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Journal of Mental Health Law

Articles and Comment

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Foreword

Nobody who works in or writes about this area of the law can fail to acknowledge that we are experiencing a period of explosive change. Since the last issue of the Journal we have seen the publication of two new draft Bills, which together promise to change the shape of mental health care and services in the future. On 18th June 2004, the Mental Capacity Bill was published, reflecting many of the recommendations made by the Joint Parliamentary Scrutiny Committee appointed last summer to consider the Mental Incapacity Bill 2003. More recently, on the 8th September, the new Mental Health Bill 2004 was finally published, and will also be subjected to pre-legislative scrutiny by an expert parliamentary committee which is due to report its findings by March 2005. Finally, this very week, the draft Code of Practice for the Mental Capacity Bill 2004 was announced by the Department of Constitutional Affairs.

Editing a Journal during this unsettled period is a frustrating affair, and despite our best efforts we have been overtaken by the events of the past few weeks. Our aim is therefore to look at the draft Mental Health Bill 2004 and Code of Practice for the Mental Capacity Bill 2004 in the next issue of the Journal.

We begin this issue of the Journal with an empirical study conducted by Dr Jacqueline Atkinson, Helen Garner and W. Harper Gilmour at Glasgow University and James Dyer, former Director of the Mental Welfare Commission for Scotland. They examine the changes introduced by the Mental Health (Patients in the Community) Act 1995 in Scotland, through the restriction of leave of absence to 12 months and the introduction of Community Care Orders. The study considers the relationship of these new measures with the Care Programme Approach and provides comment on the implications of community based compulsory treatment orders which were introduced in Scotland by the Mental Health (Care and Treatment)(Scotland) Act 1995.

The answer to the question 'what is a hospital?' is not as straight forward as it first appears. Following the National Health Service and Community Care Act of 1990 and the creation of the NHS hospital trust, there has developed some uncertainty surrounding the meaning of 'a hospital' as defined in the Mental Health Act 1983. David Hewitt looks at the reasons why the definition of a 'hospital' has caused such confusion since the 1990 Act and concludes that the proposed new Mental Health Act will do little to clarify our understanding, nor will it resolve the uncertainties surrounding the detention, removal or transfer of patients to and from hospital which exist under the current and proposed new legal framework.

Dr Tim Exworthy looks at the provisions of the new Mental Capacity Bill 2004 that cover the making of advance decisions. Under the provisions of the Bill, advance decisions allow a competent person to make a decision to *refuse* treatment in the future should they lose capacity and be unable to make a legally binding decision at that time. However, a person can only make an advance decision to refuse future treatment under the provisions of the Bill and there is no provision for a person to express a positive preference for a certain type of treatment. The author argues that this represents a missed opportunity that would allow clinicians and patients to engage

in a more constructive approach to treatment-planning and for the Government to create a law that is truly therapeutic in intent and practice.

For many years Lucy Scott-Moncrieff has represented patients who are detained under the Mental Health Act and has experienced first hand 'the lower levels of service that people with psychiatric problems receive as against people with other medical problems'. In an absorbing personal account, she discusses the David Bennett inquiry, the infamous *Re C* case and the compulsory treatment provisions of the Mental Health Act 1983, and sets out her case for why she considers the National Health Service is guilty of institutional racism.

In our casenotes section, Joanna Sulek reviews the case of *R (on the application of HP and KP) v London Borough of Islington* [2004] EWHC 7 (Admin) which concerns alleged breaches by the London Borough Council of Islington of its duties under s47 of the National Health Service and Community Care Act 1990. As the title of this review suggests, the case highlights the confusion that may arise between two assessment processes, the CPA assessment and the Community Care assessment, which although similar, are nevertheless distinct and separate. The case is important, not only for showing that there is a need for guidance which clearly sets out the duties of local authorities when carrying out community care assessments, but it also highlights how serious the consequences can be for the individual when a public body fails to fully appreciate the processes in which they are legally obliged to engage.

In our book reviews section, Professor William Bingley reviews the third edition of Luke Clements' Community Care and the Law, Dr Martin Humphreys looks at the Mental Health Act Commission's tenth Biennial Report 2001–2003 and Richard Charlton reviews the second edition of Assessment of Mental Capacity – Guidance for Doctors and Lawyers.

On a personal note, this is the last issue of the Journal of Mental Health Law I will be editing. The current Assistant Editor, John Horne, with whom I have worked closely over the years, has agreed to assume the role of Editor from now on. His extraordinary knowledge of mental health law and his fastidious attention to detail will mean that the Journal is in very safe hands.

I would like to say that I am immensely proud of this Journal and all that it has achieved over the years. Since its launch in 1999, it has become a respected and much quoted authority in the mental health field and has become a source of reference for hundreds of mental health professionals and academics across the country. It has been a pleasure and a privilege to work with our editorial board and those who have contributed to the Journal, - amongst them, I consider, are some of the most inspiring academics and professionals currently researching and practicing mental health law. Together they have helped to ensure the quality and integrity of the Journal - and will do so, I hope, for many years to come.

Charlotte Emmett

Editor

The Care Programme Approach and the end of indefinitely renewable Leave of Absence in Scotland

Jacqueline M Atkinson*
Helen C Garner*
W Harper Gilmour*
James A T Dyer OBE**

Abstract

Objective

To consider the relationship between the restriction of leave of absence (LOA) to 12 months, the introduction of community care orders (CCOs) and the implementation of the Care Programme Approach (CPA).

Design

Multiple methods were employed: scrutiny of Mental Welfare Commission for Scotland (MWC) records; questionnaire to consultant psychiatrists and mental health officers (MHOs) regarding attitudes; survey of psychiatrists in respect of outcomes for named patients.

Setting

Scotland

Subjects

Two hundred and sixty six patients who were affected by the changes introduced by the Mental Health (Patients in the Community) Act 1995.

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Results

Information was available for 195 (73%) patients in relation to CPA. Of these 113 (58%) were included on CPA and for 63/113 (56%) (63/195 (32%)) CPA was considered to have enhanced patient care.

Where CPA was considered useful it was because it was seen as bringing people together, enhancing the patient's role in treatment and managing difficult situations. Negative comments regarding CPA were that it was unnecessary as the patient's needs were straightforward, it duplicated current practices or it was too bureaucratic.

Conclusions

Despite concerns expressed by professionals about the restriction to LOA and the guidance that patients should be on CPA, for only a minority of patients was CPA described as enhancing care. Questions are raised about the low use of CCOs and CPA by psychiatrists for patients who reached the new limits of LOA.

The CPA is designed to ensure good interagency collaboration thus facilitating care and or supervision in the community for people with severe, long-term and complex mental health problems[1]. It has had a chequered history of development and implementation in Scotland and in many areas was reported as being underdeveloped[2].

Patients in Scotland can be subject to compulsion in the community in three ways: leave of absence (LOA), Community Care Orders (CCO) and Guardianship. The latter is not used in relation to enforcing medication and is not discussed here. The Mental Health Act 1984 allows patients detained on a Section 18 to live in the community on LOA. The understanding was that this allowed similar treatment without consent in the community as Section 18 allowed in hospital. LOA was renewable indefinitely in Scotland until the Mental Health (Patients in the Community) Act 1995 which restricted it to 12 months. This Act also introduced CCOs which required patients to comply with conditions approved by a sheriff. These conditions could include where the person lived, where they spent time and the requirement to give access to staff. Although it was believed that CCOs did not allow patients to be compelled to take medication, the majority of CCOs contained conditions that implied or directly stated that patients should comply with medication[3].

The Scottish Office guidelines[4] indicate that good practice requires that all patients on LOA or a CCO should have care plans that comply with the Care Programme Approach (CPA)[5]. A questionnaire survey indicated that almost all mental health officers (MHO)[6] and three-quarters

1 *Greater Glasgow Health Board (1996) Operational arrangements and recommendations arising from the Glasgow Care Programming pilot project 1st July – 31st December 1995*

2 *Social Work Services Inspectorate and Accounts Commission for Scotland (1998) Implementing the Care Programme Approach. Social Work services Inspectorate Edinburgh*

3 *Atkinson, J M, Garner, H C, Gilmour, W H & Dyer, J A T. (2002 a). The introduction and evaluation of Community Care Orders following the Mental Health (Patients in the Community) Act, 1995. Journal of Mental Health 11, 4, 417–429*

4 *Scottish Office (1996a) Draft Guidance on the Mental Health (Scotland) Act 1984 as amended by the Mental Health (Patients in the Community) Act 1995. FRP14203. Edinburgh: Scottish Office.*

5 *Scottish Office (1996b) Community Care: Care Programme Approach for People with Severe and Enduring Mental Illness, Including Dementia Social Work Services Group Circular SWSG 16/96*

6 *Mental health officers are social workers charged with responsibilities under the Mental Health (Scotland) Act 1984 similar to those of approved social workers in England and Wales under the 1983 Act*

of consultants agreed with this, although there were some reservations about its appropriateness in all cases[7].

As part of a wider study evaluating the impact of the Mental Health (Patients in the Community) Act 1995 in restricting LOA and introducing CCOs, the relationship of these new measures to CPA was investigated. Details of the full study including methodology are given elsewhere[8,9]. Since this study was started community-based compulsory treatment orders (C-B CTOs) have been introduced in the new Mental Health (Care and Treatment)(Scotland) Act 1995[10]. This also introduces the need for care plans to be approved by mental health tribunals for patients subject to compulsory treatment. Possible implications of this are discussed.

METHODOLOGY

Information for the study comes from three sources, records of the Mental Welfare Commission for Scotland (MWC) to identify patients, a follow-up survey to consultant psychiatrists about named patients and an anonymous questionnaire to consultants and MHOs about the 1995 Act.

Population

The MWC receives details of all patients in Scotland detained under the Mental Health (Scotland) Act 1984. Their records were scrutinised to find all patients whose LOA reached the new limits between 1 April 1996 when the Act was implemented and 31 December 1998 and all those who were placed on a CCO between these dates.

Named patient survey

A questionnaire was designed to collect follow-up data on all these patients. This was sent to the patient's Responsible Medical Officer (RMO). The RMO at the time of discharge from LOA was identified from the MWC case records. For many patients the RMO had changed and RMOs were asked to indicate to whom care had been transferred. Thus, 308 questionnaires were sent to 146 RMOs regarding 266 named patients. The questionnaires were sent in May 1999 and a reminder in June 1999.

Questionnaire to consultants and mental health officers

A postal questionnaire was designed to obtain consultants and MHOs views about the changes brought about by the Mental Health (Patients in the Community) Act 1995 and their views on CPA. Questionnaires were sent to all adult general psychiatrists in Scotland and a sample of currently practising MHOs. MHOs were more likely to agree with the Scottish Officer guidance regarding CPA than psychiatrists and more positive regarding the limitation of LOA and the introduction of CCOs. Both groups of professionals however made similar assessments of resources available for patients. Peay discusses in detail the differing attitudes of approved social workers and psychiatrists in relation to decisions around detention in England & Wales.[11]

7 *Atkinson, J M, Gilmour, W H, & Garner H C. (2000). Views of consultant psychiatrists and mental health officers in Scotland on the Mental Health (Patients in the Community) Act 1995. Journal of Mental Health, 9, 385–395*

8 *see note 3*

9 *Atkinson, J M, Garner, H C, Gilmour, W H & Dyer, J A T. (2002 b). The end of indefinitely renewable Leave of Absence in Scotland: The impact of the Mental Health (Patients in the Community) Act, 1995. Journal of Forensic Psychiatry 13, 2, 298–314*

10 *Scottish Parliament (2003) The Mental Health (Care and Treatment) (Scotland) Act 1995Edinburgh: The Stationery Office*

11 *Peay, J. Decisions and Dilemmas. Working With Mental Health Law Hart Publishing, 2003*

Full details of the survey and views about the Act are reported elsewhere[12], however the detailed comments regarding the development of CPA across Scottish Local Authorities are reported here.

Ethics approval

Ethical approval was granted by the Multi-Centre Research Ethics Committee for Scotland and 13 Local Research Ethics Committees.

RESULTS

Patients

Two hundred and sixty-six patients were identified from MWC records. The details of the numbers in each health board and estimated rates per 100,000 population are given in Table 1. Any patients from Orkney or Shetland on LOA are included in Grampian Health Board

Health Board	No of patients	Population of Health Board 1998	Rate per 100,000
Ayrshire and Arran	11	375,400	2.9
Argyll and Clyde	16	426,900	3.7
Borders	4	106,300	3.8
Dumfries & Galloway	5	147,300	3.4
Fife	30	348,900	8.6
Forth Valley	10	275,800	3.6
Greater Glasgow	50	911,200	5.5
Grampian (+ Shetland & Orkney)	23	567,660	4.1
Highland	10	208,300	4.8
Lanarkshire	21	560,800	3.7
Lothian	54	773,700	7.0
Tayside	32	389,800	8.2
Western Isles	0	27,940	0

Table 1. Study population by health board n = 266

Source of population figures: ONS Population Estimates series PE no1 (1999)

Development of CPA across Scotland

The data in Table 2 comes from the questionnaire to MHOs and consultants. There were 246/293 (84%) responses from consultants and 259/315 (82%) responses from MHOs. Of those professionals working with detained patients, 202/244 (83%) of MHOs and 160/208 (77%) of consultants responded to the question about how well was CPA developed in their area. Details by local authority are given in Table 2. Although CPA is largely health led, MHOs are employed by

Local Authority	MHOs n=202		Consultants n=160	
	Negative	Positive	Negative	Positive
Aberdeen City	0	13	2	10
Aberdeenshire	2	0	1	3
Angus	0	4	0	3
Argyll and Bute	2	3	4	1
City of Edinburgh	17	19	5	4
Clackmannanshire	3	1	0	3
Dumfries and Galloway	0	5	0	7
Dundee	3	1	5	1
East Ayrshire	5	0	0	1
East Dunbartonshire	0	3	1	4
East Lothian	4	3	0	1
East Renfrewshire	2	0	2	0
Falkirk	4	0	3	3
Fife	0	7	2	9
Glasgow	6	19	7	25
Highland	6	1	7	1
Inverclyde	1	1	1	2
Midlothian	2	0	2	1
Moray	1	2	2	1
North Ayrshire	3	1	0	0
North Lanarkshire	8	7	2	3
Orkney	1	0	0	0
Perth and Kinross	3	1	3	0
Renfrewshire	4	0	7	0
Scottish Borders	1	6	0	6
Shetland	1	0	0	0
South Ayrshire	6	1	2	1
South Lanarkshire	2	2	4	2
Stirling Council	0	5	0	1
West Dunbartonshire	1	2	0	2
West Lothian	2	5	0	2
Western Isles	0	0	0	1

Table 2. Views on the development of CPA by local authority from MHOs and consultants who treat patients detained under the MHA 1984

local authorities who therefore co-determined the implementation of the policy at the smallest unit at which it was possible to gather opinion on its success.

Small numbers in some areas make comparisons difficult but there is broad agreement between the two professions as to the development of CPA in their area. Only a minority of local authorities, 9/32 (28%), were described as having well developed CPA by both sets of professionals and 6/32 (19%) were described as having poorly developed CPA.

CPA and individual patients

Replies were received to the named patient survey from 130/146 (89%) consultants for at least some patients. Of the 308 questionnaires, 250 (81%) were returned, of which 231 (75%) were analysed (the remainder being blank or the patient was unknown to the RMO). There is some information available for 195/266 (73%) of the patients in relation to the impact of CPA. Details are given in table 3. For 8% of the patients for whom forms were returned, the RMO either missed out the questions on CPA or reported they did not know the impact of CPA on that patient's care.

Health Board	Not included on CPA	Enhanced Care	Not affected care	Impaired care	Number of patients
Ayrshire & Arran	5 (63%)	1 (13%)	2 (25%)	0 (0%)	8 (100%)
Argyll & Clyde	8 (80%)	0 (0%)	2 (20%)	0 (0%)	10 (100%)
Borders	0 (0%)	1 (25%)	3 (75%)	0 (0%)	4 (100%)
Dumfries	0 (0%)	0 (0%)	5 (100%)	0 (0%)	5 (100%)
Fife	2 (7%)	19 (66%)	8 (28%)	0 (0%)	29 (100%)
Forth Valley	2 (29%)	2 (29%)	3 (43%)	0 (0%)	7 (100%)
Greater Glasgow	18 (50%)	16 (44%)	2 (6%)	0 (0%)	36 (100%)
Grampian	10 (63%)	4 (25%)	2 (13%)	0 (0%)	16 (100%)
Highland	5 (56%)	1 (11%)	3 (33%)	0 (0%)	9 (100%)
Lanarkshire	3 (38%)	3 (38%)	1 (13%)	1 (13%)	8 (100%)
Lothian	18 (42%)	12 (28%)	12 (28%)	1 (2%)	43 (100%)
Tayside	11 (55%)	4 (20%)	5 (25%)	0 (0%)	20 (100%)
Total	**82 (42%)**	**63 (32%)**	**48 (25%)**	**2 (1%)**	**195 (100%)**

Table 3 Views on the impact of CPA by Health Board from consultants with patients who reached the legal limit of LOA n = 195

Of the 195 for whom information is known 82 (42%) were not included on CPA. If only the 113 (58%) patients who were included on CPA are considered, for 63 (56%) consultants considered the patient's care was enhanced, for 45 (42%) CPA made no difference and in 2 (2%) cases CPA impaired care. For 82 patients psychiatrists said that to their knowledge they had not been included on CPA. Thus for the group as a whole, only one third had enhanced care from CPA.

