ISSN 1466-2817

Journal of Mental Health Law

Articles and Comment

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The Case for "Good" Legal Representation – Is it worth fighting for?

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This strange republic of the good – Community treatment orders and their conditions

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S.117 MHA 1983 re-visited: the liability of the State and the existence of a duty of care

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Book Review

Monitoring the use of the Mental Health Act in 2009/10

Spring 2011 Edition 21 pages 1–124

Journal of Mental Health Law

Spring 2011 Edition No. 21. Pages 1–124

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Potential contributors should note that this is the final issue of the Journal of Mental Health Law to be published by Northumbria Law Press. Therefore no material intended for publication should be sent to Northumbria Law Press or John Horne, Editor.

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Foreword

The gestation period of this issue of the Journal has been the longest in its 12 year history, and for that, as Editor, obviously I must – and do – take responsibility and apologise.

Regular readers will be all too aware that regrettably in recent years, I have struggled to maintain the twice yearly publication to which we have been committed. There have been a number of reasons for this, not least an insufficient quantity of publishable material. It being a refereed journal, I have been determined to maintain the Journal's high standards, even though too frequently that has meant a delay in publication. In May 2010 I was delighted to co-edit with Professor Genevra Richardson what we called a Special Issue, entitled '*A model law fusing incapacity and mental health legislation – is it viable?; is it advisable?*'. No issue has been published since then. This is clearly unacceptable, and, as subscribers know, both I and Northumbria Law Press, the publishers, have therefore decided to call it a day. Sadly this is the last issue of the JMHL in its present format. Since the announcement of the Journal's demise, a number of individuals have expressed the hope that a similar publication will emerge in due course. Members of the Editorial Board and I share that wish, and we are committed to doing what we can to seeing it come to fruition.

But what of this issue? The Contents page speaks for itself. As usual, the contributions cover a wide range of issues of interest and relevance to all those with an interest in, and knowledge of, mental health law and mental capacity law. We start off by subjecting to scrutiny certain features of practice and procedure within the *First-tier Tribunal (Mental Health)*. This is followed by an interesting exploration of *indefinite and preventive detention* permitted by both mental health law and criminal law. *Community Treatment Orders* and the *Nearest Relative* then come in for further and illuminating reflections, as does the concept of *objection* under the recently-introduced complex *Deprivation of Liberty Safeguards* regime. An overdue consideration of the significant *Convention on the Rights of Persons with Disabilities*, followed by a comprehensive analysis of case-law of relevance to a re-visiting of *section 117 Mental Health Act 1983*, are the subjects of our final two substantive articles.

Interesting and important judicial pronouncements have emerged from various quarters since the Winter 2009 issue, the last published issue of the JMHL in its 'normal' format. The Court of Protection and the Upper Tribunal (Administrative Appeals Chamber) have been particularly busy. The JMHL has never attempted to provide a comprehensive round-up of all relevant case-law, however much many readers would no doubt have welcomed that. Other publications and websites do provide such a service. What we have done is subject certain decisions to expert detailed analysis. On this occasion we are pleased to publish thoughtful accounts and considerations of two cases – one from the European Court of Human Rights and the other from the Irish High Court.

The Winter 2009 issue concluded with a summary of '*Some Recent Publications*'. I ended that article about various books published in the preceding two years, with the comment that those of us interested in mental health/capacity law are "very fortunate" to be able to access so many sources of information, advice and opinion. Our good fortune continues. In the last year, not only have new editions of Richard Jones's two invaluable Manuals – '*Mental Health Manual*'[1] and '*Mental Capacity Manual*'[2] – been published, but also the following:[3]

1 *13th ed. Sweet & Maxwell (2010)*

2 *4th ed. Sweet & Maxwell (2010)*

3 *It is perhaps unwise to attempt such a list as omission of a relevant publication might so easily cause offence. It needs to be stressed that any such omission is inadvertent, and that no conclusions should be drawn from any failure to list any particular publication.*

- The long-awaited 5th edition of '*Mental Health Law*', by Brenda Hale[4];
- '*Principles of Mental Health Law and Policy*', a weighty tome of 1000 pages, edited by Lawrence Gostin, Peter Bartlett, Phil Fennell, Jean McHale and Ronnie Mackay[5];
- '*Rethinking Rights-based Mental Health Laws*', edited by Australia-based Bernadette McSherry and Penelope Weller[6];
- '*Essential Mental Health Law – a Guide to the new Mental Health Act*', by Tony Maden and Tim Spencer-Lane[7];
- '*Mental Health – Law and Practice*', by Phil Fennell[8];
- '*Mental Health and Crime*', by Jill Peay[9];
- '*Liberty and Other Misunderstandings – Some more notes on health care law*', by David Hewitt[10];
- '*The Court of Protection Practice 2011*', under the general editorship of Gordon Ashton[11].

It had been intended that reviews of at least some of these books would be included in this issue. However for various reasons this has not in fact proved to be possible, and for that a further apology is due. What we *have* included is a review of the *Care Quality Commission's* first report on the exercise of its functions in keeping under review the operation of the *Mental Health Act 1983*. Given the vital role the CQC has in relation to the application of mental health law in England, it is fitting that this final issue of the JMHL concludes with this review, written by a former (and the first) Chief Executive of its predecessor, the *Mental Health Act Commission*.

It only remains for me to thank not only the contributors to this issue (not least for their patience as they have awaited publication of their efforts), but also all those many others who have been willing to share their knowledge and expertise within the covers of the twenty one issues which have been published since February 1999. The Editorial Board have played a critical role in maintaining the JMHL's standards, and a considerable debt of gratitude is owed to them, particularly to (a) Charlotte Emmett who had the vision and the energy to launch the JMHL and to guide it so skilfully as editor for the first half of its life, and (b) the two Assistant Editors of recent years, David Hewitt and Mat Kinton. The conscientious commitment of Ann Conway of Northumbria Law Press, and others involved in the production of each issue, must also be expressly acknowledged.

It is of course with considerable sadness that I observe that this Foreword must also act as the Endnote of the JMHL, at least in its present format. The final expression of gratitude must go of course to the many readers and subscribers who throughout the life of the JMHL have shown considerable appreciation, encouragement and forbearance. Without that essential support, the JMHL would not have reached the not unimpressive figure of 21 issues. Many thanks indeed.

John Horne

Editor

4 *5th ed. Sweet & Maxwell (2010)*
5 *Oxford University Press (2010)*
6 *Hart Publishing (2010)*
7 *Hammersmith Press Limited (2010)*
8 *2nd ed. Jordans (2011)*
9 *Routledge (2010)*
10 *Northumbria Law Press (2011)*
11 *Jordans (2011)*

Is There a Burden of Proof in Mental Health Cases?

Jeremy Cooper[1] and Howard Davis[2]

Background Positions

This article examines the concept of the burden of proof in the context of the First-tier Tribunal (Mental Health). Whereas it is well established that in an adversarial system the burden of proof in a case will always rest with the party bringing the action, the position in an inquisitorial system is far less clear. At least 4 positions have been competing for supremacy on this issue for over 30 years as follows:

1. There is no burden of proof in any jurisdiction that adopts an essentially inquisitorial approach to the conduct of its cases. This position was first articulated by Lord Denning MR in 1974 in the case of *R v National Insurance Commissioner ex parte Viscusi*[3], stating:

   "The proceedings are not to be regarded as if they were a law suit between opposing parties. The injured person is not a plaintiff under a burden of proof."[4]

2. Following French legal principles there is only one rule of evidence, that of 'weight'.[5] Under this approach the tribunal simply attaches to every piece of evidence such weight as it thinks fit and does not consider itself bound by the strict rules of evidence that apply for example in the criminal courts. This approach is classically expressed in the procedural rule governing the conduct of mental health tribunals which permits the tribunal:

   'To admit evidence whether or not the evidence would be admissible in a civil trial in England and Wales'.[6]

   Under this interpretation, the parties are expected to work together with the tribunal panel to reach an adjudication characterised by Baroness Hale as "a cooperative process of investigation in which both the claimant and the [state as respondent] play their part."[7] According to Baroness Hale:

   "If that sensible approach is taken, it will rarely be necessary to resort to concepts taken from adversarial litigation such as burden of proof."[8]

---

1. *Professor Jeremy Cooper, Judge of the Upper Tribunal.*
2. *Dr Howard Davis, Reader in Law, Bournemouth University.*
3. *[1974] 1 WLR 646.*
4. *Ibid at 651.*
5. *It is interesting to note that evidence is not a discrete topic of jurisprudence in French legal education.*
6. *Tribunal Procedure (First-tier Tribunal) (Health Education and Social Care Chamber) Rules 2008 Rule 15 (2).*
7. *Kerr (AP) v Department for Social Development (Northern Ireland) [2004] UKHL 27.*
8. *Ibid at para. 63*

The 'overriding objective' of all proceedings in the First-tier Tribunal (which includes mental health) and set down in all the post-2007 First-tier Tribunal Rules of Procedure is for the tribunal to deal with cases 'fairly and justly'. Prescriptively, the parties must 'help the tribunal to further the overriding objective'.[9] In the case of the mental health jurisdiction, this is to be achieved by the parties inter alia 'agreeing to co-operate with the Tribunal generally', 'avoiding delay', 'avoiding any unnecessary formality' and 'seeking flexibility in the proceedings'. A strict burden of proof could potentially conflict directly with such facilitation.

3. A third and slightly different position concerning the burden of proof in an inquisitorial tribunal has been adopted in the First-tier Chamber (Immigration and Asylum). On a formal level the Chamber adopts the general principle, based in international law, that the burden of proof in an asylum seeker application rests with the person seeking asylum. But as the very nature of asylum often means that the person seeking asylum has no documentation or proof of other status, no proof of age, and no proof of the reasons they left their own country that might enable them to discharge this burden of proof, this may prove to be an unattainable chimera. Recognising this to be a fundamental problem in its jurisdiction, and one that would arise specifically as a consequence of adopting the standard burden of proof, the Chamber has ingeniously evolved its own test. An applicant must show a 'reasonable degree of likelihood' that he or she has a well-founded fear of being persecuted if obliged to return to their country of origin. In this context the Chamber accepts that the duty to ascertain the relevant facts to establish the answer to this question is shared between the applicant and the tribunal.
4. In all matters it is for the applicant to prove his or her case and the respondent to rebut it, with the tribunal's case management role limited to the exercise of its powers to 'fill the evidential gaps' left by the parties. This position has been significantly nuanced by the Court of Appeal in the recent case of *R (on the application of AN) V Mental Health Review Tribunal*[10] when the Court queried the value of the formal language of 'burdens' and 'standards' in circumstances where, as in most mental health hearings, risk is being evaluated:[11]

   "Proof' in the phrase 'standard of proof' and 'probabilities' in the phrase 'balance of probabilities' are words which go naturally with the concept of evidence relating to fact, but are less perfect with evaluative assessments. That is why the courts have started to speak of the 'burden of persuasion."

   The deliberate replacement of the adversarial word 'proof' with the more flexible and subtle concept of 'persuasion' may to some be no more than semantic sophistry. It nevertheless marks an attempt to use language to wrestle away a concept that sits increasingly uncomfortably in an inquisitorial context.

What is the Position of the First-tier Tribunal (Mental Health) concerning the Burden of Proof in Mental Health Cases?

So which of these various approaches to the burden of proof is the most appropriate to the conduct of the First-tier Tribunal (Mental Health)?

Given the importance of the issue there is surprisingly scant authority or guidance in mental health case law on the burden of proof in mental health cases. Let us begin with the statute.

9. *Supra f/n 6 at 2 (2).*
10. *[2006] MHLR 59*
11. *Ibid at para 100.*

Statute

The wording of s 72 of the *Mental Health Act 1983* is clear as to what the tribunal must do if it is not satisfied as to certain facts concerning the patient's current mental state, the availability and appropriateness of treatment for the patient in hospital, and any risks associated with their discharge. The tribunal, if not satisfied that the facts are established on the balance of probabilities[12], *must discharge the patient*. The section is however silent as to where the burden of proof lies. Prior to 2002, the statute was taken to require the patient to be discharged only if the tribunal was satisfied that at least one of the criteria for detention was not made out – a position that (using the term only as a useful shorthand) imposed a "burden of proof" on the applicant that was then held to be incompatible with Article 5 (4) Schedule 1 *Human Rights Act 1998*[13] leading subsequently to the first Remedial Order in England, passed subsequent to the *Human Rights Act 1998* s. 10.[14]

Case Law

Despite this statutory change, the idea that there remains a place for a burden of proof in mental health tribunal cases is still current. In *Re X's Application for Judicial Review*[15] for example (albeit a Northern Ireland case), it was said that one of the "salient principles" governing the court is that the "burden" or "onus" of proof (both terms are used) is on the "party seeking to justify detention". This case was decided under *Mental Health (Northern Ireland) Order 2004* which, as with section 72 *MHA 1983*, had been amended to remove a burden of proof on the applicant. The most important English case concerning the burden of proof in mental health cases is that of *R (AN) v Mental Health Review Tribunal*.[16] Although this case was essentially concerned with the standard of proof in mental health cases, reference was also made in passing by Munby J (as he was) (at first instance), to the general burden of proof in mental health cases in the following terms:

> *"104. I recognise, ….that the Strasbourg Court held in Reid v UK [2003] Mental Health Law Reports 226, (2003) 37 EHRR 211 at para [73] that the burden – what the Court called the "onus" – lies on the detaining authority to establish all the relevant criteria, including in particular whether the patient is "amenable to treatment". And the onus on the detaining authority is.. to establish those criteria 'on the merits': HL v UK [2004] Mental Health Law Reports 236 para [137."*

Significantly however, Munby J went on to add the following gloss to this statement:

> *"106. I accept….that the burden lies on the detaining authority to establish the relevant criteria. I do not enter into jurisprudential debate, and the point is, if you like, semantic but, in common with Lord Bingham, Keene LJ, Kennedy LJ and Sullivan J, I prefer in this context not to use the expression 'burden of proof'. The more accurate and appropriate expressions are either 'onus' – the word which, as I have said, was used by the Strasbourg court in Reid v UK at para [73] – or 'persuasive burden'."*

As stated above, the Court of Appeal in this case added a further layer of subtlety concerning the difficulties establishing a burden of proof in mental health cases. First the Court of Appeal stressed that the tribunal is not only considering if the case for detention is made out, it is also discharging a further

12. *R (AN) v MHRT [2006] MHLR 59*
13. *R (H) v Mental Health Review Tribunal for North and East London Region [2002] QB 1, 9.*
14. *Mental Health Act 1983 (Remedial) Order 2001 (SI 2001/3712).*
15. *[2008] NIQB 22,*
16. *[2005] MHLR 56*

and important public protection function, which might well conflict with the patient's wish for discharge and the regaining of his or her freedom:

> *"73. … the mental health context is very different from other situations where individual liberty is at stake. The unwarranted detention of an individual on grounds of mental disorder is a very serious matter, but the unwarranted release from detention of an individual who is suffering from mental disorder is also a very serious matter. ………..*
>
> *74. …………….. One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma … It cannot be said, therefore, that it is much better for a mentally ill person to 'go free' than for a mentally normal person to be committed. Furthermore the consequences that may flow from the release of a person suffering from mental disorder include not only a risk to the individual's own health and safety (e.g. self-harm, even suicide), but also a risk of harm to other members of the public."*[17]

The implication of Lord Justice Richards' comments, as cited above, is that it is ultimately disingenuous to use concepts such as 'burden of proof' in mental health cases when the issues engage a set of competing rights that ultimately need to be balanced one against the other. The point had already been recognised by Stanley Burnton,J. who described the procedure of a Mental Health Review Tribunal as being "*to a significant extent inquisitorial*".[18]

What does the Intervention of the European Court of Human Rights contribute to the Debate?

This concern with the burden of proof derives from the impact of Article 5 (4) and Article 6, scheduled Convention rights in the *Human Rights Act 1998*. The declaration of incompatibility in *R (H) v Mental Health Review Tribunal for North and East London Region*[19] led to statutory amendment which by requiring a tribunal to be satisfied that the detention conditions were satisfied, might be thought to have created sufficient change so that further requirements relating to the burden of proof would no longer be significant; but *R (AN) v MHRT* (discussed above) suggests that this is not the case.

Despite case law acknowledgment that tribunals pursue an inquisitorial approach,[20] burden of proof concepts continue to play a role in English law in mental health cases. The need for compatibility with Article 5 (4), as interpreted by the European Court of Human Rights in *Reid v United Kingdom*[21], is the explanation for this continued reference to the burden of proof which is said to fall on the detaining authority. The case concerned Mr Reid, a Scottish man who claimed that the requirement that he had the burden of proof to establish that his psychopathic disorder was not treatable was a breach of his Article 5 rights under the Convention.[22] The Strasbourg Court ultimately found in Mr Reid's favour.

> *"Whilst there is no Convention case law ruling on the onus of proof in Art 5(4) proceedings, it is implicit in the case law that it is for the authorities to prove that an individual satisfies the conditions for compulsory detention."*

17. *Supra f/n 12 per Richards LJ.*
18. *R (Ashworth Hospital) v MHRT [2001] EWHC Admin. 901, paragraph 16.*
19. *Supra f/n 13; see text to f/n 13, supra.*
20. *See remarks of Burnton J at supra f/n 18.*
21. *(2003) 37 EHRR 9.*
22. *Ibid*

This statement is clearly inconsistent with the inquisitorial approach and the co-operative procedure and principles which mental health tribunals, under statutory rules, are bound to adopt. We do not believe that *Reid* can continue to carry the weight of being the principal authority justifying the imposition of a burden of proof on the procedures of Mental Health Review Tribunals for four reasons.

1) In *Reid* the Court of Human Rights was dealing with a statutory provision which, as in *R (H) v Mental Health Review Trbunal for North and East London Region*[23], required the court (in the form of the Sheriff) to discharge a patient only when satisfied that the detention criteria were not made out. Consequently the case need not be taken to be controlling authority for tribunals which, under the reformed law, are now required to satisfy themselves that the detention criteria are made out.

2) It is true that (in the words quoted above) the Court refers to an onus of proof resting on the authorities. However, the reason for the finding of a violation in this case was that the law, as it then was, placed a burden of proof on the applicant which, in respect of the domestic law requirement that the patient's condition be treatable, seemed, on the facts, to determine the outcome of the case. The requirement that there must not be a burden of proof placed on the applicant that could determine the outcome of a case to his or her detriment does not imply that there must be a burden placed on the authorities. It is equally consistent with the argument of this article that the concept of a burden of proof, wherever placed, is at odds with the proper approach to its procedure by a First Tier Tribunal (Mental Health).

   Reid appears to turn primarily on the undesirability of imposing a burden of proof on a patient, rather than a lack of any burden on the detaining authority. And in our view the circumstances of a mental health case are just too complex and the consequences of a wrong decision too grave, for so simple a formula to apply. It is no co-incidence that when mental health review tribunals were introduced in England and Wales in 1983 to adjudicate mental health detentions in compliance with the Article 5 requirements, an inquisitorial as compared to an adversarial setting was selected as the chosen model. Indeed it is not difficult to provide an example of circumstances where a strict requirement that the burden be on the detaining authority *as applied to discharge*, would give rise to an unacceptable and/or dangerous outcome. Take for example the case of the patient who presents at the tribunal as floridly psychotic, and furthermore appears to be likely to a danger both to himself and potentially to the public, if discharged. If the hospital fails for whatever reason to provide any evidence in support of his detention other than the fact that he is detained, and his lawyer argues for his immediate discharge on the grounds that the detaining authority has failed to discharge the burden of proof, is this an outcome the Strasbourg Court had in mind when it made its ruling in the Reid case? This seems somewhat unlikely.

   At paragraph 72 the Court said:

   "It is true in this case that there was considerable medical evidence before the Sheriff concerning the applicant's condition and that the Sheriff made clear and unequivocal findings as to the existence of a serious mental disorder and the risk of the applicant re-offending. These conclusions were reached on an assessment of the evidence as a whole and the burden of proof does not appear to have played any role."

   It seems clear from this paragraph therefore that the Strasbourg Court was prepared to accept that

23. *Supra f/n 13.*

crucial aspects of a mental health case did not require any specific burden to be discharged, and that its concerns regarding burden were limited to the issue of treatability.

3) Reid is principally a case about treatment and diagnosis rather than the issue of risk. The need for a burden of proof was said to be "implied" from the requirement, in *Winterwerp v The Netherlands*[24] and *Johnson v United Kingdom*[25], that the criteria for detention, enunciated in the former case, have "reliably to be shown".[26] In *Winterwerp*, however, it is only the first of three criteria, the diagnostic requirement that the applicant must be of "unsound mind", that must be reliably shown.[27] The point has a principled justification which is to ensure that there is "objective medical expertise" before the tribunal. In neither *Winterwerp* nor *Johnson* does the "reliably...shown" requirement, expressly apply to the risk judgment that the mental disorder must be of a kind or degree "warranting" compulsory confinement. The elision in Reid of the diagnostic and the risk criteria in respect of what must be "reliably shown" goes further, it is submitted, than is required or justified by the Strasbourg authorities it purports to follow.

It is true that in later cases, such as *Varbanov v Bulgaria*[28], although "reliably be shown" still relates only to the diagnostic element of the *Winterwerp* criteria, the Court went on to require that it must also "be shown" that the deprivation of liberty is "necessary" in the circumstances. There is nowhere in this drafting an express requirement that a burden of proof be placed on the authorities. The problem dealt with in *Varbanov* was the need for the tribunal to consider other options to detention. Other cases on the same point deal with the need for the tribunal to have access to expert evidence.[29]

The point is significant because the judgment of risk (from which the need for detention flows) is not susceptible to the same degree of expert guidance as the diagnostic issue. English courts accept that this is a matter that involves discretionary judgment and is not susceptible to objective proof.[30] The proper disposition of a judicial body determining a person's liberty by reference to the risk to themselves or others seems to depend on context. Thus the need for the authorities to prove the need to detain a recalled prisoner, in the statutory context of an "extended sentence"[31], can be contrasted with the imposition of an implicit burden of proof on the applicant in the statutory

24. *(1979-1980) 2 E.H.R.R. 387*
25. *(1999) 27 EHRR 296.*
26. *Reid v United Kingdom (2003) 37 EHRR 9, paragraph 70.*
27. *Supra f/n 24, para 39. The Court, in Reid, attributes the quotation: "if it can reliably be shown that he or she suffers from a mental disorder sufficiently serious to warrant detention" to Winterwerp (paras 39-40) and Johnson, supra f/n 25, para 60. Both those latter cases, in fact, only predicate "reliably be shown" on the diagnostic fact of the patient being of unsound mind.*
28. *Varbanov v Bulgaria app 31365/96 judgment of 5 October 2000, para 46, citing Litwa v Poland (2001) 33 EHRR 53..*
29. *See Puttrus v Germany app 1241/06 admissibility decision of 24 March 2009, page 8.*
30. *R (Henry) v Parole Board [2004] EWHC 784, para 12 (a non-mental health case): "in assessing risk the Board is making a judgment about an issue that is inherently incapable of proof". The words were adopted by Munby J in R (AN) v MHRT [2005], supra f/n 16. Of course this does not mean that the assessment should be arbitrary. The Court of Appeal, in AN, accepted that assessing risk, in a mental health context, involves "judgment, evaluation and assessment"; applying a standard of proof (a balance of probabilities) to this process has some, albeit limited, relevance in respect of ensuring the sufficiency of a tribunal's reasoning – R (AN) v MHRT, supra f/n 12 paras 98 and 104.*
31. *R (Sim) v Parole Board [2003] EWCA Civ 1845..*

context of a life sentence or sentence “at Her Majesty’s pleasure”.[32] As the passage by Richards LJ in *R (AN) v MHRT*[33], quoted above, indicates, the seriousness of the consequences which can follow an unwarranted release put Mental Health Review Tribunals (as they then were) into a different position from courts or some other bodies dealing with the right to liberty. The focus on the issue of risk explains why the statutory context of a Mental Health Review Tribunal (now a First-tier Tribunal (Mental Health)) is inquisitorial, based upon a cooperative procedure rather than one in which there should be an implicit burden of proof on the hospital.[34]

In *Reid* the Court of Human Rights accepted there was ample evidence on the issue of risk for the Sheriff to make up his own mind without reference to the authorities discharging a burden of proof. The violation of Article 5 was established when the Sheriff, faced with a division of expert evidence on treatability, decided that issue by reference to an implied burden of proof placed on the applicant. In these particular circumstances the Court of Human Rights saw the burden of proof placed on the applicant, as being capable of “influencing the decision”.

4) *Reid* influences English law because section 2 *Human Rights Act 1998* requires United Kingdom courts to take the judgments of the Court of Human Rights “into account”. This has been taken to mean that normally (even if reluctantly) the general principles laid down by Strasbourg, as distinct from their decisions on the facts of particular cases, should be followed.[35] A recent decision of the Supreme Court, on the compatibility of criminal convictions based “solely or decisively” on hearsay evidence admitted on the basis of statutory conditions, reaffirms that even where there are clear, constant and reiterated principles, coming from Strasbourg, these need not be followed where it appears that particular aspects of national law have not been properly appreciated or understood and where the Strasbourg analysis is less than fully convincing.[36] There is some relevance in this formulation to the burden of proof issue.

Firstly, both hearsay and burden of proof involve the right to a fair hearing, relevant to both Article 6 and Article 5 (4). Here the Court of Human Rights has frequently said that it has only a reviewing role, concerned with the overall fairness of the process, rather than authority to lay down particular procedural requirements: these are left to national law.

Secondly, the disputed legal principle in both situations does not come from a careful and principled analysis by the Strasbourg Court. Regarding the burden of proof, it comes from an “implication” which is merely asserted and then adopted, without further argument, in later cases.

Finally, *Reid* is a Chamber decision and not a focused and deliberate decision of the Grand Chamber. It is therefore submitted that there is no compelling need to follow *Reid* on the need for

32. *R v Lichniak [2002] UKHL 47. In Comerford v United Kingdom app 29193/95 Commission decision 9 April 1997, the Commission accepted that releasing only if satisfied as to safety was not incompatible with Article 5. In Henry v Parole Board, supra f/n 30, it was accepted, provisionally, that an implicit burden on the applicant (serving a sentence at Her Majesty’s pleasure) to prove it was safe to release on licence was not incompatible with Article 5.*
33. *See text accompanying f/n 17.*
34. *In Scotland there is an express statutory requirement that the risk issue, in respect of those detained in a secure hospital following a criminal prosecution, is determined on the basis of a burden of proof on the Scottish Ministers, Anderson v Scottish Ministers [2001] UKPC D5, see paragraph 56.*
35. *See, R (Ullah) v Special Adjudicator [2004] UKHL 26, paragraph 20; in SSHD v JJ [2007] UKHL 45, Lord Bingham, at paragraph 13, made the point that Strasbourg is “laying down principles and not mandating solutions to particular cases”.*
36. *R v Horncastle [2009] UKSC 14.*

burden of proof in mental health tribunal cases. Following *R Horncastle*[37] it is suggested that here we have an arguable exception to the normal approach to section 2 of the Human Rights Act. This argument, of course, is an invitation for a more principled decision, properly sensitive to the legal context in the UK, by the Court of Human Rights in Strasbourg and ultimately by the Grand Chamber[38].

What is the Impact of Article 5 of the European Convention on Human Rights on Burden of Proof arguments in the First-tier (Mental Health) Jurisdiction?

The previous section suggests that *Reid* need not be taken as compelling authority for the view that, at least on the issue of risk, there is a burden of proof on the detaining authority. A tribunal should be able to form its own judgement, based on an inquisitorial and cooperative procedure, on whether the conditions for continued detention have been made out without recourse to any notion of a "burden". The question then arises whether, independently of Reid, there is any requirement for a burden of proof based on Article 5 (4) or Article 6 of the Convention.[39]

Article 5 stipulates the grounds on which a person can be deprived of his or her liberty and also imposes a condition, under Article 5 (4), that effective review of the continuing grounds for deprivation should be available within a reasonable time. A patient's initial detention must be for a purpose compatible with Article 5 (1) (e) and following a "procedure prescribed by law".[40] This means not only that the procedure must meet the general Strasbourg conditions of "accessibility" and "foreseeability" but, also, that the initial deprivation must not be arbitrary. The procedure for original detention may depend on the circumstances. At the very least, it will require the opinion of a medical expert, although it will not necessarily require a hearing with a judicial character at the time of the initial detention.[41] These requirements should also apply to the reviewing procedures under Article 5 (4).

At the heart of Article 5 (4) is the applicant's right to apply to an appropriate judicial body[42] and much of the case law relates to the effective availability of this right under national law. The body need not be a court in the narrow sense of the term but must follow judicial procedures. It has been said that these need not include the same guarantees as required under either the civil or the criminal aspect of Article 6. Nevertheless the tendency is to stress the similarity of the procedural requirements under both Articles.[43] The Court of Human Rights has made it clear on numerous occasions that it is for the States – the signatories to the Convention – to establish the procedure that satisfies Article 5 (4). Its role is as a reviewing court intended primarily to ensure that national procedures, considered overall, meet the appropriate standard of fairness. The position is the same with Article 6: the Court in Strasbourg is not

37. *Ibid.*
38. *It is unclear at the time of writing (April 2011) what position the Supreme Court will adopt if its invitation to the Grand Chamber, to accept that the statutory law on hearsay is Convention compatible, is rejected.*
39. *Mental health tribunals, by deciding on a person's right to liberty, are determining their "civil rights", thus engaging Article 6, Aerts v Belgium (2000) 29 EHRR 50, paragraph 69, confirmed in a mental health context in Reinprecht v Austria (2007) 44 EHRR 39, paragraphs 50 and 51. The general principle is that Convention Articles should be in harmony with each other.*
40. *See, for instance, Storck v Germany (2006) 43 EHRR 6..*
41. *Though such a hearing can be incorporated into the initial process, Varbanov v Bulgaria, supra f/n 28, paragraph 58.*
42. *The "cornerstone guarantee of Article 5(4)" – see Rakevich v Russia app 58973/00, judgment of 28 October 2003.*
43. *Shtukaturov v Russia App 44009/05, judgment of 27 March 2008, "the 'procedural' guarantees under Article 5 (1) and 5 (4) are broadly similar to those under Article 6 (1)", paragraph 66.*

there to require a particular set of procedures necessary to guarantee a fair hearing.

Frequently the Court has stated that the procedures under Article 5 (4) must be "adversarial"[44]. In the context of Article 6, adversarial has been said to mean "the opportunity for the parties to have knowledge of and comment on the observations filed or the evidence adduced by the other party".[45] Issues of significance are that the hearing need not be by a regular court, but must be conducted by a body which has a judicial character in the sense of being properly independent of the executive and the parties[46]. It must be capable of deciding the issues relevant to Article 5(1), such as, in mental health context, the *Winterwerp* criteria. The hearing must have a judicial character in the sense that there must be "equality of arms" between the parties (a "distinct procedural right that can be subsumed within the general principle of adversarial proceedings"[47]). The forms of procedure may vary, but what is important is that the body is able to order the applicant's release.

In relation to determining civil rights there is, absent *Reid*, little if any evidence that an adversarial procedure requires there to be a burden of proof placed on the authorities (as distinct from it not being on the applicant). In mental health cases such as *Keus v Netherlands*[48], for instance, the Court refers to the "fundamental adversarial principle" of an article 5 (4) hearing. The case turns, however, on the applicant's access to a judicial authority for a review of his detention. Burden of proof is not an issue. The evidence was that a judge would have ordered release " if he had accepted [the applicant's] arguments"[49]; it cannot be implied from that statement that a burden of proof must be on the authorities. *Shtukaturov v Russia*[50] deals with the procedure for determining legal capacity and the consequences of determinations of that issue for the applicant's liberty. The case is dealt with under Article 6 but with reference to Article 5. The Court found a breach of the "principle of adversarial proceedings enshrined in Article 6(1)". Again the trigger for the finding is the lack of an opportunity to be seen and heard[51].

The Court also requires, in respect of Article 5 (4), that there must be safeguards for the applicant which are appropriate to the kinds of loss of liberty involved.[52] There is no reason to suppose that such safeguards require the judicial body to proceed on the basis of a burden of proof. The inquisitorial approach, based on a proper attention of the judicial authority to the applicant's case but with a necessary awareness of the issues of risk with which it must deal, can provide such safeguards. Indeed a combination of the procedural flexibility,[53] the encouragement of the active role of the panel, and the power of the panel to admit any relevant evidence even though not admissible in a court[54], provide a strongbox of powers available to a tribunal to ensure adherence to these safeguards.

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44. *This was recently confirmed by the Grand Chamber in A and others v UK (2009) 49 EHRR 29. 'Thus the proceedings must be adversarial and must always ensure "equality of arms" between the parties' (paragraph 204). This was not a mental health case, but the same principle has been asserted in such cases, including Reid, supra f/n 21, para 67 (see cases in the next paragraph).*
45. *Ruiz-Mateos v Spain (1993) 16 EHRR 505, paragraph 63.*
46. *De Wilde et al v Belgium (No 1) (1979-80) 1 EHRR 373, paragraph 78; independence is an express provision of Article 6(1).*
47. *Harris, O'Boyle & Warbrick Law of the European Convention on Human Rights 2nd edition 2009 Oxford: OUP p 191.*
48. *(1991) 13 EHRR 700.*
49. *Ibid, paragraph 28.*
50. *[2008] MHLR 238.*
51. *Ibid para 73. There was also a violation of Article 5(4) based on the general lack of access to a court under Russian law (see paragraph 123).*
52. *Winterwerp, supra f/n 24, paragraph 57; Lexa v Slovakia (no. 2) judgment of 5 January 2010, paragraph 67.*
53. *See Rules supra f/n 6, Rule 5.*
54. *Ibid, Rule 15 (2).*

Conclusion

The First-tier Tribunal (Mental Health) is expected, under its formal Rules, to operate a procedure which is relatively informal, co-operative, flexible and is not subject to delay. Any requirement of the law that this procedure must also embody a burden of proof placed on the authorities is likely to create tensions with these Rules' objectives. It is accepted that it is for the authorities to prove the objective, diagnostic question of whether or not the claimant is of "unsound mind" and there must be convincing, professionally validated, evidence of this before the Tribunal. The key issue to be determined in most mental health tribunals, however, concerns an assessment of the risk that is attached to discharging a patient from section, and on that issue it is not at all clear that any burden of proof rests with the detaining authority.

In so far as a place for a burden of proof is still accepted by the English courts as a necessary part of the procedure in these cases, the legal authority for this continued acceptance is not particularly strong. Examination of the Strasbourg case law suggests that an insistence on a burden of proof is incorrect law. At its strongest the argument states that the applicant must not be under a burden of proving that the conditions for his or her continued detention no longer exist. But this proposition is consistent with the view that placing a burden of proof on the detaining authority, is also inappropriate for these procedures. And in any event it relates to a statutory formulation of the questions a tribunal must ask itself which no longer exists.

In conclusion, *Reid v United Kingdom* need not, in our view, be treated as a precedent binding on English courts on the question of burden of proof in establishing the lawfulness of a patient's detention. Likewise there is nothing in the case law on Article 5 (4) and Article 6 which, independently of *Reid*, requires a burden of proof to be an essential part of an adversarial procedure in this context.

The Case for "Good" Legal Representation

Is it worth fighting for?

Paul Veitch[1]

> *"The key to any successful professional service is recruiting good calibre candidates, good training, continuing education, adequate funding and a strong professional body that is able to enforce standards of conduct"*[2]
>
> *"If we interfere with the principles which underpin law, fritter them away, pick them out of the crannies of our political and social architecture, restoration is impossible. Our only hope is an order governed by law and consent"*[3]
>
> *"It gave me the impetus to get better as you have someone on your side"*[4]

A very recent right

The legal representation of patients detained under the *Mental Health Act 1983* (the Act) by way of public funding is very recent. Prior to the Act legal representation was not commonplace and was not seen as desirable. A Royal Commission report in 1957 commented that *"As the proceedings on applications to Mental health Review Tribunals will usually be informal and neither the patient nor the hospital or local authority will usually need to be legally represented…"*[5] It was the Legal Aid Act 1974 that granted public funding for a solicitor to prepare a case for a Mental health Review Tribunal under the Legal Advice Scheme (the Green Form, remember those uncomplicated days!). This was means-tested but did not grant funding for actual representation. Public funding for representation at the hearing was only granted on 1st December 1982 under 'Assistance by Way of Representation'. A time span up until today's date of only 28 years!

The current threat

It cannot be taken for granted, that the right to publicly funded representatives will be preserved in years to come. The Legal Aid scheme enshrining this right is relatively new and vulnerable to arguments that

1. *Solicitor who has his own practice specialising in Mental Health Law; Fee Paid Tribunal (Mental Health) Judge; Assessor of the Law Society's Mental Health Tribunal Panel; Past Mental Health Act Commissioner and trainer for the Mental Health Tribunal.*
2. *A.Eldergill, "The Best is the Enemy of the Good: The Mental Health Act 2001 (Part 2)" pp13 JMHL Spring 2009*
3. *Page 9 Helena Kennedy "Just Law: The Changing Face of Justice – and why it matters to us all" 2004 Chatto and Windus*
4. *Quote from one of the writer's client's*
5. *Page 152 Royal Commission on the Law relating to Mental Illness and Mental Deficiency 1954-1957 Report, Her Majesty's Stationery Office May 1957*

others less qualified could carry out this role.[6] This would create savings that the Government is desperate to secure from the Legal Aid budget. It is also noteworthy that the number of members of the Law Society's Mental Health Tribunal Panel (the Panel) is falling. From the inception of the Panel in 1986 until 2002 membership increased each year. Membership in 2002 stood at 498; since then the numbers have dropped each year, the figure for Jan 2009 being 395. It is therefore timely to remind ourselves as to why patients detained under the Act having access to good legal representation is a fundamental right. I stress 'good' because if it is not good, then the arguments for diluting this right will grow stronger, and second, the legal profession will have failed in their duty to represent the weak and the vulnerable.

To make the case I divide this article into three sections. The first section will explain why we need good legal representatives. The second section will analyse what makes for a good legal representative. The final section will attempt to give some answers as to how we can develop the conditions to ensure that good legal representation remains a permanent feature of the Tribunal system.

Why the need for good representation?

The representation premium

In a recent paper Michael Adler analyses the outcomes of Tribunal hearings and concludes that *"in some circumstances, the unrepresented applicant/appellant can do almost as well, if not as well, as his/her represented counterpart."*[8] Alder argues that provided appellants take advice before the hearing, they should be able to take advantage of the Tribunals "facilitating" approach. However in view of the highly vulnerable client group involved in Mental Health Tribunals.[9] (MHTs) Alder's research does not challenge the findings of the Hazel and Yvette Genn's study of representation in Tribunals. This research concluded that having representation before a MHT increased the chances of success by 15%. They termed this the "representation premium."

Inadequacy of self representation

The White Paper (2004) on '*Transforming Public Services: Complaints, Redress and Tribunals*" accepted that *"some people will always need a lot of help, perhaps because of learning difficulty or physical disability or language problems'*[10]. The paper went on to conclude that in some cases users of Tribunals will therefore need advocacy.

Given the client group, MHTs would seem unique among all the other Tribunal jurisdictions in requiring that patients have advocacy. By definition those appearing before MHTs are deemed mentally disordered and may therefore have great difficulty in self advocacy. This may be because they are thought disordered

6. *Par 20.11 of the Code of Practice Mental Health Act 1983 DH London TSO 2008 clearly states Independent mental health advocates will not "affect a patients right to seek advice from a lawyer"; nevertheless a suspicion remains that in time IMHA's could take on the role of solicitors/panel members*
7. *Membership figures for the Panel obtained from the Administrative office of the Panel*
8. *Page 1 Michael Adler "Self-Representation, Just Outcomes and Fair Procedures in tribunal Hearings: some inferences from recently completed research", Senior Presidents conference for Tribunal Judges 20.05.09*
9. *Genn, Hazel and Genn Yvette "The Effects of Representation in Tribunals", London. Lord Chancellors Department 1989*
10. *page 48 "Transforming Public Services: Complaints, Redress and Tribunals", Secretary of State for Constitutional Affairs and Lord Chancellor Cm 6243 July 2004*

or delusional, or because they have learning disabilities. Whilst the MHT attempts to be informal, there still remains an adversarial quality to the proceedings and a case to be put by cross examination and submissions, which would be beyond the capacity of most patients. Even if the patient is mentally settled, he will not possess the legal skills or knowledge of the law to be able to advocate his case. Many patients will also lack capacity to be able to engage in the proceedings. Given the gravity of the proceedings, which involve issues concerning deprivation of liberty, appropriateness of treatment and future care options, self representation would be totally inadequate.

