have capacity so unjustified assumptions are outlawed and there is a 'balance of probabilities' approach;
- individuals should be helped to make own decisions with simple explanations and they may make unwise decisions;
- there must be participation in decision-making and consultation with others;
- a 'least restrictive' approach is to be applied to intervention.

The *new* Court of Protection

SIX key changes have been made in creating a new Court of Protection – it may be the same name but it is a very different body. So:

- the new court is a Superior Court of Record and not merely an office of the Supreme Court;
- there is a President and a Vice-President, respectively the President of the Family Division of the High Court and the vice-Chancellor of the Chancery Division, so senior Judges with clout!;
- there is a also a resident Senior Judge, initially the former Master of the old Court of Protection to provide continuity;
- there will be nominated High Court, Circuit & District Judges who will sit in the new Court;
- there will also be regional courts, following the example of the 'Preston pilot' whereby for the past five years I have sat as a Deputy Master running the northern Court of Protection;
- new Court of Protection Rules will be created which are likely to follow the Civil Procedure Rules 1998.

It may therefore be anticipated that the new Court will be more accessible with greater involvement of local practitioners. There will be active case management and hopefully improved training and more reporting of court decisions. But the most important point is that we now have a proper court with full status to deal with the entire range of decision-making on behalf of those who cannot make their own decisions.

Office of the Public Guardian

The Public Guardian, with an office and staff, has *SEVEN* key functions:

- maintaining register of LPAs;
- maintaining register of deputies;
- supervising deputies;
- arranging reports from Visitors;
- receiving security from deputies;
- receiving reports from attorneys/deputies;
- hearing representations about attorneys/deputies.

The new role is both administrative and supervisory. The Public Guardian will be a supporter of patients, family and carers and a friend of good attorneys and deputies. Also a channel for whistle-blowers and an enemy of abusers. The intention is that the Office of the Public Guardian (OPG) will administer the Court of Protection and clearly in most cases there is a need to work in collaboration, but this may not be wise if the Public Guardian desires to be represented in hearings and reserves the right to appeal decisions. The new Public Guardian now has a statutory existence and role, whereas the former Public Guardianship Office did not exist as a legal body.

The *new* Jurisdiction

There are *EIGHT* general points that I wish to make about the new statutory jurisdiction.

- there will be a wider range of cases;
- there will also be an increased volume of cases;
- more people will be involved;
- the unmet need will emerge;
- there will be a new variety of outcomes;
- the Court should be more accessible;
- many parties will be unrepresented.
- alternative dispute resolution is likely to be imposed prior to any contested hearing

Implementation has been put back from 1st April 2007 to 1st October 2007 because there is still so much work to be done in writing the new Rules, nominating and training the Judges and setting up the new regional courts.

WILL THE NEW COURT DAMAGE YOUR MENTAL HEALTH?

Under this final heading I intend to return to the issues identified at the beginning of this presentation, but first identify some specific issues for the Court and the Public Guardian.

Issues for the *new* Court of Protection

One thing that troubles me is that there is a merger of two cultures, namely that of the historically mature Court of Protection and the residual inherent jurisdiction discovered by the Family Division High Court Judges when they started making declarations of best interest. Which will prevail, the informal yet essentially practical style of the Master or the Rolls-Royce trial of the High Court? It is my hope that both will co-exist and that as part of active case management a District Judge will either adopt an informal procedure or direct that the case must be heard by a High Court Judge. This means that the formality of each hearing will depend on the type or the severity of the case and be a matter for judicial discretion. There may be allocation to a Track as under the Civil Procedure Rules but I hope that cases will be dealt with by two levels of judge rather than three, with district and circuit judges being interchangeable. This is a specialist area and experience is needed rather than seniority.

I see a closer working relationship with the main stream courts under the new system. I already find that other judges turn to me for help when they encounter capacity issues because of my known involvement in this field of work. I contemplate that there will be cases where it is sensible to 'kill 2 birds with 1 stone'. In other words a judge may sit in a dual capacity, for example following a broken marriage where there is a dispute over residence and contact relating to the children and one is an adult with severe learning disabilities. We must, however, recognise that there may be a conflict of roles in multi-tasking – I have encountered this when asked to determine the amount and apportionment of a past care award following a large damages claim. The role of the Court of Protection is to address the best interests of the 'patient' and not to determine disputes with others.

Who should be the parties to proceedings in the Court of Protection? The claim will usually arise as a result of a dispute so clearly the parties to that dispute must be parties, and the opportunity should be

given to other members of the family and carers to be involved. But there are human rights arguments to the effect that the incapacitated person should always be a party. That would involve appointing someone (perhaps the Official Solicitor) to act for him or her as a 'litigation friend' and such person will generally wish to be represented by a solicitor who in turn may instruct counsel. Who will pay for all this, and would it be proportionate? There is, of course, a costs vulnerability for any party and the new Court will have to work out its policies in regard to costs orders. This should penalise those who pursue cases without merit or in an unreasonable way, but should not discourage genuine whistle blowers.

Issues for the Public Guardian

What is the true role of the Public Guardian,? Is it administrative, supervisory or interventionist? Active or passive? Will the office become a facilitator of mediation? Who will be the personnel involved as Visitors, reporters, independent advocates and litigation friends? Will the Public Guardian seek to become a party to some proceedings (albeit on rare occasions) with a right of appeal? There will be close involvement with the Court and a special relationship, but how close can this be?

Community care

Who will use the Court? Presumably spouses and partners, families and carers but also social services and health authorities. Will it support community care provision by removing uncertainty and avoiding delay? Will it support health care by facilitating medical treatment whilst guaranteeing patient autonomy? Whatever the answer, there must be an increased potential under the new jurisdiction for social services and health care providers to intervene in family affairs (for better or worse). Even though the Court holds the balance, the threat of proceedings is likely to intimidate many people into accepting the approach of the public authority. The balance of power and influence is likely to shift, unless the involvement of the legal profession and the reporting of cases educates society.

Discrimination

The new Court must be a model for other courts in avoiding discrimination. In particular it must operate in disability friendly premises with a range of aids being available, and be served by disability aware judges and adequately trained staff.

The Act is intended to remove the discrimination in decision-making, but is a decision specific assessment of capacity viable or will it create too much uncertainty compared with the present system where a person either is or is not a patient? Is there sufficient protection for those who are vulnerable to influence (not just undue influence) due to mental frailty? Will family and carers adopt best interests as defined or do what they think is best? Will the emphasis be on protection (which means playing safe) or empowerment (which involves risk taking)?

Access to Justice

Will the Court be used by those who need it? Only if it is accessible and affordable. Will people be able to cope with the procedures or will legal representation be available, in which event who will pay the costs in non-financial cases? There may be too many unrepresented parties but will those advocates who do attend be litigators or personal client lawyers? For many of these cases the latter would be preferred, in particular the type of solicitor who is willing to be an attorney, but all too often they are deterred from appearing as an advocate in court and involve their litigation partners. This is unfortunate when the issue is the best interests of the incapacitated person and they best understand this concept.

Will the procedure be inquisitorial whilst seeking consensus, adversarial based on resolving disputes or conciliatory with encouragement for mediation? Will the emphasis be on resolving disputes or addressing best interests, in which event what will happen if there is a struggle for control with no-one seeking to address best interests (as so often happens when dysfunctional families bring their long-standing disputes to the Court)? The approach adopted may well depend upon the type of case and some flexibility should be built into the system.

Human rights

Whose rights are we talking about? Those of the incapacitated person, the spouse or partner, or the relatives and carers? It seems to me that family and personal relationships also give rise to human rights in others. Does a 'best interest' test for the incapacitated person infringe the human rights of those others? If the primary rights to be protected are those of the incapacitated person, how is he or she to be represented? Must this person be a party to proceedings in every case with a litigation friend and solicitor, or may a report by one of the Visitors be sufficient as in private law children cases with the best interests test being applied? In the case of a dysfunctional family the appointment of a professional Deputy introduces an independent element.

Conclusion

I am sorry that I have asked more questions than I have attempted to answer. But there is a reason for this. The new jurisdiction will be what we now make it and all these questions will need to be addressed in the process. For my part, I am beginning to worry that the legislation may prove to be too complex and theoretical. Something a bit more rugged could perhaps have proved more workable, but then it might discriminate against disabled people and would not comply with the ever growing jurisprudence of human rights.

Amending the Mental Capacity Act 2005 to provide for deprivation of liberty

Robert Robinson[1]

Introduction

The Government's Mental Health Bill[2] includes amendments to the Mental Capacity Act 2005 (MCA) intended to remedy the defects in domestic law identified by the European Court of Human Rights (ECtHR) in *HL v United Kingdom* (the Bournewood case).[3] The ECtHR found that where a mentally incapacitated adult had been deprived of his liberty by informal admission to a psychiatric hospital:

a) the common law doctrine of necessity did not satisfy the "in accordance with a procedure prescribed by law" requirement in Article 5(1) of the European Convention on Human Rights (ECHR); and

b) pre-Human Rights Act habeas corpus and judicial review proceedings were not capable of performing the court's function under Article 5(4) to review the lawfulness of a deprivation of liberty arising from mental disorder.

The judgment is relevant to anyone who has a mental disorder and is an informal patient in a psychiatric hospital or is resident in a care home, but only if the care regime deprives them of their liberty. The problem for the Government is that some people who may be deprived of their liberty in such circumstances are outside the scope of the Mental Health Act 1983 (MHA) detention powers and are thus caught in what has come to be referred to as the Bournewood gap.[4] The most obvious examples are those people who are in psychiatric hospital informally because they are compliant, those in care homes where MHA detention powers cannot be applied, and those in psychiatric hospital who have a learning

1 *Solicitor, Scott –Moncreiff, Harbour and Sinclair (London); Solicitor for HL*

2 *Clause 38. In this article references to the Mental Health Bill are to the Bill, without amendments, as introduced in the House of Lords.*

3 *HL v UK (Application 45508/99), judgment was given on 5th October 2004. Reported as HL v United Kingdom (2005) 40 EHRR 761.*

4 *This phrase was first coined following the judgment of the House of Lords in the Bournewood case (R v Bournewood Community and Mental Health NHS Trust Ex p. L [1998] 3 All. ER 289) where in his speech Lord Steyn had commented adversely on the denial of the safeguards of the Mental Health Act 1983 to compliant incapacitated psychiatric patients. Following the later judgment of the European Court of Human Rights in the case, it is now used to refer to the denial of Article 5 safeguards, whether in hospitals or care homes.*

disability which does not fit the statutory definitions of either mental impairment or severe mental impairment and who are thus excluded from detention under section 3 or other longer term sections of the MHA. What is required for all such people, if they are being deprived of their liberty, is an Article 5 compliant legal framework. This is what the Government proposes by way of amendments to the MCA.

During the committee stage of the Mental Health Bill in the House of Lords the responsible minister stated that the purpose of the proposed amendments was not to increase the number of people deprived of their liberty, but rather that the legal position of those necessarily deprived of their liberty will be regularised:

> *"This is not about taking new powers to detain people. It is about giving safeguards to the most vulnerable in care homes and hospitals who need to have their liberty curtailed and considered and who, in some cases, need to be deprived of aspects of their liberty in order to keep them safe and protected and to provide the highest quality care."*[5]

The people the Government has in mind are cognitively impaired, whether this arises from a learning disability, brain injury or dementia, to a degree which renders them incapable of validly consenting to the care they are receiving.

As will be seen, the new legal regime for such mentally incapacitated people deprived of their liberty is based on different legal criteria for detention, compared with the MHA, and operates according to different procedures. It also provides different safeguards for those who are deprived of their liberty. An important question is whether having two separate regimes for depriving mentally disordered people of liberty will result in inconsistencies and anomalies.

The main justification for two separate regimes is that, compared with MHA detention, the proposed MCA procedures will be less demanding of resources. In its briefing sheet on the proposals the Government says it "has sought to minimise new burdens arising from the safeguards, but some will inevitably arise".[6] The extent of the additional demand for resources will be a function of the number of people who come within the MCA deprivation of liberty regime and the average resource burden per case. The former will in large part be dependent on what is meant by deprivation of liberty. In the same briefing sheet the Government says that it "does not consider that deprivation of liberty would be justified in large numbers of cases but recognises that such circumstances may arise". Coincidentally with the passage of the Bill through the House of Lords, judgment was given in the High Court in a case where, relying on the ECtHR's judgment in *HL v United Kingdom,* it was alleged that, in breach of Article 5, a mentally incapacitated care home resident (DE) was being deprived of his liberty while being cared for under the common law doctrine of necessity.[7] As is discussed below,[8] the analysis of case law under the ECHR which led Munby J to conclude that the regime in the care home deprived DE of his liberty differs from the view expressed by the Government in the draft illustrative code of practice which accompanies the proposals.[9] If Munby J's analysis is correct, it must follow that the Government has underestimated the number of mentally incapable people whose care amounts to deprivation of liberty, and the demand for additional resources will be correspondingly greater.

5 *Baroness Ashton of Upholland, House of Lords Hansard, 17th January 2007, column 763.*

6 *Bournewood Briefing Sheet, Department of Health – November 2006.*

7 *JE and DE v Surrey County Council and EW [2006] EWHC 3495 (Fam).*

8 *See also Lucy Scott-Moncrieff "Two steps forward, one step back", in this issue of the Journal of Mental Health Law.*

9 *The Bournewood Safeguards: Draft Illustrative Code of Practice, paragraphs 140-141, published 22.12.06.*

This article considers the Government's legislative proposals against the domestic law background, specifically their relationship with existing detention powers in the MHA and the provisions already enacted by Parliament in the MCA which expressly do not authorise deprivation of liberty. Consideration is given to whether the proposed amendments to the MCA create undesirable overlap with the existing detention powers under the MHA.

The final part of the article questions the Government's approach to demarcating the boundary between the two detention regimes. It proposes that if MCA detention were confined to those who lack capacity and do not object to their care, compliance with Article 5 could be achieved more simply and at less cost than under the Government's proposed amendments to the MCA.

Historical background

If the proposed amendments to the MCA are a response to the ECtHR's decision in the Bournewood case, the case itself arose from the application of legal principles which had been developed in the course of modernising English mental health law during the twentieth century. Those principles determined where the line was to be drawn between psychiatric patients whose hospital care warranted the use of legal powers of detention and patients for whom such powers were not considered necessary.

The first significant legislative step in this process was section 1 of the Mental Treatment Act 1930, which followed a recommendation made in 1926 by the Royal Commission on Lunacy and Mental Disorder.[10] It provided for voluntary admission by allowing a person who was capable of expressing his or her wishes to make a written application to be admitted to a psychiatric hospital. Having been admitted on that basis the patient was entitled to discharge him/herself on giving 72 hours' notice.

The operation of this provision was considered by the Royal Commission on the Law relating to Mental Illness and Mental Deficiency (the Percy Commission) whose recommendations formed the basis for the Mental Health Act 1959.[11] Their main criticism was that the capability threshold for voluntary admission was too high with the consequence that powers of compulsion still had to be used in some cases where the patient was not unwilling to be admitted:

> *"Because no one may be a voluntary patient unless he can give positive evidence of his willingness to be so, some patients who are not considered capable of giving a valid signature on the application form … may only be admitted under the [involuntary] certification procedures, even though they are not positively unwilling to be admitted and even if they could in fact be treated and cared for without powers of detention."*[12]

The Percy Commission's most important proposal for reform of mental health law was that there should in future be a presumption in favour of informal admission and treatment. This placed the onus on the psychiatric patient positively to opt out of informal care, by objecting to it, thus to opt into a regime of compulsion. They saw this as placing psychiatric treatment in the majority of cases on the same foundation as other forms of medical treatment and they hoped that it would reduce the stigma associated with treatment for mental disorder.

10 *Report of the Royal Commission on Lunacy and Mental Disorder Cmd. 2700.*

11 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954 – 1957. Cmnd. 169.*

12 *Ibid. paragraph 218.*

> *"We therefore recommend that the law and its administration should be altered, in relation to all forms of mental disorder, by abandoning the assumption that compulsory powers must be used unless the patient can express a positive desire for treatment, and replacing this by the offer of care, without deprivation of liberty, to all who need it and are not unwilling to receive it.*[13]
>
> *We recommend that all admissions except under compulsory procedures should be arranged in the same was as admissions to general hospitals, with no application form to be signed by the patient and no statutory requirement for any fixed notice of any intention to leave."*[14]

In referring to deprivation of liberty, the Percy Commission equated this with the use of coercion against the wishes of the patient; if he or she did not object, there was no deprivation of liberty and therefore no need to use legal powers of compulsion.

As enshrined in practice under the Mental Health Act 1959, and later under the MHA, the crucial distinction was between the unwilling patient, in respect of whom admission could only be under compulsory powers of detention; and all other psychiatric patients, who were to be admitted and treated without the use of formal powers. In deciding whether to use compulsory powers, it was not necessary to consider the patient's mental capacity. The sole question was as to the patient's volition.

Even if the basis for the distinction was clear, its application was not always straightforward. It was sometimes difficult to know how much weight to give to what a mentally disordered person said or did if no clear purpose or intention, amounting to unwillingness, could readily be discerned. This is well illustrated by paragraph 19.27 of the current MHA Code of Practice:

> *"The safety of informal patients, who would be at risk of harm if they wandered out of a ward or mental nursing home at will, should be ensured by adequate staffing and good supervision. Combination locks and double handed doors should be used only in units where there is a regular and significant risk of patients wandering off accidentally and being at risk of harm. There should be clear policies on the use of locks and other devices and a mechanism for reviewing decisions. Every patient should have an individual care plan which states explicitly why and when he or she will be prevented from leaving the ward. Patients who are not deliberately trying to leave the ward, but who may wander out accidentally, may legitimately be deterred from leaving the ward by those devices. In the case of a patient who persistently and/or purposely attempts to leave a ward or mental nursing home, whether or not they understand the risk involved, consideration must be given to assessing whether they would more appropriately be formally detained under the Act in a hospital or a mental nursing home registered to take detained patients, than remain as informal patients."*[15]

This contemplates that it is compatible with informal status for a patient to be prevented from leaving the ward, provided that their leaving the ward is not persistent and/or purposeful. Such patients, most of whom are elderly and suffering from dementia, are regarded as not unwilling to receive hospital care.

Bournewood and the doctrine of necessity

HL, a profoundly autistic middle-aged man, was admitted to Bournewood hospital in July 1997. As he did not object or resist, the consultant psychiatrist in charge of his treatment saw no need to use MHA powers – so she admitted him informally.

The consultant psychiatrist's interpretation of the law was ultimately upheld by the House of Lords in a

13 *Ibid. paragraph 291.*

14 *Ibid. paragraph 300.*

15 *Code of Practice Mental Health Act 1983, Department of Health and Welsh Office, 1999.*

unanimous decision the following summer.[16] While there had been some understandable vagueness in the Percy Commission's report about the legal basis for admitting and treating a patient who did not express any wishes in the matter, all five Law Lords were clear that the correct legal description of HL was that he lacked capacity and that the necessary powers arose under the common law doctrine of necessity. Specifically, he lacked capacity to make the relevant treatment decisions arising from the consultant psychiatrist's clinical opinion that he needed to be admitted to Bournewood hospital for assessment and treatment of a mental disorder. The doctrine of necessity conferred on those caring for him all necessary powers to act in what they considered to be his best interests. Since the common law provided for this situation there was no need, and therefore no legal justification, for using compulsory powers under the MHA. Such powers were to be used only where there was no other lawful means of admitting and treating a patient.

The House of Lords' decision arguably left the legal landscape unchanged. The Percy Commission's presumption in favour of informal care for the 'not unwilling' had prevailed. The analysis in terms of capacity and incapacity appeared only to clarify the meaning of that phrase . Both the Mental Health Act Memorandum and Code of Practice were amended to make explicit that 'not unwilling' encompassed a patient who gives capable consent to admission, and also a patient who is mentally incapable of consent but not objecting to entering hospital.[17]

The Code and Memorandum now implied four categories of patient: with capacity and consenting; with capacity and not consenting; without capacity and not unwilling; and without capacity and objecting. In order to know in which category any particular patient belonged it was first necessary to assess their capacity to consent to admission and treatment, where previously it had been sufficient merely to ascertain whether or not they were objecting to admission. There is no reason, however, to believe that this new analysis made any difference to the practice of those assessing patients for admission under the MHA. The crucial distinction remained that between the objecting or unwilling patient (with or without capacity), whose lawful admission requires the use of MHA detaining powers, and everyone else for whom informal admission is lawful.

Bournewood and deprivation of liberty

In the domestic courts there was a division of opinion among the judges as to whether, for the purpose of the habeas corpus proceedings, HL was detained while he was an informal patient in Bournewood hospital. All three Court of Appeal judges, together with two of the five Law Lords, concluded that he was detained. The remaining three Law Lords and the first instance judge were of the contrary view.

Among the judges who found that HL was detained, the crucial point was that he was not free to leave Bournewood hospital. The Court of Appeal defined the test as:

> *"a person is detained in law if those who have control over the premises in which he is have the intention that he shall not be permitted to leave those premises and have the ability to prevent him from leaving."*[18]

In the House of Lords, Lord Nolan agreed with the Court of Appeal on the question whether HL was detained, and he explained the context:

16 *R v Bournewood Community and Mental Health NHS Trust Ex p. L [1998] 3 All. ER 289*

17 *See Paragraph 295 of the revised Mental Health Act 1983 Memorandum on Parts I to VI, VIII and X, Department of Health, 1998, and Para 2.7 of the 1999 revision of the MHA Code of Practice. .*

18 *R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998]1 All ER 634 at page 639.*

> *"[He] was closely monitored at all times so as to ensure that he came to no harm. It would have been wholly irresponsible for those monitoring him to let him leave the hospital until he had been judged fit to do so."*[19]

Lord Steyn memorably described as a 'fairy tale' the contention that HL was free to leave Bournewood:

> *"In my view [HL] was detained because the health care professionals intentionally assumed control over him to such a degree as to amount to a complete deprivation of his liberty."*[20]

The question whether or not HL was deprived of his liberty was ultimately not determinative, as both Lord Nolan and Lord Steyn found, with their three colleagues, that those responsible for admitting and treating him had acted lawfully under the doctrine of necessity.

When the case reached the ECtHR the questions were: first, whether in terms of Article 5 HL was deprived of his liberty; and second, if so, whether the doctrine of necessity provided the necessary Article 5 safeguards against arbitrary detention. In the judgment which it gave in 2004 the Court concluded, essentially on the same basis as Lord Steyn, that HL was deprived of his liberty:

> *"The Court considers the key factor in the present case to be that the health care professionals treating and managing he applicant exercised complete and effective control over his care and movements …*
>
> *More particularly, … his responsible medical officer (Dr M) was clear that, had the applicant resisted admission or tried to leave thereafter, she would have prevented him from doing so.*
>
> *Accordingly, the concrete situation was that the applicant was under continuous supervision and control and was not free to leave."*[21]

On the second question, whether the deprivation of liberty was "in accordance with a procedure prescribed by law" as required by Article 5(1), the Court found that it was not. The basis for this conclusion was not so much that the doctrine of necessity was imprecise and uncertain but rather that "the further element of lawfulness, the aim of avoiding arbitrariness, has not been satisfied". The Court found that the application of the doctrine of necessity in HL's case lacked sufficient procedural safeguards:

> *"In particular and most obviously, the Court notes the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions. There is no requirement to fix the exact purpose of admission (for example, for assessment or for treatment) and, consistently, no limits in terms of time, treatment or care attach to that admission. Nor is there any specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention. The nomination of the representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the 1983 [Mental Health] Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities."*[22]

Before discussing the Government's legislative response, the judgment's immediate implications for practice under the MHA should be noted, particularly given that by 2004 the Human Rights Act 1998 (HRA) was in force. If we return to the example of the patient who is prone to wander and who, for his or her own safety, is to be prevented from leaving the ward, we can see that the guidance in paragraph

19 *R v Bournewood Community and Mental Health NHS Trust, ex parte L (Secretary of State for Health and others intervening) [1998] 3 All ER 289 at page 302*

20 *Ibid. at page 307.*

21 *HL v United Kingdom (2005) 40 EHRR 761, at pages 792 – 793.*

22 *Ibid. page 800.*

19.27 of the Code fails to direct the reader to the crucial question which is whether the patient is being deprived of liberty. If the answer is in the affirmative, the HRA directs that, if possible, the deprivation of liberty be made compatible with the Article 5 "in accordance with a procedure prescribed by law" requirement. Moreover, given the Court's finding that HL was deprived of his liberty, though he neither wandered nor objected, the question whether the admission of a not unwilling patient amounts to a deprivation of liberty now has to be asked in every case. The effect of the ECtHR's judgment should have been to change practice in this respect. One might have expected as a consequence that MHA powers would have been used in some types of case where in the past admission and treatment would have been under common law, but this appears not to have happened. The best explanation for this is that practitioners have not been clear about what amounts to a deprivation of liberty where the patient is not objecting to or resisting admission.

Proposed amendments to the Mental Capacity Act 2005

The Government's considered response to the ECtHR's judgment is to amend the MCA so as to create a new regime for deprivation of liberty to sit alongside existing MHA detention powers. The proposed new MCA deprivation of liberty regime both sets legal criteria and creates a new statutory procedure for depriving a mentally incapacitated person of liberty. The criteria are to be found in six qualifying requirements:

(a) *The age requirement*: P has reached the age of 18.

(b) *The mental health requirement*: P is "suffering from mental disorder (within the meaning of the Mental Health Act, but disregarding any exclusion for persons with learning disability)."[23]

(c) *The mental capacity requirement*: P "lacks capacity in relation to the question whether or not he should be accommodated in the relevant hospital or care home [i.e. that in which he is to be/is being deprived of his liberty] for the purpose of being given the relevant care or treatment."

(d) *The best interests requirement*: P satisfies four conditions:

  i) That he is, or is to be, a detained resident.

  ii) That it is in P's best interests for him to be a detained resident.

  iii) That, in order to prevent harm to P, it is necessary for him to be a detained resident.

  iv) That it is a proportionate response to—

    (a) the likelihood of P suffering harm, and

    (b) the seriousness of that harm,

    for him to be a detained resident.

(e) *The eligibility requirement*: P is not ineligible to be deprived of his liberty under the MCA. Ineligibility would arise if he were detained or detainable under the MHA (see below).

23 *The relevant exclusion is to be found in clause 2 of the Mental Health Bill which defines learning disability as a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning. It further provides that in relation to detention for treatment a person shall not be considered by reason of that disability to be suffering from mental disorder "unless that disability is associated with abnormally aggressive or seriously irresponsible conduct". The effect of disregarding this exclusion is that people with learning disability who are excluded from detention under treatment sections of the MHA will be detainable under the MCA if they lack capacity.*

(f) *The no refusals requirement*: P has not made a valid advance decision and there is not some other valid decision, of a donee of a lasting power of attorney or a deputy appointed by the Court of Protection, which conflicts with the decision made by D.

These requirements add to the *substantive safeguards* that are already to be found in the MCA. First, the definition of mental disorder is not in the MCA, which instead relies on the concept of mental incapacity alone. The mental disorder requirement is needed to comply with ECtHR case law which says that a deprivation of liberty by reason of unsoundness of mind must be based on medical evidence of mental disorder.[24] Second, the mental capacity requirement is helpful in directing D to the issue in relation to which P's capacity has to be determined, but it does not add anything of substance to the capacity test in the unamended MCA. Third, the best interests requirement, when taken together with section 4 of the MCA, appears to have much the same effect as section 6 of the MCA in relation to restrictions on liberty. However, unlike section 6 it refers not to what D reasonably believes but to P's best interests as an objective state of fact, which is established by the best interests assessment.

In responding to the Bournewood judgment, the Government has emphasised the need for *procedural safeguards* and it has expressly sought to cover each of the points of criticism made by the ECtHR. The proposed safeguards have a number of elements.

i) The requirement, except in cases of urgent necessity, to obtain an authorisation for a deprivation of liberty from the appropriate supervisory body.

The duty to apply to the supervisory body for a standard authorisation is placed on the hospital or care home where it is proposed that P will reside or, in some cases, is already residing. As an interim measure an emergency authorisation, lasting no longer than seven days, can be given by the managing authority of the hospital or care home if there is an urgent need for P to be a detained resident and an application has been made for a standard authorisation.

A standard authorisation, with a maximum duration of twelve months, will only be granted if the assessments obtained by the supervisory body show that all six qualifying requirements are satisfied. The supervisory body is then bound to give the authorisation. The supervisory body, which for a hospital admission is the responsible PCT and for a residential care home is the local authority, selects the people to carry out the assessments. There must be at least two assessments, including one by a doctor which deals with the mental health requirement and one by someone other than a doctor which deals with the best interests requirement.[25] Regulations may make provision for the selection and eligibility of people to carry out assessments, covering their experience, qualifications and any connection they may have with the supervisory body or the relevant hospital or care home.

ii) The requirement for the appointment of a representative for the person who is being deprived of liberty.

The duty to appoint a representative for the patient, "as soon as practicable after a standard authorisation is given", is imposed on the supervisory body. Before appointing someone as representative for P it must appear to the supervisory body that the person would, if appointed, maintain contact with P; represent P in matters relating to the deprivation of liberty arising from P's residence in the hospital or care home; and support P in relation to those matters. Regulations may provide for how the representative is to be

24 *Winterwerp v Netherlands (1979-80) 2 EHRR 387.*

25 *The Bill does not prescribe which of the other requirements each of the assessments must cover, provided that taken together they cover all the requirements.*

selected and by whom, although the actual appointment is made by the supervisory body.[26] The draft code of practice identifies the best interests assessor as having a pivotal role in determining whether P or P's attorney or deputy have selected someone who would be eligible to act as P's representative; and, if not, to consider recommending such a person.[27]

iii) The requirement for periodic reviews to determine whether the grounds justifying deprivation of liberty still obtain.

When the period authorised by the current standard authorisation is due to expire, the managing authority of the hospital or care home must seek a fresh authorisation from the supervisory body. The process is essentially the same as for a new standard authorisation. In addition, the supervisory body will be bound to review the authorisation if requested to do so, for example by the managing authority or by the patient's representative. If the review shows that there have been relevant changes the supervisory body must obtain such further assessments as may be necessary.

iv) The right, conferred on both the patient and the representative, to apply to the Court of Protection to challenge the deprivation of liberty.

Both P and his or her representative have the right of application to challenge a standard authorisation. The detained person also has the right to apply to the Court to challenge an urgent authorisation. In determining any such application, the Court will have to decide whether P meets the six qualifying requirements.

Defining deprivation of liberty

The substantive requirements and procedural safeguards apply only in cases where P is to be, or is already, deprived of liberty. The Bill contains an interpretation provision which falls short of a definition of deprivation of liberty: "In this Act, references to deprivation of a person's liberty have the same meaning as in Article 5(1) of the Human Rights Convention."[28]

The draft illustrative code of practice makes clear that "a person may only be deprived of their liberty in their own best interests and when there is no less restrictive alternative." The proposed safeguards exist for those cases "where deprivation of liberty is an unavoidable necessity… Every effort should be made to prevent deprivation of liberty becoming unavoidable."[29] It goes on to suggest how this is to be achieved. Those involved in the provision of residential accommodation should "to the greatest possible extent that safety considerations will allow, seek to operate care regimes that promote a person's control over their daily living and maximise their autonomy …This will both reduce the likelihood of deprivation of liberty arising, and enhance their quality of life."[30] There follows a section on best practice to avoid deprivation of liberty by ensuring that alternatives to admission to hospital or residential care are considered, that any restrictions placed on the person while in hospital or residential care are kept to the minimum necessary and that proper steps are taken to help the person retain contact with family, friends and carers.[31]

26 *The patient's representative is distinct from the Independent Mental Capacity Advocate (IMCA) who under the MCA will be appointed in certain circumstances where there is no family member or carer to consult in relation to decisions affecting a mentally incapacitated person.*

27 *The Bournewood Safeguards: Draft Illustrative Code of Practice, paragraphs 140-141, published 22.12.06.*

28 *Mental Health Bill, Schedule 8 para 10(5)*

29 *The Bournewood Safeguards: Draft Illustrative Code of Practice. Para 8*

30 *Ibid para 9*

31 *Ibid para 11*

The reason given in the draft illustrative code for not including a definition of deprivation of liberty in the Bill is that "it is not possible to state that a particular measure would or would not constitute a deprivation of liberty in ECHR terms in every case. It will be necessary to consider all the factors involved on an individual basis." However, there are features which according to the draft code may be relevant in an individual case. One of those is that the person is prevented from leaving the hospital or care home and another is the choices they are free to make while they are there:

> ***"The person is not allowed to leave the facility***
>
> *If a person is, or would be, prevented from leaving the facility at all, whether by distraction, locked doors or restraint, that would be a relevant factor in considering whether or not there is deprivation of liberty. However, restrictions placed for the person's protection would not necessarily amount to deprivation of liberty in the absence of other restrictions, for example if they are only able to leave when accompanied by a friend, family member or carer, or are not allowed to leave in the middle of the night.*
>
> *A person is not deprived of their liberty simply because they lack the physical ability to leave, or the mental capacity to form a genuine intention to leave. But such a person could still be deprived of their liberty if-*
>
> - *Family, friends or carers, who might reasonably expect to take decisions under the Mental Capacity Act 2005 in relation to the person, are prevented from moving them to another care setting or from taking them out.*
> - *They are given no (or very limited) opportunity temporarily to go outside of the home or hospital (escorted or otherwise) even though that is physically possible and it seems likely that they would enjoy it, it would reduce their distress or anxiety, or would otherwise be beneficial.*
>
> ***The person has no or very limited choice about their life within the care home or hospital***
>
> *For example, where they can be within the facility, what they can do, whom they can associate with, when and what to eat. This could equally apply if choices were available but the care given to the person did not enable them to exercise that choice. If a person is not allowed any freedom of movement within the unit they are probably deprived of their liberty. Regular use of medication or seating from which a person cannot get up in order to control a person's behaviour and movement may constitute deprivation of liberty. Restrictions which are unavoidable in a group living situation, and which apply to all residents, would be unlikely in themselves to constitute a deprivation of liberty but this would depend on the context and the extent of other restrictions imposed on the person concerned."*[32]

In their legislative scrutiny report on the Mental Health Bill,[33] the Joint Committee on Human Rights commented unfavourably on this guidance, preferring Munby J's analysis of deprivation of liberty in JE and *DE v Surrey County Council and EW*.[34]

> *"We consider that deprivation of liberty is a less flexible and elusive concept than might be thought from the draft illustrative guidance. Since we posed this question to the Government, Munby J has delivered judgment in JE and DE v Surrey County Council and EW, holding that the crucial issue in determining whether there is a deprivation of liberty is not so much whether the person's freedom within the institutional setting is curtailed, but rather whether or not the person is free to leave."*[35]

The Joint Committee also commented critically on the complexity of the Bournewood safeguards and

32 *Ibid para 28*

33 *Joint Committee on Human Rights, Legislative Scrutiny: Mental Health Bill, Fourth Report of Session 2006-07, HL Paper 40 HC 288 (published 4th February 2007)*

34 *[2006] EWHC 3495 (Fam)*

35 *Ibid page 30*

questioned "whether they will be readily understood by proprietors of residential care homes, even with the benefit of professional advice." Together with other commentators, they favour the inclusion in the amended MCA of a definition that is clear and simple to operate. The advantage of their preferred definition is that it requires only a single question to be asked: whether P is free to leave the place of residence. If not, there is a deprivation of liberty.[36]

If this definition were to be inserted in the MCA it would surely increase the number of people subject to the new deprivation of liberty regime, as compared with the Government's prediction that there will not be a "large number" of cases. It would include every mentally incapacitated person who would be prevented from leaving the premises where they are being provided with residential or hospital care. The Joint Committee's definition, derived from Munby J, is much the same as that formulated by the Court of Appeal in the Bournewood case. According to evidence submitted by the Mental Health Act Commission to the House of Lords in that case, the Court of Appeal judgment would have resulted annually in an additional 48,000 MHA detentions.[37] To this figure would have to be added the considerably larger number of mentally incapacitated people who are resident in care homes, and thus outside the scope of MHA detention powers, but who are deprived of liberty in the sense that they would be prevented from leaving.[38]

Deprivation of liberty and the use of the Mental Health Act 1983

The Government considers it would be undesirable if there was overlap between the MHA and MCA detention powers such that on a case by case basis a choice had to be made as to which was the more appropriate legal regime. Its solution is that the new MCA powers are to be used only in circumstances where existing MHA powers are not available.