Comments were made by psychiatrists for a minority of patients (76, 36%). Of the 63 consultants who said CPA enhanced their patient's care, 25 (40%) made comments. The main themes were in the usefulness of bringing people together, enhancing the patient's role in their treatment and managing difficult situations. eg:

> "CPA *has allowed/enabled clear interaction between members of a complex package of care who would not otherwise meet, eg consultant in X psychiatry, consultant in Y psychiatry, consultant in Z, plus housing and social work etc.*"

> "CPA *has brought everyone together and has enabled (patient) to remain a priority despite being quiet and undemanding.*"

> "*Has allowed the patient to become a partner in their care rather than a passive recipient.*"

> "CPA *here is successful, increasing inpatient bed days but reducing community chaos and 'revolving door' situations.*"

Where consultants believed CPA had added nothing to patient care, 19 (40%) made comments. Most reflected the view that CPA was unnecessary as the patient's needs were straightforward or CPA reflected what was already happening, eg:

> "*(Patient) needs are relatively simple and would have been met with or without the* CPA."

> "*(Patient) wants are minimal (house is his/her own, income is adequate, self care is basic but adequate) as long as he/she receives his/her medication.*"

> "CPA *ensures good staff liaison – no difference to management.*"

Two consultants, however, raised different issues:

> "*Patient him/her self refused to be included on* CPA."

> "CPA *unsuccessful as scuppered by patient's behaviour and failure to comply with conditions of* CCO."

In the two cases where CPA was believed to have impaired care only one comment was made:

> "CPA *also is too unwieldy to cope with patient's changeableness.*"

CPA was not necessarily available or well developed in all areas but only one comment made reference to this. This relates to a patient who moved between health boards. The end of study LOA RMO, who was also once again RMO at time of the survey, said "CPA *was not available in this area until [after time of discharge from LOA] but I don't think it would have made any difference.*" The RMO for a period of inpatient treatment in another health board for the same patient said, "CPA *ensured that contact was maintained with patient while in the area but progress after his/her return to X last year is unknown.*"

For the patients who were not included in CPA a further 25 (total 32%) comments were made. There were three themes. Firstly, CPA was described as too bureaucratic, eg:

> "*The staff involved know the problems with the patient and the* CPA *would just create unnecessary bureaucracy.*"

Secondly, that CPA is seen as pointless as it cannot enforce medication:

> "CPA *of no value in ensuring compliance with medication so not used.*"

> "*Compliant by the time we introduced* CPA."

The third theme indicated that the patient already had co-ordinated care and that CPA did not add anything to this, eg:

> *"CPA not used as patient seeing members of team who meet regularly with patient and has own private accommodation and occupation is through [X] dept with whom [patient] has regular contact. Non NHS agencies not involved with this patient."*
>
> *"Decision was made not to proceed to CPA as patient was settled at end of LOA. Also, all professionals involved meet on a regular basis anyway to discuss his/her problems with him/her and appropriate action taken from there."*

DISCUSSION

The response rate from psychiatrists to the named patient postal survey was sufficiently high for us to assume that the data is representative as there is no real reason to suppose the sample is biased in any particular way.

The figure of 58% of patients being on CPA compares well with the 61% estimated by consultants in the postal questionnaire of their LOA patients on CPA but is slightly less than the MHOs' estimate of 71%[13]. The two populations are not entirely similar in that the named patient survey was for predominately post-LOA patients. Nevertheless, this is a group of patients for whom there is considerable concern about their continued management and for whom, despite the Scottish Office good practice guidelines, somewhat under two-thirds were on CPA. There are probably two main reasons why a patient was not on CPA.

Firstly, CPA development varied across Scotland and may not have been available for some patients. Secondly, although most psychiatrists agreed with the Scottish Office guidelines, 22% of consultants actively disagreed with the recommendation[14]. It is unlikely that the 42% of patients in the named patient survey who were not on CPA were all patients of this group of psychiatrists or in areas where CPA development was poor. There were probably other reasons why patients were not placed on CPA. For some it would seem the guidance was regarded as inappropriate. At the end of LOA, these patients' needs were not seen as complex and, thus, CPA was seen as unnecessary. This may be either because the period of LOA allowed the situation to be stabilised or because LOA was an over cautious response. In other cases patients may have benefited from CPA but consultants chose not to use it. This may have been because it was seen as overly bureaucratic or because it could not compel or ensure compliance with medication. These were the same failings psychiatrists attributed to CCOs[15]. CPA was described as useful, however, for some patients who declined services. It could ensure monitoring of mental state and allow appropriate measures to be taken before a crisis developed thus preventing further complications in patients' affairs.

The variation in the use of LOA across the country is of note, but appears to follow no particular pattern in relation to Health Board. Previous research[16] looked at the variation in the use of LOA between health boards over time. There is no apparent relationship between use of LOA and deprivation. Studies of those patients for whom psychiatrists in England would have liked to use

12 *see footnote 6*

13 *see footnote 6*

14 *see footnote 6*

15 *see footnote 3*

16 *Atkinson, J M, Gilmour W H, Dyer J A T, Hutcheson F G, Patterson L E (1998) Variation in Use of Extended Leave of Absence in Scottish Health Boards Health Bulletin 56 6 871–877.*

a hypothetical community treatment order showed that not all psychiatrists with adult community care patients used LOA[17].

Lack of CPA may not indicate that the principles of collaboration were not being adhered to but rather that this was not done in the formal name of CPA. A number of comments indicated that CPA would add nothing to current management. In some cases this would seem to account for the suggestion that CPA had made no difference to the patient's care. This should not necessarily be interpreted as saying CPA is redundant. A safety net may still be appropriate even if no one falls.

The comments about bureaucracy, echoing as they do comments made about CCOs, require further consideration. What is being complained about? Is it an administrative load and additional paperwork or is 'bureaucracy' a euphemism for all the meetings involved and the time taken by multi-disciplinary care and consultation? Comments indicated both meanings but numbers are too small for conclusions to be reached. In depth interviews would be required to elucidate this issue. The administrative load carried by consultants with multiple patients on section, LOA, CCO and CPA, however, should not be underestimated[18].

There is some evidence of patients having positive views on their experience of CPA[19], but how, if at all, this relates to their status in relation to the Mental Health (Scotland) Act 1984 is not known.

Before the introduction of the 1995 Act the use of lengthy LOA was on the increase[20]. There was consistent opposition to its restriction by psychiatrists on the grounds that it would mean that they would not be able to maintain high risk and vulnerable patients in the community without it[21]. It is therefore important to understand why the CPA that was intended to ensure that these patients did not fall through the gaps between agencies was not extensively used. Community Care Orders were also little used[22]. It is not possible to tell from this research if the low use of formal non coercive collaborative methods is due to lack of resources such as clinical time or to antipathy to the philosophy behind these approaches. Alternatively LOA is seen as justified when the only need perceived by services is that the patient continues to take their medication.

The Mental Health (Care and Treatment) (Scotland) Act 2003 raises the prospect of renewed requirements for formal care plans. It will be the MHOs duty to prepare a care plan in conjunction with the patient's psychiatrist after consulting with a wide group of involved and interested parties. The Act lays out what the care plan will need to specify. These plans will be presented to a mental health tribunal who will have the power to authorise or reject them. For patients who are to be placed on a C-B CTO this can be seen as enforcing CPA on psychiatry. Since this will now be a legal responsibility Health Boards and Local Authorities as well as individual consultants and MHOs will have to take it on board. The MHO will have a stronger role in the new legislation in relation to care planning than under current arrangements for CPA. Whether this, the time scale involved for application for compulsory treatment, and the legal imperative will make any difference to

17 *Sensky T., Hughes T, & Hirsch S. (1991) Compulsory Psychiatric Treatment in the Community II A controlled study of patients whom psychiatrists would recommend for compulsory treatment in the community. British Journal of Psychiatry 158 799–804*

18 *Tyrer P.A., Muderi O., Gulbrandsen D. (2001). Distribution of case-load in community mental health teams. Psychiatric Bulletin. 25, 10–12*

19 *Alexander, H. & Brady, L. (2001) What does receiving the care programme approach mean for service users? Health Bulletin 59 (6)*

20 *Atkinson, J M, Gilmour, W H, Dyer J, Hutcheson F, and Patterson, L (1999) Retrospective evaluation of extended leave of absence in Scotland 1988–94 Journal of Forensic Psychiatry 10 131–147*

21 *see footnote 6*

22 *see footnote 3*

attitudes remains to be seen. It might be expected that areas which have well integrated CPA might be better placed to introduce C-B CTOs.

What does seem clear is that the paperwork required by the Act will increase and that given the views on 'bureaucracy' presented in these surveys this is unlikely to be welcomed. A scoping exercise carried out for the Royal College of Psychiatrists Scottish Division[23] includes this in contributing to the need for a substantial increase in the number of consultants in Scotland. The number of additional MHOs required to fulfil the needs of the Act is likely to be even higher.

Acknowledgements

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The authors would like to thank the psychiatrists and Mental Health Officers who gave their time to completing the questionnaires.

23 *Atkinson J M, Brown K, Dyer J A T, Hall D J & Strachan J, (2002c) Renewing Mental health Law; A Scoping Exercise in Respect of the Impact on Psychiatrists' Time. Royal College of Psychiatrists Edinburgh.*

What is a hospital?

David Hewitt[1]

1. Introduction

Leslie Nielsen as Doctor Rumack: This woman has got to be taken to a hospital.

Elaine: A hospital? What is it?

Dr. Rumack: It's a big building with patients, but that's not important right now.[2]

One hesitates to cross swords with the estimable Leslie Neilson, both because he is estimable and also because, in this moment from a classic funny film, he gave a plain answer to what is, when all's said and done, a tricky question.

In the context of detained patients, the question has excited a great deal of deliberation, and it continues to cause concern and, occasionally, real problems for mental health practitioners. It's also a question that the next Mental Health Act seems unlikely to resolve.

A number of possible answers have been proposed. Though most are perfectly sensible and, to varying degrees, helpful, none resolves the question entirely. The purpose of this paper is to consider those answers and to identify the merits and demerits of each.

2. Definition

It is necessary to examine the definition of 'hospital' that appears in current law and the proposed definition under a new Mental Health Act.

2.1 The current law

On the face of it the Mental Health Act 1983 ('MHA 1983') has a comprehensive answer to the question. It states:

> ' "hospital" means –
>
> (a) any health service hospital within the meaning of the National Health Service Act 1977; and
>
> (b) any accommodation provided by a local authority and used as a hospital or on behalf of the Secretary of State under that Act.'[3]

1 *Solicitor, and partner in Hempsons. The author would like to thank John Holmes, Bill Leason and Stephen Evans, who are also partners in Hempsons, for their very helpful comments on earlier drafts of this paper*

2 *Airplane! , 1980, dirs: Jim Abrahams, Jerry Zucker, David Zucker*

3 *MHA 1983, s 145(1)*

It is, perhaps, unhelpful for the 1983 Act to provide a definition that simply refers to another definition. The National Health Service Act 1977 ('NHSA 1977') says:

' "hospital" means –

(a) any institution for the reception and treatment of persons suffering from illness;

(b) any maternity home; and

(c) any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation;

and includes clinics, dispensaries and out-patient departments maintained in connection with any such home or institution, and "hospital accommodation" shall be construed accordingly.'[4]

It might be thought that the word 'institution' is highly significant. Sadly, that is not so. The New Shorter Oxford English Dictionary defines it as:

'7. A society or organization, *esp*. one founded for charitable or social purposes and freq. providing residential care; the building used by such a society or organization.'[5]

This definition is provided here only for the sake of completeness. It takes an abstract approach and doesn't deal in mere bricks and mortar. It fails to suggest any differentiation between 'the building' used to house detained patients that is a discrete unit on a plot of its own and one that is part of a much larger medical 'campus'. As we shall see, the two forms of building are different things and their differences are of considerable importance.

It is regrettable that, despite two lengthy statutory definitions, we cannot now be sure what 'hospital' means. In fact, that uncertainty has been caused by the definitions, and by the fact that they have remained unaltered despite significant changes in the way mental health services are configured.

2.2 The Draft Mental Health Bill

The position is unlikely to be very different under the next Mental Health Act. The Draft Mental Health Bill published in September 2004 tells us that

'"Hospital", except in Parts 6,[6] 10[7] and 12[8] and sections 161(2)(c),[9] 172(2),[10] 280(1)[11] and 301(1),[12] means –

(a) any health service hospital within the meaning of the National Health Service Act 1977 (c. 49),

(b) any accommodation provided by a local authority and used as a hospital by or on behalf of the appropriate authority under that Act,

(c) any other establishment –

(i) which is an independent hospital (within the meaning of the Care Standards Act 2000 (c. 14)) in respect of which a person is registered under Part 2 of that Act, and

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4 *NHSA 1977, s 128(1)*

5 *Clarendon Press, Oxford, 1993*

6 *Which deals with the 'Informal treatment of patients aged under 18'*

7 *Which deals with the 'Functions of Commission for Healthcare Audit and Inspection'*

8 *Which deals with 'Miscellaneous' matters*

9 *Which deals with the 'Transfer of patients from England and Wales'*

10 *Which also deals with the 'Transfer of patients from England and Wales'*

11 *Which deals with the 'Ill-treatment or wilful neglect of patients'*

12 *Which contains the definition of 'carer'*

(ii) in which medical treatment is or may be provided to persons who are subject to the provisions of Part 2[13] or 3[14] of this Act."[15]

This definition is the same as the one that appeared in the Draft Mental Health Bill published in June 2002.[16]

There is nothing in the various Government publications that preceded the Draft Bills to indicate why it was thought desirable to perpetuate the old definition of 'hospital' or unnecessary to depart from it.[17]

3. Confusion

If there is confusion as to the true meaning of 'hospital' it is a comparatively recent phenomenon.

As Professor Eldergill notes, at one time the position was very clear:

> "Previously, all hospitals within a district had the same hospital managers, the local District Health Authority. If it was necessary to move a patient from the psychiatric ward of the local District General Hospital to a surgical ward, following a suicide attempt, the patient remained detained in the same hospital by the same managers. Consequently, no legal formalities had to be observed. Likewise, if a secure psychiatric unit was on the same site, but set apart from the District General Hospital, permitting the patients to wander the hospital grounds, or taking them to the general hospital for dental treatment, involved no legal formalities. The patient had not left the hospital where he was liable to be detained so no formal leave of absence was required."[18]

However, in 1990 there came the National Health Service and Community Care Act ('NHS & CCA 1990'), which fostered the creation of NHS trusts to manage hospitals (and, as we shall see, amended the statutory definition of 'the managers'), but made no change to the meaning of 'hospital'.[19]

The result was that more than one NHS trust might now be responsible for different parts of a single site, a site that was previously thought of as – and called – a hospital.

Eldergill has said:

> "The position now is that different floors of a General Hospital may be managed by different NHS trusts. For example, the local General Hospital NHS Trust may manage the first and second floors, and also those wards on the third floor which admit patients for physical conditions. The local Mental Health NHS trust may manage the open psychiatric ward on the third floor, the secure unit set apart in the General Hospital grounds, and a number of wards left on the site of the old asylum, situated some miles away. Worse still, some psychiatric wards may be shared by two Mental Health NHS trusts, both having beds on the ward."[20]

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13 *Which deals with 'Examination, Assessment and Treatment'*

14 *Which deals with 'Patients Concerned in Criminal Proceedings etc'*

15 *Department of Health, Draft Mental Health Bill, September 2004, Cm 6305-I, cl 2(3); Department of Health, Draft Mental Health Bill: Explanatory Notes, September 2004, Cm 6305-II, para 32*

16 *Department of Health, Draft Mental Health Bill, June 2002, Cm 5538-I, cl 2(3); Department of Health, Draft Mental Health Bill: Explanatory Notes, June 2002, Cm 5538-II*

17 *See, for example: Department of Health, Review of the Mental Health Act 1983: Report of the Expert Committee, November 1999; Department of Health, Reform of the Mental Health Act 1983: Proposals for Consultation, November 1999, Cm 4480*

18 *Anselm Eldergill, Mental Health Review Tribunals: Law and Practice, 1997, London, Sweet & Maxwell, p 139*

19 *See Eldergill, 1997, op cit, p 139*

20 *Eldergill, 1997, op cit, p 139*

As the MHAC has put it:

> " 'Hospitals' for the purpose of the Mental Health Act come in increasingly different shapes and sizes."[21]

Professor Eldergill suggests that:

> "[...] trying to apply the legal framework devised in 1983 for the detention, removal and transfer of patients to this new managerial system has proved difficult."[22]

There is confusion, and, as has been noted, it is unlikely to be resolved by the new Mental Health Act, which will probably replicate the existing definition of 'hospital'.

4. Competing concepts

In order to answer the question 'what is a hospital?' and make sense of the confusion that came with introduction of NHS hospital trusts, some commentators and practitioners have alighted upon two competing concepts, concepts that appear be mutually exclusive.

The result has been a certain bifurcation in professional views, which the MHAC has summarised as follows:

> "When MHA 1983 was drafted, it was thought that each 'hospital' would have a single managing body. It was not envisaged that one hospital could be divided into discrete units each of which was managed by a different body. However, now that hospitals may not be coterminous with managers, there is sometimes uncertainty as to what constitutes a hospital [...] In general, there are two schools of thought, which see a 'hospital' as: [(a)] all the buildings on a site defined by a single perimeter, even though some of those buildings may have different NHS managers than others; or [(b)] only those buildings on a particular site that are adjacent to each other and have the same NHS managers."[23]

The two schools of thought can, perhaps, be characterised as the 'wide site' concept and the 'narrow site' concept.

4.1 The wide site

The 'wide site' concept sees a 'hospital' as being defined by the largest boundary that fact or logic will allow. Like the rhinoceros, the wide site hospital is a beast that is perhaps more easy to recognise than to describe. However, where several clinical units inhabit a single site, which will usually be defined by a continuous perimeter, they will constitute a 'hospital' even though they are not all the responsibility of one NHS trust.

Adherents of the wide site concept might claim that it more truly reflects the intention of Parliament in 1983 (or 1977), because it sees a 'hospital' as being comprised of all the clinical facilities that inhabit a single site.