Strasbourg Compliance

In a number of cases before the European Court of Human Rights (ECtHR) the right to representation has been held to be a fundamental right under Article 5 and 6. In the case of Megyeri v Germany the court held

> *"Where a person is confined in a psychiatric institution on the ground of the commission of acts which constituted criminal offences but for which he could not be held responsible on account of mental illness, he should – unless there are special circumstances – receive legal assistance in subsequent proceedings relating to the continuation, suspension or termination of his detention. The importance of what is at stake for him – personal liberty – taken together with the very nature of the affliction – diminished mental capacity – compel this conclusion."*[11]

The right to legal representation where detention of the mentally disordered is being reviewed was again held to be fundamental in the case of Pereira v Portugal where the court held

> *"The purpose of the hearing in question, under Article 504 of the Code of Criminal Procedure, was to enable the judge to decide whether the applicant should be kept in detention. It is self evident that legal issues may arise during such a hearing. Secondly, the judge does not appear to have decided that it was unnecessary for the applicant to be represented, since he appointed for the purpose an official from the prison in which the applicant was detained. Even though that appointment appeared to be valid under domestic law and consistent with the case law of the constitutional court, it cannot in the Court's view, be regarded as adequate representation for the applicant."*[12]

Whilst these judgments are welcome they do not amount to an unequivocal endorsement of the need for legal representation in every case involving review of detention. References to "special circumstances" and "unnecessary" imply there will be cases where representation would not be necessary. Bartlett, Lewis and Thorold commented "*Remarkably, it* (Strasbourg) *has yet to say, in plain terms, that as a matter of invariable principle every detained patient should have access to representation, legal or otherwise.*" *They go on to conclude "the complexity of detention hearings is now such that no lay person should be expected to negociate the law without legal representation, and that the importance of what is at stake for the individual – his or her liberty – is sufficiently important that legal representation must always be provided in these circumstances. If that is the case, the ECHR jurisprudence regarding the standard of that representation would be engaged."*[14]

11. Par 584 Megyeri v Germany Application Nu. 13770/88, judgment 12.05.93 15 EHRR

12. Par 61 Pereira v Portugal, Application No. 44872/98, judgment 26.02.02 (2003) 36 EHRR 49

13. Page 70 P.Bartlett O.Lewis O.Thorold "Mental Disability and the European Convention on Human Rights", 2007, Martinus Nijhoff Publishers Leiden/Boston

14. Page 244 Ibid

Nevertheless given the client group and the gravity of the proceedings, even with these caveats it would be difficult to foresee a set of circumstances where the court might find that representation was not required.

What makes a good representative?

Instructions or Best Interests

The solicitor gets back to the office and with a broad smile he announces to his principal, "I got her off". Of course this may be a cause to celebrate, but it would be simplistic in the extreme if this was seen as the sole purpose of representation. The starting point is the same as for any client-solicitor relationship, namely to act in accordance with the client's instructions and in the best interests of the client; and where the client lacks mental capacity to provide instructions, the representative should act in the client's best interests. As to whether the client is able to give instructions the threshold test is not high, *"and people severely disabled by a mental disorder may still be able to provide instructions if you explain matters simply and clearly"*[15]

It can be very difficult to distinguish between a client who can give instructions and one who can not. This is part of the skills a representative has to acquire through practice, as little if no training is offered to any prospective applicant to the Panel. The good representative will no doubt have a good working knowledge of the Law Society's' guidance document '*Representation before mental health tribunals*' which was published on the 13th August 2009 (and is now being rewritten following Judge Rowland's comments in the AA case[16]). This lacks the clarity of its predecessor document, published in June 2004. A good knowledge of the *Mental Capacity Act 2005* (MCA) will also be essential.

Some helpful pointers were made in a recent Appeal to the Upper Tribunal by Judge Rowland.

> *"The distinction between valid instructions and the mere expression of a wish is important. As Ms Morris succinctly puts it: "An incapable patient… can very frequently express a wish, even if he cannot express a capable opinion." Where a patient lacks the capacity to give valid instructions, wishes that are expressed cannot bind the solicitor in the same way as instructions." And later in the Judgment "What, then, is the position if the patient does have the capacity to give instructions on some matters but not others? The Law Society's guidance is unequivocal: a solicitor is bound to act in accordance with the instructions that have been given. Therefore, the more a patient has the capacity to give detailed instructions, the less the solicitor has complete freedom of action."*[17]

The representative must therefore be highly sensitive to the client's needs, wishes and wants. It is important for the representative to discover these by gentle probing. It is also essential for the representative to enable the client to decide what they want by explaining the various powers and recommendations available to the Tribunal. This includes the Tribunal's powers to make non statutory recommendations (which are just as valid in non-restricted cases) which can be highly influential.[18] The

15. *Par 3.5 "Representation before mental health tribunals, Law Society's Mental Health and Disability Committee" 13.8.09. See also Baroness Hale "the threshold for capacity is not a high one" R (MH) v Secretary of State for Health (2005) MHLR 302 HL*
16. *AA v Cheshire and Wirral Partnership NHS Foundation Trust (2009) UKUT 195 (AAC) Appeal No. M/827/2009*
17. *Pars, 16 and 19 AA v Cheshire and Wirral Partnership NHS Foundation Trust (2009) UKUT 195 (AAC)*
18. *The writer represented in a restricted case which resulted in the Tribunal making a forceful non-statutory recommendation that the hospital should provide video link to the patient's family. The hospital provided this shortly thereafter but had not been willing to do this prior to the decision. In view of the distance between the client and the relatives, there was no possibility of visits, and the client was likely to stay in hospital all his life. The video link significantly enhanced the client's well being.*

client is likely to have no idea as to the wider remit of the Tribunal other than the power to discharge. This subtler and discerning approach to taking instructions is important if representatives are going to make a difference to those they serve. This approach was firmly supported by Peter Bartlett, Oliver Lewis and Oliver Thorold

> *"They may well want a result that is not a simple legal win. A client in an institution may want simply to be free of the whole psychiatrist system, but alternatively he or she may want to be out of the institution, but to continue his or her relationship with the institution as an out-patient. A client may want a change of medication, rather than to be free of the system as a whole. A client may understand his or her need to be in an institution, but wish to be in an institution closer to family members, or in a less restrictive department of the institution...... Failure to identify the client's vision of success may well lead to unfortunate consequences. It would be a Pyrrhic victory if a lawyer successfully obtained the complete separation of the client from the mental health system, if what the client really wanted was a change in medication"*[19]

Case Preparation

Detailed case preparation is essential. Without it any advocacy will be froth, with no substance and no prospect of effecting worthwhile change. The representative's role is critical both before and after the hearing. The role beforehand includes the timing of the application, obtaining independent reports, interviewing of witnesses, advising clients on the merits of the case etc. Action after the hearing will include acting upon formal and informal recommendations, advising on grounds of appeal etc. No representative who is a panel member and employed in a publicly funded firm can excuse himself for not knowing what good preparation entails. Quality standards have been imposed upon the profession through legal aid contracts and the requirement to provide *"consistently good quality services for clients"*[20] The peer review criteria, coupled with regular training should ensure high standards. Eldergill provided a definitive account of what good case preparation entails, in Chapter 16 of *'Mental Health Review Tribunals'*.[21] Another worthwhile document which representatives would do well to consult is the American Bar Association's document *'How to prepare for an involuntary Civil Commitment'*.[22]

Expertise

Whilst the establishing of a canon of mental health law may have been slow, there have been a number of significant developments which have speeded up the process. The *Human Rights Act 1998* has led to an increase in legal challenges in the upper courts. This was predicted by Thorold in an article published in 1996 when he stated *"The current pace of challenge is very likely to quicken, particularly if incorporation, so long advocated, becomes a reality."*[23] Together with the development of case law we now have the *Mental Health Act 2007* and the MCA. These have also introduced a fiendishly complex piece of legislation

19. *Page 237 Op. Cit.*
20. *page 2 A.Sherr "Improving your Quality A guide to the common issues identified through peer review Mental health", Independent Quality Assessment of Legal Services July 2006. This document is has recently been re published in Oct.09.*
21. *A.Eldergill "Mental health review tribunals Law and Practice" Sweet and Maxwell 1997*
22. *"How to Prepare for an Involuntary Civil Commitment Hearing" American Bar Association Commission 37 Prac Law (1991) 39*
23. *"The Implications of the European Convention on Human Rights for United Kingdom Mental Health Legislation" Oliver Thorold [1996] EHRLR Issue 6 Sweet and Maxwell.*

concerning the deprivation of liberty of mentally incapacitated persons.[24] We also have a new Upper Tribunal (Administrative Appeals Chamber) which has already delivered a number of Judgments.

Effective representatives therefore have to be highly skilled practitioners who need to keep up-to-date with the ever changing complexities of mental health law. This was acknowledged by Mr Justice Brooke who commented

> *"We are worried, however that the board* (then the Legal Aid Board) *has not yet appreciated how difficult Mental Health Law is, and how generally solicitors cannot pick up the expertise needed to serve clients effectively unless they have a strong and practical grounding in this field of law."*[25]

There are now so many training opportunities that representatives are spoilt for choice. The gold standard would see representatives commit themselves to a LLM/Diploma in Mental Health Law. In the past, representatives have never had the opportunity to study the subject thoroughly, since it is not part of a solicitor's training. For the last 11 years Northumbria University has provided a Mental Health Law option on its Legal Practice Course. The LLM/Diplomas in Mental Health Law and Mental Health Law and Practice are two year distance learning courses but with opportunities for study days at the University. The modules include Mental Health Tribunals, Community Care, The Elderly, Children and Young persons, Compulsory Civil Admissions, Treatment and the Mentally Disordered Offender. There is also the opportunity to meet other colleagues and to complete a dissertation of your choice.[26]

Professional detachment

It is inspiring when prospective applicants explain to the Panel assessors what it is that motivates them to represent mental health patients. Their answers usually betray a concern and compassion for this disadvantaged group. The work is at the cutting edge of issues involving despair, incarceration, powerlessness and loneliness. Given the level of financial reward and lack of professional status attached to this work, it is not money but humane values that generally motivate representatives. Returning to Eldergill: *"Being able to take proper instructions, helping the client to formulate what he wants, and then pursuing those objectives in a constructive way, may require more empathy than is usually necessary in most other legal fields."*[27] Given the emotional pull that a client may have on a representative, the fundamental principles that govern the solicitor-client relationship must also remain to the fore. These are contained in The Solicitors Practice Rules 1990 and the Annex "Advocacy Code". Par 2.6 of the Annex States that advocates must not

> *"(a) Permit their absolute independence and freedom from external pressures to be compromised;*
>
> *(b) Do anything (for example accept a present) in such circumstances as may lead to an inference that their independence may be compromised;*
>
> *(c) Compromise their professional standards in order to please their clients, the court or a third party."*

24. *Paul Bowen commenting on these provisions "the new triumph of legalism, the provisions so labyrinthine and bureaucratic" in The Preface to "Blackstone's Guide to the Mental Health Act 2007" 2009 Oxford University Press*
25. *Par 569 R v Legal Aid Board ex parte Mackintosh and Duncan 2000 EWHC Admin 294, 16.02.00 Case nu. Co/4807/99*
26. *The writer is a graduate of Northumbria University, having completed the LLM in Mental Health Law.*
27. *Page 884 Ibid*

Non-solicitors who act as representatives are not subject to these rules of professional conduct, but if they are members of the Mental Health Lawyers Association (MHLA) they are obliged to follow the Association's Code of Conduct. In addition they would be wise to know and follow the Solicitors Rules of Professional Conduct. Training courses for panel membership should spend time on these Rules. This would help non-solicitors in dealing with the highly complex and ethical issues they will face. An advocate who becomes too emotionally involved at a Tribunal hearing does his client no favours.

Adversarial or Inquisitorial?

Should a representative adopt an adversarial or a more cooperative and consensual approach? The courts have leaned towards seeing the Tribunal format as primarily inquisitorial. This view has been strengthened with the adoption of the new Tribunal Rules.[28] In particular the Overriding Objective as stated in Rule 2 imposes an obligation to cooperate with the other parties and the Tribunal so that the case can be dealt with "fairly and justly". Rule 2 (4) could not be clearer:

> *"Parties must*
>
> *(a) Help the tribunal to further the overriding objective; and*
>
> *(b) Co-operate with the Tribunal generally"*

This approach was supported in the first appeal case to the Upper Tribunal where it was stated

> *"These provisions therefore impose an express obligation upon the parties to assist in the furtherance of the objective of dealing with cases fairly and justly, which include the avoidance of unnecessary applications and unnecessary delay. That requires parties to co-operate and liaise with each other concerning procedural matters, with a view to agreeing a procedural course promptly where they are able to do so, before making any application to the tribunal. This is particularly to be expected where parties have legal representation.*[29]

Note however that the requirement to co-operate refers to procedures. In respect of the hearing and the giving and challenging of evidence, the parties generally want to achieve different outcomes. Parties have rights, and an adversarial element to the proceedings is therefore implicit; advocates should not shy away from this. The Law Society's Code for Advocacy states

> *"Advocates must promote and protect fearlessly and by all proper and lawful means the client's best interests and to do so without regard to their own interests or to any consequences to themselves or to any other person."*[30]

Eldergill summed it up well: *"The model is therefore a mixed inquisitorial-adversarial model, but hopefully not confrontational"*[31] Or, as Collins J, put it, " *it is not particularly helpful to label the proceedings one way or the other."*[32]

28. *The Tribunal Procedure(First-Tier Tribunal) (Health,Education,and Social Care Chamber)Rules 2008*
29. *Par 13 Dorset Heathcare NHS Foundation Trust v MH UKUT 4 (AAC) 8.1.09*
30. *Rule 2.3 (a) Law Society's Code for Advocacy, Annex 21A to the Solicitors Practice Rules 1990*
31. *Page 14 Ibid. Although A. Eldergill was making his comments with regard to the Republic of Ireland's main piece of legislation, the Mental Health Act 2001, his comments equally apply to the English and Welsh Tribunal systems*
32. *Par 24 R (X) v MHRT (Admin Court) 2003 MHLR 299. For further consideration of the 'Adversarial or Inquisitorial?" debate see "Is there a Burden of Proof in Mental Health Cases" by Jeremy Cooper and Howard Davis in this issue of the Journal of Mental Health Law.*

The Undertaking

To become a member of the Panel the applicant has to sign an undertaking which states: "*I will not normally delegate the preparation, supervision, conduct or presentation of the case, but will deal with it personally*". The undertaking does permit some delegation but the intention is clear. Being so vulnerable, the client needs to develop a trusting relationship with one person, i.e. the person who will eventually advocate for him at the tribunal. It is out of this relationship that instructions can evolve and the client's case can be put at its strongest. Such a relationship could not possibly exist where the client never gets to know the Panel member until the day of the hearing.

Financial pressures are growing for the spirit of the undertaking to no longer apply. There are firms that only pay lip service to the undertaking and who employ unqualified staff who are not Panel members to prepare the whole case. The Panel member's only involvement is that of supervisor and turning up for the hearing.

Jack Straw whilst Lord Chancellor suggested that legal services should operate like high street opticians with the customer using a sales person rather than the optician to choose the frame. He went on to say

> *" A further question individual practices need to consider is whether or not all of the functions currently carried out by qualified solicitors and barristers need always to be carried out by them……As paralegals take on more responsibility, as the legal executive profession develops, there should be scope to do more, quicker and at lower cost, without standards falling."*[33]

The reference to "lower costs" is significant, and the suggestion that standards would not fall is neither reassuring nor convincing. Provided the Law Society through the Panel remains committed to the undertaking, any dilution of its principles will be difficult to achieve.

The way forward

The implementation of the following proposals would significantly help in keeping standards high among legal representatives and attract more applicants to the Panel, reversing the current downward trend.

1. For at least three years the Panel has not had a Chief Assessor. As a consequence the Panel has become rudderless with no one at the top making any strategic decisions. The Law Society has at last made a commitment to appoint a "Chief Assessor". It is essential that this post is filled immediately.[34]

2. The Legal Services Commission (LSC) have considered making it a contract requirement that representation at a hearing can only be by a Panel member. This has not yet been introduced. When it is it should include special rules allowing trainee Panel members to represent. This would cut out most non-qualified, non-panel members representing at Tribunal hearings.

3. With the development of Mental Health and Mental Capacity law, the Law Society should introduce a compulsory training module at some stage in a solicitors training. This area of law affects so many other branches of law that knowledge of Mental Health and Mental Capacity Law is essential. For example, criminal practitioners need an intimate knowledge of Part 3 of the MHA; probate solicitors need to know about the MCA; civil litigation plaintiff solicitors need to know about the Court of Protection etc.

33. *Page 5 Jack Straw MP (former Lord Chancellor and Secretary of State) speech at the LSE 3.3.09*
34. *See postscript to this article*

4. Professional Ethics should become a compulsory element of training for panel membership.

5. Strasbourg must give a definitive ruling that in all hearings reviewing detention, the patient must always be legally represented

6. The LSC does not acknowledge that the introduction of the Fixed Fee system has led to a decline in providers. The MHLA disagrees, and points to a drop in fee income.[35] There should be an independent review into the fixed fee system as recommended in the last Biennial Report of the Mental Health Act Commission. The Report states: "Given the fundamental issues at stake in a Tribunal hearing, we think that these changes should be subject to systematic monitoring, and as such we repeat the call… for Government to commission and fund an independent review of the effects of the revised fee system, with a particular focus on tribunal representation."[36]

7. The MHLA deserves great credit for its campaigning over the last few years in defending and promoting the role of mental health lawyers. It is essential at this time of great uncertainty that the Association continues in this role and remains in constant dialogue with the LSC, Government and the Law Society.

A case worth fighting for

Representing the mentally disordered can be a lonely, stressful and thankless task. Yet it remains a fundamentally important task. The representative provides the skilled voice for a patient who has lost his liberty. Representatives should take pride in what they do and never doubt the difference they can make to the lives of those who are unable to fight their case alone.

Postscript

This article was accepted for publication in the spring of 2010. Since then there have been profound changes which make some of my above proposals obsolete. The good news is that the Law Society has appointed Robert Robinson as Chief Assessor of the Panel. He has already started giving a much needed lead. On the down side the results of the mental health tendering process have been published. There have been significant winners with firms that overbid and are now trying to recruit staff to fulfil their bids. There have also been significant losers. In particular, small and medium sized firms which did not overbid have had their case load cut by between a half and a third. This is a most unfair outcome to a bidding process that was not transparently fair. The outcome will make it difficult for some firms to survive. It will also mean that established and respected providers will have to turn their clients away when they run out of new matter starts. Luke Grant summed it up well in the Law Gazette in September 2010:

> *"What am I to say to a client I have represented for the best part of 20 years, when I tell them my legal aid quota has run out and they will now have to see someone else? They will not understand the market place which is now the legal system"*[37]

Despite this undesirable outcome, the present Government Minister with responsibility for legal aid, Mr Jonathan Djanogly, has said

35. *See Sheila Carrick "Opinion:Legal representation at MHRT's in South West England hanging by a thread", Adjust Newsletter Dec 2008. This account was challenged by the LSC.*

36. *Par 2.110 "Coercion and Consent monitoring the MHA 2007-20009" MHAC Thirteenth Biennial Report 2007-2009 The Stationery Office*

37. *Luke Grant, letter to the Law Society Gazette 2.9.10*

> *"Our priority is not what lawyers do, or the number of lawyers there are doing certain things. Our priority is legal representation for vulnerable people."*[38]

That is a worthy priority, but the problem the minister fails to address is that representation is meaningless unless it is provided by advocates of choice and competence. The market place of the legal aid system is in danger of not meeting this requirement. If only the LSC implemented the modest reform which I proposed above namely restricting representation at MHT's to those who were Panel members or applying to become a Panel member, then standards would have a chance of remaining high.

38. *J.Djanogly The Law Society Gazette 14.10.10*

When protective powers become threatening

***Deborah Padfield*[1]**

Indefinite and preventive detention: two archetypal danger-areas for the civil-libertarian mind. Both are permitted by criminal and mental health law, subject to the safeguards provided by common law and the European Convention on Human Rights (ECHR). Watchful eyes need to remain focused on the interpretation of such powers of detention.

That any coercive power that can be abused by authority will be so abused seems a reasonable rule of thumb. Certainly it is the assumption on which responsible legislators ought to work; even if they are willing to trust their own imperturbability in the face of events they have no right to do so, or so to trust their successors. Stop-and-search has been heavily abused,[2] while the limits on control orders are under judicial scrutiny domestically and at Strasbourg.[3]

Terrorism trials and those involving notoriously violent criminals catch headlines, especially where mental disorder is involved. My concern here is the looseness of provisions which, operating out of the public eye, can indefinitely detain people on preventive grounds.

Popular fear as basis for detention

In the context of mental health, government has a major anti-stigma campaign in operation. Thus a Department of Health (DoH) perspective:

> *'...the killing of strangers by people with mental illness is rare; most stranger homicides are committed by young men without mental illness who are under the influence of alcohol or drugs. The public may fear the mentally ill but they are more at risk from heavy drinkers.'*[4]

Risk-aversion, however, having gained a popular voice which no politician can ignore, has become a political tool which few politicians will eschew. Speaking at the 2010 Conservative Party Conference, Justice Secretary Ken Clarke espoused community sentencing for short-term prisoners while reiterating that the goals of prison were public safety and punishment, 'and also' reduction of reoffending.[5] His policy shift has not diluted a former Home Secretary's emphasis on risk:

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1. *Student on the LLM (Mental Health Law) programme, University of Northumbria 2008-2010.*
2. *See for example the comments of Helena Kennedy QC in 'Access to justice after New Labour' (January 2010) Legal Action news 6-9.*
3. *Notably in SoS for the Home Department v AF (No 3); Same v AN; Same v AE [2009] UKHL 28; A and others v United Kingdom [2009] ECHR 3455/05; N v SoS for the Home Department [2010] EWCA Civ 869; R (AP) v SoS for the Home Department [2010] UKSC 24.*
4. *Department of Health, Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, (London: TSO 2001), p152. Government's enthusiasm for wider-reaching anti-discrimination measures will be indicated by the speed of implementation of the Equality Act 2010's public sector equality and socio-economic duties; the latter is disappointingly weak.*

> *"I am... proposing to take new powers to enable dangerous and high-risk offenders to be better managed... The plans which we have recently announced to amend mental health legislation will help to ensure that mentally disordered offenders get the treatment they need and that the risk which they pose to the public is minimised..."*[6]

This is an idealised win-win scenario. It suggests that offenders are thus detained for their own sake *and* the protection of others. That is not what the *Mental Health Act* says. Rather, patients can be detained for their own health and safety or for the protection of other people. *The Mental Health Act* – before and after the reform of 2007 – provides for psychiatric detention purely on the grounds of dangerousness.

Both perceptions are true: violence by mentally disordered people represents a minority of crimes but a small number of serious offences remain the high-profile work of seriously disturbed (mainly) men. Policy thus has to tackle stigma and public protection. The question here is whether policy addresses not merely actual but also perceived danger, an inflation resulting in the lawful but unnecessary detention of people whose human rights are inadequately protected by domestic or Convention law.

Though Parliament has not inhibited assaults on civil liberties[7] and the Courts have shown an uneven resistance,[8] there are checks on centralised control. Indeed, the Labour administration showed no coherent purpose of increasing such control, in its first term incorporating the ECHR in the *Human Rights Act 1998* and passing the *Freedom of Information Act 2000*.

Nevertheless, thresholds of detention have been falling under criminal and mental health law. That fall relies significantly on public fear. After every public-authority-related tragedy, even while the seeds of future tragedies continue to be sown, the same meaningless mantra is mouthed: 'it must never happen again'. Where detention is concerned, a sense of entitlement to a uniquely risk-free society combines with denial of the limitations of risk prediction to produce an uncritical appetite for control, or 'management'.[10] Following rather than engaging with media reactions, politicians help to create a climate within which borderline discharge decisions become ever more difficult.

In relation to criminal law, the Labour government legitimised an expansion of prison populations by arguing that the policy is '"protecting the public from thousands of offences a year which might otherwise

5. *http://www.telegraph.co.uk/news/newsvideo/uk-politics-video/8043713/Ken-Clarke-calls-for-prison-reform.html*
6. *Home Secretary Charles Clarke, New Public Protection Measures: Home Office press release following the murder of John Monckton in 2005 by a prisoner on licence, (20 April 2006). http://press.homeoffice.gov.uk/press-releases/new-protection-measures. See also the White Paper on Sentencing, 2002, quoted in the Bennett Report, The social costs of dangerousness: prison and the dangerous classes, Centre for Crime and Justice Studies, (2008) p6.*
7. *For example 'counter-terrorism' legislation, the growth of administrative penalties and erosion of the jury system. The House of Lords has arguably shown more backbone, for example in its debates over mental health reform in this century.*
8. *However, the Appeal Court's recent ruling in R (Mohamed) v SoS for Foreign & Commonwealth Affairs [2010] WL 442342 importantly affirms open justice as one of the central factors to be considered in balancing public interest concerns.*
9. *Though some sceptics suggest that these were effectively unavoidable inheritances from the John Smith years.*
10. *See H. Southey, 'A personal overview', in N. Padfield (ed.), 'Who to Release: Parole, fairness and criminal justice', Willan Publishing, (2007) p239; J. Thompson, 'The recall and re-release of determinate sentence prisoners', in the same volume, p157.*

have occurred".[11] Crime is disproportionately presented as violent and sexual, provoking an exaggerated perception of the need for penal and preventive imprisonment.[12]

Inevitably, the stakes are raised by high-profile tragedies. The 2006 Anthony Rice murder[13] helped to provoke then-Prime Minister Blair into requiring Home Secretary John Reid to question whether judicial interpretation of the HRA was unacceptably overruling government policy.[14] It is a valid question for the executive; but the overall message of government's response was to use the tragedy as an opportunity of responding to popular fear, rather than of tackling the far-from-zero-sum relationship between individual freedom and public safety.

Scare stories about tragically ill-fated releases of psychiatric patients show a corresponding rationale.[15] A study of 'Media influences on mental health policy' following the Clunis and Silcock cases concluded that while press coverage had been partly motivated by a desire to improve psychiatric care, policy responses to public fears had produced increased constraints upon mentally disordered people.[16] Citing a Texan judgment in 2006, Richards LJ commented revealingly on the rights of mentally ill people:

> *'"One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma… It cannot be said, therefore, that it is much better for a mentally ill person to 'go free' than for a mentally normal person to be committed."*
>
> *'Furthermore the consequences that may flow from the release of a person suffering from mental disorder include not only a risk to the individual's own health and safety..., but also a risk of harm to other members of the public.... [A] person whose case is being considered under section 73 was detained in the first place pursuant to a hospital order... following conviction for a criminal offence, often an offence of violence: the appalling facts of N's [sic] own case are very much in point....'*[17]

Various points here. Firstly, the belief that neither liberty nor freedom from stigma is possible for a 'debilitatingly' mentally ill person, so that incarceration is less bad (damaging? painful? morally suspect?) than for a 'mentally normal person'. Such demotion of minorities to marginal subhumanity has a malign history. Secondly, note the slippage from the particulars of AN's 'appalling' case to generalisation about people suffering from mental disorder.

11. *Bennett Report (2008) pp14-16, quoting the Home Office, 2006. In particular, he singles out Home Secretary John Reid's 'high profile review' of 2006 which while highlighting concerns about 'serious, violent and dangerous offenders', 'made no attempt at all to define dangerousness, although did specifically mention a range of offences from serious organised crime to domestic violence to the carrying of knives. This again indicates that, for politicians, dangerousness is an imprecise, flexible and broad concept.' See Home Office (2006), Rebalancing the Criminal Justice System in Favour of the Law-Abiding Majority: Cutting Crime, Reducing Reoffending and Protecting the Public, Home Office. See also N. Padfield and S. Maruna, 'The revolving door at the prison gate: Exploring the dramatic increase in recalls to prison' (2006) 6 Criminology & Criminal Justice 329-352.*
12. *Bennett Report (2008) p7.*
13. *'a sex attacker who killed a mother-of-one while on licence from a life sentence': BBC News Channel, 10 May 2006. http://news.bbc.co.uk/1/hi/uk/4756435.stm*
14. *Prime Minister Tony Blair, Letter to Home Secretary John Reid. Number10.gov.uk, 14 May 2006. See also R. Morgan, Review of 'Who to Release? Parole, Fairness and Criminal Justice' N. Padfield (Ed.). Willan (2007). (July 2008) 47 The Howard Journal, pp332-333.*
15. *For example in 1992, Jonathan Zito was killed by Christopher Clunis, diagnosed with paranoid schizophrenia, and Ben Silcock, also suffering from schizophrenia, was badly mauled after climbing into a lion's den at London Zoo. Michael Stone, diagnosed with a personality disorder and drug-induced psychosis, killed Lin and Megan Russell in 1996.*
16. *A. Hallam, 'Media influences on mental health policy: long-term effects of the Clunis and Silcock cases' (2002) 14 International Review of Psychiatry 26-33.*
17. *See R (AN) v Mental Health Review Tribunal (Northern Region) [2006] EWCA Civ 1605 at [74].*

This is not an isolated instance. A few years earlier, quoting a judgment of the European Court of Human Rights (ECtHR), Lord Clyde had referred approvingly to the ECHR's equation of 'persons of unsound mind, alcoholics and drug addicts'.

> *"The reason why the Convention allows the latter individuals, all of whom are socially maladjusted, to be deprived of their liberty is not only that they have to be considered as occasionally dangerous for public safety but also that their own interests may necessitate their detention."*[18]

The specific outcome was to legitimise the indefinite detention of 12 men diagnosed with 'psychopathic personality disorders' and assessed as highly dangerous, but not amenable to lawful imprisonment or assessed as treatable; the 'own interests' argument, with no place in mental health law, can be little more than a paternalistic attempt at moral justification.

The problem here is not the (uncontentious) assertion that some mentally disordered people may be 'occasionally dangerous', but the suggested presumption of such a connection. A similar carelessness – or prejudice – marks his judgment a little earlier: "One of the immediate concerns which one has about such persons is that of public safety..."[19] It is a presumption which one-sidedly weights the evidence needed for courts balancing the interests of mentally disordered people and public safety, and which gives authority to popular fears.

The judiciary is not blind to its relationship with popular fear. The Parole Board in 1977 agonised over the extent to which its decisions on notorious prisoners should be influenced by public opinion; its 1986 Report 'felt it necessary to spell out that public perceptions were part of the risk assessment process with the Board taking into account "the degree of abhorrence with which society regards that offence and the likely public reaction to the offender's early release from custody". This can be contrasted with the long-standing principle that public reaction is not relevant to judicial sentencing and release decisions.'[20] That principle is spelt out by Goff LJ in the Venables and Thompson case: "I wish to draw a distinction... between public concern of a general nature with regard to, for example, the prevalence of certain types of offence, and the need that those who commit such offences should be duly punished; and public clamour that a particular offender whose case is under consideration should be singled out for severe punishment. It is legitimate for a sentencing authority to take the former concern into account, but not the latter".[21] It is a principle deserving closer consideration in political as well as judicial contexts.[22]

Governments shrink from confronting populist fears, being characteristically unwilling to open up discussion of the limits of risk assessment or of the complex relationship between incarceration and risk reduction. The former administration's simultaneous desire to present the DoH anti-stigma campaign made incoherence inevitable. One had to take centre stage; the Ministry of Justice (MoJ) won. The Coalition government has not indicated any shift in this balance.

Levels of detention

What is the evidence to support government's enthusiasm for preventive detention? One needs to look

18. *Anderson v Scottish Ministers [2003] 2 AC 602 at [63].*
19. *Anderson at [60].*
20. *S. Creighton, The Parole Board as a court, In N. Padfield (ed.), 'Who to Release? Parole, fairness and criminal justice', (Willan Publishing 2006) p110.*
21. *R (Venables) v SoS for the Home Department; R (Thompson) v the same [1998] AC 407 at [491].*
22. *For a passionate (and evidenced) indictment of the current administration's record on responding to public opinion rather than evidence see P. Toynbee, Bad politicians are slave to public opinion. Good ones try to change it, The Guardian, (27 November 2009).*

at the kinds of detention involved. Part III of the *Mental Health Act* deals with people who are facing, or have faced, criminal charges, while indeterminate prison sentences – now primarily mandatory and discretionary life sentences and sentences of Imprisonment for Public Protection (IPP) – permit imprisonment beyond the penal minimum term.

Looking therefore at the relevant figures: while overall NHS psychiatric bed numbers are falling,[23] those in NHS medium-secure units have been rising;[24] the units for Dangerous & Serious Personality Disordered (DSPD) patients,[25] High-Security Hospitals (HSHs) and private facilities[26] are additional to that rise. In 2009, the Mental Health Act Commission (MHAC) welcomed a 'recent upturn' in the use of s37 hospital orders, 'on the grounds that every individual case is a diversion from the criminal justice system'; however, 'in the light of the massive increase in prison population during this period... the overall proportion of diversions may have fallen considerably....'[27] Moreover, the upturn is accounted for solely by 37/41 detentions – restricted hospital orders.[28] Singh and Moncrieff argue that a rise in ss 2, 3 and 37/41 detentions, combined with steady levels of discharge on appeal, may suggest a lowering of the threshold for detention (restricted and unrestricted) and rise of that for discharge.[29] Last year saw a record number of Part III detentions.[30]

Tracking figures is not straightforward. Though 2009/10 saw a slight reversal in the trend since 2002-03 towards court and prison disposals in private hospitals at the expense of NHS facilities,[31] the private sector remains significant. 'Information is not collected by the Department [of Health] on the proportion or cost of personality disorder placements made in the private sector'; furthermore, '[i]nformation is not collected centrally on the effectiveness of personality disorder placements commissioned by PCTs [primary care trusts] from the private sector.'[32] Given that the Care Quality Commission relies heavily

23. *P. Pillay and J. Moncrieff, 'The Contribution of psychiatric disorders to occupation of NHS beds: Analysis of Hospital Episode Statistics', Presented at the Royal College of Psychiatrists Annual Meeting (2009): http://www.rcpsych.ac.uk/press/pressreleases2009/nhsbeddays.aspx. Their research also shows that psychiatric disorders remain among the top ten users of NHS hospital beds in 2007-08. Falling numbers of psychiatric beds and their implications have been under discussion since the 1950s at least: see G. Thornicroft and G. Strathdee, 'How Many Psychiatric Beds? The Debate Shouldn't Be Swayed By Moral And Political Considerations' (1994) 309 BMJ 970-971.*
24. *An email from Mark Quinlan of the Department of Health Customer Service Centre dated 2 October 2009 evidenced this rise in medium secure units and lack of data on independent sector beds. He adds that 'the NHS provision represents approximately 60 per cent, the rest being provided by the independent sector providing NHS funded services (at the latest count there were 41 NHS medium secure units and 25 independent medium secure units).'*
25. *Introduced by a joint Department of Health/Home Office initiative in 2004 (contemporaneously with the introduction of IPP sentences). See http://www.dspdprogramme.gov.uk/*
26. *See Hansard: House of Commons Written Answers, (15 June 2009), for secure unit bed numbers; see also Bennett Report (2008) p13 on numbers and role of DSPD units.*
27. *Mental Health Act Commission, Thirteenth biennial report: 'Coercion and consent: monitoring the Mental Health Act 2007-2009', (2009) para 4.12. On the same caveat, see also K. Edgar and D. Rickford, Too Little Too Late: an independent review of unmet mental health need in prison, (2009) p6.*
28. *MHAC 2007-09 para 4.13.*
29. *See D. Singh and J. Moncrieff, 'Trends in mental health review tribunal and hospital managers' hearings in north-east London 1997-2007' (2009) 33 Psychiatric Bulletin p16.*
30. *NHS Information Centre (October 2010), table 2.*
31. *See NHS Information Centre, In-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, Annual figures, England 2009/2010 (October 2010), pp 8-9. See also NHS Information Centre, In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1997-98 to 2007-08, (2008).*
32. *Hansard: House of Commons Written Answers, (15 June 2009): Tom Brake MP.*

on self-assessment by private providers, such lack of information is unsurprising.[33] People confined in a unique 'position of inferiority and powerlessness'[34] are being lost to official or public sight.

Meanwhile, seriously worrying numbers of mentally disordered people are in prison[35] while prisoner numbers are at a record high and rising, albeit more slowly than in the recent years.[36] The rise was linked to the introduction of IPP under the *Criminal Justice Act 2003* (CJA),[37] together with an upward trend in recalls, tougher licence conditions, greater surveillance of those on licence and growing risk-aversion by the Board[38] and the withdrawal of End of Custody Licence in March 2010. The levelling-off is attributable partly to the *Criminal Justice & Immigration Act 2008* (CJIA),[39] including amendments to IPP which reduced the remarkable swathe of offences accounted dangerous.[40] CJIA also restored judicial discretion in sentencing, abolishing the mandatory assumption that those committing offences potentially attracting IPP were indeed dangerous.[41]

Detention for the safety of others

So what are the legal grounds for non-punitive detention on the grounds of dangerousness to others? The quick answer is 'very broad'.

The Parole Board is "the court" responsible under Article 5(4) of the ECHR for deciding the continuing lawfulness of detention of prisoners for whom the original justification under Article 5(1)(a) has ended. Statute and case law have in the last couple of decades produced a complication of sentences, but the Board's remit includes indeterminate prisoners who have served their punitive minimum term. Lawfulness after this is on the grounds solely of public safety. The Board has an apparently-specific criterion for continued imprisonment in the 'life and limb' test for lifers,[42] recognised as leaving the level

33. *All health providers providing publicly funded services are subject to inspection by the Care Quality Commission; however, see www.cqc.org.uk/guidanceforprofessionals/healthcare/guidanceforindependentstaff/ourroleasregulator/risk-basedinspection.cfm for its policy in relation to private providers.*
34. *Herczegfalvy v Austria [1993] 15 E.H.R.R. 437 at [82].*
35. *See Bradley Report, Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, Department of Health, (2009) pp97 et seq.. However, numbers transferred and diverted have fallen proportionate to those imprisoned. See also House of Commons Justice Select Committee: Sentencing (2008) para 201.*
36. *Prison Reform Trust, Bromley Briefings Prison Fact File, (July 2010); also FactFile (2009). Ministry of Justice, Prison Population Projections 2010-2016, England and Wales: Ministry of Justice Statistics bulletin, (30 September 2010).*
37. *The range of offences for which the IPP can or must be used contrasts with the outlook of Stuart Smith LJ in 1990: 'The imposition of the life sentence itself can only be justified by a very high degree of perceived public danger: there would otherwise be the temptation to impose it altogether too often simply in the interests of long-term public safety.' In R (Bradley) v Parole Board [1990] 3 All ER 828 at [146].*
38. *N. Padfield, 'The Parole Board in Transition' (2006) 3 Crim.L.R. 3-23 p8. See also N. Padfield and S. Maruna, 'The revolving door at the prison gate: Exploring the dramatic increase in recalls to prison' (2006) 6 Criminology & Criminal Justice 329-352.*
39. *MoJ statistics bulletin (2009) p16.*
40. *Under CJA 2003 ss224-36 and Sch 15, subsequently amended by Sch 15A under the CJIA 2008.*
41. *For some trenchant commentary, see Lord Judge in R v C; Attorney General's Reference No. 55 of 2008 (C and Others) [2008] EWCA Crim 2790.*
42. *See Ministry of Justice, The Future of the Parole Board: consultation paper 14/09, (2009) para 29, and Secretary of State's Directions to the Parole Board under Section 32(6) of the Criminal Justice Act (August 2004) para 4.*

of acceptable risk 'wholly undefined' because indefinable[43] and subject to executive direction.[44] The concept of burden of proof has been ruled 'inappropriate when one is involved in risk evaluation',[45] but the prisoner must in practice demonstrate that the risk he poses is not more than minimal.

The element of arbitrariness built into such judgments is illustrated by the comparison of monthly average figures for the numbers detained under IPP pre- and post-2008 and their average pre-tariff sentence-length. Under the original range of offences whose perpetrators were accounted dangerous, 140 IPP prisoners were received per month, serving 38 months. Under the amended terms of reference, 45 IPPs were received, serving 60 months. The sentence now focuses on fewer, more serious offenders. Yet the Parole Board's assessment inevitably has as its starting point the assessment of all these prisoners, pre- and post-2008, as 'dangerous'. The loss of any connection between imprisonment and rehabilitation is an easy casualty, despite the inclusion of rehabilitation in the purposes of imprisonment in the *Criminal Justice Act 2003*.[46] Nor does this amendment to IPP signal diminished faith in detention; it merely trims a notoriously under-considered piece of legislation.[47]

The Mental Health Tribunal is the Article 5(4) reviewing 'court' for people detained under the MHA and covered by Article 5(1)(e). A criterion for MHA detention is an undefined need for 'the protection of other persons'.[48] Under that provision, there is a yet more serious loss of connection – that between detention and treatment, even for the symptoms of mental disorder;[49] to lose that link would be to accept that psychiatry had become an overt means of control.