Schedule 7 of the Mental Health Bill inserts a new schedule 1A in the MCA: "Persons Ineligible to be Deprived of Liberty by this Act". In giving precedence to the 1983 Act, this schedule includes not only the obvious case of people who are already detained pursuant to an application or order under the MHA, it also excludes from detention under the MCA people who are "within the scope of the Mental Health Act". Paragraph 12 of the schedule defines what is meant by being within the scope:

> *"(1) P is within the scope of the Mental Health Act if—*
>
> *(a) an application in respect of P could be made under section 2 or 3 of the Mental Health Act, and*

36 *This is consistent with what in JE and DE v Surrey County Council and EW Munby J referred to at paragraph 77 ii) b) of his judgment as the necessary objective element in a deprivation of liberty: "In the type of case with which I am here concerned, the key factor is whether the person is, or is not, free to leave …".*

37 *Lord Goff summarised the evidence provided by the Mental Health Act Commission: "First and foremost, the effect of the [Court of Appeal's] judgment is that large numbers of mental patients who would formerly not have to be compulsorily detained under the 1983 Act will now have to be so detained. Inquiries by the commission suggest that 'there will be an additional 22,000 detained patients resident on any one day as a consequence of the Court of Appeal judgment plus an additional 48,000 admissions per year under the Act' (written submission para 3.4). This estimate should be set against the background that the average number of detained patients resident on any one day in England and Wales is approximately 13,000."*

38 *In respect of what is the largest group, people suffering from dementia, a recent study estimates that in the UK there are currently 424,378 people with late-onset dementia who are living in private households and a further 244,185 living in care homes. (Dementia UK – A report into the prevalence and cost of dementia prepared by the Personal Social Services Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 27th February 2007). Given that residence in a care home is usually associated with greater deterioration of functioning in a progressive condition, it seems reasonable to assume that, for their own safety, the majority of such people are not free to leave the care homes where they are residing.*

(b) P could be detained in a hospital in pursuance of such an application, were one made.

(2) The following provisions of this paragraph apply when determining whether an application in respect of P could be made under section 2 or 3 of the Mental Health Act.

(3) If the grounds in section 2(2) of the Mental Health Act are met in P's case, it is to be assumed that the recommendations referred to in section 2(3) of that Act have been given.

(4) If the grounds in section 3(2) of the Mental Health Act are met in P's case, it is to be assumed that the recommendations referred to in section 3(3) of that Act have been given.

(5) In determining whether the ground in section 3(2)(c) of the Mental Health Act is met in P's case,[39] *it is to be assumed that the treatment referred to in section 3(2)(c) cannot be provided under this Act [i.e. the MCA]."*

The object is to capture established practice under the MHA and to prevent any change that would result in people being detained under the MCA in future in circumstances where currently they would be detained under the MHA. If, on the other hand, someone would not now be detained under the MHA, but is nonetheless being deprived of liberty, the MCA is to be used. For example, a person who lacks capacity and does not object to hospital admission would not now be detained under the MHA. It is proposed that in future such a person, if deprived of liberty, would be detainable under the MCA. It is not clear, however, that Schedule 1A will have the result intended by the Government. Arguably, the effect of paragraph 12(5) of the schedule is that anyone who is deprived of liberty in a psychiatric hospital is detainable under the MHA and should be so detained rather than being deprived of liberty under the proposed MCA provisions. The only exception to this would appear to be people whose mental disorder excludes them from detention under section 3 and other treatment sections because of the restricted definitions of the classified forms of mental disorder currently to be found in section 1(2) of the MHA.[40]

If we return again to the wandering patient and the guidance in paragraph 19.27 of the MHA Code of Practice, the question being addressed there is whether such a person is to be understood as objecting to being in hospital – the test being whether they are persistently and/or purposely trying to leave. If, however, deprivation of liberty does not, in such a case, depend on the person's intentions but solely on whether, regardless of their intentions, they would be allowed to leave, the guidance can be of no assistance. It cannot in any case provide the answer to the question whether, assuming there is a deprivation of liberty, it could lawfully be under the MHA. It is not possible to identify any provision in the MHA which precludes its use in such circumstances. The point is made succinctly in the current edition of the Mental Health Act Manual: "An assessment for the sectioning of a mentally incapacitated person who is compliant to being in hospital should be made if the patient is being deprived of his or her liberty as a failure to detain the patient under [the MHA] would violate the patient's right under Art. 5 of the ECHR."[41] Once it is accepted that it would be lawful to detain such a person under the MHA, the effect of paragraph 12(5) of schedule 1A is that they are *within* the scope of the MHA and thus excluded from the proposed MCA deprivation of liberty regime. This is apparently not the Government's intention. The Bournewood Briefing Sheet says: "The new [MCA] procedure cannot be used to detain people in hospital for treatment of mental disorder in situations where the Mental Health Act could be used instead

39 *Section 3(2)(c) says: "it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section."*

40 *In the Mental Health Bill the exclusion of certain people with learning disability from detention under treatment sections of the MHA is continued - see footnote 23 above.*

41 *Mental Health Act Manual, Richard Jones, Thomson, Sweet & Maxwell, 10th ed. 2006 page 23.*

if they are thought to object to detention for the purposes of such treatment. This will mean that people who object will be treated in broadly the same way as people with capacity who are refusing treatment for mental disorder and who need to be detained as a result."[42] The implication is that people who do not object will not be detained under the MHA, but instead will be deprived of their liberty under the MCA. If the Government does not want such people to be detained under the MHA it may have to make clear in the legislation which classes of people with mental disorders who are deprived of liberty fall to be dealt with under the MHA and MCA respectively.

What of the person with dementia who, albeit mentally incapacitated, does object to the hospital regime and subsequently to the residential care home? According to the Government, such a person is clearly *within* the scope of the MHA where admission to hospital is being considered or is effected. With the move to residential care, even though still objecting, he or she is clearly *outside* the scope, for the simple reason that the MHA is not capable of authorising a deprivation of liberty outside hospital. Such a person would therefore move from one legal regime to another at the point of leaving hospital. It is difficult to identify any principled reason why a different regime, with different legal criteria and procedural safeguards, should apply according only to the place of detention.

Another example is a person with what the Mental Health Bill defines as a learning disability: "a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning". If that person's learning disability is not "associated with abnormally aggressive or seriously irresponsible conduct on his part", he or she will be detainable under section 2 of the MHA for a maximum of 28 days but thereafter, assuming a lack of capacity, will be detainable in hospital only under the MCA,[43] regardless of his or her attitude to being in hospital and to the treatment being offered. The explanation for this is historical and may now appear anachronistic, the policy aim having been to avoid the use of formal legal powers in relation to most people with a learning disability who require in-patient psychiatric treatment. If that same individual objects to care in a nursing home he or she will, of course, be detainable only under the MCA.

Discussion

The following criticisms can be made of the Government's proposals:

1) The two detention regimes, respectively under the MHA and MCA, are designed for different purposes but in drawing the boundary between them the Government has not taken this into account. Instead the Government has sought, while not changing the scope of MHA detention powers, to create by amendments to the MCA a residual regime for deprivation of liberty outside the MHA. A consequence of the Government's proposals is that the same individual can move between the two regimes, by reason only of considerations such as the place of detention or a technical definition of mental disorder in the MHA, where there is no change in the individual's mental condition or attitude to receiving care. Moreover, the distinction between those within and outside the scope of the MHA is less clear than the Government has assumed. This may lead to inconsistencies in practice.

2) Another consequence of the Government's approach is that the new MCA detention regime has to cover a wide range of people who have in common only that they are in need of care in a

42 *Bournewood briefing sheet, Department of Health – November 2006.*

43 *The Government would presumably say, additionally, that MHA detention would only be available in such a case if the patient was objecting.*

> hospital or other residential setting and they lack capacity to consent to it. If the proposed MCA powers were to be confined to those patients who are compliant with their care and whose mental incapacity is associated with a significant degree of cognitive impairment, it is arguable that a less complicated, and potentially less costly, regime would suffice to satisfy the Article 5 "in accordance with a procedure prescribed by law" requirement. This is of particular relevance because it appears that the Government has underestimated the number of mentally incapacitated people who are necessarily being deprived of their liberty and therefore the total cost of the new deprivation of liberty regime.

In relation to the first criticism, the MHA and MCA detention regimes are designed for different purposes. They have different legal criteria for detention and different procedural safeguards. As the historical background demonstrates, the essence of detention under the MHA is that the State takes away an individual's liberty against that person's will. The MHA, reflecting ECHR norms, sets a risk threshold before the state can legitimately intervene and it provides the individual with recourse to the mental health review tribunal to challenge the judgments of the professionals, whether about the presence or nature of a mental disorder or the risks associated with it. The tribunal has to consider the proportionality of any deprivation of liberty by balancing the risks, including to the patient himself, against the loss of liberty which detention necessarily entails. From the individual's point of view, the desired outcome in such proceedings is the recovery of liberty: the freedom to choose whether to remain in hospital or to return home.

The proposed MCA regime serves a different purpose, particularly if deprivation of liberty is equated with the individual not being free to leave the place where residential care is being provided. If for such an individual, like HL in the Bournewood case, it would, as Lord Nolan said, be "wholly irresponsible … to let him leave",[44] it is difficult to envisage how there could be a successful challenge to such a deprivation of liberty. There may of course be instances where the professionals get the judgment wrong, such that it would be safe for the person to be free to leave; but where the mental incapacity is associated with significant cognitive impairment it is unlikely that there would be many such cases. Different considerations will arise in cases such as HL's where at all times there was available a better alternative to hospital care. However, it would surely be a mistaken view to see this as an Article 5 issue equivalent to the patient detained under the MHA who asserts the right to return home. For someone like HL, the question whether to remain in hospital or to return home is essentially a judgment made by others about his best interests. It is not about deprivation of liberty, as presumably he would not be free to leave wherever he was being properly cared for, for the reason give by Lord Nolan. Within the framework of the MCA, the question as to an incapacitated person's place of residence would normally be considered applying the principles and procedures in the main body of the Act, rather than through the proposed new deprivation of liberty regime.

It is no doubt true that many of those who are detained under the MHA, including those with mental illnesses such as schizophrenia who are not cognitively impaired, lack capacity at the point of admission. What they have in common is that they object to being in hospital or to receiving treatment. To a greater or lesser degree they assert the right to be free to make their own choices. The MHA is undoubtedly the appropriate legal framework for such people. It is no less appropriate because they happen to be in a nursing home rather than a hospital or because they have a learning disability which is not associated with "abnormally aggressive or seriously irresponsible conduct". The first element of a coherent approach to

44 Per Lord Nolan – see footnote 20 above.

the ECtHR's judgment in the Bournewood case would be to bring within the MHA all those who object to the care regime which deprives them of their liberty. This would mean extending MHA detention to settings other than hospitals, possibly through an enhanced MHA guardianship regime.

The second element would be to exclude from detention under the MHA all those who do not object to the care regime which deprives them of their liberty. It is accepted that it may sometimes be difficult to know whether a person is or is not objecting but this is something which, as now, could be the subject of guidance in a code of practice.

The third element would be to include within the MCA a definition of deprivation of liberty of the kind proposed by the Joint Committee on Human Rights. People who lack capacity and are deprived of liberty because of mental disorder, but who do not object or resist, would come within a new MCA detention regime.

Turning to the second criticism, in seeking to ensure that the new MCA regime complies with the Article 5 "in accordance with a procedure prescribed by law" requirement, the Government's approach has been to meet the criticisms made by the ECtHR in the Bournewood case. Its proposed procedural safeguards mirror those criticisms. The Government appears to have assumed that in drawing attention to the lack of specific procedural safeguards in connection with HL's admission to Bournewood, the ECtHR intended to lay down minimum standards for an Article 5 compliant procedure in cases where deprivation of liberty arises from mental disorder. This would be a misreading of a judgment in which the Court also commented favourably on what was then the Mental Capacity Bill and is now the MCA:

> *"The Court notes, on the one hand, the concerns about the lack of regulation in this area expressed by Lord Steyn [and others]. On the other hand, it has also noted the Government's understandable concern to avoid the full, formal inflexible impact of the 1983 [Mental Health] Act. However, the current reform proposals set out to answer the above-mentioned concerns of the Government while at the same time making provision for detailed procedural regulation of the detention of incapacitated individuals."*[45]

If the Government had started from the position that the proposed MCA detention powers would only apply to people who are compliant and whose mental incapacity is associated with significant cognitive impairment, it could then have asked both what was desirable to safeguard their interests and what was minimally necessary to comply with the Article 5 "in accordance with a procedure prescribed by law" requirement.

The aim is to ensure that decision-making which leads to an individual being deprived of liberty is not arbitrary. As was acknowledged by the ECtHR in Bournewood, the decision-making framework of the MCA, as now enacted, goes considerably further than common law to reduce the risk of arbitrariness. If it were felt that decisions resulting in deprivation of liberty raise issues requiring special consideration, the provisions already enacted in section 6 of the MCA, which deal with restraint, provide a model for incorporating additional substantive safeguards in relation to decision-making under the MCA. Many of the points of criticism in the ECtHR's judgment in Bournewood, such as the exact purpose of admission and the requirement for a continuing clinical assessment of the persistence of a mental disorder, could be incorporated into the MCA by way of safeguards for decisions resulting in deprivation of liberty. Additional safeguards could include an explicit proportionality requirement and other matters pertinent to such a decision. It is difficult to see that anything more is needed. Such matters would have to be considered as part of the decision-making process under the MCA which leads to the incapacitated

45 *HL v United Kingdom (2005) 40 EHRR 761, page 801.*

person being placed in hospital or residential care and would be covered in the resulting care plan. There should not normally be any need for further medical or other assessments specifically for the purpose of compliance with Article 5.

As to formal procedural safeguards, if the MCA deprivation of liberty regime were to be reserved for people with significant cognitive impairment who do not object to their care, less stringent and complex safeguards would be needed than those now proposed by the Government. There are only two essential requirements. First, to identify, record and notify the registration body whenever a mentally incapacitated person is being deprived of their liberty by a public authority in circumstances where the person is not objecting. If the legal test under the MCA for deprivation of liberty is whether they would be prevented from leaving the hospital or care home, this should present few difficulties to mental health professionals and care providers. The second requirement, in order to comply with Article 5(4) of the ECHR, is that the person deprived of liberty, or someone else on their behalf, must have the opportunity to challenge the deprivation of liberty by an application to the Court of Protection. This entails the appointment of a representative by a body which is independent of the place of detention. There would need to be a procedure for identifying the most suitable person to act as representative. This would usually, though not invariably, be a family member.

Conclusion

The Government's response to the problems thrown up by the Bournewood case in the ECtHR is limited and pragmatic. While recognising the necessity to regularise the legal position of people who are unlawfully being deprived of liberty under common law powers, it does not wish to extend the full MHA detention regime to everyone who may be deprived of liberty. It therefore proposes to fill the Bournewood gap but to leave the scope of MHA detention powers unchanged. There are serious disadvantages in approaching law reform in this way. Legislation which is not underpinned by clear principles and legal definitions is likely to result in unforeseen consequences, for example an increased number of detentions of compliant patients under the MHA. By failing to define who will come within the proposed new MCA provisions, it risks creating an unnecessarily complex and costly detention regime under the MCA with little discernible benefit to the people whose interests it is intended to protect.

The Michael Stone Inquiry – A Reflection[1]

Robert Francis[2]

On 9th July 1996 Lin Russell and her two young daughters, Megan and Josie, were subjected to an horrific assault with a hammer after being tied up. All but Josie were killed, and she was badly injured. The attack took place in broad daylight in a peaceful country lane and was perpetrated by someone completely unknown to them, The encounter was clearly a random chance bringing together an entirely innocent and happy family with someone bent on terrible violence. Not surprisingly these events triggered a wave of national horror. This turned to anger when, Michael Stone, a man with a history of mental disorder, drug abuse and violence was arrested, over a year later, following information passed to the police by his psychiatrist in response to a *Crimewatch* reconstruction.

Mr Stone denied any involvement in these crimes, a denial he maintains in spite of his conviction, after a trial, a retrial, and the rejection of his final appeal. The case was marked by the absence of forensic evidence and the Crown's reliance on allegations of confessions made to cell-mates.

Following the initial conviction, an inquiry was set up in accordance with government policy requiring such an investigation following a homicide committed by a person in receipt of mental health services.[3] The initial terms of reference included three stages, fact-finding, evaluation and policy. In the event it was not practicable to proceed to the third stage. [4] To produce a properly informed consideration of the policy implications of the case it would have been necessary to publish the report on the first two stages. The protracted nature of the appeal process in the criminal proceedings made this impossible within a reasonable timescale.[5]

It would have been difficult to find a person with a background more likely to fuel a debate about the protection of society from dangerously disordered individuals than Mr Stone. He had spent much of his childhood in institutional care. There was a history of drug abuse. After convictions as a teenager for offences of dishonesty and one of arson, he went on to be convicted of a number of offences of robbery, and assault for which he was sent to prison. In 1987 he was sentenced to 8½ years imprisonment for offences of robbery, possession of a firearm, burglary and theft. The sentencing judge is reported to have described him as "*an extremely dangerous man*", and a probation officer described him in 1991 *as "the most dangerous man I have dealt with".* In 1994 he was convicted of burglary and unlawful possession of a gun, for which a probation order was made. He was compulsorily admitted to a mental hospital for a short period later in the same year. Between his discharge from section 3 detention and the murders, a period

1 *The author chaired the Independent Inquiry into the Care and Treatment of Michael Stone, and as such was co-author if its report. While this article contains a summary of some of the findings of the inquiry, that summary and any other views expressed in this article are his personal views and responsibility.*

2 *Robert Francis QC, 3 Serjeants' Inn, London.*

3 *For the policy at the time see Circular HSG(94)27*

4 *South East Coast Strategic Health Authority et al, Report of the Independent Inquiry into the Care and Treatment of Michael Stone, September 2006 p 2. The report was delivered to the commissioning agencies in November 2000.*

5 *ibid p 374*

of 17 months, he was in constant contact with statutory agencies. He was recorded as having told various professionals of homicidal thoughts. On at least two occasions he was alleged to have said that he felt like killing children, on another that he had wanted to stab someone, on yet another that he had been making explicit threats about decapitating children. Shortly before the Russell murders he was said to have expressed a threat to kill a probation officer and rape his wife.

Mr Stone's initial conviction for the murders was met with conflicting official responses. The statutory services who had been responsible for providing him with mental health, drug addiction, probation and social services issued a statement, which had been subjected to amendment by the Department of Health, and, it has been suggested, by the Prime Minister's spokesperson,[6] at the end of the trial from the courthouse steps. Mr Stone was, it was emphasised, not mentally ill, but someone with an anti-social personality disorder who had abused multiple drugs for a long time. He was responsible for his own actions, and in answer to the question of whether he was "mad" or "bad", he was not mad. The statement denied that Mr Stone had been ignored by the statutory agencies or had requested in-patient treatment for which he was rejected. On the other hand the Liberal Democrats and the Government, as represented by the Home Secretary, Mr Jack Straw, attributed responsibility for cases such as this to the psychiatric profession in refusing to accept that patients such as Mr Stone were treatable, and therefore detainable, under the Mental Health Act 1983. Mr Alan Beith MP asked the Home Secretary the following question:[7]

> *Does the Home Secretary believe that further measures will be needed to deal with offenders who are deemed to be extremely violent because of mental illness or personality disorder, but whom psychiatrists diagnose as not likely to respond to treatment? Is he aware that this concern has arisen not simply following the conviction of Michael Stone for those two brutal and horrible murders, but because there has been a tendency in recent years for psychiatrists to diagnose a number of violent people as not likely to respond to treatment?*

Mr Straw replied:

> *Sir Louis Blom-Cooper, who has a distinguished record in this field, said on the radio on Sunday that one of the problems that has arisen is a change in the practice of the psychiatric profession which, 20 years ago, adopted what I would call a common-sense approach to serious and dangerous persistent offenders, but these days goes for a much narrower interpretation of the law. Quite extraordinarily for a medical profession, the psychiatric profession has said that it will take on only patients whom it regards as treatable. If that philosophy applied anywhere else in medicine, no progress would be made in medicine. It is time that the psychiatric profession seriously examined its own practices and tried to modernise them in a way that it has so far failed to do.*

The divide between those who favour treatability as the correct criterion for detention under mental health legislation, and those who consider that the availability of treatment, in its broadest sense, should allow detention when the public requires protection from a dangerous individual, continues in the present parliamentary debate on the current Mental Health Bill. The extent to which Mr Stone's case informs the debate is also in dispute. Thus Lord Carlile of Berriew said recently:[8]

> *I want to say one thing about the Mental Health Bill. We know that the Government intend to introduce a new Bill, which is merely an amendment of the Mental Health Act 1983. I plead with them that we*

6 *Rutherford, Dangerous People: Beginnings of A New Labour Proposal in Newburn & Rock (ed), The Politics of Crime Control, 2006, OUP, pp 73-74*

7 *Hansard (HC) vol 319, col 9, 26 October 1998*

8 *Hansard (HL) (60612-22) 12th June 2006 col 95*

> *should not find ourselves getting bogged down in the Michael Stone question all over again. Mental health is not about a small number of people who unfortunately are not cured, are released from hospital, possibly by mistake or maybe by negligence, and commit terrible acts. It is tough to say so, but we can say it in this place because we are not elected: those kinds of accidents happen from time to time. We must talk about the real questions in mental health and not the headline questions, such as Michael Stone.*

And Lord Patel said in later debate:[9]

> *The medical profession, particularly the Royal College of Psychiatrists, is very concerned about the way that some politicians, members of the Government and parts of the media have linked the need for new mental health legislation with violence. Major problems with the mental health services include lack of trained staff, unpleasant in-patient environments, and lack of funding for research on both the causes of mental illness and potential treatments. …*
>
> *Neither the most recent homicide report on the care and treatment of John Barrett, which highlighted significant failings in the system, nor the inquiry into the case of Michael Stone, which was highly influential in directing the Government's development of this legislation, recommended any new legislation.*
>
> *There is a widespread perception among the general public that violence, and homicide in particular, are rising problems caused by the introduction of care in the community and loopholes in the current Mental Health Act. That assumption makes good tabloid headlines but is incorrect.*

The official opposition health spokesperson in the Lords said:[10]

> *All sorts of new programmes and treatments have been developed in recent years to help many people with personality disorders. To the extent that such people are gaining access to these programmes, it is hard to see what the problem is. If such people are being denied access to those programmes, that surely is not a fault of the law or of definitions; it is either because of resources or because clinicians have misunderstood the law. The remedy for either of those things does not lie in amending the legislation. One high-profile example is the inquiry into the Michael Stone case, which did not recommend that the law needed to be changed. It criticised a number of things, but criticised in particular the lack of hospital beds in medium secure units. The amount and the intensity of care that Stone received were, in fact, considerable.*

Lord Soley disagreeing with this, said:[11]

> *The Front Bench opposite referred to the Stone case. Michael Stone had had previous psychiatric treatment, but when he went back to another hospital and asked to be readmitted because he would do something very damaging or dangerous otherwise, he was refused. This was a common experience for probation officers and other people who were working in this area in the 1970s. It has remained so since then. Although I have left the profession, plenty of contacts tell me of instances—although there are fewer of them—of people who are refused admission or treatment because their condition is regarded as not treatable. This is a major problem.*

Thus both sides of the argument appear to want to use the case of Mr Stone as supporting their argument. Therefore it is an opportune moment to reflect on what, if anything, can be drawn from the case to assist the current debate.

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9 *Hansard(HL) (28th November 2006 (pt 6) col 686-687*

10 *Hansard (HL) 10th January 2007 col 297*

11 *ibid col 299*

Mr Stone presented with a number of problems which included a severe antisocial personality disorder, multiple drug and alcohol abuse and occasional psychotic symptoms consistent with having been induced by the drug abuse, or his personality disorder. Much about him remains unknown in spite of a searching inquiry, and the conscientious efforts of the many professionals who saw him over the years. Thus it was only at the inquiry that it was discovered that Mr Stone had been visiting more than one general practitioner under a different names. This lack of information was compounded by the way in which he would appear to different professionals. Thus to some he would appear to be very threatening while at almost the same time he would appear compliant and to be genuinely seeking help. He would issue blood-curdling threats and express terrible things he claimed to want to do, but usually in the context of expressing dissatisfaction with some aspect of his medication. It must have been very difficult to evaluate whether he meant what he said or whether he merely said such things for effect.

Mr Stone was not someone who was ignored by statutory services and left to his own devices, Indeed the range of services he received and the intensity with which they were provided was remarkable, particularly given the lack of any real progress with him. For example, in the 17 month period leading up to the murders, Mr Stone was seen approximately 20 times by staff in the addiction services. In the same period he was seen by staff of the local forensic psychiatric unit about 18 times. Between August 1995 and April 1996, when his probation order expired, Mr Stone was seen about 19 times by a probation officer. The inquiry report doubted that much more would have been done for Mr Stone anywhere else in the country at the time.

However there were questions over the effectiveness of what was done. The community mental health services showed a reluctance to acknowledge that it had a role in the care of someone considered to be dangerous, apart from seeking to persuade others of the danger. The addiction service failed to provide adequate planning or implementation of a coherent and proactive programme of rehabilitation. In particular Mr Stone's requests for in-patient detoxification were ignored. In contrast the forensic psychiatric service was judged to have provided conscientious and accurate assessments of Mr Stone and offered continuous contact with a skilled community psychiatric nurse. Contrary to some media reports at the time, there was no question of the forensic service refusing to admit Mr Stone to hospital. Indeed they went beyond their remit on one occasion by offering in–patient detoxification when other units were unwilling or unavailable to do so.

One failing pervaded virtually all service contacts with Mr Stone: a failure to apply the Care Programme Approach effectively so as to ensure that all interventions and programmes were coordinated, leading to a lack of clarity of purpose and coordination.

The most striking matter for criticism concerned events on 4th and 5th July 1996. Mr Stone was recorded as having become angry in the presence of a community psychiatric nurse and threatened to kill a probation officer. The incident was reported to the consultant forensic psychiatrist who directed that inquiries be made of various people to ascertain more about Mr Stone's mental state. Among these, Mr Stone's general practitioner was to be asked about the depot medication being given. When asked about this, the general practitioner did not inform the forensic services that Mr Stone was overdue for his depot, or give an accurate account of the medication he, the general practitioner, was prescribing and administering. The consultant told the inquiry that if he had known that Mr Stone had missed his injection and had become aggressive, he might have considered that as a rationale for treating Mr Stone under the Mental Health Act. As he was never confronted with that information he did not know what his decision would in fact have been; he might have felt that the known stability of the depot medication in the blood was such that this could not be an explanation of any deterioration in behaviour. Indeed the

inquiry made it clear that it did not find that delays in receipt of depot medication had any significant adverse clinical effect on Mr Stone.[12] As it was, he was assured that there was no such problem and therefore he did not deem it necessary to see Mr Stone for assessment.

In the context of the debate on mental health reform occurring since the inquiry, the core issue appears to be the issue of treatability as a criterion for compulsory admission to hospital. The Government's argument appears to be that this is used as an excuse to avoid admission. The opposite view is that people should not be admitted to hospital unless there is something beneficial which can be done for them by way of treatment and care. The consultant forensic psychiatrist to whom the aggressive outburst of 4th July was reported, described his thinking in relation to Mr Stone in clear terms:

> *If he had been off the Haldol and there were clear mental illness symptoms which had just emerged, then, yes, that would push me into use of the Mental Health Act for reasons of mental illness. That would be fairly clear… where he is off the Haldol and there is aggression and volatility, yes, I guess that would have given some rationale for treatability, some reasonably short-term prospect of treating the aggression in his personality disorder, bringing it down from a certain level to a somewhat lower level. So there would have been a therapeutic prospect for an admission.*
>
> *Listening down the phone to what [the community psychiatric nurse] was telling me, I was waiting, I suppose, for some reason to take particular courses of action, something that could usefully be done. If one of the many things she might have said was, "Actually he has got worse recently, the two or three times I have seen him and he actually is more paranoid than he used to be and he has told me today that he has not been along to the surgery for his Haldol", then a way forward emerges. There is a picture of a temporary deterioration. It might be regarded as in some ways an element of mental illness or at least a treatable component of personality disorder, but there was nothing like that….*
>
> *…I did not see how compulsory treatment could change a personality disorder that was so long ingrained, and, in particular, I did not see how compulsory treatment could change his attitude to drug use. So even if we did manage to successfully contain any attempts of his to abscond or escape, on past form he would return immediately, or rapidly at least, to the same lifestyle with all the same risks, having gained no benefit from any admission. The last part of what I imagined was that that would then mean that any detention on the grounds of personality disorder would be an indefinite detention.*
>
> *… there is no definition of treatability in the Mental Health Act, and in practice every psychiatrist has to think of a patient's treatability in the unit to which they have access, admission under them, or admission to the unit under discussion, the proposed admission, when a mental health assessment has been called for. So I was thinking about treatability in my unit.*[13]

The inquiry in effect accepted that this psychiatrist's judgment on this patient was correct and that there was no justification under the law as it then stood for compulsory admission. The reasoning of the consultant suggests that the issues with which those proposing reform have to grapple must include:

- Is compulsory detention in a medical facility appropriate or justifiable for someone whose behaviour is principally caused by his voluntary abuse of illegal drugs or an unchangeable personality disorder?
- Should detention in a medical facility be restricted to those facilities which have a regime of treatment or care which is likely to bring about some beneficial change in the subject's behaviour or condition?

12 *Report Chapter 6 paragraph 20.1*

13 *Quoted from the Report, chapter 9, paragraph 8.13*

- If so, should detention of some other sort be available where no such facilities exist?
- Alternatively is it acceptable to detain a person in a medical facility even where there is no prospect of effecting beneficial change, other than separating the individual from the public?

Understandably the focus of governmental and public concern is on the danger posed to the public by people such as Mr Stone, and on how the public may be protected from them. Since the inquiry there have been a number of reforms to the sentencing powers of the criminal courts, principally in the Criminal Justice Act 2003. These include a wider range of circumstances in which indeterminate sentences can be handed out, and a greater focus in sentencing on risk and danger. For example a life sentence or imprisonment for public protection must be imposed in respect of convictions for specified serious offences if certain conditions are fulfilled.[14] One of the conditions is that the court

> *Is of the opinion that there is a significant risk to members of the public of serious harm occasioned by the commission by him of further specified offences.*[15]

There is a rebuttable presumption that there is such a risk in the case of an offender over the age of 18 who has been previously convicted of one or more relevant offences.[16]

These changes have led to recent expressions of concern at the increase in the numbers of prisoners on indeterminate sentences and the difficulties involved in processing their assessment for release.[17] In January this year the Home Secretary urged the courts to send fewer offenders to prison. He said that the courts should not be

> *..squandering taxpayers' money to monitor non-dangerous and less serious offenders... the public have a right to expect protection from violent and dangerous offenders… Prisons are an expensive resource that should be used to protect the public and to rehabilitate inmates and stop them reoffending.*[18]

More recently the Prison Governors Association

> *has warned that a substantial overuse of new "indeterminate" sentences is creating chaos, and that inflexible "breach" procedures that see released offenders "whisked back into custody" for being late for appointments is driving prison numbers up.*[19]

This admittedly early experience may suggest that there is a difficulty in pin-pointing precisely which offenders present the risk of significant harm which requires indeterminate detention in order to protect the public. The same difficulty is likely to attach to use of mental health legislation for the same purpose.

Section 3 of the Mental Health Act 1983 currently contains the following requirements as to condition for admission:

> *(1) A patient may be admitted ot a hospital and detained there for the period allowed by the following provisions of this Act … in pursuance of an application made in accordance with this section*
>
> *(2) An application for admission for treatment may be made in respect of a patient on the grounds that*
>
> *(a) he is suffering from mental illness, severe mental impairment, psychopathic disorder or*

14 *Although it should be noted that the Mental Health Act Hospital Order 'route' remains open to the sentencing judge. See section 37 (1A) Mental Health Act 1983 (inserted by para 38 schedule 32 Criminal Justice Act 2003).*

15 *Criminal Justice Act 2003 sections 225(1)(b), 226(1)(b), 228(1)(b)(i)*

16 *Criminal Justice Act 2003 section 229(3)*

17 *Sentence reforms are crowding Jails – Ben Leapman, Sunday Telegraph 11th February 2007*

18 *BBC News on-line 24th January 2007: http://news.bbc.co.uk/1/hi/uk/6293225.stm*

19 *Prison governors call for fewer jailings not more jails – Alan Travis The Guardian 10th April 2007*

mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration in his condition; and

(c) it is necessary for the health or safety of the patient of for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section

"Medical treatment" is defined[20] as including

nursing, and also includes care, habilitation and rehabilitation under medical supervision:

The Government's attempts to reform the existing law have met with considerable and to some extent successful opposition, although the final outcome of the legislative battle has yet to be determined. Without engaging in a full narrative of the passage of the Mental Health Bill through the House of Lords, a glance at recent proposals may be instructive. The changes proposed by the Government in the Mental Health Bill in 2006 would have amended the above provision as follows:[21]

(1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act … in pursuance of an application made in accordance with this section

(2) An application for admission for treatment may be made in respect of a patient on the grounds that

(a) he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(b) …

(c) it is necessary for the health or safety of the patient of for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and

(d) appropriate medical treatment is available for him

(4) In this Act, references to appropriate medical treatment, in relation to a person suffering from a mental disorder, are references to medical treatment which is appropriate in his case, taking account of the nature and degree of the mental disorder and all other circumstances of his case.

A fierce debate ensued on what were said to be the dangers of a patient being detained even where there was no treatment which was likely to alleviate his condition.[22] In an attempt to allay these concerns the Government proposed to amend sub-clause 4 by deleting the words *"which is appropriate ..... all other circumstances of his case"*, and replacing them with the following:

… which is likely to alleviate, or prevent a worsening of the disorder or one or more of its symptoms or effects.

This proposal and the original proposed amendment was defeated in the House of Lords. In the version of the Bill now[23] being considered in the House of Commons, sub-clause 4 reads:[24]

In this Act, references to appropriate medical treatment, in relation to a person suffering from mental

20 *Mental Health Act 1983 section 145(1)*

21 *Mental Health Bill, HL Bill 1 (2006) 7th March 2007, clause 4*

22 *See for example Lords Hansard 19th February 2007 col 925 et seq*

23 *This article was accepted for publication on 12/04/07.*

24 *Mental Health Bill, 7th March 2007, clause 5*

> *disorder, are references to medical treatment which is likely to alleviate or prevent a deterioration in his condition.*

In other words, the test reverted to that in the existing Act. However it is of interest that the Government argued that even its original proposed amendment did not imply an intention to detain people with personality disorders who have not committed a crime:[25]

> *Nothing could be further from the truth. We hope that abolishing the treatability test will help change attitudes that have limited services available for people with personality disorders and excluded them from available services… We think that the treatability test has inhibited the health service from providing the right care and treatment to the group of people we are talking about. Nothing in the Bill, in case law or in the Government's policy equate detention with medical treatment. Detaining someone is not treatment…*

The Government seems to have travelled a long way since Mr Straw's pronouncement in the immediate aftermath of the Russell murders. However there is no doubt that it is proposed to widen the scope of treatment which is to be taken into account. The definition of "medical treatment" is proposed to be changed to read as follows:

> *nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.*[26]

In other words psychological treatment and techniques are to receive a prominence not previously accorded to them in the Act.