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21 MHAC, *Seventh Biennial Report: 1995–1997, 1997, London: The Stationery Office, para 10.10.2*

22 *Eldergill (1997), op cit, p 139. See also: Richard Jones (2003), Mental Health Act Manual, eighth edition, London, Sweet & Maxwell, para 1–208*

23 MHAC, 1999, *Issues Surrounding Sections 17, 18 and 19 of the Mental Health Act 1983, Guidance Note GN 1–99; accessible at www.mhac.trent.nhs.uk/s17.pdf . See also:* MHAC, 1997, *op cit, para 10.10.2;* MHAC, *Placed Amongst Strangers – Tenth Biennial Report: 2001–2003, 2003, London, The Stationery Office, para 9.40*

It is the wide site conception of a hospital that is favoured by the MHAC.[24] However, it is worth noting that the Commission is by no means adamant in its propagation of this view. It states:

> "The MHAC is aware that its preferred definition of 'hospital' is not shared by some commentators, and it does not insist that its preference is followed by NHS Trusts. However, every Trust should be in no doubt as to the physical limits of the hospital(s) of which it is the managers for the purposes of MHA 1983, and it should take legal advice where necessary."[25]

4.2 The narrow site

The 'narrow site' concept defines a 'hospital' by reference to its shortest logical boundary. Therefore, in the case of clinical units on a single site, it would see each of those – or, at the very least, each unit or group of units managed by a single NHS trust – as a discrete 'hospital'.

Again, however, adherents of the narrow site concept might choose to claim it as the true inheritor of the spirit of 1977 (or 1983), as it conceives of a 'hospital' as an entity under a single organ of management. This is certainly so in the case of Professor Eldergill, who says:

> "[...] the Act was drafted on the assumption that all of the wards on a single site would form a single hospital managed by a single group of managers."[26]

Professor Eldergill prefers the 'narrow site' concept. He says:

> "Although the idea that one institution can comprise two hospitals seems odd at first glance, it is no different from a block of flats within which each floor has a different legal owner. The idea only seems strange because for historical reasons such institutions are known by a single name."[27]

His submission is:

> "The context now requires that the term 'hospital' in section 145 means *that part* of an institution which is vested in an NHS trust."[28]
>
> "Where two or more NHS trusts manage different parts of an institution which is a hospital for the purposes of the National Health Service Act 1977, each separately managed part is a hospital for the purposes of the admission, detention and discharge provisions in the Mental Health Act 1983."[29]

It may be that in the first of these passages Professor Eldergill overstates the position somewhat. The *context* may be less immutable than he suggests. The physical boundaries of a patient's confinement can only be governed by the provisions that permit him/her to be confined, and as we shall see, different provisions in MHA 1983 now invoke different definitions of 'hospital'.[30] Therefore, the context in which the word is used is not everywhere the same. However, and to anticipate the chief conclusion of this paper, it would seem that the conclusion in the second of these passages is broadly correct.

Richard Jones, after re-stating the views of Professor Eldergill and the MHAC, concedes that he prefers the conception of 'hospital' that is here labelled the 'narrow site', because it is "consistent with the scheme of" MHA 1983.[31]

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24 *MHAC, 1999, op cit. See also:* MHAC, 1997, *op cit, para 3.4;* MHAC, *Eighth Biennial Report: 1997–1999, 1999, The Stationery Office, para 4.58; MHAC, 2003, op cit, para 9.40*

25 MHAC, 1999, *op cit*

26 *Eldergill, 1997, op cit, p 139*

27 *Eldergill, 1997, op cit, p 141*

28 *Eldergill, 1997, op cit, p 141 (original emphasis)*

29 *Eldergill, 1997, op cit, p 141*

30 *See, for example, para 5.1, below*

31 *Richard Jones, Mental Health Act Manual, 2003, eighth edition, London, Sweet & Maxwell, para 1–208*

In order to understand the problem fully, and also if one wishes to resolve it, it is necessary to look at its various manifestations; to consider each use of the word 'hospital' in MHA 1983 and the context in which it is used, together with the practical effects of the competing definitions.

5. Issues

What follow are not the only uses of the word 'hospital' in MHA 1983, but they are among those that are the most significant.

5.1 The consequences of admission

Under MHA 1983, a patient may be detained in the 'hospital', and only there. As far as an application for 'civil' – that is, non-criminal – confinement is concerned, section 6(2) states as follows:

> 'Where a patient is admitted [...] to the hospital specified in such an application [...], or, being within that hospital, is treated by virtue of section 5 above as if he had been so admitted, the application shall be sufficient authority for *the managers* to detain the patient in the hospital in accordance with the provisions of this Act.'[32]

With regard to patients committed to psychiatric detention by the criminal courts, section 40(1) states

> 'A hospital order shall be sufficient authority – [...] (b) for *the managers* of the hospital to admit him at any time within that period and thereafter detain him in accordance with the provisions of this Act.'[33]

In order that a patient may be confined within the permitted boundary and given free movement inside it, it is important to know the limits of the 'hospital' in which MHA 1983 authorises and compels him/her to be detained.

The wide site

If the 'wide site' conception of the word were to be applied, 'the hospital' to which it would be possible to confine a patient would have to be viewed expansively, and as consisting of all the land and buildings contained within its largest conceivable boundary.

The narrow site

If the 'narrow site' concept were to be applied, it would only be possible to confine the patient to a discrete unit, even where that unit was part of a larger medical campus. (It would, of course, be possible under MHA 1983, section 19(3) to 'remove' the patient to a second unit that was managed by the same NHS trust as the first. However, the second unit would not be part of the same 'hospital' as the first, for the section 19(3) power is to remove the patient 'to any *other* such hospital.'[34])

Discussion

It will be noted that in MHA 1983, sections 6(2) and 40(1), the power to detain a patient in the 'hospital' is given to 'the managers'. This is significant, for if one ignored the role of the managers and attempted merely to divine the one true definition of 'hospital', the 'narrow site' concept would be of equal force where the whole of a medical campus was within the management of a single NHS body. In such circumstances – and particularly so where it bore its own distinct name

32 MHA 1983, s 6(2) (emphasis added)

33 MHA 1983, s 40(1)(b) (emphasis added)

34 Emphasis added

– a psychiatric unit within a general hospital managed by a single NHS trust would be a discrete 'hospital', and its tight bounds would mark the limits within which a patient might be detained and beyond which s/he would require formal leave of absence.

However, it is to 'the managers' that the detention power is entrusted. Unlike the definition of 'hospital', that of 'the managers' *has* changed with the times.

As amended by NHS & CCA 1990,[35] and also by a subsequent statutory instrument,[36] MHA 1983, section 145 states:

> ' "[T]he managers" means –
>
> (a) in relation to a hospital vested in the Secretary of State for the purposes of his functions under the National Health Service Act 1977, and in relation to any accommodation provided by a local authority and used as a hospital by or on behalf of the Secretary of State under that Act, the Health Authority or Special Hospital Authority responsible for the administration of the hospital;
>
> (bb) in relation to a hospital vested in a Primary Care Trust or a National Health Service trust, the trust;
>
> (c) in relation to a registered establishment, the person or persons registered in respect of the establishment;
>
> and in this definition "hospital" means a hospital within the meaning of Part II of this Act.'[37]

It is submitted that this revised definition, and particularly the part contained in sub-section (bb), is hugely significant. It identifies a hospital by reference to the physical responsibilities of the NHS trust that manages it. The 'hospital' ends at the point where the trust's writ ceases to run.[38]

Sub-paragraph (bb) does not appear to contemplate the possibility that a 'hospital' will be 'vested' in more than one trust. There is, it is true, nothing to suggest that the discounting of this possibility is to be inferred, nor that it was anything more than inadvertent. Furthermore, there seems to be nothing to preclude the argument that a hospital may be vested in more than one trust. However, 'vesting' can only ever be the result of a precise legal process, and its consequences can be verified objectively. A NHS trust would know if a hospital had been vested in it (and in another NHS trust), and if it had been so vested, the NHS trust would probably know the precise physical boundaries of the hospital for which it was now responsible.

Where two or more trusts share a single site, it is unlikely that all of the hospital that site comprises can be said to be 'vested' in each of them, or that any one trust can be said to be seized of parts of the site beyond those that have been vested in it. Therefore, although it may differ from the intention of the 1983 legislators, this newer, more restricted definition of 'hospital' is by no means illogical.

If the analysis set out in this section is correct, and the definition of 'the managers' means that 'the hospital' in which a patient is detained is now to be regarded as synonymous with the NHS trust detaining him/her there, it is hard to see how the 'wide site' concept can be preferred, at least for the purposes of MHA 1983, section 6(2) or wherever in the Act powers in connection with the 'hospital' are provided for the use of 'the managers'.

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35 *NHS and CCA 1990, s 66(1)*

36 *The Health Act 1999 (Supplementary, Consequential, etc., Provisions Order 2000, SI 2000 No 90, Sched 1, para 16(3)*

37 *MHA 1983, s 145(1)(a)*

38 *The new Draft Bill contains provisions to much the same effect. See: Department of Health, Draft Mental Health Bill, September 2004, Cm 6305–I, cl 2(4)*

Whether the word 'hospital' – which must be assumed to have been intended in 1983 to have a common meaning wherever it occurred in the Act – may now be given different, possibly contradictory, meanings is open to dispute, but the possibility seems remote. However, there are occasions when the use of the word 'hospital' in provisions of the MHA 1983 does not coincide with a reference to "the managers".

5.2 Conveyance to the hospital

MHA 1983 contains various powers to convey a patient to the 'hospital' in which s/he is to be detained. Thus, in the case of a 'civil' patient, section 6(1) states:

> 'An application for the admission of a patient to a hospital under this Part of this Act, duly completed in accordance with the provisions of this Part of this Act, shall be sufficient authority for the applicant, or any person authorised by the applicant, to take the patient and convey him to the hospital [...].'

As far as offender patients are concerned, section 40(1)(a) states:

> 'A hospital order shall be sufficient authority – (a) for a constable, an approved social worker or any other person directed to do so by the court to convey the patient to the hospital specified in the order within a period of 28 days [...].'

Unless those conveying the patient know what the 'hospital' comprises to which s/he may be conveyed, they cannot know how far s/he must be carried and where on a particular medical campus s/he may be deposited.

The wide site

If the 'wide site' concept is accepted, a patient need be conveyed only to the first boundary of the overall hospital site, even if the physical limits of the mental health unit in which s/he is to be confined lay some way inside that boundary.

The narrow site

The 'narrow site' concept would require that the patient were taken onto the hospital site and deposited only at the door of the psychiatric unit. If s/he were to attain his/her liberty at an earlier point, the only power of confinement that might be exercised over him/her would be the one contained in MHA 1983, section 137(1) and (2) (which deals with the 'Provisions as to custody, conveyance and detention').

Discussion

On the face of it, there is nothing to preclude use of the 'wide site' concept in connection with MHA 1983, sections 6(2) or 40(1)(a). In neither case is the power to convey provided for the use of 'the managers'; indeed, it is clear that a wider range of statutory actors may exercise that power, including some individuals whose authority doesn't simply derive from the managers.

However, it is unlikely that the law would allow a multiplicity of definitions of the same word in a single Act. Therefore, in view of the comments made in connection with the power to detain,[39] one is probably forced back onto the narrow site conception.

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39 *See paragraph 5.1*

5.3 Detention in the hospital

The power to detain a patient under the civil provisions of MHA 1983 is also expressed in terms of 'a hospital'.

To some extent, MHA 1983, section 2(1) – which permits a patient's admission to hospital for assessment – replicates the power contained in MHA 1983, section 6(2). It states:

> 'A patient may be admitted to a hospital and detained there for the period allowed by subsection (4) below in pursuance of an application (in this Act referred to as "an application for admission for assessment") made in accordance with subsections (2) and (3) below.'

The same is true of MHA 1983, section 3(1) – the power to admit a patient to hospital for treatment – which states:

> 'A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for admission for treatment") made in accordance with this section.'

The wide site

Acceptance of the 'wide site' concept would mean that a patient would be regarded as being still within 'the hospital' whenever he remained on the campus within which his psychiatric unit was contained, and even though he had left the unit itself behind him.

Moreover, where he was first detained in a part of the hospital that did not provide mental health care and treatment, he would also be regarded as having been admitted under section to that part of the campus that provided psychiatric care. The two would be of a piece, and, because he was simply swapping one part of 'the hospital' for another, his movement between them would be possible without any degree of formality. This would impact upon the need to invoke the power of transfer in MHA 1983, section 19[40] or the power to grant formal leave of absence under section 17.[41]

The narrow site

Adoption of the 'narrow site' conception of 'hospital' would mean that a patient detained in the 'general' part of a health care campus would not be regarded as having also been admitted to the psychiatric part. The two would have to be seen as entirely discrete units, and the patient would need formal leave or transfer in order to move to the psychiatric part while still subject to MHA 1983. For the reasons that follow, it is probably the narrow site concept that must prevail.

Discussion

Although they are not mentioned in MHA 1983, section 2 or 3, it is clear that the powers of detention referred to there are to be utilised by 'the managers'. MHA 1983, section 6(2), which has been discussed already,[42] states:

> 'Where a patient is admitted [...] to the hospital specified in such an application [...], or, being within that hospital, is treated by virtue of section 5 above as if he had been so admitted, the application shall be sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions of this Act.'[43]

40 *See paragraph 5.7*
41 *See paragraph 5.5*
42 *See paragraph 5.1*
43 *MHA 1983, s 6(2)*

Therefore, arguments made about detention under MHA 1983, sections 6(2) or 40(1)(b) would appear to have equal force here. It would seem that one is forced to adopt the 'narrow site' concept in this case, or at least to proceed as though it had been adopted. The same goes for admissions pursuant to an 'emergency application' under section 4, which also give rise to a power to detain that is governed by MHA 1983, section 6(2).

5.4 Holding a patient in the hospital

One of the greatest controversies about the meaning of 'hospital' has concerned the use of the 'holding powers' contained in MHA 1983, section 5(2) and (4).

Under MHA 1983, s 5(2):

> 'If, in the case of a patient who is an in-patient in a hospital, it appears to the registered medical practitioner in charge of the treatment of the patient that an application ought to be made under this Part of this Act for the admission of the patient to hospital, he may furnish to the managers a report in writing to that effect; and in any such case the patient may be detained in the hospital for a period of 72 hours from the time when the report is so furnished.'

MHA 1983, s 5(4) states:

> 'If, in the case of a patient who is receiving treatment for mental disorder as an in-patient in a hospital, it appears to a nurse of the prescribed class – (a) that the patient is suffering from mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital; and (b) that it is not practicable to secure the immediate attendance of a practitioner for the purpose of furnishing a report under subsection (2) above – the nurse may record that fact in writing; and in that event the patient may be detained in the hospital for a period of six hours from the time when that fact is so recorded or until the earlier arrival at the place where the patient is detained of a practitioner having power to furnish a report under that subsection.'

The authority provided by MHA 1983 section 5(2) may be used to detain 'a patient who is an in-patient in a hospital'. In such circumstances, the section states, "the patient may be detained in *the* hospital."[44] It seems reasonable to infer that s/he may be detained only in the hospital in which s/he is already an in-patient (whatever the extent of that 'hospital' might be).

The authority provided by MHA 1983 section 5(4) is for a patient's detention within the 'hospital' in which s/he is 'receiving treatment for mental disorder as an in-patient.'

These powers are of particular relevance in the case of a patient accommodated on a general medical ward who appears to be suffering from mental disorder. If the two are not to be considered part of the same 'hospital', a patient may not be moved from a general ward to a psychiatric ward while remaining detained under MHA 1983, section 5. Neither may MHA 1983, section 19 be used to transfer him/her to another 'hospital', for the relevant provisions in section 19(1)(a) and (2)(a) apply only to 'a patient who is for the time being liable to be detained in a hospital by virtue of *an application* under this Part of this Act.'[45] A patient who is subject to one or other of the holding powers is not so subject 'by virtue of an application'. Therefore, the only solution would appear to be to apply for the patient's substantive admission to the psychiatric unit under MHA 1983, section 2 or 3 while s/he was still held on the general ward under section 5(2) or (4).

44 *Emphasis added*

45 *Emphasis added*

Professor Eldergill has suggested that it was at first assumed that a patient who nevertheless remained subject to MHA 1983, section 5(2) or (4) might be moved from one hospital to another, provided s/he was detained throughout the permitted 72-hour period by a single set of managers.[46] Now, however, when not just different medical units but different wards within those units might be under different management, that assumption no longer holds good. There is, Professor Eldergill suggests, a paradox, which can be summarised as follows:

(i) to allow movement without formality between different NHS trusts may perpetuate the freedoms that existed before the NHS & CCA 1990, but it also contradicts the statutory principle that the authority to detain a patient cannot be transferred to different hospital managers; however

(ii) the prohibition of such movement "is inconsistent with the original statutory assumption, expressed in section 145(1), that one institution equals one hospital."[47]

Therefore, Professor Eldergill submits:

> "Patients detained on a general ward under section 5(2) may not be removed to a psychiatric ward under section 19(3) if that ward is separately managed. Nor can the authority to detain them be transferred to another NHS trust under section 19(1). [...] In extreme cases, their removal may be justified under common law and recourse may be had to section 4."[48]

In fact, it is unlikely that use of the common law to transfer a patient from a psychiatric ward to the ward in a 'general' hospital where s/he might receive treatment for a cardiac arrest (for example) is confined to extreme cases. If, being capable, the patient is an adult who consents to such a transfer, it will be lawful; the same will be true in the case of an incapable adult patient, provided the treatment is in his/her 'best interests'.[49]

Professor Eldergill's conclusion is doubtless correct, but for at least one reason that he does not give. It is a reason that this paper has discussed already.[50]

The wide site

It might be argued that on the strict wording of MHA 1983, section 5(2) or (4), the detention permitted is detention in 'the hospital', and therefore that if the 'wide site' concept is adopted, a patient detained under either of those provisions in the psychiatric part of a much larger hospital site might be moved to the general part while still subject to MHA 1983, section 5(2) or (4), even though the general part and the psychiatric part are managed by different NHS trusts.