After 1983, the scope of the original provision of detention solely for the protection of others was gradually extended by the judiciary.[50] The battle for reform finally producing the MHA 2007 challenged that extension: referring to an earlier Bill but making an argument pertinent to the final Act, the Mental Health Alliance was 'particularly disturbed by the over-emphasis in the Bill on protection of the public from "dangerous" people and the disastrous impact this will have on those people it targets and on the vast majority of mental health patients who pose no danger to anyone.'[51] In the upshot the 2007 Act's inclusion of personality disorders[52] through abolition of the old 'categories', and its wider definition of

43. *In Bradley at [146]: 'it seems inevitable that one can say really no more than this: first, that the risk must indeed be "substantial" ..., but this can mean no more than that it is not merely perceptible or minimal. Second, that it must be sufficient to be unacceptable in the subjective judgment of the Parole Board...'*
44. *See A. Thornton, 'Current practice and future changes: a judicial member's perspective', in N. Padfield (ed.), 'Who to Release? Parole, fairness and criminal justice', Willan Publishing (2007) p130 on the difference between case-law and (then) Home Secretary directions.*
45. *Keene LJ in R (Sim) v Parole Board [2004] QB 1288 at [42].*
46. *See Brown LJ in R (Wells) v Parole Board [2009] UKHL 22 at [48] for the situation pertaining until July 2008 and the amendments then made.*
47. *See Hope LJ in Wells at [3]; see also Collins J in R (B) v The Parole Board [2009] EWHC 1638 (Admin) at [23].*
48. *In Mental Health Act Manual, 13th ed., Sweet & Maxwell, (2010) para 1-055, Richard Jones remarks tersely that 'there is no requirement for the two recommending doctors to agree on the nature of the risk which justifies detention under this section'. Neither does the Tribunal have any criteria by which to assess it.*
49. *See for example R (A) v Canons Park Mental Health Review Tribunal [1995] QB 60; H [2001]; R (P) v Mental Health Review Tribunal [2002] MHLR 253 CA.*
50. *Notably in legitimating hospitalisation for control and supervision: see Hutchison Reid v United Kingdom [2003] 37 E.H.R.R. 9 and D (1987).*
51. *Hansard, Joint Committee on the Draft Mental Health Bill Minutes of Evidence: Memorandum from the Mental Health Alliance (DMH 105) (9 March 2005) at para 1.8. See also Hansard, Minutes of Evidence taken before Joint Committee on the Draft Mental Health Bill: Uncorrected Transcript of oral evidence to be published as HC 95-xii, (Wednesday 26 January 2005) and Uncorrected transcript of oral evidence to be published as HC95v, (Wednesday 15 December 2004).*
52. *For guidance on treatment of personality disordered patients under the MHA, see Code of Practice (2008) paras 3.18 and 3.19, and Chapter 35.*

'treatment',[53] merely confirmed judicial extension of the law.[54]

During the passage of the MHA 2007, the Mental Health Act Commission expressed concern that detention could be legitimised by merely *intended* benefit to the disorder or its symptoms without evidence of *likely* benefit. It cited the draft Code of Practice, case-law and Jones to argue that individual 'best interests' should remain a criterion,[55] but the published Code contained no such reference. Indeed, while under the Code 'Simply detaining someone – even in a hospital – does not constitute medical treatment', detaining that person with nursing and 'specialist day-to-day care' under clinical supervision and in a 'safe and secure therapeutic environment with a structured regime' does.[56] It is a largely semantic distinction.

The Code follows the case-law.[57] cited above is Lord Clyde's assertion of the power under MHA 1983 and the EHRC to detain people for the sake of public protection on the basis of their mental disorder and in the absence of treatment. That judgment followed *Ashingdane*, where only the minority judgment emphasised the difference in purpose between imprisonment and hospital detention, the latter involving the '…duty of the executive… to strive after the means most likely to bring a cure….'[58] The majority followed *Winterwerp* in ruling that the right to appropriate treatment could not be derived from Article 5(1)(e).[59] For Lady Hale, the indefinite confinement of capable and untreatable non-criminals under MHA could not be a 'justifiable discrimination'; she deplored Strasbourg's refusal to define 'unsound mind' in Article 5(1)(e) and thus restrict its potential abuse.[60] Her concern mirrored that of the Mental Health Alliance.[61]

This lack of clear definition of 'mental disorder' or 'appropriate treatment', including the distinction between detention in a therapeutic 'milieu' and mere containment, continues to exercise judges. Unfortunately, their rulings remain so hedged about by 'if', 'may', 'might' and other qualifiers that their call to Tribunals to apply the statutory conditions to the specifics of each case produces more appearance than reality of safeguard.[62] Lack of definition remains a mighty weapon.

53. *MHA s145(4).*
54. *See for example Auld LJ in R (JB) v Haddock (Responsible Medical Officer) [2006] on the role of 'value judgments' in 'often difficult and complex questions of diagnosis and prognosis on which there may be some difference of medical opinion.' See also Hutchison Reid [2003].*
55. *Mental Health Act Commission, Policy Briefing for Commissioners, (July 2007) p2. The Briefing also comments wryly on the effectively meaningless circularity of definition of 'appropriate'. In mental health law, as in penal law in relation to 'dangerousness', lack of definition is a useful tool for those wanting to reduce possibilities for appeal against detention. The reference is to R. Jones, Mental Health Act Manual, 10th ed., Thomson: Sweet & Maxwell, (2006).*
56. *Code of Practice (2008) paras 6.16-6.17.*
57. *Phillips LJ commented obiter on the common law 'best interest' requirement for medical treatment, citing the relevance of such 'wider considerations' as the possibility of less intrusive treatments to 'achieve the same result'. Since that 'same result' has to include the considerations not only of health but of others' safety, it is unlikely that 'best interests' can go far in limiting the scope of the law. See R (B) v (1) Dr S; (2) Dr G; (3) SoS for Health [2006] EWCA Civ 28 at [62].*
58. *Ashingdane v UK [1985] 7 EHRR 528 at [551]. Ashingdane also ruled that psychiatric detention must be in an appropriate institution.*
59. *Winterwerp v The Netherlands [1979-80] 2 E.H.R.R. 387. See also Ashingdane at [44] for a ruling that there must be 'some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention'.*
60. *B. Hale, 'Justice and equality in mental health law: The European experience' (2007) 30 International Journal of Law and Psychiatry 18-28 p27. The case is closely similar with the non-definition of 'appropriate' treatment and indeed of its 'availability'; which will also no doubt exercise the judiciary.*
61. *Hansard, Joint Committee on the Draft Mental Health Bill Minutes of Evidence: Memorandum from the Mental Health Alliance (DMH 105) (9 March 2005), in particular Part 4.*
62. *DH-L v Devon Partnership NHS Trust [2010] UKUT 102 (AAC) at [33] and [24]; MD v Nottinghamshire Healthcare NHS Trust [2010] UKUT 59 (AAC) at [48].*

Prison or hospital?

If people can be detained purely for the protection of others under criminal and mental health law, what is the distinction between them?

In principle, and probably in practice in terms of the experiential difference between even a HSH and a high-security prison, there is a profound distinction in terms of the institutions' rationale and the motivations and professional ethos of the detaining authorities. Hoggett, now Lady Hale, is a prime proponent of a principled difference between the two regimes. 'The gulf between pure preventive detention and some sort of medical care and treatment may be very narrow, but it is nonetheless deep...; although she also makes it clear that a gulf so narrow is liable to be bridged.[63] Dyson LJ subsequently spelled out the 'subtle yet important differences' between Tribunal and Board. Before the Tribunal, '[w]hile risk to the public is a factor it is not determinative in the absence of evidence that the patient meets the criteria for detention in hospital under the Act'. Before the Parole Board, 'primacy of risk' to the public must be respected.[64]

Hallett LJ insists on the principle that 'the Mental Health Act regime under a hospital order focuses on reducing the risk of a recurrence of mental illness as opposed to reducing the risk of re-offending...'[65] Parallel reasoning holds for restricted patients: the judiciary must resist any temptation to see a transfer direction as a means of prolonging penal detention.[66] Though restriction-direction patients continue to serve their sentence while detained in hospital, psychiatric detention is not (in principle) punitive. So at least Lady Hale argues, commenting on the tendency of Strasbourg to treat psychiatric hospital and prison together and referencing her own Appeal Court ruling in *Munjaz* on their different purposes.[67]

Sentencing courts must therefore (try to)[68] distinguish where on the gradient a law-breaker stands: between offences directly attributable to a mental disorder and those where, despite such a disorder, the causal link is 'diminished' or absent.[69] At the one end lies a hospital order, probably with restriction;[70] at the other a prison sentence, even if a transfer/restriction direction is subsequently needed;[71] in the middle a hospital/limitation direction.[72]

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63. *B. Hoggett, Mental Health Law, 3rd ed., London: Sweet & Maxwell, (1990) p289. The reference to 'the gulf' is repeated on page 273 of B. Hale, Mental Health Law, 5th ed., London: Sweet & Maxwell (2010).*
64. *R v Staines [2006] EWCA Crim 15 at [22], quoting a 'conspicuously impressive' consultant psychiatrist witness.*
65. *R v Rajesh Kumar Dass [2009] EWCA Crim 1208 at [46].*
66. *See Stanley Burnton J in R (D) v SoS for the Home Office, SoS for Wales [2004] EWHC 2857 (Admin) at [20].*
67. *B. Hale, 'What can the Human Rights Act do for my mental health?' (May 2005) J. Mental Health L., p10. R (Munjaz) v Mersey Care NHS Trust and Others [2003] EWCA Civ 1036 at [55].*
68. *See J. Shaw et al, 'Rates of mental disorder in people convicted of homicide: National clinical survey' (2006) 188 British Journal of Psychiatry 143-147, for an analysis of the mental health diagnoses most and least frequently associated with a hospital order, and of the incidence of those convicted of manslaughter on the grounds of diminished responsibility nevertheless receiving a prison disposal.*
69. *See Mustill LJ in R v Birch [1989] 90 Cr. App. R. 78 at [89]. For a more recent discussion of the 'balancing act' necessary in deciding between hospital and prison disposal, see Hallett LJ in Dass at [46] et seq..*
70. *MHA s37/41. See Birch at [87] for discussion of the difficulty facing the sentencing judge in assessing whether a s41 restriction order is required. The House of Commons Justice Select Committee considered that 'sentencers would benefit from better guidance on their options with regard to persons requiring different levels of mental health support': see its Fifth Report of Session 2007/08: Sentencing, (8 July 2008) para 210.*
71. *MHA ss47/49.*
72. *MHA s45A, inserted by the Crime (Sentences) Act 1997, s46. There is no provision for voluntary psychiatric hospitalisation of prisoners; in-patient mental health care must be compulsory, however compliant – or eager for it – prisoners may be.*

Such complexities make for effectively arbitrary disposals. The MHA 2007 has removed the separate provisions for mental illness and 'psychopathic disorder'. But legal and clinical understandings of mental disorder continue to differ, driven by different agendas.[73] In *Murray*, sentencing guidelines and M'Naghton Rules enforced a penal disposal, though the Appeal Court subsequently moved the claimant to hospital.[74] However, the rules remain open to the influence of fear: either hospital or prison can be chosen as providing the longest and securest sentence. Thus the MHAC disapprovingly cited the refusal of the sentencing judge to send Nicky Reilly (diagnosed with Asperger's syndrome and learning disability) for assessment in Broadmoor before passing a life sentence.[75] In *Simpson*, the Appeal Court overturned the original prison disposal primarily on the grounds not of the offender's treatability, but because 'the best chance of minimising the danger lies in a Hospital Order…'. While Toulson LJ spoke of the (dim) hope of rehabilitation through medical treatment, the security implications were decisive.[76] The situation was even clearer in *IA*, where the sentencing judge handed down a life sentence in the 'hope and expectation' that Mr IA would be detained in hospital; however, 'little or nothing appeared to [be] done to effect the transfer'.[77]

It is partly a question of supply and demand. Given that prison beds are uniquely available on demand whatever the overcrowding, many prisoners assessed as needing hospital are not transferred.[78] The ruling in *IH* is interesting: continued detention of a patient potentially fit for conditional discharge is not unlawful where the 'nature' criterion is satisfied and where no appropriate community provision is available.[79] The funding priorities of PCTs and local government thus define the limits of lawful detention.[80]

So while prisons bulge with mentally disordered inmates, beds in secure units and HSHs are occupied by patients 'sectioned' more for security than health reasons. AT indicates the readiness with which Hoggett's 'gulf' can be bridged by the use of hospital as place of indefinite preventive detention.[81] Personality disorder diagnoses in particular are open to control-oriented interpretation: prisoners put forward by the Prison Service for transfer under the MHA can be deemed unsuitable by the Secretary of State [SoS] because of their 'untreatable' personality disorder[82] yet identically-diagnosed prisoners

73. *See G. Richardson and D. Machin, 'Judicial Review and Tribunal Decision Making: A Study of the Mental Health Review Tribunal' (2000) Public Law p501 for discussion of the inability of JR processes to define the legal meaning of the criteria under the MHA, definable only on a case-by-case basis.*
74. *R v Murray [2008] EWCA Crim 1792.*
75. *MHAC 2007-2009 para 4.7.*
76. *R v Jonathan Paul Simpson [2007] EWCA Crim 2666 at [28-30].*
77. *R v IA [2005] WL 1801234 at [2] and [17].*
78. *See for example Prison Reform Trust, Too Little Too Late (2009). In 2007 the Trust had reported continuing high numbers of severely mentally disordered prisoners and persistent serious delays in transfer to hospitals, despite some improvements since 2004: see Prison Reform Trust, Indefinitely Maybe: how the indeterminate sentence for public protection is unjust and unsustainable, (2007) pp19 et seq..*
79. *R. (IH) v SoS for the Home Department and another [2003] UKHL 59. See also P. Bartlett and R. Sandland, Mental Health Law: Policy and practice, 3rd ed., OUP, (2007) p108 for comments on lack of lower-security facilities.*
80. *See also Creighton 2006, p114 for discussion of AT v UK [1995] 20 EHRR CD 59. The possibility of a transfer direction depends upon availability of a hospital bed, and long delays are common.*
81. *See L. Moncrieff, 'Discharge of Restricted Patients from Special Hospitals in England and Wales', in K. Diesfeld and I. Freckleton (eds.), Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment, Ashgate, (2003) p279 for discussion of the effective bed-blocking in high security hospitals by patients whom the SoS refused to recategorise to lower security levels; and p275 on the way in which indeterminate restricted patients early in their sentences can be confined in high security hospitals on grounds of procedural ineligibility not dangerousness. See also Bartlett and Sandland (2007) p108.*
82. *Professor Charlie Brooker of Lincoln University, cited in Prison Reform Trust, 'Too Little Too Late' (2009) p23.*

hitherto deemed 'untreatable' can now be transferred under that same Act, and detained indefinitely.[83] In *TF*, the Appeal Court ruled that a transfer direction effected in September 2008, just before MHA 2007 was implemented and on the eve of young TF's release, was under s47(1)(b) unlawful in the absence of adequate medical evidence; the SoS' eleventh-hour attempt to continue detaining that personality-disordered offender had been one degree too clumsy.[85]

The rationale of recalls is similarly blurred. The SoS can recall a conditionally discharged patient though his disorder is not of the statutory 'degree' for initial detention 'because the combination of the patient's mental disorder and his behaviour makes it necessary' for public safety.[86] The recall decision depends only 'partly' on medical advice, 'comparatively minor irregularities of behaviour or failure to cooperate with supervisors being sufficient'; though behaviour unconnected with the mental disorder does not merit the 'sanction' of recall, 'the decision will always give precedence to public safety considerations' – a powerful catch-all.[87] The SoS apparently regards recall as a 'sanction' though its role is non-punitive.

But perhaps the most revealing indicator of an effectively arbitrary executive use of detention is the MoJ's range of responses when a conditionally discharged patient is reconvicted and sentenced to prison. '[T]he SoS will often reserve judgement on the patient's status under the *Mental Health Act 1983* until he nears the end of his prison sentence, when he will seek fresh medical evidence....', on the basis of which he may allow conditional discharge to resume, direct immediate recall to hospital or authorise absolute discharge.[88] The 'need' for hospital is again provoked only by the proximity of release.[89]

Optimists in search of rationales based on criminogenic or therapeutic priorities may despair. The Board's judgments on criminogenic risk can face executive challenge on the grounds that the offender's mental health renders its evidence unsafe, thus challenging the validity of its specialist work.[90] Meanwhile, the SoS' focus on immediate risk-avoidance must be deeply frustrating for courts aware that for some personalities, continued detention and over-stringent risk management on release increase longer-term risks of reoffending.[91]

Again, the Tribunal may review pre-tariff lifer restriction-direction patients whose detention may have no therapeutic or a counter-therapeutic effect, without effective power to discharge them: that lies with the Board. The discharge of post-tariff lifers under restriction directions, assessed by the Tribunal as ready for conditional discharge into the community but not back to prison, may be indefinitely blocked by a

83. *As in Anderson supra f/n 18.*
84. *The arrival of such evidence after the transfer took place did not render the initial action retrospectively lawful.*
85. *R (TF) v SoS for Justice [2008] EWCA Civ 1457.*
86. *Ministry of Justice, Guidance for clinical supervisors, (18 March 2009) para 63.*
87. *MoJ Guidance (2009) para 62. This guidance closely follows Toulson LJ's ruling in R (MM) v SoS for the Home Department [2007] EWCA Civ 687. The judgment emphasises at [48] the potential difficulty of assessing the moment at which recall is justified; the Guidance is simpler in its emphasis on the priority of public safety.*
88. *MoJ Guidance (2009) para 70.*
89. *The MoJ Guidance (2009) must be seen in the light of its genesis as a response to 'failures in supervision which contributed to homicides being committed by conditionally discharged patients: ' ibid para 2.*
90. *See Murray v Parole Board [2003] EWCA Civ 1561 at [13] et seq., quoting Oldham v UK (Application no 36273/97, 26 September 2000. Despite strong positive evidence of a prisoner's reduced criminogenic dangerousness, the SoS argued for continued imprisonment on the grounds that 'mental instability posing risks of dangerousness' is innately less amenable to change over time than 'mental disorder in the context of mental illness'.*
91. *See J. Craissati, 'The paradoxical effects of stringent risk management: community failure and sex offenders', in N. Padfield (ed.), 'Who to Release? Parole, fairness and criminal justice', Willans Publishing, (2007) p227.*

Board wary of their lack of criminogenic course-work or testing in open prison.[92] Tribunal members clinging to belief in the MHA's therapeutic rationale will be troubled by the evidence in *A and Others* of the psychological impact of indefinite detention.[93]

Anderson presents the incoherences starkly. His disorder having been assessed as untreatable, Mr Anderson could not be held in a prison hospital wing because (unsurprisingly) no treatment was available for him; he could nevertheless be indefinitely detained in hospital. Furthermore, while he required hospitalisation because he was too dangerous to be held in prison, assessment of his dangerousness was deemed to be beyond the Tribunal's sole remit.[94]

Thus while the Board can grant parole to mentally disordered prisoners who have (randomly) avoided restriction directions, the Tribunal cannot free restriction direction patients. The logic is comprehensible given that the criminal sentence has priority as the detaining rationale: Article 5(1)(a) rather than 5(1)(e). But since the Board's task of risk assessment is shared by restricted patient Tribunal panels in addition to their mental health responsibilities, it seems absurd for these Tribunals with their 'exalted membership' not to have the power of release.[95] The situation is a looking-glass land of situations whose essential likeness is revealed yet divided by law.

Perhaps the least adequately defined of all prisoners and patients are the 'personality disordered',[96] whose situation encapsulates the potential arbitrariness of the dual system. 'Why does he keep committing crimes? Because he is a psychopath. How do you know he's a psychopath? Because he keeps committing crimes.'[97] It is the next twist which is deadly: the 'extent to which abnormally aggressive or seriously irresponsible conduct now occurs may throw light on whether there is a psychopathic disorder, but the disorder may still exist, even if there has been no such conduct for several years.'[98] How do you know he's a psychopath? Because he used to be seriously irresponsible.

The problem has two sub-divisions. One is the legitimacy in principle of indeterminate preventive detention. The other is the lack of any clear division between incontrovertibly dangerous 'psychopaths' and other personality disordered individuals. For Lord Bradley, the government's DSPD programme (for dangerous and severe personality disordered people) was a positive step towards treating the hitherto 'untreatable' PD population.[99] Others are more suspicious. For them it is a confirmation of all that is prejudiced and stigmatising;[100] an attempt to conceal indefinite detention behind mental health legislation;[101] a malign use of hospitalisation for social control.[102] Psychiatrists have denounced the

92. *Current conversations suggest that the current MoJ Consultation (2009) is likely to elicit many calls, from Board members amongst others, for the Board to give itself more flexibility about such requirements.*
93. *See A and others v United Kingdom [2009] ECHR 3455/05 at, for example, [76].*
94. *See Anderson at [63-65], supra f/n 18.*
95. *See Hoggett (1990) p291, supra f/n 63. With reference to the 'exalted membership', it should be noted that those eligible to preside at restricted patient hearings have been extended beyond Circuit Judges and Recorders who are also Queen's Counsel, to include a number of salaried Tribunal Judges.*
96. *See the anxieties on this subject expressed by the Mental Health Alliance: Memorandum (9 March 2005), para 6.5.*
97. *P. Mullen, 'Dangerous and severe personality disorder and in need of treatment' (2007) 190 British Journal of Psychiatry s4.*
98. *Pill LJ in R (P) v Mental Health Review Tribunal [2002] MHLR 253 CA at [23].*
99. *Bradley Report (2009) p109.*
100. *For a passionate response by a senior psychiatrist, see D. Kingdon, 'DSPD or 'Don't Stigmatise People in Distress'' (2007) 13 Advances in Psychiatric Treatment 333-335.*
101. *See Mullen (2007) s3.*
102. *See P. S. Appelbaum, 'Dangerous Severe Personality Disorders: England's Experiment in Using Psychiatry for Public Protection' (2005) 56 Law & Psychiatry, pp397-98. Appelbaum quotes the 2000 White Paper which cites public protection as a key priority in mental health legislation.*

categorisation as undefined and clinically unrecognised.[103] DSPD has been described as a 'monster' created by government as a precursor to 'draconian legislative powers', which though not themselves materialising had an equivalent in IPP.[104] Moncrieff has a parallel concern, focused on the treatment of patients restricted for a wide variety of reasons 'as if they were restricted for the same reason – the protection of the public from serious harm.'[105] In a culture in which indefinite detention has become legally normalised, lack of definition permits 'dangerousness' to become the scientist's despair: an unfalsifiable proposition and a statement of prejudice and aversion.[106]

Conclusion

Moral cowardice lay at the heart of the previous government's discussion and formulation of policy on dangerous individuals. The British Association of Social Workers noted the contrast between the extension of compulsory powers to include personality disordered patients under the *Mental Health Bill 2007* with the lack of actual funds for treatment of such disorders, in hospital or the community.[107] It is hard to make sense of government policy save by recognising its desire to be seen as tough on crime and disorder and the individuals which exemplify them, without needing to take on the long-term expenditure needed to address the needs of electorally unrewarding social misfits.

Compulsion, whether in hospital or in the community, is a policy of containment which minimises costs while maximising electoral advantage. Were the motives otherwise, the DoH anti-stigma campaign, supported by coherent policies of health and social care, would be at the forefront of political self-presentation and funds, not the MoJ's crime and disorder agenda. For the policy rides in the face of evidence that popular fears legitimate unnecessarily harsh legislation and counter-productively cautious decision-making on sentencing and release.[108]

Concern about the implications of this legal situation for effectively arbitrary detention need not rest on any political judgment about the intentions of the last or present government. Legal safeguards exist to protect us against potential as well as actual danger; when abuse ceases to be potential, it is probably too late to guard against it. Therein lies the inadequacy of denying the threat to civil liberties posed by recent terrorism legislation on the grounds of government's benign intentions.

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103. *A. Buchanan and M. Leese, 'Detention of people with dangerous severe personality disorders: a systematic review' (2001) 358 The Lancet, p1955. See also Department of Health, Executive Summary of the Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, (1999), its criticisms inter alia of the 'lottery' by which severely personality disordered people, treatable or not, were consigned to prison or hospital, turning the latter into 'quasi-prisons'. While Ashworth has undergone significant subsequent reform, the criticism retains a broader currency.*

104. *P. Tyrer, 'An agitation of contrary opinions' (2007) 190 British Journal of Psychiatry, s1.*

105. *Moncrieff (2003) p268. Lady Hale has commented on the tendency of Strasbourg to treat psychiatric hospital and prison together, pointing to the importance of her own ruling in R (Munjaz) v Mersey Care NHS Trust and Others [2003] EWCA Civ 1036 at [55] in defining the difference in their purposes. See Hale (2005) p10, supra f/n 67.*

106. *See D. Kingdon, 'DSPD or 'Don't Stigmatise People in Distress'' (2007) 13 Advances in Psychiatric Treatment p333.*

107. *British Association of Social Workers, Memorandum: evidence to the House of Commons Public Bill Committee on the Mental Health Bill, MH 25, (2007), paras 10-14.*

108. *See for example concerns that the claimant's previous high-profile escape was colouring the fairness of his consideration for recategorisation in R (Williams) v SoS for the Home Department [2002] 1 WLR 2264 at [18]. For a view of how incarceration and frequent recall may feed recidivism, see Ralph Coleman et al v Arnold Schwarzenegger et al; Marciano Plata et al v Arnold Schwarzenegger et al [2009] NO. CIV S-90-0520 LKK JFM P; NO. C01-1351 TEH at [169-70].*

Challenges to populist myths about the equations of mental disorder and crime with dangerousness by one part of government are swamped by executive pronouncements, statute and case-law which validate them. Fantasies about a risk-free society are politically manipulated. Lawful powers exist and are exercised to detain people indefinitely and preventively; such detention can be maximised by the selective use of mental health and criminal law. The ECHR provides protection against abuses, but is generous in its definition of the lawful.

The problem of dangerous anti-social behaviour is real, and the balance to be struck between individual freedom and public safety demands continuing debate. But such conversation must involve more imaginative consideration of how a society can deal with its own 'brokenness', less fear-driven approaches to mental disorder and more historical awareness of the significance of civil liberties.

This strange republic of the good

Community treatment orders and their conditions

David Hewitt[1]

Introduction

The Community Treatment Order (CTO) was introduced by the *Mental Health Act 2007*, and from the start, it was controversial. There is evidence that even the principle of community compulsion was opposed by a majority of psychiatrists,[2] and it was said that many would resign rather than implement CTOs. Happily, that prediction has not been realised. In fact, it seems that many psychiatrists, and more than one Approved Mental Health Professional (AMHP), have seized upon CTOs with something approaching alacrity.

In the seventeen months after 3 November 2008, when the changes came into effect, 6,237 CTOs were made; and as at 31 March 2010, there were 4,272 of them still in place.[3] In fact, recent estimates published by the Mental Health Alliance suggest that by the end of July 2010, over 7,000 CTOs had been made and the numbers were still rising.[4] If we consider another set of figures, however, it seems something else is going on.

According to the Mental Health Minimum Dataset, between 1 April 2008 and 31 March 2009, there were about 32,600 detentions under the *Mental Health Act*.[5] That 'headline' figure is virtually the same as in the previous year, but it hides significantly different ethnic trends: while the proportion of detained patients in the 'White' census category fell, by 1.6 per cent, that of 'Black/Black British' patients rose, by 9.7 per cent. Patients in the 'Black/Black British' category accounted for 12.3 per cent of those detained

1. *Solicitor, Visiting Fellow of Northumbria University and Lincoln University. This paper is based upon one delivered at the Taking Stock 2010 conference, at the Royal Northern College of Music on 15 October 2010.*
2. *Vanessa Pinfold and Jonathan Bindman, 'Is compulsory community treatment ever justified?' The Psychiatrist (2001) 25: 268.*
3. *The Health and Social Care Information Centre ['HSCIC'], October 2010, 'In-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment', Annual Figures, England 2009/10, pages 4 & 13.*
4. *Mental Health Alliance, August 2010, Briefing Paper 2 – 'Supervised Community Treatment', pages 2, 5 & 6.*
5. *HSCIC, November 2009, Mental Health Bulletin: Third report from Mental Health Minimum Dataset annual returns, 2004-2009.*

in hospital under the *Mental Health Act*. While that might be worrying in itself, it is made more so by the fact that patients in this category represented fully 18 per cent of those on CTOs.[6]

We know that black patients form a greater proportion of the detained than of the general population of the United Kingdom: if they form a still greater proportion of community patients, that is surely an even greater cause for concern. They might, of course, be finding it easier than white patients to gain at least some form of discharge; but equally, they might be finding it harder *absolutely* to gain their discharge.

Before the CTO

It is clear that community compulsion existed long before the CTO. The Parliamentary committee that scrutinised the Draft Mental Health Bill of 2004 said:

> *"In reality, both the 1959 and the 1983 Acts […] contained 'back-door' methods which allowed scope for treating people under compulsory powers in the community."*[7]

Those 'back-door' methods were threefold: guardianship, extended leave and supervised discharge.

Supervised discharge had a relatively brief life. Introduced in 1996,[8] it was abolished by the *Mental Health Act 2007* and disappeared entirely nearly two years ago.[9] A patient on supervised discharge might have been made subject to conditions concerning residence, attendance and access.[10] These were the only conditions that could be applied, and yet a study published in 1998 found that in a third of cases in which supervised discharge was used, the patient was subject to a requirement that he accept medication.[11]

As much as a decade before the CTO, therefore, it seems some clinicians were finding imaginative, if unlawful, ways of bolstering their control of patients in the community. The same might be said of leave, but only to a degree.

In section 17, the *Mental Health Act 1983* says a detained patient may be given leave of absence.[12] Such leave may be granted only by the patient's Responsible Clinician (RC), and it may be made subject to conditions. The RC enjoys wide discretion in that regard. The Mental Health Act Code of Practice says only that the conditions should be "*necessary in the interests of the patient or for the protection of other people*".[13]

As the Code acknowledges, leave may be granted for lengthy, even indefinite periods of time.[14] In 2005, the Mental Health Act Commission said:

> *"There is an unknown but probably relatively significant proportion of the approximately 13,500 patients detained under the 1983 Act at any one time whose care and treatment involves significant periods of leave from hospital."*[15]

6. *This would appear to be supported by statistics cited in Mental Health Act Commission, 2009, Coercion and consent: Thirteenth Biennial Report, 2007-2009, paragraph 1.36 et seq.*
7. *Joint Committee on the Draft Mental Health Bill ['Joint Committee'], Session 2004-05, Draft Mental Health Bill, HL Paper 79-I, HC 95-I, paragraph 184.*
8. *Mental Health (Patients in the Community) Act 1995.*
9. *Mental Health Act 2007 ['MHA 2007'], section 55 & Schedule 11, Part 5.*
10. *Mental Health Act 1983 ['MHA 1983'], section 25D(3).*
11. *A Knight, D Mumford and B Nichol, Supervised discharge orders: the first years in the South and West Region, Psychiatric Bulletin (1998) 22: 418.*
12. *MHA 1983, section 17(1).*
13. *Department of Health, 2008, Code of Practice: Mental Health Act 1983 ['MHA 1983 Code'], paragraph 21.7.*
14. *Ibid.*
15. *Joint Committee, op cit, Ev 13, paragraph 2.36.*

Now, of course, if a RC is to give a patient leave for more than seven consecutive days, he or she must first consider using a CTO.[16] That is because of changes made by the *Mental Health Act 2007*, and those changes were themselves prompted by a line of cases on leave of absence. In 1986, the High Court said a patient's detention could not be renewed while he was on leave, and that he could not be recalled to hospital simply to enable renewal to take place.[17] Since then, however, things have gone the other way. In 1999, the Court of Appeal said detention *could* be renewed during leave, provided the treatment contained some elements of in-patient care.[18] And in 2002: the High Court said it was sufficient that a patient was attending the hospital two-days-a-week, for occupational therapy and the ward round;[19] and it upheld the refusal to discharge a patient who was only attending hospital every four weeks, for a ward round and injections.[20]

Reflecting upon this state-of-affairs, Brenda Hale, has asked whether CTOs were in fact necessary:

> *"Once the courts had increased the flexibility of long term leave of absence, where was the need to introduce another power to achieve something not quite as effective?"*

She concludes: "*The situation needs to be watched*".[21]

Making conditions

Conditions are, of course, a significant element of a community treatment order. Every CTO will have at least two of them: a patient must make himself available for examination, both when the prospect of renewal presents itself and when a SOAD certificate is required.[22]

If a CTO were confined to those mandatory conditions, all would be fine; it is the possibility of *discretionary* conditions that is most troubling. There are civil liberty concerns, of course, but they are apt to be over-stated. If one wanted to make a civil liberties case *for* the CTO, for example, one might seek to draw attention to the bigger picture. Consider, for example, John Stuart Mill, that 'Saint of Rationalism' (as Gladstone called him), who perhaps did most to elucidate the liberal ideal. Mill argued that some of the poor should be prevented by law from having children.[23]

It should not surprise us, therefore, that some have tried to see the good in the CTO. The British Psychological Society, for example, said community compulsion might "*offer a better 'least restrictive alternative' than the [un-amended] Act, which permits only admission*".[24] Even the Richardson Committee was in favour.[25] The longer-term treatment order the Committee proposed would, of course, have been made by a mental health tribunal. But crucially, it would have been available on an in-patient or a community basis.

16. *MHA 1983, section 17(2A).*
17. *R v Hallstrom, ex parte W [1986] QB 1090.*
18. *B v Barking, Havering and Brentwood Community Healthcare NHS Trust [1999] 1 FLR 106.*
19. *R (DR) v Mersey Care NHS Trust [2002] MHLR 386.*
20. *R (CS) v Mental Health Review Tribunal [2002] MHLR 355.*
21. *Brenda Hale, 'Mental Health Law', Sweet & Maxwell, 2010, 5th edition, page 252.*
22. *MHA 1983, section 17B(3).*
23. *John Stuart Mill, 'On Liberty', 1859, chapter V.*
24. *British Psychological Society (Ev 594, question 2), quoted in Joint Committee, op cit, paragraph 188. Less surprisingly, perhaps, this was also the line of argument adopted by the government (see: Letter dated 17 January 2007, from The Rt Hon. Rosie Winterton MP, Minister of State, Department of Health, quoted in Joint Committee on Human Rights ['JCHR'], Fourth Report of Session 2006-07, Legislative Scrutiny: Mental Health Bill, HL Paper 40, HC 288, paragraph 55 and Appendix 3).*
25. *Department of Health, 1999, Review of the Mental Health Act 1983: Report of the Expert Committee, paragraphs 5.105-5.113.*

a) Any conditions would be set out in the order itself, and they would be based on the committee's key principle of reciprocity: the compulsory order would identify "the services which the health or social services NHS Trust or other service provider is required to provide".[26]

b) The patient would have to reside in a particular place and make himself available for visits by care workers.[27]

c) The conditions would cut both ways: the Richardson Committee envisaged a "*parallel obligation*" on the care team to keep appointments.[28]

In fact, the amended Act is a good deal less prescriptive about the conditions of a CTO. We are told that they may only be ones that the RC thinks "necessary or appropriate" for certain purposes. That is a disjunctive test, but it does not posit two equal alternatives: 'appropriate' will always suffice; and whereas something can be 'appropriate' even if it isn't 'necessary', anything 'necessary' is surely also 'appropriate'. So 'necessary' is never actually necessary.

The *Mental Health Bill 2006* was quite specific as to the types of condition that could be added to a CTO:[30]

a) That the patient reside at a particular place.

b) That he make himself available at particular times and places for the purposes of medical treatment.

c) That he receive medical treatment in accordance with the RC's directions.

d) That he make himself available for examination.

e) That he abstain from particular conduct.

The Joint Committee on Human Rights was, however, concerned that the parameters were vague; so vague that they might permit conditions that breached a patient's privacy rights.[31] The government's response was to be even less specific.

Now, the permitted purposes are:

a) Ensuring that the patient receives medical treatment.

b) Preventing the risk of harm to the patient's health or safety.

c) Protecting others.[32]

These are pretty broad, and the job of setting limits is left to the Code of Practice. It says, first of all, that the broad statutory purposes are the only ones for which a CTO may be made,[33] and secondly, that they should:

a) Be kept to the minimum necessary.

b) Restrict the patient's liberty as little as possible.

c) Have a clear rationale, linked to one or more of the three permitted purposes.

26. *Ibid, paragraph 5.106(i).*
27. *Ibid, paragraph 5.106(ii) & (iv).*
28. *Ibid, paragraph 5.106(iv).*
29. *MHA 1983, section 17B(2).*
30. *Mental Health Bill 2006, clause 25.*
31. *JCHR, op cit, paragraphs 38-58.*
32. *MHA 1983, section 17B(2).*
33. *MHA 1983 Code, paragraph 25.31.*

d) Be clearly and precisely expressed, so that the patient can readily understand what is expected.[34]

But this fairly loose combination of Act and Code is as prescriptive as the law gets, and it probably would not satisfy the Human Rights Committee. The Committee recommended that any limits on CTO conditions be placed in primary legislation; and that those limits ensure that "*provisions for non-residential orders [are] simple and used to specify only: requirements or limitations on a person's place of residence; and medical treatment*".[35]

The breadth of its possible conditions has, of course, led to the community treatment order being described as a 'mental health ASBO'.[36]

A question often arises as to whether any discretionary conditions must be agreed by the patient to whom a CTO will apply: It seems they must. There is nothing in the Act to say that, of course, but the Minister did tell Parliament:

> *"[…] if an individual did not accept the conditions of the CTO, it would not work so there would be no point giving it in the first place. This is not about saying, 'This is what you are going to do', with the person sitting there saying, 'I don't accept any of that', because a CTO will not be given if the individual does not accept the conditions."*[37]

That message is reinforced in subsequent guidance (although the Code of Practice speaks not of the patient 'accepting' the conditions, but of his "*agreeing to keep*" them).[38] But what of someone who is in no position properly to register an objection? May an incapable patient ever be put on a CTO? Neither the Act nor the guidance tells us, but the logic of the position – a community patient must both understand and accept what is expected of him – suggests that he may not.

Challenging conditions

There is no direct way of challenging the conditions of a CTO; not in the legislation, at least. An amendment providing a right of appeal was defeated in Parliament. The government said it was not necessary, because no condition could be made that the patient had not agreed. Concern persists, however, despite the government's attempts at reassurance.[39]

The Human Rights Committee, for example, has noted that under the 2004 Draft Bill, the CTO, its conditions and, indeed, the treatment plan would have had to be approved by the tribunal. The Committee said the need to obtain AMHP approval would not be a significant safeguard, as the AMHP might not be truly independent of the RC and the clinical team. It recommended that the requirement for any conditions to be proportionate should be enshrined in statute, and that every community patient should have right to have his conditions reviewed by the mental health tribunal.[40]

34. *Ibid, paragraph 25.33.*
35. *JCHR, op cit.*
36. *In fact, this term was used not about conditions, but about the effect of a CTO generally (see: Joint Committee, op cit, paragraph 194). It appears first to have been the suggestion of the Wales Branch of Depression Alliance (see: ibid, HL Paper 79-III, HC 95-III, Ev 895).*
37. *Rosie Winterton MP, 10 May 2007, Hansard, Public Bill Committee, Session 2006-07, Cols 305-358 at col 334.*
38. *See, for example: NIMHE, 2008, Supervised Community Treatment: A Guide for Practitioners, section B; MHA 1983 Code, paragraph 25.35.*
39. *See, for example: Letter dated 17 January 2007, from The Rt Hon. Rosie Winterton MP, Minister of State, Department of Health, quoted in JCHR, op cit, paragraph 55 and Appendix 3.*
40. *JCHR, op cit, paragraphs 56-58.*

Deprivation of liberty

It is in the nature of CTO conditions that they dictate the terms upon which a community patient may engage with the world. At the most benevolent level, he will have to visit hospital every so often, and perhaps stay away from the Red Lion on a Saturday night.

Despite the government's best intentions,[41] it is at least possible that community patients will have their liberty restricted, to the extent that we shall have to ask whether, in truth, they are deprived of liberty. The Joint Committee on Human Rights is but one of the organisations that have expressed concern about this.[42] But it is not just in respect of the CTO that such concern now arises.[43] First, there is the ASBO.

There must be a real possibility that a community patient will feel as though he is the subject of an Anti-Social Behaviour Order (ASBO). But the ASBO is apparently, and perhaps thankfully,[44] a thing of the past.[45] Next, however, there is conditional discharge.

The Mental Health Act contains special provisions for people who suffer from mental disorder and are convicted of a criminal offence. If necessary, they can be placed under restrictions in hospital and conditions can be attached to their eventual discharge.[46] The High Court has held that to impose a condition requiring a patient to remain at the hospital from which he has ostensibly been discharged will amount to an unlawful deprivation of liberty,[47] and also, that if they are very strict, even community arrangements might have that result.[48] And then there are 'control orders'.

The Government has long been frustrated by those whom it suspects, but cannot prove, to have been involved in terrorism. The 'control order' is the latest of several attempted solutions and it allows someone to be placed under often stringent conditions. By definition, those conditions cannot engage Article 5 of the Human European Convention on Human Rights, so they must not amount to deprivation of liberty.[49]

The most significant decision was made by the House of Lords. It concerned six men, whose control orders confined them to their one-bedroom flats for all but six hours-a-day; allowed those premises to be searched by the police; restricted the areas the men could visit when out-of-doors and required them to wear electronic tags; limited their use of communications equipment; and prohibited them from meeting anyone not authorised by the Home Office. Their Lordships said those orders breached Article 5 and were therefore unlawful.[50] And finally, there are the DoLS.

41. *See: fn 37.*
42. *JCHR, op cit, paragraphs 56-58. See also, for example: Justice, Mental Health Bill Briefing for House of Lords Second Reading, November 2006, paragraph 46, quoted in JCHR, op cit, paragraph 53.*
43. *See: David Hewitt, New perspectives on the Mental Health Act, Solicitors Journal, volume 152 number 44, 18 November 2008, pages 13 & 14.*
44. *See: David Hewitt, Bovvered? A legal perspective on the ASBO, Journal of Forensic and Legal Medicine 14 (2007) 355-363.*
45. *The Right Honourable Theresa May MP, Moving beyond the ASBO, speech at the Coin Street Community Centre, London on 28 July 2010.*
46. *MHA 1983, section 41(1).*
47. *R (G) v Mental Health Review Tribunal and the Home Secretary [2004] EWHC (Admin) 2193.*
48. *R (Home Secretary) v Mental Health Review Tribunal [2004] EWHC 2194 (Admin). In an earlier case, however, similar facts led the court to the opposite conclusion (see: R (Home Secretary and PH) v Mental Health Review Tribunal [2002] EWCA Civ 1868). The very recent Upper Tribunal decision of Secretary of State for Justice v RB [2010] UKUT 454 (AAC) requires us to take a fresh look at this issue.*
49. *Prevention of Terrorism Act 2005.*
50. *Home Secretary v JJ and others [2007] UKHL 45. They reached the opposite conclusion where the conditions imposed on a suspect were less robust (see: Home Secretary v E and S [2007] UKHL 47; Mahmoud Abu Rideh v Home Secretary [2007] EWHC (Admin) 2237).*

The Deprivation of Liberty Safeguards (DoLS) are now part of the *Mental Capacity Act 2005*.[51] That Act provides a framework within which all kinds of care and treatment may be provided to people who lack the capacity to consent to it. If such is in his best interests, an incapable person may be admitted to a hospital or care home without recourse to the *Mental Health Act*. The novelty of the DoLS lies in the fact that they might allow the person to be deprived of liberty in that place, but only if official permission is obtained first.