What fate awaits these proposals in Parliament, only time will tell. However governmental thinking still appears to be informed by a belief that persons with personality disorders are denied treatment which is available and effective and is more than mere detention. It is not within the expertise of the writer to say whether or not such a state of affairs exists, but the facts of Mr Stone's case may be instructive. He was not denied such treatment as was available, apart from, for a time, in-patient drug detoxification. In any event this was treatment which he appeared to be seeking: therefore detention to give it would not have been appropriate. Further, not only was he offered this in the end, drug misuse is not a ground on which to diagnose mental disorder. As much is accepted by the Government as being the position under existing law, and this is now potentially reinforced by an opposition amendment to section 1(3) of the Act inserted in the Bill[27] in the House of Lords:

> *(3) For the purposes of subsection (2) above, a person shall not be considered to have a mental disorder as defined in this section solely on the grounds of—*
>
> *(a) his substance misuse (including dependence upon, or use of, alcohol drugs);*
>
> *(b) his sexual identity or orientation;*
>
> *(c) his commission, or likely commission, of illegal or disorderly acts;*
>
> *(d) his cultural, religious or political beliefs.*

There was no evidence that the local forensic unit was unwilling to consider admitting Mr Stone should grounds for doing so have been demonstrated. It was more than unfortunate that the unit was denied the chance to make a fully informed decision about Mr Stone's state shortly before the murder by an inadequate communication from a general practitioner. However it could not be said with any certainty that even the correct information would have revealed a clinically justifiable need to detain Mr Stone.

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25 *Lord Hunt of Kings Heath, Lords Hansard 19th February 2007 col 934*

26 *Mental Health Bill, 7th March 2007, clause 9*

27 *Mental Health Bill, 7th March 2007, clause 3*

The real issue that concerns the public in a case such as Mr Stone's is whether anything can be done to ensure that someone like him is not able to perpetrate horrific crimes on innocent members of the public. The answer, it might be thought, does not lie within the remit of the mental health service but the law enforcement agencies. The perceived difficulty in relation to dangerous individuals who have not been convicted of offences is a somewhat artificial construct. It is difficult to believe that there are many persons who are known to the statutory agencies to be so dangerous that they would warrant detention to protect the public, but who have not been convicted of at least one serious offence. Mr Stone was certainly not such a person: he had more than one conviction for a serious offence and was regarded within the criminal justice system as being dangerous. In this regard to such cases the sentencing powers and obligations under the Criminal Justice Act 2003 provide a more fruitful means of reassuring the public than the kind of proposal that has been considered, but so far rejected by Parliament. It is at least arguable that, if the events had occurred after the 2003 Act came in to force, Mr Stone would have been eligible for an indefinite sentence and, at the time of his concerning behaviour in July 1996, could have been considered for recall to prison. This may be thought to be a more appropriate means of dealing with cases such as his, than to place the responsibility on mental health services who may have a very limited clinical role to play in them.

The challenge is to ensure that the new powers are used to target those who actually need to be detained indefinitely and not to fill up the prisons with those who do not. It is suggested that this requires the allocation of considerable resources to the criminal justice system, and in particular the probation service, to enable the relevant expertise to be developed and improved. A risk of using the mental health legislation for non-clinical purposes is that the hospitals will become as full as the prisons are now, with the consequent adverse effect on the care and supervision of those already within that system, to the detriment not only of the patients themselves, but to the public who deserve properly focussed and informed protection.

A Nasty Act?

Kamlesh Patel[1]

Like most newly-appointed cross-bench peers, I went into House of Lords with the expectation and intention that whilst there I will be able to do something to the good in the areas for which my professional background has prepared me. That background includes five years as MHAC Chairman, and a number of years as a member of the MHAC before that.

I am not aware of any planning, on the part of anyone, behind the fact that my entry into the House of Lords was, more or less, coincident with the introduction of the Mental Health Bill. But whereas I might otherwise have looked to my first months of Westminster life as a time to become gently acclimatised to the Upper House, instead I was faced with a very steep learning curve and a Bill that touched very directly on my professional background and concerns.

The highly stylised forms of language and behaviour in the House of Lords take some getting used to. The House strives towards courtly manners, consensus and multi-partisan co-operation[2], but it occasionally erupts into more recognisable Westminster hostilities, especially when a member calls for a vote (a 'division'). Towards evening, when there are fewer Lords around, such a call is unlikely and debates can take on the unreal aspect of phoney war. But up until dinner-break the House may erupt into its great set-piece divisions, with the party-affiliated troops marshalled by their respective whips through one or the other voting lobby. A vote late in the day can appear to be less a test of the merits of an argument, than a test of the relative strengths of the whips offices to have persuaded party-affiliated members to remain in the vicinity of the House.

From such a combination of diplomatic compromise and tests of numeric strength emerges what Lord Carlile memorably described as "that often hilarious concept – the intention of Parliament"[3]. But however much the results of votes may depend upon all sorts of extraneous factors, it seems clear from the tenor of its debates that the Upper House demanded and, however temporarily, won some important amendments to the Government's proposals.

Viewed from the time of writing, the Bill still has an uncertain future. Before the Upper House had done with the Bill, the Minister in the Commons announced her intention to undo its key amendments[4]. This may signal some rough water ahead, whether or not such intransigence leads in the Commons to any significant revolt of back-benchers from the Government whip[5]. There is no guarantee that the Upper House will be prepared to give way on some issues of principle. The late and very much lamented Lord Carter, who was a member of the Joint Committee scrutinising the draft Mental Health Bill of 2004, noted in the context of another debate that "It is a curious feature of our constitution that, once a Government have a working majority in the Commons, the separation of powers between the executive

1 *Professor Lord Patel of Bradford OBE, Chairman of the Mental Health Act Commission; Head of the Centre for Ethnicity & Health, University of Central Lancashire..*

2 *Hansard HL 19/02/07, col 925/6 (Earl Howe)*

3 *Ibid., col 890 (Lord Carlile)*

4 *Rosie Winterton, Minister of State for Health Services: Local Government Association conference, Mental Health Bill, 1 March 2007. Downloaded on 2 March 2007 from www.dh.gov.uk*

5 *Openmind 144 (March April 2007) 'Government will extend compulsion powers, says MP'*

and the legislature is more evident in the Lords"[6]. Indeed, Lord Owen warned Government at the start of our debates that it has already lost Bills in this area and could well lose this one unless it showed "a good deal of feeling and understanding for expert opinion"[7].

On some matters, the Ministers in the Lords did listen to expert opinion and relatively happy compromises were reached over some questions, such as the legal basis for the admission of minors[8], or the introduction of an ability to transfer between places of safety[9]. Indications have been given that further Government amendments will appear in the Commons to address the call for patient choice in identifying Nearest Relatives[10] and for some statutory provisions around advocacy[11]. Alongside some of the uncontested 'tidying up' provisions in this Bill (notable amongst which is a reversal of the current restrictions over who may sit on a Foundation Trust managers' review hearing[12]), these amount to some good reasons to hope that the Bill is not, in the end, lost.

What follows is a step back from the fine detail of the Bill and its amendments, to enable a wider view of the polarised positions occupied by Government and its detractors.

Libertarians and Paternalists?

The Conservative front bench has accused the Government of starting from "a profoundly paternal attitude towards mental health patients…that accepts only grudgingly that the autonomy and decision-making ability of those with a mental illness matter at all and … would actually much prefer these people to jolly well accept what is good for them whether they like it or not"[13]. The Minister, of course, disputed this[14]. Government's general response to this charge has been to argue that it has struck an appropriate balance between coercive powers and protective limitations on such power. Thus the Government characterises the real contention as between its Bill, which seeks to establish specific safeguards and thresholds in the working criteria for compulsion, and the Bill's critics, who are seeking either unnecessary and dangerous limitations on psychiatric power, or else declaratory but essentially otiose phrases and words that would signal good intentions but have little practical effect[15].

I have great sympathy for Lord Hunt's position as the responsible Government Minister in the House of Lords debate, who has a long-standing interest in mental health service provision, is highly regarded by noble Lords on all sides of the House[16], and who inherited this Bill with his re-appointment to the front benches. I have *some* sympathy with the general proposition that a good mental health law would be drafted to be so explicit in its applicability that there should be little need for it to contain declaratory statements of intent. But, even if such legislation *can* be drafted, I do not believe that this Bill is it. In any case, there continue to be worrying signals from the Government camp that the intention behind the Bill is *actuall*y to leave the scope of compulsory powers to be determined by professional discretion rather than by any meaningfully restrictive statutory criteria.

6 *Hansard HL 21/01/07, col 583 (Lord Carter)*
7 *Ibid., col 582 (Lord Owen)*
8 *Hansard HL 26/02/07, col 1462 (Lord Hunt)*
9 *Ibid., col 1467 (Lord Hunt)*
10 *Hansard HL 06/03/07, col 135 (Baroness Royall)*
11 *Hansard HL 26/02/07, col 1484 (Baroness Royall)*
12 *Mental Health Bill [HL as amended on report] clause 43*
13 *Hansard HL 26/02/07, col 1414 (Earl Howe)*
14 *ibid. col 1414-5 (Lord Hunt).*
15 *see, for example, Hansard HL 19/02/07, col 920 (Baroness Royall).*
16 *See Hansard HL 06/03/07cols 122–135*

Before the Lords debated and voted upon the question of whether the Bill should set out more explicit exclusions to the scope of Mental Health Act powers[17], an all-party group meeting was told by the Government's mental health *czar*, Professor Appleby, that "every exclusion is a person not receiving the treatment they need"[18]. A similar argument was whispered to my colleagues in the corridors of the Palace of Westminster to warn against *an*y amendments seeking to restrict the scope of the general criteria for compulsion. The response to Government defeats in the Upper House by the Minister in the Commons (the Rt Hon Rosie Winterton MP) took the same line, stating that "every barrier that is put in the way of getting treatment to people with serious mental health problems puts both patients and the public at risk"[19] and, rather curiously (given that the context here was the scope of community treatment orders, which even under Government plans could only be imposed upon a patient who is already detained in hospital under the Act), "every restriction is a patient untreated, a family in distress"[20].

The assumption that the law should not fetter clinicians in helping those who need help has a superficial reasonableness (or at least anyone challenging it will feel the chill of shrouds being waved in his or her direction), but in the context of mental health law concerned with compulsion it actually has rather ominous implications. Not least, it conflates the notion of receiving treatment for mental disorder with the notion of *compulsor*y treatment for mental disorder, and therefore appears to assume that people with serious mental health problems cannot be helped unless they are 'helped' by force. Of course the 1983 Act is built upon the legal reforms of the 1950s which took precisely the opposite view, and elevated informal treatment as the basis upon which mental health services should be provided unless and until compulsion could be justified in any individual case. There is a risk in the Government's stance of not so much updating the law for the start of our new century as pushing it back to the early years of the last century, when 'voluntary' status as a psychiatric patient was a privilege. If this is really the direction that Government wishes to travel, what would a potential patient have to demonstrate in order *not* to be 'helped' through compulsory psychiatric intervention, especially given the inherent difficulties of predicting actual risk to the public from individuals with mental disorder? And what signal does the Government's apparent focus on compulsion as the only means of service provision send to all those outreach workers whose daily professional lives focus on helping patients access services before compulsion becomes necessary?

In reality, of course, the criteria for psychiatric intervention of any sort is often determined by questions of resources. Where patients are left untreated in the care of, or to the distress of their families, it is more likely to be because they are waiting for an over-subscribed hospital bed, or in contact with similarly overstretched or underdeveloped community teams. Ministers quite understandably become peevish that not enough credit is given to Government for the ways in which it has sought to increase resource levels on the ground. It is unfortunate for them that the legislative agenda over the last seven years has distracted both attention and, in the end, resources, from continuing initiatives to establish specialist services for previously marginalised diagnostic groups, such as people with personality disorder, and suitable services for previously ill-served demographic groups, such as women or children. It is something of a political feat to have alienated such a comprehensive body of user, carer and professional mental health groups in the midst of such a development programme.

17 *Amendment No.3 at report stage: see Hansard HL 19/02/07, cols 906–925*

18 *Hansard HL 19/02/07, col 910 (Baroness Barker)*

19 *Press Association, 19/02/07 "Peers inflict three defeats over mental health powers"*

20 *ibid., n.4 above.*

Discretionary powers: clinician knows best?

Although the ministerial line is that the Bill struck a "balance between getting treatment to those who need it, putting in place patient safeguards and minimising the risk to the public"[21], it seems to me that the Government's approach *is* in fact skewed by a dangerously paternalistic view of the purpose of mental health legislation. I accept, of course, that there is a balance to be struck between the areas that the Minister mentions. It has also been argued that striking the right balance between paternalism and protection, on the one hand, and patient determination and autonomy on the other, is as achievable as finding the Holy Grail[22]. That may be so, but I do not think that the Government's Bill would, at least in its original state, have improved upon such balance as there already is in the provisions of the 1983 Act. In its desire to 'help' mentally disordered persons (or to keep them from the public) by catching them in a broad-cast net of compulsion, Government failed to pay sufficient attention to the need for the law to protect personal autonomy from unwarranted interference from the state.

Certainly the criteria for compulsion that were first proposed under the Bill did not establish such safeguards, but instead relied on ill-defined and therefore highly subjective terms such as 'appropriate' at their core. This leaves too much to the discretion of those operating coercive powers. In contrast to the Government's apparent approach, the great majority of those who spoke in the House of Lords' debates addressed the proposed changes in the law from a starting point that assumes that mental health legislation cannot be simply an enabling Act to provide powers for the interference of health bodies in the lives of people of this country, but must also be a means of circumscribing and limiting those powers. They have pointed to areas where the Government's proposals created ill-defined powers that would rely heavily on the discretion of practitioners, and suggested and voted for ways in which to tighten the criteria. I am therefore deeply disappointed that the Minister in the *other place* announced her view that "for the sake of mental health patients themselves and the safety of the public, these changes must be overturned" even before the Upper House had completed its reading of the Bill[23]. Government seems to be incapable either of listening or understanding the very real concerns that were set out in the debates of the Upper House.

The purpose of psychiatric compulsion

One area in which the Minister signalled her intention to overturn the House of Lords' vote was with regard to its determination that therapeutic benefit should form a criterion for compulsion under the Act. The Minister's statement does not acknowledge the fact that the Lords voted upon an amendment that was already a compromise solution aimed to meet Government half way[24]. It instead relies upon the same arguments, although still no actual evidence, for the need to reverse the Lords' vote as were originally employed against the test of 'treatability' that the Bill was designed, in part, to remove. Firstly, it is suggested that patients and their lawyers' are scheming of ways to convince the courts that the tests must be interpreted in some way as to 'secure premature discharge for some of the most dangerous patients'[25]. This is unnecessarily alarmist, there being very little prospect that the courts would reverse precedent interpretations of 'treatability' that include not only symptomatic treatment but even the beneficence of care in a structured environment. Secondly, and here I find either muddled logic or else an outrageous sleight of hand in the Government's argument, it is suggested that mental health professionals

21 *ibid., n.19 above.*

22 *Unsworth, C (1987) The Politics of Mental Health Legislation. Oxford University Press.*

23 *ibid,. n.4 above*

24 *Hansard HL 19/02/07, col 927(Lord Carlile)*

25 *ibid,. n.4 above.*

misinterpret the existing test and incorrectly exclude potential patients as a result, and therefore the test must be expunged from the Act to remove this excuse for services to deny services to patients. It is by now a well-worn, if still important, argument against the muddled thinking that, if professionals are misinterpreting the Act, this is a matter for training rather than new legislation. In the words of one of the qualified psychiatrists on the Lords' benches, 'bad psychiatry does not justify bad legislation'[26].

To be worthwhile legislation, the Mental Health Act must provide a check against unfettered clinical discretion and delineate the powers given to mental health professionals over patients who cannot or do not consent. The Bill is better in this regard following the amendments made in its passage through the Lords: no doubt it could be better still. Whilst some practitioners and commentators have questioned what all the fuss is about on the issue of 'treatability', given the current very broad definition of that term, my own view is that here is an issue where Parliament needs to set down a specific view, and articulate that in legislation, so that the law is explicit in its intention and in its basis as a health measure. Government would have Parliament remain silent over the purpose of the use of compulsory psychiatric intervention, and this is not acceptable.

Countering institutional racism in psychiatric coercion

The fact of gross overrepresentation in the detained patient population of patients from Black and minority ethnic groups is now generally recognised. It is also generally agreed that there is an urgent need to do something about this, although of course what exactly is to be done is a more contentious matter. It is, I think, a valid question to ask whether there is anything that can be put into mental health legislation that can address this problem in any practical way. After all, the overrepresentation takes place in a legal context where public authorities are already under a specific duty not only to eliminate racial discrimination, but also to promote equality of opportunity and good race relations[27]. I take the view that a declaratory statement in the 1983 Act would serve to remind practitioners that they operate under this general duty, and can only strengthen whatever effect if does have.

The compromise reached over the question of whether there should be a statement of principles on the face of the Act will at least guide practitioners towards a similar message in the Code of Practice, but the Code already contains an anti-discrimination principle[28] and it could be said that this has not proved effective up to now. Perhaps more importantly, given that decisions regarding psychiatric coercion are inevitably value-judgments, the most important task of a responsible legislature to avoid perpetuating or fostering discrimination would be to make the criteria for such decisions as precise – and justiciable – as possible. By contrast, the open-textured nature of legal powers in the Bill as presented to Parliament could have removed some existing checks on further overrepresentation of Black and minority ethnic patients.

Legislating for services

One other way in which the provisions of a Mental Health Act could ensure that patients receive appropriate treatment is, of course, by establishing some kinds of reciprocal duties upon services to provide such treatment to those in need.

Government has very emphatically rejected some amendments that aimed to make such duties explicit

26 *Hansard HL 10/01/07, col 312 (Lord Alderdice)*

27 *Race Relations Act 1976, s.71, as amended by Race Relations (Amendment) Act 2000, s.2.*

28 *Department of Health (1999) Mental Health Act Code of Practice, para 1.1*

in this Bill, including my own amendment that would have given statutory force to the requirements of care-planning. The argument against such amendments is that ring-fencing or prioritising one aspect of the health or social care service may be at the cost of other aspects of such services, and that legal requirements to concentrate resources on specific aspects can distort local planning and accountability, or even fetter the legal discretion of the Secretary of State[29].

Such a proposition is irrefutable at an abstract level, but the realities of health and social care service provision are already subject to some such pressures, and some of these stem directly from legislation. A straightforward example is section 4 of the NHS Act 1977, which establishes a duty to provide 'special hospitals' for dangerous and offender patients. Furthermore, there is a sense in which the Mental Health Act 1983 itself can be seen as a series of legal requirements for the provision of particular services, such as the assessment of specifically qualified professionals, as a condition of using coercive powers of detention. The 1983 Act also sets out explicit duties, such as the duty under section 117 to provide aftercare to some detained patients upon discharge; the requirement to specify hospitals that have arrangements for admitting emergencies (section 140) and the duty to provide sufficient numbers of approved social workers (section 114).

Although it may be ungracious to point this out, the Government position is also inconsistent in its approach to this issue, as is evidenced, for example, by its concessionary offer to look again at making specific provision in the Bill requiring authorities to provide advocacy services for detained patients in response to amendments tabled by Lord Williamson and myself. Of course, this is hardly a revolutionary use of the law: section 35 of the Mental Capacity Act 2005 establishes a clear precedent for the use of mental health legislation to establish such a positive duty to provide advocacy services to vulnerable patients.

Whilst I can sympathise with ministerial exasperation over the stream of claims for priority in terms of resources from this or that aspect of the health service or from various patient groups, the position of a detained psychiatric patient is unique amongst health service recipients and the law already discriminates, in various ways, such a patient from the rest of healthcare provisions. I very much welcomed the amendment aiming to provide that child patients should be accommodated in suitable facilities[30]. It is Government policy that this should be so, but in the current financial climate it is difficult to see how the many health authorities who are looking for substantial financial savings will turn that policy into a reality. It is obvious that such authorities who are faced with difficult decisions over balancing their budgets will, of course, look for savings in those parts of their service that are neither their core business nor a legal requirement. In the absence of any legal requirement to provide services, development in these areas may stall and existing services will always be under threat. These threats are very real. In relation to children's services, the House of Lords heard that between 1999 and 2006 there has been only a four per cent increase in general child and adolescent mental health beds between 1999 and 2006[31] In relation to advocacy services, as I write this I have a letter on my desk announcing the closure after ten years' work of one London-based advocacy group, because the Primary Care Trust (which is looking to make substantial savings to reduce its overspend) has withdrawn funding.

29 *Hansard HL 26/02/07, col 1374 (Lord Hunt)*

30 *Hansard HL 26/02/07, cols 1365-1378*

31 *Hansard HL 16/02/07, col 1375 (Baroness Meacher)*

A nasty Act?

Late in the evening of the House of Lords' penultimate day of debate at report stage of the Bill, I suggested to a slightly startled House that the differences in provisions made regarding advocacy services in the Mental Health Act and Mental Capacity Act are

> *not only unethical in terms of equity of provision but dangerous. It is dangerous because we run the risk of having two statutes that have considerable overlap. The Mental Capacity Act is, and is seen to be, forward-thinking, concerned with patient rights and protections, and so on, whereas the Mental Health Act appears to be a set of second-rate provisions, outdated attitudes and the shifty machinations of a Home Office forever seeking unfettered powers of social control.*
>
> *Every time we allow some unjustifiable inequity between the way in which these two statutory frameworks deal with patients, we move a step closer towards the Manichean system of a nice mental health law and a nasty mental health law. The danger, as this House has heard before, is that the nasty mental health law drives away those whom we would wish to seek early treatment, not least on grounds of safety.*[32]

I stand by these words, notwithstanding the eyebrows that were raised at their tone. I think that there is a real danger in the Government's announcements over its Bill, as exemplified by Rosie Winterton MP's response to the Lords' amendments, of creating a perception – and it was *perceptions* that I spoke of in the House – that the 1983 Act is all about controlling the actions of dangerous people, or solely concerned with the prevention of homicide and suicide. Of course, no-one could argue for a moment that this was the reality of the Act – obviously it is concerned with much else besides, and its powers are far wider than that would imply. But there is a sense in which any law that seeks to guide professional action, or perhaps any sort of human agency, has an important symbolic aspect. Many people who are professionally involved with the Act do not know its detail, and a great many people who are made subject to its powers, or who know someone who is, will have neither opportunity nor inclination to understand the context or extent of those powers. The Government's Bill unbalanced the Act by casting aside some of its definitional safeguards, and its presentation of its case for doing so has further characterised the Act as being concerned, above all else, with public safety. This has been the most indelicate handling of legislation that in fact requires the most delicate of balances to be made.

This is why I supported those amendments to the Bill as presented to Parliament that Government dismissed as 'declaratory'. That is also why it is important that the Mental Health Act, like the Mental Capacity Act, should be principled legislation that sets out the value of personal autonomy and the need to use the least restrictive option when intervening for the health of patients, or the protection of patients or others. And, finally, that is why Government needs to temper its reaction to the reasoned debates over its Bill, and listen to the weight of expert opinion that is behind the Lords amendments and, I hope, further amendments to come.

32 *Hansard HL 26/02/07, cols 1482-3*

Re-considering the Mental Health Bill: The view of the Parliamentary Human Rights Committee

David Hewitt[1]

1. Introduction

The Mental Health Bill has finally seen the light of day.[2] Because the Government has changed tack, it proposes, not to abolish the Mental Health Act 1983 ('MHA 1983'), but to amend it.

The new Bill has a lengthy antecedence: an expert report;[3] a Green paper;[4] a White Paper;[5] and two draft Bills.[6] It was introduced into House of Lords on 16 November 2006, and has finally finished being debated there.[7] On 6 March 2007, the Bill was sent to the House of Commons.

Lately, the Bill has been scrutinised by the Parliamentary Joint Committee on Human Rights ('JCHR').[8]

The JCHR decided to consider the Mental Health Bill because it raises "significant human rights issues". The Committee also sought further information from the Government and received evidence from groups such as the Mental Health Alliance and the Council on Tribunals.[9]

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2 *Mental Health Bill 2006, HL Bill 1, 54/2 www.publications.parliament.uk/pa/ld200607/ldbills/001/2007001.pdf*

3 *Department of Health, November 1999, Review of the Mental Health Act 1983: Report of the Expert Committee www.dh.gov.uk/assetRoot/04/06/26/14/04062614.pdf*

4 *Department of Health, November 1999, Reform of the Mental Health Act 1983: Proposals for Consultation, Cm 4480 www.dh.gov.uk/assetRoot/04/08/57/76/04085776.pdf*

5 *Department of Health, December 2000, Reforming the Mental Health Act: Part I – The new legal framework, Cm 5016 www.dh.gov.uk/assetRoot/04/05/89/14/04058914.pdf Department of Health, December 2000, Reforming the Mental Health Act: Part II High risk patients, Cm 5016-II www.dh.gov.uk/assetRoot/04/05/89/15/04058915.pdf*

6 *Department of Health, June 2002, Draft Mental Health Bill, Cm 5538 www.dh.gov.uk/assetRoot/04/07/47/22/04074722.pdf Department of Health, September 2004, Draft Mental Health Bill, Cm 6305 www.dh.gov.uk/assetRoot/04/08/89/14/04088914.pdf*

7 *Reports of the Parliamentary debates may be found at http://www.publications.parliament.uk/pa/pabills/200607/mental_health.htm*

8 *Joint Committee on Human Rights, Legislative Scrutiny: Mental Health Bill, Fourth Report of Session 2006-07, HL Paper 40, HC 288, 4 February 2007 ('JCHR Report') http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/40/4002.htm*

9 *JCHR Report, Appendices 1–5*

This is not, of course, the first time the Government's proposals have been subjected to Parliamentary scrutiny. The first draft Bill was itself the subject of a JCHR report,[10] and the second draft Bill had a committee of its own.[11] Like those, the JCHR's new report is critical of the Bill, which it says creates nine human rights compatibility issues and omits two means to enhance or promote human rights.[12]

2. An unsound mind

The first question the JCHR considers is what constitutes an 'unsound mind'.[13]

This is important because 'unsoundness of mind' is one ground upon which a person might be deprived of liberty under Article 5 of the ECHR.[14]

Although the European Court of Human Rights ('ECtHR') has steadfastly refused to define the term 'unsoundness of mind',[15] we know that:

- it must be construed narrowly;[16]
- if the exception is to be made out, there must be a "true mental disorder";
- the disorder in question must be "of a kind or degree warranting compulsory confinement";
- this must be established by "objective medical expertise"; and
- a patient's confinement on grounds of mental disorder will remain valid only for as long as the disorder persists.[17]

The Committee is satisfied that current and proposed MHA 1983 admission procedures fulfil these requirements.[18]

The Mental Health Bill will apply to those who are suffering from 'mental disorder', a term that it defines in a new way. Instead of the four-limbed definition that is the keystone of the un-amended MHA 1983, 'mental disorder' will be, simply, "any disorder or disability of mind."[19]

The Government believes this definition to be compatible with the ECHR conception of 'unsoundness of mind', but JUSTICE, the all-party law reform and human rights organisation, regards it as "too broad and sweeping".[20] The JCHR does not state which of these views it prefers. Its particular concerns are about sexual deviancy.

10 *Joint Committee on Human Rights, November 2002, Draft Mental Health Bill, HL Paper 181, HC 1294 www.publications.parliament.uk/pa/jt200102/jtselect/jtrights/181/181.pdf*

11 *Joint Committee on the Draft Mental Health Bill, Session 2004-2005, Draft Mental Health Bill, Vol I, HL Paper 79-I, HC 95-I; Vol II, HL Paper 79-II, HC 95-II; Vol III, HL Paper 79-III, HC 95-III www.publications.parliament.uk/pa/jt/jtment.htm. See, David Hewitt, To improve, not bury, the draft Mental Health Bill, New Law Journal, vol 155, no 7172, 15 April 2005, p 561. See also: Department of Health, July 2005, Government response to the report of the Joint Committee on the draft Mental Health Bill 2004, Cm 6624 www.dh.gov.uk/assetRoot/04/11/52/68/04115268.pdf; David Hewitt, Mind games, Solicitors Journal, vol 149 no 32, 12 August 2005, p 966*

12 *JCHR Report, para 5*

13 *Ibid, Report, paras 6-16*

14 *ECHR, Art 5(1)(e)*

15 *Winterwerp v Netherlands (1979) 2 EHRR 387 at para 37*

16 *Litwa v Poland (2001) 33 EHRR 53*

17 *Winterwerp v Netherlands (1979) 2 EHRR 387*

18 *JCHR Report, para 16*

19 *Mental Health Bill 2006, cl 1(2)*

20 *JCHR Report, para 7*

Trans-sexualism

At the moment, a person may not be deemed suffering from mental disorder "by reason only of […] sexual deviancy".[21] But what does that mean? Who are the deviants now?

It would seem to be common ground that 'paedophiles' should be capable of being detained under MHA 1983. The Government certainly doesn't take issue with the suggestion.[22]

The problem, according to the JCHR, is that instead of retaining the 'sexual deviancy' exception but ensuring that paedophiles can't claim its protection, the Government has decided to abolish the exception altogether. This, the Committee fears, might allow an amended MHA 1983 to be applied to trans-sexuals, and also to masochists and fetishists.[23]

The Government says that sexual fetishism and sexual masochism *should* be capable of being regarded as 'mental disorder', and of being addressed under MHA 1983, at least "where they reach a level of clinical significance."[24] However, the Government "does not see" how trans-sexualism could reasonably be classed as 'sexual deviancy' and suggests that it will not, therefore, be affected by the Mental Health Bill.[25] The JCHR is not so sure. It suggests that principles of non-discrimination and proportionality be inserted into MHA 1983.[26]

Drunkenness

At the moment, a person may not be dealt with as suffering from mental disorder "by reason only of […] dependency on alcohol or drugs."[27]

At one time, the Government had proposed abandoning this exception, stating, for example,

> "We intend that mentally disordered people should not be excluded from compulsion where it is necessary in their case simply because they are […] alcohol dependent […].[28]

This decision was widely criticised, not least by the Parliamentary committee that scrutinised the draft Mental Health Bill of 2004.[29]

The Government has changed its mind, and the relevant exception will say, "dependence on alcohol or drugs is not considered to be a disorder or disability of the mind."[30] But this might not be the full story.

Alongside the new Bill, the Government has published a draft Code of Practice.[31] Explaining the new version of the old exception, it says:

> "[MHA 1983] does not exclude other mental disorders relating to the use of alcohol or drugs. *Some such disorders, for example uncomplicated acute intoxication, may only rarely justify the use of powers under the Act*, whilst others, for example withdrawal state with delirium or associated psychotic disorder may justify use more often, provided the other criteria are met."[32]

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21 *MHA 1983, s 1(3)*

22 *JCHR Report, para 10 and Appendix 3*

23 *Ibid, para 11*

24 *Ibid, para 11 and Appendix 3, para 3*

25 *Ibid, Appendix 3, para 5*

26 *Ibid, paras 14 & 15*

27 *MHA 1983, s 1(3)*

28 *Department of Health, September 2004, Improving Mental Health Law: Towards a new Mental Health Act, para 3.20 www.dh.gov.uk/assetRoot/04/08/89/17/04088917.pdf*

29 *Joint Committee on the Draft Mental Health Bill, op cit, para 104 www.publications.parliament.uk/pa/jt200405/jtselect/stment/79/79.pdf*

30 *Mental Health Bill 2006, cl 3*

31 *Department of Health, November 2006, Draft Illustrative Code of Practice www.dh.gov.uk/assetRoot/04/14/07/68/04140768.pdf*

32 *Ibid, para 1B.8 [emphasis added]*

The Committee believes the effect of this is clear. It says the draft Code "creates the possibility that Mental Health Act powers may be used in relation to drunk people."[33]

3. Replacing the treatability test

Next, the JCHR examines the Government's plan to replace the 'treatability test'.[34]

The treatability test

According to the four-limbed definition referred to above, 'mental disorder' comprises mental illness, mental impairment, severe mental impairment and psychopathic disorder.[35]

Where a patient is suffering from mental illness or severe mental impairment, the test will apply only when detention is being renewed, so that at first, s/he will be detainable even if it is not fulfilled.[36] However, no patient with mental impairment or psychopathic disorder may be detained unless s/he is 'treatable' from the outset.[37] This, of course, is the 'treatability test'.

The available appropriate treatment test

The Government has on several occasions given its reasons for replacing the treatability test.[38] It told the JCHR:

> "The intention is (*inter alia*) to remove the ground for argument about the efficacy or likely efficacy of a treatment which can be used to prevent detention of people who present a risk to themselves or others."[39]

The new test would make it possible to use MHA 1983 where "medical treatment which is appropriate to the patient's mental disorder and all other circumstances of their case is available."[40]

On the face of it, this would diminish the treatability test. In order to justify compulsion, it would no longer be necessary to show that treatment would improve or at least prevent a worsening of a patient's mental state; s/he would be capable of being brought within MHA 1983 merely if there was 'appropriate' treatment that was 'available' to him/her.

Previous versions of this test have been heavily criticised. In 2004, for example, the Parliamentary scrutiny committee said that compulsion should only be possible if it would bring 'therapeutic benefit' to the patient concerned.[41]

Yet, the law does not require therapeutic benefit – or, for that matter, treatability.

The lawfulness of the new test

The JCHR accepts that the abolition of the treatability test does not engage the ECHR.[42] This is because Article 5(1)(e) neither entitles a patient to treatment appropriate to his/her condition nor requires that

33 *JCHR Report, para 9*

34 *Ibid, paras 17-20*

35 *MHA 1983, ss 1 & 3*

36 *MHA 1983, ss 3(2) & 20(4)(b)*

37 *MHA 1983, s 3(2)(b)*

38 *See, David Hewitt, A suitable case for treatment? New Law Journal, vol 156 no 7230, 23 June 2006, pp 1008-1009*

39 *JCHR Report, para 18 & Appendix 1, para 8*

40 *Mental Health Bill 2006, cl 4*

41 *Joint Committee on the Draft Mental Health Bill, op cit, paras 140 & 148*

42 *JCHR Report, Appendix 1, para 8*

s/he be 'treatable' in order to be detained.[43] Indeed, the ECtHR has gone as far as to say that people of unsound mind might be detained:

- merely because of public safety concerns;[44]
- because "they have to be considered as occasionally dangerous for public safety";[45] or
- "because of considerations dictated by social policy."[46]

This shows how weak the ECHR is, and it suggests that the Government might be wrong to see the treatability test as a bar to detention.[47]

The Committee ends its discussion of this point on a note of caution. Its attention was drawn to Council of Europe Recommendation No (2004) 10, which was published after the last of the cases on which the ECHR treatment jurisprudence now stands.

Recommendation 17(1)(iii) states that the 'involuntary placement' of someone with mental disorder will only be permitted if, *inter alia*, "the placement includes a therapeutic purpose",[48] a term that, we are told, "includes prevention, diagnosis, control or cure of the disorder, and rehabilitation."[49]

The Recommendation does not, however, say that detention must be contingent on treatment. It doesn't mention 'treatment' at all. Indeed, it seems to permit involuntary placement simply on the grounds that it will prevent, control or cure the person's mental disorder, or simply allow it to be diagnosed.

Even if the definition of 'therapeutic purpose' were to include 'treatment', it is unlikely that it would be any stronger. The definition of 'treatment' adopted elsewhere in the Recommendation is vague:

> "[A]n intervention (physical or psychological) on a person with mental disorder that, taking into account the person's social dimension, has a therapeutic purpose in relation to that mental disorder. Treatment may include measures to improve the social dimension of a person's life."[50]

It seems, therefore, that the Recommendation does not go so far as to require that a person be treatable before s/he is detained, and that the restriction it imposes is no greater than is already imposed by the ECHR and the cases decided under it.