Whilst superficially engaging, this analysis cannot withstand a detailed analysis of the full ambit of the power. Although they are not mentioned in MHA 1983, section 5(2) or (4), it is clear that the power of detention referred to there is to be utilised by 'the managers'. As been stated,[51] MHA 1983, section 6(2) states:

> 'Where a patient is admitted [...] to the hospital specified in such an application [...], *or, being*

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46 *Eldergill, 1997, op cit, p 140*

47 *Eldergill, 1997, op cit, p 140*

48 *Eldergill, 1997, op cit, p 141*

49 *F v West Berkshire Health Authority and another (Mental Health Act Commission intervening) [1989] 2 All ER 545; Re T (Adult: Refusal of Medical Treatment) [1992] 4 All ER 649, CA, per Lord Donaldson MR; Re MB (Medical Treatment) [1997] 2 FLR 426, CA; R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998] 3 All ER 289, [1999] 1 AC 481*

50 *See para 5.1, Discussion*

51 *See paragraph 5.1*

> *within that hospital, is treated by virtue of section 5 above as if he had been so admitted*, the application shall be sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions of this Act.'[52]

Therefore, arguments made about detention under MHA 1983, sections 6(2) or 40(1)(b) would appear to have equal force here. It would seem that one is forced to eschew the 'wide site' concept in the case of patients detained in a hospital under MHA 1983, section 5(2) or (4).

The narrow site

On the basis of the foregoing, it must be assumed that the MHA 1983 powers of transfer will not apply to a patient while s/he is detained under MHA 1983, section 5(2) or (4), and that, if they have different 'managers', s/he may be moved from the psychiatric to the general part of a hospital only: (i) once s/he has been detained under a substantive section of MHA 1983; (ii) if s/he is incapable, in his/her 'best interests' under the common law doctrine of 'necessity'; or (iii) if s/he is capable, with his/her consent.

5.5 Leave to be absent from the hospital

A patient who is subject to MHA 1983 need not remain forever confined to the hospital to which s/he is detained. Under section 17(1),

> 'The responsible medical officer may grant to any patient who is for the time being liable to be detained in a hospital under this Part of this Act leave to be absent from the hospital subject to such conditions (if any) as that officer considers necessary in the interests of the patient or for the protection of other persons.'[53]

It is in connection with this provision that Richard Jones deals with the definition of 'hospital' at most length. He states:

> 'A particular difficulty has arisen where a single hospital site contains a psychiatric and a general facility and the two facilities are administered by different NHS Trusts. In this situation, should a detained patient who needs treatment for a physical disorder at the general facility be sent to that facility under the authority of section 17 leave? As this Act was not drafted in contemplation of NHS trusts, the answer to this question is not easy to determine.'[54]

The question of whether it will be *necessary* to grant a patient leave to move from one ward, managed by one set of managers, to another ward, managed by a different set of managers, even though the two are on the same wide site, is not one that is created by MHA 1983, section 17, for that provision is entirely permissive.

In fact, the question is raised as a result of MHA 1983, section 2 or 3 (or section 37), which, as has been pointed out above, state that a patient may be detained in – but only in – the 'hospital' to which an admission application is made. In that context, the provisions in MHA 1983, section 17 for the giving of formal leave to be absent from the hospital are the solution to this problem. However, wherever a patient is detained under the Act, it becomes necessary to ask, not so much *when* s/he must be granted leave, but *how far* s/he may venture without it becoming necessary at all.

For the purposes of MHA 1983, the place within which the patient is detained is the 'hospital'.

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52 *MHA 1983, s 6(2) (emphasis added)*

53 *MHA 1983, s 17(1)*

54 *Richard Jones, 2003, op cit, para 1–208*

The narrower the confines of that place, the greater is likely to be the need for formal leave of absence, granted under MHA 1983, section 17, for it is only with such leave that a detained patient may leave 'the hospital'.

The wide site

If the 'wide site' concept were adopted, a patient would not need formal leave to move within the greater hospital site, even though the discrete unit in which s/he was detained only occupied a part of that site and was managed by a NHS trust that did not manage the whole site.[55] (However, s/he *would* still require such leave if, in making his/her passage across the greater hospital site, s/he would encounter a phenomenon for which none of the NHS trusts in whom various parts of that site were vested was responsible in law. This would be the case, for example, where a detained patient's journey from a psychiatric ward to a newsagent's stall, each of which were situated within a single hospital site, would take him/her across a public road.)

Richard Jones has identified a flaw in the 'wide site' conception in so far as it is applied to MHA 1983, section 17. He states:

> '[I]f the patient moves from a part of the hospital that is managed by the NHS trust that is detaining him to a part of the hospital that is managed by another NHS trust, the staff of that other trust would not be authorised to detain him. This is because the application for the patient's detention would not have been addressed to the Hospital Managers of that other trust.'[56]

The MHAC has said that it accepts this argument 'in part.' However, it continues:

> 'Even in a Trust that is a detaining authority, staff employed in capacities that are neither nursing nor medical probably have limited powers of control over detained patients. The Act does allow that any "officer on the staff of the hospital" (the definition of which encompasses any employee of a detaining hospital) may take into custody and return an AWOL patient under section 18(1), and may be authorised by a patient's RMO to act as that patient's escort as a condition of leave (section 17(3)).'[57]

This would not appear to address Jones's specific point: what powers are to be enjoyed by doctors and nurses employed, not by the detaining authority, but by the NHS trust that manages another part of the same 'hospital' site? Are they 'on the staff of' the detaining 'hospital', as the 'wide site' concept would appear to imply, or can they utilise the take and return powers in section 18 only if they have been expressly authorised to do so, as the 'narrow site' conception implies? The MHAC does not answer this question, nor does it say which part of Jones's argument it accepts (and which it rejects).

The narrow site

As the MHAC has put it, the implication of adopting the 'narrow site' concept would be that:

'[...] formal leave would be required under MHA 1983, section 17 for a patient to move from a part of the hospital site that was managed by one NHS body to a part of the site that was managed by another NHS body.'[58]

55 *See* MHAC, 1999, *op cit*

56 *Jones, 2003, op cit, para 1–208*

57 MHAC, 2003, *op cit, para 9.42*

58 MHAC, 1999, *op cit*

Discussion

Clearly the question is not without practical significance: a Trust that adopted the wide site concept might deny itself powers of control that it ought in fact and law to possess; whereas inappropriate insistence on the narrow site conception might open a Trust up to judicial challenge.

The intricacies of the former situation have been discussed already.[59] With regard to the latter situation, a patient might have a cause of action against those who detained him/her if s/he were prevented from going from one part of the greater hospital site to another solely because, on the basis of the 'narrow site' test, s/he was thought to require formal leave of absence and his/her mental state was not thought robust enough to warrant the granting of it.

This is the mirror image of the problem encountered under MHA 1983, sections 6(2) and 40(1)(b). It concerns, not how closely a patient may or must be confined, but how far s/he may venture without requiring formal leave of absence. However, and as has been indicated, in truth this problem is created by MHA 1983, sections 2 and 3. That is important, because, unlike MHA 1983 section 6(2) or 40(1)(b), neither section 2 nor section 3 involves 'the managers'. This means that the word 'hospital' stands alone for the purposes of those sections. Therefore, the word is unqualified, so that there is nothing to prevent its being given a wider definition. Nothing, that is, save the general illogicality of having the same word defined in two different – possibly contradictory – senses at different points in the same Act.

5.6 The returning of a patient to the hospital

Detained patients who go absent without leave ('AWOL') may be retaken and returned to the hospital from which they have absconded. Under MHA 1983, section 18:

> 'Where a patient who is for the time being liable to be detained under this Part of this Act in a hospital –
>
> (a) absents himself from the hospital without leave granted under section 17 above; or
>
> (b) fails to return to the hospital on any occasion on which, or at the expiration of any period for which, leave of absence was granted to him under that section, or upon being recalled under that section; or
>
> (c) absents himself without permission from any place where he is required to reside in accordance with conditions imposed on the grant of leave of absence under that section,
>
> he may, subject to the provisions of this section, be taken into custody and returned to the hospital or place by any approved social worker, by any officer on the staff of the hospital, by any constable, or by any person authorised in writing by the managers of the hospital.'[60]

There are two aspects of this provision to which the definition of 'hospital' is relevant: determining the point at which a detained patient becomes AWOL; and identifying the individuals who may re-take him/her.

The wide site

Under the 'wide site' conception of 'hospital', a patient might be re-taken and returned there by a larger number of staff, the pool of whom might include those from all units on a single site, even

59 *See para 5.1*

60 *MHA 1983, s 18(1)*

if those units were managed by different NHS Trusts. However, there would be fewer cases in which such a patient would be AWOL, as, if s/he wandered away from the psychiatric unit into the grounds of a 'general' hospital that, though it was managed by a different NHS trust, was contiguous with the grounds of the psychiatric unit, s/he would not have left the 'hospital' that both units comprised.

The narrow site

The patient would be AWOL immediately s/he left the grounds for which the NHS trust that managed the psychiatric unit was responsible. S/he could only be re-taken by someone 'on the staff of' the psychiatric unit.

Discussion

The power to authorise persons to retake a patient who has gone AWOL is granted solely to 'the managers', and so must be taken to be exercisable only by the NHS trust in which is vested the premises in which the patient is liable to be detained.[61]

However, there is nothing in MHA 1983, section 18 to limit the substantive power to re-take a detained patient to 'the managers': it may be exercised by, *inter alia*, 'any officer on the staff of the hospital.' There is, of course, now some uncertainty as to what the word 'officer' means, and in particular, whether it includes an employee who has no managerial involvement in his employer's affairs.[62] That uncertainty apart, there is nothing in the wording of the statute itself to prevent a wider conception of 'hospital' being adopted and a wider pool of possible patient-takers being created. However, such a course would be inconsistent with the approach that, it would seem, must be taken in respect of other manifestations of the word 'hospital'. It has already been suggested that it would be curious if contradictory definitions of the word were permitted to co-exist within a single Act; it is surely the more so in the case of a single section of an Act.

5.7 Transfer from the hospital

The transfer of a detained patient from one hospital to another is dealt with in MHA 1983, section 19(1), which states:

> 'In such circumstances and subject to such conditions as may be prescribed by the Secretary of State –
>
> (a) a patient who is for the time being liable to be detained in a hospital by virtue of an application under this Part of this Act may be transferred to another hospital [...].'

Once a transfer has been effected in accordance with MHA 1983, section 19(1)(a), section 19(2) provides:

> '(a) in the case of a patient who is liable to be detained in a hospital by virtue of an application for admission for assessment or for treatment and is transferred to another hospital, as if the application were an application for admission to that other hospital and as if the patient had been admitted to that other hospital at the time when he was originally admitted in pursuance of the application[.]'

61 *See paragraph 5.1*

62 *R (on the application of PD) v West Midlands and North West Mental Health Review Tribunal [2004] EWCA Civ 311, per Lord Phillips MR at paras 22–25*

(Where, in the case of hospitals that are incontrovertibly distinct, they are nevertheless under the management of a single NHS trust, a detained patient may be transferred between them without formality under MHA 1983, section 19(3).[63] This possibility is considered in section 5.1, above.)

The wide site

Adoption of the 'wide site' concept would imply that a patient wouldn't leave the 'hospital' – and therefore would not need to be formally transferred under MHA 1983, section 19 – where all s/he did was quit one ward or unit on a larger medical campus for another, even though the latter ward or unit was managed by a different NHS trust than to the former.

The narrow site

The 'narrow site' concept would require that a transfer of the kind described above be made with formality, under MHA 1983, section 19.

Discussion

Once s/he has been transferred to a new hospital under MHA 1983, section 19(1), a patient's detention is to be regarded as always having been in that hospital.[64] Therefore, it is assumed, the managers of the new hospital will find their authority to detain him/her in the same provision that would have protected the managers from whom the patient has been received – in other words, in MHA 1983, section 6(2). This, it will be recalled, permits 'the managers to detain the patient in the hospital in accordance with the provisions of this Act.' However, in this context, the managers 'in relation to a hospital vested in a Primary Care Trust or a National Health Service trust' is merely 'the trust'.[65] Therefore, to apply the argument that has been already advanced,[66] whatever the institution to which the patient has been transferred, it would seem that it is only the NHS trust in which that institution is 'vested', and not a NHS trust responsible for another part of the site on which that institution is situated, that might detain him/her thereafter. Once again, the 'narrow site' concept must be introduced, even if only at arm's length.

5.8 Recommending that a patient be admitted to hospital

There is one other use of the word 'hospital' that should be addressed. It is different to the other uses described in this paper.

In section 12(3), MHA 1983 deals with the medical recommendations that must support an application for a patient's admission to hospital. The section states:

> 'Subject to subsection (4) below, where the application is for the admission of the patient to a hospital [...], one (but not more than one) of the medical recommendations may be given by a practitioner on the staff of that hospital [...].'

This provision creates a conundrum that is, perhaps, the mirror image of those discussed above, for the wider the concept of 'hospital' that one applies the more one reduces one's room for manoeuvre.

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63 *As amended by NHS & CCA 1990, s 66(1) and Sched 9, para 24(2), and by The Health Act 1999 (Supplementary, Consequential, etc., Provisions) Order 2000, SI 2000 No 90, Sched 1, para 16(3)*

64 *MHA 1983, s 19(2)(a)*

65 *MHA 1983, s 145(1)(a)*

66 *See para 5.1*

As to which concept of 'hospital' is to be preferred, the MHA 1983 Code of Practice is of no practical assistance. All it says is:

> "Where a Trust manages two or more hospitals which are in different places and have different names[,] one of the two doctors making the medical recommendations may be on the staff of one hospital and the second doctor may be on the staff of one of the other hospitals."[67]

In the situations discussed in this paper, the hospitals – insofar as the plural is the appropriate form to use – are not in different places, but on the same site, and they are not managed by the same NHS trust.

The wide site

The effect of MHA 1983, section 12(3) is to require at least one of the recommendations supporting a patient's detention to be provided by a medical practitioner who is not on the staff of the hospital in which s/he is detained. Clearly, therefore, if one conceives of the hospital in broad terms, one may reduce the pool of practitioners who may be called upon to assist.

The narrow site

If the hospital is conceived of as a small entity, the number of practitioners outside it – and therefore not on its staff – will be that much greater than if one were to conceive of it as a large thing.

Discussion

As it is used in MHA 1983, section 12(3), the term 'hospital' is not linked to 'the managers', and therefore, there would seem to be nothing to require the narrow reading of the former term that is required by the up-dated definition of the latter term.

However, and as discussed before, it would seem to be unlikely that one and the same word might have different, contradictory meanings at different places in the Act. The word 'hospital' must probably be taken to mean the same wherever it appears. If so, the 'narrow site' concept will have to prevail, and the larger will become the number of doctors who may provide the second recommendation for a patient's detention under MHA 1983.

5.9 A specific hospital

There is at least one situation to which the foregoing discussion is irrelevant. Under the Crime (Sentences) Act 1997, when sending to a hospital a patient who is subject to restrictions, the Courts or the Home Secretary may direct that s/he be detained in a *specific* unit or part of that hospital[68]. This element of specificity goes beyond anything provided for in MHA 1983.

6. Summary

The argument advanced in this paper may be reduced to a number of propositions:

(a) It is now necessary to attempt to apply the Mental Health Act 1983 in situations very different from those anticipated by the Act's first framers.

(b) This is especially so when one is dealing with a provision that relates to 'a hospital'.

(c) It is unhelpful to attempt to divine the true meaning of the word; the entity that was called 'a

67 *Department of Health and Welsh Office, MHA 1983 Code of Practice, 1999, para 2.30*

68 *Crime (Sentences) Act 1997 s.47. Also, see Home Office Circular 52/1997, paras 10–12*

hospital' in 1983 has, for the most part, ceased to exist.

(d) In any case, the task cannot be carried out in the abstract; one must define the word according to the context in which it is used and with regard to the powers with which it is associated in a particular case.

(e) The existing definition of 'hospital' does not correspond to modern practice.

(f) However, other terms – for example, 'the managers' – *have* been revised in to take account of changed circumstances.

(g) Wherever the term 'the managers' is used in conjunction with 'hospital', the more restrictive definition of that term introduced by the National Health Service & Community Care Act 1990 would seem to require that the 'narrow site' concept of 'hospital' be adopted. Therefore, and must crucially:

  (i) a patient who is subject to MHA 1983 may only be confined within the boundary that marks the limit of the responsibilities of the NHS trust that confines him;

  (ii) formal leave of absence will be required if s/he is to cross that boundary;

  (iii) a patient who is subject to the section 5 holding power may only be moved within the 'hospital' managed by the Trust whose doctor or nurse applied that power to him/her.

(h) There is nothing in MHA 1983 to require adoption of the 'narrow site' concept of 'hospital' in cases where it is not qualified by mention of 'the managers', but it is unlikely that two competing conceptions of the word could be allowed to co-exist in one statute.

7. Conclusion

Sadly, the definition of hospital that is provided by the Mental Health Act 1983 is neither more clear nor more helpful than the one given by Leslie Nielsen in Airplane! However, as this paper has attempted to explain, there was one respect in which his otherwise admirable reply got it wrong: right now, the question is important.

If we base our argument on an attempt to divine the true meaning of "hospital" as it is used in MHA 1983, we could go on arguing forever. It has not been revised in the light of significant changes to the way mental health services are configured, and it is now hopelessly out of date.

However, some areas of MHA 1983 have been revised to take account of those changes. They include the definition of 'the managers' in MHA 1983, s 145. The amendments to this definition that were made in 1990, coupled with the failure to make such amendments to the definition of 'hospital', suggest that it was the government's intention that, at least in so far as concerns the power of detention (and the other powers specifically endowed upon 'the managers'), they should be exercisable by each discrete NHS trust in – and only in – the premises for which it was responsible. This paper has, perhaps, provided the least equivocal evidence for supposing that that is so.