Crucially, conditions can be imposed when such permission is given. There is a discrete code of practice on the DoLS, and it says any conditions might concern "*contact issues*", "*issues relevant to the person's culture*" and

> *"other major issues related to the deprivation of liberty, which – if not dealt with – would mean that the deprivation of liberty would cease to be in the person's best interests."*

There is no equivalent in the DoLS of the bit of the *Mental Health Act* that sets out the permitted purposes of CTO conditions. The DoLS Code does, however, suggest that conditions should not be set "*that do not directly relate to the issue of deprivation of liberty*". And in an echo of what the Mental Health Act Code says about CTOs, the Code also says that any deprivation of liberty conditions "*should aim to impose the minimum necessary constraints*".[53] Although the DoLS Code also warns that conditions should not be a substitute for a properly constructed care plan, the Department of Health says they are in fact being used in that way.[54]

Of course, DoLS conditions differ from CTO conditions: they are directed at the detainor, not the detained; and, as that language – 'detainor' and 'detained' – makes plain, they only come into effect where someone is already deprived of liberty; they are not what might deprive him of liberty in the first place. In one way, however, those involved in a DoLS admission are in the same position as those involved in conditional discharge or a control order: they need to know what it means to be deprived of liberty. That is no small thing.

Regrettably, the Deprivation of Liberty Safeguards have no clear idea of that which their name connotes: the legislation is silent on the point and the Code of Practice is only slightly more forthcoming. It says we have to look to the cases.[55] Clearly, that is not just mental capacity cases, but across the board; from conditional discharge to control orders. Yet once we do that, the picture becomes less, not more, clear. The cases say, for example, that although the control order suspects confined to their homes for hours on end *were* deprived of liberty, two females who are locked in their bedrooms over night are not.[56]

For different reasons, then, those who make or are subject to Community Treatment Orders find common cause with people involved in conditional discharge, control orders and the DoLS: they are all doomed to frustration when they try to find out what it means to be deprived of liberty.

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51. *MHA 2007, section 50 and Schedule 7; Mental Capacity Act 2005, Schedule A1.*
52. *Ministry of Justice, 2008, Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice, paragraphs 4.74 & 4.75.*
53. *Ibid.*
54. *Department of Health, April 2010, The Mental Capacity Act 2005 Deprivation of Liberty Safeguards – the early picture, paragraphs 17 & 18.*
55. *For example: Nielsen v Denmark (1988) 11 EHRR 175; HM v Switzerland (2002) 38 EHRR 314; Storck v Germany (2005) 43 EHRR 96; JE v Surrey County Council [2006] EWHC (Fam) 3459.*
56. *A Local Authority v A, B, C, D & E and the Equality and Human Rights Commission [2010] EWHC 978 (Fam).*

The Great Confinement

The late, great French theorist Michel Foucault spoke about the 'great confinement' of the insane, which swept across Europe in the years of the Enlightenment.[57] It began, Foucault says, in 1656, with the founding, from numerous disparate elements, of the *Hôpital Général* in Paris. It is clear that the reach of that institution exceeded its own perimeter. Responsibility was entrusted to directors, who,

> *"exercised their powers not only in the buildings of the Hôpital, but throughout the city of Paris, over all those who came under their jurisdiction."*

This was, in short, a confinement without, as much as within, these walls, and its subjects were the poor of all kinds:

> *"of both sexes, of all ages and from all localities, of whatever breeding and birth, in whatever state they may be, able-bodied or invalid, sick or convalescent, curable or incurable."*

Thirty-two such schemes had developed in France by the time of the Revolution, and they spread to England, with its workhouses and bridewells, and also to Germany, Italy and Spain.

Foucault tells us that the same walls, walls that surrounded the community, and not just the hospital,

> *"could contain those condemned by common law, young men who disturbed their families' peace or who squandered their goods, people without profession, and the insane."*

This compulsion, we might conclude, is nearly as comprehensive as the one that gives common cause to those with mental disorder or mental incapacity, restricted patients on conditional discharge and terrorism suspects under control orders; to say nothing of people with ASBOs. Foucault, naturally, has a term for this; he calls it "*the abusive amalgam of heterogenous elements*".

This great confinement produced something new. For the first time, Foucault says,

> *"men were confined in cities of pure morality, where the law that should reign in all hearts was to be applied without compromise, without concession, in the rigorous forms of physical constraint. Morality permitted itself to be administered like trade or economy."*

This was a manifestation of

> *"the great bourgeois, and soon republican, idea that virtue, too, is an affair of state, that decrees can be published to make it flourish, that an authority can be established to make sure it is respected."*

Discussion

The Community Treatment Order, then, has proved troublingly popular and maybe, in the manner of both its construction and its use, just plain troubling. Its effect is not, however, entirely novel: leave, and even supervised discharge, have long been used – distorted, maybe – to similar effect.

It will be uncomfortable for those involved with CTOs, and more so for those involved with people who suffer from dementia or a learning disability, to have to calibrate their care according to the restrictions placed on terror-suspects. But that seems to be the way of the world.

57. *Michel Foucault, 'The History of Madness', 2006, Routledge, chapter 2 (full English translation of work originally published in 1961 as 'Folie et déraison: Histoire de la folie à l'âge classique').*

Care, in these febrile times, is caught up with custody and, inevitably, security, and we are seeing emerge whole new communities of the confined. Michel Foucault seems to have anticipated this. At the height of the *Nouvelle Vague*, employing the present tense but looking only backwards, he said:

> *"In the shadows of the bourgeois city is born this strange republic of the good, which is imposed by force on all those suspected of belonging to evil."*

The Nearest Relative and Nominated Person: A Tale of Parliamentary Shenanigans

Tim Spencer-Lane[1]

The nearest relative (NR) has proved to be a resilient feature of mental health legislation. The powers and the rules for the identification of the NR remain largely unchanged since the role was introduced in the *Mental Health Act 1959*, with the *Mental Health Acts 1983* and *2007* only having made relatively minor modifications. The NR has even survived two attempts to abolish it, in the draft Mental Health Bills of 2002 and 2004.[2]

Few would doubt that the NR provides an important legal safeguard for the rights of mental health patients. However, the rules for establishing the identity of the NR relative are, by common consent, deeply flawed. The identification rules are rooted in the 1950s and reflect many of the assumptions about the structure and role of the family that were prevalent in the immediate post-war period. As such, they fail to reflect the lives and circumstances of mental health patients in the twenty-first century.

This paper outlines, briefly, the role of the NR and the changes introduced by the *Mental Health Act 2007*, and the main criticisms of the rules for identifying the NR. Its main purpose, however, is to set out the reforms to those rules that were nearly achieved by the Mental Health Alliance during the passage of the Mental Health Bill 2006 and to document the ensuing Parliamentary debates. The paper concludes by considering the future of the NR.

Powers of the Nearest Relative

The powers of the NR were largely untouched by the *Mental Health Act 2007*, although they have been extended to cover Supervised Community Treatment. Those powers are summarised below.

(a) The right to require an assessment to be made

Section 13(4) of the *Mental Health Act 1983* (as amended) ('*MHA 1983*') enables a NR to require a local authority to ask an Approved Mental Health Professional ('AMHP') to consider a case, with a view to

1. *During the passage of the Mental Health Bill, the author was Head of Policy for the Mental Health Alliance and special adviser to the opposition parties in the House of Lords. He is now a lawyer employed by the Law Commission. The author is extremely grateful to David Hewitt and John Horne for their expert assistance with this article.*
2. *For 'The Recent History of the Nearest Relative', see chapter 1 of 'The Nearest Relative Handbook' by David Hewitt, Jessica Kingsley Publishers (2nd edition; 2009).*

making an application for a person to be admitted to hospital. If admission does not take place, the NR is entitled to a written explanation from the AMHP concerned

(b) The right to apply for compulsory admission or guardianship

The NR can apply for a patient to be admitted to hospital under section 2, 3 or 4 of the MHA 1983, or for guardianship under section 7. In practice, however, this happens rarely, and the Code of Practice advises that in the majority of cases, an AMHP will be the more appropriate applicant.[3]

(c) The right to be consulted or informed

Section 11(4) of the *MHA 1983* states that, before making an application for detention under section 3 or for guardianship under section 7, an AMHP must consult the person appearing to be the NR, unless such consultation is not reasonably practicable or would involve unreasonable delay. Section 11(3) contains a similar qualified right for the person appearing to be the NR to be informed of (but not consulted about) a patient's detention under section 2.

(d) The right to object to section 3 admission or guardianship

Under section 11(4) of the *MHA 1983*, an application for admission to hospital under section 3 or for guardianship under section 7 cannot proceed in the face of an objection by the person consulted as NR. In such circumstances, an application can be made only if the NR is displaced by the county court and the new NR does not object.

(e) The right to order discharge of the patient

Under sections 23 and 25 of the *MHA 1983*, the NR can order the discharge of a patient who is detained in hospital under section 2 or 3, or is subject to Supervised Community Treatment, by giving the hospital managers at least 72 hours' notice in writing. The patient must be discharged unless, within 72 hours of the giving of notice, the Responsible Clinician certifies that in his or her opinion the patient, if discharged, would be likely to present a danger to themselves or others. Where such a 'barring certificate' is issued, the NR may apply to the mental health tribunal, unless the patient is detained under section 2 of the *MHA 1983*. So far as guardianship is concerned, the NR can direct discharge of guardianship forthwith. Since there is no provision for barring by the Responsible Clinician, a discharge order of guardianship by a NR will be effective immediately it is given.

The 2007 Amendments

The *Mental Health Act 2007* made a number of significant changes to the system for identifying and displacing a person's nearest relative.

Section 26(1) of the *MHA 1983* lists the people who might qualify to be a patient's NR. That list, which in fact provides for a hierarchy of relatives, was not changed by the 2007 Act, save that civil partners were added to it and given equal status with spouses, and with cohabitants of more than 6 months' standing.[4]

Furthermore, section 29 of the *MHA 1983* now allows patients themselves to apply to a county court for the displacement of their NR. Prior to this, only a relative, someone living with the patient or an Approved Social Worker (the predecessor to the AMHP) could make such an application. The 2007 Act

3. *Department of Health, Code of Practice: Mental Health Act 1983 (2008) paragraph 4.28.*
4. *Mental Health Act 2007, section 26(2) -(5).*

also added a fourth ground for displacement:[5] the NR is not, in the court's opinion, a 'suitable' person to act as such. Section 29 was amended to provide that where the person nominated by the applicant is, in the court's opinion, not suitable or there is no nomination, the court may appoint any other person it considers suitable.[6]

Finally, the 2007 Act introduced a new right for the patient to apply to discharge, or vary, an order appointing an acting-NR. A displaced NR, too, can apply for such an order, but he or she must first obtain leave of the court. The courts were given a new power to appoint an acting-NR for an indefinite period in certain circumstances; previously, appointments were only for a fixed period.[7]

Ongoing Criticisms

While welcoming the changes to the NR provisions, the Mental Health Alliance described them as little more than a sticking-plaster and criticised the failure to address some of the fundamental deficiencies in the rules for identifying a NR. These deficiencies are summarised below.

(a) The identification lottery

The process for identifying a NR can be described as a lottery. It may select the best person for this role and, equally, it can select the worst. The NR might easily be someone the patient hardly knows – for example, a nephew or niece to whom he or she speaks only once-a-year.

During the Parliamentary debates on the Mental Health Bill 2006, Baroness Murphy said,

> *"The business of the nearest relative is a complete nightmare. If you section someone in London who is looked after by their brother next door but has an older brother in Edinburgh, the brother in Edinburgh is classified as the nearest relative. It is as simple and stupid as that."*[9]

It may be, of course, that in Baroness Murphy's example, the London brother would be promoted to become the patient's NR by virtue of section 26(4) (a) of the MHA 1983. That would, however, depend upon how much care he was providing to the patient.[10]

Furthermore, the role of the NR can be a burdensome imposition for some carers, many of whom have no-one to whom they can delegate their powers. AMHPs are not obliged to find alternatives in these situations,[11] and cash-strapped local authorities may be reluctant to fund court applications unless the situation is sufficiently serious.

5. *Section 29(3) (a)-(e) set out the grounds for displacement of a NR, and appointment of an acting nearest relative. Ground 29(3) (a) is not in effect concerned with displacement, since it covers the situation where the patient has no NR, or it is not reasonably practicable to identify one.*
6. *Mental Health Act 2007, sections 21 & 23, and Schedule 2, paragraph 7.*
7. *These provisions are set out in the amended sections 29(5) and 30 of the MHA 1983.*
8. *The Mental Health Alliance was a coalition of 75 organisations from across the mental health spectrum, working together to secure improved mental health legislation.*
9. *Hansard (HL), 17 Jan 2007, volume 688, column 668.*
10. *The care provided will have to be 'more than minimal': Re D (Mental Patient: Habeas Corpus) [2000] 2 FLR 848.*
11. *Although, at paragraph 8.10 et seq, the revised Code of Practice to the MHA 1983 urges 'consideration' of a county court application by an AMHP.*

(b) "Staid and out of date"[12]

The rules that govern the identification of the NR have become outdated. During the Public Committee stage of the Mental Health Bill 2006, Angela Browning MP provided the following analysis of the NR list:

> "[T]he list set out in section 26 of the 1983 Act is now somewhat anachronistic. It reads like an inheritance tax situation in which the bloodline goes down through the family and people find that they have been left a lot of money by a nearest relative whom they have never met. The idea when talking about someone's mental health that a person, simply because of a blood relation, is suddenly responsible for or is even interested in them, is not how society works now. Many years on from the 1983 Act, families tend to be more disparate, and other relationships come into play."[13]

The *Bournewood case* was often cited during the Parliamentary debates as an example of why choice is important:[14]

> "[I]n that famous *Bournewood* case, HL's carers, although they were paid carers, had responsibility for his day-to-day care, whereas his blood relative had nearly no contact with him at all. They were well placed, had the psychiatrists at the time been willing to engage them in conversation, to explain his behaviours, how he reacted in certain situations and so on."[15]

It is important to note, however, that HL's carers, or at least the elder of them, could have become his NR by virtue of section 26(3), (4) and (7) of the *MHA 1983*.

The NR identification rules fail to recognise non-traditional family structures, for example where relatives ordinarily reside abroad. Such relatives are normally excluded from the role unless the patient also ordinarily resides abroad.[16] Similarly, the identification rules will normally exclude a long-term friend of the patient irrespective of how well they know the patient or whether they are best placed to act in the patient's best interests (unless the two have ordinarily resided with each other for at least five years[17]).

The NR rules also fail patients who have no identified relatives. This is particularly a problem in inner-city populations, where a large proportion of patients have lost contact with their families. Finally the rules for identifying the NR of a child are also outdated. For example, the father of a child cannot (at least by reason solely of the paternity) be the NR unless he is married to the child's mother or otherwise has parental responsibility for the child. [18]

(c) Identification complexities

Identifying the NR can be straightforward in some instances, but in others it can be one of the most complex tasks in the *MHA 1983* and as a result mistakes are common. In some cases, these mistakes may invalidate the detention and mean that the patient is unlawfully detained. [19]

It can be particularly difficult to identify the NR in circumstances where a patient has or appears to be having relationship problems, or is in the process of separating from their husband, wife or civil partner

12. *Hansard (HC), 8 May 2007, Mental Health Bill Committee, 8th sitting, column 272 by David Kidney MP.*
13. *Ibid, column 277. See also footnote 32.*
14. *HL v United Kingdom, Application number 45508/99, Decision of 4 October 2004. See also: R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] 1 AC 458.*
15. *Hansard, op cit, columns 277 to 278.*
16. *MHA 1983, Section 26 (5)(a).*
17. *MHA 1983, section 26(7).*
18. *MHA 1983, Section 26(2)(b).*
19. *As noted in the text, the obligation on the AMHP to inform or consult, is towards the person who appears to be the NR. (MHA 1983, sections 11(3) and 11(4)).*

but it is uncertain how permanent this separation will be. In such circumstances, it is often unclear legally whether the person is still the NR. Some of these difficulties will be exacerbated by the nature of the patient's mental health problems, such as where they are delusional or paranoid about the nature of the their relationship with the NR.

In order to establish the identify of a NR, AMHPs may be required to ask what will often appear to be inappropriate or intrusive questions of the patient or their family, such as "who is your oldest grandparent?" or "were your parents married when you were born?". These types of question might provoke hostile reactions at the best of times, but even more so during the trauma of a mental health breakdown and alongside a full Mental Health Act assessment.

(d) An inactive safeguard

There has not been much research into the NR, but the small body of literature that does exist suggests that generally, NRs do not know their rights and, perhaps not surprisingly, seldom use their powers.[19]

The research also indicates that the role of the NR as a safeguard of the rights of the patient varies according to the quality of the relationship between the patient and the NR.[20] If the relationship is good, the NR has the patient's best interests at heart and is more likely to be assertive (in which case, the role of the NR is an effective safeguard). If the relationship is poor, or even based on abuse, the NR is virtually useless as a safeguard

(e) Difficulties with the displacement process

A patient who wants to be free of an inappropriate NR will often have to rely on the displacement process. This can be complex and protracted. Access to a county court, and the procedures that such access entails, are daunting to many people, let alone to someone with mental health problems who is, by definition, likely to be unwell and possibly in hospital.

To expect the patient to take a case to a court stating that their relative is 'unsuitable' is unreasonable in any circumstance. In a situation where the patient is at their most vulnerable, and is dependent emotionally or financially on the relative to some extent, it will be simply unfeasible.

This was recognised by Lynne Jones MP during the Mental Health Bill 2006 debates:

> "[A] t various meetings we have had put to us examples of people who have no contact whatever with their relatives, but who would find the prospect of a court process to displace them somewhat daunting. I am disappointed that the government cannot find a way to make provision that enables the nearest relative to be changed without going to a court."[21]

Furthermore, the displacement process often ends with the Director of the Local Social Services Authority being appointed as the NR, which removes the independent characteristic of the role.

(f) Human rights concerns

The High Court, in *R (E) v Bristol City Council*[22], recognised the importance of the patient's wishes and feelings in circumstances where the patient had capacity and objected to the NR being consulted and

19. *Joan Rapaport, 'The Ghost of the Nearest Relative under the Mental Health Act 1983 – Past, Present and Future' (2003) 9 Journal of Mental Health Law, page 51.*
20. *Ibid.*
21. *Hansard (HC), 18 June 2007, volume 461, column 1110.*
22. *2005] EWHC 74 (Admin).*

there were significant relationship problems between the patient and the NR. It was held that where such a course would be detrimental to the patient, in that it would breach his or her right to respect for private and family life under Article 8 of the European Convention on Human Rights (ECHR), the Approved Social Worker (now, the AMHP) should not consult the NR.

As the Joint Committee on Human Rights concluded during the passage of the Mental Health Bill 2006: "Under this Bill, [*R (E) v Bristol City Council*] will remain good law, and the patient can choose [sic] who will not be consulted as their nearest relative, but the only way of displacing a nearest relative, and replacing them with someone acceptable to the patient, will be if they are 'unsuitable'".[23]

Summary

The difficulties associated with the NR were summed up eloquently by Diane Hackney, a campaigner and a user of mental health services:

> "My mother is my nearest relative but she is 76 years old and lives 150 miles away from me. My sister has an eating disorder and is currently in hospital receiving treatment for it – she is likely to be there for at least 6 months. For these reasons, I have changed my next-of-kin to someone who lives close to me, someone who knows me well and with whom I have a good relationship. This person is not related to me in any way.
>
> "My mortgage provider and other financial institutions have accepted this change as indeed has my GP. Therefore as far as anything to do with my financial assets, my property and my physical health is concerned this non-blood relative will be contacted, but when it comes to my mental health and my nominating the same person to be contacted and consulted about my care and treatment should I become unwell and/or sectioned is impossible. This is just not logical."[24]

The Parliamentary Campaign

During the passage of the Mental Health Bill 2006, six issues dominated proceedings: exclusions from mental disorder; treatability; the renewal of detention; age-appropriate treatment for children; impaired decision-making; and Supervised Community Treatment. One of the consequences of this focus was that other important issues, such as the NR, were over-shadowed. Behind the scenes, however, the Mental Health Alliance nearly achieved significant amendments to the statutory process by which the NR is identified.[25] These amendments aimed to introduce a new system whereby patients could nominate their nearest relative.

The House of Lords

Although the then Government was in a minority in the House of Lords, opposition peers did not call for a division on the NR amendments. Only seven votes in total took place on the Mental Health Bill 2006 in the Lords. Voting in the Lords can only take place when sufficient opposition and backbench peers are guaranteed to be available, and the divisions themselves can take a substantial time. Consequently, only

23. *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, paragraph 37.*

24. *Mental Health Alliance, Nearest Relative: House of Lords Committee Stage Briefing (2007) page 6.*

25. *The author was 'behind the scenes'. The authority for much of what follows within this article, derives from his 'ringside seat'.*

a small number of votes were possible. At most, only three divisions took place in a single sitting, and no votes ever took place after 7.30pm. So, apart from the six amendments passed in the House of Lords, the Mental Health Alliance had to rely upon its powers of persuasion and the goodwill of the Government to achieve any changes to the Mental Health Bill 2006.

The House of Lords Committee Stage

During the Committee stage in the House of Lords, the Mental Health Alliance put forward an amendment to make it possible for a person to nominate anyone of their choice to act as NR, with a default position of the *MHA 1983* section 26 list if no nomination is made.

The nomination would have to be made using a legal form, both the nominator and the nominated person would need to have the requisite mental capacity and the nomination would have to be certified by a mental health professional. The amendment was introduced by Baroness Neuberger and supported by Lord Patel of Bradford. The Government rejected the amendment and, in doing so, the Minister set out the main reasons:

> "[T]he powers of the nearest relative mean that they are not just patient representatives, although most nearest relatives very effectively represent their patient relatives ... We also think that, in order to exercise his power the nearest relative must be free to act in a way that represents his understanding of the best interests of the patient. Sometimes that might mean that the nearest relative will use, or not use, his powers in ways that do not concur with the wishes of the patient. Of course, many people chosen by the patient would feel duty bound to act in the way that the patient wished, but the powers of the nearest relative have not been designed that way ... Someone might be chosen who will simply carry out the wishes of the patient. Given the role, the nearest relative needs to be able to act, as I said, in a way that represents their understanding of the patient's best interests and not simply to carry out the patient's wishes."[26]

The Minister was also asked to explain why the Government was opposed to a nominated person system when it had supported this in the draft Mental Health Bills 2002 and 2004 and even though this system had been implemented successfully in the the *Mental Health (Care and Treatment) (Scotland) Act 2003*. In response, the Minister argued that in the draft Mental Health Bills and the Scotland Act the introduction of an enhanced independent tribunal which authorised compulsion had meant there was no longer a need for the independent counterbalancing role provided by the NR.[27] In effect, nomination could only be contemplated if the powers of the NR were removed. This became an important argument for the Government that was repeated throughout the Parliamentary debates.

Finally, Baroness Murphy supporting the amendment, referred to an "anxiety over those patients who nominate the next eccentric person on the ward as their nearest relative".[28] This concern was acknowledged by the Minister but not developed.

Opposition peers attempted to allay the Government's concerns. Many disagreed that someone nominated by a patient would be inherently less likely to act in his or her best interests. It was pointed out that there are already checks and balances to deal with the NR's misuse of power, such as

26. *Hansard (HL), 17 Jan 2007, volume 688, columns 670 & 671 by Lord Hunt of King's Heath.*
27. *Ibid, columns 671 & 672.*
28. *bid, column 669.*

displacement and the power to 'bar' discharge; these would also apply to the nominated person. Comparisons were made with the *Mental Capacity Act 2005*, which authorises delegated decision-making on health care matters using a Lasting Power of Attorney. Many of the Government's arguments relied on the notion of the NR as an *active safeguard* of the patient's best interests; consequently some peers pointed out that the NR is too often an *inactive* and *hypothetical* safeguard.

The House of Lords Report Stage

At Report Stage in the House of Lords, the Mental Health Alliance adjusted its nominated person amendment to acknowledge some of the Government's concerns. Once again, the amendment was moved by Baroness Neuberger and supported by Lord Patel. Under the revised amendment, the patient could nominate their NR (using the same procedures stipulated in the original amendment), but they would only be able to nominate someone from the existing section 26 list (to which would be added any "carer" of the patient, as defined in the *Carers and Disabled Children Act 2000*).

In effect, this would, have given patients a restricted power to choose their NR. The nominated NR could not be simply *anyone* the patient knew or, for example, "the next eccentric patient on the ward".[29] By restricting choice to the section 26 list of relatives, the amendment also provided that the NR could only be someone who, *under the Mental Health Act 1983*, was deemed to be suitable to carry out this role and act in the patient's best interests.

For the Government, Baroness Royall of Blaisdon recognised that while the revised amendment

> "... addresses the issue of patients nominating totally inappropriate strangers as their nearest relative, it still suffers from the difficulties associated with patients having nomination rights over the person who can block their admission to hospital or discharge them from compulsion ...The role of the nearest relative is not one based on acting in the name of the patient but one that provides for nearest relatives to act in a way that they consider is right. The process of nomination can introduce an unhelpful and damaging dynamic into the relationship between the patient and the person who is to exercise the rights of the nearest relative."[30]

The Alliance's amendment was therefore rejected.

Smoke-filled rooms

The Mental Health Alliance believed that was the end of the matter. It had failed to convince the Government that reform was necessary and the issue could not be raised again at Third Reading because by convention, the House of Lords cannot discuss an issue at the third stage that has been fully debated in Committee and on Report. The Alliance also had little chance of success in the House of Commons, where the Government had a clear majority.

However, an unexpected life-line was thrown by Baroness Neuberger, who contacted the Alliance with news that she had met with Baroness Royall to discuss the NR amendments. Baroness Neuberger described the discussions as extremely helpful and suggested that the Government might be interested in the idea of a nominated NR, but only if the Alliance could find a way of preventing a patient nominating

29. *Ibid.*

30. *Hansard (HL), 26 February 2007, volume 689, column 1403.*

someone completely unsuitable. It was suggested that the Government might concede if the Alliance could devise an independent check on the suitability of the nominated NR.

The amendment was therefore revised a third time. It now provided that once a patient had nominated a NR (from the section 26 list and using the same procedures stipulated in the original nominated person amendment), the person nominated would have to be approved by a 'prescribed authority'. No such authority was defined in the amendment, but it was suggested that it might be the hospital managers or, in the case of guardianship, the local social services authority. The person nominated could be rejected if the prescribed authority was satisfied that he or she was not 'suitable' to act as such. There would be a right to appeal against this decision to the mental health tribunal.

It is understood that this amendment was considered with interest by the Government, and that while no promises were made, there was a positive response to what the Alliance was trying to achieve. In the meantime, Baroness Neuberger informed the Alliance that the Government had, somewhat unusually, agreed to this amendment being tabled at Third Reading. It appeared that the Government might be on the brink of agreeing to a nominated NR.

The Third Reading

Once again, Baroness Neuberger tabled the revised amendment. In doing so, she referred to the "helpful and informative" discussions that had taken place with Baroness Royall and paid tribute to the Government's desire "to find a way through on this issue".[31]

For her part, Baroness Royall confirmed the discussions with Baroness Neuberger and, while giving no guarantees, promised that the Government would take the amendment away and explore the issue further.[32] Accordingly, the amendment was withdrawn.

House of Commons Public Bill Committee

By the time the Mental Health Bill was introduced in the House of Commons, the Alliance had still heard nothing from the Government.. The Alliance was always aware that given the Government's large majority in the Commons, concessions were unlikely. However, by this time the row between the Commons and the Lords over the Bill had intensified and any possibility of concessions seemed more unlikely than ever.

At Committee stage in the House of Commons, both the Conservatives and the Liberal Democrats advised that it would be better not to table the amendment that the Government had taken away, on the basis that it might force the Government into a corner and make it more likely that the amendment would be rejected.

Instead, the Opposition decided to re-hash the nominated NR amendment from the House of Lords Report Stage. Alongside this amendment, David Kidney MP, a back-bench Labour MP, tabled his own NR amendment. This proposed that a patient be permitted to nominate his or her NR in an advance decision. Essentially, it took the relevant sections of the *Mental Capacity Act 2005* and applied them to the NR, so as "to bring mental health legislation in line with the more modern mental capacity

31. *Hansard (HL), 6 March 2007, volume 690, column 134.*
32. *Ibid, column 135.*
33. *Hansard (HC), 8 May 2007, Mental Health Bill Committee, 8th sitting, column 272.*

legislation". This proved to be a useful way of highlighting some of the discrepancies between the two pieces of legislation on the subject of delegated decision-making.[33] The Alliance had met with and advised Mr Kidney, but although his amendment received support from Rethink,[34] it was not an official Alliance amendment.

Disappointingly, both the Alliance's and Mr Kidney's amendments were marshalled to be discussed alongside the Opposition's advocacy amendments, and the accompanying debates were not, therefore, focused on the NR amendments.

In Committee, the relevant Minister rejected both NR amendments and presented a rather different line of argument to that put forward in the Lords. The Minister suggested that the Government's own amendments had increased patients' input into the choice of NR, since there would be a new duty placed on the court, in cases of displacement or where no NR existed, to appoint the person nominated by the applicant if that person was suitable and willing to act.[35]

Furthermore, the Minister argued that if patients were given free reign, they might simply appoint as NR the person whom they considered most willing to block admission or try for discharge. Alternatively, they might constantly change their NR, because the individual concerned had not done what the patient wished them to do.[36]

> "There is an issue about whether there is an incentive for prospective nearest relatives who do not believe in compulsion, for example, to put themselves forward and offer to discharge patients whatever the circumstances ... [The NR] is not a replacement for an advocate, for example, or a patient representative. The person needs a certain degree of independence because of the issues involved in being able to block admission or ask for discharge."[37]

The debate ended, however, with the Minister agreeing to look at inserting guidance into the *Mental Health Act 1983* Code of Practice, to assist in situations where a NR neither has nor intends to have a relationship with the patient.[38]

The Report Stage/Third Reading

By the time of the Report Stage in the House of Commons, the Mental Health Alliance had received confirmation via third parties that the Government had rejected the amendment put forward in the House of Lords, for a nominated NR who must be approved by a prescribed authority. No reasons were given as to why this decision had been made. The Alliance realised that time was running out, and so it made a final attempt to introduce some element of choice into the selection of the NR. To this end, two further amendments were drafted and tabled.

Under the first, a person would be able to nominate their carer as NR, and it would only be possible for a nomination to be made by a person who was not detained under the MHA 1983. By highlighting the position of carers, the Alliance hoped to appeal directly to the Minister and to other MPs who had an interest in carers' issues. Furthermore, if the Government could be persuaded to agree to some element

34. *Rethink is a national mental health membership charity.*
35. *Ibid, column 265.*
36. *Ibid, column 266.*
37. *Ibid, column 274.*
38. *Ibid, column 284.*

of choice, however small, it was believed this would establish an important benchmark for any future reform of mental health legislation. The second amendment would allow a patient to seek displacement of a NR on the basis that it was not, in the reasonable opinion of the patient, appropriate to permit that person to act as such. The aim was to widen the criteria for displacement.

At Report Stage, the nominated carer amendment was tabled by the Labour back-bench MP, Lynne Jones.[39] This was a welcome development, given her influence as chair of the All-Party Group on Mental Health, and a surprise one given that she had been a high-profile supporter of the Bill. Her speech articulated clearly the main arguments in favour of patient choice and also lent support to the amendments on widening the displacement criteria:

> "[T]he appointment of the nearest relative is extremely important. However … there is all too often no nearest relative who is willing to perform that role. If someone suitable is available, it is thus important that it is as easy as possible for a patient to appoint that person as the nearest relative … I have attempted to address several concerns expressed by the Government. I realise that it would not be appropriate to allow frivolous changes or appointments of the nearest relative, so my amendment would confine the appointment or changed appointment as the nearest relative to the carer … a carer is someone who is not living with the patient, but who has their best interests at heart, spends a great deal of time with them and knows their case, and is someone whom the patient can trust.
>
> "At various meetings, we have had put to us examples of people who have no contact whatever with their relatives, but who would find the prospect of a court process to displace them somewhat daunting. I am disappointed that the Government cannot find a way to make provision that enables the nearest relative to be changed without going to court, although I am pleased by the Minister's assurance that she intends to make the system as user friendly as possible. Of course, it is not necessary for the patient to take the action themselves; they can be supported in doing so, or the process can be carried out on their behalf.
>
> "[The amendments on the displacement criteria] are designed to make it possible to seek displacement on broader grounds than the Bill allows. The Joint Committee on Human Rights has criticised the provisions of the Bill and the associated code of practice, saying that they are too narrow to enable the nearest relative to be displaced unless there is some undercurrent of abuse. That important point must be addressed, and I am grateful that the Minister is willing to consider the code of practice and to discuss further whether those concerns can be properly dealt with.
>
> "As the relative of someone who has been very ill and undergone the process of sectioning, I am well aware of the concern of nearest relatives that they should not easily be set aside. I know that, at times of crisis, patients can turn against family members—the people who are most concerned about them. I therefore understand the Government's concerns, but I hope that they will do all they can to address the worry that lies behind [the proposed amendments]."[40]

The Government, however, rejected both of the Alliance's amendments. The Minister pointed to concerns expressed by carers' groups that broadening the criteria for displacement would mean that

39. *Hansard (HC), 18 June 2007, volume 461, column 1094.*

40. *Ibid, columns 1109 & 1110.*

carers who were NRs would be too easily displaced.[41] The nominated carer amendment was also rejected, on the basis that, in order to comply with the ECHR, nominations would have to be ratified “by an independent process with a suitable mechanism for appealing decisions”.[42] This would mean that the Government would have to set up a new body to do this. The Minister also pointed out that, for ECHR reasons, it would be impossible to have one system for people who were not detained and a different system for people who were detained and therefore had no access to that right. The Alliance, of course, agreed with the Minster’s final point, but its conclusion was very different, in that it believed that all people with the capacity to do so should have the ability to choose their NR.

Ultimately, therefore, the Mental Health Alliance failed to achieve any amendment to the way that a NR is identified. Although the NR is still a strong legal safeguard, identification remains a lottery and there is minimal ability for a patient to choose their NR.

The Future of the Nearest Relative

The introduction of the *Mental Capacity Act 2005* may prove to have a significant impact on the future of the NR. This Act places the views and choices of people who lack capacity – and, indeed, those who *have* capacity – at the centre of decision-making.

There are two aspects of the *Mental Capacity Act* which allow people to choose representatives whose role is comparable with that of the NR. First, using a Lasting Power of Attorney, a person may appoint someone to make important decisions about their health and welfare when they lose capacity.[43] Those decisions might include consenting to or refusing life-sustaining treatment. Second, under the Deprivation of Liberty Safeguards, a person with capacity must be invited to select their own representative and in most cases this person will be appointed to this role.[44]. The representative has powers to initiate a review of the deprivation of liberty and to make an application to the Court of Protection. However, even though a person with capacity can nominate an attorney or representative, they cannot choose their NR. *The Mental Capacity Act* therefore enshrines choice in a much more positive manner than the *Mental Health Act* does, even though it can apply to equally vulnerable people in equally vulnerable situations. Increasingly, the NR is looking “staid and out-of-date” in comparison.[45]

There is also a complex relationship between the various representatives under the *Mental Capacity Act* (including advocates, representatives and attorneys) and the NR under mental health legislation. In some cases – where, for example, an attorney or representative takes one view about a patient’s best interests and the NR takes a different view – it might be difficult to decide which view should prevail. Professionals must be clear under which legislation decisions are being taken and who should be consulted as a result. When making everyday decisions about a patient’s care, professionals may naturally lean towards involving representatives who have been appointed under the *Mental Capacity Act*, on the basis that they have been chosen by the patient. If the NR increasingly becomes a formal role, reduced entirely to its statutory functions and not otherwise involved in the patient’s care, it is difficult to see how the NR can adequately represent a patient’s best interests (which was a key argument used by the Government in rejecting the NR amendments).

There is also the possibility that reform of the NR will be introduced by the back door, via the courts.

41. *Ibid, column 1098.*
42. *Ibid.*
43. *Sections 9 and 10 Mental Capacity Act 2005.*
44. *Paragraph 7.12 of the Deprivation of Liberty safeguards supplement to the MCA 2005 Code of Practice.*
45. *See footnote 12.*

The interpretation of 'suitability', when deciding whether to replace a NR may allow the patien's wishes and feelings to be taken into account. Furthermore, in order to comply with the requirements of the ECHR, it is possible that if new cases come to light where a NR was consulted in the face of opposition from the patient and this has had a detrimental effect, the courts may seek to broaden the circumstances in which the patient can influence who should not be consulted as their NR. Ideally, reform should take place in the open and be based upon a fully reasoned and well- debated set of principles negotiated by service-users, carers and practitioners; it should not be effected *ad hoc* by judges.

The NR role remains intact, despite several attempts either to amend or to abolish it. Its longevity is particularly surprising given all of the difficulties associated with the identification rules. These difficulties were brought to light as long ago as the parliamentary debates on the *Mental Health Act 1959*, when Dr Edith Summerskill, who was then shadow spokesperson for health, gave the following analysis:

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

The concept of objection under the DOLS regime

Matthew McKillop,[1] John Dawson[2] and George Szmukler[3]

Acknowledgement: The authors are grateful for the comments and suggestions of Professor Genevra Richardson of the School of Law, King's College, London.

Introduction

In England and Wales, there are now two regimes under which an adult can be deprived of liberty when receiving mental health treatment: the regime established by the *Mental Health Act 1983* (MHA), and the Deprivation of Liberty Safeguards (DOLS) authorisation regime established by the *Mental Capacity Act 2005* (MCA). Where both regimes might apply to a mentally disordered person in hospital for mental health treatment, a major dividing line between them is the ability of the patient to "object" to being a mental health patient or to being given mental health treatment. If such an objection occurs, a hospitalised patient is ineligible for the DOLS regime and only the MHA regime may be used to authorise the deprivation of their liberty.

This concept of objection is somewhat difficult to grasp. It may not always be clear that a mentally disordered person has objected: where, for example, that person fluctuates between forceful objection and content acceptance of their deprivation of liberty, or where a person only objects following the visitation of an influential family member or friend.

There are other complications of the DOLS regime. The law was plainly intended to provide better procedural protections for patients who would previously have been admitted informally, by filling what is commonly termed the "*Bournewood* gap".[4] However, there is some risk that over-reliance on the DOLS regime, which has fewer procedural safeguards for psychiatric patients detained in hospital than the MHA, could lead to a watering down of the protections mental health patients would otherwise enjoy.

It is unclear whether clinicians will find the DOLS regime simpler and more economical to use than the MHA. Some may find the DOLS regime cumbersome and unfamiliar, and, if there is a choice, they may prefer to continue to rely on the MHA, whose process is well-known. Moreover, patients who are not under treatment for mental disorder may have to live within the DOLS regime, when they are deprived of their liberty, regardless of its shortcomings. However, it does not seem to have been any part of the legislative intent, in enacting the DOLS regime, to water down the existing procedural safeguards for

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4. *So-called following the case of R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998] UKHL 24, [1999] 1 AC 458.*

patients who would have been detained previously under the MHA.

So it is important to take a consistent and workable approach to the concept of objection, which constitutes one cutting line between the two regimes, to ensure that all compulsory mental health patients receive the benefit of proper procedures and protections. By attempting to better define the test of objection in this article, we aim to make clearer the dividing line between the two enactments, in light of the purpose and context of the DOLS regime.

A background to "objection"

The language of "capacity" and "consent" is familiar to English mental health law. However, a successful application[5] to the European Court of Human Rights (ECtHR) brought on behalf of HL, who was informally detained in a psychiatric hospital but incapable of giving consent, led to the addition of a new but related concept: the notion of deprivation of liberty, short of confinement under the MHA, which may be authorised under the DOLS regime. But this regime is only available in limited situations. Paragraph 5(4), Schedule 1A MCA provides that a person is ineligible to be subject to a DOLS authorisation where he "objects" either to being a mental health patient, or to receiving mental health treatment.

Previously the House of Lords in *Bournewood*[6] had considered HL's position. HL was an autistic middle-aged man being kept at Bournewood Hospital, outside any statutory framework and despite the objections of his community carers. He did not (or could not) request to leave the hospital, nor did he attempt to do so, but he would have been prevented had he tried. The House of Lords (by a majority) concluded this did not amount to detention under the common law, but the ECtHR ruled it was a deprivation of liberty under European human rights law.[7]

The Lords' judgment may well have been influenced by the fear that sectioning every hospitalised mentally disordered person under the MHA would prove a terrific burden on the resources available to hospitals, Mental Health Review Tribunals (as they were)[8] and the Mental Health Act Commission (as it was),[9] as the number of detained patients might nearly treble.[10] In light of the ECtHR decision that English law was insufficient in this domain, the DOLS regime was enacted to protect the liberty interests of such patients. The proper application of this regime permits the deprivation of liberty, by the managing authority of a hospital or care home,[11] of a person who lacks the capacity to consent. It now operates alongside the scheme for compulsory treatment found in the MHA.