4. Renewal of detention

The JCHR is concerned that the renewal of a patient's detention under the amended MHA 1983 might breach the ECHR. There are two reasons for this.[51]

43 *Winterwerp v Netherlands (1979) 2 EHRR 387; Hutchison Reid v United Kingdom, Application no 50272/99, Judgment of 20 February 2003. See also, Koniarska v United Kingdom, Application no 33670/96, Decision of 12 October 2000, unreported*

44 *Luberti v Italy, 6 EHRR 440, 449, para 28*

45 *Guzzardi v Italy (1980) 3 EHRR 333, 366, para 98*

46 *Litwa v Poland, Application no 26629/95, Judgment of 4 April 2000, para 60*

47 *See, David Hewitt, Treatability tests, Solicitors Journal, vol 146 no 37, 4 October 2002, pp 886-887*

48 *Council of Europe, Committee of Ministers, Recommendation (2004) 10, Concerning the protection of the human rights and dignity of persons with mental disorder, adopted on 22 September 2004, Art 17(1)(iii)*

49 *Ibid, Art 2(3)*

50 *Ibid*

51 *JCHR Report, paras 21-26 & 27-29*

Objective medical expertise

As we have seen, detention will only be lawful under Article 5(1)(e) of the ECHR if its subject is shown to be of 'unsound mind' by objective medical expertise.[52]

The JCHR accepts that the procedures for a patient's initial detention under MHA 1983 will continue to fulfil this requirement.[53] It takes a different view, however, with regard to the *renewal* of a patient's detention.[54]

Once MHA 1983 has been amended, a patient's detention – or, as we must learn to call it, *compulsion* – will be renewed by the successor to the Responsible Medical Officer ('RMO'), the Responsible Clinician ('RC').[55] Crucially, the RC will not need to be medically qualified and might in fact be a nurse, a psychologist, an occupational therapist or a social worker.[56]

The Government considers this to be consistent with the ECHR. It says that 'objective medical expertise'

> "means relevant medical expertise, and not necessarily that of a registered medical practitioner;"[57]

and that in *Winterwerp*, the phrase

> "was used in the wider sense and the [ECtHR] was not seeking to lay down which sort of qualifications available in a national system would be acceptable and which would not."[58]

The JCHR does not accept this analysis, and it relies instead on the *Varbanov* case.[59]

Quoting at length from the judgment of the ECtHR, the Committee concludes,

> "[T]he opinion of a medical expert who is a psychiatrist is necessary for a lawful detention on grounds of unsoundness of mind."[60]

As we have seen, detention might be lawful under Article 5(1)(e) merely because it is in the interests of public safety or social policy.[61] If that is so, why is it necessary for any such detention to be justified by objective medical expertise? This might logically be so where the reason relied upon is 'unsoundness of mind', but:

(a) does reliance upon that ground exclude reliance on broader, public safety or social policy grounds subsequently (for example at renewal)?

(b) even in the case of someone suffering from unsound mind, is it not possible to eschew the 'unsoundness of mind' ground and claim instead that his/her detention is lawful on those broader grounds?

In either case, objective medical expertise would add nothing to the issue of whether detention was justified, which would instead turn on questions of safety or public policy.

52 *Winterwerp v Netherlands (1979) 2 EHRR 387*

53 *MHA 1983, s 12(2)*

54 *JCHR Report, paras 21-29*

55 *Mental Health Bill 2006, cl 8(4)(a)*

56 *Mental Health Bill 2006, cl 8(9) & (10) and Explanatory Notes, n 52; JCHR Report, para 22*

57 *JCHR Report, para 23 and Appendix 1, para 9*

58 *Ibid, Appendix 3, para 7*

59 *Varbanov v Bulgaria, Application no 31365/96, Decision of 5 October 2000; JCHR Report, para 26*

60 *JCHR Report, para 26*

61 *Luberti v Italy, 6 EHRR 440, 449, para 28; Guzzardi v Italy (1980) 3 EHRR 333, 366, para 98; Litwa v Poland, App No 26629/95, 4 April 2000, para 60*

Who may renew?

A patient's detention under section 3 of MHA 1983 will be renewed once the appropriate report is furnished by his/her RMO to the hospital managers,[62] and the managers need not consider the report for it to have that effect.[63]

The JCHR notes the ECHR requirement – first stated in the *Winterwerp* case – that in order to be "in accordance with a procedure prescribed by law" and so comply with Article 5,

> "any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary."[64]

The Committee notes that as far as MHA 1983 is concerned, the 'appropriate authority' that detains non-offender patients is not the RMO, but the hospital managers. It worries that because the managers need only receive, and need not approve, a report by the RMO, the renewal process might breach the ECHR.[65]

The Government's response to this concern was two-fold. First, it said that the ECHR does not require that a patient's detention be renewed, merely that it be kept under review, and that it is the RC, not the managers, that performs this function.[66]

The second limb of the response was perhaps surprising. The Government said that renewal by someone other than the managers is consistent with the ECHR because:

(a) once a patient has been admitted to hospital under MHA 1983, responsibility for his/her case passes to the RMO; and

(b) at that point, the hospital managers cease to be the detaining authority.[67]

The Committee says it finds this argument "unconvincing", and it adds, "It is not apparent to us how and by what process the responsible clinician becomes the competent authority for Convention purposes."[68]

It might be added that MHA 1983 gives the managers a number of functions that can only be exercised or performed after a patient has been detained, at a time when, on the Government's assumed analysis, responsibility has shifted to the RMO. These powers and duties are neither granted to nor imposed upon the RMO.

5. The nearest relative

The JCHR next considers the proposals to address the nearest relative problem.[69]

It is accepted that in the case of a detained patient, the mechanism for identifying his/her nearest relative breaches Article 8 of the ECHR. That is because it is inflexible, and also because it allows a patient neither to select his/her nearest relative nor to remove one that is unsuited to the role.

62 *MHA 1983, s 20(3)*

63 *R v Warlingham Park Hospital Managers, ex parte B (1994) 22 BMLR 1*

64 *Winterwerp v Netherlands (1979) 2 EHRR 387 at para 45*

65 *Although this possibility was brought to the Committee's attention in a briefing from JUSTICE, it would appear to derive from the work of Professor Fennell. See, for example, Phil Fennell, Medical Law [1995] All England Law Reports: Annual Review, pp 354-396 at pp 383-384. Professor Fennell was the Committee's specialist adviser. See also: Koendjbihaire v The Netherlands (1990) 13 EHRR 820; Keus v The Netherlands (1990) 13 EHRR 701*

66 *JCHR Report, para 29 & Appendix 3, para 19*

67 *Ibid, para 22*

68 *Ibid, para 29*

69 *Ibid, paras 30–37*

Following adverse proceedings in the ECtHR,[70] the Government promised to make the necessary reforms. It proposes that MHA 1983 make it possible:

(a) for a patient to seek displacement of his/her nearest relative;[71]

(b) for displacement to be ordered on a further ground: the nearest relative is not a 'suitable' person to act as such;[72]

(c) for a patient to nominate his/her own nearest relative;[73] and

(d) for the appointment of a replacement nearest relative to be of indefinite duration.[74]

These proposals are a good less radical than those contained in the draft Mental Health Bills of 2002 and 2004.[75] Nevertheless, with one caveat, the JCHR says that they appear to satisfy the promise the Government made to the ECtHR.[76]

The caveat is, however, a significant one. It concerns the notion of 'suitability', which the Committee was concerned might be used to justify displacing a nearest who is simply a 'difficult customer' and has a tense relationship with the authorities.[77] The Government said this was not its intention:

> "It is vital […] that the nearest relative should be free to exercise his powers in the way that he feels is in the best interests of the patient. [We do] not wish to restrict this role by allowing for the displacement of a nearest relative for acting independently in this way."[78]
>
> "The judgement of 'unsuitability' in relation to a nearest relative is, then, not a judgement of how well he exercises his powers but rather relates to the suitability of him having this type of relationship with the patient in question."[79]
>
> "It is [our] intention that 'not a suitable person to act as such' should cover cases in which it would be detrimental to the welfare of the patient to have such a relationship with the person who is the nearest relative."[80]

The JCHR is not reassured by this explanation, and it concludes that the concept of suitability is "potentially too broad".[81]

But what also concerns the JCHR is that a patient might fall out with his/her nearest relative but still be unable to displace him/her. The Committee feels that the Government has paid insufficient attention to this possibility, which, it says, demonstrates that the concept of 'suitability' is not only too broad,

> "It is too narrow to enable a patient to displace a nearest relative with whom they emphatically do not get along, unless there is some undercurrent of abuse."[82]

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70 *JT v United Kingdom, Application no 26494/95, Judgment of 30 March 2000; (2000) 1 FLR 909; FC v United Kingdom, Application no 37344/97, Decision of 7 September 1999. See also R (M) v Secretary of State for Health [2003] EWHC 1094 (Admin)*

71 *Mental Health Bill 2006, cl 21(4)*

72 *Mental Health Bill 2006, cl 21(5)(b)*

73 *Mental Health Bill 2006, cl 21(3)*

74 *Mental Health Bill 2006, cl 22(7)*

75 *Department of Health, Draft Mental Health Bill, Cm 5538, 2002, cl 148-158; Department of Health, Draft Mental Health Bill, Cm 6305, cl 232-246. See, David Hewitt, Relative progress? New Law Journal, vol 157, no 7257, 26 January 2007, pp 126-127. This issue is further explored in, David Hewitt, The Nearest Relative Handbook, 2007, Jessica Kingsley Publishing, ch 1*

76 *JCHR Report, para 33*

77 *Ibid*

78 *Ibid, Appendix 3, para 23*

79 *Ibid, para 24*

80 *Ibid, Appendix 3, para 25. See also, HL Deb 17 Jan 2007, col 672, Lord Hunt of King's Heath*

81 *Ibid, para 37*

82 *Ibid. The Government's position is set out at HL Deb 17 Jan 2007, col 672*

Even if circumstances do not permit a nearest relative to be displaced, it is possible that they will lead an Approved Social Worker to conclude that it would be 'impracticable' to consult him/her before making an application for the patient's detention under section 3 of MHA 1983.

This possibility arises, of course, out of the case of *E*,[83] which, the JCHR tells us, establishes that:

> "the Approved Social Worker's duty to consult the nearest relative about compulsory admission if appropriate and practicable does not apply if the patient objects to that person being consulted as the nearest relative."[84]

This is surely to over-state the effect of the *E* case. There will, mercifully, be few cases in which the potential consequences of consulting a nearest relative will be as grave for the patient as they were said to be there. Yet, it is only where the facts are comparable that the judgment will be relevant and the duty to consult might be waived. In any case, although the judgment might excuse an ASW from the duty of consultation, it cannot be used to deprive a nearest relative of his/her other rights under MHA 1983. The case of *E* does not provide a comprehensive solution to the problems identified by the ECtHR (and acknowledged by the Government).

6. Community treatment

Making a community order

One of the most significant features of the Mental Health Bill is the Community Treatment Order ('CTO'), a device that would extend compulsion from hospital into the community.[85] A patient might be made subject to a CTO if s/he was detained under MHA 1983, under either section 3 or Part III.[86]

Although the CTO might be viewed as a strengthened version of Supervised Discharge, the Bill does not conceive of it as such, preferring to see it as a species of leave.

The Bill abolishes Supervised Discharge and provides that in a case where s/he might grant a patient leave of absence for more than seven consecutive days, the RC must first consider a CTO.[87]

This confirms a common suspicion: under the un-amended Mental Health Act, leave of absence – and particularly *long* leave of absence – has increasingly come to be used as a form of community compulsion.[88]

One feature of the CTO that has caused particular concern is the possibility that it might have attached to it conditions, whose breach would lead to a patient's being recalled to hospital and, possibly, re-detained.[89]

Any such conditions would usually relate to the patient's residence, medical assessment and acceptance of medical treatment.[90] However, and perhaps ominously, the Mental Health Bill says that a CTO might include "a condition that the patient abstain from particular conduct".[91] There is a concern that such a condition need not relate to the patient's mental disorder or treatment.

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83 *R (E) v Bristol City Council [2005] EWHC 74 (Admin)*

84 *JCHR Report, para 37*

85 *Mental Health Bill 2006, cl 25-29*

86 *Mental Health Bill 2006, cl 25(2)*

87 *Mental Health Bill 2006, cl 26(2)*

88 *R (DR) v Mersey Care NHS Trust [2002] EWHC 1810 (Admin); David Hewitt, There is no magic in a bed – The renewal of detention during a period of leave, Journal of Mental Health Law, August 2003, pp 87-101; R (CS) v Mental Health Review Tribunal [2004] EWHC 2958 (Admin). See also, David Hewitt, An inconvenient mirror: Do we already have the next Mental Health Act? Journal of Mental Health Law, November 2005, pp 138-149*

89 *Mental Health Bill, cl 25*

90 *Mental Health Bill, cl 25(2)*

91 *Mental Health Bill, cl 25*

The Government has rebutted that concern. So, for example, the draft Code of Practice states that a conduct condition:

> "may be appropriate, where, for example, the patient needs to avoid usage of illegal drugs because it is known that if he does not do so, the likelihood of relapse will be greater. It should not be used unless the conduct in question is directly relevant to the patient's medical condition."[92]

Nevertheless, the draft Code goes on to state:

> "The above is not an exhaustive list of conditions which may be applied – there may be others depending on the patient's individual circumstances."[93]

Concern has been voiced that the CTO might turn out to be a 'mental health ASBO'. Those fears have been officially expressed, both by the Parliamentary committee that scrutinised the 2004 Mental Health Bill[94] and during the debates that have attended the present, substantive Bill.[95]

For its part, the JCHR notes those fears.[96] They are hardly allayed by the Government's latest word on the subject. In a letter to the Committee, the Right Honourable Rosie Winterton wrote:

> "[I]t is appropriate only to attach conditions that are considered clinically necessary to ensure that the patient continues to receive the treatment that he needs while residing in the community or *which relate to his own safety and that of others – including a condition that would operate to restrict the behaviour of a patient*. […] [T]he conditions attached to a CTO should be kept to a minimum consistent with ensuring that the patient gets the treatment he needs *and to protect the patient and others from harm*. The Codes will also encourage the involvement of the patient, and those who are to provide care to him in the community, from the outset in setting the conditions of a CTO so that there is perhaps little likelihood in practice that the conditions imposed will be ones with which it is not reasonably practicable for the patient to comply or which are not accepted by the patient."[97]

Although it is intriguing that a patient might be able to veto the conditions of his/her CTO, it is perhaps dispiriting that those conditions will be capable of being imposed solely for public protection.

Still concerned about a possible breach of Article 8, the JCHR suggests that each CTO be authorised by the hospital managers, and that this process be enshrined in the Act and not simply left to a Code of Practice.[98]

Reviewing the conditions of community treatment

The JCHR is concerned that a CTO might also breach the right to liberty under Article 5 of the ECHR, "if for example there were conditions that a patient had to reside in a certain institution, and was subject to an extensive curfew or supervision."[99]

The Government said:

(a) that a RC could only impose conditions on a patient's CTO with the consent of the Approved Mental Health Professional ('AMHP'), and that both the RC and the AMHP would be a 'public authority' for the purposes of the Human Rights Act 1998 and so obliged to act compatibly with the ECHR;[100] and

92 *MHA 1983 Draft Code of Practice, para 12A.23 [emphasis added]*

93 *Ibid*

94 *Joint Committee on the Draft Mental Health Bill, 2005, op cit, para 194; HL Deb, 17 January 2007, cols 707-8*

95 *HL Deb, 17 January 2007, cols 707-8*

96 *JCHR Report, para 48*

97 *Ibid, Appendix 3, para 32 [emphasis added]*

98 *Ibid, paras 49-51*

99 *Ibid, paras 53 & 54*

100 *Ibid, Appendix 3, para 131*

(b) that "it would [not] be appropriate for the RC and the AMHP to impose conditions on a CTO which are so restrictive in nature that they would effectively amount to a deprivation of liberty."[101]

The Committee is not reassured by these suggestions. It recommends:

(a) that if it is not to be permissible to impose CTO conditions that amount to a deprivation of liberty, an express statement to that effect be enshrined in the statute, and not just in the Code of Practice; and

(b) that a patient should be entitled to apply to a MHRT for a review of the conditions of a CTO.[102]

This is not an order

The JCHR makes a further, telling comment, which perhaps speaks to our deepest fears about the motive behind the current Mental Health Bill and the Bills and pronouncements that preceded it. The Committee says:

> "It may be noted in passing that in terms of the nomenclature adopted by the 1959 and 1983 Act the term community treatment order is a misnomer, since under the scheme of the Act, orders are made by courts. None of the civil powers to detain operate by orders, but by applications to the hospital managers."[103]

7. Compulsory treatment

The Committee is concerned that the new SOAD test won't comply with the ECHR.[104]

At the moment, of course, a SOAD may authorise the compulsory treatment of an incapable patient, or of a capable patient who refuses to accept it, where, "having regard to the likelihood of its alleviating or preventing a deterioration" of the patient's condition, such treatment "ought to be given".[105]

As far as the new test is concerned:

(a) it will be that "it is appropriate for the treatment to be given";[106]

(b) treatment will be 'appropriate' "if it is intended to address the mental disorder(s) from which the patient is suffering and which (alone or in combination) form the basis of the decision to detain (or continue to detain) the patient";[107] and

(c) we are told that 'intended to address' means that the purpose of the medical treatment is to "alleviate, prevent deterioration in or otherwise manage the disorder itself, its symptoms or manifestations or the behaviours arising from it."[108]

The problem, as far as the JCHR sees it, is that although the first of these stipulations will appear in MHA 1983, the second and third will not: they will be confined to the Code of Practice.

The Government sees little difference between the old and the new tests,[109] and the draft Code says that "scrupulous adherence" to the latter will ensure compliance with the ECHR.[110] The JCHR, however, points out that there is little in the Act to require such scrupulousness. The Code of Practice is not

101 Ibid, para 57 and Appendix 3, para 38
102 Ibid, para 58
103 Ibid, para 42
104 Ibid, paras 59-66
105 MHA 1983, s 58(3)(b)
106 Mental Health Bill 2006, cl 6(2)
107 MHA 1983, Draft Illustrative Code of Practice, para 2A.4
108 Ibid
109 JCHR Report, para 59
110 MHA 1983, Draft Illustrative Code of Practice, para 15.2e

absolutely binding and practitioners may depart from it where they have cogent reason for doing so.[111]

The Committee notes that the full requirements of the ECHR, may be found, not just in Articles 3 and 8, but also in the cases they have generated,[112] and it recommends that those requirements be set out in the Act itself, and not just in the Code of Practice.[113]

The Committee also suggests that it might now breach Article 8 of the ECHR to permit a patient to be treated compulsorily for three months before a second opinion need be obtained.[114] A similar suggestion was made in the course of the Parliamentary debates.[115]

8. Forcible feeding

The JCHR notes that in some circumstances, forcible feeding may be given under section 63 of MHA 1983 without the need for consent or a second opinion.[116] This, it suggests, might constitute "a significant and potentially traumatic invasion of physical integrity" and so breach Articles 3 and 8 of the ECHR.

Basing itself on the relatively recent decision in the *Storck* case,[117] the Committee says that the state has a positive obligation to secure Article 8 rights for its citizens, that this obligation "requires effective supervision and review of decisions to treat against an individual's will" and, perhaps contentiously,

> "that the direction of the responsible clinician, even if that person is a medical practitioner, is not sufficient to provide such supervision and review."[118]

This suggestion is not entirely contingent upon *Storck*: the state's positive obligation under Article 8 have been recognised for some time.[119] Neither, of course, does it constitute a criticism of the new Bill; it might have been made at any time since the 1983 Act was first introduced. That said, and unless the Government decides to heed the Committee's warning (as it seems highly unlikely to do), it will surely provide useful ammunition to patients in the course of future legal proceedings.

9. Bournewood

The Committee also considers the Government's proposals to close the '*Bournewood* gap'.[120] They hinge on the notion of a 'deprivation of liberty': if s/he is deprived of liberty, an incapable patient will be eligible for certain safeguards; if s/he isn't, s/he won't. The safeguards will include a requirement that anyone depriving – or proposing to deprive – an incapable patient of liberty obtain authorisation for doing so.

The Government does not consider it necessary to define 'deprivation of liberty' in the Act itself, preferring to provide mere guidance in another code of practice.[121]

The JCHR, however, is not impressed by such an approach. It says that "deprivation of liberty is a less

111 *JCHR Report, para 60*

112 *See, for example, R (N) v Dr M and others [2002] EWCA Civ 1789*

113 *JCHR Report, para 65*

114 *Ibid, para 66*

115 *HL Deb, 15 Jan 2007, cols 490-496*

116 *JCHR Report, paras 67-69*

117 *Storck v Germany, Application no 61603/00, Decision of 16 June 2005*

118 *JCHR Report, para 69*

119 *See, for example, X and Y v The Netherlands (1986) 8 EHRR 235; Hatton and others v United Kingdom, Application no 36022/97, Judgment of 8 July 2004*

120 *JCHR Report, paras 70-91. See Mental Health Bill 2006, cl 38*

121 *Department of Health, The Bournewood framework: Draft Illustrative Code of Practice, December 2006, paras 19-28 – http://www.dh.gov.uk/assetRoot/04/14/17/64/04141764.pdf; JCHR Report, Appendix 3, para 52*

flexible and elusive concept than might be thought" from the guidance;[122] and it suggests that confining the essential detail of 'deprivation of liberty' to a code might mean that the new framework cannot constitute a procedure prescribed by law and will therefore breach the ECHR. As before, therefore, the Committee suggests that this key detail be placed on the fact of the Act.

When discussing the notion of a deprivation of liberty, the Committee invokes the recent case of *JE*,[123] in which, it says, Munby J held that:

> "[T]he crucial issue in determining whether there is a deprivation of liberty is not so much whether the person's freedom within the institutional setting is curtailed, but rather whether or not the person is free to leave."[124]

But this might be slightly to mis-state the *ratio* in *JE*, and also to over-state the importance of the case. The words of Munby J may be taken to mean nothing more than that the circumstances of the case were *among those* in which a person would be held to have been deprived of liberty; they need not imply that it would *only* be in those circumstances that such a deprivation would be made out.

Such a reading would be consistent with the Government's draft guidance, which says that an act that prevents a person from leaving when s/he has made a meaningful attempt to do so might "contribute" to a deprivation of liberty.[125] It would also appear to be inconsistent with the decision of the ECtHR in the *Bournewood* case itself.[126]

The Committee has, however, prompted the Government to concede that an authority granted in respect of a '*Bournewood* patient' will not carry the power actually to *convey* him/her to the place in which s/he is to be deprived of liberty.[127]

The Committee does not like this state-of-affairs. It recommends that, as in MHA 1983, the authority to detain should include the power to convey into detention, for

> "[I]f it is known that a person will be taken from their home to a place where they will be prevented from leaving, and complete and effective control will be exercised over them, moreover, that person is deprived of liberty from the point of removal from their home."[128]

The Committee also expresses its concern about the complexity of the new framework, which it says might breach Article 5(1) of the ECHR because it is not

> "sufficiently precise to allow the citizen – if need be with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail."[129]

In the course of the Parliamentary debate, the Government confirmed that, subject to a means-test, a person might have to pay for the accommodation in which s/he was deprived of liberty.[130] The Committee feels this state-of-affairs might breach Articles 5 and 6 of the ECHR, and also Article 14 (which is the prohibition of discrimination).[131]

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122 JCHR Report, para 86

123 JE and DE v Surrey County Council [2006] EWHC 3459 (Fam)

124 JCHR Report, para 86

125 Department of Health, The Bournewood framework: Draft Illustrative Code of Practice, December 2006, para 25

126 That said, Munby J does provide a very helpful summary of the authorities on this point

127 JCHR Report, para 88 & Appendix 3, para 56

128 Ibid, para 89

129 Ibid, para 90

130 HL Deb, 17 January 2007, col 764

131 JCHR Report, para 91

10. Other issues

The Committee also considers what, from a human rights perspective, appear significant omissions from the Bill. The first of these is also related to the new *Bournewood* framework.

Treatment under the Bournewood proposals

The Committee is concerned that although the new framework will allow incapable patients to have their liberty taken away, it is silent as to the treatment that might be imposed on them.[132]

The Government says it will be possible to treat such patients under the Mental Capacity Act 2005 ('MCA 2005'), or even the common law,[133] but the Committee is not so sure. It notes that the principal effect of MCA 2005 is to "provide a retrospective defence for a person who gives treatment which they reasonably believe to be in a patient's best interests."[134] In *Storck*, however, when commenting on similar or stronger measures available in German law, the ECtHR said, "such retrospective measures alone are not sufficient to provide appropriate protection of the physical integrity of individuals".[135]

Drawing on the baleful example provided by the investigation into learning disability services in Merton and Sutton,[136] the JCHR concludes: "effective supervision and review requires more than the common law or the Mental Capacity Act currently provide."[137] The Committee says that in the case of treatment given to '*Bournewood* patients', that review should come *via* a second opinion system or an inspectorate such as the Mental Health Act Commission ('MHAC').[138]

Seclusion

The Committee says that the second significant omission from the Mental Health Bill is anything about seclusion.[139]

We know that seclusion is lawful,[140] but it is regulated, not by MHA 1983 or even by secondary legislation, but by guidance in the MHA 1983 Code of Practice. The House of Lords has confirmed that practitioners and services may depart from that guidance if they have "cogent reason" to do so.[141]

The problem is Article 8(2) of the ECHR, which requires that any interference with the right to respect for one's privacy be, *inter alia*, in accordance with the law in the sense that its consequences are predictable. The Committee believes this means that the relevant regulatory mechanism must be contained in statute, and not a mere code.[142]

If a code were sufficient, the only adjudication on the question of whether a departure was 'cogent' – and therefore lawful – would come retrospectively. As before, the JCHR suggests that retrospective supervision and review will not be enough to amount to Article 8(2) predictability.[143]

132 *Ibid, paras 93-101*

133 *Ibid, para 101*

134 *Ibid*

135 *Storck v Germany, Application no 61603/00, Judgement of 16 June 2005*

136 *Healthcare Commission, January 2007, Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust – http://www.healthcarecommission.org.uk/_db/_documents /Sutton_and_Merton_inv_Main_Tag.pdf*

137 *JCHR Report, para 101*

138 *Ibid*

139 *Ibid, paras 102-110*

140 *R (Munjaz) v Mersey Care NHS Trust; R(S) v Airedale NHS Trust [2003] EWCA Civ 1036. See, David Hewitt, A secluded view, New Law Journal, Vol 153, No 7090, 25 July 2003, p 1133*

141 *R (Munjaz) v Mersey Care NHS Trust and others [2005] UKHL 58. See, David Hewitt, Dancing on pinheads, New Law Journal, vol 155, no 7199, 4 November 2005, pp 1658 &1659*

142 *JCHR Report, para 106*

143 *Ibid, para 107; Storck v Germany, Application no 61603/00, Judgement of 16 June 2005, para 150*

The Committee seems to favour a system of regulation by statute (or at least statutory instrument).[144] This would accord with recommendations made by MHAC,[145] and also by the last JCHR.[146] It was a system that at one time, the Government seemed to favour as well,[147] but which it has now disavowed.

The Committee believes that safeguards should be inserted into MHA 1983

> "to ensure that seclusion is only used when strictly necessary and that individuals subject to it should have access to review at intervals to ensure that it is brought to an end when no longer necessary."[148]

11. Conclusion

The new report of the Joint Human Rights Committee is not the easiest of reads. It is discursive and, at times, elliptical. Sometimes, its discussions are not pursued to a point and there is a vague sense of tailing off; of thoughts being, perhaps, withdrawn.

What is crystal clear, however, is that many of the issues raised by the JCHR are of wider concern. A majority of the defeats inflicted on the Government during the Mental Health Bill's passage through the House of Lords is prefigured in this report.

And the Joint Committee has performed another service, whose true value might only become clear long after the Mental Health Act has been amended. It has wrung from the Government a number of concessions that will serve as guidance – if not hostages to fortune – in days to come.

144 *JCHR Report, para 107*

145 *MHAC, Eleventh Biennial Report, 2003-2005: In place of fear, London, 2006, para 4.237 & 4.238*

146 *JCHR, Third Report of Session 2004-2005, Deaths in custody, HL Paper 15-1 HC 137-1, para 245*

147 *MHAC, 2006, op cit, para 4.237*

148 *JCHR Report, para 110*

Developing a capacity test for compulsion in mental health law

Chris Heginbotham[1] ***and Mat Kinton***[2]

Concepts of mental capacity are taking on an increased importance in the mental health law of the United Kingdom. For England and Wales, the proposal to introduce a threshold requirement of 'impaired decision-making' into the criteria for detention under sections 2 and 3 of the Mental Health Act 1983 was the first amendment to be voted upon in the House of Lords' reading of the Mental Health Bill. Despite its emphatic (and whipped) resistance to this amendment, Government lost the vote by a wide margin[3], although it seems possible, at the time of writing[4], that the Government will seek to overturn their defeat in the Commons[5].

It is therefore timely to re-examine the role of such capacity tests in mental health legislation dealing with detention and treatment. This paper describes as yet unresolved definitional questions that must be encountered when concepts of mental capacity operate as a threshold for coercive psychiatric detention and/or treatment.

Mental capacity tests in the Mental Health Act 1983 and other legislation

In the House of Lords debate, the Minister stated that the proposal to introduce a test of impaired decision-making was "one of the core amendments that will undermine the broad intent of the Bill"[6]. Indeed, the clear implication of the Government's resistance to this amendment was that the introduction of any sort of capacity-based criteria for detention would undermine the purpose of the Mental Health Act 1983 itself. The 1983 Act was described as "based upon need and risk" where "it is the needs of patients and the risk that their disorder poses to themselves and to others, not their decision-making ability, that must determine whether compulsion should be used"[7]. This is undoubtedly a correct description of the practical test in the current law, but it is arguably an inexact account of the intention of legislators.

1 *Professor of Mental Health Policy and Management, University of Central Lancashire and Chief Executive, Mental Health Act Commission.*

2 *Senior Policy Analyst, Mental Health Act Commission.*

3 *The amendment introducing an impaired decision-making test was accepted by 225 votes to 119. All but one of the 119 peers who voted against the opposition amendment were from the Government benches. Three Labour members (Lords Bragg and Winston, and Baroness Wilkins) defied their whip to vote alongside 222 other peers from all benches who supported the amendment. 25 Labour peers abstained from voting.*

4 *16 March 2007*

5 *Rosie Winterton, Minister of State for Health Services: Local Government Association conference, Mental Health Bill, 1 March 2007. Downloaded on 2 March 2007 from www.dh.gov.uk*

6 *Lords Hansard, 10 Jan 2007, Column 243 (Lord Hunt of Kings Heath)*

7 *ibid., column 243-4.*

It is true that the nineteenth century codifications of rules relating to the civil compulsion of mentally disordered people in England and Wales, from which the current law has evolved, were founded upon the paternalistic assumption that authorities could recognise a 'proper person to be taken charge of and detained under care and treatment'[8] without specific terms being established by statute. However, legal developments in the twentieth century have addressed the question of criteria for such recognition and, for certain circumstances, recognised that an absence of mental capacity to provide consent to intervention could be the threshold for coercive intervention: for example, the Mental Treatment Act 1930 allowed that temporary treatment procedures available under that Act could only be invoked to detain a patient 'for the time being incapable of expressing himself as willing or unwilling to receive such treatment'[9].

The framework of current law relating to the detention of psychiatric patients in England and Wales was established with the enactment of the Mental Health Act 1959, itself based upon the recommendations of the Royal Commission led by Lord Percy between 1954-7. The Percy Commission concluded that

> *the use of compulsory powers on grounds of a patient's mental disorder is justifiable when [inter alia] …, if the patient himself is unwilling to receive the form of care which is considered necessary, there is at least a strong likelihood that his unwillingness is due to a lack of appreciation of his own condition deriving from the mental disorder itself.*[10]

Thus the Percy Commission envisaged mental incapacity (which interestingly, for the time, it defined in terms of "lack of appreciation") as the basis upon which psychiatric compulsion could be justified. Rather than proposing that such a principle should be expressly stated in the law, the Percy Commission sought to establish a general legal framework that would translate it into practice[11].

It could be argued that the legal framework over the last half century has disappointed the Percy Commission's expectation, although we should be careful of measuring that expectation against current concepts of mental incapacity and finding it wanting. The Percy Commission sought to enact its criterion of 'lack of appreciation' through a restriction of long-term treatment to the mentally ill or 'severely subnormal'[12], thus apparently assuming that broad classifications such as 'mental illness' could be used as a status-test of mental capacity. This is clearly incompatible with current models of incapacity.

The Government is therefore correct to conclude that the current *working assumptions* that underpin compulsory detention and treatment under the current mental health law in England and Wales are based upon criteria of best interests ('necessary for the health or safety of the patient') and dangerousness ('for the protection of other persons'), and that there is no requirement that a person must be mentally incapacitated in any sense to be detained for assessment or treatment under the 1983 Act. Indeed, modern assumptions about the relationship between mental disorder and mental capacity are exemplified by the Code of Practice assumption that all detainees under the 1983 Act are presumed generally to

8 *An Act for the Regulation of the Care and Treatment of Lunatics, 8 and 9 Vict. (1845) c.100 ss.45,48; Lunacy Act 1890, 53 Vict. c.5, forms 8, 12. See Bartlett, P (1996) 'Sense and Nonsense: Sensation, Delusion and the Limitation of Sanity in Nineteenth-Century Law' in L Bentley and L Flynn (eds) Law and the Senses, London: Pluto, n.21 for a fuller listing. This phrase is discussed in Percy Commission (1957) Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957, Cmnd. 169, para 231.*

9 *Under the Mental Treatment Act 1930. The Percy Commission (1957) op cit. n.2, para 232 found that reluctance of some doctors to declare patients incapable of such expression, or lack of clarity over the meaning of this term, had limited the use of this alternative to certification under Lunacy Act powers.*

10 *Percy Commission (1957) op cit, para 317*

11 *Hoggett, B (1996) Mental Health Law , fourth edition, London; Sweet & Maxwell, p. 40.*

12 *Hoggett 1996 op cit. n.4, p.41.*

retain capacity unless and until declared otherwise[13]. But it would be disingenuous to argue from this that the notion of a capacity-based threshold for detention or other coercion was not considered, or was rejected, by those who laid the foundations of the current Mental Health Act[14].

Notwithstanding the attitudes of past legislators, over the lifetime of the 1983 Act there have been increasing calls for revisions to encompass a criterion of mental incapacity, either alone or in combination with other criteria, as the basis for civil detention and/or compulsory treatment[15]. The Government's own expert advisory committee on mental health reform was in favour of a form of incapacity test as one criterion amongst others for psychiatric compulsion[16]. The years since that committee's report have seen the introduction of a Mental Capacity Act to codify common law treatment of incapacitated patients who fall without the scope of Mental Health Act powers. Campaigners also point to other jurisdictions that have developed capacity-based legislation relating to psychiatric coercion. Mental incapacity is one criterion for civil commitment under the American Psychiatric Association's model statute[17] and, variously defined, is consequently a common but not exclusive criterion for compulsory intervention in the United States[18]. Ontario law has for some time established that no patient with capacity may be *treated* without informed consent, whether for somatic or psychiatric purposes, although the thresholds for compulsory *admission* to psychiatric hospital are based upon criteria of dangerousness[19]. The Government has reserved its right not to comply with the Council of Europe recommendation to member states that competent refusals of psychiatric treatment should be generally respected[20].