As they wrestle with the competing conceptions set out here, mental health practitioners might draw some small comfort from the fact that, no matter how wide their conception of a 'hospital', its bounds could never approach the dimensions of those suggested by Sir Thomas Browne.[69] He said:

> "For the world, I count it not an inn, but an hospital, and a place, not to live, but to die in."[70]

69 1605–1682

70 Religio Medici (1647), part ii, 11

Psychiatric advance decisions – an opportunity missed

Dr Tim Exworthy*

After a very long gestation the *Mental Capacity Bill*[1] (the *Bill*) was published earlier this year. Among its proposals was the incorporation into statute of advance decisions. These are devices whereby a person, while retaining capacity, can make certain decisions regarding their future treatment for such a time as they have lost capacity and so are unable to make legally binding decisions about their own treatment. As the *Bill* is phrased, advance decisions (ADs) only permit a person to refuse treatment. There is no provision for that person to use ADs to express a positive preference for particular forms of treatment. It will be argued this represents a missed opportunity to allow patients and clinicians to engage in a more constructive approach to treatment planning. Experience from the USA demonstrates psychiatric advance directives (PADs) have a role to play in engaging psychiatric patients and promoting adherence to their treatment plans.

This paper will only address the use of AD in relation to mental health treatment, although it is recognised they have an application far wider than this, including decisions regarding life-sustaining treatment.

Background to the Mental Capacity Bill

The process of delivering a statute codifying the law relating to the assessment and treatment of people lacking capacity dates back to 1989, when the Law Commission embarked on '*an investigation into the adequacy of the legal and other procedures for the making of decisions on behalf of mentally incapacitated adults*'[2]. This programme had been initiated following a Law Society discussion document[3] and then the judgment in *Re F*,[4] which highlighted the lacuna in English law that '*no procedure [exists] whereby any other person or court can take a medical decision on behalf of an adult patient without capacity to take that decision*'.[5]

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1 *Department of Constitutional Affairs (2004) Mental Capacity Bill. Bill 120. London: The Stationery Office.*

2 *Law Commission (1989) Fourth Programme of Law Reform: Mentally incapacitated adults. Law Com No 185 Cm 800; as summarised in Law Commission (1995) Mental Incapacity. Law Com No 231; at para 1.1.*

3 *Law Society's Mental Health sub-Committee (1989) Decision Making and Mental Incapacity: A discussion document. London: Law Society.*

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

5 *Law Commission. (1995) Mental Incapacity. Law Com No 231; at para 1.4.*

In the interim there have also been two significant cases focussing on the question of refusal of treatment for physical conditions. *Re T*[6] involved a young woman, Miss T, who was 34 weeks pregnant when she was involved in a car accident. She was admitted to hospital and some time later went into labour, which led to an emergency Caesarian section. Thereafter, Miss T's condition deteriorated and she was admitted to the intensive care unit. The consultant anaesthetist would normally have given Miss T a blood transfusion but, on this occasion, was reluctant to do so because Miss T had twice told clinical staff she did not want a blood transfusion. Both instances had occurred shortly after Miss T had had a private conversation with her mother, who was a Jehovah's Witness. Although Miss T had been brought up by her mother after her parents separated, she was not an adherent to that faith and it was contended Miss T had made her pronouncements under the influence of her mother. Miss T's father applied to the court for a declaration as to whether it would be lawful to give her the blood transfusion that was thought necessary to save her life.

The court of first instance authorised the blood transfusion and held Miss T had neither consented nor refused the transfusion in the emergency that had arisen. To proceed with the transfusion was seen to be acting in her best interests. The case went to the Court of Appeal after Miss T appealed but the importance of providing '*guidance to hospital authorities and to the medical profession on the appropriate response to a refusal by an adult to accept treatment*'[7] was also recognised.

In his leading judgment, Lord Donaldson, MR, held that

> '*Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent. ...... However, the presumption of capacity to decide, which stems from the fact that the patient is an adult, is rebuttable.*'[8]

He also emphasised that '*an adult patient who ... suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered*'.[9] *Re T* was concerned with refusal of the medical treatment proposed but this did not exclude the possibility of any patient giving consent to the future administration of treatment in particular circumstances.

The case of *Re C*[10] involved a man suffering from chronic paranoid schizophrenia who developed gangrene in his right foot. His surgeon advised amputation of the lower leg as he considered death was imminent without such radical surgery. C refused to consent to such a procedure but did agree to more conservative treatment. Faced with the possibility of a recurrence of the gangrene, C sought an undertaking, in vain, that the hospital would not amputate his leg in any future circumstances. C then approached the High Court seeking an injunction to prevent the hospital operating at that time or in the future without his consent. Judgment from Thorpe, J. confirmed a capacitous patient's entitlement not only to refuse the proposed treatment but also his right to have such a refusal respected in the future even if he should become incapacitated in the meantime.

6 *Re T (adult: refusal of medical treatment) [1992] 4 All ER 649.*

7 *Ibid, per Lord Donaldson, MR, at 660.*

8 *Ibid, at 664. See also Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] 1 All ER 643, per Lord Templeman at 666.*

9 *Ibid, at 652–3.*

10 *Re C (Refusal of medical treatment) [1994] 1 All ER 819.*

The Law Commission's final report[11] in 1995 considered '*Advance Statements about Health care*'[12] and distinguished between '*an advance expression of views and preferences .... and an advance decision..*'.[13] It pointed out many model advance directives take the form of anticipatory consent to types of treatment in relation to physical conditions.[14] Indeed, surgery under general anaesthesia, except in an emergency situation, requires an anticipatory decision to consent to the proposed procedure.[15] The Law Commission also made the point that case law in this area will focus on advance decisions to refuse particular forms of treatment, since if the person has already consented, prior to losing capacity, to the type of treatment the treating physician later wishes to administer, there will be no dispute and the treatment will be given. However, this presupposes there is no conflict between the treatment specified by the patient and the treatment considered appropriate by the physician. For example, both patient and psychiatrist may agree on the desirability of restarting antipsychotic medication but while the former is only willing to consider oral medication the latter may believe the long acting preparations given by depot injections are necessary.

Advance consent is considered in three paragraphs with the remaining 25 being concerned with advance refusals of treatment. The Commission's Report does argue that '*to maintain the effect of the present law* (by incorporating the judgments of *Re C* and *Re T* into statute) *is consistent with our policy aim of enabling people to make such decisions as they are able to make for themselves*'.[16] This appears to sidestep the issue of advance consent although does not exclude it. Patients with capacity are able to make decisions to give consent as well as to refuse treatment options. The common law, however, would recognise the latter but not the former as an advance decision.

Advance Statements in England and Wales

The General Medical Council (GMC) acknowledges capacitous adult patients '*can express their wishes about future treatment in an advance statement*' but notes only a valid advance refusal of treatment is legally binding.[17] It makes no distinction between treatment for physical and mental disorders.

The British Medical Association (BMA) has drawn up a Code of Practice on advance statements.[18] It recognises that accommodating a patient's views, values and attitudes about his treatment is both fundamental to good practice but also a curb on clinical decision-making. Advance statements can take many forms, varying from a general description of a person's preferences and belief systems to a clear instruction not to provide certain treatments (advance directive). However, any advance statement is limited by existing statute and so could be overridden by the provisions permitting

11 *Ibid. This report had been preceded by four consultation papers published in 1989 (1) and 1993 (3).*

12 *Op cit Note 5. Law Commission 1995, Part V.*

13 *Ibid; at para 5.1. This is later expanded on (at para 5.10) and the difference between 'anticipatory decisions' and mere statements of wishes made in advance of the person's loss of capacity is emphasised.*

14 *Ibid; at para 5.11.*

15 *Francis, R. and Johnston, C. Medical Treatment: Decisions and the Law. (2001). Butterworths: London; at p22.*
Technically all consents or refusals are given in advance of the proposed treatments, albeit the period between consent and providing the treatment is almost always very short. 'Treatment without consent or despite a refusal of consent will constitute the civil wrong of trespass to the person and may constitute a crime' – Lord Donaldson in Re T at 653.

16 *Op cit Note 5; at para 5.16.*

17 *General Medical Council (2002) Withholding and withdrawing life-prolonging treatments: Good practice in decision-making. London: GMC.*

18 *British Medical Association (1995) Advance Statements about medical treatment – Code of Practice. London: BMA.*

compulsory treatment for mental disorder under the Mental Health Act 1983. Such statements also cannot direct a clinician to act in a manner that is harmful, illegal, inappropriate to accepted clinical practice or contrary to their conscience.

In psychiatry, clinical guidelines for the treatment of schizophrenia, commissioned by the National Institute for Clinical Excellence (NICE), have advocated '*advance directives about the choice of medication*' should be filed in patients' records.[19] This would permit positive choices as well as refusal of particular medication to be documented. The report's actual recommendations withdraw from this absolute position, recognising '*there are limitations with advance directives regarding the choice of treatment for individuals with schizophrenia*' but encouraging they are developed as part of the care programme.[20] The nature of those limitations is not spelt out in the report.

Judging by the published research there is little practical experience of the use of advance statements or directives in psychiatry. One group, at the Maudsley Hospital, London, encouraged the use of 'crisis cards' among known psychiatric patients.[21] 'Crisis cards' record, among other details, a patient's current treatment and '*preferences in anticipation of a later occasion when the patient might be too ill to express them directly*'. The cards were drawn up in discussion with the patient's clinical team so as to produce an agreed plan of action to manage the next crisis for the patient. 65% of patients stated certain treatment preferences and 53% made advance refusals of specific medication. At follow up one year later the rate of hospital admission for this group of patients had been reduced by 30% and the researchers also commented on the psychological benefits to the patients accruing from working collaboratively with the psychiatric services. However, another research team, also in London, found that patients who had completed an '*advance directive*' did not have a lower readmission rate compared to patients without such a document.[22] As Geller has pointed out, these were not '*directives*' but rather '*preference statements*' and this may account for the lack of a demonstrable reduction in readmission rates.[23] While more research is required to isolate the '*active ingredient(s)*' in such documents, Geller's comments highlight a problem: the literature is replete with examples of loose terminology in this area. Advance statements may be decisions, or directives or simply a record of certain preferences by the patient. As such they contain differing blends of collaboration, directive force and import.

The interpretation of ADs may also be problematic. In one study health professionals, presented with a hypothetical vignette concerning a patient with dementia, came to very different conclusions as to how to proceed.[24] Those who chose to override the AD seemed to be prepared to make subjective interpretations on quality of life issues when to uphold the AD was regarded as not being in the patient's best clinical interests. The authors cautioned that anyone completing

19 *National Collaborating Centre for Mental Health (2003) Schizophrenia: Full national clinical guidelines on core interventions in primary and secondary care. London: Gaskell and the British Psychological Society. At para 7.10.3.*

20 *Ibid; at para 7.10.4.*

21 *Sutherby, K., Szmukler, G.I., Halpern, A. et al (1999) A study of 'crisis cards' in a community psychiatric service. Acta Psychiatrica Scandinavica* 100*, 56–61.*

22 *Papageorgiou, A., King, M., Janmohamed, A. et al (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. British Journal of Psychiatry,* 181*, 513–519.*

23 *Geller, G.L. (2003) Advance directives about treatment preferences had little impact on compulsory readmissions for people with serious mental illness.* Evidence-Based Mental Health, 6, 88.

24 *Thompson, T., Barbour, R. and Schwartz, L. (2003) Adherence to advance directives in critical care decision making: vignette study. British Medical Journal,* 327*, 1011–1014.*

an AD cannot be assured of a particular outcome in a particular situation. Another commentator advised when an AD appeared to advocate a course of action that would be detrimental to the patient, its validity should be carefully scrutinised to ensure it was applicable to the situation under discussion.[25]

A patient has no enforceable right to demand a particular type of treatment. However, is advance consent for a particular drug a demand for that drug and no other; or is it consent to take that drug should it be prescribed by the doctor who has, in the exercise of professional judgment, decided it is the most appropriate treatment? In one respect at least, psychiatric patients have an advantage over other people drawing up advance statements with regard to, for example, end of life decisions. Having had a previous episode of illness they have their own experiences to draw on and these can inform their subsequent decisions as to what treatment strategies, including medication, were helpful and which were not. Intuitively, advance treatment plans are likely to be most successful if they have been constructed in a collaborative fashion, rather than either party taking up unrealistic or dogmatic positions.

Psychiatric Advance Directives in the USA

Szasz is credited with first proposing what he termed a '*psychiatric will*'[26] but psychiatric advance directives became more prominent with the passage of the *Patient Self-Determination Act* in 1991. This Act required hospitals receiving federal funding to inform all admitted patients of their right to formulate an advance directive. As elsewhere, in the United States of America advance directives can be divided into instructional directives, which record the person's decisions regarding treatment in anticipation of the time when they do not have the capacity to take such decisions, and proxy directives, which may also be combined with specific directions regarding treatment. These appoint another person who is empowered to take health care decisions whenever the individual is lacking capacity.

All American states now have advance directive statutes, covering healthcare generally, and 14 states have explicit laws addressing psychiatric advance directives.[27] An example is North Carolina's *Advance Instructions for Mental Health Treatment*.[28] The advance directive can be used to consent to or refuse specific psychiatric treatment.[29] Although the person can specify his options for mental health treatment these can be set aside if the instructions are not consistent with established standards of appropriate practice or with the availability of the treatment requested. This has raised concerns that non-clinical factors may determine whether an advance instruction is honoured or not.[30] In addition an individual can appoint a proxy decision-maker to act on his behalf when he is incapable of making a decision, through the Health Care Power of Attorney Act.

25 *Treloar, A.J. (1999) Advance Directives: Limitations upon their applicability in elderly care. International Journal of Geriatric Psychiatry, 14, 1039–1043.*

26 *Szasz, T.S. (1982) The psychiatric will: A new mechanism for protecting persons against 'psychosis' and psychiatry. American Psychologist, 37, 762–770. See also: Appelbaum, P.S. (1991) Advance directives for mental health treatment. Hospital and Community Psychiatry, 42, 983–4.*

27 *Bazelon Center for Mental Health Law. Analysis of state laws. In: Power in Planning: Self-determination through psychiatric advance directives. www.bazelon.org/issues/advancedirectives/publications/powerinplanning/index.htm Accessed 4 June 2004.*

28 *North Carolina General Statute. Chapter 122C-71, et seq. This was modelled on Oregon's statute and was later amended by the passage of the Health Care Power of Attorney Act (1998).*

29 *Overview of PADs in the US at present. Accessed on 1 June 2004 from: http://pad.duhs.duke.edu/background.html*

30 *Op cit Note 27.*

The appointee is obligated to act in accordance with the individual's previously stated decisions.

In Washington D.C. the *Health Care Decisions Act* of 1988[31] made provision for a person's treatment preferences to be included in a durable power of attorney for health care, which would be followed by the appointee or any other substitute decision-maker. In 2001 the *Mental Health Consumers' Rights Protection Act*[32] emphasised the importance of a psychiatric advance directive. Medication could only be administered with the consent of the patient. If incapacitated then the patient's proxy decision-maker was bound by the treatment decisions contained within the patient's advance directive or durable power of attorney.

Psychiatric advance directives are regarded as potentially powerful, non-coercive instruments that make the clients the '*active agents*' and so enhance their '*sense of autonomy, control and dignity*'.[33] By engaging the person in the process of deliberating on their illness history and the factors, including medication, that had been effective during previous psychiatric episodes it is believed advance directives could improve the therapeutic alliance between clinicians and patient and may improve the person's treatment adherence[34] with its consequent benefits in terms of quality of life and reduced need for hospitalisation. Through such a process a PAD could be beneficial even if the person does not lose their capacity for decision-making and the document is never formally enacted. Perhaps not surprisingly, patients have been more enthusiastic about PADs than clinicians, who tend to have concerns over their clinical autonomy and legal liability in following or not following the person's advance instructions.[35]

There is also a perceived risk that PADs could increase the use of commitment orders permitting psychiatrists to bypass the patients' advance instructions[36] or, alternatively, if drafted with too many caveats may be frequently ignored and leave patients feeling further marginalized in their own treatment decisions.[37] However, used sensitively, they have been advocated as '*a means of reconciling* (patient) *autonomy and the initiation of non-consensual treatment at an early stage of relapse*', which could avert the need for rehospitalisation and, in the future, the need for more coercive community treatment orders.[38]

31 *D.C. Code Ann. ss21–2201 et seq. 1998.*

32 *Title II, section 101, et seq.*

33 *Swanson, J.W., Tepper, M.C., Backlar, P. and Swartz, M.S. (2000) Psychiatric Advance Directives: An alternative to coercive treatment? Psychiatry, 63, 160–172.*

34 *American research has demonstrated active engagement with the patient during decision-making enhances treatment compliance even when the outcome is contrary to the patient's original wishes. See Monahan et al (1996) Coercion to in-patient treatment: initial results and implications for assertive treatment in the community. In: Coercion and aggressive community treatment: A new frontier in mental health law. Editors D. Dennis and J. Monahan. Kluwer Academic Publishers.*

35 *Swanson, J.W., Swartz, M.S., Hannon, M.J. et al (2003) Psychiatric Advance Directives: A survey of persons with schizophrenia, family members, and treatment providers. International Journal of Forensic Mental Health, 2, 73–86.*

36 *Ibid.*

37 *Op cit Note 33.*

38 *Halpern, A. and Szmukler, G. (1997) Psychiatric advance directives: reconciling autonomy and non-consensual treatment. Psychiatric Bulletin, 21, 323–327.*

The Mental Capacity Bill for England and Wales[39]

The *Mental Capacity Bill*[40] (the *Bill*) was presented to Parliament in June 2004. A *draft Mental Incapacity Bill*[41], published the previous year, had been subjected to pre-legislative scrutiny by a Joint Committee from the two Houses of Parliament.[42] A number of recommendations were made and responded to by the Government.[43]

The *Bill* applies to people over the age of 16 years, who lack decision-making capacity. It is not concerned with the compulsory detention or treatment of patients suffering from mental disorder[44] but its provisions will replace Part VII Mental Health Act (MHA),[45] as well as the Enduring Powers of Attorney Act 1985.[46] The Bill's purpose is '*to clarify a number of legal uncertainties and reform and update the current law where decisions need to be made on behalf of others. The Bill .... covers a wide range of decisions, on personal welfare as well as financial matters and substitute decision-making .... and clarifies the position where no such formal process has been adopted*.'[47]