One circumstance in which a DOLS authorisation may be granted is where an eligible person with a mental disorder requires medical treatment in their best interests, but does not have the capacity to consent to the deprivation of their liberty for that purpose.[12] The need for authorisation appears to fulfil the requirement in article 5(1)(e) of the European Convention on Human Rights that mentally disordered persons may only be deprived of their liberty "in accordance with a procedure prescribed by law", while the availability of review by the Court of Protection[13] meets the requirement in article 5(4)

5. *HL v United Kingdom (2005) 40 EHRR 32.*
6. *Above n 4.*
7. *HL, above n 5, [90].*
8. *Now replaced in England by the First-Tier Tribunal (Mental Health), established by the Tribunals, Courts, and Enforcement Act 2007.*
9. *The Mental Health Act Commission was abolished by the Health and Social Care Act 2008, and its functions subsumed within the Care Quality Commission.*
10. *Bournewood, above n 4, 481-2.*
11. *Mental Capacity Act 2005, Schedule A1, para 2.*
12. *Mental Capacity Act 2005, Schedule A1, Part 3.*
13. *Mental Capacity Act 2005, s 21A.*

that the legality of the person's detention must be readily testable by a court.

The applicability of the DOLS regime centres on various inclusion and exclusion criteria. The inclusion criteria[14] are the mental health requirement, the mental capacity requirement, the best interests requirement and the age requirement. Under the exclusion criteria, a person does not qualify for a DOLS authorisation in certain circumstances. This includes where the person objects to being a mental health patient or to being given mental health treatment, or where some competing legal regime applies (the eligibility requirement);[15] and where they have made a valid advance decision that contradicts the intervention, or the proposal to deprive them of liberty would conflict with a valid decision of a donee acting under a lasting power of attorney or of a deputy appointed by the Court of Protection (the no refusals requirement).[16] The tests for eligibility, in particular, are complex, with their detail being explained in a separate Schedule 1A to the MCA.[17]

Objection will arise as an issue where a person is within the scope of the *Mental Health Act 1983* (by virtue of a mental disorder and meeting the other criteria for detention), but is not currently the subject of a compulsory treatment regime whereby they are deprived of liberty. Ineligibility by objection is not a simple matter of objecting to a deprivation of liberty, however. Rather, where a DOLS instrument would otherwise authorise a person to be deprived of liberty as a mental health patient, and that person objects either to that status or to treatment arising from that status, the person will be ineligible to be treated under the DOLS regime. An objection of that kind, then, makes a person ineligible only where the purpose of a DOLS authorisation would be treatment for mental disorder.

There is no need for a person to have the capacity to object: the eligibility criteria treat a person as if they had such capacity.[18] Lack of capacity to consent to a deprivation of liberty is already a requirement of a DOLS authorisation; requiring an objection to be made with capacity would create an unobtainable exception.

Objection to what?

As noted above, for an objection to be an effective limit on DOLS eligibility, it must be an objection to being a mental health patient, or to receiving mental health treatment. A "mental health patient" is defined as a person accommodated in a hospital for the purpose of being given treatment for a mental disorder, while "mental health treatment" is simply medical treatment for mental disorder received as a "mental health patient".[19] The definition of the latter is explicitly subsumed into the former; the grounds of objection, then, are largely interchangeable. Objection will not exclude a person from the scope of the DOLS regime when they are deprived of liberty for mental health treatment in another type of facility (such as a private care home),[20] or where the treatment is not for the person's mental disorder but for some unrelated medical condition[21] which is not a symptom or manifestation of a mental disorder.[22]

14. *Mental Capacity Act 2005, Schedule A1, para 12(1).*
15. *Mental Capacity Act 2005, Schedule A1, para 12(1)(e) and Schedule 1A.*
16. *Mental Capacity Act 2005, Schedule A1, paras 12(1)(f) and 18-20.*
17. *Mental Capacity Act 2005, Schedule 1A.*
18. *Explanatory Notes to the Mental Health Act 2007, para 204.*
19. *Mental Capacity Act 2005, Schedule 1A, para 16(1).*
20. *W Primary Care Trust v TB [2009] EWHC 1737 (Fam), [39].*
21. *GJ v The Foundation Trust and Ors [2009] EWHC 2972 (Fam), [2010] Fam 70, [128].*
22. *See the definition of 'treatment' in Mental Health Act 1983, s 145(4).*

Objection to treatment does not affect DOLS authorisations granted for reasons other than treatment for mental disorder, so long as the deprivation of liberty is in the best interests of the person and all the other inclusion criteria for a DOLS authorisation have been met. The purpose of objection is therefore to exclude a patient from the DOLS regime, and to require their treatment under the MHA hospital treatment regime, *where a person is otherwise eligible for both regimes*. So a person's objection will only exempt them from eligibility under the DOLS regime when their deprivation of liberty for treatment for mental disorder under the MHA is currently occurring or feasible: that is, they currently meet the criteria for compulsory treatment for mental disorder under that Act.

Objection is therefore a critical factor in determining whether a person is treated under the hospital treatment regime of the MHA, or under a DOLS authorisation, with the former having primacy.[23] Obviously there could be scope for overlap between the two regimes, but it was made clear in *GJ v The Foundation Trust*, a detailed judgment of the Court of Protection,[24] that decision-makers should not approach the MHA and DOLS schemes as equal alternatives but should recognise and give effect to the primacy of the MHA.[25] We take this principle of primacy to mean that all patients who would previously have been treated under the MHA hospital treatment regime should continue to be treated under it, with the DOLS regime reserved firstly for non-objecting mental health patients who would previously have fallen into the *Bournewood* gap,[26] and secondly for patients whose donee or deputy has "made a valid decision to consent to each matter" to which the patient objects.[27]

Points of difference between the DOLS and MHA regimes

Some groundwork is necessary before difficult cases of objection can be addressed. When defining the boundary between the DOLS and MHA regimes, it is important to bear in mind the different legal consequences of treatment under these regimes. Jones has briefly described some of the distinctions between the two regimes, concluding that, where there is a choice between the two, the latter is preferable.[28]

Some of Jones' points are worth expanding upon. He correctly states that the protections relating to treatment contained in Part IV of the MHA are not replicated in the MCA.[29] These protections are not insignificant: they concern such matters as the special regime governing electro-convulsive therapy,[30] and they require a clinician to certify in writing the capacity and the consent of a patient after three months of compulsory pharmacological treatment, or to obtain a second opinion from a doctor appointed for the purposes of Part IV of the Act.[31] In contrast, the MCA provides that decisions as to medical treatment[32] may be made by a court order or by an appointed deputy,[33] or by a person holding a lasting power of

23. *GJ, above n 21, [58]; see also Mental Capacity Act 2005, s. 28.*
24. *See Allen, Neil "The Bournewood Gap (As Amended?): GJ v Foundation Trust [Commentary]" (2010) 18 Med L Rev 78, 82.*
25. *Above n 21, [65].*
26. *Whether or not HL actually fell into the part of the Bournewood gap that is now filled by the DOLS regime is a valid point of contention: see Allen, n 24, 84.*
27. *Where the donee or deputy does consent to this, the patient may be deprived of liberty under the DOLS regime: Mental Capacity Act 2005, Schedule 1A, para 5(5).*
28. *Jones, Richard "Deprivations of Liberty: Mental Health Act or Mental Capacity Act?" (2007) J Mental Health L 170, 172-3; see also Jones, Richard Mental Capacity Act Manual (3rd ed, Sweet & Maxwell, London, 2008), 2-030.*
29. *Ibid, 172.*
30. *Mental Health Act 1983, s 58A(1).*
31. *Mental Health Act 1983, s 58.*
32. *Mental Capacity Act 2005, s 17(1)(d).*
33. *Mental Capacity Act 2005, s 16(2).*

attorney, as long as the person lacks the capacity to make a treatment decision; or by a clinician or carer where the person lacks capacity and the actions taken are in the best interests of that person.[34] The specific treatment protections under the MHA regime are not replicated. This difference is symptomatic of the different intended applications of the two enactments: the MHA is aimed at providing compulsory mental health treatment for mentally disordered persons, whereas the MCA is intended to provide substitute decision-making for a range of personal decisions based on lack of capacity, including decisions about medical treatment, living arrangements, and property and welfare issues.[35] It therefore has a broader focus than the MHA, but offers fewer specific procedural protections concerning psychiatric treatment.

Jones also claims that the mental health patient's nearest relative "has no role to play under the MCA",[36] compared to the significant protective powers available to a nearest relative (NR) formally designated for a compulsory patient under the MHA. While it is true that this NR has no specific function under the MCA (since the NR's formal role is confined to the context of the MHA), there is still provision for the compulsory appointment of a relevant person's representative (RPR) whenever a DOLS authorisation is made.[37] The NR under the MHA will normally be the closest relation of the patient,[38] whereas the RPR may be some other family member, friend or carer.[39] An NR is designated by virtue of their familial relationship, and has a number of powers under the MHA, but has few particular requirements to fulfil: they are not obliged by law, for instance, to consider whether they should exercise all their powers. The RPR, on the other hand, must be able to keep in contact with the relevant person and be willing to be their representative;[40] they must act in the person's best interests;[41] and can be selected by a relevant person with the capacity to do so.[42] A NR can be replaced where they are incapable of exercising their powers, or act unreasonably or irresponsibly, or are deemed "unsuitable" for the role, but they can only be replaced by court order,[43] whereas the RPR can be replaced by the supervisory body for certain reasons, without application to a court.[44]

As a whole, then, the RPR appointment appears to be better considered, and have more immediate oversight, than the appointment of an NR. However, the NR's specific powers to direct the discharge of a patient from compulsory assessment or treatment[45] are not granted to the RPR. As above, this reflects the broader focus of the MCA.

Perhaps the most striking point Jones makes about the MCA is the lack of automatic judicial oversight of long-term deprivation of liberty, compared with the position under the MHA.[46] This conflicts with the claim made by Bartlett that the MCA provides better protection of patients' rights because it provides for

34. *Mental Capacity Act 2005, s 5(1).*
35. *See also Richardson, Genevra "Mental Capacity at the Margin: The Interface between Two Acts" (2010) 18 Med L Rev 56, 57.*
36. *Jones, above n 28, 172.*
37. *Mental Capacity Act 2005, Schedule A1, para 139(1).*
38. *In some instances, however, the application of the detailed provisions of s 26 Mental Health Act 1983 may not have precisely this effect.*
39. *Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008 (SI 2008/1315), regs 5(1), 6(1), 8(1).*
40. *SI 2008/1315, reg 3(1).*
41. *SI 2008/1315, reg 13(g).*
42. *SI 2008/1315, reg 5(1).*
43. *Mental Health Act 1983, s 29.*
44. *SI 2008/1315, reg 13.*
45. *Mental Health Act 1983, s 23(2). The nearest relative's direction for discharge can, however, be barred by the patient's responsible clinician on specified grounds: Mental Health Act 1983, s 25(1).*
46. *Jones, above n 28, 172.*

an independent assessment of a patient's best interests.[47]

These statements cannot both be right: the true position may be closer to that described by Jones. Bartlett claims that "meaningful safeguards to detention" in the MHA regime are "triggered by the patient", so will not be effective where a patient has no ability to ask for a review.[48] This is questionable. While a patient *can* trigger review by the Tribunal,[49] hospital managers are also under a duty to refer cases to the Tribunal where a patient's case has not been brought to the attention of the Tribunal in the first six months of detention under Part II,[50] or where the patient's case has not been considered by the Tribunal for three years.[51] An NR of a patient detained for treatment may also apply for review when their direction for discharge has been barred by the relevant clinician.[52] There may be some delay before the tribunal hearing occurs. But, as these provisions show, not all meaningful safeguards to detention are triggered by the patient. Some safeguards can be, and sometimes must be, triggered by others.

Bartlett also says the best interests assessors are an "independent party" reviewing the condition of the patient.[53] But, while the best interests assessor will never be the professional with day-to-day care of the relevant person,[54] they may well be a colleague of that professional, employed in the same Trust. A person is barred from performing the role of best interests assessor when they have a financial interest in the managing authority,[55] when they are a relative of the relevant person,[56] and when they are employed by the supervisory body and that body and the managing authority are the same.[57] But that is not sufficient to ensure assessors are completely "independent" of the professionals who provide the patient's day-to-day care. They may be independent of the relevant person so far as normal care decisions are concerned, but they may still have a close working relationship with the professional with day-to-day responsibility for that person's care. In contrast, the Tribunal is a judicial body, assessing each case objectively as an outside party, so is more independent than a best interests assessor.

In light of these differences between the two regimes, it might be thought that the MHA regime has certain procedural advantages for mental health patients. When discussing the concept of objection, which forms one boundary for the mental health patient between the two schemes, these advantages should be kept in mind.

Economic issues

In addition, the differences between the regimes raise questions of cost. There is an economic justification for using the regime with lower compliance costs. It is not entirely clear which regime will entail the lower costs, particularly as the statutory duty to provide after-care for patients treated under the MHA[58] has no equivalent for patients under the DOLS regime.[59] But the financial implications of using the MHA regime for all informal patients were strongly emphasized in the *Bournewood* litigation.[60] It is clear that

47. *Bartlett, Peter "Civil Confinement" in Gostin, Lawrence et al. (eds) Principles of Mental Health Law and Policy (Oxford University Press, Oxford, 2010), para 12.228.*
48. *Ibid.*
49. *Mental Health Act 1983, s 66(1)(i).*
50. *Mental Health Act 1983, s 68(2).*
51. *Mental Health Act 1983, s 68(6).*
52. *Mental Health Act 1983, s 66(1)(ii).*
53. *Above n 47.*
54. *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 (SI 2008/1858), reg 12(1).*
55. *SI 2008/1858, reg 11.*
56. *SI 2008/1858, reg 10.*
57. *SI 2008/1858, reg 12(2).*
58. *Mental Health Act 1983, s 117.*
59. *Jones, above n 28, 173.*
60. *Above n 4.*

the MHA is intended to have primacy over the DOLS regime,[61] and that persons subject to the MHA enjoy greater procedural safeguards. So, who should be treated for mental disorder under the possibly cheaper, but less procedurally rigorous, DOLS regime?

The answer, if one emphasizes the value of due process to detained patients, would be those patients least likely to benefit from the additional procedural protections of the MHA regime. Such patients would normally be suffering from a long-term mental disorder, with little likelihood of recovery or improvement in their condition, so that the focus of clinicians is more on palliative than curative care.[62] Some suitable examples of such mental disorders may be degenerative conditions such as dementia, serious intellectual or learning disabilities, or permanent brain injuries caused by alcohol abuse, traumatic brain injury or cerebral hypoxia. Patients with conditions that tend to have a fluctuating course, on the other hand, such as schizophrenia, or disorders of mood or affect, or other psychotic conditions, may be less suited to the DOLS regime.

The meaning of "objection"

The MHA Code of Practice offers some guidance on the meaning of objection. The matter should be considered, it says, "in the round, taking into account all the circumstances, so far as they are reasonably ascertainable", and "the reasonableness of [the] objection is not the issue".[63] In addition, both this Code[64] and the MCA[65] specifically mention the need to consider the patient's behaviour, wishes, feelings, views, beliefs, and values, so far as they can be ascertained. The Code adds that a person is to be taken as objecting when there is reason to think they would object, if able to do so;[66] refusal through an applicable advance directive is to be considered an objection;[67] it is sufficient if the patient objects to some, though not all, elements of their mental health care;[68] and the need for restraint of the patient to protect others is a strong indicator that the MHA should be used.[69] But can we take the matter further?

Objection is objectively assessed

First, it cannot be the case that the existence of an objection can be established purely subjectively: that is, it should not be viewed solely from the perspective of either the subject of a DOLS authorisation or the staff member administering the treatment. A patient's subjective intention to object may not be sufficiently obvious to be recognised by a particular DOLS assessor. Alternatively, a particular staff member might not recognise the manifestation of an objection when the person is acutely psychotic or of a changeable disposition. But the actual views of the patient or staff member should not necessarily be definitive, in either case. The proper assessment of objection must be objective, viewed from the point of view of a reasonable and fair-minded observer looking on.

Such an observer should not be fixed with an in-depth knowledge of the objector's psychiatric history. This avoids the sort of subjective assessment of objection that a carer may be prone to making, such as a determination that there has not been a *proper* objection in law, due to the mental state of the objector.

61. *GJ, above n 21.*
62. *We do not mean palliative in the sense of treatment for an illness causing death, but merely in the sense of treatment for an illness from which significant recovery is unlikely.*
63. *Department of Health Code of Practice: Mental Health Act 1983 (2008) (MHA Code of Practice), para 4.19.*
64. *Ibid.*
65. *Mental Capacity Act 2005, Schedule 1A, para 5(6).*
66. *MHA Code of Practice, above n 63, para 4.19.*
67. *Ibid, para 4.20.*
68. *Ibid.*
69. *Ibid, para 4.21.*

Capacity to object is irrelevant. A reasonable observer must be able to recognise the behaviour constituting an objection, without reflecting on the capacity of a person to object, or any deficit in the mental processes of an objector as a result of mental disorder.

It is clear too that an effective objection need not be a verbal one. In determining whether a person has objected, eligibility assessors are required to take into account the person's *behaviour*, as well as their wishes, feelings, views, beliefs and values. These latter views will normally require communication through language, either verbally or otherwise, but the concept of behaviour clearly encompasses all the responses of a person to their deprivation of liberty, including physical responses. The DOLS Code of Practice is effectively making the same point when it says that the necessity for physical restraint may indicate that an objection is occurring.[70]

An assessor should look at the totality of the person's behaviour to determine whether objection has cumulatively occurred, rather than considering whether each of a series of isolated incidents is sufficient. A parallel can be drawn with the cumulative effect principle applied by the ECtHR to determine whether a deprivation of liberty has occurred, which takes into account all the elements of a person's living conditions.[71] The cumulative approach in this case would take into account the duration, persistence and character of the behaviour.

This approach provides a helpful framework for assessment, but there must still be some threshold for objection generally agreed upon for consistency to be achieved. Situations of objection are limited only by the variety of human behaviour, so no bright line may exist. But by illustrating difficult cases, where assessors may struggle to determine whether an objection has occurred in light of the practical and legal consequences of the choice between regimes, we hope to make this boundary clearer.

Borderline cases of objection

An objection may be difficult to discern, but a DOLS assessor should have no trouble recognising a clear and persistent verbal objection. In *Re DE*,[72] for example, the man made his desire to leave "perfectly clear"[73] by repeated objections to the deprivation of his liberty. Over a seven-day period in November 2005, DE's objections were recorded by care home staff five times, and included statements such as "You are holding me against my civil rights, all I want to do is be with my wife"; in conversation with his advocate, "come and get me, I want out of here"; and in conversation with his wife, "I'm coming home … I am bloody coming home".[74]

However, some scenarios are not so clear-cut. People whose resolve fluctuates, between plain objection to a deprivation of liberty at some times and ambivalence or acceptance at others, are not so clearly classed as objectors. Less still are those without faculties of speech or movement. An inability to communicate feelings verbally, combined with an inability to make controlled movements indicative of a desire or attempt to leave a place, would make objection very difficult. Some individuals may be so profoundly disabled that there is no feasible way for them to object to a deprivation of liberty.

As these scenarios show, the inquiry requires us to consider the practical realities of objection. A broad

70. *Ministry of Justice Deprivation of Liberty Safeguards Code of Practice (2008), para 2.13.*
71. *Guzzardi v Italy (1980) 3 EHRR 333, [95].*
72. *Re DE; JE v Surrey County Council [2006] EWHC 3459, [2007] 1 MHLR 39.*
73. *Ibid, [112].*
74. *Ibid, [90].*

interpretation of the concept may result in a considerable increase in the number of detained patients under the MHA, necessitating greater spending on psychiatric hospitals, assessment and administrative personnel, and on the Tribunal. An overly strict approach to objection, however, might see clinicians increasingly opt for DOLS authorisations over the MHA, which may result in a lower standard of patient protection and less specificity of powers than is available under the more specialised MHA regime.

The problem of "fluctuating" objection

A variable mental state due to mental disorder may lead to a fluctuating state of objection, with a person expressing a strong objection to treatment or deprivation of liberty at one time, and ambivalence or acceptance at another. Contradictory statements or behaviour from day to day, or even over shorter periods, may evidence such fluctuation. A variable mental state may be due to the natural course of the person's mental disorder, or could develop through ineffective treatment or non-compliance with treatment, or simply through change of attitude towards their position.

Approaches taken to the problem of fluctuating capacity provide a possible parallel. DOLS patients will normally lack the capacity to make decisions relating to their care, but may enjoy periods where that capacity is present. Use of the MCA where consent to treatment is likely to be refused when the person regains capacity is not advised.[75]

The DOLS Code of Practice gives some guidance on how to deal with such a problem, suggesting a balance must be struck between the need to terminate a DOLS authorisation where a person has capacity, and the time and resources spent where a DOLS authorisation is regularly reviewed, terminated and re-applied for due to fluctuating capacity.[76] The test for capacity recommended by the Code to preserve this balance is "consistent evidence of the regaining of capacity on a longer-term basis."[77]

The test for objection should be somewhat similar, but while consistency of conduct is important in determining whether an objection has occurred, testing whether that conduct has continued "on a longer-term basis" would not sit well with the underlying presumptions of the eligibility requirement. Capacity to object is assumed. It is the conduct, not the mental state of the objector, which is assessed. Where sufficient, that conduct is presumed to constitute a competent objection. The time period for an effective objection, then, need only be long enough to show that the person's objection to deprivation of liberty is settled and unlikely to change in the short term. Consistency of objecting conduct over several days should, in most cases, be of a sufficient duration cumulatively to constitute an objection in law, even where a person has demonstrated a changeable resolve.

This test fits well with cases where a person is already deprived of liberty, but what of the case where a DOLS authorisation is applied for in advance? It may be difficult for an assessor to gather data indicating a consistent objection over a sufficient time course where a patient is not already resident in hospital. The information of family, friends or carers is not necessarily reliable. Objecting conduct or compliance during past admissions may be relevant, but the assessor is permitted to take into account past behaviour of a proposed patient "only so far as it is still appropriate to have regard to [it]."[78]

Given the difficulties in gathering information that would indicate such an objection, it would seem

75. *MHA Code of Practice, above n 63, para 4.21.*

76. *Above n 71, para 8.22.*

77. *Ibid, para 8.23.*

78. *Mental Capacity Act 2005, Schedule 1A, para 5(7).*

prudent that a proposed patient should be taken to object wherever an assessor knows of evidence that they are objecting at the time of assessment or prior to it. If this is inconsistent with that person's compliant behaviour during a prior period of assessment or treatment, then that prior behaviour should be disregarded as per para 5(7) of the eligibility test.[79] Such an approach, while rather cautious and likely to lead to use of the MHA regime, better protects a proposed patient's rights when they are initially deprived of liberty through use of a more robust regime. It may also be the most economical approach, despite the concerns of the Bournewood interveners:[80] incorrect use of the DOLS regime may later necessitate an admission under the MHA, unnecessarily complicating the administrative process by invoking both regimes in succession.

Advance decisions

It is clear that an advance decision to refuse treatment[81] made with capacity will preclude treatment under the MCA so long as the advance decision remains valid at the time the necessity for treatment arises.[82] Other than in respect of ECT in non-emergency situations,[83] an advance decision will not prevent compulsory treatment under the MHA regime.[84] This is, in effect, another distinction between the two regimes for mental health treatment.

Influence or free-will?

Another difficult case arises where a person who would not normally object to a deprivation of liberty shows a great attachment to, or dependence on, a family member or carer, and so may be influenced by them to attempt to leave the facility connected to their DOLS authorisation, or to vocalise a previously unheard objection. Such behaviours would normally be sufficient to constitute an objection in law so long as the person does not have a history of fluctuating between objecting behaviour and acceptance of their deprivation of liberty, as discussed above. Where the behaviour only arises briefly after a family visitation or other forms of influence, though, can it really be said to be an objection? And what if a previously contented person begins to persistently object to their deprivation of liberty over a longer period of time, following a meeting with his or her immediate family?

One solution to these problems has been to prevent influence over a person by stopping visitation by influential people. The care facilities in both *Bournewood*[85] and *DE*[86] took this step, but this is an unattractive approach to the problem. Preventing a person from having contact with their family, friends and carers, simply to avoid the implementation of a more complex legal regime for their compulsory care, would not be a sufficient reason to limit the person's right to respect for private and family life contained in art 8(1) of the ECHR. Limiting visitation under the MHA to prevent "incitement to abscond"[87] is justifiable, as the MHA provides a stringent legislative process under which compulsory treatment is permitted for legitimate ends, to which the patient's objection to deprivation of liberty is not relevant. But prevention of objection (and the need to invoke the MHA regime) by an informal method, where a person is subject to the DOLS regime, is not a legitimate limitation under art 8(2) ECHR. Assuming that

79. *Ibid.*
80. *Above n 4, 481-2.*
81. *Mental Capacity Act 2005, ss 24-26.*
82. *Mental Capacity Act 2005, Schedule A1, para 19.*
83. *Mental Health Act 1983, s. 58A (2), (5)(c).*
84. *Fennell, Philip "Mental Capacity" in Gostin, Lawrence et al. (eds) Principles of Mental Health Law and Policy (Oxford University Press, Oxford, 2010), para 4.86.*
85. *Above n 4.*
86. *Above n 73.*
87. *MHA Code of Practice, above n 63, para 19.13.*

visitation will occur, then, we should determine what constitutes an objection from an impressionable or dependent patient.

A good approach may be to assess whether the patient's behaviour is sufficient to cumulatively indicate a settled objection, as we have done with the problem of fluctuating objection. Applying this test to the case of brief objecting behaviour following each family visit, it is unlikely that an objection in law will be found. Such short-term complaints may in fact represent a longing for family, carers or close friends, rather than an objection to treatment or to being a mental health patient. Wishing that one could live with family is not equivalent to objecting to a deprivation of liberty; a person subject to a DOLS authorisation may be resigned to its necessity, while strongly desiring that the situation could be different. Persistent objecting behaviour, on the other hand, must be treated as objection in law, even if it only arises following the influence of a family member.

Carers may seek to curtail more than just influential visitors to prevent objection. Locking doors to prevent a person from leaving, or the persistent use of restraint, may prevent behaviour indicative of an objection, but the person may still be objecting nevertheless. A person may be unmanageable without such measures being taken, but the need for the carer's behaviour may be indicative of an objection in law.

Delusional reasons for being in hospital

A further difficult scenario may arise wherein a patient has delusional reasons for staying in hospital – solely to escape their persecutors, for instance. The patient may make it quite clear that the only reason they agree to stay in the hospital is their physical safety, not their need for treatment. Should that be treated as implicit objection? Perhaps not, if they have not actually expressed the desire to leave. The matter should clarify itself, in any case, when they are asked to take medication. At that point, should they refuse to take it, as required, they could be considered to object to their mental health treatment, requiring activation of the MHA.

Inability to object and objection by proxy

Critically incapacitated patients deprived of liberty for mental health treatment under the MCA may be unable to express their wishes or feelings, or their views, beliefs and values, or to express their views meaningfully in their behaviour. This could prevent an eligibility assessor from determining whether or not they object. This raises the problem of objection by proxy, if some other person concerned for the patient nevertheless believes they can perceive signs of objection from the patient that others cannot read.

First, the matter might be taken up by any donee or deputy of the patient, who might both seek to withdraw any consent they had previously given to the person's treatment as a mental health patient, and argue – simultaneously – that the patient is now to be understood as objecting to that treatment – an argument that, if accepted in total, would render the patient ineligible for further treatment under the DOLS regime.[88] But whether the patient is *really* to be taken as objecting in such cases – in the necessary *legal* sense – could still be an open question, and the regime confers no express authority on a donee or deputy to make that decision, or to object definitively for the patient by proxy.

88. *Mental Capacity Act 2005, Schedule 1A, para 5(4) and (5).*

Nevertheless, it might seem a reasonable proposition that other people whose concern for the patient is formally recognised by law should be able to object on behalf of a person without the ability to do so: that is, an objection might be made by a donee, a deputy, a relevant person's representative (RPR), an independent mental capacity advocate (IMCA), a guardian or an immediate family member who would be designated the NR under the MHA – even if these possibilities are not expressly provided by the MCA.

An IMCA, for instance, might be particularly apt for this role, as they are required to ascertain the wishes, feelings, beliefs and values of the patient[89] with regard to care decisions, and these are the same elements to be considered when assessing eligibility.[90] Moreover, the RPR is specifically designated as the person's representative for certain purposes. However, even permitting those performing such recognised roles to object definitively on behalf of the patient would seem to run against the larger scheme of the MCA, which already includes a clear review structure.

An RPR can apply for compulsory review of a DOLS authorisation by the supervisory body that issued it,[91] and can apply to the Court of Protection for a ruling on the validity of a DOLS authorisation (under s 21A MCA), and does not require the permission of the Court to proceed.[92] These powers allow the RPR to have a DOLS authorisation reviewed by the issuing authority or an independent judicial body. It would not make sense to permit an RPR to stand in the shoes of a patient to make an objection as well, as that would clearly end the authorisation and undercut the established processes of review or judicial oversight.

An IMCA has the same right to challenge a care decision as a person interested in a patient's welfare or engaged in their care.[93] But this confers no formal power. Presumably, it means the IMCA can assist or represent the RPR or an interested party (such as a family member or close friend) in their communication with the supervising authority or an application to the Court of Protection. But there is no automatic right to apply to the supervising authority or Court for review, as no formal role is contemplated for family or friends of a patient besides that of the patient's RPR. An interested person can make an application to the Court of Protection, but permission to proceed will depend on the person's connection to the detained patient, the reasons for the application, the benefit to the patient, and whether the benefit can be achieved in any other way.[94]

Given this review process, which centres on the RPR's powers to apply for automatic review, it would be unusual to permit the RPR, IMCA or any other person to definitively object as well and so undercut the RPR's established statutory role. However, the RPR and IMCA are clearly contemplated as having some degree of input on the matter of objection. The RPR's role is to "represent the relevant person in matters relating to, or connected with, the deprivation of liberty"[95] generally. The IMCA's role is even more specific, as described above.

Where a person is unable to express an objection due to severe impairment, then, the RPR or IMCA will not have the power to object definitively. However, their statutory roles, and those of others in similar positions, suggest that any conclusion they might reach about the patient's views or wishes should be strongly persuasive in a determination of whether a DOLS authorisation should be granted.

89. *Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 (SI 2006/1832), reg 6(5)(b).*

90. *Mental Capacity Act 2005, Schedule 1A, para 5.*

91. *Mental Capacity Act 2005, Schedule A1, para 102.*

92. *Mental Capacity Act 2005, s 50(1A); The Court of Protection Rules 2007, r 51(2A).*

93. *SI 2006/1832, reg 7(2).*

94. *Mental Capacity Act 2005, s 50(3).*

95. *SI 2008/1315, reg 12(1)(a)(ii).*

MHA primacy as an underlying principle

The case of *GJ*[96] touches on an important principle, which we have reflected throughout the examples discussed above. The DOLS regime was not intended to diminish the use or importance of the MHA, but to increase the protection afforded to incapacitated persons who would not previously have been treated under the existing legislation, but under common law justifications. The MHA has a position of primacy over the MCA, as the Court of Protection has made clear, and where there is a choice between the two regimes (as there may be where an incapacitated patient meets the civil commitment criteria), decision-makers should "take all practical steps to ensure that that primacy is recognised and given effect to."[97] This is particularly relevant "in areas of doubt".[98] This leads easily to a general rule that eligibility assessors should follow where there is uncertainty as to whether an objection has occurred: *when in doubt as to whether an objection has occurred, use the MHA regime*.[99] This is quite different from saying that one should always use the MHA regime when its elements are satisfied, because then all other people who fall "within the scope of" the MHA,[100] and are deprived of liberty, but are clearly not objecting, would have to be brought under the MHA as well, even though that is not the intention of the statutory scheme.

The MHA and DOLS regimes exist to provide procedural protections for mental health patients. In light of the non-consensual nature of the mental health treatment, there may be considerable value for patients in the safeguards provided, so their treatment may be properly tested, and endorsed or rejected, according to a rigorous process. Patients will have differing requirements, depending on the nature of their mental disorder. Approaching the choice between regimes with the primacy of the MHA in mind ensures that patients who will most benefit from its procedural protections are not deprived of liberty under lesser safeguards. Likewise, a generous approach to objection where doubt exists will result in a more comprehensive and specialised legal approach to the mental health treatment of the objecting person.

The principle of primacy accorded to the MHA therefore gives the DOLS regime a secondary role, primarily focused on the long-term treatment of patients with enduring mental disorders who lack capacity but clearly do not object to their hospital-based mental health care.

96. *Above n 21.*
97. *Ibid, [65].*
98. *Ibid.*
99. *This principle is also reflected in the MHA Code of Practice, above n 63, para 4.19.*
100. *Mental Capacity Act 2005, Schedule 1A, para 2, Case E.*

The Convention on the Rights of Persons with Disabilities and the social model of health: new perspectives

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Contemporary mental health laws are embedded in basic human rights principle, and their ongoing evolution is influenced by contemporary human rights discourse, international declarations and conventions, and the authoritative jurisprudence of the European Court of Human Rights (ECrtHR). The *Convention on the Rights of Persons with Disabilities* (CRPD)[2] is the most recent expression of international human rights applicable to people with disability including people with mental illness.[3] It provides a fresh benchmark against which to assess the human rights compatibility of domestic mental health laws.

The CRPD emphasises social entitlement and a positive right to 'treatment' understood broadly as encompassing the social determinants of health. This is an innovative and powerful contribution. Historically, human rights law accepted that the obligations to respect the (negative) rights expressed in the *International Covenant on Civil and Political Rights*[4] were immediately realisable, whereas the obligations to respect the (positive) rights expressed in the *International Covenant on Economic, Social and Cultural Rights*[5] are subject to the principle of progressive realisation.[6] Underpinned by this distinction, arguments in support of a positive right to psychiatric treatment, have interpreted it either as derivative

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2. *Convention on the Rights of Persons with Disabilities, opened for signature Dec. 13, 2006, 46 I.L.M. 443. [Entered into force 3 May 2008, ratified by the United Kingdom of Great Britain and Northern Ireland on 8th June 2009]*
3. *Id. art. 1.*
4. *International Covenant on Civil and Political Rights, opened for signature Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force 23 March 1976).*
5. *International Covenant on Economic, Social and Cultural Rights, opened for signature Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force 3 January 1976).*
6. *Henry Steiner & Philip Alston, International Human Rights in Context 275 (2d ed. 2000).*

of negative rights,[7] as arising from the principle of reciprocity,[8] or as an extension of the prohibition of torture and cruel, inhuman or degrading treatment.[9] Despite these cogent arguments, acceptance by the Courts of the artificial distinction between the two types of rights appears to have contributed to the reluctance to accept positive rights and entitlements as justiciable matters.[10]

This paper argues that the CRPD moves toward a conceptual fusion of social, economic and cultural rights with civil and political rights,[11] through its adoption of a social model of health. Accordingly, the CRPD sets out positive obligations on State parties to provide timely and appropriate treatment to people with mental illness, including the provision of adequate community and social services and a coherent system of integration between community and institutional facilities. The CRPD also supports a strict limitation on the provision of involuntary medical treatment, and reconciles these apparently competing objectives through an emphasis on autonomy, self determination and supported decision making. This interpretation of the CRPD, set out below, is based on an analysis of the thematic interconnections between the CRPD framework, the right to equal recognition before the law in Article 5 and Article 12, right to enjoyment of the highest attainable standard of health in Article 25, and the right to respect for physical and mental integrity in Article 17. It reads the CRPD as embedding a 'new age' of mental health law in the social model of health, and a recovery model of mental health.[12]

The Convention Framework

The CRPD is the first convention to be drafted with the full participation of people with disabilities.[13] This brings a unique dimension to the text. It lends an interpretive weight that recognises the contribution of participating organisations, and the aspirations of the broader disability community.[14] The slogan accompanying implementation of the CRD is 'nothing about us, without us.'

The guiding framework for the CRPD is found in the general principles in Article 3. These are:

(a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;

(b) Non-discrimination;

(c) Full and effective participation and inclusion in society;

(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

7. *Gerard Quinn, Civil commitment and the right to treatment under the European Convention on Human Rights 5 Harv. Hum. Rts. J.1 (1992).*
8. *Genevra Richardson UK Department of Health, Report of the Expert Committee, Review of the Mental Health Act 1983 (1999).*
9. *Peter Bartlett, et al, infra note 39*
10. *Amita Dhanda, The Right to Treatment of Persons with Psychosocial Disabilities and the Role of the Courts, 28 Int'l J. L. & Psychiatry 155, 157 (2005).*
11. *Penelope Weller, Human Rights and Social Justice: the Convention on the Rights of Persons with Disabilities and the quiet revolution in international law, 4 (2) Pub Space 17,18 (2009)*
12. *Anna Lawson, The United Nations Convention on the Rights of Persons with Disabilities: New Age or False Dawn? 34(2) Syracuse J. Int'l L. & Com. 563, 563 (2007).*
13. *Don MacKay, The United Nations Convention on the Rights of Persons with Disabilities 34(2) Syracuse J. Int'l L. & Com. 323, 324 (2007).*
14. *Amita Dhanda, Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?, 34(2) Syracuse J. Int'l L. & Com. 429, 430 (2007).*

(e) Equality of opportunity;

(f) Accessibility;

(g) Equality between men and women;

(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Importantly, the first principle is respect for inherent dignity and individual autonomy including the freedom to make one's own choices. This statement poses a close link between inherent human dignity, which is a foundation human rights principle, and the freedom to make one's own choice. It is followed by the principle of non-discrimination. Together these principles emphasise the abilities of people who experience disability, their capacity for individual autonomy, and the burden which is imposed upon them by discriminatory environments and the attitudes of people around them.[15] In relation to mental health, discrimination may manifest, among other things, as misplaced determinations of incapacity, or an assumption that decisions should be overridden on paternalistic 'best interests' grounds. It may be expressed as an arbitrary categorization of people with mental illness as appropriately subject to compulsory treatment, or as intrinsically dangerous. It may be evident in the structure and organisation of mental health systems, the content of mental health law, and in the under-resourcing of facilities and institutions. It may manifest as unwarranted intervention or as neglect.

In recognising the salience of discrimination for people with disability, the CRPD addresses the interaction between the person and their environment, emphasising the obligations upon State parties to modify the hostile environments in which people with disability may find themselves. It exhorts State parties to support the abilities of people with disabilities, and to counter embedded discriminatory attitudes and practices by raising community awareness, developing strategies for social inclusion and creating human rights compliant health and legal systems.

When the different treatment of people with disability is the result of discrimination, human rights law recognises an immediate obligation to reinstate equality, whether or not the rights in question are characterised as negative or positive rights.[16] The embedded nature of discrimination against people with mental illness requires a careful examination of many taken-for-granted practices. With this requirement in mind, the following sections discuss supported decision making, the nature of the obligation to provide appropriate health services and the overarching obligation to respect the physical and mental integrity of the person.

Supported decision making

The CRPD conceptualises people with disabilities as equal subjects of law who are entitled to benefit from modifications in practices and systems that have traditionally excluded them. In setting out the obligation to promote equality before the law, the CRPD addresses the substance of decision making processes.

Article 5 sets out a legal framework for people to be 'equal before and under the law' and to be entitled 'to the equal protection and equal benefit of the law'. Article 5(1) requires that all persons be recognised

15. *Gerard Quinn & Therese Degener, Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability (United Nations Publications, 2002).*

16. *Paul Hunt, The Health and Human Rights Movement: Progress and Obstacles, 15 J.L. & MED. 714 (2008).*

before the law. Article 5(2) requires the effective provision of legal protection against discrimination. Article 5(3) requires that appropriate steps be taken to ensure 'reasonable accommodation' as defined in Article 2, and Article 5(4) requires that specific measures to achieve or accelerate equality are not regarded as discriminatory. These requirements underpin the obligations in Article 12 to enable people with disability to participate in legal processes.

Article 12(1) affirms that 'persons with disabilities have the right to recognition everywhere as persons before the law' and Article 12(2) requires that people with disabilities 'enjoy legal capacity on an equal basis with others in all aspects of life'. People with disabilities, including people with mental illness, complain that they are not infrequently denied legal capacity on erroneous or spurious grounds, either because a disability is automatically equated with incompetence and incapacity, or because there is failure to accommodate the disability in a way that would enable the person to exercise their legal capacity. Thus, Article 12(3) requires State parties to 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'. Article 12(3) recognises that decision making is a process of communication and that decision making ability is a variable human attribute. The vast majority of persons, whether or not they have a disability, are more or less able to reason and understand the content and consequences of a course of action depending on how much information they receive, in what form the information is received, in what context the information is received, how much time is provided to process the information, and how much opportunity there is to discuss or test the information with trusted persons. This is especially so in relation to health information. In mental health, the complexity of communication processes may be burdened by the effects or side effects of medication and other treatments, and the cyclic or unstable nature of the condition. A range of strategies, some of them already familiar in developed mental health systems, could easily facilitate a supported decision making approach if their practice was informed by and oriented toward the achievement of supported decision making. A culture of supported decision-making could be enhanced by:

- the education of mental health professionals around the concept of informed consent and their obligations in law
- the education of mental health professionals around the processes of reasoning
- the appointment and involvement of advocates in decision making
- the involvement of support persons
- the development of case managers as facilitators
- the effective use of treatment plans
- the effective use of psychiatric advance directives, or
- substituted decision making arrangements where the substituted decision maker is clearly bound by the wishes of the patient.

Given the complexity and ongoing nature of the decision-making process, and the importance of understanding the particular problems faced by a person who seeks support in decision making, the involvement of a person who is nominated by and is acceptable to the person with a mental illness is often seen as the most practical and effective way of ensuring that the outcome of a supported decision making process is acceptable to the person with mental illness.