"Impaired decision making" as a capacity test

The amendment passed by the House of Lords in January does not establish a test of mental incapacity as a threshold for detention under sections 2 or 3, but rather imposes a "lower test"[21] of impaired decision-making alongside the existing criteria for detention under section 2 or 3 of the 1983 Act. The clear model for this is the Mental Health (Care and Treatment) (Scotland) Act 2003. This establishes a prospective

13 *Department of Health (1999a) Mental Health Act Code of Practice, London: Stationery Office, p.66.*

14 *Traces of a concern with capacity thresholds are more apparent in the 1983 Act's provisions regarding treatment than with its criteria for detention. The 1983 Act requires patients' capacity status to be assessed and recorded in relation to certain treatments (including ECT and, in some circumstances, psychotropic medication), but does not preclude the imposition of such treatments where a capacitated patient refuses consent. The only determinative capacity-based threshold in the current law relates to treatments falling under s.57 of the 1983 Act (such as neurosurgery for mental disorder), which are explicitly removed from the Act's general coercive framework, and may only be given with capacitated and informed consent from the patient as well as a favourable multi-disciplinary clinical opinion.*

15 *see for example, Szmukler, G & Holloway F (1998) 'Mental health legislation is now a harmful anachronism', Psychiatric Bulletin 22, 662-5; Campbell T. and Heginbotham C, (1999) Mental Illness: Prejudice, Discrimination and the Law, Aldershot: Dartmouth, p.217ff; Gunn, M (2000) 'Reform of the Mental Health Act 1983: the Relevance of Capacity to Make Decisions', JMHL 3; 39-43; Zigmond, T & Holland, A J (2000) 'Unethical Mental Health Law; History Repeats Itself' JMHL 3;49-57*

16 *Department of Health (1999b) Report of the Expert Committee: Review of the Mental Health Act 1983. London, p.88ff.*

17 *Raymont, V, Bingley W, Buchanan, A, David A S, Hayward P, Wessely, S, and Hotopf M (2004) 'Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study' The Lancet Vol 364 October 16, 2004.*

18 *Wilbur, K H and Zarit, S H (1999) `To decide or not to decide for others: competency, choice and consequences' Ageing and Mental Health 3(4):277-280.*

19 *Bartlett, P (2003) 'The Test of Compulsion in Mental Health Law: Capacity, Therapeutic benefit and Dangerousness as Possible Criteria'. Medical Law Review 11, 326-52*

20 *Council of Europe (2004) Recommendation (2004)10 of the committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder. Adopted by the Committee of Ministers on the 22 September 2004.*

21 *Lords Hansard, 10 Jan 2007, Column 246 (Lord Hunt of Kings Heath)*

patient's inability to make a safe decision about care and treatment as one of five criteria for a compulsory treatment order, and requires that capacitated refusal of consent to ECT should be respected except in 'emergency' situations[22].

The concept of 'significantly impaired decision-making' is not defined in the Scottish Act, although it is discussed in the Code of Practice to that Act[23]. The only specific distinction made between "significantly impaired decision-making ability" and "incapacity" in that Code is a statement that the former must always be consequent to mental disorder, whereas incapacity (as defined by the Adults with Incapacity (Scotland) Act 2000) may also be caused by physical disability. Aside from this distinction, the Scottish Code suggests that each concept relies upon similar factors: the extent to which the person's mental disorder might adversely affect his or her ability to believe, understand and retain information concerning care and treatment, make decisions based on that information, and communicate those decisions to others. The Code warns against determining a person to have an impairment of decision-making ability by reason *only* of a lack or deficiency in a faculty of communication, and against conflating disagreement with professional opinion with an impaired ability to decide upon treatment.

As such, the phrase 'significantly impaired decision-making' would appear to be wider than, and therefore inclusive of, any form of mental incapacity discussed in this paper. The potential breadth of its application may undermine its use as a meaningful threshold for coercion. Whilst studies of the Scottish Act's practical implementation are not yet were not available, Chiswick[24] has questioned whether the decision-making test in that Act adds anything to the other four criteria for compulsory treatment. The other criteria are: (1) presence of mental disorder; (2) availability of medical treatment likely to treat the disorder or alleviate symptoms; (3) significant risk to the patient's health or safety, or to the safety of others, without such treatment; and (4) necessity of making a compulsory order[25]. Such a critique must be similarly applicable to the changes proposed by the amendment to the 1983 Act.

The indeterminacy of mental incapacity as a test in law

Although it would appear that mental incapacity is a narrower concept than impaired decision-making, it is itself broadly and loosely defined in many clinical and even legal contexts.

The inconsistencies in the statutory language of capacity tests are in part a result of the way in which the law has been created in a piecemeal fashion over time, as well as the different contexts in which the tests are applied. The capacity test in the Mental Health Act 1983 (section 58) speaks of the patient being "capable of understanding the nature, purpose and likely effects of" the treatment, whereas that of the Mental Capacity Act 2005 (section 3) describes a person as incapacitated to make a decision if s/he is unable "(a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means)". In part, the Capacity Act test is simply a reflection of case-law over the interpretation of the 1983 Act's test. As this case law is reflected

22 *We have previously expressed concern that the essentially indeterminate thresholds for incapacity are liable to distortion where clinicians are required to find incapacity if they are to override patients' resistance to ECT treatment: see MHAC evidence to the Joint Committee on the Draft Mental Health Bill, Session 2004-05, HL Paper 79-II, HC 95-II, Ev 33-4 (paras 6.9 – 6.12).*

23 *Scottish Executive (2005) Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice, volume 2 - civil compulsory powers (parts 5, 6, 7 and 20), Edinburgh, paras 22-7.*

24 *Chiswick, D (2005) 'Test of capacity has little practical benefit' BMJ 2005;331: 1469-70*

25 *Mental Health (Care and Treatment) (Scotland) Act 2003, s.57(3)*

in the Mental Health Act Code of Practice, the practical implementation of the two capacity tests is likely to be roughly the same, or at least it would be so insofar as that Code is actually followed by practitioners. The Mental Health Act Commission still encounters a variety of understandings of the 1983 Act's use of mental capacity[26]. From April 2007, either statutory framework could be used to impose treatment for mental disorder in England and Wales[27].

The leading case on the 1983 Act's definition of capacity (and the definition used in common law) is usually taken as *Re C (Adult: Refusal of Medical Treatment)*[28], in which Justice Thorpe formulated a test that went beyond cognition when considering the proposed amputation of a Broadmoor patient's gangrenous leg. Justice Thorpe stated that "the question …whether…C's capacity is so reduced by his chronic mental illness that he does not sufficiently understand the nature, purpose and effects of the proffered amputation" depended on "first, comprehending and retaining treatment information, second, believing it and, third, weighing it in the balance to arrive at choice". The patient was deemed to have capacity to refuse the amputation, notwithstanding his delusional belief that he was an internationally renowned doctor able, with God's help, to treat himself. The court was impressed by the fact that Mr C appeared to accept that he might die without the amputation, but had decided (as do many older people) that, if so, he would rather die with two feet than one[29]. In *B v Croydon District Health Authority*[30], a case concerning the proposed force-feeding of a personality-disordered patient, Justice Thorpe initially found that the patient had mental capacity, but the Court of Appeal found otherwise in 1995 on the grounds that the patient's self-starvation was not a "true choice", in that "she did not appreciate the extent to which she was hazarding her life, was crying out inside for help but unable to break out of the routine of punishing herself". In a later case, *Re MB (medical treatment)*[31], the Court of Appeal ruled as incapable a patient who had the cognitive ability to comprehend and retain information about a proposed treatment, but whose needle-phobia made her "unable to use the information and weigh it in the balance".

In January 2006, the then Master of the Rolls (Lord Phillips) stated that section 58 of the Mental Health Act "seems to lay down the relevant test of capacity when it speaks of the patient being 'capable of understanding the nature, purpose and likely effects of' the treatment", but continued:

> *Arguably these words do not go far enough to define capacity. In R (Wilkinson) v Broadmoor Hospital Authority … Hale LJ suggested that the test of capacity laid down by this court in relation to treatment for a physical disorder in In re MB (Medical Treatment) [1997] … was suitable for assessing capacity for the purpose of section 58(3)(b) of the Mental Health Act. That test includes the requirement that the patient is able to use the information "as to the likely consequences of having or not having the treatment" and "weigh it in the balance as part of the process of arriving at the decision".*
>
> *Whatever the precise test of the capacity to consent to treatment, we think that it is plain that a patient will lack that capacity if he is not able to appreciate the likely effects of having or not having the*

26 *Mental Health Act Commission (2006) In Place of Fear? Eleventh Biennial Report of the Mental Health Act Commission 2003-05. London, Stationery Office, p.240; Kinton, M (2006) 'Seminal Issues in Mental Health Law by Jill Peay' (review article) JMHL 14:102-6, p.105.*

27 *The Mental Capacity Act 2005 comes into force in England and Wales on the 1 April 2007.*

28 *Re C (Adult: Refusal of Medical Treatment) [1994] 1 W.L.R. 290; 1 All E.R. 819.*

29 *Subsequently (after Mr C had won his case and had survived the gangrene with both legs intact) his solicitor realised that he was incapable of making a will because of his delusional ideas about death itself, although these delusions were unknown to the solicitor and the court at the time of Justice Thorpe's decision. See Scott-Moncrieff, L (2004) 'Capacity, Choice & Compulsion' JMHL 11;142-153*

30 *B v Croydon District Health Authority [1995] 1 W.L.R. 294; 1 All E.R. 683.*

31 *Re MB [1997] 2 F.C.R. 541; 2 F.L.R.426.*

> *treatment. The judge found that this was the position so far as Mr B was concerned in that he did not accept even the possibility that he might be mentally ill and thus in need of treatment*[32].

Thus legal narrative accepts an elision of different definitions of capacity - even in the face of statutory language that might suggest a more restrictive approach - and resists formulating a closed definition of what it means to have, or to lack, mental capacity for a particular decision. This is not a recent phenomenon of legal practice. Indeed Bartlett[33] has provided an historical account, arguing that legal tests of capacity operative throughout much of the nineteenth century were based upon the presence or absence of delusion, at least until cases in the 1880s began to consider the intellectual or cognitive function of persons with delusory beliefs. According to this account, when the terminology of 'delusion' fell into misuse in medico-legal practice during the twentieth century, the courts increasingly focussed on loosely-formulated conceptions of cognitive capacity, but without having successfully articulated what it was that they had moved to consider. This indeterminacy extends from civil cases relating to such matters as healthcare or financial decisions, to the use of notions of concepts of mental capacity in determining culpability for criminal acts.[34]

The indeterminacy of capacity as a test in clinical practice

The practical application of a concept such as mental incapacity or impaired decision-making is more frequently a matter solely for clinicians than the courts. In general terms, 'capacity is a state of affairs granted by the doctor'[35]. There is some evidence that clinicians use a variety of capacity tests, including status and outcome approaches[36], and that findings of incapacity may be poorly evidenced in such a way that it is not always apparent how and why the finding was made[37]. There is, in any case, no single definition of mental capacity for use in a clinical context. The British Medical Association's five-point test, for example, although referring directly to the standard legal test of capacity set out in *Re. C*, differs from it both by addition (for example the BMA test includes the ability to 'make a free choice' – i.e. one that is 'free from pressure') and by subtraction (the BMA test excludes the *Re. C* elements of believing the relevant information and of weighing it in the balance in arriving at a choice). The Mental Capacity Act 2005 widens the traditional English legal test a little with its inclusion of the ability to 'use or weigh …information as part of the process of making the decision' (s.3(c)), but it remains an essentially cognitive approach based on functional tests and *may* be interpreted to exclude the element of belief.

A more sophisticated capacity test is established by the MacArthur Competence Tool for Treatment (the MacCAT-T test), widely used in both research and medico-legal practice in North America and

32 *R (on the application of B) v (1) Dr SS (Responsible Medical Officer) (2) Second Opinion Appointed Doctor (3) Secretary of State for the Department of Health, Court of Appeal, 26th January 2006, paras 33-4.*

33 *Bartlett (1996) op cit; Bartlett and Sandland (2003) op cit, p.581*

34 *For our discussion of the capacity thresholds determining "insanity" and "unfitness to plead" in criminal law, see MHAC (2006) op cit, p.353-358.*

35 *Kennedy, I and Grubb, A (2000) Medical Law Texts and Materials. London: LexisNexis Butterworths.*

36 *Scott J (2003) 'Tests for Decision-making Capacity in Medical Treatment – Practical or merely theoretical?' unpublished LLM Dissertation, University of Northumbria, December 2003; Helmes A, Lewis V E, and Allan A (2004) 'Australian lawyers' views on competency issues in older adults' Behav. Sci. Law 22:823-831.*

37 *See, for example, Suto, W M I, Clare, I C H, and Holland, A J (2002) 'Substitute financial decision-making in England and Wales: a study of the Court of Protection' Journal of Social Welfare and Family Law 24(1):37-54*

elsewhere[38]. Researchers have found good inter-rater reliability of assessments using this tool[39], although some of this research may have been testing for the appearance of significant impairment that should not necessarily be equated with a legal threshold of incapacity to make a decision[40]. The MacCAT-T test includes an element of 'appreciation' that is absent from, or at least different to, the tests described above[41]. 'Appreciation', whilst itself inherently quite a loose term, is defined in the literature[42], and generally implies a recognition of the value or significance of something, or an understanding of a situation. As a criterion in evaluating capacity, appreciation is less to do with the straightforward assimilation of facts required by cognitive tests, than with choices and decisions based upon an evaluation of personal possibilities.

The differences between the tests of capacity described above are more than mere differences in drafting, and *would* have practical implications for the application of such tests *if* they were attended to carefully by those who apply them. Such a difference could be described in terms of the subtle distinction between *capacity* as the ability to take in or hold information and *competence* in having sufficient abilities in the rivalries and demands of life to use that information. A test of competency in the latter sense raises thorny problems of normative judgments, and it is perhaps understandable that the theory and practice of the law reverts to tests of cognitive ability and the view that the threshold for capacity should not be too demanding[43]. The Mental Capacity Act 2005, for example, allows that short-term memory may be adequate for capacity, which implies a model of capacity reliant upon an intellectual or cognitive ability to take in and hold information long enough to use it. But *competence,* as previously described, may require longer-term memory essential to maintain the beliefs that make us what we are.

A sophisticated capacity test (and certainly any test to determine impairment in decision-making ability) must look beyond the question of cognitive capacity. Such a test should address the interplay between cognition (knowing), emotion (evaluating) and volition (acting). A person's 'reasoning defect' may be linked to any of these 'capacities', and perhaps is more likely to result from an emotional or psychological deficit than any obvious failure in cognitive function. Impairment of decision-making ability is often a result of diminished or absent emotions, such as embarrassment, sympathy and guilt, that may be related to an impairment of emotion-related signals and the failure to activate an emotion-related memory[44]. Emotion-related signals are especially important as they are associated with the future outcome of actions

38 *Grisso T, Applebaum P S, and Hill-Fotouhi (1997) 'The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions' Psychiatric Services 48:1415-1419.*

39 *Cairns, R., Maddock, C., Buchanan, A., et al (2005a) 'Reliability of mental capacity assessments in psychiatric in-patients'. British Journal of Psychiatry, 187, 372 –378; Raymont et al (2004) op cit, n.17 above.*

40 *The study of Raymont et al, which deal with elderly medical patients, used a modified version of the MacCat-T that set aside the question of the patient's understanding of their disorder, and did not take account of potential risks and benefits of treatment to establish what the particular 'legal' threshold of capacity might be in each case. It may be that it is this aspect of capacity testing, rather than medical agreement that there is significant impairment of capacity, that is most liable to variability.*

41 *Grisso, T and Appelbaum, P S (1995) 'Comparison of standards for assessing patients' capacities to make treatment decisions' Am J Psychiatry; 152:1033-1037.*

42 *Grisso T, and Applebaum P S (1998). Assessing Competence to Consent to Treatment: A Guide for Clinicians and Other Health Pofessionals. New York: Oxford University Press, p.49-51.*

43 *i.e. Hale LJ in R (on the application of Wilkinson) v Broadmoor Hospital, Responsible Medical Officer & Ors [2001] EWCA Civ 1545, para 80: "Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify". That the threshold is in fact low may be disputed: it may rather depend upon the perception, in the assessor, of the seriousness of the decision or likely outcome involved. See* MHAC (2006) *op cit, para 3.28.*

44 *Damasio A. (2003). Looking for Spinoza. Joy, Sorrow and the Feeling Brain. London: Heinemann, p.144*

and self-preservation. They "…signal a prediction of the future, an anticipation of the consequences of actions"[45]. If emotion-related ability is severely damaged it may undermine completely a person's ability to appreciate and to weigh in the balance the necessary facts of the case, even if those facts can be understood at a cognitive level.

Although some account may be taken of a person's ability to 'weigh in the balance' information relating to a healthcare decision, we do not believe that the above aspects of capacity-testing are articulated clearly in court decisions or in many day-to-day clinical judgments. For example, patients suffering from major depression without psychotic features may be assessed as having retained capacity (when this is measured in terms of the "cognitively skewed" model in general use), even though they show indifference and lack of drive to act on the appropriately appreciated benefits and risks of treatment and the disorder impacts on treatment preferences to the extent that they are not consistent with previous wishes[46].

However, many clinical and judicial assessments of capacity, usually for the best of motives, consider not only cognitive but also other forms of capacity. In extending the reach of what is ostensibly a test of cognitive capacity, such pragmatic use of the law paradoxically at once incorporates *and* marginalises proper consideration of other forms of capacity. The key question is whether such practice can, nevertheless, provide a sufficiently robust approach necessary for considering treatment of an individual against his or her will, applying compulsory powers, or taking away a person's liberty as a result of mental disorder. Without explicit recognition of the way the assessment has been undertaken a person may be found to be incapacitated, not on cognitive grounds but on unstated or inadequately defined emotional or volitional grounds, but which are elided into the legal definition of capacity in a way that cannot readily be challenged.

Problems in capacity-based thresholds for coercive psychiatric admission / treatment

These problems would become critical in the cases of the many patients whose cognitive capacities are not clearly ineffectual, but whose decision-making capacity may be undermined by lack of motivation or delusional thinking related to mental disorder[47]. For example, in many clinical situations where patients present with psychotic delusions or hallucinations it is unclear whether an act or a failure to act is a result of defective or impaired judgement or impaired volition. It may be difficult to gauge whether a patient with anorexia who presents as understanding her condition but continues to behave in a way that is detrimental to her future physical health displays an underlying 'failure' of evaluation or judgement or a 'failure' to act on the information. Cognitively she may well have capacity and be able fully to understand and discuss her condition. Compulsory treatment under these conditions, using the current elastic version of (legal) capacity, either subsumes the patient's beliefs and emotional evaluations as demonstrating a lack of cognitive capacity (on the 'common sense' approach that no-one with capacity would interpret the available information in that way), *or* allows the clinician to implicitly substitute an evaluative (or possibly volitional) test. In this context 'failure of judgement' is itself highly value laden and judgmental.

Such problems of subjectivity would not necessarily be overcome through the articulation of an

45 *Damasio A. (2003) op cit, p.147.*

46 *Rudnick A (2002) 'Depression and competence to refuse psychiatric treatment' Journal of Medical Ethics 28:151–55.*

47 *Silver, M (2002) 'Reflections on determining competency' Bioethics 16(5) 455-468*

'appreciation' model of incapacity that is central to the idea of 'impaired decision-making'. In such a model, capacity is not simply the dry intellectual ability to process particular sorts of information, but a component part of 'self' that is historically, culturally and developmentally determined, and must be perceived in the historical timeframe of the construction of the 'self'. Only by understanding such formative influences can anyone who is concerned with individuals' decision-making ability understand the values they bring to their choices. If the clinician or other mental health professional assessing capacity does not understand or is ill-prepared (or otherwise unable) to recognise the very different formative influences on the service user compared to her, then the assessment may be flawed because of discriminatory assumptions based not necessarily on irrelevant criteria but on relevant criteria that are wrongly weighted.[48]

Yet there are bound to be difficulties inherent in making such subjective judgements of a persons 'holistic' capacity. Although we would welcome any system that encouraged professionals to pay greater attention to a patient's own views, values and personal life choices when considering questions of compulsion, in such circumstances it may be questionable whether the values of the decision-maker (i.e. involving the protection of human life and a risk-based approach to safety) are either easily or justifiably set aside.

Developing 'values-based practice'[49] that is robust enough to survive the pressures of decision-making in compulsion will be something of a challenge; but if it can result in practice that truly takes account of the personal viewpoint of a prospective patient, and can avoid the problems of generalisation or "abstract humanism"[50], then there are potentially great benefits to be had.

There are, however, other inherent problems in operating evaluations of mental capacity as a legal thresholds. Lack of 'appreciation' in the MacCAT-T equates, or should equate, centrally with the particular kind of loss of evaluative or judgmental ability (sometimes called 'insight') that is characteristic of the group of disorders that are most likely to be treated on an involuntary basis, namely the functional psychotic disorders such as schizophrenia, hypermania and major depressions. However, the possible use of this as a criteria for compulsion raises the problem identified by Robinson[51] of how a measurement of 'lack of insight', which the Oxford Textbook of Psychiatry deems to be 'not simply present or absent, but rather a matter of degree', is to be translated into a determination of capacity, which must be considered to be either present or absent if it is to serve as a medico-legal threshold for the use of compulsory powers. There are serious questions as to the justiciability of criteria for compulsion resting primarily upon professional assessments of patients' own understanding and beliefs about their mental disorder and its treatment, (however much these are based on a full understanding of the patient's 'values') rather than upon evidenced judgements about the nature of that disorder and the likely consequences of it not being treated[52].

Even a well structured test of 'appreciation' does not lead to a readily workable boundary to capacity. Grisso and Applebaum[53] have described four types of evaluative processes that should be considered in

48 *See Campbell and Heginbotham (1991) op cit for a fuller discussion of this point.*

49 *See Fulford B, Dickenson D L, Murray T (2002) Healthcare Ethics and Human Values: An Introductory Text with Readings and Case Studies. Oxford: Blackwell Publishers; Mental Health Act Commission (2003) Placed Amongst Strangers. Tenth Biennial Report of the Mental Health Act Commission 2001-03. London, Stationery Office, p.56-60; Woodbridge K, Fulford B (2004) Whose Values?: A Workbook for Values-based Practice. London: Sainsbury Centre for Mental Health*

50 *Mulholland, J (1995) 'Nursing, humanism and transcultural theory: the bracketing out of reality' Journal of Advanced Nursing 22, 442-449*

51 *Robinson, R (2000) 'Capacity as the gateway: an alternative view' JMHL 3; 44-8, p.47*

52 *Robinson, R (2000), op cit p.48.*

53 *Presented at a NIMHE/CSIP conference in September 2004*

determining capacity. Of these, two, possibly three, would lead to a determination of incapacity; but the line between capacity and incapacity remains defiantly hazy. Type A are those patients that apply false beliefs with patently (and provably) false premises, related to illogical and rigidly held beliefs that lead to a distorted perspective on meaning, and often associated with psychotic disorders. Type B is where the patient applies what Grisso and Applebaum refer to as significantly 'impoverished perspectives', often associated with developmental disability or cognitive dementias. Type C patients apply adaptive distortions or subjective transformations that are functional in reducing anxiety and uncertainty, but at the risk of maladaptive ideas or perspectives. Such patients are not applying patently false beliefs as in Type A, but have developed defence mechanisms which may or may not lead to lack of decisional capacity. This group may or may not be considered to lack capacity. Finally, Type D are those patients that apply non-logical evaluative premises or use unprovable (non-falsifiable) belief systems which are taken to extremes or are held rigidly. These are often associated with subjective presumptions about the world or are rooted in religious beliefs and moral convictions that may in themselves be not unreasonable if applied appropriately in differing situations. Whilst these categories assist in describing capacity more fully they do not of themselves offer a workable capacity threshold.

The problem of determining when decisional impairment becomes a legal threshold of decisional incapacity is compounded by the judiciary's determination that the more serious the decision, the greater the (cognitive) capacity needed for that decision[54]. This raises a number of difficult logical points, such as, for example, that it creates an asymmetric test where a person could be considered competent to agree to an intervention but not to refuse it[55]. Furthermore, given that capacity determinations in relation to healthcare decisions are made most frequently by doctors who are proposing or considering a medical intervention, the practical capacity threshold that would validate a treatment refusal could be beyond the reach of many people refusing medical treatment, because of the danger of circularity, whereby the refusal of medical advice is itself seen as a result of impaired judgment[56]. Indeed, there is a scandalous logical *reductio ad absurdum* which would say that none of us may be competent to take the most serious (i.e. life or death) decisions in the face of a different view from a medical professional whose scientific understanding claims to be greater than our own. Loosely-drawn criteria for determining mental capacity increase the likelihood of subjectivity or circularity, or both, in its application as a threshold for intervention.

Formulating a workable capacity test is thus fraught with difficulty. In practice, the present legal definition may be serviceable in covering most aspects of capacity in relation to mental disorder, with the possible exception of those who have deeper emotional or evaluative problems concerned with fundamental presentations of the self, rooted in historical and personal constructions and formative influences and which underpin or contextualise the evaluative judgements which go to inform decisions. It would undoubtedly be difficult to enact the complexities of an 'appreciation' model of incapacity, that would encompass such cases, into a statutory definition that could serve as a threshold of coercive psychiatric treatment. If it could be done, there might be a danger that this would either establish (or at least imply) an unworkably *high* threshold of capacity, so that too many people would fail it, or it would allow too *broad* a discretion to decision-makers, reducing the test's utility as a threshold for interventions.

54 *Re M B [1997] 2 F.C.R. 541*

55 *Culver, C M and Gert, B (1990) `The inadequacy of incompetence' Milbank Quarterly 68(4):619-43; Buchanan, A (2004) 'Mental capacity, legal competence and consent to treatment' J R Soc Med 97:415-20.*

56 *Mental Health Act Commission (2006) op cit.*

Can a capacity test operate as the threshold for coercive psychiatric admission / treatment?

There appear to be two sets of practical problems in achieving a capacity test that would function as a threshold for coercive psychiatric treatment, however desirable such a test might be. The first set of problems, which turn on the definition of capacity used, are the principal focus of this paper; the second set of problems is associated with what would happen to persons in evident distress, especially those thought possibly to be a danger to others, but who retain capacity on whatever test is used. The Richardson Committee's answer to the latter problem was to propose mental incapacity as one amongst several criteria for compulsion, some of which (for example dangerousness) might take precedence in practical usage[57]. Whilst this position has been criticised by some commentators[58], we think that such compromise may be inevitable and is certainly common in other jurisdictions. Nevertheless, there must be some doubt as to the effectiveness of a criterion of mental incapacity to promote 'autonomy' if it can be overridden by other criteria (such as a criterion relating to 'risk' or 'harm'), particularly in relation to *detention* (as opposed to *treatment*), given the pressures upon the psychiatric service to attend to 'risk-assessments' and the 'dangerousness' of its potential clients. In part this turns on the objective of legislation: is it to enable maximum autonomy for the patient, or is it concerned essentially with achieving an amalgam of patient and public safety with the emphasis firmly on the latter?

Making capacity the sole legal criterion for detention or treatment will not 'magic away' the pressures on psychiatry to attend to risk. The way in which concepts of 'risk' would be likely to influence or distort a broadly drafted criterion of incapacity (even if it was the sole operative criterion) is evident from the conclusion of the Richardson Committee that "most 'mentally ill' patients who present the required level of risk will not retain the necessary capacity"[59]. There is a striking similarity between this sentiment and that expressed fifty years ago by the Percy Commission which we quoted at the start of this paper. This similarity was noted by Robinson[60], who argues that, by adopting a model of capacity that would apply to mentally ill people in a unique way through its equation of incapacity with a lack of insight, the Committee undermined its claim that a capacity test would end the discrimination between psychiatric patients in comparison to people undergoing treatment for somatic medical disorders, and in effect proposed looser criteria for compulsion than are presently operable under the 1983 Act.

It may be that the best hope for capacity-based mental health legislation is through a separation, as in Ontario law, between the criteria for detention and those for treatment, with a right to refuse the latter being based upon a threshold of capacity. In England and Wales this is already a "developing area of law"[61], or is at least the subject of a sustained campaign of test-cases, starting with the *Wilkinson* case, aiming to show that the current legal overriding of autonomy in relation to treatment to be incompatible with the European Convention of Human Rights. Whether or not such an approach is ultimately successful, there are perhaps lessons from the fact that, after a decade of various forms of a right to refuse treatment in the United States, Appelbaum noted that "refusing patients almost always receive treatment in the end"[62]. This suggests to us that forms of coercion more subtle than the law are at work in such systems: to Appelbaum this "point[s] up the essential illogic of allowing committed persons to refuse treatment that would permit their freedom to be restored".

57 *Department of Health (1999b) op cit.*

58 *For example, Gunn, M (2000) 'Reform of the Mental Health Act 1983: the Relevance of Capacity to Make Decisions' JMHL 3; 39-43*

59 *Department of Health (1999b) op cit, p.72.*

60 *Robinson, R (2000), op cit p.45*

61 *Bowen, P (2002) 'Detained patients and the right to refuse treatment' JMHL, February, 59-66.*

62 *Appelbaum, P S (1988) 'The right to refuse treatment with antipsychotic medications: retrospect and prospect' Am J Psychiatry 145:413-419.*

Service users may not welcome a separate capacity test for evaluative/emotional or volitional capacities (and such an approach might be far too unwieldy) but neither are they likely to accept thresholds relating to the imposition of compulsory powers that assess evaluative capacity implicitly, ostensibly as part a cognitive test, without making explicit the grounds on which the assessment is being conducted. To be workable as a practical criterion for psychiatric detention and/or compulsory treatment, a capacity test must be (i) defined carefully and explicitly so that it is understandable by all those that have to use it or are affected by it, (ii) sufficiently extensive so as to capture what matters but not so broad as to nullify limited but workable mental capacity, and (iii) clinically acceptable and meaningful, and sufficiently rigorous as to be replicable under similar clinical conditions and challengeable to an appeals system. Furthermore, the choice of test for measuring incapacity will affect the type and proportion of patients classified as incapable[63]. This presents a dilemma. Whilst the current Mental Capacity Act and *Re C* test could be relatively straightforward to implement, it may not meet the above criteria of establishing clear thresholds; and, if it does do so, may not 'capture' all that matters, and thus not cover all those who might benefit from compulsory admission and/or treatment.

A richer and more nuanced capacity test, which dealt explicitly rather than implicitly with emotional and volitional capacity impairments, could be legally and clinically complex. It would be thus at once difficult for clinicians, lawyers and lay persons alike to understand and communicate, but also more inclusive or elastic in its application. A further dilemma is that, unless it would be determined as acceptable for there to be different capacity tests for psychiatric patients in the context of compulsion to those otherwise operable for any other healthcare decision (in which case the tests would be open to a charge of discrimination), any broadening of the definition of mental incapacity in the context of compulsion could result in equivalent broadening of what it means to be incapable in other contexts. There is some evidence that mental incapacity, as currently defined, is often overlooked in general medical practice[64]. However, in a commentary on that study, O'Keefe has warned against imposing unduly challenging standards for competence to make treatment decisions, arguing that doctors should respect autonomy by seeking to identify and to maximise the decision-making abilities of patients, rather than declaring patients incapacitated, and describing as "chilling" the prospect that more extensive capacity-testing (even with a narrow cognitive focus) might be used "to regulate the freedom to decide" of patients such as elderly people with mild stages of cognitive impairment[65].

The more a capacity threshold for coercive interventions is defined to incorporate evaluative notions such 'appreciation', the more danger there is of elasticity and result-oriented jurisprudence based upon general normative standards. Incorporating terms like 'weigh' or 'appreciate' can be used very flexibly in practice to determine whether a person does or does not have capacity. Whether consciously or not, and for the best of motives, clinicians would be able to tailor their assessment far too readily to their own view of the circumstances. An objection to these concerns is that tests such as the MacCAT-T are already in use in clinical situations, and there is little indication that the theoretical basis of such tests has collapsed under the weight of the problems that we have suggested. Furthermore, it is true that the existing criteria for compulsory detention and treatment are not above criticism for their potential for subjective interpretation, and (of course) for the fact that they 'discriminate' against people with serious mental disorders by denying them the same theoretical right to refuse treatment that would apply were they

63 *Grisso, T and Appelbaum, P S (1995) 'Comparison of standards for assessing patients' capacities to make treatment decisions' Am J Psychiatry; 152:1033-1037.*

64 *see, for example, Raymont et al (2004) op cit.*

65 *O'Keefe, S (2005) 'Mental capacity of inpatients' The Lancet (correspondence) Vol 365 February 12, 2005*

suffering from somatic medical conditions[66]. It is possible that some valuable empirical information will emerge form the operation of Scottish legislation and, once it is operational, the Mental Capacity Act 2005. The use of the term 'weigh' in the Mental Capacity Act may become defined similarly to 'appreciation', and as such careful research into the criteria used by clinicians assessing incapacity may shed some light on the value of 'appreciation' as a test.

Conclusion

The law of incapacity "creates roles of authority and dependence, discipline and control, power and subordination", engaging issues of institutionalisation and learned dependency, and risking conflict between the best or true interests of the incapacitated person and the view or personal convenience of the decision-maker[67]. A label of 'incompetence' may have a number of deleterious effects on a patient, including the inhibition of performance or motivation due to reduced self-esteem or altered conception of self; exacerbation of depressive symptoms; learned helplessness (i.e. the generalisation into a global sense of powerlessness of feelings generated by specific situations[68]); and social disadvantages due to the ways in which the label may alter the way others see or react with the patient[69].

Whether or not the law of England and Wales adopts a capacity-based threshold for detention under the Mental Health Act, we believe that further research is needed into the nature of capacity and its determination before a capacity test can be used adequately in mental health law, and that careful guidance is required in the Code of Practice. To be used as a threshold test for compulsion, a sufficiently rich and robust understanding of capacity is required, based on practical assessments of capacity undertaken in the messy real world of mental health and other human services.

66 *Robinson (2000), op cit, questions whether the language of 'discrimination' is appropriate in this context.*

67 *Bartlett, P & Sandland R (2003) Mental Health Law; Policy and Practice (second edition). Oxford University Press, p.582*

68 *See the 1970s research of the experimental psychologist Martin Seligman. A full list of references is in Winick, B J (1995) 'The Side Effects of Incompetency Labelling and the Implications for Mental Health Law' Psychology, Public Policy, and Law Vol 1, No 1, 6-42.*

69 *Winick, B J (1995) op cit, n.21*

The Mental Health Bill 2006 – a social work perspective

Roger Hargreaves[1]

This article considers the government's current attempt to amend the Mental Health Act 1983 from the perspective of social work, and in particular from the viewpoint of Approved Social Workers (ASWs). It reflects the state of play as it was immediately after the Third Reading in the House of Lords on 6 March 2007.

ASWs have no formal role in the criminal processes in Part III of the Mental Health Act, and so it is perhaps not surprising that they have found it difficult to get excited about the 'Home Office agenda' which has tended to dominate the debate on the reform of the legislation over the last eight years. They are mainly concerned with the civil detention process in Part II, under which they assess in the order of 72,000 people per year of whom around 47,000 will subsequently be detained.[2] By contrast, the DSPD (dangerous severe personality disorder) group which has so exercised the government is estimated to contain no more than about 2000 people[3] who will very rarely be made subject to the civil procedures - in 21 years as a practising Mental Welfare Officer and ASW I was never once asked to detain someone on the grounds of 'psychopathic disorder'.

ASWs also find much of the debate about the entry criteria and the exclusions to be rather academic, given that the existing criteria would allow detention in a much wider range of circumstances than would be considered reasonable at present. As Baroness Murphy pointed out in the debate in the Lords on 8 January 2007,[4] "the law has been used as an excuse" – psychiatrists' (and ASWs') frequent claims that the Act prevents them from admitting particular individuals are largely bogus, but are made in order to justify their preserving scarce treatment facilities for those who are the most ill or who can derive the most benefit. Widening the criteria in the absence of a major expansion of facilities and a change in the professional consensus as to when detention is appropriate will therefore make very little difference to actual practice, given that in the present Bill, as opposed to the abandoned 2004 draft Bill, the professionals retain the discretion *not* to detain even where the minimum conditions for doing so are met.

1 *'Lead' on the Mental Health Bill for the British Association of Social Workers; formerly an Approved Social Worker.*

2 *In-patients formally detained in hospital under the Mental Health Act 1983, England 2005, The Information Centre 2006; Admission of patients to mental health facilities in Wales, 2003-4, Report no SB/69/2004, National Assembly for Wales; Detained - Social Services Inspectorate inspection of ASW services in 10 local authorities, February 2001*

3 *Managing Dangerous People With Severe Personality Disorder, proposals for policy development, Department of Health July 1999*

4 *Hansard (HL) Debates 8/1/07 Column 76*

Community Treatment Orders and Responsible Clinicians

ASWs have also made only a limited input into the debates about two of the government's other 'flagship' proposals, for Community Treatment Orders (CTOs) and the replacement of the Responsible Medical Officer (RMO) by the multi-professional Responsible Clinician (RC). Whilst the social work consensus on CTOs would almost certainly be in favour of very tight criteria as per the amendment made at Report Stage in the Lords,[5] many ASWs will remember the ballyhoo in 1995 about Supervised Discharge, now applied to only 600 people per year[6] – even fewer than Guardianship – and will note that a succession of recent judicial decisions[7] has given RMOs powers under Section 17 which equate very closely to the proposed CTO but which they have hardly been rushing to use.