The Expert Committee reviewing reform of the MHA[48] placed importance, in its General Principles, on '*respect for patient autonomy [which] implies respect for the treatment choices of those who have the capacity necessary to make them. Patient autonomy therefore brings with it an inevitable emphasis on capacity*'.[49] The *Mental Capacity Bill* includes, as its first principle, a presumption in favour of capacity; adding that a person cannot be said to lack capacity for a particular decision '*unless all practicable steps to help him*' have been tried or, conversely, simply because he makes '*an unwise decision*'.[50]

Clause 2 of the *Bill* defines a person lacking capacity as one who is unable to make a decision '*because of an impairment of, or a disturbance* [whether permanent or temporary] *in the functioning of, the mind or brain*'.[51] It is a functional test which is both specific in time and to the type of decision to be made. Clause 3 then defines the four bases on which a person may be unable to make a decision: being unable to understand, retain or use the relevant information in making a decision, or unable to communicate the decision using any means. The test thus codifies the threshold of capacity articulated in *Re C*.[52]

39 *Scotland passed its Adults with Incapacity (Scotland) Act in 2000. This statute does not provide for advance directives although proxy decision-making does permit cognisance to be taken of the patient's past and present wishes.*

40 *Op cit Note 1.*

41 *Department of Constitutional Affairs (2003) Draft Mental Incapacity Bill. Cm 5859. London: The Stationery Office.*

42 *House of Lords, House of Commons Joint Committee on the Draft Mental Incapacity Bill (2003) Draft Mental Incapacity Bill. Session 2002–03. Volume I. HL Paper 189-1, HC 1083-1. London: The Stationery Office. Accessed on 20 January 2004, at: www.parliament.uk/parliamentary_committees/jcmib.cfm*

43 *The Government Response to The Scrutiny Committee's Report on the draft Mental Incapacity Bill. February 2004. Accessed from the Department of Constitutional Affairs website on 20 April 2004. (www.dca.gov.uk/pubs/reports/mental-incapacity.htm)*

44 *Op cit Note 1; Explanatory Notes para 86.*

45 *Dealing with the 'Management of Property and Affairs of Patients'.*

46 *Op cit Note 1; Explanatory Notes para 5.*

47 *Op cit Note 1; Explanatory Notes para 4.*

48 *Expert Committee (1999) Review of the Mental Health Act 1983 (Chair: Professor G. Richardson). London: Department of Health.*

49 *Ibid; at para 2.4.*

50 *Op cit Note 1; Clause 1.*

51 *Op cit Note 1; Clause 2(1).*

52 *Op cit Note 10.*

Outline of the new Statutory Scheme for Decision-Making

The concept of 'best interests' provides the overriding consideration for decisions taken on behalf of incapacitated people and it appears throughout the proposed statutory scheme. Even for people lacking capacity the *Bill* encourages their participation '*as fully as possible in any act done for him and any decision affecting him*'.[53] Best interests is broader than just focussed on medical interests but includes the person's '*past and present wishes and feelings ... and the other factors ... he would be likely to consider if he were able to do so*'. Additionally, views on the same issues should be sought, if '*practicable and appropriate*' from any person nominated by the person, any carer or those '*interested in his welfare*', donee of a lasting power of attorney and any court appointed deputy (see below).[54] However, none of the views is binding but need only be '*take(n) into account*'.[55] Indeed, it may not be appropriate to involve a donee or deputy if their role is related to decision-making in a different sphere of the person's life.

(i) Acts in connection with care or treatment

This provision provides '*statutory protection against liability for certain acts done in connection with the care and treatment of another person*'.[56] Previously the power of '*General Authority*' in the *draft Mental Incapacity Bill*,[57] this provision relates to everyday decisions taken by a carer on behalf of an incapacitated person but hitherto on an informal, and potentially unlawful, basis. It aims '*to clarify aspects of the common law principle of necessity as it applies to key actions done for people who lack capacity*.'[58] Its informality persists as the power will be assumed by, rather than given to, the provider of care. Its assumption is based on a reasonableness test: that the carer '*reasonably believes*' the person lacks capacity and the act is in the person's best interests'.[59] It will exist for the duration of the task under consideration. The Joint Committee recommended recognition of a concept of '*general incapacity*' for people with on-going incapacity, which would avoid the necessity of a series of repeated decision specific assessments of capacity.[60] This was not accepted in the Government's Response and has also failed to appear in the *Bill*. The *Bill* places certain limitations on the exercise of this provision[61] but as the Government's Response made clear it is not expected to be limited entirely to everyday, routine matters.[62]

(ii) Lasting Power of Attorney

A capacitous person (donor) may elect to confer on another person (donee) the authority to make decisions in the spheres of personal welfare and/or property and affairs when the donor no longer has capacity[63] (otherwise known as lasting power of attorney: LPA).[64] The authority has to be conferred via an instrument, which may contain conditions or restrictions, and is subject to the overriding principle of being in the donor's best interests.[65] In the sphere of personal welfare, the scope of LPA extends to health care decisions, namely, the '*giving or refusing consent to the carrying*

53 *Op cit Note 1, Clause 4(4).*

54 *Op cit Note 1, Clause 4(6).*

55 *Ibid.*

56 *Op cit Note 1, Explanatory Notes para 30.*

57 *Op cit Note 41; Clause 6.*

58 *Op cit Note 1; Explanatory Notes; at para 30.*

59 *Op cit Note 1; Clause 5(1).*

60 *Op cit Note 42; at para 68.*

61 *Op cit Note 1; Clause 6.*

62 *Op cit Note 43; Response to Recommendation 36.*

63 *Op cit Note 1; clause 9(1).*

64 *Under existing provisions in the Enduring Powers of Attorney Act 1985 (which would be repealed by the Bill on becoming law) the appointed donee has no authority to act for the donor in matters of healthcare.*

65 *Op cit Note 1; Clause 9(4).*

out or continuation of a treatment'[66] but does not extend to giving or refusing consent to life-sustaining treatment unless the donor has expressly stated that is his intention before he loses capacity.[67] Depending on the degree of thoroughness and specificity in the instrument, the authority of LPA may be restricted to enacting previously made decisions on behalf of the incapacitated person or it may take the form of substituted decision making.

(iii) Court of Protection and its deputies.

The *Bill* will create a new Court of Protection[68] with extended jurisdiction '*(1) to make substitute decisions about personal welfare or property and affairs for persons lacking capacity, or (2) to appoint a deputy to do so.*'[69] The Court will also have the authority to make declarations.[70]

In the realm of welfare matters the court appointed deputy will be permitted to decide on health care issues including '*giving or refusing consent to the carrying out or continuation of a treatment*'.[71] In the *draft Bill*, deputies also had the authority to give consent to the withdrawal of life-sustaining treatment. The Joint Committee '*strongly urged*' the Government to exclude such a provision when the *Bill* was redrafted and reserve such decisions to the Court of Protection itself.[72] The Government declined to take up this recommendation, believing it was not necessary to have '*a blanket exclusion of a power to refuse treatment*'.[73] However, the Bill now requires the Court of Protection to give '*express authority*' to the deputy to refuse consent for life sustaining treatment.[74]

Advance Decisions in the Mental Capacity Bill

The Minister of State for the Government Department responsible for the *Bill*, the Department of Constitutional Affairs, has declared that '*advance decisions are just one aspect of a Bill that will empower vulnerable people to make as many decisions for themselves as possible*'; adding that '*positive requests for treatment will need to be taken account of when making a decision on behalf of a person lacking capacity*'.[75]

Clause 23 of the Bill defines an '*advance decision*' as

> '*a decision made by a person, after he has reached 18 and when he has capacity to do so, that if –*
>
> *(a) at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and*
>
> *(b) at that time he lacks capacity to consent to the carrying out or continuation of the treatment,*
>
> *the specified treatment is not to be carried out or continued.*'[76]

Thus the *Bill* permits anticipated decision making by the person concerned since it is made while the person retains capacity but only becomes operative after capacity has been lost and when the

66 *Op cit Note 1; Clause 11(6).*

67 *Op cit Note 1; Clause 11(7)(a).*

68 *Described in Part 2 of the Bill: 'The Court of Protection and the Public Guardian'.*

69 *Op cit Note 1; Explanatory Notes, para 58.*

70 *Op cit Note 1; Clause 15. The Court may make declarations as to whether a person has capacity for a particular decision or whether 'an act or proposed act was or would be lawful'. In its exercise of the latter power the Court would function as a superior court of record with a range of powers and authority similar to the High Court (see Explanatory Notes to the Bill, para 57).*

71 *Op cit Note 1; Clause 17(1)(d).*

72 *Op cit Note 42; para 184.*

73 *Op cit Note 43; Response to Recommendation 54.*

74 *Op cit Note 1; Clause 20(5).*

75 *Lord Filkin: Department of Constitutional Affairs Press Release 180/04, 22 April 2004.*

76 *Clause 24 (1).*

treatment specified is being contemplated. While the person retains capacity the AD may be amended or withdrawn at any time.[77] The AD will become invalid if the person does '*anything else clearly inconsistent with the advance decision remaining his fixed decision*'.[78] It will also not apply if the proposed treatment is not included in the AD, the circumstances described are absent, or novel circumstances exist which the person did not foresee but had they been anticipated '*would have affected his decision*'.[79] The last point calls for an element of '*substituted judgment*' on the part of the health professional, in deciding whether to make the AD inapplicable but the wording sets the higher threshold of 'would' rather than 'may have' affected the decision. An AD can also be overridden when the person subsequently makes a lasting power of attorney that specifically relates to the treatment detailed in the AD.[80] Furthermore the effect of an AD can be suspended pending a declaration by the Court of Protection as to whether or not it is applicable to the proposed treatment.[81]

Advance decisions '*give statutory confirmation to existing court rulings*[82] *that a treating doctor is obliged to respect a lawfully-made advance decision about a specified treatment*'.[83] Many of the submissions to the Joint Committee scrutinising the *draft Bill* were concerned with the withdrawal of life-sustaining treatment and ADs. The Committee rejected the argument this would bring euthanasia a step closer; instead regarding an AD as '*appropriate continuation of respect for a patient's individual autonomy*'.[84] Among the Committee's recommendations the importance of having access to professional advice when preparing an advance decision was mentioned, as was the need for guidance in the Code of Practice as to what constituted a valid and applicable AD. The Government signalled its willingness to work with health professionals and patient groups in formulating the Codes of Practice[85] and ADs are specifically included in the Codes required of the Lord Chancellor by the *Bill*.[86]

Advance Decisions and Mental Health Treatment

The *Bill* has an '*enabling*' philosophy[87] and is constructed around the concept of capacity whereas the Mental Health Act 1983 is concerned with compulsion, which is not reliant on the lack of capacity. Views have been expressed that the next Mental Health Act should be based around capacity[88] or, indeed, that there would be little need for one if a Mental Incapacity Act was comprehensive.[89]

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77 *Clause 24 (3).*

78 *Clause 25(2)(c).*

79 *Clause 25(4)(c).*

80 *Clause 25(2)(b).*

81 *Clause 26 (4). While the declaration is awaited, interventions to prevent the death of the person or to prevent a serious deterioration in the person's condition are permitted.*

82 *Op cit Notes 6 (Re T) & 10 (re C).*

83 *Op cit Note 42; para 194.*

84 *Op cit Note 42; para 199.*

85 *Op cit Note 43; Response to Recommendation 61.*

86 *Op cit Note 1; Clause 40(1)(e).*

87 *Op cit Note 42; para 29.*

88 *Op cit Note 48: The Expert Committee reviewing the MHA put the principle of patient autonomy and the 'notion of capacity which flows from it' as one of its Guiding Principles. See also Szmukler, G. and Holloway, F. (2000) Reform of the Mental Health Act: Reform or safety? British Journal of Psychiatry, 177, 196–200.*

89 *Oral evidence taken before the Joint Committee on the Draft Mental Incapacity Bill. Wednesday 8 October 2003. Response to Q298 (Dr Zigmond). The Bill is not seen as comprehensive enough to fulfil that function. For example, separate legislation would still be required for mentally disordered offenders but the suggestion of a Mental Disorder Offenders Bill would be seen by many in the profession as discriminating and highly stigmatising to many patients. In addition, many of the safeguards of the MHA are absent from the Mental Capacity Bill.*

Under the provisions of the *Bill* it would be possible for treatment for mental disorder to be given under the authority of Clause 5[90] or within the scope of LPA[91] and even in the face of resistance from the person concerned.[92] These provisions would give a statutory footing to the provision of psychiatric treatment, which was both necessary and in their best interests, to *Bournewood* patients[93] who, by definition, would not be detained under the MHA. To the Joint Committee, the *Bournewood gap* represented the lack of statutory safeguards[94] for such patients. It highlighted the current paucity of safeguards in the *Bill* and clarification as to what measures might be incorporated to fill '*the gap*' was called for.[95]

Clause 28 specifically excludes the mechanisms in the *Bill* from being applied to treatment for mental disorder if that treatment is '*regulated by Part IV of the Mental Health Act*'.[96] The Government has clarified that when a person is subject to the relevant powers of the MHA then the provisions of the *Bill* will be inapplicable.[97] However, Clause 28 will still not apply to the majority of psychiatric patients receiving treatment, including voluntary patients in hospital, those detained under the MHA but not subject to Part IV MHA[98] and those in the community and not liable to be detained.[99] Nonetheless, this would mean that an otherwise valid and applicable advance decision would be overruled for detained patients for whom Part IV, MHA applies.

The position of advance decisions in the proposed reform of the Mental Health Act also requires consideration. The White Paper '*Reforming the Mental Health Act*'[100] made brief reference to what it termed '*advance agreements*'[101]. It noted patients may draw on their past experiences of treatment to state '*what sort of treatment he or she would prefer if the mental disorder deteriorates*', adding that such a record would be an important source to consult in determining '*what care and treatment is in a patient's best interests*'. Advance agreements, as their name suggests, should be drawn up in consultation with the clinical team, who would '*be expected to take account of any recent advance agreement developed in consultation with specialist mental health services*'[102].

As set out in the White Paper advance agreements could state positive preferences for treatments. This would incorporate the express principle of patient autonomy espoused by the Expert Committee reviewing the Mental Health Act 1983.[103] The Expert Committee also suggested that '*advance directives be recognised as expressions of a patient's capable wishes, and that they be allowed to*

90 *Op cit Note 1; Clause 5: Acts in connection with care or treatment.*

91 *Op cit Note 1; Clause 11(6)(c).*

92 *Op cit Note 1; Clauses 11(1) to 11(5).*

93 *That is, compliant but incapacitated patients. From: R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998] 3 All ER 289.*

94 *Ibid; at 308, per Lord Steyn. This was made in reference to the MHA 1983.*

95 *Op cit Note 42; at para 225.*

96 *Op cit note 1; Clause 28(1).*

97 *Op cit Note 43; Response to Recommendation 67.*

98 *As defined in section 56, MHA and comprising those patients detained under sections 4, 5(2), 5(4), 35, 135, 136 and conditionally discharged restricted patients.*

99 *In other words those receiving treatment as out-patients on a voluntary basis and not subject to section 17 MHA.*

100 *Department of Health and Home Office (2000) Reforming the Mental Health Act. Part I: The new legal framework. Cm 5016-I. London: The Stationery Office.*

101 *Ibid; paras 5.14–5.15.*

102 *A literal interpretation of this phrase would suggest the advance agreement need only be considered but not necessarily followed, even if the circumstances envisaged in the document correspond to those prevailing at the time; that 'old' agreements could be disregarded as could those produced unilaterally by the patient.*

103 *Op cit Note 48; at p22. The Committee themselves recommended that 'advance agreements about care' be introduced by statute and that they should 'address the patient's treatment preference (if any) in relation to any possible future care and treatment for mental disorder' (at p106).*

prevail in the same circumstances under the new act as those in which the wishes of the patient with capacity at the time would be allowed to prevail'.[104]

By the time the *draft Mental Health Bill*[105] was published advance statements had been relegated to the Code of Practice[106] but they are still framed as positive statements allowing patients to identify '*what sort of treatment they would prefer if they become unwell*' (emphasis added). However, as befits an advance statement as opposed to an advance directive, they need only '*be taken into account*' during the formal assessment and should be recent as well as drafted '*in consultation*' with the mental health professionals.[107] On the face of the *draft Mental Health Bill* negative phraseology is used. Clause 121 refers to circumstances when informal treatment is not available because

> '*(a) the patient is not capable of consenting to the treatment, and*
>
> *(b) he either –*
>
> *(i) would resist the treatment if given, or*
>
> *(ii) ....*
>
> *(4) .... it is to be assumed that a patient who has at any time indicated that he does not want to receive treatment for mental disorder or particular treatment would resist such treatment.*'

The Explanatory Notes to this *draft Bill* reinforces that the advance statement '*whether in writing or otherwise*' would be couched in terms of withholding consent.[108] Moreover, the contents of an advance statement could be overridden '*in a case of urgency*' or if the proposed treatment was included within the terms of a (mental health) order made under the provisions of Part II of the Bill.[109]

In cases of informal treatment of patients not capable of consenting[110] the role of the '*nominated person*'[111] becomes an important safeguard. '*If it appears to the nominated person*' that the patient would not have consented to the proposed treatment, had he been capable, then the nominated person '*must inform the clinical supervisor*' who '*must then ensure*' that the proposed treatment is not used '*except in a case of urgency*'.[112] This could occur when the nominated person is aware of the patient's advance statement, which refers to the circumstances proposed.