The extension of personal support arrangements for people with impaired decision making ability,

however, raises some difficulties in practice. The law of informed consent, which provides the legal basis for the provision of voluntary medical treatment, requires that the person is competent, informed and is voluntarily giving their consent.[17] When a person is dependent upon others for assistance with decision making, the assumption that they are rational, independent and freely choosing people, as required by the law, is easily displaced. While clinicians must remain alert to the problem of undue influence in any clinical situation, they must also be confident that the support person understands their facilitative role, and is not compromised by competing interests or motivations. Similarly, the person with a disability must understand the support role and process. Development of a culture of supported decision making in mental health is likely to require the implementation of a range of strategies including the development of training programs and practice guidelines to ensure that people with disabilities, clinicians, and support people fulfil their respective roles in a supported, communicative process.

The nature and extent of the support that may be necessary will vary from person to person, and may sometimes require high levels of support. The operation of the principle of 'reasonable accommodation', although yet to be tested, may work to limit the level of support that could reasonably be expected to be provided to persons with disabilities. Whether or not 'reasonable accommodation' has been provided is also relevant to a determination of whether the conduct in question was discriminatory. Ultimately, the expected standard will depend on the standard of medical care that is generally available. In developed western health systems it is not unusual for very high levels of communicative support to be provided to people with, for example, gross communication deficits. The principle of non-discrimination requires that persons with mental illness should be provided with similarly high levels of support.

In CRPD terms, the goal of supported decision making in health decisions is to achieve full and informed consent. People with mental illness complain that the willingness to attribute capacity to them evaporates when they seek to refuse medical treatment, or express a preference for an alternative medical treatment, often on the basis that they 'lack insight' into their illness and the benefits of treatment. McSherry refers to the uneven determinations of capacity as a 'Catch 22'.[18] The circularity of reasoning associated with capacity determinations in mental health is encouraged in jurisdictions where mental health laws rest treatment decisions with the discretion of the clinician.[19] In these jurisdictions, unless the clinician accepts the legitimacy of a person's refusal of treatment, the person's legitimate exercise of legal capacity may be overridden. As is demonstrated in health research,[20] a person's treatment preferences are more likely to be respected when there is optimal communication between the person and the clinician. In CPRD terms, legal frameworks that unduly limit the legitimate exercise of capacity are unacceptable.

The CRPD acknowledges that people who are unable to achieve capacity, even with the provision of support, may benefit from substituted decision making arrangements that are closely tailored to the needs

17. *Loane Skene, Law and Medical Practice Rights, Dutie, Claims and Defences ch. 3 (2d ed. 2004). See discussion in Gillick v. West Norfolk and Wisbech Area Health Authority, [1985] 3 All E.R. 402 (HOL); Secretary, Department of Health and Community Services v. JMB and SMB ['Marion's case'] (1992) 175 C.L.R. 218 (Aus.); Glass v. United Kingdom, (2004) 39 E.H.R.R. 15.*
18. *Bernadette McSherry, Monash University, Opening Minds not Locking Doors, Address at the 50th Anniversary Public Lecture, Education 08, (Oct. 9, 2008) (transcript available at http://www.law.monash.edu.au/rmhl/50-anniversary.html).*
19. *For e.g., Mental Health Act, 1983 (England and Wales) as emended by the Mental Health Act, 2007 (England and Wales), provides, inter alia, that a person with mental disorder (s.1) may be detained and treated in the interests of their health or safety or to protect other persons (s.2/s.3). In certain circumstances a second opinion must be obtained if the person lacks capacity or refuses certain treatment (s.58; s.58A) (s.58).*
20. *David Silverman, Communication and Medical Practice: Social Relations in the Clinic (1987).*

of the person. Article 12(4) requires that any 'measures that relate to the exercise of legal capacity'

- respect the rights, will and preferences of the person,
- be free of conflict of interest and undue influence,
- be proportional and tailored to the person's circumstances,
- apply for the shortest time possible, and
- be subject to regular review by a competent, independent and impartial authority or judicial body.

Article 12 exhorts State parties to accommodate an individual's requirement for assistance. When a person is unable to make decisions for themselves, including medical decisions, Article 12(4) sets out a finely articulated process that balances the need to intervene with a range of safeguards that are guided by respect for the rights, will and preferences of the person, are proportionate to the degree to which such measures affect the person's rights and interests, and are sensitive to the deeply embedded discriminatory attitudes that can colour determination for capacity. Article 25 applies similar principles to express the obligation upon State parties to attend to systemic deficits.

Articles 5 and 12 indicate that decision making processes must always attend to the particular abilities and requirements of the person at the centre of the process. In relation to mental health, this suggests, in the absence of an examination of the substance of the decision making process, that the traditional legal safeguards of second medical opinion, review or appeal are useful, are useful but insufficient strategies to ensure CRPD compliance.

The obligation to provide appropriate health services

In respect of the right to enjoyment of the highest attainable standard of health, Article 25 requires State parties to ensure that health professionals give substance to the human rights of people with disabilities, including people with mental illness, by providing high quality health care, without discrimination, on the basis of free and informed consent and according to the principles of accessibility and acceptability. It requires that the health services that are provided are accessible, gender sensitive and of the 'same range, quality and standard' as those that are provided to other persons.[21] Services must address both general and disability specific health needs of people with disability and include the provision of sexual and reproductive health and population-based public health programmes. Services are to be provided 'as close as possible to people's own communities'.[22] State parties are also required to assist and support health professionals to provide services of the same quality as are provided to other persons on the basis of free and informed consent.[23] They are required to raise the awareness amongst health professionals about human rights issues and to support the development and promulgation of ethical standards in both public and private health care. The non-discriminatory obligation extends to the provision of health and life insurance and prevents the denial of services, food or fluids on a discriminatory basis.[24]

21. *Convention on the Rights of Persons with Disabilities, supra note 2, art. 25(a).*
22. *Id. art.25(c).*
23. *Id. art.25(d).*
24. *Id. art. 25(e) & (f).*

Article 25 must be read in light of General Comment 14 which is an authoritative statement on the scope of the right to heath published by the United Nations Committee on Social, Economic and Cultural Rights.[25] The right to the highest attainable standard of health is governed by the principles of availability and accessibility. Availability refers to quantity, distribution and functioning of public health and care facilities, goods and services,[26] whereas accessibility refers to physical accessibility in terms of location, safety and disability access, and economic accessibility in terms of cost and access to equitable funding and insurance structures. Health care information must also be accessible and available, and supported by a right to seek, receive and impart information and ideas concerning health information. Health services must be available on a non-discriminatory basis to all members of the community including the most vulnerable and marginalised,[27] in a culturally appropriate manner which is mindful of gender and life cycle issues[28] and utilises appropriate scientific and medical technology. The principles of availability and accessibility are particularly important in mental health where access to both mental health and general health information can be limited by a range of individual or systemic issues. The right to enjoyment of the highest attainable standard of health and mental health requires the provision of medical care which is available, accessible, acceptable and of good quality. People with mental illness are equally entitled to exercise control over their own bodies and equally entitled to health protection and health care.

Importantly for mental health, Article 25(b) requires the provision of

> *those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons.*

In developed western jurisdictions the chronic under-resourcing of mental health systems following global de-institutionalisation in the context of neoliberal economic policies[29] has compounded the inadequate provision of appropriate community services,[30] placed stress on acute services resulting in inappropriate discharge practices and limited access to appropriate general health care.[31] The overall reduction in services breaches the entitlement to health protection and health care,[32] increases reliance on coercive interventions, engenders fear in potential users and entrenches discriminatory community attitudes toward people with mental illness.

Article 25, in contrast, looks to the provision of timely, appropriate services that are provided on the basis of free and informed consent, or appropriately fashioned substituted decision making arrangements, where respect for the integrity of the person is an integral part of the service delivery culture.[33]

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25. *General Comment No 14: The Right to the Highest Attainable Standard of Health, U.N. Comm. on Econ., Soc. & Cult. Rights, 22nd Sess., U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).*
26. *Id . para 12(a).*
27. *Id. para 12(b).*
28. *Id. para 12(c).*
29. *Terry Carney, The mental health service crisis of neoliberalism – An antipodean perspective 31(2) Int'l J. L. & Psychiatry 101 (2008).*
30. *Sev. A. Ozdowski, Time for Governments to Act on Mental Health Care, 14 Health Soc. Rev. 203 (2005).*
31. *Special Rapporteur for Health, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005).*
32. *Amita Dhanda, The Right to Treatment of Persons with Psychosocial Disabilities and the Role of the Courts, 28 Int'l J.L. & Psychiatry 155, 157 (2005).*
33. *Amita Dhanda, The Convention on the Rights of Persons with Disabilities, Conference Workshop Presentation at Australian & New Zealand Association of Psychiatry, Psychology and Law 28th Annual Congress (Oct. 2008).*

Protecting the integrity of the person (Article 17)

The principle of non-discrimination animates Article 17 which protects the 'right to respect for his or her physical and mental integrity on an equal basis with others'. Its truncated text is the product of a 'negotiated silence' during the drafting of the CRPD which was aimed at reinforcing an implied prohibition against involuntary treatment in the CRPD.[34] Article 17 draws attention to a range of taken-for-granted practices in psychiatric care that compromise the physical and mental integrity of the person. The United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment identifies these as:[35]

- Poor conditions of detention;
- The use of restraints, including the use of medication as a form of chemical restraint;
- Drugs administered as punishment or restraint;
- The use of seclusion and isolation;
- Experimentation or experimental treatment without consent;
- Forced treatments that are intended to correct and alleviate particular impairments;
- Intrusive or irreversible treatment, such as lobotomy and psychosurgery;
- Forced abortion or sterilisation without free informed consent;
- Modified electroconvulsive therapy without free and informed consent. (Informed consent must include information about 'the secondary effects and related risks such as heart complications, confusion, loss of memory and even death');
- Forced psychiatric interventions that amount to political or social repression;
- Forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics, for the treatment of a mental conditions especially in the presence of extreme and debilitating side effects;[36]
- Involuntary commitment to psychiatric institutions on an arbitrary basis. Involuntary detention may be arbitrary where the criteria for involuntary admission includes only the diagnosis of mental disability coupled with additional arbitrary criteria such as being a 'danger to oneself and others' or in 'need of treatment'; and
- Violence, including sexual violence.[37]

Although developed western nations may regard their mental health systems as free from the worst instances of abuse, some of the practices listed above remain common. At the very least, Article 17 works to confine these practices.[38]

34. *Id. See also Amita Dhanda, Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?, 34(2) Syracuse J. Int'l L.& Com. 429,432 (2007).*
35. *Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [Special Rapporteur on Torture], Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, U.N. Doc. A/63/175 (July 28, 2008), para 45.*
36. *cf Grare v. France, (1993) 15 E.H.R.R.C.D. 100.*
37. *Special Rapporteur on Torture, supra note 35, paras 52-69.*
38. *Bernadette McSherry, Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment, 26(2) L. In Context 1 (2008).*

It can be argued that Article 17 may encompass a positive right to have treatment choices respected. As discussed above, the circular reasoning associated with determinations of capacity may render a person with mental illness vulnerable to an assessment of incapacity on the basis that they fail to appreciate the benefits of treatment. While there may be legitimate reasons to refuse all recommended medical treatment, refusal is usually associated with preference for one form of treatment over another.[39] In these situations, the right to respect for the physical and mental integrity of the person, considered in light of the importance of autonomy and non-discrimination in the CRPD framework, requires that the person's views be given proper consideration. Where these are relevant and adequately expressed, they should displace the objectively determined 'best interests' standard. Giving scope to Article 17 allows credence to be given to the subjectively determined choices of the person who is subject to treatment. This reasoning may have surprising results. For example, a person who has cogently expressed a preference to remain free from medication, even if the choice will invoke the imposition of a restriction of physical liberty on public safety grounds, would be entitled to do so. Conversely, a person who has not or is unable to express a treatment preference is entitled to the best possible care, including active intervention, provided the intervention is appropriately limited by respect for the physical and mental integrity of the person.

Conclusion

Mental health laws in England and Wales have responded specifically to the determinations of the European Court of Human Rights.[40] The legislature is now bound to do so following the adoption of the *Human Rights Act 1998* which incorporates the European Convention on Human Rights into the law of the United Kingdom. The United Kingdom is also a party to the major international conventions including the CRPD.[41] International human rights obligations are embedded in the common law as an integral part of the legal system in common law jurisdictions. International covenants also influence the interpretation of European Convention of Human Rights and the development of the 'living tree' of human rights law.[42]

As outlined above, the CRPD expresses a positive right to service provision and appropriate treatment. A positive right to treatment, does not equate with an obligation to accept treatment, nor an obligation to impose treatment. Rather, the right to respect for physical and mental integrity in the CRPD aligns the elements of the decision making process in mental health care in a way that incorporates subjective determinations of wellbeing into the decision making process. This shift in the decision making process does not entirely resolve the question of involuntary treatment. Instead, it recognises the different needs of people who seek mental health care, allowing maximum recognition of individual decisions at the same time as it enhances the obligation to provide appropriate, but limited, treatment to those people who are (temporarily) unable to consent to treatment. Ultimately, the balance between the obligation to support and the obligation to intervene in a social model of health is dictated by the ongoing process of recovery.

39. *Peter Bartlett, Oliver Lewis & Oliver Thorold, Mental Disability and the European Convention on Human Rights 29 (Martinns Nijhoff Publishers) (2007).*

40. *For example, see X v United Kingdom, Application No 7215/75, judgement, 5 November 1981; (1981) 4 E.H.R.. 188; H.L. v the United Kingdom , Application No 45508/99. Judgment 5 October 2004, (2005) 40 E.H.R.R 32.*

41. *See above note 2.*

42. *Bartlett et al, above note 39, p17.*

Mental health legislation in England and Wales has recently witnessed the introduction of compulsory measures in the community in the form of community treatment orders (CTOs).[43] The Mental Health Alliance (UK) reported that in the first 12 months of operation 4,000 CTOs had been issued under the new provisions[44] While CTOs may ensure access to community treatment, they do not guarantee access to appropriate community services. It seems unlikely that they will enhance the development of self directed pathways to recovery. While a closer examination of the operation of CTOs is clearly required, the reliance on coercive interventions engendered by the new provisions appears to offend the CRPD principles of equal recognition before the law, the provision of appropriate services and respect for the physical and mental integrity of the person, outlined above.

Mental health laws are more than symbolic. As Clive Unsworth noted more than two decades ago,

> '*[l]aw actually constitutes the mental health system, in the sense that it authoritatively constructs, empowers, and regulates the relationship between the agents who perform mental health functions*'.[45]

The current experience in England and Wales suggests that this is so. Laws that remain inured to emerging human rights principles, stymie the development of innovative practice in the care and treatment of people with mental illness. The challenge ahead is to read the CRPD as a model for a new generation of mental health laws.

43. *ss.17A-G and Part 4A Mental Health Act 1983 (as amended by the Mental Health Act 2007).*
44. *Detentions in hospital have increased from 28,100 in 2007/08 to 28,700 in 2008/09, Mental HealthAlliance (UK), 3rd Nov 2009. http://www.mentalhealthalliance.org.uk/news/practanniversary.html, accessed 22/3/2010.*
45. *Clive Unsworth, The Politics of Mental Health Legislation (Oxford: Clarendon Press, 1987) p 5.*

S.117 MHA 1983 re-visited: the liability of the State and the existence of a duty of care

Jonathan Butler[1]

This article seeks to summarise the movement towards an increased likelihood of branches of the state (in this case, either social services or health trusts) being found to owe a duty of care to specific categories of people. The issue was phrased thus in 2005 by Lord Bingham of Cornhill: '*The question does arise whether the law of tort should evolve, analogically and incrementally, so as to fashion appropriate remedies to contemporary problems or whether it should remain essentially static, making only such changes as are forced upon it, leaving difficult and. in human terms, very important problems to be swept up by the Convention. I prefer evolution*'.[2] In adopting that Darwinian approach to the development of the law, it is necessary to look at the recent history of duties of care that may be owed by the State. The starting point is ***X v Bedfordshire County Council***[3] **(1995)**; the end point (so far) is ***AK v Central and North West London Mental Health NHS Trust and Royal Borough of Kensington and Chelsea***[4] (2008).

Evolution of the Law

X v Bedfordshire[5] (1995)

This case cast an extremely long shadow over this area of tort, in terms of creating formidable obstacles for those who sought to establish tortious liability against local authorities in the discharge of their statutory obligations within the specific area of what has come to be known (broadly) as community care law. It informed many of the subsequent decisions of the courts, and in particular insofar as mental health law is concerned, that of ***Clunis (Christopher) (by his next friend Christopher Prince) v Camden and Islington Health Authority***[6] **(1998)**. Hitherto, the latter authority has supported the proposition that

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2. *JD v East Berkshire Community Health NHS Trust and others [2005] UKHL 23).*
3. *HL[1995] 2 FLR 276*
4. *QBD [2008] EWHC 1217; [2008] 11 CCLR 543*
5. *f/n 3 above*
6. *[1998] 1 CCLR 215*

any purported failure to discharge obligations pursuant to s.117(2) will not found an action for breach of a duty of care. As a result of the decision in ***AK***[7], this may no longer be the case.

It is difficult to do justice to the leading judgment of Lord Browne-Wilkinson in ***X v Bedfordshire*** by way of paraphrase. However, the principles which emerged are now well known and may be summarised as follows. All of the claims raised '*in one form or another the difficult and important question to what extent authorities charged with statutory duties are liable in damages to individuals injured by the authorities' failure properly to perform such duties*' (282 B). The answer is in part given at the beginning of the lengthy judgment, thus '*It is important to distinguish such actions to recover damages, based on a private law cause of action, from actions in public law to enforce the due performance of statutory duties, now brought by way of judicial review. The breach of a public law right by itself gives rise to no claim for damages. A claim for damages must be based on a private law cause of action*' (282 E). Furthermore, the principles applied then (as now) derive from ***Caparo Industries plc v Dickman***[8] **(1990)**, which are (a) was the damage to the claimant reasonably foreseeable?; (b) was the relationship between the claimant and the defendant sufficiently proximate?; (c) is it just and reasonable to impose a duty of care?. It is the final question which was the largest obstacle to establishing whether a duty of care existed. That difficulty is stated thus: '*the question whether there is such a common law duty and if so its ambit, must be profoundly influenced by the statutory framework within which the acts complained of were done*' (290 F).

Lord Browne-Wilkinson had commented earlier that '*your Lordships were not referred to any case where it had been held that statutory provisions establishing a regulatory system or a scheme of social welfare for the benefit of the public at large had been held to give rise to a private right of action for damages for breach of statutory duty. Although regulatory or welfare legislation affecting a particular area of activity does in fact provide protection to those individuals particularly affected by that activity, the legislation is not to be treated as being passed for the benefit of those individuals, but for the benefit of society in general … the cases where a private right of action for breach of statutory duty has been held to arise are all cases in which the statutory duty has been very limited and specific as opposed to general administrative functions imposed on public bodies and involving the exercise of administrative discretions*' (283 F-H). Similarly, he held that the mere assertion that that there had been a careless exercise of such a duty or power was also insufficient upon which to base a cause of action. In respect of the co-existence of a statutory duty and a common law duty of care, he drew a distinction between cases where it is alleged that an authority owes a duty of care in the manner in which it exercises that statutory discretion, and cases where the duty of care is said to flow from the manner in which the duty has been implemented in practice. If the decision complained of came within the ambit of an exercise of statutory discretion, then it could not be actionable at common law. However, if the decision was so unreasonable that it must fall outside that discretion conferred upon the authority, then '*there is no a priori reason for excluding all common law liability*' (287 G). It follows from this concession, however, that the Court must then proceed to consider whether or not the alleged fault derives from an assessment of what are termed 'policy' decisions. He concluded that '*…a common-law duty of care in relation to the taking of decisions involving policy matters cannot exist*' (290 D).

Even if, however, the claim fell into an area where notwithstanding all of the above, the claim was still justiciable, then it might still fall foul of the principle in ***Caparo*** set out above (the 'just and reasonable' argument, within the context of this general area of legislation). In respect of this particular area, it was held that it was not just and reasonable to superimpose a common-law duty of care on local authorities

7. *f/n 4 above*
8. *[1990] 2 AC 605*

(within the sphere of child protection). Lord Browne-Wilkinson further relied upon ***Caparo*** for the proposition that (in effect) to extend the law in this area would be to develop a novel category of negligence, and that this could only be done incrementally and by analogy with decided categories. He held that '*the plaintiffs are seeking to erect a common-law duty of care in relation to the administration of a statutory social welfare scheme*' (302 E). It followed that the claims which were predicated by such a statutory basis failed. It should be noted, for the sake of completeness, that some of the claims were also based upon vicarious liability (ie that the professionals involved had been negligent) but these were also dismissed, for similar reasons to those summarised above.

Clunis[9] (1998)

As mentioned above, the first litigation which arose on this point within the context of the *Mental Health Act 1983* immediately fell foul of the principles referred to above. For the general purposes of this article, it is as well to set out the current relevant statutory provision at this point:

> ***S.117 (2) Mental Health Act 1983 (as amended)***
>
> *It shall be the duty of the Primary Care Trust or Local Health Board and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the Primary Care Trust or Local Health Board and the local social services authority are satisfied that the person concerned is no longer in need of such services….*

The facts of ***Clunis*** are well known. Beldam LJ immediately fastened upon the ratio of Lord Browne-Wilkinson to identify this statutory provision as being '*designed to promote the social welfare of a particular class of persons and to ensure that the services required are made available to individual members of the class*' (224 J). He adopted the caution of ***X*** in respect of permitting a claim unless there was '*exceptionally clear statutory language to show a parliamentary intention that those responsible for carrying out these difficult functions should be liable in damages…*' and concluded (based upon ***X***) that the wording of the section was not such as to create a private law cause of action for failure to carry out duties under the statute. Further, in dismissing the claim, it was accepted by the Court that '*the question of whether a common law duty exists in parallel with the authority's statutory obligations is profoundly influenced by the surrounding statutory framework …. the duties of care are, it seems to us, different in nature from those owed by a doctor to a patient…* (225 I-K). It followed that ***Clunis*** has remained since as authority for the prevention of a private law action for breach of a statutory duty, or a claim for an action in breach of a common-law duty of care.

Barrett v Enfield LBC[10] (1999)

In the meantime, the issue of litigation as against local authorities continued, and again required the attention of the House of Lords, and in particular that of Lord Browne-Wilkinson. The facts of this case involved an allegation that children's services had failed to make proper provision for a child once he had been taken into its care. By the time that the matter came to be determined, two cases had been decided

9. *See f/n 6 above*
10. *[1999] 2 CCLR 203; [1999] 3 WLR 79. This case was reviewed in JMHL October 1999. See 'A Duty of Care?' by Fenella Morris and Matthew Seligman @ pp 159-164.*

which were to have a profound impact on this area of law. The first was ***Phelps v Hillingdon LBC***[11] (which at that stage had only reached the Court of Appeal) and the second was ***Osman v United Kingdom***[12]. ***Phelps*** is considered at greater length below. In respect of ***Osman*** it is clear that at this stage in the evolution of the law, Strasbourg jurisprudence was beginning to make a significant difference in the way in which the domestic courts were interpreting the law in respect of local authority/state liability. Lord Browne-Wilkinson held that '*In my speech in the **X** case …. I pointed out that unless it was possible to give a **certain** answer to the question whether the plaintiff's claim would succeed, the case was inappropriate for striking out….In my judgment it is of great importance that such developments should be on the basis of actual facts found at trial…*' (207 H). Further, despite his comments on the reasoning in ***Osman*** he held that '*In view of the decision in the **Osman** case it is now difficult to tell what would be the result in the present case if we were to uphold the striking out order. It seems to me that it is at least probable that the matter would then be taken to Strasbourg….In the present very unsatisfactory state of affairs, and bearing in mind that under the Human Rights Act 1998 Article 6 will shortly become part of English law, in cases such as these it is difficult to say that it is a clear and obvious case for striking out*' (209/210).

In general terms, the propositions set out in ***X*** remained, save that the distinction between operational and policy decisions was again emphasised. In essence, if the operational conduct of an authority (ie day to day implementation of a decision made) were sufficiently deficient, and the conditions in ***Caparo*** were fulfilled, then it might be possible that the authority owed a duty of care, and be in breach of that duty of care.

Phelps v Hillingdon LBC[13] (2000)

The specific statutory context of the claim arose out of legislation in respect of the provision of education, and particularly special educational needs. As Lord Slynn of Hadley observed (citing Auld LJ in the Court of Appeal in ***Re G (a Minor)***)[14] '*The law is on the move, and much remains uncertain*' (158 K). He held that: '*It does not follow that the local authority can never be liable in common law negligence for damage resulting from the acts done in the course of the performance of a statutory duty… This House decided in **Barrett v Enfield LBC**… that the fact that acts which are claimed to be negligent are carried out within the ambit of a statutory discretion is not in itself a reason why it should not be held that no claim for negligence can be brought in respect of them* [166 F] *…. I do not see why as a matter of principle a claim at common law in negligence should never be possible. Over-use of the distinction between policy and operational matters so as respectively to limit or create liability has been criticised, but there is some validity in the distinction. Just as the individual social worker in **Barrett v Enfield** could be 'negligent in an operational manner' … so it seems to me that the local education authority could in some circumstances owe a duty of care and be negligent in the performance of it*' (171 C-D). Although framed by way of vicarious liability (of a psychologist employed by the local authority in this instance) it is clear that between 1995 and 2000 there had already been a substantial alteration in the substantive law regarding the potential for the existence of a duty of care owed by the state towards an individual where there was prima facie evidence of negligence (ie in an *operational* sense).

11. *[1998] ELR 587*
12. *(23452/94) [1999] 1 FLR 193*
13. *HL [2000] 3 CCLR 156*
14. *Unreported 27/7/2000.*

JD v East Berkshire Community Health NHS Trust and Others[15] (2005)

This case again gave cause for the House of Lords to reconsider the law in relation to a duty of care in this area[16]. Lord Nicholls observed '*the law has moved on since the decision of your Lordship's house in **X** …There the House of Lords held that it was not just and equitable to impose a common law duty on local authorities in respect of their performance of their statutory duties to protect children. Later cases …. have shown that this proposition is stated too broadly. Local authorities may owe common law duties to children in the exercise of their child protection duties*' (211 I-J). It should be noted that by the time the case came to be determined in the House of Lords, the defendant health authorities already accepted that there was a duty of care owed to the children in respect of whom a diagnosis of abuse (which had turned out to be unfounded) had been made. The sole issue was whether or not a duty was owed to the parents of the children. For reasons that are not of specific relevance to the purpose of this article, such a duty of care was found not to exist.

Evolution and Current Law

AK v Central and North West London Mental Health NHS Trust and Royal Borough of Kensington & Chelsea[17] (2008)

The factual background to this case is sadly all too familiar. The claimant had been detained under the MHA 1983, and was entitled to after care. He was discharged from hospital, but subsequently made a substantial attempt on his own life, which failed, but left him with very serious injuries. His assertion (framed in negligence) as against both the NHS Trust and Local Authority was that (a) there had been a failure to appoint a competent social worker or care co-ordinator, and (b) a failure to provide appropriate accommodation (the suicide attempt was by way of jumping from a second floor window of B&B accommodation). However, he also asserted that there had been a breach of Articles 2, 3 and 8 of the *European Convention of Human Rights* (ie a failure to take positive steps to preserve his life; that the consequences of incompetent after-care amounted to inhuman or degrading treatment; that there had been a failure to protect his family life by virtue of the same failures in effective care planning and the consequences that flowed from the failure). Initially, summary judgment was given in favour of the defendants upon the basis that there was no reasonable prospect of success. The appeal against that decision was successful (apart from that aspect which was founded on Article 2), upon the following basis. It is that success that brings together all of the above points in respect of the changes in the law over the past decade or so, and which are of particular significance for practitioners in this area.

King J commences his judgment with reference to both the ***X*** case, and ***Barrett, JD v East Berkshire***, and ***Phelps***. He stated that '*I was reminded that notwithstanding the apparent definitive ruling of the House of Lords in **X** … that it was not just and equitable to impose a common law duty on local authorities in respect of their performance of their statutory duties to protect children, subsequent case law has (to cite the words of Lord Nicholls in **JD v East Berkshire HA**) 'shown this proposition to be stated too broadly'. It is now clear for example that common law duties can exist, albeit they mirror or arise out of a statutory duty owed both by a local*

15. *[2005] UKHL 23; [2005] 8 CCLR 185*
16. *The European Court of Human Rights had considered X in the interim (TP & KM v UK [2001] 2 FLR 549 and Z & Ors v UK [2001] 2 FLR 612)*
17. *See f/n 4 above [2008] 11 CCLR 543*

authority both under various child protection statutes… and under the Education Act (as in ***Phelps v Hillingdon LBC****). A publicly employed health care professional may now owe a common law duty of care to a child with whom that professional is dealing, albeit 'until recently it would have been unthinkable' (per Lord Nicholls in* ***JD*** *supra) since 'the law has moved on since the decision of your Lordships house in* ***X****…".* (para 4; page 546 E-G).

Basis of Claim

Despite an apparent lack of clarity in the formal pleadings as against the Defendants, King J held that '*I have no doubt that the pleaded case in negligence is an allegation of common law negligence in the carrying out of a particular statutory function/duty and in negligently failing to provide services pursuant to that particular statutory duty, namely that falling within section 117.*' (551 G-H). The purported liability of each of the Defendants was one of joint liability for the consequences of that negligence.

The Claimant also asserted that the Care Programme Approach (CPA) guidance, with which the Defendants could have been expected to comply, was the source of further responsibilities which in turn formed the basis for a duty of care (and one which was unaffected by the ratio in ***Clunis***). However, this argument failed in that it was held that '*the Care Programme Approach cannot be the source of responsibilities imposed on these defendants independently of their responsibilities under section 117* [32] … *the reference to the CPA cannot in my judgment derogate from the basic premise of the claim namely that in purporting to follow the CPA guidance the defendants were exercising their section 117 function*' (35; 553). Moreover, an attempt to incorporate into the claim a suggestion that the Trust were in addition bound by virtue of sections 1 and 3 of the *National Health Service Act 1977* was also rejected, not only on the grounds that the claim was framed as one of joint liability, but also since those sections only created a target duty, whereas s. 117 '*places an enforceable joint duty on both local authorities and health bodies to consider the aftercare needs of* ***each individual*** *to which it relates*' (37; 554 B). Similarly, the *National Health Service and Community Care Act 1990*, the *Chronically Sick and Disabled Persons Act 1970 (s.2)* and section 29 of the *National Assistance Act 1948* '*can have no relevance to the pleaded cause of action … which as indicated is expressly pleaded as a joint liability with the first defendant. These statutory provisions only apply to the local authority*' (37; 554 C). Further, King J held (by reference to ***R v Manchester CC ex parte Stennett***[18] **(2004)** that '*services provided under section 117 are provided under section 117 alone. It is not a gateway provision which leads to services under other statutes*' (38; 554 D). The proposition that s.117 stands apart from other community care legislation has been recently reaffirmed in ***R (on the application of M) v (1) Hammersmith & Fulham LBC (2) Sutton LBC; R on the application of Hertfordshire CC v Hammersmith & Fulham LBC***[19] **(2010)**.

Analysis of Claim

The starting point in respect of the reliance of the Defendants upon ***Clunis*** is summarised thus: '*The submission of both Defendants that the decision in* ***Clunis*** *effectively excludes the existence of the common law duty of care to support such a private law action in negligence is on any view a formidable one*' (43; 555 F). King J then referred to parts of the judgment in ***Clunis*** to which reference has already been made in this article. That ratio was distinguished on the following basis: '*In reaching the conclusion which the Court of Appeal undoubtedly did on the facts of* ***Clunis*** *that it would not be fair and reasonable to impose a common law duty of*

18. *HL [2004] 4 A11 ER 124; [2002] 5 CCLR 500*
19. *[2010] EWHC 562 (Admin)*

care on the defendant health authority in relation to the performance of its statutory duties to provide after-care, in parallel with its statutory obligations to make such provision under section 117…. the court clearly had regard not only to its view of the statutory framework but also to its characterisation of the duties which ***in the instant case*** *it was alleged that the defendant had failed to perform as essentially 'administrative' ones, which the court crucially regarded were different in nature from those owed by a doctor to a patient whom he was treating and for whose lack of care in the course of such treatment it was conceded in the local health authority might be liable. Thus although I fully accept that the overall thrust of the judgment … is to support the proposition put forward by the defendants….it is still nonetheless the position in my judgment that the court in* ***Clunis*** *was addressing its mind specifically to the nature of the 'errors and omissions of the kind alleged' .. in that case*' (45; 555-556). On the facts of the case in ***Clunis***, it was '*easy to understand why the court felt able to characterise the duties which the defendants had allegedly negligently failed to perform as 'essentially in the sphere of administrative activities in pursuance of a scheme of social welfare in the community' in respect of which it would not be 'fair and reasonable' to superimpose on the defendant local authority a common law duty of care to provide those particular after-care services*'.

The analysis of this distinction allowed the Court to continue to reach the judgment that '*it seems to me that one has to be careful in using* ***Clunis*** *as authority for the proposition that in all circumstances any alleged failure of an authority to provide an after-care service under section 117 is necessarily an allegation of a failure to carry out simply an 'administrative duty' not amenable to the imposition of a common law duty of care, or that any alleged failure under that section which can be characterised as failure to carry out an 'arrangement duty' as opposed to a 'treatment duty' … necessarily excludes the existence of a common law duty of care in relation to the performance of that duty*' (47; 556-557).

Analysis of outcome

King J held that '*on a narrow reading of* ***Clunis*** *its ratio is no more than that simply because a person is cared for under section 117, no* **general** *(ie general to the class of persons whose social welfare it is designed to promote….) common law duty of care to provide section 117 after-care services automatically arises and a claimant cannot lay claim to the benefit of such a duty just because he can show he is a member of the particular class*' (49; 557).

In terms of the application to strike out the claim, it followed that upon the basis of the facts in the case which he was considering '*it would be wrong to debar the appellant from arguing at trial that on the facts of his case there was a relationship and proximity between him and the defendants that was far closer than between the claimant and the defendant health authority in* ***Clunis***' (50; 557). He accepted that it was arguable that the the defendants were not involved simply in an administrative capacity but '*were directly responsible on an ongoing basis for aspects of the care of a person whom they already knew to be vulnerable and reliant upon them*' (50; 557). It is a reflection of the strength of the judgment that (in part at least) this proposition implicitly and seamlessly draws upon the partial concession by Lord Browne-Wilkinson referred to at the beginning of this article (and contained in ***X***) that if the decision was so unreasonable that it must fall outside that discretion conferred upon the authority, then there '*is no a priori reason for excluding all common law liability*' (287 G).

King J also relied for his judgment on ***Gorringe v Calderdale MBC***[20] **(2004)** in that: '*The observations of Lord Steyn at paragraph 3 emphasise that in his judgment in the case of a claim framed in negligence against the*

20. [2004] UKHL 15

background of a statutory duty or power, a basic question is whether the statute ***excludes*** *a private law remedy which was not a question directly addressed in* **Clunis**. *Secondly even Lord Scott who said at paragraph 71 in a passage heavily relied upon by the defendants, that he was 'inclined to go further' and expressed the opinion that 'if a statutory duty does not give rise to a private right to sue for breach, the duty cannot create a duty of care that would not have been owed at common law if the statute were not there', did however in paragraph 73 make the further point that 'there are of course many situations in which a public authority with public duties has a relationship with a member of the public that justifies imposing on the public authority a private law duty of care towards that person and the steps required to be taken to discharge that duty of care may be steps comprehended within public duties.* ***Barrett*** *…. and* ***Phelps*** *are examples*' (52; 558).

Finally, he relied by way of analogy on ***Smith v Chief Constable of Sussex***[21] **(2008)**. He acknowledged that in that case, sanctioning the removal of any blanket ban on claims in negligence against the police (within a different statutory context) '*which was thought to exist by reason of the House of Lords decision in* ***Hill v Chief Constable of West Yorkshire***,[22] *the court did demonstrate* ***how the very proximity of the parties on particular facts*** *may lead to a different conclusion being reached than hitherto, and that that which might have been regarded as definitive expositions of principle at the highest level as to when a common law duty of care might or might not arise, have to be considered in the light of that proximity. Thus Sedley J … observed at paragraph 17 that nonetheless 'it has become clear … that in some cases involving the police the very proximity of the parties can not only create a duty of care but can overcome the public policy considerations which would otherwise bar the claim*' (54; 558).

As a consequence of the above, '*even if contrary to my present view,* ***Clunis*** *has to be read as authority for the proposition that a common law duty of care in the exercise of a statutory duty under section 117 is absolutely excluded in all cases whatever the facts, such a wide proposition is no longer tenable in the light of subsequent legal developments in this area at a level higher than that of the the Court of Appeal, and that* ***Clunis*** *cannot be regarded as 'the final chapter on the destiny of claims such as the present' (to adapt the words of Rimer LJ in* ***Smith****) and that this is not a case where a strike out application of the claim of common negligence should succeed when there has been no investigation on the facts*' (55; 558-559).

Conclusion

This article began with a reference to the words of the late Lord Bingham in relation to the evolution of the law. In many respects, the decision in **AK** marks the end of a period of some 15 years during which the basic principles of the tort of negligence had become occluded by a reluctance to permit an organ of the state to be liable within the context of community care law.

The propositions that can be extracted from that process are (not exhaustively) as follows. Generally, the impact of the *Human Rights Act* 1998 has plainly had a considerable effect upon the domestic courts (primarily Article 6). In addition, where there is a proximate relationship between an individual and an agent of the state discharging duties conferred by a statute, and where there has been a specific assumption of responsibility towards that individual, then all things being equal, if the traditional elements of the tort of negligence can be made out, then liability and damages will follow as in any other case of negligence. Specifically, it will be no longer possible for a defendant to rely upon the assertion that a statute designed to promote social welfare is (in itself) impervious to assault by way of a claim in negligence. This is certain where the facts may reveal (a) the necessary degree of contiguity between the

21. *[2008] EWCA Civ 39*
22. *[1998] 2 All ER 238*

claimant and the defendant, (b) an assumption of responsibility towards the claimant, and (c) the necessary lack of competence in discharging the duties so imposed. Finally, the exegesis of the higher courts in respect of the manner in which the relevant statutes are phrased and the inferences that may or may not be drawn from parliamentary draftmanship have now been almost completely reversed. The warning sounded in ***X*** that '*the question … must be profoundly influenced by the statutory framework*…(supra) has now been replaced with '*a basic question is whether the statute excludes a private law remedy*' (***AK*** supra).

It has been quite a long journey from ***X*** to ***AK***, but the consequence must now be that the law of tort has evolved (to paraphrase the words of Lord Bingham) so as to fashion a remedy for what are very contemporary and human problems, without merely leaving those problems to be '*swept up by the Convention*'.

Seal v UK: The End of the Story or Time for a Fresh Beginning?

Seal v UK, ECtHR, appn 50330/07

7 December 2010, [2011] MHLR 1

Kris Gledhill[1]

Introduction

In a number of different legal settings, there are statutory provisions to the effect that permission is required to commence an action. Since litigants do not always abide by procedural obligations, a question might then arise as to what is the consequence of a failure to obtain permission: is the action a nullity or was there a procedural flaw that can be corrected? In other words, what actually was the nature of the obligation – a mandatory obligation that determines the jurisdiction of the court to proceed or a directory provision that ought to be met but is not an essential precursor to commencing an action?

This is a question that may be acute if the limitation period has expired by the time of the ruling as to whether or not the action is a nullity: in such a situation, absent an unlikely concession from a defendant that the limitation defence will not be raised if a further action is commenced, a finding that the procedural error has rendered the action a nullity effectively means that the merits of the action will never be assessed.

One of the relevant provisions is in the *Mental Health Act 1983*. Section 139 is headed "Protection for acts done in pursuance of this Act". It provides, first, a defence of substance:

> '(1) No person shall be liable, whether on the ground of want of jurisdiction or on any other ground, to any civil or criminal proceedings to which he would have been liable apart from this section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules made under this Act, ..., unless the act was done in bad faith or without reasonable care.'

In addition, there is a procedural safeguard:

> '(2) No civil proceedings shall be brought against any person in any court in respect of any such act without the leave of the High Court; and no criminal proceedings shall be brought against any person

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> in any court in respect of any such act except by or with the consent of the Director of Public Prosecutions.'

Section 139(4) of the 1983 Act disapplies the provisions of the rest of the section in relation to proceedings against the Secretary of State for Health or NHS bodies.[2] But this does not apply in relation to private hospitals, local authorities or the police.

In *Seal v Chief Constable of South Wales Police*,[3] it was held that the effect of section 139(2) was that an action commenced without leave was a nullity. It has now been determined by the European Court of Human Rights that this did not breach the right of access to a court for the purposes of Article 6 ECHR: see *Seal v UK*.[4] However, it is suggested that this is not the end of the story, in particular because there is an argument of substance that remains open, namely that Article 14 ECHR, the non-discrimination provisions, have not been taken into account.

Similar Language in Other Contexts

In order to understand the potential of the Article 14 argument, it is worth bearing in mind what has been decided in the other settings where there is a procedural safeguard such as that in section 139(2): indeed, it is essential to a demonstration of discrimination, namely unjustified differential treatment on the basis of status.[5] It is certainly the case that similar provisions in other legal contexts have been found to operate in a different manner, namely that the failure to obtain permission in advance does not render the action a nullity, but creates a procedural requirement that can be met by obtaining the necessary permission when the point is raised.