There has been concern that, in the present risk-averse climate, professionals may be tempted to impose CTOs to 'cover their backs', and also that they will be used as a means of discharging patients who are not fully well in order to free beds; indeed, the government makes it clear in the Regulatory Impact Assessment that it expects substantial savings from reduced bed occupancy.[8]

However, as against this, there is a general understanding that it is unwise to invoke community powers unless the patient is highly likely to co-operate with them (and with any conditions attached to them), since the professionals otherwise put themselves at severe risk of censure when the patient does something for which the public and the media will hold them responsible but which they were powerless to prevent. Once any initial over-enthusiasm has died away, therefore, CTOs are likely to be applied mainly to the narrow band of patients who will not respond to 'assertive outreach' alone but who are not so alienated as to be unsupervisable regardless of their legal status. There has, for instance, been much talk of patients being required to abstain from alcohol or illicit drug use, but experienced ASWs know that unless the patient is under close supervision, for instance living in a 24-hour staffed hostel, it will be impossible to police such conditions and there would therefore be little point in making them unless the patient was strongly minded to comply with them in any event.

ASWs have also shown limited interest in the prospect of becoming RCs, although this may have something to do with their average age, which is higher than that of consultant psychiatrists;[9] the immediate career concern of most is about the status of the role of Approved Mental Health Professional (AMHP) to which the government is expecting them to transfer. Even for the mere 10% who are under 35,[10] it may take several years to develop career pathways to the RC role, and the creation of satisfactory governance arrangements may be problematic given that only about 10% of social workers are members of their professional association, the British Association of Social Workers (BASW,) and that their regulatory body, the General Social Care Council, has been functioning only since 2001. However, these things will be less of an obstacle if the role remains as amended by the Lords, as basically that of an overarching care manager, with no powers to impose or to extend compulsion other than with a concurring opinion from a psychiatrist, since this is essentially what ASWs do already.

5 *Ibid 26/2/07 Column 1418*

6 *A Question of Numbers: the potential impact of community-based treatment orders in England and Wales, Simon Lawton-Smith, King's Fund September 2005*

7 *Jones, R Mental Health Act Manual, 10th Edition 1-213 et seq*

8 *Mental Health Bill 2006, Regulatory Impact Assessment November 2006 para 55*

9 *The Department of Health stated in its evidence to the Joint Committee on the Draft Mental Health Bill (Ev 483) that at September 2003 66% of consultant psychiatrists were under 50; a survey (unpublished) of local authorities conducted in February 2006 by the Association of Directors of Social Services (ADSS) found that 61% of ASWs were under 50*

10 *ADSS survey, ibid*

The government's proposal, however, is that non-medical RCs should assume all the powers of the existing RMO, its argument being that it will not otherwise be possible to substitute them for scarce (and expensive) psychiatrists. It has not so far expanded on its reasons for believing that non-medics can make statutory decisions which require "objective medical expertise" despite being challenged to do so in the Lords, but it would appear from its reply to questions from the Joint Committee on Human Rights (JCHR) that it thinks this would depend on the individual having some sort of "medical qualifications".[11] However, if that *is* the test, it will be easier to satisfy in the case of psychology and nursing than of social work, which is not a health profession. The decisions of social workers under the present Act are made from an explicitly non-medical perspective which is intended, as the JCHR[12] pointed out, to be in "creative tension" with the medical viewpoint, and whilst many ASWs will already possess the level of "medical expertise" set out in the draft regulations (which is not especially high) they will have acquired this more from experience and observation than from systematic formal training which can be validated.

Nearest Relatives

ASWs do have an immediate interest in the government's proposals in respect of Nearest Relatives since it is they, as AMHPs, who will have to administer them. The original 1959 scheme was straightforward, with a simple heirarchical list of blood relatives, who could be counted only if they were ordinarily resident in the United Kingdom, but it was made more complex in 1983 in order to accommodate non-blood relationships of long-standing and to give priority to carers, and this introduced a degree of subjectivity into the decision as to who should be consulted by the ASW; and it has been made more complex still by caselaw, and in particular by *R(E) v Bristol City Council*,[13] which gives ASWs a potentially very broad discretion not to consult the Nearest Relative if it would cause the patient "significant distress."

In addition, family structures are much more intricate than they were in 1959, and families more dispersed, with many people resident in more than one country. ASWs often have to work their way through family trees involving multiple separations, cohabitations, divorces and step-relationships, and parents who spend the winter in Spain, before they even consider whether one or other relative 'ordinarily cares for' the patient, and if the patient is under 18 and from a 'fractured family', the identity of their Nearest Relative may depend on family law. Richard Jones, in the 10th Edition of his Mental Health Act Manual[14], devotes no less than 12 pages to commentary on the subject of identification and consultation, and even then does not detail the caselaw around parental responsibility.

This would be less of a problem if ASWs could determine the identity of the Nearest Relative on the basis of full information about family structure and roles and with time to consult their lawyers, but in practice they are often wrestling with this question late at night, in the house of a patient they have not met before and for whom they have no records, and whilst all hell is breaking loose around them. Not surprisingly, they sometimes get it wrong, and although they are only required by Section 11 to consult with the person "appearing to be the nearest relative" and are "not required to don the mantle of Sherlock Holmes"[15] by making extensive enquiries, it is not possible for them to be certain that a court would regard them as having acted with reasonable care if they make a mistake. It would be more likely to do so if they were

11 *Joint Committee on Human Rights, Legislative Scrutiny, Mental Health Bill, January 2007 Appendix 3 page 53*

12 *Ibid para 56*

13 *R (on the application of E) v Bristol City Council [2005] EWHC 74 QBD(Admin)*

14 *Mental Health Act Manual (10th ed.) (2006) (Sweet & Maxwell).*

15 *R (on the application of WC) v South London and Maudsley NHS Trust and David Orekeye [2001] EWHC Admin 1025; [(2001] MHLR 187, para 28*

making a subjective judgement, for instance about the identity of the main carer, but much less likely to do so if they made an error in law, for instance by misinterpreting the provisions of the Children Act and accompanying caselaw relating to the status of an unmarried father, even though this would be outside the area of competence of most ASWs, who are now no longer even in the same local authority department as children-and-families workers (and it will be even more outside the competence of AMHPs from a health background). In consequence, when hospitals are made aware, often by the patient's lawyer, that the wrong person was consulted in respect of an admission under Section 3, there is a tendency for them to act self-protectively and to discharge the section immediately, regardless of the safety of patient or public or indeed of the strict legal necessity of doing so.

The government's proposals would make this scheme even more complex, and therefore open up yet more possibilities of error, without achieving very much for the most vulnerable patients. It proposes that patients should be able to apply to the County Court for displacement of their Nearest Relative on the grounds that they are "not a suitable person to act as such", but it also recognises, in the Regulatory Impact Assessment, that Nearest Relatives in that situation are very likely to contest the application,[16] which means that the patient will need to be capable of instructing a solicitor and providing evidence of unsuitability and if necessary of facing their relative (and their lawyer) in court. In practice, this is not a course which most patients are likely to be able to contemplate or have the ability to carry through, even with advocacy and legal support, bearing in mind that the "unsuitable" Nearest Relative may be someone who has been abusing or oppressing them for years and who they are in fear of. In addition, it is likely to be difficult for them to prove "unsuitability" unless they can adduce extensive social work and possibly medical evidence.

An AMHP will have the power to make an application on the same ground, but no *duty* to do so even if the Nearest Relative is patently unsuitable, and bearing in mind the costs involved in a contested application, local authorities are likely to refuse to fund such actions unless the Nearest Relative is obstructing the wishes of the professionals. This 'right' will not therefore be a practical reality for most patients unless there is a procedure whereby they can require the local authority to take up a reasonable case for displacement.

Alternative approaches

The alternative proposed by the Mental Health Alliance would give precedence to the patient's own choice, albeit only from the present list of eligible relatives in Section 26, if they were judged by an AMHP or other "prescribed person" as having the capacity to make such a choice. This might not always be the case at the time of admission where the patient was very disturbed or the circumstances very fraught, but the Alliance proposal would give them the option of nominating a "named person" as Nearest Relative, or of changing their nomination, at any point in the future. Failing such a nomination, the heirarchical system would apply as at present.

This scheme differs substantially from the "nominated person" proposals in the 2004 Draft Bill in that, whilst they would also have given precedence to the patient's nomination (which was not limited to a list), the AMHP would then have had the power to reject that nomination on the grounds either that the person was not eligible due to their health status, an issue which at present can only be decided by the County Court, or more broadly that they were not "suitable." Many ASWs felt uncomfortable about having this level of discretion, which would have been an invitation to bar someone who was likely to

16 *Regulatory Impact Assessment Annex A para 41 page 56*

disagree with them; the present system may not produce the outcome the patient wants, but the professionals *also* have to work with whoever it throws up unless they behave in such a way as to create grounds for displacement (or the ASW can avoid contacting them on the grounds of likely distress to the patient.) The Alliance scheme would limit the AMHP's discretion to the application of a simple capacity test, and mistakes and legal challenges would be much less likely since, in a great many if not the majority of cases, the AMHP would be holding the patient's written nomination.

The weakness of the Alliance proposal, however, is that, since it is simply tacked onto the existing scheme, the nominated Nearest Relative would then acquire all the existing powers, including the power to make an application, to discharge a Section 2 and to object to a Section 3. The 2004 'nominated person', by contrast, was essentially a patient's representative lacking formal powers. Not surprisingly, the government is objecting to patients having a virtually-unfettered right to nominate a Nearest Relative who would then have the power either to discharge them or to bar their admission; and it would also be incompatible with the (very rarely-used) power to make an application, since where a heirarchical Nearest Relative was proposing to do so, the first duty of the AMHP on arrival would be to inform the patient that they had the right to nominate someone else.

Basically, it is just not possible to frame a scheme which preserves the existing powers of the Nearest Relative, which carers and indeed many patients see as being very important, whilst giving patients unfettered nominating rights; but if those rights were fettered by the AMHP's discretion, it would open up an opportunity for the misuse of professional power which does not exist at present. The 1959 scheme was logical and consistent, as was the 2004 "nominated person", but they are quite different in concept and any attempt to 'mix and match' is bound to result in illogicalities and inconsistencies which AMHPs will find impossible to resolve. At Third Reading in the Lords, the Alliance introduced a compromise amendment[17] which the government agreed to "take away for consideration" and which would involve the discretion being exercised not by the AMHP but by three-member panels of local authority councillors or hospital managers; however, although this would largely avoid the conflict of interest, it raises a whole host of other practical and procedural issues.

The civil detention process

The primary concerns of ASWs, however, are not surprisingly around the civil process for assessment and admission. Given the impact which this has on the rights and freedoms of so many people, it is remarkable, even allowing for the fact that it is marginal to the 'Home Office agenda', that it has attracted so little attention over the last eight years. This was certainly not the case in 1983, when concerns about the misuse of medical authority and the absence of a strong social counterbalance led to the creation of the ASW[18], and this apparent lack of interest is perhaps an indication of how well that role has functioned since, both in ensuring the fair application of the law and in 'oiling the wheels' of the process.

In addition, much more so than in 1983 the recent debate has been shaped by caselaw, the volume of which is in turn influenced by the level of legal activity and the availability of Legal Aid to fund it, and (with the exception of cases about use of police powers under Section 136) this has been focussed mainly on patients who have already been detained for substantial periods. Patients usually acquire lawyers only when they apply to the Mental Health Review Tribunal (MHRT), but only about 38% of Section 2

17 *Hansard (HL) Debates 6/3/07 Column 133*

18 *Hargreaves, R A Mere Transporter - the legal role of the Approved Social Worker, Journal of Mental Health Law, Edition 4 December 2000*

patients make such an application and only 25% remain detained for long enough to get a hearing[19], and by the time of a Section 3 hearing the circumstances of their admission have often faded into the background. Earlier access to advocacy services might increase the 'visibility' of these circumstances to lawyers, but the situation would still not be remotely comparable to the criminal detention process where lawyers are involved almost from the beginning.

A further factor may be that the major concerns in recent times have tended to be not about inappropriate detention but about failure to assess and admit people who are in desperate need of it (and who are frequently requesting it.) As Baroness Meacher pointed out in the Lords Report Stage debate on an Alliance amendment to introduce a right to assessment,[20] a quarter of people who ask for help at present are turned away. The complainants are, however, more likely to be family and carers than patients themselves, and the duties of NHS Trusts are so ill-defined (hence the Alliance amendment) that judicial review is well-nigh impossible, so again this is an area which has been largely invisible in terms of caselaw.

Conveyance

All is not well, however, with the assessment-and-admission process itself, and ASWs have expressed particular concern about two main issues[21], the first of which is the procedure for conveyance and admission to hospital. Having signed an application, the ASW then needs to secure a bed, suitable transport, and where necessary assistance from the police, which may also be needed during the assessment if violence is anticipated. None of this was a problem in 1959 – there were then too many beds, and the ambulance staff, police, and the ASW's predecessor, the Mental Welfare Officer, all worked for the same local authority – and it did not really become a problem until the late 1990s, when bed reductions began to bite and when the police and ambulance services, which had long since been detached from local government, began to tighten their priority criteria in pursuit of performance targets. As a result, in many places it can now take several weeks for an ASW to get a seriously-ill and perhaps dangerous patient into hospital.

This has highlighted the fact that no public body, other than the ASW, has any legal responsibility to ensure prompt and safe conveyance and admission. Even where the patient is an existing patient of the Trust which runs the community mental health service, and the Trust itself has requested the assessment, it assumes no legal responsibility until the patient has been accepted onto a hospital ward. Nor is the Primary Care Trust, which issues the ambulance contract, under a specific duty to ensure that adequate assistance is available, and the involvement of the police is purely voluntary over and above their normal duties to preserve public order. The local authority, as the ASW's employer, has a responsibility for their health and safety, but not for the conveyance process itself as this is placed by Section 6 on the ASW in person.

In addition, the application must be made out to a named hospital, and not infrequently ASWs arrive there with the patient only to be turned away, either because the promised bed has been taken or because the patient is judged to be too disturbed to be managed in that unit. If a bed is not immediately available in another hospital, allowing a fresh application to be completed on the spot, the authority to hold the patient lapses.

19 *Mental Health Review Tribunal, Secretariat Activity Report 2001-5*

20 *Hansard (HL) Debates 26/2/07 Column 1457*

21 *A detailed account of ASWs' concerns is set out within a Memorandum from the ASW Leads' Network to the House of Commons Committee on the Mental Health Bill (May 2007).*

As a result of the difficulties in getting assistance from the police it has also become apparent that rights of entry to private premises are not as clear as they had been assumed to be. The ASW would appear to have an inherent right to enter premises in order to carry out an assessment, since Section 129(1) makes it an offence to refuse access, but this right does not extend to the police attending to protect the ASW and the doctors since they are not "authorised under this Act" until an application has actually been signed, at which point the ASW can authorise them under Section 6(1) to assist with conveyance. Section 17 (1) (e) of the Police and Criminal Evidence Act 1984 does not appear to cover circumstances in which the possibility of violence has been anticipated but has not yet occurred.[22] ASWs are understandably not happy to enter a house whilst the police wait outside until they can hear an assault actually being committed, and so many police forces are insisting that the ASW should apply for a warrant under Section 135(1) even where access is not being physically denied.

This creates yet further delay, and in turn raises the question as to whether it is lawful or proper for magistrates to issue a warrant in these circumstances. In addition, it has drawn attention to the criteria for the issue of such a warrant, which are derived from the comparable provisions in the Lunacy Act 1890 and the Mental Deficiency Act 1913 and which are that the patient "has been, or is being, ill-treated, neglected, or kept otherwise than under proper control, or being unable to care for himself is living alone." Leaving aside the obsolete and stigmatising language (as one legal respondent to the Joint Scrutiny Committee on the 2004 Draft Bill put it, "we are not talking about dogs")[23] this clearly does not cover all of the situations in which ASWs would need police protection, since many patients are neither being ill-treated or neglected nor are living alone.

BASW and the ASW National Leads' Network (which represents the operational managers and trainers of ASWs) tabled a series of amendments on these issues in the Lords, but the government's response was essentially to deny that problems existed in relation to the access powers, and to say that placing explicit responsibilities on the public bodies in respect of the conveyance process would make no difference in practice – or to put it another way, that it would not increase the supply of beds or cause police or ambulance services to modify priorities driven by government targets. This may be so, but it is still invidious that the personal responsibility – and the legal liability if anything goes wrong – rests on the ASW who has no effective control over any of the resources needed.

Assessment

The greatest concern of ASWs, however, has been about the assessment process. Many have been concerned about the extension of the ASW role to include health professionals (who will mostly be nurses), and whether they will be able as AMHPs to operate from the distinct social perspective of the ASW and to resist pressure from medical colleagues and their employing Trust, but the advanced age-profile of the ASW workforce and the problems being experienced by local authorities in maintaining numbers are such that it has been difficult to make a credible case against the government's proposals, insofar as they are necessary to maintain the service.

In addition, as David Hewitt pointed out in a paper in this journal in November 2005,[24] the AMHP may already have arrived, at least to some extent. 40% of ASWs are already seconded to or in a few cases

22 *Entry is allowed under this section only "for the purpose of saving life or limb or preventing serious damage to property"*

23 *Memorandum from IMHL and Peter Edwards Law, Ev 1118 para 4.4*

24 *Hewitt, D. An Inconvenient Mirror - do we already have the next Mental Health Act ? Journal of Mental Health Law Edition 13 November 2005*

directly employed by Mental Health Trusts (and seconded back to the local authority when on ASW duties),[25] and their employment by the Trusts will eventually become the norm, with newly-qualified social workers going straight into the Trusts and eventually acquiring the status of ASW/AMHP without any working experience within local authorities. The concern is, therefore, not that the revised Act would create a completely new situation, but that it might exacerbate problems which already exist.

There are basically two ways of conceptualising the assessment process, in which the patient is interviewed by two doctors and an ASW who then makes an application "founded on the medical recommendations." One is to regard it as an explicitly quasi-judicial process, the other to see it as a multi-disciplinary decision by the clinical team as to the best way to manage and treat its patient. These two views are bound to be incompatible, since good multi-disciplinary team practice requires decisions to be taken where possible by professionals who know the patient well, have a close working relationship with one another, and share common perspectives, whereas a quasi-judicial process requires at least the body making the final decision (which in this case is the ASW) to be impartial and disinterested, and in particular to have no connection with the detaining authority.

The quasi-judicial view would appear to make the most sense from a human rights standpoint. The power of the three assessors is, after all, enormous. If a patient is detained from the outset under Section 3 (and this is so in about 28% of all cases)[26] they can be held for up to six months, given medication against their will for three months before they are entitled to a second opinion, and, if they appeal, cannot expect a hearing in under six weeks.

When I first acted under the 1959 Act in 1971, most assessments would have reached a quasi-judicial standard, since it was often the case that the three assessors – usually the G.P., the consultant from the (often distant) hospital, and the Mental Welfare Officer (MWO) from the local authority – had never even met one another, and the latter two had frequently not met the patient. There was, therefore, no danger of collusion between colleagues, and no doubt whatever that there was at least an element of impartiality, and that the MWO was not beholden to the detaining body.

The corollary was that common perspectives were often markedly absent, and there was no sense in which the assessors constituted a multi-disciplinary team. However, since then, practice has steadily evolved in that direction, and this trend has gathered pace in recent years with the development of joint community mental health teams and most recently with the secondment of ASWs to Trusts. It is quite likely now that the psychiatrist and ASW will be close colleagues in the same team, and that the latter will be accountable in their non-statutory role to a manager employed by the Trust. In addition, it is likely that they will both know the patient well, and that they may have been working for weeks to contain a crisis before a team decision is made to invoke the Act.

The psychiatrist and ASW in this situation now form a very powerful partnership to which the second doctors are an increasingly weak counterbalance. Since the introduction of the new G.P. contracts in 2004, they are much less likely to be the patient's G.P., and although most will be approved under Section 12 of the Act as having psychiatric experience, they will rarely be psychiatrists of consultant status. Bearing in mind also that they are called out by the ASW and for a very generous fee, there is little incentive for them to challenge the collective view of the multi-disciplinary team, and as Richard Jones

25 *See footnote 10 above*

26 *See footnote 2 above*

points out in the foreword to the Tenth Edition of the Mental Health Act Manual[27], research has shown that this is a rare event. If the doctor *is* the patient's own G.P., they may arguably have more standing because of their continuing responsibility for the patient, but where the patient has been receiving support from a community team it is also arguable that the G.P. is a *de facto* member of that team, and a party to its collective decision-making.

The government's approach

The government's view in 1999[28] appeared to be that this process was no longer human-rights compliant and that the initial decision should therefore be confirmed very quickly by a tribunal, but it now appears to have forgotten this and seems quite happy for practice to slide even further away from a quasi-judicial standard, in order not to impede the development of integrated community services. The draft Code of Practice invites local authorities, if they so wish, "to enter into arrangements with the Mental Health Trust to provide the AMHP service on their behalf"[29] (i.e to place *de facto* control of a supposedly-independent service in the hands of the detaining authority), and the Minister, Baroness Royall, stated in the Lords that "one of the advantages in broadening the professional groups who can become AMHPs is that it will be easier for Crisis Resolution and Home Treatment Services carrying out an urgent assessment to progress that to a MHA assessment without having to involve a professional from outside the team."[30] Many ASWs have expressed concern about the decision-making processes within the new Crisis Teams, which, as the number of ASWs has remained static as community services generally have expanded, often at present do not contain an ASW[31], but it seems clear that the government does not want independent outsiders intruding on those processes and asking awkward questions.

The government's response to concerns about the independence of the AMHPs has been, first of all, to state in the Bill that (whilst unlike ASWs they need not be officers of the local authority) they will be acting "on the local authority's behalf." On the face of it this is reassuring; however, it does raise the question as to how meaningful this will be if the authority in turn contracts with the detaining Trust to run the AMHP service 'on its behalf'. On whose behalf will the AMHPs really be acting?

It also, albeit unintentionally, appears to compromise the AMHP's independence from the local authority when making a decision under the Act. ASWs at present do not assess under Section 13 "on behalf of the local authority" – they are appointed by it, must be officers of it, and can be directed by it to undertake the assessment, but once the assessment starts they act as an independent public authority, with personal liability. The government's view is that the Bill makes it clear that AMHPs are to be "independent professionals", and that the new phraseology does not therefore alter the current precedent; however, the concept of an independent professional is derived from NHS practice, where doctors in particular act on behalf of their employing Trust whilst making independent clinical and legal decisions, and it is foreign

27 *Page vi, Mental Health Act Manual (10th edition) (2006) (Sweet & Maxwell), citing 'Performing the Act: A Quantitative Study of the Process of Mental Health Act Assessments – Final Report to the Department of Health' Alan Quirk et al (March 2000).*

28 *'Reform of the Mental Health 1983 – Proposals for Consultation' (the Green Paper) (Department of Health) (November 1999).*

29 *Mental Health Bill 2006, Draft Illustrative Code of Practice 1A 10 page 13*

30 *Hansard (HL) Debates 17/1/07 Column 749*

31 *The Adults of Working Age Mental Health Service Mapping Exercise (Durham University) showed than in 2004 nurses outnumbered social workers by about 2.6 to 1 in community mental health services overall, but by about 5 to 1 in the new Crisis Resolution Teams. Since these teams were then in their infancy, this imbalance is likely to have increased substantially with subsequent growth*

to local government where all officers of whatever professional status (unless, like ASWs, they have a parallel legal existence) ultimately have to do as their chief officer or the political leadership tells them.

Secondly, in the same vein the government is saying that the independence of the AMHPs will not be compromised if they are Trust employees or are being managed by the Trust, since this will derive from their professionalism, and their training for the role will ensure that they will always act in an independent way. The simplest way of grasping the unreality of this is to consider the worst-case scenario (which is by no means unlikely) - where a relatively junior nurse, ambitious for promotion and new to the AMHP role, disagrees with a recommendation from the consultant psychiatrist in her team who is also the Trust's Medical Director. Experienced ASWs not infrequently find themselves in this sort of situation, and it can be very uncomfortable, but they do (or did until recently) have the security that their career prospects are not dependent on the Trust. And the training will be based on the existing ASW programmes, which last just 600 hours over 6 months[32]. It is hardly surprising that the Joint Committee on Human Rights concluded, in respect of the making of a CTO, that due to the concerns about their independence from the psychiatrist "we do not consider that the need to obtain the AMHP's agreement represents a significant safeguard."[33]

A lack of human-rights compliance?

If this view is accepted, it would be difficult to argue that the decision-making process under Sections 2, 3 and 4 is human-rights compliant, given that it is the AMHP who will be making the final decision. The government would no doubt say that the minimum requirement is met by the need to obtain a recommendation from a second doctor, but for the reasons already given, this is likely to be a protection only against the most blatant abuses of professional authority; and it would also be difficult for the government to explain why it is setting a much higher test of impartiality for the less-draconian 'Bournewood' powers, the regulations for which will stipulate that the 'best interests' assessor, the equivalent of the AMHP, must not be involved in the care of the person they are assessing, in decisions about their care, or be on the staff of the hospital or care provider which will be the detaining authority.[34]

It would, however, neither be practicable nor in the patient's best interests to insist on a strict quasi-judicial process. Decisions must frequently be made at very short notice, and often out-of-hours, and in many rural districts the three assessors will often be the only qualified professionals available; the Bournewood procedures, by contrast, are unlikely to be applied in an emergency. In addition, it is not in the interest of the patient for the assessors to reach a conclusion which is legally immaculate but ill-informed, and it can be very difficult for a complete outsider, in the very limited time which is often available, to assimilate all the information required to make a sound and reasonable decision. There does, therefore, need to be a balance between disinterestedness on the one hand, and the in-depth knowledge of the circumstances and of the options available which is only possessed by the professionals who have been closely involved with the patient.

Several local authorities do nevertheless prohibit their ASWs from acting in respect of their own clients or those of their own team, but others argue that an ASW from outside the team is much less likely to be able to influence the thinking of the psychiatrist in the team, who is still very much the most powerful player in the whole process. However, this argument makes more sense in respect of the present body of

32 *'Assuring Quality for Mental Health Social Work' Central Council for Education and Training in Social Work (CCETSW) (2000).*

33 *Joint Committee on Human Rights para 56*

34 *The Bournewood Safeguards – Draft Illustrative Guidance, December 2006 para 97*

ASWs, who are mostly very long-serving and who still have at least one foot in the local authority structure, than for the forthcoming generation of NHS-bred AMHPs.

A reasonable balance

BASW and the ASW Leads'Network believe that a reasonable balance would be struck if, first of all, the present arbitrary rules in Section 12 governing conflicts of interest between assessors were replaced by a more flexible regulation-based approach, based around a set of principles which would place the onus on the assessors to recognise when it was not appropriate for any two or three of them to act together. The present rules are mainly concerned with the relationship between the two doctors and take little heed of the possibility of collusion between the ASW and a doctor, that being far less likely in 1959. A principle-based formula would make it much easier for an AMHP to decline to act when they felt themselves to be in a position where they were vulnerable to improper influence or to accusations of bias. The first step towards this has now been achieved in that the government has accepted an amendment[35] which creates the regulation-making power, although discussions have yet to take place as to the content of the regulations.

Secondly, BASW and the ASW Leads' Network believe that the independence of AMHPs employed by the Trusts would be sufficiently protected if the local authorities were required to retain direct responsibility for those management functions, such as performance monitoring, capacity and disciplinary issues, complaints, dispute resolution, and setting of local practice standards and guidelines, which if delegated to the Trust would severely compromise independence. In addition, legal support to AMHPs should definitely *not* come from the Trust's lawyers. This would not prevent delegation to the Trusts of the operational control of the AMHP service – in other words, deciding how many there should be, and who goes where – which is better done by the body which has overall responsibility for the management of the local mental health service.

Resistance to this, however, is likely to come as much from the local authorities as from central government or the Trusts. Whilst the local authorities' responsibilities for the training and approval of AMHPs will be set out in regulations, the government and the local authority bodies were united in opposition to the amendment proposed which would have required the management arrangements to be subject to the same central prescription. Local discretion is now the watchword; however, it is not appropriate for arrangements which impinge on the liberty of the individual to be left, as the Minister put it, to "local practice,"[36] even when subject to government guidance, especially given the strong financial incentive there will be for local authorities to transfer their AMHP services lock, stock and barrel to the Trusts along with the rest of their mental health services rather than retain the managers in-house. It does, however, appear that the government is willing to issue detailed guidance, and it has fallback powers under Section 7 of the Local Authority (Social Services) Act 1970 to issue directions in the case of widespread non-compliance. In addition, the local authorities' lawyers may well point out to them that, since AMHPs will be 'acting on their behalf', it would not be legally prudent to surrender all effective control over them.

35 *Hansard (HL) Debates 26/2/07 Column 1392*

36 *Hansard (HL) Debates 15/1/07 Column 540*

Conclusion

BASW and the ASW Leads' Network are pleased that, by tabling nine amendments in the Lords, they have at least drawn attention to the processes of civil detention and admission to hospital which have hitherto been largely overlooked. However, the government's responses have tended to confirm that it has limited interest in retaining the independence of the present ASW role and that it is prepared to sacrifice it in the interests of ensuring the smooth operation of the new community services, prioritising collective decision-making over quasi-judicial principle.

At the same time, it is assuming that the existing ASWs will be happy to transfer to the new AMHP role regardless of this loss of status, and the impression is that it regards them essentially as useful administrative functionaries, oilers of wheels rather than guardians of rights, who will continue to operate the civil processes without complaint as indeed they have very largely done since 1983. However, it is also assuming that, as the current long-serving ASWs retire, significant numbers of health professionals will be willing to step into their shoes; although the Regulatory Impact Assessment recognises that it will take time to introduce them, it forecasts that by 2012/13 they will make up 15 % of the AMHP workforce.[37]

The perseverance of the existing ASW workforce cannot, however, be taken for granted, given that many ASWs are within sight of retirement and have attributes which are highly valued elsewhere in social care. Nor can it be assumed that health professionals will be queuing up to take their places; they have shown very little enthusiasm so far, which is hardly surprising in view of the difficulties which they observe their ASW colleagues to be experiencing. In particular, the arrangements for assessment and conveyance of potentially-violent patients, dependent as they are on unreliable police and ambulance support, would not be regarded as a "safe scheme of work" by NHS health-and-safety standards. The government may at present be complacent and dismissive of these difficulties, but ultimately it has no choice but to address them if it wishes to ensure that the civil procedures of the amended Act will continue to be administered as effectively by AMHPs as they have been by ASWs for the past 24 years.

37 *Regulatory Impact Assessment Annex A, Table A3 page 54*

Sexual Predators, Extended Supervision, and Preventive Social Control: Risk Management Under the Spotlight[1]

Warren J Brookbanks[2]

Introduction

In 2004 New Zealand introduced legislation aimed at managing the long term risks posed by child sex offenders in the community. In this regard it was responding to widespread public apprehension about the special dangers posed by this group of offenders, the new "monsters" in our demonology of society's most despised members.[3] The vehicle for achieving this in New Zealand is a post-sentence supervision order known as "extended supervision", which enables the Department of Corrections to monitor medium-high and high-risk child sex offenders for up to ten years following release from prison.

The legislation, the Parole (Extended Supervision) Amendment Act 2004, came into force in July 2004. Its expressed statutory purpose is to "protect members of the community from those who, following receipt of a determinate sentence, pose a real and ongoing risk of committing sexual offences against children or young persons."[4] The Act provides that the Chief Executive of the Department of Corrections may apply to the sentencing court (which may be either the District Court or the High Court) for an extended supervision order (ESO) in respect of an eligible offender. Factors including the level of risk posed by the offender, the seriousness of harm that might be caused to victims and the likely duration of risk must be considered. The application must also be accompanied by a health assessor's report addressing the likelihood of future sexual offending by the offender, his ability to control his sexual

1 *An earlier version of this paper was delivered by Professor Brookbanks at the 'Comparative Mental Health Law Seminar' hosted by the Law School, Northumbria University in October 2005.*

2 *Professor of Law, University of Auckland, New Zealand.*

3 *M Perlin, "Symposium: 'There's no success like failure/ and failure's no success at all': Exposing the Pretextuality of Kansas v Hendricks" (1998) 92 Northwestern University law Review 1247.*

4 *Parole Act 2002, s 107 I (1), as inserted by the Parole (Extended Supervision) Amendment Act 2004.*

impulses, the offender's predilection and proclivity for sexual offending and his acceptance of responsibility and remorse for past offending.

The extended supervision model imitates the responses of legislatures in other jurisdictions to the unique challenges presented by child sex offenders, although it must be said that at this stage of its legislative development the New Zealand response to the problem is significantly less draconian than the typical US 'sexual predator' statutes.[5] However, beyond the particular *form* the legislation takes, there is a more pressing concern. This is the fact that the legislation represents a shift in focus from punishing criminal conduct to regulating the danger potentially inherent in the individual[6]. More importantly, as a form of preventive detention, the legislation is objectionable because it permits detention after the expiration of the offender's sentence, thereby undermining settled principles of criminal process.[7]

The purpose of this article is to assess the legitimacy of this model of preventive detention in light of the legislative response to sex offenders in other jurisdictions, notably the United States and England. I will argue that the growing legislative practice of imposing administrative detention post-sentence represents a dangerous trend in criminal justice and disguises a largely undeclared agenda to isolate and demonise sex offenders as a class. It also has implications for other offender groups who may be targeted because the particular class is perceived as presenting a particular type of risk. Since the empowering legislation is often passed in haste and without due consideration of its long term impacts, it bears the hallmarks of a pre-reflective, "at least we're doing something," response to the problem of sex offending. It also provides a context for pretextual and sanist judicial values to operate, permitting distorted and ill-informed judicial decision-making, particularly where judges' thinking is infected by populist punitive approaches. Invariably, such legislation and the policy surrounding it, fails completely to address fundamental causal patterns underlying sex offending phenomena.

I suggest that in order to address these phenomena squarely, it will be necessary to abandon the current tendency towards isolating sex offenders and refocus our energy on traditional responses of retribution, reform and rehabilitation within conventional principles of criminal process.

Assessing Extended supervision

It is still to early to assess the impact of the New Zealand legislation on patterns of offending and, more importantly, recidivism. According to Department of Corrections publicity, the implementation of the legislation is "progressing well."[8] As at 21 January 2005, ten applications for ESOs had been granted by the courts, with a further 32 applications in progress. It is now clear that New Zealand judges are using the new option with increasing frequency, viewing it as a useful means of protecting children and young persons from the risk of future sexual abuse by recidivist offenders.[9] While such an approach is unobjectionable per se, the concern which is at the heart of this discussion is that the normalisation of the use of post-sentence detention undermines cherished principles of criminal procedure and exposes offenders to an increasing risk of executive punishment.