Conclusion

This paper, although it describes the proposed decision-making scheme for proxy directives contained within the *Mental Capacity Bill*, is primarily concerned with instructional directives. The *Bill* is promoted as 'enabling' and 'empowering' but, by restricting the instructional directives to recognition only of a refusal to consent to treatment, it places a significant impediment on the expression of an individual's ability to have his choice respected after he has lost the capacity to make legally competent decisions. The *Bill* does permit positive preferences for treatment to be expressed. However, these have to be mediated through the proxy of a lasting power of attorney

104 *Op cit Note 48; at p106.*

105 *Department of Health (2002) Draft Mental Health Bill. Cm 5538-I. London: The Stationery Office.*

106 *Department of Health (2002) Mental Health Bill. Consultation Document. Cm 5538-II. London: The Stationery Office. At p20.*

107 *Ibid.*

108 *Ibid; Explanatory Notes, at p45.*

109 *Op cit Note 105; clause 121(2).*

110 *Op cit Note 105; Part 5.*

111 *The successor person to the nearest relative from the 1983 Mental Health Act.*

112 *Op cit Note 105; clause 128(2).*

rather than via a directive giving advance consent to a specified treatment.[113]

In *Re T* Butler-Sloss, LJ. quoted, with approval, from the Canadian case of *Malette v Shulman*:

> '*The right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority*'.[114]

In English law it is accepted that '*an advance refusal made with capacity simply survives any supervening incapacity*'.[115] Equally, in surgery advance consents survive the incapacity of general anaesthesia. A surgeon can discuss the possibility of needing a more extensive operation than the one anticipated and the patient is asked to consent to that, as well as the planned operation, in advance and without knowing whether the 'second' consent will be acted upon after he has lost (temporarily) capacity.

Advance decisions in favour of specified psychiatric treatments offer the prospect of more than just a ready reference to a person's legally competent choices after he has lost capacity. The process of formulating an appropriate and relevant advance decision demands a dialogue between the individual concerned and the mental health professionals. This can be beneficial in its own right and can also have a more pervasive effect on the therapeutic relationship and the person's subsequent psychiatric career. However, ultimately, advance decisions, to consent and to refuse, are about the limits we place on the person's right to self-determination and for that autonomy to exist beyond the time when capacity has been lost.

The *Mental Capacity Bill* has squandered the opportunity to go beyond statutory recognition of the existing common law and create a law that could have been truly therapeutic in intent and practice. Perhaps the debate over advance decisions is ultimately less to do with missing that opportunity and is more concerned with opposing further moves towards capacity-based mental health legislation.

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113 *Absurdly, it would be possible to use advance refusals to give consent, for example, to a particular drug – by, for instance, giving advance refusal to all antipsychotic medication, both in oral and in injectable forms, except for drug A!*

114 *(1990) 72 OR (2d) 417; per Robins JA at 432.*

115 *Op cit Note 5; para 5.14.*

Capacity choice and compulsion

*Lucy Scott-Moncrieff**

Harold C, originally from Jamaica, was admitted to Broadmoor Hospital in the 1960's. In 1993, at the age of 68, he developed gangrene in his foot and was transferred to Heatherwood Hospital for treatment.

Mr Rutter, the orthopaedic surgeon treating Mr C, considered that he only had a 15% chance of survival if he did not have his foot amputated. However Mr C refused to agree to the amputation, and as Mr Rutter said that he would not amputate without Mr C's unequivocal consent, the wound was simply cleaned up, although Mr Rutter considered that there was a high likelihood of infection spreading from the wound to other organs, causing them to fail. He therefore continued to believe that amputation was in Harold C's best interests. Mr C wanted to get a guarantee that the hospital would not amputate his foot without his consent, whatever might change in the future, so I wrote to the hospital, asking for an undertaking to this effect. The hospital refused to give the undertaking, and pointed out that if the infection spread there was a real likelihood that Mr C would become delirious, would thereby lose the capacity to make decisions about his treatment, and the hospital could then, acting in his best interests, amputate his foot. Mr C went to court, to seek a declaration that the hospital could not operate on him without his written consent.

The judge, Mr Justice Thorpe, had to decide first whether Mr C had the mental capacity to refuse the amputation. If he did have capacity, the judge then had to decide whether he had the right to make a decision about his future treatment that would be binding on the hospital even if he subsequently lost the mental capacity to make treatment decisions.

The judge used a three part test to assess Mr C's mental capacity:

a) Could Mr C take in and retain information about the treatment being offered, including the consequences of not accepting the treatment?

b) Did he believe what he was told?

c) Could he weigh the information, balancing risks and needs?

Mr C's position was that he was an internationally famous doctor, who had never lost a patient, and who was capable of treating himself successfully. He believed that God would help him, and he did not believe that his gangrenous foot would cause his death, although he acknowledged that he could be wrong about this. He was also very clear that even if lack of treatment lead to his death,

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he would rather die with two feet than live with only one. At first glance, therefore, it would appear that he lacked capacity, as he had delusional beliefs about his own ability to cure himself. However the judge was impressed with his acceptance of the possibility that he might be wrong (not commonplace in people with delusions) and that he might die if he did not have the operation; particularly after he heard from the surgeon, who said that it was not at all uncommon for elderly people to refuse life-saving amputation, and Mr C was no different from many others of his patients in this respect.

Mr C won his case. The judge decided that he did have capacity to refuse the operation and that he should be allowed to make an advance directive about his future treatment, which would be binding on the hospital. (This was the first time an advance directive was endorsed by a UK court) In the course of the judgment the judge quoted from the case of re T (An Adult: Medical Treatment) [1992] 2 FCR 861.

"(a) Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent. This is so, not withstanding the very strong public interest in preserving the life and health of all citizens. However, the presumption of capacity to decide which stems from the fact that the patient is an adult is rebuttable.

(b) An adult patient may be deprived of his capacity to decide by long-term mental incapacity.

(c) If an adult patient did not have the capacity to decide at the time of the reported refusal and still does not have that capacity, it is the duty of the doctors to treat him in what ever way they consider in the exercise of clinical judgment to be in his best interests.

(c) Doctors faced with a refusal of consent have to give very careful and detailed consideration to what was the patient's capacity to decide at a time when the decision was made. It may not be a case of capacity or no capacity; it may be a case of reduced capacity. What matters is whether at that time the patient's capacity was reduced below the level needed in the case of a refusal of that importance, for refusals can vary in importance. Some may involve a risk to life or of irreparable damage to health; others may not".

Delightfully, not only did Harold C win his case, he also survived. The gangrene did not recur; the infection did not spread; he was transferred to a nursing home on the South Coast and he lived out his days with both legs, and a crutch.

Subsequent events caused me to doubt whether Mr C had actually had the capacity to make this decision about his treatment. He was quite a wealthy man; he did not smoke and he wore hospital-issue clothes, so he had accumulated thousands of pounds in unspent benefits. He had lost touch with his family, and after the court case I suggested to him that he might like to write a will if he did not want all his money to go to the State when he died. He agreed that this was a good idea, and asked me to draw up a will in which he would be the sole beneficiary. He explained that he wanted to take his money with him.

I did not need the help of a doctor to work out that he lacked the capacity to make a will, as he did not appear to accept the finality of death or, at least, the inevitable loss of the ability to spend money that accompanies death.

It is clear that what tipped the balance with Mr Justice Thorpe was Harold C's assertion that he knew

that he might die if he did not have the operation, but he that would prefer to die with two feet than live with one. Harold C's instructions in relation to his will suggested that his ideas about death and dying were so unusual that his assertion that he was not afraid to die probably reflected a conviction that death did not involve any loss of identity or autonomy, but merely a change of scene.

If Mr C had flatly said to the judge that he did not believe what the doctors were saying about the risk to his life, and that he refused the operation for this reason, I think it likely that the judge would have decided that he lacked capacity. The fact that Mr C turned out to be right would not have invalidated the correctness of the judge's decision – it is possible to be right for the wrong reasons, just as it is possible to be wrong for the right reasons.

Not everyone is as lucky as Harold C.

David Bennett, also originally from Jamaica, was first admitted to a psychiatric hospital in the early 1980's. He was then in and out of hospital for many years until his final admission to the Norvic Clinic in October 1995.

The Norvic Clinic is a medium secure unit: less secure than a high security hospital such as Broadmoor, but completely secure for all ordinary purposes. It has a high perimeter fence; all the doors are very solid and lockable; and the glazing bars on the windows are a fine example of form following function where the function is containment rather than illumination.

All the patients at the Norvic Clinic are detained under the Mental Health Act 1983. Some of them will be there because they are too ill to be managed in local, open, psychiatric hospitals; some of them will be prisoners who are too ill to be treated in prison; and some of them will be people who have been in a special hospital such as Broadmoor and who are on their way out to the community via medium security.

The different pathways into the Norvic Clinic are likely to be reflected in the different attitudes of the patients. For some, the Norvic Clinic will be a blessed refuge from the inadequacies of the prison psychiatric services. For others it will be an irksome, restrictive but bearable step on the way to freedom. Those who have come in from their homes or from open hospitals are most likely to be unhappy about their stay there, as they are likely to perceive that the alternatives for them would be less restrictive.

It is not only the pathways and the attitudes that will vary considerably. Some of the people coming in will be acutely psychotic, unstable, and unpredictable. Others will be very well, very stable, and hoping for the opportunity to continue with their Open University degrees as they move towards discharge into the community. What they all have in common is their subjection to the provisions of the Mental Health Act 1983 and, therefore, their exclusion from the general principle that adults with mental capacity cannot be given medical treatment without their consent.

David Bennett died at the Norvic Clinic shortly before midnight on the 30th October 1998.

The independent inquiry set up to investigate his death reported in February 2004. It records that:

"At about 22.00 hours in Drayton Ward, a patient (DW) was making a telephone call to his mother. There was one telephone in Drayton Ward for patients to use. Occasionally two or more patients wanted to use this telephone at the same time but normally there were no problems. That evening, DW had been on the telephone for about 45 to 60 seconds when David Bennett asked him how long he was going to be. DW described how David Bennett then left and a little later returned. He appeared quite angry and said, "give me the fucking phone". DW told him to go away and

David Bennett grabbed the phone out of DW's hand, who grabbed it back again. Then David Bennett threw a punch at DW's face; his hand hit the phone which itself hit DW's face. It was quite a hard blow. DW put his hand to his mouth and saw blood on his hand.

DW's mother made a statement in which she confirmed the words used by David Bennett to her son. She also heard a thud and then heard DW say, "that was my fucking face". As soon as that call had ended, DW's mother telephoned the Norvic Clinic and was told that DW was being examined by a doctor.

Shortly after being hit, DW went to David Bennett's bedroom, kicked on his door and shouted at him. He was extremely offensive and racist in his remarks. The evidence is that he called him, "a black bastard" and, said, "you niggers are all the same". David Bennett opened his bedroom door suddenly and DW punched him on his chin. This too was quite a hard blow. David Bennett took a step back and said, "please don't do that".

Nursing assistant Bartlett was the first member of staff on the scene. He saw David Bennett come out of his bedroom and he saw the two men start to fight. He saw DW using his fists and David Bennett trying to kick DW in karate style. He then saw DW hit David Bennett with a powerful punch to his jaw. By this time two other nurses had arrived. They took hold of DW and took him away from David Bennett. DW was still uttering obscenities and racists remarks".

The nursing staff decided that the two men should be apart for a while, and it was decided that David Bennett should move to Thorpe Ward, which was a smaller ward than Drayton, with a higher ratio of staff to patients; a higher dependency ward.

The patient culture perceives transfer from a lower dependency ward to a higher dependency ward as a retrograde step and, particularly after a violent incident, a form of punishment. A patient is likely to have a strong sense of grievance if he feels that he is the innocent (or, at least, less guilty) party in a violent incident, and yet he is moved to a higher dependency ward and the other patient is allowed to remain "unpunished" on the lower dependency ward.

Although David Bennett had apparently initiated the incident between the two men, and although he had certainly struck the first blow, he would have good reason to consider himself the less guilty party. Many patients in secure hospitals have what are rather primly called impulse control and anger management problems. The standard advice is that the person on the receiving end of such problems should not retaliate, should walk away, and should report the matter to staff. This, of course, reflects the standards of behaviour in society at large; if someone comes up to you and punches you in the face, and then walks away, you are meant to report the matter to the police. If you run after him and beat him up you are likely to find yourself in the dock, possibly facing a more serious charge than your assailant.

When David Bennett was told that he needed to move to Thorpe Ward, he was in an agitated state, but said, "I won't mind a little while on Thorpe Ward". Having arrived on Thorpe Ward he appeared calmer, but the staff then decided that he would need to spend a night on the ward, and a nurse who knew him well went over to him to tell him this.

"She bent down, putting her hand on his arm and said, "I am going back to Eaton Ward and I just want to tell you that you are going to stay the night here on Thorpe Ward". David Bennett said, "Yep, yep, ok", then he said, "What about DW?" She said, "No, he will be staying...". That is as far as she got because David Bennett then punched her on the left side of her face at least three times. The blows were very hard. The first punch knocked her backwards and she tried to block

the other punches. She put her arm up to shield her face. SN Hadley considered that in hindsight the trigger factor was probably the fact that DW was staying on Drayton Ward."

Nursing staff restricted David Bennett, and he ended up on the floor with five, and subsequently four, nurses pinning him down. He was restrained in this way for about 25 minutes, at the end of which time he was dying or dead. Less than 90 minutes had elapsed since he first approached DW.

The inquiry in to the death of David Bennett found that "the possibility of moving David Bennett to Thorpe Ward should have been discussed with him carefully and gently before a final decision was made. He should not have been presented with the decision already made. When he arrived in Thorpe Ward the evidence indicated that he had calmed down further and was capable of having a rational conversation.

Some witnesses have told us that, with the benefit of hindsight, their view is that David Bennett should never have been transferred to Thorpe Ward. We recognise that when a situation of violence occurs, it is difficult for the staff to deal with. Immediate decisions have to be made and its possible to get them wrong. But we have formed the strong impression that on that evening David Bennett was not treated by the nurses as if he were capable of being talked to like a rational human being, but was treated as if he was "a lesser being" to use his sister's phrase, who should be ordered about and not be given a chance to put his own views about the situation before a decision was made".

The inquiry report quotes Dr. Ball, the clinical director of the Norvic Clinic. In a letter to the Chief Executive of the NHS Trust, referring to David Bennett's transfer to Thorpe Ward, he said "his sense of injustice together with the singularly grievous sense of insult generated by a racist taunt should not be underestimated".

The inquiry also found that:

"Even if it was a correct clinical decision to take David Bennett to Thorpe Ward temporarily, further consideration should have been given to the problem before deciding to keep him there for the night. This decision too was not dealt with in a sensitive way. He was simply informed of the decision. We consider that this must have seemed to him to be the last straw. But we wish to make it clear that despite the criticisms we have made, we do not condone his actions in hitting out at SN Hadley."

Why were Harold C and David Bennett treated so differently? Why was Mr C given the opportunity to go to court to establish his right to refuse treatment, whereas David Bennett was not even consulted about the decision to move him to a higher dependency ward?

It is very likely that the heart of the problem lies in the deeply discriminatory compulsory treatment powers of the Mental Health Act1983.

Under the Mental Health Act, nearly all forms of treatment can be given to patients without their consent, regardless of their mental capacity. Some treatments, such as medication and ECT, can only be given if a capacitous patient consents or if a second opinion doctor confirms the treatment should be given.

All other forms of treatment for mental disorder, such as restraint, seclusion, transfer to another ward, withdrawal of privileges ("treatment for mental disorder" is defined very widely), require neither consent nor a second opinion, regardless of whether the patient has capacity to make his own decision on the issue. The Mental Health Act contains no explanation or justification for this state of affairs: the only explanations that I can come up with are expediency and the unexamined prejudice that people with mental health problems are, by definition, not entitled to autonomy.

Harold C got lucky and David Bennett got so very unlucky because, although they were both black men with schizophrenia detained under the Mental Health Act 1983, the compulsory treatment provisions did not apply in Harold C's case. It is clear that Mr C's consultant psychiatrist would have authorised the amputation if she had had the power to do so, because she believed that the operation was very much in his best interests. However, as treatment for gangrene cannot be seen as treatment for mental disorder, the provisions that would have allowed his refusal to be overruled did not apply. In David Bennett's case, it appears that the staff felt that the violence and abuse that he had suffered had rendered his mental state fragile, and he therefore needed to be moved to a higher dependency ward. This amounted to treatment for mental disorder, and decisions could be made (and were made) without consulting him or considering his wishes.

Remarkably, when assessing a patient to see if he should be detained under the Mental Health Act, those carrying out the assessment do not even have to consider whether or not the person being sectioned has the capacity to make his own treatment decisions. It is sufficient for them to decide that he has a mental disorder, and it is necessary, in his own interests or to protect others, that he should receive treatment for it. It is true, of course, that people with mental disorders are more likely than the general population to lack capacity to make decisions, at least some of the time. However the Mental Health Act does not say that decisions can be made without the agreement of the patient because the patient lacks capacity; it specifically provides for the decisions of detained patients to be overruled, even when they have capacity.

Imagine what it would be like if all medical treatment could be imposed in this way – we would have to build many vast new hospitals to cater for all the alcoholics, heavy drinkers, smokers, drug addicts, body-building steroid abusers and morbidly obese people who did not accept their doctor's advice about their harmful and life-threatening habits, and who would therefore need to be admitted for some compulsory treatment in their own best interests.

It is easy to be scared in hospital. However big and brave and clever and successful you are in your ordinary life, when you go in to hospital you are in another world. You are on the receiving end of other people's knowledge and competence and efficiency and systems. And you are ill, so you really hope that the doctors and nurses know what they are doing, and if you get a feeling that they do not know what they are doing, you may not feel strong enough or assertive enough to do much about it. If your sense of reality is also adrift, if you are depressed or hallucinating or dementing or delusional, it may be even harder to believe in the validity of your own opinion about what is best for you. What must it be like to have hung on to your decision-making ability throughout the vicissitudes of mental illness, removal from home, and enforced hospitalisation, only to be told that you have no right to refuse the medical treatment that your doctor has decided on? This treatment, of course, can include medication with commonplace side-effects such as impotence, huge weight gain, unbearable feelings of restlessness, uncontrollable dribbling, lethargy, slurred speech, jerky movements (and sometimes all of these).