Rendall v Blair[6] involved an action brought by a school-teacher seeking an injunction to prevent his dismissal from a school run by a charity (and consequent removal from his accommodation), but he had not obtained the leave of the Charity Commissioners. This led to the action being struck out at first instance as a nullity, but it was reinstated by the Court of Appeal, which held that any necessary leave could be obtained after the point had been raised. The relevant statutory language was section 17 of the *Charitable Trusts Act 1853*, which provided that:

> 'Before any suit, petition, or other proceeding … for obtaining any relief, order, or direction concerning or relating to any charity, or the estate, funds, property, or income thereof, shall be commenced, presented, or taken, by any person whomsoever, there shall be transmitted by such person to the said board, notice in writing of such proposed suit, petition, or proceeding, and such statement, information, and particulars as may be requisite or proper, or may be required from time to time, by the said board, for explaining the nature and objects thereof …'

The subsection continued by allowing the board (namely the Charity Commissioners) to authorise such action. There was also language to explain the consequence of a failure to obtain permission:

> 'and (save as herein otherwise provided) no suit, petition, or other proceeding for obtaining any such relief, order, or direction as last aforesaid shall be entertained or proceeded with by the Court of Chancery, or by any Court or Judge, except upon and in conformity with an order or certificate of the

2. *In Wales, this covers the Welsh Ministers, who carry out the functions of the Secretary of State by reason of devolution: see the Government of Wales Act 2006.*
3. *[2007] UKHL 31, [2007] 1 WLR 1910, [2007] MHLR 282.*
4. *ECtHR, appn 50330/07, 7 December 2010; [2011] MHLR 1*
5. *This is discussed further below.*
6. *(1890) 45 ChD 139.*

> said board. Provided always, that this enactment shall not extend to or affect any such petition or proceeding in which any person shall claim any property or seek any relief adversely to any charity.'

So the operative language is that the relevant consent is required before the action "shall be commenced" and the consequence of a failure to obtain it is that the action cannot be "entertained or proceeded with".

The Court of Appeal was doubtful that the proceedings commenced by the school-teacher were within the section, since the case did not relate to the administration of the trust deed, but held that if any consent was required, the action could be stood over to obtain it and would only be dismissed if the consent was not forthcoming at that point: in other words, it did not have to be obtained in advance. So mandatory language to the effect that the action could not be "entertained" without the relevant consent did not mean that it was a nullity: once the procedural defect had been noted, the relevant consent could be sought. Mr Justice Kay, sitting at first instance, had dismissed the claim: he held that the purpose of the section was to prevent charities being harassed with actions, and so a flagrant violation of the provision would mean that the action was a nullity.[7] Lord Justice Bowen summed up the reasons for disagreeing with this: the statutory language was not clear in showing that the action was a nullity as opposed to being one that the courts could not consider further until the condition was fulfilled, and there was authority to show that various actions had been stood over to allow consent to be obtained after proceedings had been issued and the point had been noted. On the question of the statutory language, Bowen LJ noted:[8]

> "… We are all of us familiar with the way in which Acts of Parliament are drafted to prevent actions being brought at all or writs being issued unless some condition precedent has been fulfilled. The language of such sections we are all familiar with, and the draftsman or the Legislature requires no obscure language if they desire to enact such laws. But this section is not framed in the way in which sections are framed when it is intended that some preliminary steps should be taken before the action is maintainable at all. On the contrary, both from the way in which it is framed, from the omission of the usual words, and also from the presence of words which seem to me to, indicate that the absence of the consent of the Commissioners is only a bar to the Courts dealing with the action, and not a bar to the original institution of the suit – on all those three grounds I come to the conclusion that this section enables the Court, in such cases as I have indicated, to allow the action, to stand over in order that the blot which has occurred may be cured if possible. In the first place, the section only begins with the enactment, "Before any suit shall be commenced there shall be transmitted notice in writing to the board"; but it abstains altogether from saying that the action is to be dismissed if no, such notice is transmitted. On the contrary, it only indicates that, "save as hereinbefore provided, no suit, petition, or other proceeding shall be entertained or proceeded with by the Court"; that is to say, the enactment is directory. It directs what ought to be done. Unless the duty is complied with by the litigant the Court must hold its hand. But it does not oblige the Court to close the gates of mercy upon the applicant, but enables it to stay proceedings until that consent, which as a matter of duty ought to be obtained in the first instance, is obtained at last. …"

In short, the procedural duty is of a directory nature, and the court cannot proceed with the action in the absence of the necessary consent: but the court will not consider the action to have been a nullity; consequently, other procedural obligations, such as the need to commence an action within a limitation

7. *Pages 149-150.*
8. *Pages 157-158.*

period, would be considered to have been met.

Similarly, section 130 of the *Insolvency Act 1982* sets out the consequences of a winding-up order in relation to company. One of those, in section 130(2) is that "no action or proceedings shall be proceeded with or commenced against the company or its property, except by leave of the court …". The effect of this was considered in *Re Saunders*,[9] in which it was held that the 1982 statutory language had not been designed to alter the practice already in place of allowing leave to be obtained after proceedings had been commenced. Mr Justice Lindsay, in so holding, declined to follow cases to the contrary, citing a lengthy list of cases from various common law jurisdictions to the effect that the statutory language did not prevent retrospective leave, despite the directive prohibiting the commencement of an action without leave.

A recent addition of a similar provision is section 329 of the *Criminal Justice Act 2003*. This regulates civil proceedings brought by an offender for trespass to the person, namely the situation in which a person has been convicted of an imprisonable offence but brings a civil action in relation to the same incident, claiming assault, battery or false imprisonment. A typical scenario for this would be an allegation of excessive force in relation to an arrest for an offence, or excessive time in police custody in breach of the requirements of the *Police and Criminal Evidence Act 1984*. Section 329(2) provides that that "Civil proceedings relating to the claim may be brought only with the permission of the court". The section goes on to provide a defence to any claim for the defendant to prove that the action about which complaint is made was motivated by crime prevention or investigation and that the act was not "grossly disproportionate". In order to obtain leave, the claimant must show that there is evidence that these two defence conditions are not met.

The effect of the substantive defence was described as an extreme one by Sedley LJ, giving the judgment of the Court of Appeal in *Adorian v Commissioner of Police of the Metropolis*:[10]

> "The consequences should not go unnoticed. In place of the principle painstakingly established in the course of two centuries and more, and fundamental to the civil rights enjoyed by the people of this country – that an arrest must be objectively justified and that no more force may be used in effecting it than is reasonably necessary – the section gives immunity from civil suits, not confined to those involving personal injury, to constables who make arrests on entirely unreasonable grounds, so long as they are not acting in bad faith, and accords them impunity for using all but grossly disproportionate force in so doing. … there is no indication that Parliament was aware, much less intended, that what it was enacting would have this effect."

The question arising in *Adorian* was the procedural point of whether the proceedings were void because leave had not been sought in advance. The claimant had been arrested for disorderly behaviour in August 2004, subsequently charged with and convicted of obstructing police officers and granted a conditional discharge. But there was medical evidence that he suffered multiple fractures at the top of his right leg and hip of a sort that required trauma equivalent to falling from a significant height. A writ was issued just before the expiry of three years from the incident, naming trespass to the person and negligence as the causes of action. At that time, the incident was the subject of a complaint to the Independent Police Complaints Authority which had not yet been resolved (which might have been relevant to the litigation, including the prospects of settling it without the need to commence an action). A few months later, in

9. *[1997] Ch 60.*
10. *[2009] EWCA Civ 18, [2009] 1 WLR 1859.*

January 2008, the House of Lords ruled that a claim for battery causing personal injury was subject to the three-year limitation period that had been thought to be applicable only to negligently caused personal injury[11] rather than the six-year limitation period that had been thought to apply to trespass to the person in the form of assault or battery:[12] see *A v Hoare*,[13] overturning *Stubbings v Webb*.[14] The context of the House of Lords' decision was historic sex abuse claims: if they were not governed by the personal injury provisions, then they were time barred because they were more than six years old; but if they were covered by the personal injury provisions, they might be able to proceed because the three-year limitation period can be extended if it is equitable to do so.[15]

So the situation in *Adorian* was one in which sympathy would be with the claimant: there was an unexplained but serious injury consistent with a significant breach of his rights, he had not rushed to litigation because he had been taking sensible pre-action steps of complaining to the relevant investigative body, and he had been caught in a limitation trap because the House of Lords had changed the law. In that context, the police argument that his claim was a nullity because he had not sought leave in advance could be seen as an attempt to take advantage of a procedural bar to avoid a claim with clear prima facie merit. There was, however, little prospect of any such ruling preventing the claim being re-lodged because the circumstances of *Adorian* were such that the three-year limitation period would have been extended, as it would clearly have been equitable to do so. Nevertheless, the Court of Appeal ruled that the effect of section 329 was not to render the claim a nullity in the event of non-compliance with the requirement of leave being obtained to bring proceedings. Rather, the requirement to obtain permission to bring proceedings was one that could be met after those proceedings had been commenced; the consequence of getting the procedure wrong was limited to an order relating to costs. Sedley LJ summarised the conclusions of the Court of Appeal:

> "40. … in our judgment s329 stipulates only that a claimant who sues someone for assaulting him in trying to prevent a crime or to apprehend him for committing it will have to show merits sufficient to defeat the special statutory defence if his action is to be allowed to proceed. It makes it legitimate to visit in costs an application which is made later than it should have been, but it does not either explicitly or implicitly involve the drastic step of nullifying proceedings, however sound, which have been initiated without first clearing this hurdle.
>
> 41. It follows, as it does in limitation cases, that a lawsuit within s329, begun without permission, can properly proceed to trial if the permission point is not taken. Where the claim is plainly eligible for permission, this is an economical and practical course. If it were otherwise, the point could not only be unanswerably taken against the claimant at an advanced stage of the proceedings, and costs be resisted on the ground that the progress of the action without permission has been entirely unlawful, but the judge would be required to take the point at trial. Moreover, a perfectly sound claim issued

11. *Section 11 of the Limitation Act 1980: it provides that "(1) This section applies to any action for damages for negligence, nuisance or breach of duty … where the damages claimed by the plaintiff for the negligence, nuisance or breach of duty consist of or include damages in respect of personal injuries to the plaintiff or any other person. … (4) … the period applicable is three years from– (a) the date on which the cause of action accrued; or (b) the date of knowledge (if later) of the person injured. …"*
12. *Section 2 of the 1980 Act provides that the limitation period for other tort claims is six years.*
13. *[2008] UKHL 6, [2008] 1 AC 844.*
14. *[1993] AC 498.*
15. *Pursuant to Section 33 of the 1980 Act: it applies only to the limitation period set in section 11, not that set in section 2. Section 33 also provides for various factors that should be taken into account, though all the circumstances of the case are said to be relevant: the reasons for the delay are expressly said to be relevant, as are steps taken to obtain appropriate advice, including legal advice.*

late in the limitation period could be defeated, or at least placed at risk, by an opportunistic motion to strike it out, brought in the knowledge that by the time permission could now be obtained the claim will be out of time. In any such event a case which everyone knows is perfectly sound would collapse…

42. We hold accordingly … that the requirement of s329 of the *Criminal Justice Act 2003* that the court's permission must be obtained to bring proceedings in the circumstances specified by the section is procedural and directory. It will follow that if such proceedings are brought without permission the defect can, if appropriate, be cured on application to the court, which can reflect in costs its view of the conduct of the proceedings. …"

The Contrasting Finding in Seal

As has been noted, the provision of the *Mental Health Act 1983* that was in play in the *Seal* litigation was section 139 and its indication that "(2) No civil proceedings shall be brought against any person in any court in respect of any such act without the leave of the High Court…". The language in *Adorian* – that proceedings "may be brought only with the permission of the court" – is the corollary of this: a direction that proceedings shall not be brought without leave is to the same effect as one that indicates that it is permissible to bring an action only if such leave is obtained. In neither case does the statutory language deal expressly with the consequence of the failure to abide by the direction. Parliament could easily have clarified this with additional language that made clear that the need for leave was mandatory, such as that "Civil proceedings purportedly commenced without first obtaining the leave of the court shall be a nullity". Of course, it could equally be said that the language of the statute does not make clear that the provision was directory in relation to the timing of obtaining leave; and it might be thought that the starting point should be to ask what is the point of having a requirement of leave if breach of it has no significant consequence. Such language would pose no real difficulty: for example, a provision that "No proceedings shall go to trial without the leave of the court" would make clear that the implication of the requirement of leave to commence proceedings was directory only. But the absence of language making clear that the provision is directory is not a matter on which much reliance can be placed in arguing that the language is mandatory: this is because the substantive point of principle outlined by Bowen LJ in *Rendall v Blair* was that the consequence of preventing access to a decision on the merits was such that very clear language was required to produce the result that the statutory language was mandatory rather than directory. This was also central to the reasoning in *Adorian*. It is a principle that is reflected in the common law in general: so, in *Pyx Granite Co Ltd v Ministry of Housing and Local Government*[16] it was said by Viscount Simmonds that:

"It is a principle not by any means to be whittled down that the subject's recourse to Her Majesty's courts for the determination of his rights is not to be excluded except by clear words. That is … a 'fundamental rule' from which I would not for my part sanction any departure."

In *Seal*, however, the holding in the domestic litigation was that the language was not merely directory but mandatory, such that a failure to obtain leave in advance meant that the action was a nullity. In the subsequent application to the European Court of Human Rights, it was held that this did not breach the right to a fair trial guaranteed by Article 6 ECHR. A separate argument that there was a breach of Article 14 as well, because of the differential treatment of those bringing claims caught by section 139 of the *Mental Health Act 1983*, was found to be inadmissible because it had not been argued in the domestic proceedings.

16. *[1960] AC 260 at p286.*

The facts in *Seal* can be boiled down to the following. In December 1997, Mr Seal was arrested inside his mother's house in Merthyr Tydfil for breach of the peace. He was taken outside and then a decision was made that he would be removed to a place of safety under section 136 *Mental Health Act 1983*. This power can only be exercised in a public place, and so could not have been exercised inside the house. Concerns have been expressed that the section 136 power of detention is used disproportionately in relation to people who are outside their homes, including after the use of another arrest power to remove the person to the public place. The Mental Health Act Commission, which operated as a statutory watchdog under the *Mental Health Act 1983* but which has now been merged into the Quality Care Commission, has expressed these concerns. So in its Twelfth Biennial Report, covering 2005-2007 and called "*Risk, Rights, Recovery*"[17] it stated at paragraph 4.63, having mentioned the facts in *Seal*:

> '... we have heard of several other instances where s136 has been used to detain a person who has been asked or made to step outside of their home (or another private property) by police. Indeed, at a meeting with one London-based social services authority in this period, we noted that its audit showed that 30% of s136 arrests were recorded as having been made at or just outside the detainee's home. Police officers were 'inviting' people out of their homes, or arresting them for a breach of the peace and 'de-arresting' them once outside to then invoke s136 powers. We suggested that this was at the very least a misuse of the powers given under the Act, and that the social services and police authorities should jointly explore alternative means of managing persons about whom the police have concerns that would not undermine the protections offered by the Act. We suggested, for example, that the police could be given a dedicated telephone number to contact ASWs and trigger an assessment under the Act.'

After being placed under section 136, Mr Seal was taken to a hospital and detained under section 2 of the *Mental Health Act 1983*; he was released by a Mental Health Review Tribunal. In August 2003, a pre-action letter was sent; this was done with legal assistance, and the claim made was that there had been no justification for the use of section 136. At the very end of the limitation period, Mr Seal, who was now acting without solicitors, commenced proceedings against the South Wales Police for damages arising out of his arrest and detention, naming "trespass, assault, wrongful arrest, misuse of police powers, misuse of section 136 of the 1983 Act, falsehood and personal injuries sustained" as the causes of action: central to the claim was that he had not been found in a public place and so section 136 had been misused. The defence raised various procedural points, including that there was no allegation made of bad faith or a failure to take reasonable care (as required by section 139(1)) and the absence of leave under section 139(2).

It was the latter procedural point that was litigated thoroughly. The entire claim was struck out by the District Judge on the grounds that the proceedings were a nullity in the absence of the necessary permission of the High Court under section 139(2). On appeal, the Circuit Judge reinstated that part of the claim that did not relate to the police's purported exercise of power under section 136, but the rest remained struck out. The Court of Appeal agreed with the Circuit Judge, rejecting the contention for Mr Seal – who was represented during the appeals – that the requirement for the leave of the High Court was directory rather than mandatory and that his failure to obtain leave initially could be remedied by a subsequent grant of leave with a stay of proceedings in the meantime.[18] Mr Seal's further appeal to the

17. *Available at http://www.cqc.org.uk/findareport.cfm, which under the heading Publications from previous commissions links through to the National Archives website and the relevant reports. This concern was repeated in its Thirteenth Biennial Report, Coercion and Consent, covering the period 2007–2009, at paragraphs 2.138–2.139.*
18. *[2005] EWCA Civ 586, [2005] 1 WLR 3183, [2005] MHLR 137.*

House of Lords was unsuccessful, albeit only by a majority of 3 to 2.[19] In the House of Lords there was an additional argument raised, namely that any construction other than that the statutory language was directory would breach Mr Seal's right of access to a court, as guaranteed by Article 6 ECHR; this was also dismissed. It is to be noted that there was no reliance on Article 14 of the Convention, the non-discrimination provision.

The consequence of the decision of the majority of the House of Lords was that, the limitation period having expired and the police having indicated that they would take the limitation defence in relation to any further proceedings, Mr Seal had no prospect of raising the central point in his claim, namely the police use of section 136. It is recorded in the European Court of Human Rights' judgment that he did not proceed with the remainder of the claim, which was clearly ancillary.[20]

The reasoning of the majority – Lords Bingham, Carswell and Brown – looked at the domestic interpretation and then considered Article 6. In relation to the question through domestic eyes, the finding was that cases under the 1959 Act had held that proceedings were a nullity and so the statutory language used in the 1983 Act was to be interpreted on the basis that Parliament understood that and so had not effected any change.

Lord Bingham noted that the language of section 139(2) was not so markedly different from that considered in *Rendall v Blair* and in *Re Saunders* as to lead to a different result as a matter of the ordinary meaning of the language used; he also noted that the tendency of the law was not to elevate formal requirements over considerations of substantive justice.[21] As such, he felt that it was necessary to look at wider considerations to work out the putative intention of Parliament in using the legislative language. The starting point for this inquiry was the legislative history.

The language that became section 139(2) of the 1983 Act was introduced by section 60 of the *Mental Health (Amendment) Act 1982*, as was the language that became section 139(4). These changes were then consolidated into the 1983 Act. The predecessor to section 139 of the 1983 Act was section 141 of the Mental Health Act 1959, which had the same heading, provided the same defence of substance in section 141(2), but had a slightly different provision for the procedural requirements:

> '(2) No civil or criminal proceedings shall be brought against any person in any court in respect of any such act without the leave of the High Court, and the High Court shall not give leave under this section unless satisfied that there is substantial ground for the contention that the person to be proceeded against has acted in bad faith or without reasonable care.
>
> (3) This section does not apply to proceedings for an offence under this Act, being proceedings which, under any provision of this Act, can be instituted only by or with the consent of the Director of Public Prosecutions.'

So the changes were (i) leave in criminal proceedings moved from the High Court to the Director of Public Prosecutions in all cases,[22] and (ii) the test for leave was changed from a "substantial ground" test to a judicial discretion. The test for leave has been held to be an arguable case: *Winch v Jones*.[23]

19. *[2007] 1 WLR 1910, [2007] MHLR 282.*
20. *[2007] UKHL 31, [2011] MHLR 1 at para 32.*
21. *[2007] UKHL 31, [2007] 1 WLR 1910, [2007] MHLR 282, para 8. See also Baroness Hale, who dissented; she noted at para 43 that the words considered in Rendall v Blair were "no less peremptory".*
22. *The provision to the effect that the leave requirement did not apply if the proceedings had to be brought by or with the consent of the DPP remains: section 139(3).*
23. *[1986] QB 296.*

A similar provision to that in section 141 of the 1959 Act was contained in section 16 of the *Mental Treatment Act 1930*. This statute was the one that introduced the requirement of leave to bring proceedings: previously, section 12(1) of the *Lunancy Acts Amendment Act 1889*, which was consolidated into the *Lunacy Act 1890*, provided the protection of substance – namely that there was immunity for action taken in good faith and with reasonable care – but had as a procedural safeguard that the defendant could seek a stay if there was no reasonable ground to allege a lack of good faith or reasonable care.

The initial statutory language put the onus on the defendant to raise the point of substance, though that could be done before the expense of a trial was incurred by making it possible to seek a stay: such an application had no impact on whether proceedings were valid. The revised statutory language, requiring leave in advance, does not deal in terms with the consequence of a failure to obtain leave, and in particular whether any proceedings are a nullity. As has already been noted, such language would not be difficult to imagine - "Civil proceedings purportedly commenced without first obtaining the leave of the court shall be a nullity", which would make clear that leave was mandatory. However, Lord Bingham opined that

> "… the words first introduced in s16(2) of the 1930 Act ("No proceedings, civil or criminal, shall be brought ...") appear to be clear in their effect and have always been thought to be so. They were introduced with the obvious object of giving mental health professionals greater protection than they had enjoyed before."[24]

Well, the response to that is surely that similar language in other statutes had not been felt to be clear; and the protection to the proposed defendant arises from the substantive defence in section 139(1). Clearly there was a change in procedure that puts the onus on the claimant rather than the defendant: but why does that have as a corollary that the failure of the claimant to obtain leave means that every step taken has been meaningless? An example of what might happen in practice makes this plain: what if the action had been commenced without leave long before any limitation problem, but the defendant had not raised the point in a defence or at a pre-trial stage; suppose then that the matter is listed for trial at a time after the limitation period has expired and at that stage the failure to obtain leave is raised for the first time. On the reasoning of the majority of the House of Lords, the trial judge would have no jurisdiction to do anything but declare that the proceedings were a nullity: this is such a harsh conclusion that the reasoning set out in *Rendall v Blair*, namely the need for clear language before such an unattractive conclusion is reached, is surely preferable.

There is, however, an additional part to Lord Bingham's reasoning, namely that the effect of the language had always been understood to be that proceedings were a nullity. There were two aspects to this: the first was the absence of any academic writing to contrary effect;[25] and there was case law to the effect that criminal proceedings obtained without leave were a nullity.[26] But the absence of scholarly writing is not something that counts for much; and it is open to argument that the obligations on criminal prosecutors to be scrupulous in their compliance with procedure are of a different nature to those applicable to claimants in civil proceedings – particularly as there is no limitation problem to deal with,

24. [2007] UKHL 31, [2007] 1 WLR 1910, [2007] MHLR 282, para 18.

25. Paragraph 15.

26. Paragraph 12, citing R v Bracknell JJ ex p Griffiths [1976] AC 314 and other cases.

at least not in relation to indictable offences, such that the quashing of the proceedings as a nullity would not mean the loss of the chance to prosecute.

Having reached his view on the domestic approach, Lord Bingham then considered whether Article 6 of the ECHR required a different interpretation, and he concluded that the real issue was the limitation defence; a six-year limitation period had been found to be unobjectionable, referring to *Stubbings v UK*, in which it had been found by the European Court of Human Rights that English limitation periods did not breach the right of access to a court.[27] As to the question of whether section 139(2) breached Article 6, it was noted that it had been held in Convention proceedings that it was legitimate to offer protection against harassment of those responsible for the care of psychiatric patients, referring to *Ashingdane v UK*.[28]

It has to be accepted that the particular facts of Mr Seal's case were such that he caused significant problems by leaving the matter so late. But, as noted above, the consequence of the decision could mean that a timely action would be dismissed without consideration on the merits if the procedural point that could have been taken at the outset was not taken until very late in the day but after the limitation period had expired. If the proceedings are a nullity, there is no option for the court to take the view that the defendant should be estopped from raising the procedural issue late in the day: it simply has no way of getting to the merits of the claim because there is no cause of action properly before it.

The decision on the point of law raised was clearly a close one, since, as has been noted, two members of the House of Lords, Lord Woolf and Baroness Hale, dissented. The minority conclusion was that there was inadequate clarity in the language of section 139(2) and so it could not be concluded that Parliament intended that the proceedings should be a nullity. This is consistent with the approach taken in all other circumstances. Baroness Hale noted that there was no reason to treat the authorities relating to criminal proceedings (which had involved concession rather than argument on the point as to whether the procedural error rendered the proceedings a nullity)[29] as having the same effect in civil proceedings, which raised different considerations.[30] The central point, she felt, was that in civil proceedings, the aim of leave was to protect a defendant from unmeritorious proceedings: whereas the conclusion that the proceedings were a nullity could mean that a meritorious claim was lost because of a procedural failure. As she put it:

> "53. If spotted in time, the failure to obtain leave for civil proceedings can readily be put right and without prejudice to the legitimate interests of the defendant. If it is not spotted in time, and the action succeeds, no injustice will be done to the unsuccessful defendant if the judgment is allowed to stand; but a serious injustice will be done to the successful claimant if it has to be set aside, for by then it is not at all unlikely that the action will be statute barred. The fact that leave is required at all may not emerge until a relatively late stage in the proceedings. That a claimant who has suffered a wrong should be deprived of his remedy merely because of a procedural failure which no-one noticed at the time is an affront to justice."

27. *Paragraph 20; Stubbings v UK (1996) 23 EHRR 213.*
28. *Paragraph 20; Ashingdane v UK (1985) 7 EHRR 528.*
29. *And Lord Woolf had, as counsel, made that concession in the case of R v Bracknell JJ ex p Griffiths [1976] AC 314; he suggested that it breached the principle that limiting access to the courts required clear language, and was not binding in relation to a civil proceeding.*
30. *Paragraphs 52 and 53.*

Lady Hale also felt that any other conclusion would breach Article 6 of the Convention, because it would be disproportionate.[31]

The European Court Proceedings

Two arguments were raised in *Seal v UK*,[32] the first being a repetition of the Article 6 points that had been raised in the House of Lords in the domestic proceeding; the second was that there was a breach of Article 6 together with Article 14. The European Court of Human Rights agreed with the views of the majority of the House of Lords in relation to the first point, which was the only aspect of the claim it considered on the merits.[33] In short, it held – following its previous case law, which had been cited by the House of Lords – that any right of access to a court to consider the merits of a claim could be subject to restrictions that were for a legitimate purpose and not disproportionate: the limitation period pursued the legitimate aim of securing finality and certainty and preventing stale claims coming to court (and the Court noted that there had been no good reason put forward for the delays in Mr Seal's case), and the requirement of leave under section 139 of the 1983 Act pursued the legitimate aim of providing protection for those who exercised sensitive powers under that Act. The Court also noted that Mr Seal's legal advisors should have been aware of the provisions of section 139.

As to the second argument, namely that raising Article 6 together with Article 14, the Court noted that it had not been raised in the domestic proceedings, and so it could not be raised before the Court, given the rule about the need to exhaust domestic remedies first, contained in Article 35 of the Convention.

Discussion

The argument that Article 6 is breached by a six-year limitation period is not one that can be raised in the near future, given that the decision in *Seal v UK* upholds the approach already set in *Stubbings v UK* that it is a legitimate provision that does not breach Article 6. The other argument that was canvassed in full, namely the proper interpretation of section 139(2) as a matter of domestic law and whether the interpretation so far adopted is consistent with Article 6 ECHR, may also be difficult to raise as a practical matter, given that it will be necessary to take the argument at least to the Supreme Court to persuade it that it should depart from the domestic precedent and hold the language to be directory only (ie to adopt the approach exemplified by *Adorian*). Similarly, any reliance on Article 6 to support this view may well require a case that proceeds to the European Court of Human Rights to persuade it no longer to follow the approach in *Ashingdane v UK* as aopted in *Seal v UK*. However, the argument relating to Article 6 taken together with Article 14 has not been considered on the merits: as it was not taken in the domestic proceedings, it was not considered there, and so it was not legitimate to raise it in the European Court proceedings.

So what of this argument? Article 14 prohibits discrimination in the enjoyment of the other rights set out in the ECHR on the basis of status. This breaks down into several sub-issues. First, since Article 14 is not a free-standing right not to be discriminated against, the treatment involved has to be within the ambit

31. *Paragraph 61.*
32. *[2011] MHLR 1, ECtHR, appn 50330/07, 7 December 2010.*
33. *The Government argued that Mr Seal had failed to exhaust his domestic remedies because he had not pursued the rest of his claim or sought to start a fresh action: but this was dismissed on the basis that the claim he had been prevented from bringing was that relating to the misuse of section 136 of the 1983 Act, to which the rest of the claim was irrelevant, and there was no basis for suggesting that he could have brought a fresh claim, given that the limitation point would have been raised against him.*

of another right: in the circumstances, that is clearly met, the other right being the right to a fair trial in Article 6. Secondly, there has to be discrimination and, thirdly, this has to be on the basis of some form of status. The meaning of these second and third criteria has been considered recently in the case of *Clift v UK*,[34] which involved the question of whether requiring very long-term determinate prisoners – ie those serving 15 years or more – to satisfy both the Parole Board and the Secretary of State before they could be released on parole breached Article 14. The Court summarised the law as follows. First, in order to amount to discrimination there had to be a differential treatment that was not justified.

> "66. The Court has established in its case-law that in order for an issue to arise under Article 14 there must be a difference in the treatment of persons in analogous, or relevantly similar, situations ...
>
> 73. A difference of treatment is discriminatory if it has no objective and reasonable justification, in other words, if it does not pursue a legitimate aim or if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be realised."

It went on to note that this was a matter in relation to which a margin of appreciation would be allowed, and offered guidance on the question of the scope of such a margin of appreciation. Wide margins would be allowed in relation to economic or social strategy, including penal policy, but a lesser margin in relation to issues of potentially arbitrary loss of liberty.[35] On the facts, there was a difference of treatment as between Mr Clift and others in his position and those serving either less than 15 years or a life sentence, both of whom were released if the Parole Board alone so decided.[36]

Turning then to the question of the discrimination being on the basis of some matter of "status", the Court noted that, whilst it had often used "status" to require some innate or inherent personal characteristic as opposed to a factual difference such as having been sentenced to a particular category of sentence, this would not necessarily prevent membership of a group of very long-term determinate prisoners from being within Article 14,[37] and in any event the proper approach to Article 14 could allow a status to arise from the fact of the differential treatment about which complaint was made:

> "60. … It should be recalled … that the general purpose of Article 14 is to ensure that where a State provides for rights falling within the ambit of the Convention which go beyond the minimum guarantees set out therein, those supplementary rights are applied fairly and consistently to all those within its jurisdiction unless a difference of treatment is objectively justified."

It then concluded that the importance of securing an absence from arbitrary detention was such that there was a need for "careful scrutiny of differences of treatment in this field", and so Mr Clift was treated differently on the basis of a matter of status.[38]

What this amounts to, in effect, is the flexible construction of Article 14 so that it is a tool to prevent arbitrary differential treatment in sensitive areas such as the right to liberty, which is done by finding the very difference in treatment to be the status on the basis of which the difference has to be justified. On

34. *Appn 7205/07, 13 July 2010.*
35. *Paragraph 73.*
36. *Paragraphs 66-68. In other words, there was only one key rather than the two keys that detained Mr Clift, whose release had been delayed by some 2 years because a recommendation for release by the Parole Board was not adopted by the Home Secretary.*
37. *Paragraph 59.*
38. *Paragraphs 62 and 63.*

the facts of Mr Clift's case, the House of Lords had already concluded[39] that the difference in treatment between very long-term determinate prisoners and others was not justifiable; the European Court agreed with this.[40]

Applying this to a situation such as that involving Mr Seal, the starting point is that there is clearly differential treatment: in contrast to those who are raising a claim where they have been detained and prosecuted successfully (the *Adorian* situation) those who have been detained under Mental Health Act powers both have to seek permission in advance and face the consequence that their action is a nullity if they do not follow the procedural requirement whereas the former group merely have to obtain the relevant permission if the point is at some stage raised. It is a matter that arises within the ambit of Article 6, the right to a fair trial, which includes the right of access to a court. That leaves the questions of whether it is a treatment based on "status" and whether it is justified.

Is it a difference of treatment based on "status"? The Government was keen to note in *Seal v UK* that it was not a matter of the differential treatment of those with a mental disorder (which would quite obviously be a matter of status), but a difference based on the source of the power used by the defendant. The Court accepted this, noting at paragraph 77 that, whilst a number of Contracting States regulate the right of access to a court on grounds such as minors, bankrupts or persons of unsound mind, this did not apply to Mr Seal, and that the purpose of the provision was to protect those who act under the 1983 Act, which does not come with an assumption that those who have been on the receiving end are vexatious in some regards. This explanation, however, was in the context of whether there was a breach of Article 6 alone, not in the context of whether there was a breach of Article 6 taken with Article 14. In the Article 14 context, the question is the status of the claimant. In determining whether there is a difference based on a matter of status, whilst it will not be the case that everyone to whom section 139(2) applies will have been mentally disordered at the time (given the possibility of the professionals making an error, which error might well be the matter that is central to the litigation), it will be the case that everyone to whom section 139(2) applies will have been *thought* to be mentally disordered by someone whose decision is under challenge. That is the precursor to the use of any of the powers under the Act, and seems to be a differentiation of a group that has a status: and following *Clift*, it is a group to whom a different regime applies in relation to an important matter, namely access to a court, which should accord to it a status.[41] In any event, the simple point is that the vast majority of people who will be affected by the provision will be people who do have a mental disorder: that is a group in relation to whom there is a sensitivity as to discrimination that should encourage a court to to give a meaning to "status" that does not prevent it moving to the question arising on the merits, namely whether the differential treatment is justified.

39. *R (Clift, Hindawi and Headley) v Secretary of State [2006] UKHL 54, [2007] 1 AC 484, [2007] Prison LR 125. The House dismissed his claim, however, on the basis that the unjustified differential treatment was not on the basis of a matter of "status".*

40. *Paragraph 78.*

41. *In R (S and Marper) v Chief Constable of South Yorkshire [2004] UKHL 39, [2004] 1 WLR 2196, the House of Lords held that the retention of DNA from people who had been arrested but acquitted was not on the basis of a "status" of belonging to a group, namely those who had been arrested. In the follow-on proceedings, S and Marper v UK (2009) 48 EHRR 50, the European Court held that the House of Lords was wrong not to find that the retention of such DNA breached Article 8 ECHR and, in light of that, did not consider Article 14. However, it is clearly open to argument that the domestic conclusion in S and Marper is difficult to justify in light of Clift, whose status arose just as much from a fact, namely the sentence imposed, as the fact in S and Marper that the applicants had been arrested.*

Turning, then, to justification: the contrast between *Adorian* and *Seal* is worth restating. Both involved police officers who were acting in difficult conditions: in the former, there was a public order arrest that was justified because there was a conviction, in the latter a Mental Health Act arrest; in both situations, there was a claim that powers had been misused in some way. So the question of justification has to ask why should it be that the police who are alleged to have misused Mental Health Act powers require a mandatory leave requirement in the civil proceedings whereas police who are alleged to have misused criminal arrest or detention powers require protection only in the form of a directory leave requirement? There is a further point of context, namely that there are powers to control vexatious litigants, to require those who are mentally disordered at the time of the litigation to act through a litigation friend, and to apply to a court for summary determination of a claim without merit. It seems clear that there is no obvious justification for the differential treatment.

It should also be noted that section 139(4) disapplies the requirements of the rest of the section – so both the substantive defence and the need for leave – in relation to the Secretary of State and National Health Service bodies. So there is another question as to why the police require additional protection compared to these public bodies. The same can be said of the other actors who are protected, namely local authorities, whose social workers have a central role, and the many private hospitals that are engaged in carrying out the state power of detention under the 1983 Act. Whilst the contrast with the *Criminal Justice Act 2003* provision does not operate in their context, there is the question of why they should have a different protection from the other bodies exercising state power in relation to whom leave is not required. As for individual mental health professionals, who are in the same position as the police, the contrast with the 2003 Act can again be made. It will apply to a victim of crime who has overused self-defence or other powers to protect property against someone who is convicted of a criminal act: the question will be why should a professional operating under the 1983 Act have a different sort of procedural protection than a victim of crime who has confronted his or her assailant and is then sued by that assailant.

There is a hint of a justification given in *Adorian*. At paragraph 34, Sedley LJ states that "litigation by mental patients past or present, especially those acting in person, is a very particular problem". It is fair to say that the judge was referring to an early acceptance of that proposition, since he quoted Sir John Donaldson MR, who, in *Winch v Jones* said:[42]

> "To be more specific, there are two fundamental difficulties. First, mental patients are liable, through no fault of their own, to have a distorted recollection of facts which can, on occasion, become pure fantasy. Second, the diagnosis and treatment of mental illness is not an exact science and severely divergent views are sometimes possible without any lack of reasonable care on the part of the doctor."

This is not acceptable: it is the sort of broad-brush tarring of a group and making of assumptions that reveals an attitude that must be guarded against; it is a comment that requires good evidence.[43] Such improper attitudes were behind the United Nations Convention on the Rights of Persons with Disabilities which was adopted by the UN General Assembly in December 2006[44] and opened for signature in March

42. [1986] 1 QB 296 at 302.

43. In this context, see paragraph 57 of the speech of Baroness Hale in Seal in the House of Lords, where she notes the problems of the blanket restriction in section 139 despite the great variations in patients, and the lack of any empirical evidence that all patients should be treated as somehow suspect.

44. 13 December 2006, during the 61st session of the UN; General Assembly resolution A/RES/61/106.

2007:[45] it currently has 147 signatories, and 98 states have fully ratified it.[46] The United Kingdom signed it on 30 March 2007 (the first day it was open for signature) and ratified it on 8 June 2009. The preamble to the CRPD points to the need to counter problems faced by persons with disabilities arising from attitudes in society towards people with disabilities: "disability" is described as an evolving concept that:[47]

> '(e) … results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others …'

The provisions of the CRPD are designed to overcome these problems. Non-discrimination is the first obligation, set out in Article 5, which states:

> '1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.'

This is reinforced in relation to access to justice by Article 13, which provides that:

> '1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others …'

These provisions no doubt supplement the arguments that arise under Article 14 ECHR. There is clearly a significant argument to be had: hence the suggestion that *Seal v UK* is the end of a chapter involving Mr Seal, but by no means the end of the book because there are arguments that have not yet been ventilated fully that merit a hearing.

45. *See Art 42 of the Convention.*
46. *See http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en (last accessed 3 March 2011). Entry into force was 30 days after the twentieth ratification: Article 45(1); for countries that ratify subsequently, the Convention enters into force 30 days after they deposit the instrument of ratification or accession with the UN (see Art 45(2)).*
47. *An interesting prospect arising from the use of an impact-based definition and the acceptance that it may change over time is that certain things might cease to be counted as a disability – and indeed the concept of disability might cease to exist – if society changes so that there is no longer an impact arising. Indeed, that could be seen as an aim of the Convention, namely to create a situation in which it falls into desuetude because it has achieved its purpose.*

Benevolent Paternalism or a Clash of Values: Motherhood and Refusal of Medical Treatment in Ireland

Fitzpatrick v. K [2008] IEHC 104 (25 April 2008) (H.Ct) (Ir.)[1]

***Kay Wilson*[2] *and Penelope Weller*[3] [4]**

Introduction

The recent decision of the Irish High Court in *Fitzpatrick* is both a typical and an extraordinary case. It is typical in that it reflects a long line of refusal of treatment cases in England that illustrate the reluctance of the courts to respect a patient's choice where the outcome of the decision is unpalatable.[5] It is extraordinary because (i) it arises from unique facts where the outcome of the patient's decision was particularly emotive; (ii) the failure of the patient to take into account the interests of a third party was deemed a critical factor in the judicial finding of a lack of capacity;[6] and (iii) it displays a willingness by the Court to require that 'capacity' is demonstrated by a high level of understanding.

Notably, there were two contradictory approaches in *Fitzpatrick* on the issue of the patient's capacity. At the initial ex parte hearing Mr Justice Abbott granted an order to authorise the hospital to override the

1. *Available at http://www.bailii.org/ie/cases/IEHC/2008/H104.html) (last visited March 2010)*
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4. *The authors would like to thank Professor Bernadette McSherry and an anonymous referee for their comments on earlier drafts of this paper.*
5. *See Alasdair R. Maclean, Advance Directives and the Rocky Waters of Anticipatory Decision-Making, 16, Med. L. Rev 1 (2008).*
6. *Mary Donnelly, The Right of Autonomy in Irish Law, 14(2) M.L.J.I 34, 37 (2008).*

patient's refusal of a blood transfusion on religious grounds, because the constitutional rights of the patient's baby to be cared for and nurtured by his mother outweighed the rights of the patient to refuse medical treatment. The actual content of the ex parte hearing in relation to the issue of the patient's capacity is controversial. It was not formally reported, the only record being the order itself, a solicitor's note and press coverage. At the subsequent plenary hearing, Ms Justice Laffoy found that Mr Justice Abbott, in making the ex parte order on constitutional grounds, had accepted by implication that the patient was a competent adult. At the plenary hearing, however, Ms Justice Laffoy found that the patient was not a competent adult and upheld the ex parte order based on the patient's lack of capacity. The incapacity finding meant that Her Honour did not consider it necessary to rule on the rights of the patient's baby under the Irish constitution as to do so would "in effect, amount to an advisory judgment on an issue which has been rendered moot by the decision on the capacity question."[7]

The ex parte order "sparked heated debate"[8] in Ireland. Irish commentators were quick to point out that it may have gone too far in departing from *In Re A Ward of Court (Withholding Medical Treatment) (No.2)*[9] which involved the withdrawal of treatment from a near permanent vegetative state (P.V.S) patient (and which is almost identical to the English authority of *Airedale N.H.S Trust v. Bland*).[10] In *Re A Ward of Court* the Irish Supreme Court affirmed the rights of a competent adult to refuse life sustaining treatment. Irish commentators noted that the ex parte order in Fitzpatrick "would find little supporting jurisprudence in modern jurisprudence in other jurisdictions."[11] They also argued that the decision could not be justified by the constitutional obligation of the State to defend the rights of the unborn (Article 40.3.3), because the patient's baby was born so that her decision to refuse blood threatened her own life but not her baby's.[12]

At the plenary hearing the High Court affirmed that patient autonomy is a right protected by Irish law, but validated the ex parte order to administer a blood transfusion on the basis that the patient lacked capacity. The High Court decision was welcomed by Irish commentators as "another aspect of judicial guidance in the on-going discussion of the doctrine of consent".[13] Unlike the ex parte order, however, it has received little critical comment or analysis. This paper will provide an overview of the *Fitzpatrick* case, critically analyse the formulation and application of the capacity test, and compare *Fitzpatrick* with English jurisprudence. The paper concludes with a consideration of the implications of the decision.