In this regard the New Zealand extended supervision model exemplifies important philosophical and

5 *See eg EW Fitch, Sex offender commitment in the United States: legislative and policy concerns" (2003) Ann NY Acad Sci 989, 489-501; J S Levenson, " Reliability of Sexually Violent Predator Civil Commitment Criteria in Florida" (2004) 28 Law and Human Behaviour 357.*

6 *B McSherry, " Indefinite and preventive detention: From caution to an open door" (2005) 29 Crim LJ 94.*

7 *Ibid.*

8 *Corrections News, February 2005, at p 6.*

9 *See Chief Executive of the Department of Corrections v Subritzky 26/10.05, HC Auckland, CRI 2004 404 98, Lang J, at para 9.*

policy developments in Western jurisdictions which indicate major changes in both the *perception* and *management* of dangerous offenders. The new focus, as has been noted by other commentators, is now upon the criminal actor rather than the crime committed, an approach which is inconsistent with the prevailing offence-oriented stance of modern penal legislation. In the Australian case of *Kable v DPP (NSW)*[10] the High Court of Australia held that specially crafted legislation[11], which was designed specifically to preventively detain a nominated dangerous offender, in order to protect the public, compromised the integrity of the judicial system because it obliged the Supreme Court of New South Wales to exercise a non-judicial function. One judge held that because the legislation required the court to perform a non-judicial function in making a preventive detention order when there was no offence and no finding of guilt, it diminished public confidence in the integrity of the judiciary.[12]

While such judicial commentary identifies serious constitutional concerns about the nature of such legislation, it is clear that developments in the use of post-sentence detention are manifestations of a reactive stance in penal policy which threatens a dangerous (con)fusion of preventive, punitive and therapeutic mandates. The likely outcome of these developments are negative long term changes in criminal justice and penal values, with a growing focus on *preventive* (crime control) at the expense of *due process* (human rights) values.

In order to test these claims I will briefly examine the sexual predator laws with reference to particular examples in the US, comparing these to the model currently employed in NZ. I will then comment on the 'preventive' model of criminal justice advocated by Christopher Slobogin, in a recent article in the Vanderbilt Law Review[13]. Next I will consider the 'anticipatory containment' concept in relation to proposed legislation for dangerous psychopaths in the UK and Scotland. Finally, I will offer some suggestions as to the management of sex offenders ,which may be less restrictive of their personal rights and freedoms, using the "inclusive" theory of criminal justice advocated by David Cornwell.[14]

Sexual predator laws

Sexual predator statutes, now increasingly popular in the US, exemplify the new generation incapacitation regimes springing up across jurisdictions, that represent a major departure from traditional punishment models of liberty deprivation. Previous models of indeterminate preventive detention, such as that currently employed in NZ penal legislation[15], invariably followed conviction for a fault-defined antisocial act and usually required a minimum term in prison as part of a retributive penalty.[16] However, the new sexual predator statutes, operating in at least 20 US jurisdictions, permit long-term post-sentence confinement based on a finding of dangerousness. While these statutes require that the dangerousness result from a "mental abnormality" affecting volitional or emotional capacities, and predisposing the person to sexual offending, the triggering mechanism is not an incapacity-based mental disorder, but rather a mental *abnormality* or personality disorder that makes the offender likely to commit another crime. Thus targeted offenders (predominantly paedophiles) may be indefinitely detained in a therapeutic setting *as though* they were mentally disordered when, in strictly clinical terms, they are neither mentally

10 *(1996) 189 CLR 51; 70 ALJR 814.*

11 *See the Community Protection Act 1994 (NSW).*

12 *Kable v DPP (NSW) (1996) 189 CLR 51; 70 ALJR 814, per Toohey J, at 98 and see discussion of the case in B McSherry, "Indefinite and preventive detention legislation", supra, n 4, at 99-100.*

13 *C Slobogin, " The Civilization of Criminal Law" (2005) 58 Vand. L. Rev. 121.*

14 *See D J Cornwell, Criminal Punishment and Restorative Justice; Past, Present and Future Perspectives, (Winchester: Waterside Press, 2006).*

15 *See Sentencing Act 2002(NZ) s87*

16 *C Slobogin, "The Civilization of the Criminal Law (2005) 58 Vand. L. Rev. 121,123.*

ill nor treatable. As well as contributing to the social rejection of sexual offenders, this legally dubious process confuses the boundaries between therapy and punishment, while creating a pretext that such persons are being detained for "treatment". The hidden agenda is, however, indefinite secure incapacitation.

The pretextual nature of these legislative models has been noted by a growing number of critical commentators. Amongst the most outspoken of these is Michael Perlin, an American mental health law academic, who has written of the pretextual character of the decision of the US Supreme Court in *Kansas v Hendricks*[17], in which the Court upheld the constitutionality of the Kansas sexual predator statute. Perlin's principal criticism is that the majority decision supports a statutory scheme that has the potential of transforming psychiatric treatment facilities into de facto prisons, while using mental health treatment as a form of social control, and endorsing the "medicalization of deviancy".[18] Yet he warns,[19] America's social policy in dealing with individuals like Leroy Hendricks has been a total failure. New legislation like the Kansas Sexually Violent Predator Act, designed to remedy failures in social policy, is labelled a success, in the absence of a complete lack of supporting empirical evidence, while attracting significant popular support.[20]

Perlin's claim of the pretextuality of much sexual predator legislation is based on the view that the legal system accepts dishonest testimony unthinkingly and regularly subverts statutory and case law standards. Of equal concern is his claim that the mental disability law system often deprives individuals of liberty disingenuously and for reasons that have no relationship to case law or to statutes. While it is unlikely that this claim could be sustained in relation to judicial decisions around extended supervision in New Zealand, which are typically closely aligned to statutory criteria and clear reasons, it stands as a stark critique of the attitudes of some judges involved in this area of law and practice.

Eric Janus, writing in the Lancet, has also criticised sexual predator laws on the basis that they are legally and morally controversial because they incarcerate individuals in anticipation of future predicted crimes, while using psychiatry and allied mental health professions as a central prop of legitimacy.[21]

Of particular concern is the criticism that judgments made by professionals in sexual predator cases are largely political. Professionals are required to judge whether the individual meets the legal criteria for a diagnosis based on mental condition and level of risk. Such experts are then asked to measure their estimates against the legal threshold for risk which, as Janus notes, are expressed qualitatively using heuristic terms such as "likely" or "highly likely". However, because these legal concepts are so indeterminate, medical professionals are effectively required to make political judgments to determine the balance between public safety and individual liberty.[22]

By "political", Janus is suggesting that sexual predator laws effectively commandeer the traditional power of state mental health systems and put it in service as a core function of the criminal justice system. On this view the "transposition" of civil commitment has forced psychiatry to legitimate and arbitrate

17 *117 S.Ct 2072(1997)*

18 *See M L Perlin, "Symposium: 'There's no success like failure/and failure's no success at all': Exposing the Pretextuality of Kansas v Hendricks" (1998) 92 NW U..L Rev. 1247, 1269.*

19 *Ibid, 1253.*

20 *Ibid, 1249. The judgement that New Zealand's Extended Supervision legislation is "progressing well" is difficult to evaluate in the light, similarly, of an almost complete absence of evaluative empirical data. However, it must be assumed that "progressing well" is a reference to the implementation of the legislation rather than a statement about its effectiveness as a measure of penal control.*

21 *E S Janus, "Sexually violent predator laws" psychiatry in service to a morally dubious enterprise" (2004) 364, The Lancet 50.*

22 *Ibid.*

"the boundaries of an aggressive and highly contested form of state coercion". Thus, according to Janus, sexual predator laws are constructed to imitate civil commitment in order to achieve constitutional and moral legitimacy.[23]

Another face of the pretextuality of sexual predator laws is shown by an article which appeared in the New York Times in 2003.[24]In it the writer, Laura Mansnerus, discussed the case of a New Jersey man, Robert Deavers, one of 287 "sexually violent predators" in the state. Deavers had served 15 years in prison, following conviction for two rapes, before being committed as a sexually violent predator. At the time of publication of the article Deavers had been subject to a sexual predator declaration for 5 years and was facing his third review hearing in an attempt to be released from the sexual predator order. The article states that he "quickly lost hope" when he heard the state psychiatrist, who had never met him but had reviewed his records, note that he tended to be self-righteous and had been "overconfident" in group therapy. Evidence about his having "bumped into" a female guard was evidently determinative of the judge's decision that he was too dangerous to be released.

Mansnerus notes that Deavers case is typical of other "sexually violent predators", only a handful of whom have been released, and comments on the view held by critics of the legislation, that it is merely an exercise "rigged to keep sex offenders locked up for a lifetime".[25]

The pretextual character of sexual predator legislation and the hearings that often accompany them is well illustrated in a scenario occurring at the end of a review hearing for one William Anderson, discussed in Mansnerus' article. Anderson had pleaded guilty to two felonies - the rape of a 21 year old woman and the aggravated assault on a 12 year old girl - and had served 7 years in prison. Eventually, the Judge announced her decision, having considered the weight to be given to evidence of events that had occurred ten years earlier. She noted a detail from Anderson's record, namely, that he had fathered 5 children by age 18, "only three in wedlock." The Judge concluded : "That does clearly indicate a maladaptive pattern of behaviour", noting that she did not find any evidence "given denials, rationalizations and blame-shifting, that the respondent's treatment has in any respect diminished his risk".

Examples abound in the judicial rhetoric surrounding these hearings of such meretricious and flawed judicial responses.

However, there is an even more disturbing feature of this legislative model. It has been noted that unshackled from the traditional mental illness and sentence-range limitations, the emergence of the dangerousness criterion as a basis for confinement could spell the end of the criminal justice system as we know it. Its logic could, conceivably, be applied to a range of antisocial conduct, including drink-drivers, domestic abusers, and drug users. Indeed, as Justice Stevens observed in his dissenting judgment in *Allen v Illinois*[26] such laws presage the development of a "shadow" criminal code that permits the state, after nabbing a perpetrator, to choose between punishment for a crime or incapacitation based on danger.[27] It is this feature that I wish to focus on with reference to the newly-articulated "preventive" model.

23 *Ibid.*

24 *See "Questions Rise over Imprisoning Sex Offenders Past their Terms" New York Times, 17 November, 2003.*

25 *Ibid.*

26 *478 US 364 (1986).*

27 *Ibid, 380. Cited in C Slobogin, " The Civilization of the Criminal Law" (2005) 58 Vand L Rev.121126(Hereafter "Civilization").*

Slobogin's 'preventive' model

In an article in the Vanderbilt Law Review,[28] Christopher Slobogin explores the jurisprudential and practical feasibility of what he has called a "preventive" regime of justice. The philosophical forebears of this new model are thinkers such as Barbara Wooton, Sheldon Glueck and Karl Menninger who, decades earlier, had envisioned a system that is triggered by an antisocial act, but pays no attention to desert or general deterrence. Slobogin notes that like the sexual predator regimes, the only goal of the system they proposed, was individual prevention through assessments of dangerousness and the provision of treatment designed to reduce it. It is this model that Slobogin now embraces as appropriate for the management of sexual predators. But unlike current sexual predator models, the regime envisioned would not involve a 'two-track' system of "punishment" and "commitment", but instead the intervention would take place immediately after the antisocial act, rather than at completion of the sentence[29].

In such a system, gradations of culpability are irrelevant at both the threshold of intervention and the dispositional stage, the theory being that freed from the "obsession" with punishment, courts would be at liberty to deal with lawbreakers in a manner best calculated to discourage future lawbreaking.[30]

According to Slobogin, the "preventive" model would neither slight human dignity nor undermine the general-deterrence and character-shaping goals of the criminal law. He argues, in addition, that such a regime would be much better at assimilating the proliferation of scientific findings that call into question humans' abilities to control their actions – the principal premise of a punishment system based on desert.[31]

The adoption and advocacy of this "preventive" model is a remarkable about face by a scholar who, on his own admission had, until very recently, rejected as "repugnant" the so-called "two-track" regime of criminal justice, exemplified in the sexual predator models.[32] His ability to now embrace the preventive model evidently proceeded from the premise that the dehumanisation objection attaching to the preventive model would not obtain if intervention based on dangerousness were the government's *only* liberty-depriving response to antisocial behaviour. In such circumstances, "invidious comparisons" with a second autonomous group worthy of blame simply cannot occur and the new system of liberty with dangerousness as the sole predicate for intervention becomes "constitutive" of the renewed criminal code. [33] In other words risk assessment is substituted for culpability determination as the paradigm mode of assigning accountability for antisocial behaviour.

Although he acknowledges the very controversial nature of these proposals Slobogin is committed to them as a significant step towards "civilizing" the criminal law.[34]

Risk management

The renewed focus of this model upon risk assessment and risk management, is in contrast to the punitive stance of the desert and deterrence - based approaches of the present criminal justice system. According to Slobogin, risk management aimed at dealing with individual substance abuse, mental disorder and antisocial behaviour patterns is more likely than a punishment model to prevent further crime amongst those offenders who perceive no risk of apprehension or have no thought about the likely punishments for their crimes[35]. Slobogin's optimism in improvements in prediction science occurring in the last

28 *"Civilization", supra.*
29 *Ibid, 127.*
30 *Ibid.*
31 *Ibid 130.*
32 *Ibid, 126.*
33 *Ibid, 127.*
34 *Ibid, 168.*
35 *Ibid, 142.*

22 years leads him to conclude that the vagaries in scientific investigation associated with the risk management approach are "trivial compared to the calibration chores that afflict a retributivist regime bent on ascertaining degrees of culpability, a deterrence-based system that purports to modulate the penalty based on cost-benefit analysis, or a virtue ethics scheme that tries to measure fault for character."[36]

By contrast, risk management, through focussing on highly individualized interventions, based on the need to deal with specific risk factors, is structured to achieve the precise aims of the prevention model.[37]Because, under a prevention regime, review is usually constitutionally mandated and risk constantly monitored, community dispositions may be both legally and pragmatically necessary; and where risk management is itself linked to new and emerging "experimentalist" courts like drug courts, according to this model, offers the prospect of modifying dispositions to maximize behaviour change, even in sexual predator programs.[38]

Whatever the perceived advantages of the "preventive" model may be, the principal objection to it as applied to sex offenders, is the risk of enduring indeterminate detention while public officials debate the risk calculus applicable to the individual offender. It is a model that exudes a profound uncertainty as to the conditions and length of detention, effectively disguising "the possibility of cruelty and injustice without end".[39]Further, as CS Lewis warns, such models of justice remove sentences from the hands of jurists, "whom the public conscience is entitled to criticise," and puts them into the hands of "technical experts" to whom the categories of "rights" and "justice" are irrelevant.[40] He continues:

> *" To be taken from my home and friends; to lose my liberty; to undergo all those assaults on my personality which modern psychotherapy knows how to deliver; to be re-made after some pattern of "normality" hatched in a Viennese laboratory to which I never professed allegiance; to know that this process will never end until either my captors have succeeded or I have grown wise enough to cheat them with apparent success – who care whether this is called Punishment or not? That it includes most of the elements for which any punishment is feared - shame, exile, bondage, and years eaten by the locust - is obvious. Only enormous ill-desert could justify it; but ill-desert is the very conception which the Humanitarian theory has thrown overboard."*

If we were to substitute "Preventive" for "Humanitarian" in the above quotation, it captures precisely the dilemma faced by sex offenders under current sexual predator laws. Yet however bad the behaviour which such legislation aims to address, the marginalisation of notions of guilt and responsibility implicit in such statutes is a matter of serious concern. In particular, any legislative model which allows for the detention of an unconvicted individual, ostensibly to eliminate the risk of future serious offending, runs a high risk of breaching fundamental human rights, for example the prohibition against unlawful detention or rights to liberty and security.[41] Nevertheless, it is precisely such models that are in contemplation as governments strategise to control the dangerous behaviours of sex offenders and other 'at risk' populations.

In the United Kingdom the approach of enacting new powers in civil and criminal proceedings for the indeterminate detention of unconvicted dangerous severe personality disordered individuals (DSPD) has

36 *Ibid, 147.*

37 *Ibid.*

38 *Ibid, 149.*

39 *CS Lewis, " The Humanitarian Theory of Punishment" 6 Res Judicata 224.*

40 *Ibid, 226.*

41 *See New Zealand Bill of Rights Act 1990, s 22 (Right not to be arbitrarily arrested or detained); European Convention on Human Rights, Article 5.*

been investigated in response to the activities of a small group individuals with personality disorders who are said to be responsible for a disproportionate amount of violent and sexual crime. [42] This legislative response has been termed "anticipatory containment".

Anticipatory containment

"Anticipatory containment" bears some similarities to the "preventive" model proposed by Slobogin, in that it would permit the detention of unconvicted persons on the basis of an assessment of risk alone, regardless of questions of culpability. Professor JK Mason has drawn attention to the dangers of anticipatory containment, in the context of evaluating what were the English proposals for a dangerous severe personality disorder order (DSPD order), which in theory could have been applied whether or not the individual had committed any offence.[43] The legislation would not have specifically targeted sex offenders, although such persons, provided they had a serious personality disorder, would have been eligible for containment under the proposed legislation. In effect the proposed legislation would have allowed the detention of an unconvicted person with a personality disorder if there was a significant risk of future serious offending. The legislation was not passed in its original form, despite the Government's claim that the DSPD proposals were fully compliant with the Human Rights Act 1998[44]. However the changes to the Mental Health Act 1983 proposed by the Mental Health Bill 2006 have borrowed from the DSPD 'model' by leaving the door open to the use of commitment powers for essentially untreatable persons with personality disorders[45] [46]. Undoubtedly, sexual psychopaths - the sorts of people who would have fallen within the 'sexual predator' net in the US and New Zealand's extended supervision regime – will become a focus of concern, and at risk of indeterminate detention for *being* sex offenders.

Professor Mason notes that the original proposal was driven by the government's determination to protect the public and would have permitted the detention of dangerous seriously personality disordered people for the whole time that they represented a serious public risk. To this extent the model is indistinguishable to that proposed by Slobogin.

A criticism of Professor Mason's is the fact that the government's DSPD proposals depended crucially upon evidence of dangerousness derived from members of a variety of disciplines who, in his view, may not have had the necessary expertise to make such assessments.[47] A more hard hitting critique of the proposals was offered by Prof Paul Mullen, who viewed them as a pretextual system for locking up men and women who frighten officials.[48] Significantly, he saw the proposals as, in effect, proposals for preventive detention, not far removed from the dangerous offender and sexual predator laws of North America.[49] Both writers agreed, however, that that there was something seemingly sinister in these proposals that took them far beyond being simply advocating mental health services for severely personality disordered individuals. As Professor Mullin rightly observes, they invoked a sense of foreboding.[50]

42 *A Feeney, " Dangerous severe personality disorder" (2003) 9 Advances in Psychiatric Treatment 349, 356.*

43 *See JK Mason, The Legal Aspects and Implications of Risk Assessment (2000) 8 Medical Law Review, 69, 81.*

44 *Feeney, supara, note 39, at 356.*

45 *P s Appelbaum, "Law & Psychiatry: Dangerous Severe Personality Disorders: England's Experiment in Using Psychiatry for Public Protection" (2005) 56 Psychiatric Services 397-399.*

46 *Although four DSPD units have been set up to provide assessment and treaatment for 'DSPD' individuals, the two hospital-based units function within existing mental health legislation. The other two are prison-based and thus 'outside' mental health legislation.*

47 *Ibid, 81.*

48 *P Mullen, "Dangerous People with Severe Personality Disorder" (1999) 319 Brit Med.J.1146.*

49 *Ibid.*

50 *Ibid.*

A dangerous synergy?

There is a common element in all these proposals that should be of the greatest concern to those who value human liberty and freedom. It is the fact that all the proposals discussed treat the human subjects of such state-sanctioned intervention *instrumentally*, as objects to be *made* to conform, rather than as persons to be *held* accountable, whether or not they *choose* to conform. A similar point is made by CS Lewis in his classic essay.[51] Lewis suggests that when we cease to consider what the criminal *deserves* and only consider what will *cure* him or *deter him* (essentially Slobogin's "preventive" model), we tacitly remove the person from the sphere of justice. "Instead of a person, a subject of rights, we now have a mere object, a patient, a 'case'.[52] The instrumentalism of many modern criminal justice models dictates that offenders are often viewed as observable phenomena capable of technical manipulation producing conformity, not people whose lives may be changed for the better by moral persuasion. Furthermore, the detention of individuals solely for public protection lacks reciprocity, in that the detainee has a right to some benefit in exchange for the loss of his/her freedom.[53]Accordingly, there is a risk that measures designed to reduce the risks to the public may actually alienate the target group, ultimately leading to increased risk.[54]

The problem with the new "preventive" or "anticipatory containment" models, whether or not they represent a "two track" or a unitary system, is that they abandon a justice-based approach in favour of a technocratic model, which has yet to prove its true worth. Furthermore, it is not clear that most people have made the ideological leap in their own thinking and values that would lead them to embrace this new wave of scientific special pleading, as scholars like Slobogin and others seems to think they ought. As Mason warns, the trend (at least in the UK) towards using high security hospitals as places of detention, backed by "the wave of popular and political sentiment that is as much antagonistic to those with personality disorder as it is in favour of public safety"[55], threatens to amplify the doctor's role of gaoler, at the expense of his private duty as therapist.[56] This is undoubtedly the case with the US sexual predator laws, and may well prove to be true of new generic legislation, such as New Zealand's Parole (Extended Supervision) Amendment Act. Insofar as all these models are based on assessments of dangerousness, we can expect that the role and powers of assessing 'experts' will be enhanced, and likely to be much more coercive, be they medically trained or not.

Appelbaum has noted that there is also a question of fairness.[57] He suggests that in contrast with persons who are transferred to new units from prisons, people who are committed from the mental health system may never have been convicted of a crime. Yet, on the basis of a prediction of "uncertain validity" about their future behaviour, they are at risk of indefinite detention without a strong prospect of therapeutic gain. "Psychiatry's collaboration with this process risks corrupting its treatment orientation and making the field subservient to the government's public safety agenda".[58]

51 *6 Res Judicata 224.*
52 *Ibid, 225.*
53 *Feeney, supra, at 356.*
54 *Ibid.*
55 *Mason, supra, 84.*
56 *Ibid.*
57 *Appelbaum, supra, note 43, at 399.*
58 *Ibid.*

A way forward – the "Inclusive" theory

Writing in *Criminal Punishment and Restorative Justice* (2006) David Cornwell has suggested a case for an "inclusive" theory of criminal justice, capable of accommodating all the justifications for punishment, but in a manner that has relevance for contemporary societies and the need to reduce crime within them.[59]According to Cornwell, an inclusive theory of punishment needs to provide a moral and operational reconciliation of the necessity that offenders are sanctioned for *committing* offences and maximise the likelihood that they will refrain from future offending.[60] However, it is impossible to reconcile with the "preventive" model considered here, which applies, as we have seen, to unconvicted persons. The preventive model also fails to reflect other criteria suggested by Cornwell favouring an inclusive theory, in that it cannot reflect the extent of the harm done (no harm has been done) and should not be manifestly excessive in pursuit of the secondary aim of crime reduction (it is clearly manifestly excessive because it punishes in the absence of any crime having been committed)[61]. Furthermore, the preventive model of criminal justice appears to completely disregard the requirements of the imperative of proportionality (restriction of the extent of punishment to the harm done) because it neither concedes that the preventively detained offender is being punished nor that there need be a 'harm' to which punishment must be related.

As Cornwell urges, if our concept of punishment is to be "universal" or "inclusive", it must be able to demonstrate a potential to deal with all offenders with equal clarity of purpose and with a morality that is beyond question.[62]Regrettably, both of these pillars of punishment are observed in the breach when preventive social control is in contemplation.

For these reasons I would suggest that sexual predator and extended supervision legislation represent a backward step in the development of enlightened penal policy. As a response to the demands of populist punitiveness, such legislative models are excessively focussed on the offender as a *potential* risk-bearer, while seemingly unconcerned about the requirement for objectively verifiable criminal conduct as a minimum condition of criminal culpability. To the extent that we permit such models to gain a foothold in penal practice, we stand in danger of severely compromising cherished ideals of criminal justice, while assigning the offending population to the uncertainties and vagaries of a forever changing stream of penal innovation and experimentation.

59 *Cornwell, supra, note 12, at 97.*
60 *Ibid, 98.*
61 *Ibid.*
62 *Ibid, 100.*

Casenotes

Two Steps Forward, One Step Back

Lucy Scott-Moncrieff[1]

In the matter of DE (an adult patient) …. and JE v (1) DE (by his litigation friend, the Official Solicitor) (2) Surrey County Council
[2006] EWHC Fam 3459 (Munby J)

Introduction

In October 2004, in the case of *HL v UK*[2], the European Court held that the provisions of the Mental Health Act that allowed incapacitated, compliant individuals to be detained in hospital informally were unlawful, in that there were no detention criteria, there was no formal detention process, and there was no right of access to a Court which could overturn the decision to detain. This was a terrific step forward in the quest to provide legal safeguards for vulnerable people informally detained in institutions. However the decision that HL was detained was based on the specific facts of his case, following the principle articulated in *Guzzardi v Italy*[3]:

> *"In order to determine whether someone has been 'deprived of his liberty' within the meaning of Article 5, the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question."*

As the facts of HL's case were quite unusual, those caring for people who might fall into the category of the informally detained, and those advising them, were not left with clear guidance to establish whether or not a particular set of circumstances amounted to detention. The consequences of the judgment are particularly problematic for those institutions that are not authorised to detain patients under the Mental Health Act, as, if they find that they are detaining any of their residents, they either have to seek authorisation from the High Court, or register to take detained patients or transfer them to establishments that are so registered. All these options would be expensive or disruptive or both, but nonetheless, the law being the law, one or other of these steps would need to be taken to remain on the right side of the law.

In December 2004 the Department of Health issued draft guidance[4] to NHS bodies and local authorities which would be purchasing or providing care for people likely to be affected by the HL decision. The guidance set out the ways in which those caring for such patients could try and ensure that anyone being

1 *Solicitor and partner at Scott-Moncrieff, Harbour and Sinclair (London)*
2 *(2004) 40 EHRR 761*
3 *(1980) 3 EHRR 333*
4 *Advice on the decision of the European Court of Human Rights in the case of HL v UK (The 'Bournewood' Case) [Gateway reference 4269] (Department of Health) (10/12/04)*

deprived of their liberty could have their care altered so that they were merely having restrictions placed on their liberty, which would not attract any ECHR requirements for legal safeguards or formal procedures. Curiously, although the guidance pointed out that detention under the MHA would not be available for all those who continued to need to be detained, it only obliquely mentioned the lawful solution to this problem, and appeared to suggest that detaining bodies should be parsimonious in their use of the MHA and perhaps should just sit tight, wait for amending legislation and hope not to get challenged. It is difficult not to get the impression that those drafting the guidance didn't really feel that the safeguards required by the ECtHR were truly necessary to protect vulnerable people.

At the time that the HL case was going through the domestic courts, the Department of Health estimated that some 48,000 people would be affected by the outcome.[5] One would have expected, therefore, that following the HL judgment there would have been a surge in the number of people being detained, particularly under s.3 of the MHA1983. Far from it. Official statistics[6] show that in 2003/04 there were 7,145 detentions under ss.2 or 3 following an informal admission, but in 2004/05, the last 5 months of which followed on from the HL v UK judgment, this figure had only gone up to 8,104, an increase of 959. Furthermore, the total of direct admissions from the community under ss2 and 3 went up from 21,885 in 2003/04 to 22,563 in 2004/05, an increase of 678. So even if all of the increases in both groups were as a result of hospitals assessing, and where appropriate detaining for treatment, informally detained patients, that still only accounts for 1,637 of the DoH's estimate of 48,000; and of course, in reality, some of the increase will have had nothing to do with Bournewood at all, but will be a result of the normal fluctuations in the detained patient population.

So where have all these people gone? One possibility is that a huge effort was made to ensure that nearly all the 48,000 had their care plans amended to ensure that they were no longer deprived of their liberty, and the few that were sectioned were those for whom there really was no alternative.

The other possibility, which seems more likely, is that the country's hospitals and care homes are still full of unlawfully detained, vulnerable and mentally incapacitated people, many of them in places with very limited official oversight. The case of *JE v DE and Surrey CC*[7] shines a bright light on a situation that is, aside from circumstantial details, probably only unusual because of the determination of the detained man's wife to challenge what was happening.

The Facts

DE was aged 76 at the time of the 2006 judgment. A major stroke in 2003 left him blind and with significant short-term memory impairment. He is disorientated and needs assistance with all the activities of daily living, including a guide when walking. Although he suffers from dementia he is able to express his wishes and feelings with some clarity and force, though expert evidence suggested that he has a psychological dependence on others which is greater than that arising from his physical disabilities, so there is room for debate as to just how genuinely independent his expressions of wish actually are. The available evidence strongly suggests that DE lacks the capacity to decide where he should live.

JE had married DE in June 2005. She had known him for many years and had taken him out of X home

5 *Quoted by Lord Goff in the House of Lords hearing – R v Bournewood Community and Health NHS Trust [1998] 3 All E.R. 289*

6 *In-patients formally detained in hospital under the Mental Health Act 1983 and other legislation, NHS trusts, Care Trusts, Primary Care Trusts and Independent Hospitals, England; 1995-96 to 2005-06 (Information Centre – part of the Government Statistical Service)*

7 *JE v DE (1) and Surrey CC(2) [2006] EWHC Admin 3459*

to live at her home in August 2004. He was placed by SCC again at the X home on 4 September 2005 following an incident earlier that day at the matrimonial home. JE, who has intermittent mental health problems of her own, felt that she could not care for DE and was not getting adequate help from social services. She placed him in a chair on the pavement in front of their house and called the police.

The following is an extract from SCC's case note dated 5 September 2005[8]:

> *"19-30hrs. PC Black rang to inform [JE] had put her husband out on the street. Following a report from a neighbour he attended home address to find [DE] who is 75 & blind, wandering down the road. [JE] told him she is not getting help from the Social Services & has thrown him out. This having happened about half an hour ago, & [DE] not having eaten all day. PC had taken him to PS for a meal. [JE] is refusing to open the door & he does not have keys. He is dressed only in pyjama bottoms & shirt with slippers. No-one locally available to take him in. Following discussion with Homecare RRT rang [JE]. She spoke almost incessantly & very critical of Social Services & [JE]'s family. She said she could no longer afford to keep him in Fags, food & pay his bills. Said [DE] should ring his family in Devon, for which she had 4 tel. no's and tell them to Fuck off out of his life for good & to unfreeze his money. She said this should happen at the police station, where it should be recorded. Said not prepared to have him home till that happened. She was very critical of services being provided & of some services not being provided at all. Referred to [DE] needing 24 hr care but she only got 2 hrs help a day during week & 1 hour at W/E's. Said carer had not brought shopping as requested yesterday & did not turn up today at all. Consequently neither of them had eaten today. Following further discussions with RRT to confirm attendance of [carer] tomorrow spoke again to [JE] but she was adamant she would not let her husband home till her demands met that he contact his family. Subsequently in liaison with police & [DE] emergency placement arranged for him at [the X home] & escorted there by police. Message left for daughter … but no reply."*

DE was placed by SCC initially at the X home and, since 14 November 2005, at the Y home. Throughout the time that DE was away from home he wanted to return, and his wife, JE wanted him back, and both had said so to anyone who would listen and many who would not. In the end JE went to court to get her husband home. The Official Solicitor represented DE's interests. The court considered whether in all the circumstances DE had been "deprived of his liberty", as "essentially a question of fact, to be considered in the light of all the circumstances and focussing upon the "concrete situation of the individual concerned" – here DE...."[9].

The Judgment

The judgment identifies considerable discrepancies between the contemporaneous record of what took place during DE's stay at the Y home, and what was asserted in court to have taken place, but the judge accepted that:

> *"... DE had within the X home, and has had and has within the Y home, a very substantial degree of freedom, just as he had and has a very substantial degree of contact with the outside world. And I can agree with Ms Morris that DE has never been subjected to the same invasive degree of control within the X home and the Y home, let alone the same complete and effective control within the two homes, to which HL ..was apparently subjected. For example, as she correctly points out, DE has never been subjected to either physical or chemical restraint within either institution."* (para114)

8 *Quoted in JE v DE(1) and Surrey CC(2), para 82*

9 *ibid, para 83*

However he went on to say:

> *" But the crucial question in this case, as it seems to me, is not so much whether (and, if so, to what extent) DE's freedom or liberty was or is curtailed within the institutional setting. The fundamental issue in this case, in my judgment, is whether DE was deprived of his liberty to leave the X home and whether DE has been and is deprived of his liberty to leave the Y home. And when I refer to leaving the X home and the Y home, I do not mean leaving for the purpose of some trip or outing approved by SCC or by those managing the institution; I mean leaving in the sense of removing himself permanently in order to live where and with whom he chooses, specifically removing himself to live at home with JE.*
>
> *After all, and this is the point made by Judge Loucaides in the passage in his dissenting opinion in HM v Switzerland (2002) 38 EHRR 314 which I set out in paragraph [44] above, prisoners detained in an open prison may be subject to virtually no physical restraint within the prison, may be allowed to have extensive social and other contact with the outside world and may even be allowed to leave the prison from time to time, yet they are indubitably "deprived of their liberty." And the reason why this is so is because, as Judge Loucaides put it, they "are not permitted to leave the place where they are detained and go anywhere they like and at any time they want." And, as Ashingdane v United Kingdom (1985) 7 EHRR 528 demonstrates, and as was recognised both by Judge Loucaides in his dissenting opinion in HM v Switzerland (2002) 38 EHRR 314 (see paragraph [44] above) and by the Strasbourg court in HL v United Kingdom (2004) 40 EHRR 761 at para [92] (see paragraph [57] above), exactly the same point can be made in relation to persons in mental and other similar institutions"*[10].

In passing, I find it interesting that the judge refers to the statement of principle in *Guzzardi v Italy*[11], and refers to the analogy of an open prison made by the dissenting judge in *HM v Switzerland*, but doesn't directly rely on the decision in *Guzzardi v Italy*.

Signor Guzzardei was a suspected mafiosi required to live within an area of about 2.5 sq km on an island just off the coast of Sardinia. Leaving aside the circumstantial details, there are many points of similarity between the accumulated restrictions placed on Signor Guzzardi and those that applied to DE.

Mr. Guzzardi was housed in part of the hamlet of Cala Reale which consisted mainly of the buildings of a former medical establishment, a carabinieri station, a school and a chapel. He lived there principally in the company of other persons subjected to the same measure and of policemen. The area around which he could move far exceeded the dimensions of a cell and was not bounded by any physical barrier, but there were few opportunities for social contacts other than with his near family, his fellow "residents" and the supervisory staff. Supervision was carried out strictly and on an almost constant basis. Thus, Mr. Guzzardi was not able to leave his dwelling between 10 p.m. and 7 a.m. without giving prior notification to the authorities in due time. He had to report to the authorities twice a day and inform them of the name and number of his correspondent whenever he wished to use the telephone. He needed the consent of the authorities for trips off the island which were rare and made under the strict supervision of the carabinieri. He was liable to punishment by "arrest" if he failed to comply with any of his obligations.

The Court in *Guzzardi v Italy*[12] stated that:

> *"…it is admittedly not possible to speak of "deprivation of liberty" on the strength of any one of these factors taken individually, but cumulatively and in combination they certainly raise an issue of categorisation from the viewpoint of Article 5 (art. 5). In certain respects the treatment complained of*

10 *ibid, paras 115 and 116*

11 *(1980) 3 EHRR 333*

12 *(1980) 3 EHRR 333*

> *resembles detention in an "open prison" or committal to a disciplinary unit.....The Court considers on balance that the present case is to be regarded as one involving deprivation of liberty...."*[13]

The 2006 hearing of *JE v DE* dealt only with the question of whether there had been a deprivation of liberty, and a further hearing will consider the lawfulness of that deprivation of liberty . One would hope that the Government would welcome the clarity that this judgment brings to the definition of deprivation of liberty, but, as it will undoubtedly throw out current calculations about the cost of implementing the Bournewood Gap proposals, I would not be enormously surprised if it intervenes to seek to have the decision overturned.

However it is the behaviour of Surrey County Council and the care home staff in this case that should be a real wake-up call to the Government that it would be rash to ignore.

The evidence that DE wanted to return home to be with his wife was overwhelming; the judgment quotes many examples of DE having made his wishes absolutely clear. The judgment also quotes from the records relating to DE, from which it is clear that the staff at Y home understood that they had both the right and the duty to prevent DE going home, and could restrict JE's access to him to ensure that she did not simply take him home. This position was communicated to JE, who was told, and understood, that if she attempted to take her husband home the police would be called.

However in her witness statement the manager of the Y home, Ms Soper, claimed that she was well aware that neither she nor the police could prevent JE from taking DE home, and that when she had referred to calling the police if JE sought to do so she meant that:

> *" the police would be called to inform them that a vulnerable adult was being removed from [the Y home]. I would not ask the police (and the police would not be able) to prevent [JE] from removing [DE] from [the Y home]."* (para101).