Facts and Judgment

As Ms Justice Laffoy commented near the beginning of the judgment:

> "Apparently, this is the first case in which an Irish court has been asked to decide the core issue which underlies these proceedings. It is whether and if so, in what circumstances, a court may intervene in

7. *Fitzpatrick, [2008] IEHC at page 34 of that transcript.*
8. *Law Reform Commission, Consultation Paper, bioethics: Advance Care Directives (LRC CP 51-2008) (Ir.), para 2.51.*
9. *[1996] 2 I.R. 79; Asim A. Sheikh, Medico-Legal Issues and Patient Autonomy – Here today, Gone tomorrow? 12(2) M.L.J.I, 54 (2006).*
10. *[1993] AC 789 (H.L)*
11. *Donnelly, supra, note 6 ,37; Asim. A. Sheikh, The Right to Life and the Right to Bodily Integrity in Human Rights Law (Brind Moriarty & Eva Massa eds., Oxford University Press 2nd Ed 2008) 218 -220.*
12. *Donnelly, supra note 6, 37. Sheikh, supra note 11 at 219. Paradoxically, a child may have greater rights in Ireland before it is born than after it is born.*
13. *Asim A. Sheikh, Issues of Capacity and Consent 14(2) M.L.J.I, 33 (2008).*

> the case of a patient, who is an adult and is not *non compos mentis*, who has refused medical treatment."[14]

The plenary hearing went for 37 days, with the resulting judgment being lengthy and complex.

Facts

Ms K was a 23 year old asylum-seeker from the Democratic Republic of Congo (DRC). She spoke only French. On 21 September 2006 at around 9.40 am, after a long labour and difficult delivery, Ms K suffered a post-partum haemorrhage, losing 50% to 70% of her blood. When blood was being prepared for immediate transfusion, Ms K told the medical staff for the first time, through her "birth partner" and interpreter Ms F, that she would not take blood because she was a Jehovah's Witness. Ms K had previously advised the hospital when booking that she was a Roman Catholic. This is because she had indicated on her visa application that she was Roman Catholic and did not want to officially record an inconsistent statement. At the trial, Ms K professed to have, but was unable to produce, an advance directive card refusing a blood transfusion.

After the initial blood loss, Ms K was stabilised without using blood products. The doctors feared that if Ms K bled again she would die if a blood transfusion was not administered. At trial, medical expert evidence differed as to the risk of death attributable to a re-bleeding without a transfusion, with the estimates varying between "better than 50%"[15] and "less than 5%".[16] Between 9.52 am and 11.30 am, on the morning following the birth, the medical team advised Ms K on at least four occasions that she needed a blood transfusion and without one she would die. Each time she refused. The Hospital Liaison Committee for Jehovah's Witnesses was contacted by Ms F at about 10.30 am and the hospital received a faxed document entitled "Care plan for women in labour refusing a blood transfusion." Most of the care plan was implemented, but the medical team considered that the need for a blood transfusion remained urgent. Ms K was then asked by the hospital about her family and the whereabouts of her husband. In what Ms Justice Laffoy subsequently concluded was "the most crucial part of the evidence"[17] Ms K told the hospital that she had no family other than the baby, and that her husband was uncontactable in the DRC. This information was untrue. Ms K's husband was in Ireland and had in fact been visiting her in the hospital. He was, however, an illegal immigrant and did not wish his whereabouts to be disclosed. Furthermore, Ms K's birth partner and interpreter Ms F, who was related to her by marriage, was party to the secrecy.

At 11.30am, the most senior obstetrician at the hospital, the Master, was summoned. He again told Ms K that because of the amount of blood she had lost she needed a transfusion or she would die. Ms K again responded "No" (in English), and suggested instead that she be given common remedies to strengthen the body, such as "coke" (referring to the drink Coca Cola), tomatoes, eggs and milk. This response was taken to indicate that she misunderstood the gravity of her condition, prompting the Master to seek advice from the hospital's solicitors.

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14. *Fitzpatrick, [2008] IEHC at page 2 of that transcript. In stating that the patient was "not non compos mentis" it appears that Ms Justice Laffoy simply meant that the patient was fully conscious and stabalised, rather than that she had capacity to refuse treatment as a matter of law: Id. page 5 of that transcript.*
15. *Id. at page 28 of that transcript.*
16. *Id. at page 30 of that transcript.*
17. *Id. at page 22 of that transcript.*

Ex parte application

At around 12.30pm that day the hospital made an ex parte application to the High Court, brought before Mr Justice Abbott, to give a blood transfusion to Ms K. Ms K was not advised of the application. The application was made on two grounds:

(i) that the Hospital "while not suggesting that she was incompetent to make the decision…[submitted that]… the question was open to the court as to what extent her refusal was made on the basis of an informed decision"[18] ("the capacity issue"); and

(ii) whether the rights of Ms K's baby to his mother's care under the Irish Constitution overrode her right to refuse the transfusion ("balancing of rights issue").

Mr Justice Abbott authorized the hospital to administer the transfusion and take all appropriate steps, including any necessary restraint, based on the balancing of rights issue. That is, His Honour held the constitutional rights of the child to be nurtured and reared by his mother 'trumped' the mother's rights to refuse the transfusion. His Honour's findings on the capacity issue are unclear, but he appears to have accepted that Ms. K was competent. Ms Justice Laffoy stated that His Honour's findings were that he "expressed no view on the capacity issue"[19], but

> "on an objective appraisal of the basis which he advanced for making the order, as set out in the attendance note, the only reasonable inference is that Abbott J. was not basing his decision on any concern as to the capacity of Ms K. to make a valid refusal. On the contrary, it is implicit in his statement that he was overriding her decision that he considered her decision [sic] to be legally valid."[20]

Outcome

At around 2.35 pm, the hospital administered the transfusion and a sedative to Ms K who resisted being transfused against her will. Ms K did not re-bleed as was feared. She made a full recovery and was discharged from hospital with her baby on 28 September 2006.

The ex parte order provided that the matter be returned to the High Court for a plenary hearing.

Plenary Hearing

At the plenary hearing, before Ms Justice Laffoy, the hospital sought declarations that the transfusion was valid. Ms K pleaded that in providing her with the transfusion against her will the hospital had either (1) exceeded the authority of the ex parte order, assuming it was valid, or (2) the ex parte order was a nullity and of no effect and should be set aside. In the event that Ms K successfully challenged the ex parte order, the hospital may have acted unlawfully, and she sought damages for assault, trespass, breach of her constitutional rights and her rights under the *European Convention on Human Rights Act 2003* ("ECHR Act").

The Attorney-General was named as a co-defendant in the plenary proceeding, but his role was limited to pleading by way of preliminary objection that the balancing of rights issue was moot and ought not be determined.

18. *Id. at page 16 of that transcript.*

19. *Id. at page 17 of that transcript.*

20. *Id.*

Decision at the Plenary Hearing

The Court found that Ms K lacked capacity to refuse treatment.

Ms Justice Laffoy accepted that patient autonomy is recognized by the Irish constitutional right to protect the person (Article 40.3.2) and the "unenumerated" right to bodily integrity.[21] Her Honour also accepted that the right of a competent adult to refuse medical treatment was established by the Irish Supreme Court *In re A Ward of Court*.[22] Her Honour was satisfied that Ms K's refusal was voluntary and that the hospital had provided Ms K with sufficient information to make a valid decision. She concluded that the matter before her turned on the question of capacity.

As there were no Irish authorities on the mental capacity test, Ms Justice Laffoy considered the English authorities.[23] She adopted the following principles:

- that there is a rebuttable presumption of capacity;
- that a patient lacks capacity if by permanent cognitive impairment or temporary factors the patient does not sufficiently understand the nature, purpose and effect of treatment and consequences of accepting or rejecting it;
- that the three-step test in *Re* C[24] is helpful. The patient must:

  (1) comprehend and retain the treatment information;

  (2) believe the treatment information and that refusal may lead to death; and

  (3) weigh the treatment information, alternatives and outcomes;
- treatment information is that which the clinician has a duty to impart;
- there is a need to identify if an irrational decision is made due to misunderstanding or misperception of the treatment information. Irrationality may be evidence of incapacity;
- the capacity assessment must have regard to the gravity of decision and clear evidence is required.

Ms Justice Laffoy applied *Re* C and concluded that in light of all of the evidence available including the consequence that she might die, Ms K failed each limb of the capacity test. That is:

(a) Ms K did not sufficiently understand and retain the information given to her by the Hospital personnel as to the necessity of the blood transfusion to save her life;

(b) Ms K did not believe that information and, in particular, that she did not believe that she was likely to die without a blood transfusion being administered; and

(c) in making her decision to refuse a blood transfusion, Ms K had not properly balanced the risk of death inherent in her decision to refuse the transfusion and its consequences, including its

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21. *Unenumerated rights are rights that have been recognized by Irish case law as being implicit in the text of the Irish constitution, even though they are not expressed in the Irish Constitution. In Ryan* v. *Attorney General [1965] I.R. 294 different judges derived these implied rights from a natural law theme and Justice Kenny in the High Court considered that they "arise from the Christian and democratic nature of the State.": Hugh O'Donoghue, Human Rights and the Irish Constitution, Human Rights Law, supra note 11 at 32 (Table 2.4.2).*
22. *[1996] 2 I.R. 79. (27 July 1995) (Ir.)*
23. *Ms Justice Laffoy did not consider the Mental Capacity Act 2005 (Eng. & Wales) or its Code of Practice, presumably because it is not binding in Ireland. As stated in note 33 infra, however, it is still a significant development in English law that codifies and has influenced the development of the capacity test.*
24. *Re C (adult: refusal of medical treatment) [1994] 2 FCR 151.*

consequences for her new-born baby, against the availability of a blood transfusion that would save her life.[25]

It is unclear from the judgment what specific findings of fact lead to these conclusions in the application of each limb of *Re* C. While Her Honour recounts the evidence of each witness in great detail it is difficult to pin-point which factors were critical in making the incapacity finding. However, Her Honour, explicitly states in applying the third limb of the test that she was concerned that Ms K had not properly weighed the consequences for her new-born baby. It seems that Her Honour:

- preferred the evidence of the medical personnel that they were concerned that Ms. K had not properly understood that she needed a blood transfusion or she might die. Essentially, even though the medical team never made a formal capacity assessment, they were not happy with the responses they were getting from Ms. K. (e.g. she was not upset enough at the news she might die) to make them feel comfortable that Ms K understood the gravity of her situation;[26]
- rejected Ms K's own evidence that she knew she was in danger of dying without a transfusion, essentially because she did not "believe" that a transfusion was "necessary" to save her life (e.g. she had some doubts about the after-effects of a transfusion and made the "coke and tomatoes" suggestion as an alternative); and
- Ms K's misrepresentation about her husband's whereabouts raised questions about her credibility and ability to understand the consequences of her decision to refuse blood for her baby's future care.[27]

Ms Justice Laffoy found that the hospital personnel should have doubted and genuinely did doubt Ms K's capacity to give a valid refusal. Her Honour found it instructive to reiterate the factors that were outlined to the court on that day, being:[28]

- Ms K's seriously compromised medical status following a difficult delivery and massive haemorrahage;[29]
- Communications difficulties as Ms K's first language was French;[30]
- The hospital's belief that Ms K had no family in Ireland from whom it could gain assurance of her religion and her understanding of her need for a transfusion;
- The hospital's belief her baby had no traceable kin, including his father; and
- The inconsistency between her disclosure, after the haemorrhage, that she was a Jehovah's Witness with the hospital's understanding that she was a Roman Catholic.

25. *Fitzpatrick, [2008] IEHC at page 34 of that transcript.*
26. *The doctors were also generally frustrated that Ms. K was refusing their advice. As the Master indicated, Ms K. was not thinking rationally because a rational person would not refuse a transfusion, a sentiment that Ms Justice Laffoy carefully pointed out was not evidence of incapacity: Id.at page 31 of that transcript.*
27. *Id. at page 23 of that transcript.*
28. *Id. at page 33 of that transcript.*
29. *This is the only factor that suggested that Ms K might have lacked capacity to process the treatment information, although there is no evidence or judicial finding that it actually interfered with her cognitive functioning on the day to the extent that she could not make a decision. The other factors all relate to matters external to Ms. K.*
30. *This is hard to reconcile with the finding that Ms. F properly communicated the treatment information and that had the hospital obtained a professional interpreter, it probably would not have helped "because obviously the communication difficulties were not limited to linguistic difficulties." Id. at page 34 of that transcript.*

On the basis of the finding that Ms K lacked capacity, Ms Justice Laffoy found that the transfusion was "necessary" to save Ms K's life and fell within the scope of what was authorized by the ex parte order because it was appropriate treatment that was medically indicated. Her Honour declined to consider the balancing of rights question.

Discussion

Fitzpatrick illustrates the unresolved tension in the law in distinguishing between an incapacity finding where there is "a misunderstanding or misperception of the treatment information in the decision-making process" (legitimate evidence of incapacity) or "an irrational decision or a decision made for irrational reasons" (irrelevant to capacity).[31]

(a) Capacity and the test in *Re C*

The test in *Re C* was central to Her Honour's incapacity finding. While *Re C* is undoubtedly a seminal English case, it is relatively old. Accordingly, Ms Justice Laffoy missed two factors that narrowed the *Re C* test in *Re MB*[32] and the *Mental Capacity Act* 2005 (Eng & Wales) ("MCA").[33] These are that (i) incapacity is limited to cases where there is some impairment or disturbance of in the functioning of the mind or brain; and (ii) the requirement to "believe" the treatment information is omitted from those inabilities listed in *Re MB* and section 3(1) of the MCA as indicative of incapacity.

While Ms K had a difficult delivery with substantial blood loss, there is no evidence that Ms K was medically compromised to such a degree that she had no capacity to decide or that she was suffering from any impairment or disturbance in mental functioning, other than revealing that she was a Jehovah's Witness at the eleventh hour. By contrast, in England where patients have been found incompetent there is some identifiable factor such as, a needle phobia,[34] belief that their blood is evil,[35] or personality disorder[36] that interfered with their decision-making ability. Even in the adult Jehovah's Witness cases, the courts have found some basis to show that there were temporary factors that interfered with the adult's decision-making process, or have overridden the patient's decision on a basis other than their capacity. For example, *In Re T (Adult: Refusal of Treatment)*[37] Ms T was found to lack capacity due to her accident, illness, being in pain, treatment with drugs and generally being "drowsy, detached and not fully compos mentis."[38] This together with the undue influence of her mother, misleading information from the hospital about her need for a transfusion and the effectiveness of alternatives to transfusion, was enough to override Ms T's refusal. In *HE v A Hospital NHS Trust*[39] and *JM v The Board of Management of Saint Vincent's Hospital*[40] the patient's refusal was overridden as there was evidence that they were either no longer a Jehovah's Witness or had only become one on marriage for cultural reasons. Although the hospital was uneasy about Ms K's lie about her religion, none of these factors were present in

31. *Id. at page 15 of that transcript.*
32. *Re MB (An Adult: Medical Treatment) [1997] 2 F.C.R 541, 553 (C.A.).*
33. *Although the MCA is not binding in Ireland it is an important development in the English Law. As set out in the REPORT OF JOINT COMMITTEE ON THE DRAFT MENTAL CAPACITY BILL, SESSION 2002-03, H.L.189-1, H.C. 1083-1,16, "the draft Bill is designed to codify existing Common Law practice in statute."*
34. *Re MB, [1997] 2 F.C.R 541.*
35. *NHS Trust v. T (adult patient: refusal of medical treatment) [2004] EWHC 1279 (Fam); [2004] 3 F.C.R. 297.*
36. *R v. Collins, ex parte Brady 58 BMLR 173.*
37. *[1993] Fam 95.*
38. *Id. 111.*
39. *[2003] EWHC 1017 (Fam); [2003] 2 FLR 408.*
40. *[2003] 1 I.R. 321 (24 October 2002) (Ir.).*

Fitzpatrick. Indeed, if simply undergoing a traumatic experience were enough to make an incapacity finding, the rights of individuals could be eroded.

As Ms K failed all limbs of the test, the disappearance of the "belief" limb is less significant to the overall incapacity finding. It is, however, the most troublesome aspect of the test. *In Re MM (an adult)*[41] Munby J found the "belief" limb had not so much "dropped off" as been "subsumed" in the more general requirements to understand and use the treatment information. Bartlett, however, argues that an "inability to believe had been part of the common law test for many years prior to the passage of that Act, in cases expressly considered by the Law Commission. Its absence from the MCA cannot be thus viewed as accidental."[42]

Fitzpatrick demonstrates many difficulties with the "belief" limb. First, it is subjective. Ms Justice Laffoy found that Ms K lacked belief in the treatment information, despite her own evidence that "when a doctor tells you that you are going to die, it is not a joke."[43] Secondly, the strength of the "belief" limb depends on the reasons for non-belief.[44] *Fitzpatrick* was not a case where the patient was suffering from a "compulsive disorder or phobia"[45] preventing her from assessing the treatment information because it did not apply to her. Rather, Ms K assessed the treatment information within an alternative framework – namely that of her religion. Thirdly, the "belief" limb prevents patients from challenging the treatment information or suggesting alternatives. As Bartlett suggests, a lack of belief can become "a euphemism for decay of trust between an individual and his or her carers."[46] This is evident in *Fitzpatrick*. The doctors had doubts about Ms K's capacity because she was not reacting to the news that she would die without a transfusion. Ms K's "coke and tomatoes" suggestion was treated as evidence of incapacity because, it was thought that if she believed that "coke and tomatoes" would save her life, she misunderstood her predicament. However, Ms K's suggestion did not necessary mean she did not believe she might die, but rather, not being able to accept a transfusion she simply "proposed what she knew."[47] As many treatment decisions are uncertain,[48] it is important that patients can question medical advice without impugning their capacity by demonstrating a lack of belief. It was far from certain that Ms. K would die without a transfusion, although her recovery would clearly be much slower without one. The ability to choose between competing medical alternatives is implicit in the principle of free and informed consent.

(b) Capacity and Informed Refusal

At the ex parte hearing the hospital submitted to the court that it was not suggesting that Ms K was incompetent but that "the question was open to the court as to what extent her refusal was made on the basis of an informed decision."[49] Ms K argued that as the hospital did not suggest that she was incompetent, it did not raise the capacity issue at the ex parte hearing and that the hospital could not raise it in the plenary hearing.[50] Ms Justice Laffoy rejected Ms K's submission by relying on the hospital's doubts at the ex parte hearing about the "quality of the refusal" and Mr Justice Abbott's implied finding that Ms K had capacity.[51] In doing so, Ms Justice Laffoy equates the concept of "capacity" with making

41. *A Local Authority v. MM [2007] EWHC 2003 (Fam); [2008] 3 F.C.R. 788.*
42. *Peter Bartlett, Capacity, Best Interests and Sex, J. Mental Health L. May 2008 at 85. The capacity test in the MCA is closely related to the test in Re MB.*
43. *Fitzpatrick, [2008] IEHC at page 26 of that transcript.*
44. *Bartlett, supra, note 42, 85.*
45. *Re MB, [1997] 2 F.C.R at 554.*
46. *Bartlett, supra note 42, 85.*
47. *Fitzpatrick, [2008] IEHC at page 27 of that transcript.*
48. *Shaun O'Keefe, A Clinician's Perspective: Issues of Capacity in Care, 14(2) M.L.J.I 41, 47 (2008).*
49. *Fitzpatrick, [2008] IEHC at page 16 of that transcript.*
50. *Id. page 17 of that transcript.*
51. *Id. page 33 of that transcript.*

an "informed" and "valid refusal" and uses those terms interchangeably throughout the judgment. This may be more than mere semantics. It captures the tension between the doctrine of informed consent (a negligence issue) and capacity to consent or refuse treatment (a trespass issue). The difficulty is that while misinforming and withholding information from a patient can vitiate consent,[52] the requirement that a patient give an informed refusal is new. It adds a gloss to the test in *Re C* that undermines the principle that treatment can be refused for reasons that are "rational, irrational, unknown or even non-existent."

(c) Capacity, the Irish Constitution and Human Rights

Even though Ms K asserted her rights under the Irish Constitution and ECHR Act, Ms Justice Laffoy only gave those rights scant consideration. In part, this is because those rights arise in relation to the "balancing of rights issue" where Ms K's rights are balanced against her baby's, which was deliberatelynot decided by the judgment. But there is also the issue of how Ms K's rights are balanced against each other, which is not addressed. While the Attorney-General submitted that the test in *Re C* should be applied taking into account "the panoply of constitutional rights and duties which form the backdrop against which the test must be applied: the rights to life, bodily integrity, privacy, self-determination and freedom to practice religion"[54] it is unclear whether Ms Justice Laffoy accepted that submission.

The only right Ms Justice Laffoy took into account in formulating the capacity test was the right to life. Her Honour held that where the decision to refuse life-saving treatment amounts to a waiver of a person's constitutional right to life, there should be "clear and convincing proof having regard to the gravity of the decision."[55] The right to life is the paramount right in Irish law, although it is not absolute. While this could be argued to be merely a reflection of the principle in *Re T*,[56] that doubt should be resolved in favour of preservation of life, if the bar is too high, it may amount to a reversal of the presumption of capacity.

The balancing of Ms K's other rights seem to have been subsumed into the capacity assessment. Ms Justice Laffoy rejected submissions that "the capacity issue was, in essence, a contrivance which had been created by the Hospital personnel and the reality was that there was no assessment of capacity because it was accepted that Ms K was a Jehovah's witness who would not take blood, the issue being one of religious belief, not of capacity."[57] Interestingly, the avoidance of this issue indicates that freedom of religion can only be exercised by patients whose capacity cannot be challenged.

(d) Capacity and the rights of Ms K's baby

Ms Justice Laffoy concluded that Ms K had failed the third limb of the test in *Re C* because she had not properly weighed the treatment information "including its consequences for her new-born baby."[58] While it could be argued that the rights of her baby was only part of the treatment information that Ms K failed to properly weigh, it is the only factor expressly referred to by the court in reaching that conclusion. It is unclear what other factors the court considered that she failed to properly weigh or how she failed to properly weigh them. This suggests that while the legal basis for ordering a transfusion changed from the balancing of rights issue in the ex parte application, to the capacity issue at the plenary hearing, the rights

52. *Re T (Adult: Refusal of Treatment) [1993] Fam 95, 115.*
53. *Id. 113.*
54. *Fitzpatrick, [2008] IEHC at page 11 of that transcript.*
55. *Id. at page 13 of that transcript.*
56. *Re T (Adult: Refusal of Treatment) [1993] Fam 95, 112.*
57. *Fitzpatrick, [2008] IEHC at page 32 of that transcript.*
58. *Id. at page 33 of that transcript.*

of Ms K's baby were still a significant, if not overriding, factor.

However, the incapacity finding may not reflect Ms K's inability to weigh the treatment information, but a failure to weigh it in the way the court thought she should have. That is, Ms K put her spiritual salvation above motherhood. As Dame Butler-Sloss warned in *Re B (adult: refusal of medical treatment)* "the view of the patient may reflect a difference in values rather than an absence of competence."[59]

(e) Capacity, Lack of Communication and Cultural factors

It is likely that the hospital's concerns that Ms K had not properly considered her baby's welfare were more a result of poor communication than incapacity. The hospital never actually asked Ms K what she wanted to happen to her baby if she died. This is a very different question from "tell us about your family." We can only speculate about Ms K's understanding of the operation of social services in Ireland and whether her response would have been different if the hospital had spelt out to her what the consequences would be for her baby if she died without anyone in Ireland to take responsibility for him. We do know that Ms K was concerned that her husband should not be arrested because she considered him to be "the only person who could stay with her baby."[60]

Ms Justice Laffoy is particularly unsympathetic to Ms K regarding her misrepresentations about her religion and the whereabouts of her husband. Her Honour stated that "the situation in which Ms K was transfused against her wishes unfortunately was of her own making."[61] While there is no doubt that these misrepresentations caused inconvenience to the hospital, Ms Justice Laffoy's attitude is surprising. Ms K explained that her misrepresentations were motivated by her fears that if she told the truth it would damage her asylum application and that her husband would be arrested, deported and unable to take care of the baby. Yet, Ms Justice Laffoy dismissed these fears as an irrational response that raised questions about Ms K's credibility and capacity in relation to her understanding of the consequences of her decision to refuse treatment for her baby's future care.

Future Implications

Despite rejecting submissions from Ms K that the ex parte order should be set aside because of defects in the order itself, a lack of full and frank disclosure, and the failure to inform Ms K of the ex parte application, Ms Justice Laffoy recommended that:

- the information required of women when booking into maternity care be improved;
- guidelines be developed for women in labour who refuse transfusions;
- General Medical Council guidelines be developed for assessing capacity and the use of advance directives;
- a legal officer be appointed to perform similar functions to the Official Solicitor in England and Wales; and
- a High Court practice direction be developed for similar cases.[62]

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59. [2002] EWHC 429 (Fam), Para 100 (v).

60. Fitzpatrick, [2008] IEHC at page 23 of that transcript.

61. Id. at page 34 of that transcript.

62. Id. at page 43 of that transcript.

Innovations such as these will improve maternity care in Ireland. Nevertheless, *Fitzpatrick* is a step back for patients' rights in Ireland. As authority for the principle that a patient can be found incapable for failing to take into account the needs of a third party, it is a significant limitation on patient autonomy. The closest parallel is the English case of *Re E (a minor)*,[63] where a 15 year old Jehovah's Witness refusing a transfusion was held to lack competence as he had not taken into account the horrible manner of his death (of which he had not been informed by his doctors) and his parents' distress in watching him die (even though his parents supported his decision). In that case, E refused treatment when he turned 18 and subsequently died.

Ms Justice Laffoy excused the failure of the hospital to make a formal capacity assessment and to inform Ms K of the ex parte application, based on the "exigencies of the emergency." This indicates that after *Fitzpatrick*, a patient's rights to be informed of proceedings and be properly assessed, even though he or she is fully conscious and stabilised, may be diminished in situations that are time pressured but fall short of an immediate emergency.

The issue of advance directives did not arise on the facts as Ms K never produced one. However, given that the case turns on Ms K's capacity on the morning she gave birth, one can only speculate whether the result may have been different had Ms K produced an advance directive card refusing the transfusion and specifying that it was applicable following the birth of a child. Patients would be well advised to put in place an anticipatory refusal, as a contemporaneous refusal may be overridden if a hospital doubts or a court finds that the patient lacks capacity on the day.

Fitzpatrick comes at a time of continuing law reform in Ireland related to bioethical issues in the *Law Reform Commissions Third Programme of Law Reform 2008-2014*. The recent Law Reform Commission Consultation Paper *Bioethics: Advance Care Directives* (LRC CP 51-2008) refers to *Fitzpatrick*, noting that guidance on the issue of capacity is warranted for healthcare decisions. It recommends that "statutory codes of practice be formulated to guide healthcare professionals when assessing the capacity of the individual."[64]

This, in conjunction with the suggestions for the future made by Ms Justice Laffoy in *Fitzpatrick* itself, while falling short of the detailed procedural guidelines the English Courts have developed in *Re MB*[65] and *St George's Healthcare NHS Trust v S*,[66] may be a starting point for law reform based on the lessons learned from *Fitzpatrick*.

Conclusion

While a patient's right to refuse medical treatment is well established in England and Ireland as a legal principle, *Fitzpatrick* provides an example of how "brittle"[67] this right can be in practice, especially where a patient makes what seems like a morally repugnant decision to people who do not share the patient's religious beliefs. The incapacity finding in *Fitzpatrick* helped to avoid: (i) the embarrassment (and liability to the hospital) of setting aside an ex parte order of the court to transfuse the patient without her consent; and (ii) creating a precedent on whether the baby's rights to the care of his mother outweighed

63. *[1993] 1 FLR 386.*
64. *See pages 80-81, para 3.33.*
65. *[1997] 2 F.C.R 541, 561.*
66. *[1999] Fam 26, 63 (C.A.).*
67. *Maclean, supra note 5, 3.*

her rights to autonomy, bodily integrity and religious freedom. In doing so, the Court did not consider the broader social context or the possibility of injustice to the patient. While it could be argued that *Fitzpatrick* is an extreme case, the boundaries of the law are set by extreme cases. Time will tell whether *Fitzpatrick* is confined to its extraordinary facts and the extent to which it will shape law reform in Ireland and elsewhere in striking a balance between benevolent paternalism, clashing values and maternal autonomy.

Monitoring the use of the Mental Health Act in 2009/10

The Care Quality Commission's first report on the exercise of its functions in keeping under review the operation of the *Mental Health Act 1983*

Published by the Care Quality Commission (2010).

ISBN: 978-1-84562-274-9

One of the most serious acts that the state can ever undertake is the deprivation or restriction of an individual's liberty on account of their mental disorder. How the state arranges for such acts to be kept under review is equally important, as is how such review activity is accounted for both to Parliament and the public more generally. In as far as the *Mental Health Act 1983* is concerned, principal responsibility for undertaking this function passed on April 1st 2009 from the Mental Health Act Commission (MHAC) to the Care Quality Commission (CQC) which published its first annual report about its monitoring of the Mental Health Act in October 2010.

This document is therefore the direct successor of thirteen Mental Health Act Commission biennial reports. The first looked a bit like a statutory instrument printed on what might be described as old fashioned HMSO paper using two colours only. It was comparatively brief, subtly written and sophisticated in its conclusions. The thirteenth biennial report was magisterial in its length, content and recommendations, professional in its presentation and generally regarded as not only being extremely helpful but also striking a suitable valedictory note for the MHAC. In between, biennial reports grew in size, topics covered, number of references to other publications in the text and the sophistication with which a national picture was painted, against which the activities and findings of the MHAC were set.

The statutory audience for both Commissions' reports remains the same, but beyond that and looking back over the 27 years since the MHAC was established, the audience has always been a bit of a moving target. At the outset practitioners and those with a particular interest in the operation of the Mental Health Act have been the primary target; after all they are the people who have to be influenced to put right concerns identified by the Commission. Early biennial reports were not good at extracting from the text recommendations and grouping them together in a way that made it easier for service providers,

practitioners and commissioners to act upon them. As the years went by, the scope of the reports expanded to include extensive summaries of relevant legal developments, discussion of potential relevant legal and policy development as well as the concerns identified by the everyday visiting activities of Commissioners. There is little doubt that future academics researching the compulsory mental heath system in England and Wales in the last seventeen years of the 20th century and the first nine of the 21st will make much resort to the MHAC's biennial reports, especially the latter ones.

This is therefore part of the context into which arrives the CQC's first Mental Health Act annual report. Inevitably it will be used as evidence as to whether the transfer of visiting and monitoring responsibilities for the Act to the CQC (not universally welcomed) has led to the enhancement or diminution of the undertaking of this role. It is of course only part of the evidence and it is for the reader to come to their own conclusion.

The report is divided into two parts, *Detention under the Mental Health Act* and *Key areas of special focus*. Each part is subdivided into three subsections. Unlike its predecessors there is less discussion of legal developments relevant to the remit and there is very little if anything about Part 3 of the Act – Patients concerned in criminal proceedings or under sentence.

Inevitably there are also matters that if you closed your eyes and willed yourself back 15 years would read substantially the same. The discussion about police use of the Mental Health Act, notwithstanding that fewer people appear to be taken to police stations as a place of safety and that at a local level there is clearly a more sophisticated understanding of what is going on, raises issues that were current concerns more than a decade ago. Really basic requirements such as the standardization of section 136 records are still to be realized. The police are key players in responding to, amongst other things, psychiatric emergencies in public places and it is dispiriting that we do not know more about how this role is undertaken. Similarly the discussion about detained patients and consent and the finding that "in a large number of visits, we find that patients have been certified as consenting when they were in fact refusing or lacked the capacity to give it" identifies an issue that was the subject of comment 20 years ago.

Appropriately the report commences with an analysis of the trends in the use of Mental Health Act detention. The overall picture is presented clearly, especially diagrammatically and records a steady year on year increase in admissions under the Act as well as an increasing proportion of in-patient beds occupied by detained patients. The nature of those receiving care as in-patients is changing: not only are many more detained, the patient mix is shifting towards those with psychotic disorders and dual diagnosis substance misuse; and an increasing number of so called Part 3 patients have been admitted. The first chapter then goes onto a detailed analysis of the admission of children and adolescents to adult wards (CQC demonstrating how it monitors one of the brand new provisions of the Act), the extensive and very welcome discussion about police use of the Act referred to above, and it culminates with an examination of various aspects of assessments for detention under the Act. Other than the fact that the general regulatory regime for all healthcare facilities has developed dramatically over the last 20 years, the discussion under the latter heading of the use of the Act in acute hospitals could have been written at any time during that period. This section concludes with five succinct recommendations to a range of providers, CAMHS commissioners and the police.

The second subsection of Part 1 focuses on the experience of detained patients and in particular how services make the trade off between the needs of security and the provision of a relatively normal "homely" environment. The issues that arise from Commissioners' observations in this regard lie at the heart of the reality of detention and again, because human nature does not change, it is perhaps

unsurprising that none will come as a surprise. It is disturbing that in an in-patent service increasingly focused on caring for psychotically ill detained patients, the majority of wards visited in 2009/10 "were either over-occupied or running at full capacity". Acquiring accurate occupancy level information as an outsider can at times be difficult – there can be a range of motives for sometimes pulling the wool over various external eyes as this author discovered back in the 1990s. Having said that, the Commissioners' sophistication at analyzing such data is now no doubt considerably greater and their concern is a worry, as is their finding that "Over the last five years, there has been no significant change in the proportion of trained staff to untrained staff, or agency staff to permanent staff when we visit".

Running alongside these observations is a reported perception amongst Commissioners and patients (especially those who experienced hospital many years ago) of an increasing emphasis on rules, especially about security including outside the secure sector. Reported are an increasing number of locked acute admission wards (caring also for informal patients), very different approaches to security evident in the low secure sector and the increasingly observed impact of a more blanket approach to security and safety on the delivery of privacy and dignity tailored to the needs of individuals. This age old conflict is perhaps exemplified by the concluding discussion about the impact of the restrictions on smoking in hospitals in force since July 2008.

Part 1 of the report concludes with observations about detained patient involvement and aspects of the protection of their rights. How service providers cope with implementing the guiding principles behind the Act and in particular those that can be seen at times to compete – for example aiming to restore autonomy through "recovery" whilst at the same time maintaining the safety of the patient and others – lies at the very heart of the experience of both patients and those who care for them. It is the reason why it was essential that the operation of the Act was monitored under the new regime by continuing to visit detained patients. Delivering choice and participation and meaningful involvement within a legal framework that is potentially very coercive is demanding but essential: in the end some kind of reasonably acceptable 'deal' between the patient and their care team is the quickest road to effective and successful care and treatment. The report can only provide the sum of some individual snapshots including observations on the implementation of the Care Program Approach and the involvement of independent mental health advocates as well as families and carers. The picture is inevitably mixed but some services clearly know how to do it. This section concludes with observations about the Mental Health Tribunal.

In its early days the MHAC forbore from commenting on tribunals but this policy changed in the early 1990s. In what is proportionately (in relation to the document as a whole) a relatively lengthy but welcome and robust discussion of the tribunal and its activity, a number of what might be termed on-going important challenges are identified: delays, the desirability of improving the range of administrative data to be collected not least in relation to ensuring compliance with the Equality Act 2010, the continuing problem of inadequate social circumstances reports and the possible impact of Legal Aid changes on the way some legal representatives contribute to tribunal hearings as well as the overall quality of some representatives. It is good to read that CQC have established a joint project with the Administrative Justice and Tribunals Council to examine patients' experience of Mental Health Tribunals.

The second part of the report turns to three key areas of special focus: the use of control, restraint and seclusion; consent to treatment; and community treatment orders. Of these three the latter is of particular novelty and importance, reporting as it does on the first full financial year that community treatment orders (CTOs) were in force, having been introduced in November 2008.

The touchstone for the report's observations about control, restraint and seclusion remains the Code of Practice and meeting all aspects of its guidance obviously remains a challenge. Enabling patients to write their own account of an incident of their disturbed behavior (that led to restraint) to be filed in their own notes; providing personal or quiet space for patients and ensuring that they have access to activities and are able to go outside; the use of various forms of mechanical restraint especially in non-acute mental health settings and learning disability services; and aspects of the use of seclusion and long term seclusion are all perhaps unsurprisingly identified as issues worthy of further attention and development. Recommendations include a national notification or data collection process for the use of mechanical restraints; a review of restraints and seclusion recording practices to include a record of any de-escalating steps taken; and the desirability of reviewing the access of patients in seclusion to basic provisions to meet their needs and ensure their dignity. To paraphrase the old saying "the price of good practice is eternal vigilance" – nowhere do Mental Health Act Commissioners continue to contribute more to that vigilance than when observing these areas of practice on their visits.

The penultimate subsection of the report concerns detained patients and consent to treatment. Part 4 and 4A of the Act are central protections: the former was amended in important ways in 2007 and the latter is a new regime accompanying the introduction of community treatment orders and is dealt with in the concluding subsection of the report along with other aspects of CTOs. The key conclusion from Commissioners' observations is that the assessment of capacity and consent and the recording of related discussions is an area in which services need to improve significantly. As noted above, this has been identified in numerous previous biennial reports. What is perhaps new and a reflection of the "teeth" possessed by the CQC and the absence of which was much lamented by many commissioners throughout the life of the MHAC, is what CQC has done about this. Using the registration regime for providers operated by the Commission, they have placed conditions on the registration of three NHS specialist mental health providers requiring them to improve their performance in this area. Observation of the initial consequences of such conditions, are positive. The report's analysis of the work of the SOAD service provides amongst other things an interesting commentary on the changing nature of those subject to detention including a steady increase in the proportion of detained patients deemed incapable of consent. Is this the consequence of greater severity of illness amongst detained patients or that clinicians are more alert to, and better at, assessing incapacity? The substantially increased use of urgent treatment powers both in relation to medication and ECT are noted, not all of which can be explained by the extreme difficulties (and embarrassment) experienced by the CQC in administering the SOAD service and consequential on the far higher than anticipated number of community treatment orders.

The concluding subsection of the report provides a particularly valuable insight into something that is really new: the community treatment order. This is the aspect of the report that attracted external attention and coverage, and not surprisingly, given that throughout almost the entire life of the MHAC the debate lasted as to whether compulsory powers in relation to mental disorder should be changed so as to reflect better that the care and treatment of even those with severe and enduring mental illness was no longer necessarily solely hospital-centered. Obtaining a reliable and external view about this important and still controversial provision is actually operating, is important. It is still early days but over and above the fact that the number of orders made is way above the predictions of the Department of Health before introduction, the following important observations are made:

- Good beginnings have been made in building a profile of those subject to CTOs. A disproportionate number are black and minority ethnic patients; most had a diagnosis of schizophrenia and other psychotic disorders; almost all were prescribed some form of psychotropic

medication; and 35% were prescribed medication above BNF recommended limits. In addition preliminary research indicates that possibly 30% in the sample under review had no reported history of non-compliance or disengagement with services after discharge.

- A range of what might be termed administrative and interpretation difficulties have been identified, including some misunderstanding about the role of the SOAD in CTO cases, difficulties with implementing the recall powers, some examples of lack of communication between hospital and community teams and some challenges experienced in the undertaking of the role of the Approved Mental Health Act Professional as a safeguard in the use of the CTO.
- Patient involvement is one of the keys to successful CTO interventions.

The central role that Mental Health Act Commissioners and SOADs must play in ensuring the proper implementation of these powers is a critical challenge for the CQC.

In the overview of the CQC's findings that accompanied the report three priority areas for improvement are identified: involving detained patients in their care and treatment; practice relating to patients capacity and consent; and unnecessary restrictions and blanket security measures. This document concludes with the re-assertion that the failure to address any systemic problems may result in conditions being imposed on a provider's registration.

At a number of levels it is unfair to contrast and compare this report with its predecessors. For one thing it is an annual report which may well explain the fact that it deals with far fewer topics than some of its biennial predecessors. In addition the responsibilities of the CQC do not extend to Wales. What is absolutely clear is that as the health service (and in particular commissioning arrangements) undergo the most radical restructuring in its history, alongside the implementation over the next four years of the most substantial savings program ever attempted, the interests of those detained under the Act, their families and carers and society at large must not be overlooked. The monitoring of the Act by the CQC is going to be central to ensuring that outcome and the importance of its annual reports can only grow in the coming years.

William Bingley

Chair of NHS North Lancashire; Chief Executive of Mental Health Act Commission from 1990 to 2000.

Designed and produced by Northumbria Graphics. 309805K_6/11