The judge commented:

> *"Mr Bowen submits tartly that these assertions belie the evidence, not least that filed by SCC itself. As he points out, some of the care notes kept by the Y home are actually signed by Ms Soper herself, including for example, as I have already mentioned, the very first note I referred to in paragraph [90] above: "[DE] continually requested to go home with [JE]. I have informed him he cannot leave, neither can [JE] take him home." In fact, during his cross-examination of her, Mr Bowen got Ms Soper to accept that she had told DE that he could not leave to return home with JE, just as she confirmed her understanding that DE was not free to go home with his wife."* (para 102).

And:

> *" In the light of this substantial and consistent volume of material it seems to me that DE quite plainly was not 'free to leave' the X home and has not been and is not 'free to leave' the Y home, with the consequence, in my judgment, that he has been and continues to be "deprived of his liberty" – a state of affairs that has continued since 4 September 2005 and is still continuing. The fact is that DE has repeatedly expressed his wish to be living at home with JE and has made it clear that he is in the Y home, as previously the X home, "against his will." It is suggested by SCC that he would not have been prevented from leaving had he actually tried to. That, in my judgment, simply will not wash. In the first place, the assertion simply does not accord with the historical reality as noted in contemporaneous records. Secondly, and in any event, as Ms Richards points out, this was never communicated to either*

13 *Guzzardi v Italy, para 95*

> *DE or JE. On the contrary, the 'message' consistently given to them was understood by them, and reasonably and unsurprisingly understood by them, as being to precisely the opposite effect: the Police would be called in order to foil any attempt to take DE back home.*
>
> *Ms Morris takes a number of points in her ultimately vain attempt to escape this conclusion. She suggests that DE's repeated statements of his wishes were, in significant measure, more the product of JE's urgings rather than of his own true wishes and feelings. Even if that were so, I do not see how it would affect the outcome, for even if DE had capacity (which is extremely doubtful) there could, in the light of what he was undoubtedly saying, be no sensible basis for any inference that he was consenting to his confinement. And in any event, Dr Jefferys expressed the view … that DE's stated wish to be with JE "appears to be deeply held and consistent." Secondly, she submits that SCC has no objection in principle to DE living elsewhere than at the Y home, for instance either with his daughter or in some other residential establishment. That may be, but it wholly fails to meet the charge that he is being "deprived of his liberty" by being prevented from returning to live where he wants and with those he chooses to live with, in other words at home and with JE. And that, after all, as Ms Morris herself has to concede, is the very thing that SCC "will not agree" … Thirdly, she submits that the Police would not in fact have had any power to prevent DE being removed, unless, for example there was a breach of the peace or some criminal offence being committed. This, I have to say, is little better than a piece of legal sophistry, and in large measure ex post facto legal sophistry at that. It is quite plain that SCC's purpose in repeatedly making it clear (both to the institutions and to JE) that the Police would and should be called was to prevent DE being removed and, as it was explained on 14 December 2005 …, to facilitate his being returned if he was in fact removed. That, as I have already said, was how JE reasonably and unsurprisingly understood what she was being told by SCC. These threats, whether or not they were as devoid of legal content as SCC would now have us believe, were intended to achieve and, as it seems to me, did achieve, the desired objective of preventing DE's removal first from the X home and then from the Y home. A person can be as effectively "deprived of his liberty" by the misuse or misrepresentation of even non-existent authority as by locked doors and physical barriers. In my judgement, none of Ms Morris's points has any substance."* (paras 124/5)

Surrey County Council knew from the outset that it would need specific authority to keep DE in residential accommodation. The minutes of an adult case protection conference on 28 September 2005 included advice from a member of the County Council's legal services:

> *"Common Law Doctrine of Necessity: This could be used to keep [DE] at [the X home] and would allow time to be taken to plan decisions but as time goes on a decision will need to be made of how specific authority is going to be obtained to make the placement...."*

An attempt to place DE under guardianship failed when JE refused to consent to this, and the County Council made no other attempt to regularise the position, until in the end JE issued proceedings just over 10 months after DE was admitted to residential care.

So it would seem that Surrey ignored its own legal advice that it needed to obtain authority to detain DE; kept DE in residential care by misleading DE into believing that he was not entitled to go home and JE into believing that it had the right to prevent her from taking DE home, and then brazenly attempted to argue in court that it had never attempted to mislead either JE or DE.

Comment

The long awaited legislation to deal with the HL judgment will amend the Mental Capacity Act 2005 to require care homes and hospitals to seek authority to detain incapacitated people who need to be detained and will require PCT's and local authorities to authorise such detentions, following a full assessment.[14] There will be no independent judicial assessment, for instance by the equivalent of the MHRT, unless a concerned person, such as JE makes an application to the Court of Protection. In effect those involved in the process will be trusted to administer it properly and will rarely be challenged, as people with the determination of JE, and with her willingness to challenge the authorities, are, understandably, thin on the ground.

JE put DE in the street because she couldn't look after him without help, and the help she received from the local authority was either absent or insufficient. Leaving aside the obvious fact that if help to the value of the cost of DE's residential care had been available, JE probably could have managed fine, it is also important to look at the way in which financial considerations are bound to distort "in principle" decisions about whether someone is being, or needs to be, detained.

It is intended that people in residential care will be means- tested, even if they are detained. This is, of course, obnoxious, as no other detained person has to pay for his or her detention in this country, and DE's case makes very clear the inextricable inter-relationship between the care part of the package and the detention part of it. Therefore there is bound to be a calculation as to whether it would be cheaper to detain someone if the equity in his/her house can then be brought into the means-testing calculation, rather than to offer them care in their own home. Once in the care home it may be financially attractive to care for them in conditions amounting to detention as a justification for higher charges (particularly as the Government has agreed to re-imburse the cost of the authorisation process). Even if the person's detention can be justified, it is possible that in independent homes he or she will be paying over the odds for the detention/care, as it is openly acknowledged that self-funders are often charged far more (often about £50–£100 but in some cases it can be as much as £200 per week)[15], than those funded by the local authority. One care home provider gave information to the Wanless Report detailing the difference between the local authority base line fees and what the home charged self funders in three southern authorities. The difference ranged between £133 per week and £219 per week. Anecdotally it is reported that some care providers are willing to confirm that this premium subsidises the cost of caring for state-funded residents. In their 2005 report 'Care Homes for Older People in the UK – a Market Study', the Office of Fair Trading reported that one in five homes were charging more than local authority funded residents for a similar package of care.

Unless guidance makes it clear that it would be unacceptable, someone moving to residential care from a period of s3 inpatient treatment may be detained under the MCA in preference to being cared for under s117 (which of course only applies when someone 'ceases to be detained'), because s117 aftercare is not means-tested.

An incapacitated person without relatives could have an employee of the local authority appointed as his or her deputy, and the same local authority may be the provider of the care home in which the person is detained and the body authorising detention. How many incapacitated people like DE will be detained

14 *See Clause 38 Mental Health Bill, 2006. See also 'Amending the Mental Capacity Act 2005 to provide for deprivation of liberty' by Robert Robinson in this issue of the JMHL*

15 *'Securing Good Social Care for Older People' Sir Derek Wanless (30 March 2006) (The King's Fund)*

against their will and have their homes sold from under them when the MCA kicks in? It seems likely that it is happening in an unofficial way already (why should public bodies that are willing to ignore the law on detention be too fussy about funding?) and the the MCA, once the Bournewood provisions come in, will make it even easier to subsume the interests of the vulnerable individual to the interests of the public body.

Of course many, probably most, providers of care, PCTs and local authorities will do their best to comply with the law as they understand it, but this case illustrates the risks of trusting public bodies to act scrupulously - the law reports are littered with many other examples. Furthermore, even those that follow the law to the letter will be dependent on the statutory assessments which will made by health and social work professionals, as to whether the individual is detained and whether the detention is necessary. Mr Justice Munby's judgment in this case is enormously helpful, but nonetheless there remain many areas of opacity and it will be up to individual professionals to interpret the guidance as best they can. The fact that they are not legally qualified isn't particularly a problem (after all it is not as if the lawyers, as a profession, have displayed any great evidence of understanding the principles), but it is a problem that there will be so many assessors, and that generally their decisions will not be subject to the routine judicial scrutiny that leads, over time, to consistency in decision-making.

The case of Mr and Mrs E displays the problems in the proposed legislation in all their grisly inadequacy. Luckily, the provisions are not due to be implemented until April 2008 (at the earliest), so it is not too late for the government to bring in proper safeguards.

Automatic tribunals are probably not necessary, but the alternative must be a robust advocacy system, not only for the unbefriended, but for all incapacitated people in residential or hospital care, so that it is not left to relatives to have to identify between: those who are informally detained who shouldn't be detained; those who are informally detained who should be detained under the MCA or MHA: those who are detained under the MCA and should be under the MHA; those who are detained under the MCA and shouldn't be detained at all; those who are detained in residential care who should be receiving services at home; and those who are correctly detained under the MCA. Without such independent, professional, scrutiny, the new law will inevitably lead to scandals of wrongful detention and financial abuse being added to the scandals of abuse in care abuse such as those identified in Cornwall[16] and Sutton and Merton.[17] Contrariwise, a robust system of personal advocacy will not only reduce the risk of people being wrongly detained and overcharged, but will also reduce abuse in residential care across the board, which is surely what all of this, including the ECHR, is ultimately intended to ensure.

16 *'Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust', Commission for Social Care Inspection and Healthcare Commission (July 2006)*

17 *'Investigation into the service for people with learning disabilities provided by Sutton and Merton PCT' Healthcare Commission (January 2007)*

'Sunlight [as] the best of disinfectants'?[1]

John Anderson[2]

Mersey Care NHS Trust v Ackroyd
Court of Appeal; Sir Anthony Clarke MR, Lord Neuberger of Abbotsbury and Leveson LJ
[2007] EWCA Civ 101 ('Ackroyd')

Introduction

The report opens with the sentence, '[t]his is a most unusual case.' It is the submission of this writer that only this circumstance can justify the result. The result is itself in any event doubtful.

The Facts

B is a patient of Ashworth Hospital, a hospital for those detained under the Mental Health Act 1983 and who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities.

A is an investigative journalist. In 1999, A was passed some of B's medical records by a source whose identity A wished to keep secret. Some of this material - which related to complaints by B of mistreatment during a ward move and the Hospital's response to a hunger strike undertaken by B in protest - was later published by the Mirror ('MGN'). The Hospital sued MGN, seeking an order that MGN reveal the source of the material. After much litigation culminating in a visit to the House of Lords[3] in June 2002, MGN was ordered to identify its source. It did so, naming A. As A was not the source of the 'leak' from the Hospital, but the person to whom the leak had been made, this advanced the Hospital's desire to identify the source of the leak no further. The Hospital then sued A, seeking an order that A, in turn, reveal his source.

After an initial success on a summary application (in the light of the outcome of the case against MGN) overturned on appeal[4], the Hospital failed, both before Tugendhat J at first instance[5] in 2006 and on appeal in 2007.

Two Questions

The first question will be, *why did the Hospital fail?*

The second question will be, *should the Hospital have failed?*

However, it is first necessary to set out the relevant legal context of the claim for disclosure and the relevant findings of fact.

1 *To borrow from and adapt Judge Louis Brandeis of the United States Supreme Court writing extra-judicially in 'Other People's Money and How the Bankers Use It' (1933), cited, albeit in Lord Bingham's reformulation from R v Shayler [2003] 1 AC 247 in Ackroyd at para. 31. All paragraph references are, unless otherwise stated, references to the judgement of the Court of Appeal in Ackroyd.*

2 *Solicitor, Eversheds (Newcastle upon Tyne)*

3 *The Court of Appeal decision is reported at [2002] 1 WLR 515 and that of the House of Lords ([2002] UKHL 29) at [2002] 1 WLR 2033 each as Ashworth Hospital Authority v MGN Ltd ('Ashworth')*

4 *'Ackroyd' [2003] EWCA Civ 663*

5 *'Ackroyd' [2006] EWHC 107 (QB)*

The Legal Context

There was never any doubt as a matter of domestic law that A could be ordered to disclose his source, as had MGN been, if wrongdoing – the threshold requirement for the disclosure sought – on the part of the unnamed source was found[6].

This the trial judge did find, as it might readily be inferred that whoever had disclosed the records, whether or not employed by the Hospital, had been in possession of those records only subject to obligations of confidentiality owed to both B and the Hospital, obligations necessarily breached by the disclosure without the consent of each.

Whatever had been B's attitude to the disclosure at different times, the Hospital had never consented to that disclosure. Furthermore, the source, whoever he was, was found not to have had any public interest defence or justification for the disclosure.

That the information might be said to be of interest to the readers of the Mirror did not mean that it was in the public interest to disclose it. It did not relate to serious misconduct or otherwise to a matter disclosure of which was important to safeguard public welfare or anything of comparable importance.

Nor were there identified any material differences between that purely domestic legislation[7] that had governed the initial stages of 'Ashworth' and the Human Rights Act 1998, which had come into force in 2000 (by which the European Convention on Human Rights[8] had been incorporated into domestic law) and which governed the proceedings (the balance of 'Ashworth' and the whole of 'Ackroyd') thereafter.

So, the Hospital succeeded in establishing (i) that there had been wrongdoing in the form of a breach of confidence (ii) that could not be justified by the anonymous source on public interest grounds.

Yet it still did not obtain an order against A in the second set of proceedings that he disclose his source.

Comment

Why did the Hospital fail?

A claimed that his Article 10 rights would be infringed if he were ordered to disclose his source.

Article 10 provides that everyone has the right to freedom of expression[9] (including the freedom to receive and impart information without interference by public authority), a freedom which can be made subject to such restrictions only as are prescribed by law and are necessary in a democratic society for, amongst other things, preventing the disclosure of confidential information.

The ability of a journalist to maintain the anonymity of his sources is accepted to be a manifestation of this right, in which the public has a vital interest.

As a general proposition, case law[10] has now established, to use the present formulation, (a) that the necessity for any restriction on the freedom of expression must be convincingly established as 'a pressing social need'[11] and (b) that the imposition of the restriction – for which sufficient and relevant reasons

6 *In this respect, the case was merely an example of the jurisdiction conferred upon the Court by Norwich Pharmacal Co v Customs & Excise Commissioners [1974] AC 133.*

7 *Contempt of Court Act 1981*

8 *References to 'Articles' are to the Articles of the Convention.*

9 *Usually wrongly called 'the right of free speech'.*

10 *cf X Ltd v Morgan-Grampian (Publishers) Ltd [1991] 1 AC 1 under the Contempt of Court Act 1981 with 'Ashworth' itself for cases after the coming into force of the Human Rights Act 1998.*

11 *A phrase seemingly owing its provenance in the domestic law context to the judgement of Laws LJ in 'Ashworth'.*

must be advanced – should be proportionate to the legitimate aim being pursued, which here would be the preservation of confidence.

In both 'Ashworth' and 'Ackroyd', it was established that the protection of the confidentiality of patient records was a legitimate aim of the Hospital, in principle fulfilling a pressing social need and both necessary and proportionate.

In the former case the Hospital succeeded but in the latter case it failed.

Essentially, this was because when at first instance in 'Ackroyd' the balancing exercise came to be made between (i) A's freedom of expression and (ii) the Hospital's domestic law and Article 8 right to privacy, matters looked different to the Court than they had on appeal in 'Ashworth'.

On appeal in 'Ackroyd', the Court was unwilling to interfere with the outcome of the balancing exercise between different factors on a question of law 'heavily fact-dependant and value-laden'[12] that had been reached at first instance.

It was no longer believed, as had been the case in 'Ashworth', that the source had been paid for the information that had been disclosed. That was something as to which A, whose evidence was necessarily not available in 'Ashworth', could give evidence, which the Hospital did not challenge. This was felt to make the risk of repetition somewhat less.

The passage of time alone was also thought to argue against disclosure. Staff turnover at the Hospital since the date of the disclosure meant both (a) that the chances of identifying the source as a current employee who might be disciplined or dismissed had reduced and (b) that what was described as the 'cloud of suspicion' hanging over all of the Hospital's employees as result of the source not having been identified, had largely dissipated, principally by that passage of time.

The risk of further disclosure was also felt to be substantially less because of changes to working practices and procedures that had been introduced since the original leak.

Further factors that weighed in the balance included that the Hospital in particular, as well as other institutions of its nature in general, had a bad record when it came to scandals disclosed by earlier journalistic reports of wrongdoing based on leaks and that A has a good record of serious and responsible investigative journalism.

Again, the nature of the information leaked, was not felt to be highly sensitive - it did not, for example, disclose details of the medical treatment to which B was subject other than the lawful and publicly acknowledged force-feeding regime imposed on B by the Hospital. In 'Ackroyd' the Court knew more about what had actually been disclosed than did the court in 'Ashworth'.

All in all, therefore, Tugendhat J felt that the Hospital had not convincingly established a present pressing social need for disclosure. Such an order would not be proportionate in the pursuit of the Hospital's legitimate aim to seek redress against the source in respect of disclosure of confidential information of the sort disclosed when balanced against the vital public interest in the protection of a journalist's source[13].

The Court of Appeal *was* concerned, however, by the consideration that both the Hospital and all the judges who had considered 'Ashworth' had been labouring under the false apprehension that an order for disclosure would reveal the name of the source.

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12 Para 35.

13 Endorsed by the Court of Appeal as a conclusion to which the judge had been entitled to come at para 85.

MGN had of course all along known that it would not and that all it would disclose would be the name of A, who would have and could assert (as he did) his own Article 10 rights.

The Court of Appeal could see that had that fact been known, no appeal would have been allowed from the first instance disclosure order in 'Ashworth' and that the trial and appeal in 'Ackroyd' would not then have been delayed by 5 years.

This is a significant point, as the fact of delay caused factors to enter the scales against the Hospital that would not otherwise have weighed against it. It is of course not possible to say that the result would have been different but for the delay but that delay, which was not the consequence of anything for which the party suffering the wrongdoing was responsible, counted against it.

That this should be so seems wrong, although the likelihood of repetition is discounted by the Court's suggestion[14] that in future a failure by an editor to confirm that his source is not a journalist with Article 10 rights should result in an application for summary judgement against the editor for disclosure of the journalist's name by the person seeking to uphold the confidence.

Of course, should the editor confirm his source as a journalist, a summary disposal of the application against the editor is also likely.

Should the Hospital have failed?

It has been said[15] (1) that neither Article 8 (privacy) nor Article 10 (freedom of expression) has priority over the other; (2) that when they are in conflict, an 'intense focus' on the comparative importance of the specific rights being claimed in the individual case is necessary; (3) that the justifications for interfering with, or restricting, each must be taken into account; and (4) that the test of proportionality must be applied to each right – collectively, this is called the 'ultimate balancing test'.

It is at least highly arguable that applying this ultimate balancing test should have resulted in a different outcome in 'Ackroyd'.

It is hard to imagine information that should enjoy a higher degree of confidentiality than medical and other hospital records relating to the treatment of patients like B.

The maintenance of full records, while critical to all proper medical practice, is surely more vital still where they will contain a range of material covering the whole treatment and therapeutic regime to which such a patient may be subject.

Those records may very well contain material consisting of opinions and observations falling outside the range of medication applied and symptoms, strictly defined, observed.

They may extend to observations of patient mood changes, word repetition and other behaviourial patterns, the changing dynamics of interaction between patient and staff and indeed other patients, all of which may be critical to treatment and other decisions directly impacting upon safety, for patient and third party alike.

Any development in the law which, however indirectly, discourages frankness and full recording in such records is to be deplored. Nothing is more likely to lead to the next 'scandal' of harm caused because 'the signs were missed' because they were not recorded or their significance not understood by those who discharge the obligation of care uninformed by comprehensive past experience of this particular patient.

A hospital does not have a collective consciousness.

14 At para 90.

15 per Lord Steyn in In re S (A Child) (Identification: Restrictions on Publication) [2005] 1 AC 593 (cited at para 29)

Much was said in the case about the 'chilling effect' on journalism should sources be named. What about the potential effect of a failure to maintain full records to the potential prejudice of the safety of patient and staff alike because the risk of disclosure causes staff to self-edit what they record? One can imagine the headlines in the Mirror now.

Set against this vital public Article 8 and domestic law interest, can one really say that A's Article 10 right was comparably more important? Applied to the facts, the answer is, in my submission, plainly not.

One of the reasons for not ordering disclosure was that part of what had been disclosed was about the non-medical aspects of a move between wards during which B alleged, it was found not without foundation, that he had suffered mistreatment.

Granted that such mistreatment is of itself capable of being a matter of legitimate public interest about which there can and should be free discussion, there never was any question of that matter being in any way suppressed, either in terms of B's remedy (he instructed solicitors to sue the Hospital) or about the allegations about mistreatment becoming public. B was always free to make the allegations of mistreatment directly by letters to the press and through intermediaries, which he did.

Where is the critical interest here then, in the public learning through disclosure of what is confidential about a matter (the alleged mistreatment) in which there is legitimate concern but of which, but for which disclosure, they would not know? There is clearly no such matter, as the matter was public knowledge and no attempt had been made to suppress it.

By contrast, the other aspects of what was disclosed consisted of edited extracts of a 'diary' maintained, amongst other things, to record B's reaction to the regime of force-feeding to which he was subject against his will, a regime that can hardly be described as secret, as its lawfulness is the subject of a reported legal decision[16].

This material is of precisely that sort that may be critical to maintaining a doctor/patient relationship and a safe system of work for patients and staff alike and no focus, intense or otherwise, on the respective importance of the conflicting rights of confidentiality and freedom of expression, with proportionality applied to the potential restriction of each right, seems to the writer to lead to a conclusion that the source should not be named. The 'pressing social need' is that he should be named.

This result would seem perfectly just, as far as the source is concerned. The source was found to have been in breach of an obligation of confidence, however derived, and to have had no legitimate public interest defence to have made the disclosure.

The protection conferred by the decision on the wrongdoer by the side wind of protecting the public's right to know by one means (breach of confidentiality) partly that (the alleged mistreatment in the ward transfer) which it would come to know anyway through another means (B's right to make free complaint) and partly that (the 'diary') in which it has no legitimate interest outweighing the need for confidentiality, seems hard to justify.

Conclusion

There is very little to be said for a result which, even with all of the various statutory and other safeguards of the rights of patients such as B, tends to the encouragement of the leaking of medical records, a fortiori where the records in question will necessarily, or ought to, cover matters of a kind not merely pharmaceutical.

It is that within the material that excites curiosity and prurience that justifies its confidentiality.

16 *R(Brady) v Ashworth Hospital Authority [2000] Lloyd's Med R 355.*

Book Reviews

Mental Disability and the European Convention on Human Rights by Peter Bartlett, Oliver Lewis and Oliver Thorold

Published by Martinus Nijhoff (2006) €130

This book examines in depth the way the European Convention on Human Rights has been used to protect and enhance the rights of individuals who suffer from mental disability, whether from mental illness, intellectual or mental impairment, brain injury or personality disorder. Mental disability has now become a major issue for the member states of the Convention as disability discrimination legislation and public awareness have brought disability issues into the mainstream of society. It has been estimated that one in four people will suffer some form of mental disability during their lifetimes, which may or may not result in a degree of mental incapacity. The consequences of this are not only the personal suffering experienced by the individual and their families and friends but also adverse legal consequences, including potential loss of liberty, compulsory treatment and loss of legal status.

The authors set out extensively the case law which has evolved from the Convention as it applies to mental disability and go on to suggest ways in which the Convention can be developed in the future. They argue that the Convention has been used in ways which the draftsmen probably never originally envisaged and point out that the only express mention of mental disability is contained in Article 5(1)(e), the right to liberty. They argue that the European Court has been unduly conservative in the way it has developed the law, despite acknowledging that the Convention is a "living tree". Since the landmark judgment in *Winterwerp v the Netherlands* in 1979, the case law of the European Court has not been as fertile and prodigious as would have been hoped. The authors suggest that this is not a reflection of the fact that the rights of the disabled are being well protected by member states but rather that this illustrates the difficulties faced by a vulnerable section of society in challenging laws and conditions which at best are paternalistic and at worse abusive.

The authors deal with each of the substantive rights guaranteed by the Convention, starting with the right to liberty enshrined by Article 5. This is the area which has attracted most cases. The meaning of detention and deprivation of liberty is discussed in detail together with the exceptions set out in the Article. In particular, for there to be lawful detention of a person "of unsound mind", the detention must have some kind of therapeutic benefit and there needs to be a process of periodic review to reflect the recovery of the patient.

The next chapter is devoted to institutional standards and controls. Three broad categories are identified. Firstly, poor physical standards such as overcrowding, insufficient heating, as well as personal issues such as failure to accommodate religious or other sensitivities, can give rise to legal challenge. Secondly, detention policies can be over-controlling, for example the use of seclusion or segregation. Finally, the right to a private life will be affected to some degree.

Medical treatment and the issues of consent and incapacity are dealt with. The clear overlap between inhuman and degrading treatment under Article 3 and the right to autonomy under Article 8 has been examined by the European Court a number of times. The court has, however, not ruled as unlawful the compulsory treatment of a detained mental patient with capacity. It is suggested that this is an area where the Court could push the boundaries, particularly in the light of what the authors call the "soft law" of United Nations conventions and European Council recommendations. This body of international instruments is increasingly being used to argue that people with capacity should no longer be forced to undergo such treatment without their consent.

The right to life under Article 2 carries with it the duty to prevent death and the authors examine the cases relating to suicide and deaths in institutions. Although not expressed in Article 2, the European Court has established that procedural obligations are required in order to make real the substantive obligation to prevent death. So, for example, the State must provide some form of effective official investigation when individuals have been killed as a result of the use of force and State agents must be held accountable. Legal aid should also be made available to relatives who would otherwise not be able to prosecute their claims. Because of the particularly vulnerable nature of a person with mental disabilities, such procedures need to be rigorously enforced.

A large part of the book is devoted to impaired decision-making. The authors argue that since legal capacity can fluctuate and that capacity depends on the factual matter of the decision to be made, the "one size fits all" approach adopted by some States can no longer be tolerated. However, in order for an individual to be allowed to enjoy his or her rights under Article 8, the authors argue that the State has a positive obligation to protect those rights. The State must therefore provide a mechanism for tailored guardianship, adequate supervision of a guardian by a court of protection and access by the individual to a court for review of a guardianship or similar order. Without this assistance, the right for a disabled individual to manage his or her own affairs remains illusory.

Having focussed on the classic Convention rights, the authors discuss the fundamental "right" of every person to be a full member of society. Disabled people have to overcome significant barriers to integration. Discrimination is still a major issue and more use could be made of Article 14. The authors bring together the jurisprudence of the European Court to suggest how the Convention can be used in a dynamic way to bring about change in the way society views disabled people. While acknowledging resource implications, they suggest that there should be a basic right to live in the community and that the State should put into place the facilities to do this such as the provision of social housing or community treatment. Likewise, positive obligations could be imposed on the State to ensure that disabled people can access education, manage their property affairs, marry and have children, vote, form associations and have the right to engage in rewarding work. In all these areas much needs to be done. The raw material of the Convention is there but the question is whether the European Court is willing to expand its remit to take into account the new generation of human rights.

The final chapters of the book explain the procedure at the European Court and highlight the crucial need for proper legal representation, which is essential if disabled people are able to enjoy their Convention rights. The authors conclude by saying that for too long people with disabilities, and people with mental health problems and intellectual disabilities in particular, have been left at the margins of the human rights debate. The Convention offers the possibility to redress this. Some change has started but there is a long way to go.

This book is well written and very readable. It is clearly aimed at those committed to campaigning for

disability rights and lawyers representing the mentally disabled. Not only does it provide a comprehensive overview of Convention law as it currently stands but it imaginatively suggests future developments which the European Court could pursue. Case citations are full and accurate and there are helpful appendices setting out the core materials. These include the Convention itself, the key Protocols, the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the Recommendation of the Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder, and the Recommendation of the Committee of Ministers to Member States Concerning the Legal Protection of Incapable Adults. There is also a list of available internet resources and a final appendix gives some useful practical advice for lawyers representing people with mental disabilities.

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The Approved Social Worker's Guide to Mental Health Law by Robert Brown

Published by Learning Matters (2006) £20

Approved social workers are something of an endangered species. We all know that their unique role will shortly be subsumed into that of the "approved mental health professional" (AMHP). However, for a number of years the juggernaut of mental health policy has been moving inexorably in the direction of 'joined-up working', which in practice translates into a takeover of mental health social services by the priorities of the NHS. Social workers increasingly feel that their skills in assessment and careful case management are becoming undervalued in favour of medication and 'quick-fix' CBT. For those of us who care about the 'social model' of mental health care it matters that the expertise and individual accountability that ASWs have developed over the last 24 years should be valued and encouraged.[1]

The central function of an ASW is, of course, the thankless task of assessing individuals for possible detention under the Mental Health Act 1983. It is vitally important that they know what they are doing: both what the law requires and how to carry out effectively their duties under the law. This is something that Rob Brown has been teaching for years: he is currently the Director of the ASWs Course in South West England, and before that he was a practising ASW in Hampshire. (Before that he was a Mental Welfare Officer – if you have been around for long enough to know what those were – so he has a lot of experience to call on.)

The present book, which was completed in January 2006 and published in May 2006, is a distillation of Brown's expert knowledge. It is designed to support trainee ASWs but, as he says in his preface, "it should also be useful for practising ASWs, other mental health professionals, service users, carers and others interested in the field of mental health law." The book is a not-very-daunting 165 pages long and is written in approachable language. (I found some of the diagrams baffling, but this may be a fault in me.)

So how has the book turned out? First, I am relieved to report that Brown's statement of the relevant law is, so far as I can see, both thorough and accurate. It covers the most-used parts of the Mental Health Act in detail. On the odd occasion where I have thought "Is that really right?" I have checked in the Act and found that it was. Take the example of a patient who is not resident in the UK: Brown surprised me by asserting that he or she could have a nearest relative who was similarly non-resident. I had not interpreted section 26(5)(a) in this way before, but when I checked the 1983 Memorandum I found that he was absolutely right: the legislators had deliberately changed the wording of the 1959 Act to achieve this very result.

Similarly, Brown's summary of recent case law is both correct and appropriate for a practising ASW. Take *Ward v Commissioner of Police [2005] UKHL 32*, which considered whether a s.135 warrant specifying a particular ASW and medical practitioners was lawful. Baroness Hale gave careful reasons why the magistrates did not have such a power: Brown simply says (p.22): "… magistrates may not apply additional requirements, e.g. naming the ASW, doctor or police officer who would then have to attend." This seems to me to say all that an ASW needs to know about their Lordships' decision.

1 *For further discussion, see 'The Mental Health Bill 2006 – a social work perspective' by Roger Hargreaves in this issue of the JMHL*

Some cases are not described as fully as I would have liked. He gives, for example, a very cursory run-down of the recent run of 'medical necessity' cases, particularly *R (application of DR) v Mersey Care NHS Trust [2002]EWHC 1810 Admin,* with its troubling elision of the difference between treatment 'in' and 'at' a hospital. But of course ASWs do not need to know the details of such cases, which concern activity within hospitals; it is more important that the cases which affect their own professional role are reported accurately, and as far as I can see they are.

I should mention some small but annoying legal inaccuracies. For example, there is not one 'European court' (preface), the Lord Chancellor's Department' (page 96) no longer exists, the Divisional Court (page 100) was abolished in 1999 along with the term 'mandamus' (page 115), and the chapter on 'Other relevant legislation' needs to be amended in several places. I would urge the publishers to have the next edition checked by an experienced lawyer. But these are minor points, and really very few faults can be found with Brown's description of the law.

However, I have three serious problems with the book. First, I find its scope confusing. It is entitled "The approved social worker's guide to mental health law", but it also contains lengthy discussions on non-binding guidance (e.g. assessments under the CPA), aspects of good practice such as report-writing, and a digest of various models of mental disorder. These may well be useful things to bring together but they are hardly 'the law'. Perhaps the title could be reconsidered before the next edition.

The second issue was partly, but not completely, beyond Brown's control: he finished his work in January 2006, and therefore gave much space to the draft Mental Health Bill 2004. As we know, the draft Bill was pulled in March 2006, and by the time the book was published in July we knew the Government's plans for amending the 1983 Act which are, at the time of writing, before Parliament. So the book was out of date by the time it was published, which was very bad luck.

However, other recent changes to the law which were available to him, have not been dealt with adequately. For example, in his preface Brown states that he covers the Mental Capacity Act 2005, which was on the statute book well before he finished writing. But the chapter on 'Consent to treatment and mental capacity' needs a complete overhaul. First he sets out what the MHA Code of Practice has to say about capacity without any reference to the 2005 Act. He then spends over a page on the 1991 Law Commission consultation, concluding: "It is not always clear in law when decisions may be taken on behalf of a person who is mentally incapacitated", as if the test in the MCA did not exist. On page 90 he says: "There is a variety of current legislation which is relevant to these issues (i.e. of incapacity) but, as noted above, it is fragmented, complex, and in many respects out of date." That was indeed the case *before* the MCA was passed- but afterwards? It is true that the 2005 Act was still some way from being implemented when the book went to press, but its principles were already in use.

It appears that the bulk of this chapter was written long before the MCA went through Parliament, and the main provisions of the Act were tacked on to the end rather than being integrated into it. A sentence on page 96 gives the game away: "All this will change *if* the Mental Capacity Bill becomes law" (my italics).

A similar problem arises with Brown's treatment of the important ASW case of *R (on the application of E) v Bristol CC [2005] EWHC 74 (Admin)*, which concerns how to interpret the 'practicability' of consulting the nearest relative in the light of Article 8 ECHR. Brown says (p.50): "… in the meantime the High Court has been supportive of Jones' view on 'practicability' … ASWs may need to seek further advice on specific cases", but makes no reference to the Department of Health briefing on how ASWs should proceed in the light of the case. This may be forgivable; but then on pages 61-62 Brown quotes

extensively from the Mental Health Act Code of Practice, including the guidance on the meaning of 'practicability' (para 2.16) which was expressly disapproved by the judge in the Bristol case, and comments "See Chapter 3 on relatives to see how this *might not be seen as* a correct view" (my italics).

All of which leads to my main criticism of this book, which is that it shows no signs of having been edited. I don't mean that it has not been proof-read; on the contrary, the text is pretty free from mistakes (apart from an unfortunate error in the preface in the address of Mark Walton's website). What it lacks is an attempt to pull the material into a coherent shape.

The result is a bit of a hotch-potch. To give a couple of examples: Why do sections 2 & 3, which are used to detain some 26,000 patients each year, together justify only 4½ pages, while guardianship (966 cases a year) gets 3½ pages and supervised discharge (some 600 cases) a remarkable 5½ pages, when it isn't even an ASW section? Why is section 117, which affects many thousands of people, considered to be worth less than one page? On a different tack, the chapter entitled 'Mental Health Review Tribunals, Hospital Managers Reviews' spends four pages on the law, then gives six pages of guidance on the writing of social circumstances reports for a variety of purposes, including proceedings which have nothing to do with MHRTs or managers.

Writing a book, particularly a technical book such as this one, is immensely time-consuming. I can't help coming to the conclusion that Brown started by putting together various materials he had written for previous lectures and articles - which is an entirely legitimate thing to do - but then was unable to spare the time to edit them together into a consistent text. This would not perhaps matter in itself, but unfortunately the publishers clearly did not spend time on the editing process either. As a result, the clarity of Brown's exposition of the law is let down by the disjointed way in which it has been presented.

It is a commonplace to describe something as 'nearly a good book', but this is truly the case here. At the moment I would recommend that it should be used with some caution. However, it has the great advantage that it will need to be revised very soon anyway, because of the forthcoming changes in the law. If the publishers can find an editor to edit it, and a lawyer to check it, I am confident that the second edition[2] will be a real asset to trainee ASWs (and eventually AMHPs) as they struggle to get to grips with their difficult role. I hope that next time it will do justice to Rob Brown's erudition, experience and commitment to helping them on their way.

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2 *Publication date – 1 October 2007.*