And what's it like from the other side? How easy is it to go on relating to the other as an equal in human terms when the law has endorsed society's view that people with mental disorders are not equal? One of the nurses who restrained David Bennett referred to him, quite unselfconsciously, as a boy: "I wanted the boy to be as calm as can be before I am prepared to let him up" and "regardless of what the boy has done, that's still someone who has died in my arms and that is a hard thing to live with". David Bennett was 38 when he died.

I do not think anyone would describe a 38 year old white man as a boy, whether he was detained in a hospital, a police station or a prison, but I also do not think that David Bennett would have been described as a boy if he had been detained in a prison or police station. There is no sense that the nurse intended to be derogatory; he gave evidence that he had a good relationship with David Bennett, and he spoke fondly of him. However, in describing David Bennett as a boy, he reveals, with utmost clarity, the status given to patients at the Norvic Clinic. David Bennett's sister, Dr. Joanne Bennett, said in her evidence "when you are mentally ill and isolated from your family in a predominately white area, when you feel oppressed and are experiencing racial abuse, you think that you are a lesser being". The words of the nurse make clear that this was a perception shared by the staff.

The law used to distinguish between men, who had legal autonomy, and women, children and lunatics, who had little or no autonomy. Women now have legal equality with men, and in most circumstances children's views are also taken into account when legal decisions are made about their lives. However in the case of people with mental disorders, there has been remarkably little change. The underlying assumption is still that people with serious mental disorders should have fewer rights, even though there is no inevitable correlation between such disorders and mental incapacity.

Psychiatry is the Cinderella service of the National Health Service. There are many reasons for this; it is not glamorous; the work is difficult; dramatic cures are infrequent, people in mental distress are often not easy to work with, or even to be with; the status of health care staff who work with psychiatric patients reflects the status that mentally ill people have in our society. Psychiatric wards, particularly acute admission wards, are often grubby, noisy, crowded and frightening places, to the extent that someone would have to be very desperate to chose to be there. But of course many of the patients on such wards have not chosen to be there. They are there under compulsion, having been detained under the Mental Health Act.

There are a number of initiatives within the NHS to try and raise standards by increasing patients' choice: patients do not have to accept treatment at their nearest hospital, and if they cannot find a hospital that will offer them satisfactory treatment within a reasonable period of time, they can go to the private sector, even abroad, and have their treatment paid for by the NHS. None of this is available to people with mental health problems.

Dr. Stephen Amiel and Dr. Iona Heath have been GP's in North London for many years. I met them to discuss my theory that the compulsory treatment powers in the Mental Health Act are implicated in the lower levels of service that people with psychiatric problems receive as against people with other medical problems. They did not altogether agree with my proposition, but did agree that people with psychiatric problems (and elderly people) get a worse deal from the NHS than everyone else. GP's frequently need to refer patients to specialists or for inpatient treatment. Generally speaking, they have the right to refer their patients to the specialist or hospital that they consider most appropriate. Strong moral and bureaucratic pressure is brought to bear to try and get them to refer to services with which the patient's Primary Care Trust already has a contract, but if they are persistent enough in referring their patients to an "out-of-area" specialist or hospital, they will eventually prevail and the Primary Care Trust will pick up the tab. It is quite different for patients in the medical specialities of psychiatry and geriatrics, where they have been told that the referrals have to be made to the catchment area services, regardless of the greater suitability of "out-of-area" services.

They believe that the inequality is compounded in that NHS psychiatrists are only able to treat within their individual catchment areas. These catchment areas are geographical areas within the larger catchment area of the NHS Trust for whom the psychiatrist works. If a patient moves from the catchment area of one psychiatrist into the catchment area of another psychiatrist, all within the larger catchment area of the Trust, the care of that individual will pass from one psychiatrist to another, regardless of the need for continuity of care.

There is a rather perverse exception to this – if a patient moves from the catchment area of one NHS Trust to that of another, the staff from the original Trust will continue to be responsible for the patient for 6 months, whether or not this is appropriate, and at the end of 6 months the patient's care will transfer to the new NHS Trust, whether this is clinically appropriate or not. This system appears to be purely driven by the bottom line.

I asked the doctors if they knew the legal rationale behind any of this, and they said that the limitations on referrals for psychiatric patients have been in existence for many years, throughout all the changes in the NHS, and they believes that the restrictions can be put down to custom and practice rather than law or regulation.

The doctors agreed that if GP's have choices in making referrals, standards are raised. Dr. Heath pointed out that if Dr. Amiel had a heart attack and needed an emergency admission, it would be perfectly acceptable to admit him to the local cardiac unit, where he would receive a satisfactory level of care. However if he had a psychotic breakdown, it is very unlikely that it would be thought acceptable for him to be admitted to the local mental health unit, because his professional colleagues in the unit would be embarrassed at the level of care that is available on such a unit. They would try and arrange for him to go out-of-area, so that his treatment was provided by people who did not know him.

It occurred to me afterwards that another reason for referring Dr. Amiel elsewhere in such circumstances might be to protect the local staff from having to engage with the discomfort of experiencing a blurring of the boundary between "them" and "us". The same blurring, of course, applies when the doctor/patient is receiving treatment for a physical illness, but the very much greater difference in status between staff and mentally ill patient would make the discomfort unbearable for the treating staff.

The lack of choice in psychiatry is pervasive. Dr. Amiel and Dr. Heath told me that if they refer a patient with back-pain to a back-pain specialist, the patient will be seen by that specialist. However if they refer a patient with a psychiatric difficulty to a particular psychiatrist or psychologist, the referral will go to the mental health team rather than to the individual specialist, and the case might then be dealt with by another member of the team, such as a nurse. Equally, a GP can decide with his mentally ill patient that the patient needs to be referred for an emergency admission. However he cannot simply call for an ambulance and arrange for the patient to be take up to the hospital. He has to make the referral to the crisis intervention team, and a member of the team, quite possibly a nurse, will assess the patient, with the express view of trying to keep the patient out of hospital if possible. The knowledge and experience of the GP is not sufficient to effect an admission, although it would be in a medical emergency within another specialism.

The David Bennett inquiry was specifically asked to look at the issue of racism within NHS mental health services. It took evidence from a large number of people on this issue, and reported that they were unanimous in saying that institutional and individual racism existed within the NHS.

One witness was reported as saying that, "using the word "racism" was not very helpful. It was necessary to deconstruct what racism was about. It was about human relationships and was based on power, namely the power of one person over another. Just using the word "racism" did not communicate to people what it was that was discriminatory about what they did. To make things better it was necessary to explain that something was wrong with the relationship and to try and put it right.

He therefore had some hesitation about the use of the term "institutional racism" which he considered had its own complexities and its own history. But he told us that the sum total of his view was that the mental health services and the NHS were racist within the meaning of the McPherson definition of instructional racism. He emphasised that black patients were particularly sensitive to any hint of regulation, control or disrespect, because they had been primed by their experiences to expect to be treated badly in society.

The inquiry adopted the definition of "institutional racism" set out by Sir William McPherson in the Stephen Lawrence inquiry: "institutional racism is the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping, which disadvantage minority ethnic people".

David Bennett's sister, Dr. Joanne Bennett, told the inquiry that, "people sometimes fail to understand that there was a huge variation in defining blackness. Individual experiences by different black people may be totally different. Just putting two black people together did not necessarily mean that the first black person understood the second black person. Nor by putting two black people together as patient and practitioner did that mean that a patient was getting the appropriate cultural care.

There were huge differences between different people who are called black, or who come from the ethnic minorities. We should pay more attention to what the person has to say about their own experiences, namely, what were the things that were significant and important for them. If doctors and nurses were prepared to spend more time talking with families that would help.

Rather than mental health services focusing on cultural matching, whatever that was supposed to mean, we should be focusing more on how we enable practitioners to deal with the people as people, with some humanity, because that was how you were going to find out what really matters to that person. If we took time to respect an individual and say to him, "what is it that is troubling you, what are your needs?" we are more likely to get it right than if we started to talk about culture, ethnicity and cultural competence. We also need to understand about the ideology of racism and how that creates stereotypes, assumptions and values. That had nothing to do with culture".

Everything said here about racism also describes the experience of people with mental disorders; particularly detained patients. It only takes a moment's thought to realise that not only common humanity but also good psychiatric practice must require that people are listened to properly, treated as individuals, shown respect and have their wishes and anxieties taken into account when decisions about treatment are being made. The fact of the matter is, however, that this is not how things work.

How ever well-intentioned the health-care staff are, they are likely to be rushed and busy, to have limited time to spend with any individual patient, and limited options to offer that patient. Also,

if the doctor has the power to impose medical treatment, he may feel an obligation to do so if he considers it to be in the patient's best interests. There is little necessity for the sort of discussion that I have when I go to my GP; she offers me her best advice based on her medical knowledge, her experience, and her awareness of the available options, and I make a decision based on her advice, and my experience and knowledge about myself. Where society's lack of respect for people with mental health problems is combined with the institutional racism of the NHS and the official paternalism authorised by the Mental Health Act, it is not surprising that the opportunities for such discussions appear to be very limited.

The David Bennett inquiry makes a number of recommendations, many of them, quite appropriately, dealing with ways of combating institutional and individual racism within the NHS. However, they also recommend that:

"All patients in the mental health services should be entitled to an independent NHS opinion from a second doctor of their choice, in order to review their diagnosis and/or care plan. If the patient, by reason of mental incapacity, is unable to make an informed decision, their family should be entitled to make it for them"

and

"All psychiatric patients and their families should be made aware that patients can apply to move from one hospital to another for good reason, which would include such matters as easier access by their family, a greater ethnic mix, or a reasoned application to be treated by other doctors. All such applications should be recorded. They should not be refused without providing the applicant and their family with written reasons".

If these recommendations were implemented, the NHS psychiatric services would, over time, be transformed. Patients would have real choice, and this would affect the culture within NHS psychiatric services. The provisions of the Human Rights Act 1998 would almost certainly ensure that the real choices available to patients with physical health needs would be extended to patients with mental health needs.

After reading the David Bennett inquiry report I spoke to Professor Sashidharan, one of the authors of the report. He has worked as an NHS consultant psychiatrist in Birmingham for many years, so his opinions and knowledge are based on great experience.

I asked Professor Sashidharan whether he thought that a culture of greater patient choice and autonomy could have prevented the tragedy at the Norvic Clinic. I was expecting a fairly non-committal reply, because the inquiry report is very careful to acknowledge that David Bennett's death occurred in the context of a difficult and emergency situation, and I knew that he would not take advantage of the luxury of hindsight. So I was surprised by his answer.

He told me that when he was working in the NHS in Birmingham, he instigated a system whereby any patient who was likely to be subject to an emergency intervention (for instance being put in seclusion, or being moved from one ward to another, or having privileges removed), had the right to request a phone call to him before the intervention was implemented. If Professor Sashidharan was not on the unit, he could be phoned at home or on his mobile. A surprisingly large number of patients availed themselves of this opportunity and, very frequently, a conversation with Professor Sashidharan resulted in the emergency intervention being proved unnecessary.

There were no doctors on duty at the Norvic Clinic on the night that David Bennett died. If David

Bennett had had the right to phone his doctor, or the Medical Director, Dr. Ball, before being moved from Drayton Ward, or before a decision was made that he had to spend the night on Thorpe Ward, perhaps a different decision would have been made. Even if the same decision had been made in the end, Mr Bennett would have had the opportunity to discuss the matter with his doctor, and he would have known that his doctor would have discussed the matter with the nursing staff before making a final decision. Perhaps he would have understood that the decision had been made in the interests of his mental health, rather than because he was being treated unfairly.

Professor Sashidharan also told me about his prescribing habits. Many psychiatrists will not only prescribe medication to be take at stated intervals, but will also prescribe "p.r.n." medication. This is medication to be given as required, and once it has been prescribed, nurses can administer it without further reference to a doctor. It is not unusual for psychiatrists to prescribe quite high doses of injectable anti-psychotic or sedative medication to be given p.r.n.

Professor Sashidharan never prescribed p.r.n. medication. If an emergency arose when he was not on duty, and the nurses felt that sedative or anti-psychotic medication needed to be given, the nurses would have to contact Professor Sashidharan, and he would have to come in to the clinic to write up the prescription. This practise ensured that there was always a pause for thought between the beginning of an emergency and the administration of medication.

The treatment of people with mental health problems is bound to change, because everything always does. In NHS mental health services the pressures for change are coming from two different directions, and it is not at all clear which will prevail. The Government has made it plain that it intends to introduce new mental health legislation that will empower doctors and other health-care professionals to impose treatment on those living in the community, including compulsory medical treatment such as injections of anti-psychotic medication. The Government has said that it is only trying to ensure that people who are currently subject to compulsory powers will be subject to compulsory powers in the community as well as in hospital. However to try and achieve this result it has defined mental disorder and the scope of compulsory powers so widely that, for instance, a psychiatrist will probably have the power to require a hyperactive child to take Ritalin (a central nervous system stimulant similar to amphetamine), even if the child's parents do not consent. Luckily, the opposition to many of the Government's proposals has been solid, and has united groups who frequently do not feel that they have interests in common, such as the Royal College of Psychiatrists and mental health user charities. Probably as a result of the strength of the opposition, the new proposals have still not been introduced in Parliament.[1]

Another promising sign is the acknowledgement by various individuals that the NHS is institutionally racist. Disappointingly, the Government has still not accepted the three key recommendations of the Bennett report – that the Health Minister, John Reid, should acknowledge the presence of institutional racism in the mental health services; that the Health Minister should appointment an ethnicity tsar to spearhead reform; and that there should be a three minute time-limit on staff restraining patients by pinning them face down on the floor.

A decisive factor, one way or the other, may turn out to be the case of John Wilkinson. John Wilkinson is an elderly, white, patient in Broadmoor who has been there since the 1960's. For many years he had been diagnosed as suffering with a personality disorder (which would not usually be treated with medication), but a few years ago he came under the care of a doctor who felt that he

1 *A new Mental Health Bill 2004 was published on 8th September 2004, as this issue of the Journal went to print. (Editor)*

may have had an underlying and untreated mental illness, which was preventing him from making the progress necessary to move on from Broadmoor. His doctor wanted to give him anti-psychotic medication, but Mr Wilkinson was vehemently opposed to this. The doctor decided to prescribe the medication in any event, and, following the rules laid down in the Mental Health Act 1983, obtained a second opinion from a doctor appointed by the Mental Health Act Commission who endorsed the compulsory imposition of medication. Mr Wilkinson said that he would strenuously resist any attempt to medicate him against his will, and, unlike many patients in such a situation, he followed through. He refused to accept the medication, and had to be pinned down on the floor by nurses and forcibly injected. He suffers from angina, and had an angina attack following the struggle. An injunction was obtained to prevent further compulsory medication until the court had had an opportunity to consider whether it was lawful to impose it in these circumstances. The injections were given in early 2000, before the Human Rights Act 1998 came into effect on the 2nd October of that year. However, because the court had to decide whether future treatment would be lawful, the case was considered in the light of the Human Rights Act when it was finally dealt with by the Court of Appeal in 2002.

The judgment contained the following remarks:

“It seems to me that the court must inevitably now reach its own view both as to whether this claimant is indeed incapable of consenting (or refusing consent) to the treatment programme planned for him by the first defendant as his RMO and, depending upon the court’s conclusion on that issue, as to whether the proposed forcible administration of such treatment (a) would threaten the claimant’s life and so be impermissible under article 2 (b) would be degrading and so impermissible under article 3 and (c) would not be justifiable as both necessary and proportionate under article 8 (2) given the extent to which it would invade the claimant’s right to privacy.”

and

“Forcible measures inflicted upon an incapacitated patient which are not a medical necessity may indeed be inhuman or degrading. The same must apply to forcible measures inflicted upon a capacitated patient. I would hesitate to say which was worse; the degradation of an incapacitated person shames us all even if that person is unable to appreciate it, but in fact most people are able to appreciate that they are being forced to do something against their will even if they are not able to make the decision that it should or should not be done. The European Court of Human Rights understood how vulnerable such patients can be and how much in need of the protection of the world outside the closed world of the psychiatric institution however well meaning”.

As yet, the domestic courts have not considered the issue, as Mr Wilkinson’s doctor has not renewed his attempts to medicate him against his will. Mr Wilkinson has taken his challenge to the European Court of Human Rights, on the basis that the provisions of the Mental Health Act which allowed his doctor to inject him forcibly in February and March 2000 are incompatible with the European Convention on Human Rights.

The case is inching its way through the ECHR. If John Wilkinson wins, the current compulsory powers will have to go, and the extension of those powers will not take place (unless the government declares a national emergency again and derogates from the European Convention on Human Rights). If he loses, look to see compulsory psychiatric treatment coming to a street near you very soon.

Casenotes

Community Care and the Care Programme Approach: Confusion between two distinct assessment processes

*Joanna Sulek**

R (on the application of HP and KP) v London Borough of Islington [2004] EWHC 7 (Admin).

Queens Bench Division, Administrative Court (8th January 2004) Mr. Justice Munby.

The Facts

This case concerns alleged breaches by Islington of its duties under section 47 of the *National Health Service and Community Care Act 1990*[1]. The judgment relates to the one issue unresolved by the time of the hearing, held on 15th December 2003, namely the adequacy of the community care assessment of Mr P by Islington LBC dated 18th March 2003[2].

The London Borough of Islington's policy *Mental Health Assessment Priorities and Entitlement Criteria* distinguished between Care Programme Approach (CPA) assessments and Community Care assessments (which relate to the provision of community care services other than under the Care Programme Approach). Where severe and enduring mental health needs existed, the adult mental health services would be responsible for future care. Where they did not, generic health or social services would be responsible. Eligibility for the CPA was determined by a list of illnesses, including persistent psychotic illness, depressive illness and other disorders where the risk of self-harm or harm to others had been serious enough for a hospital admission to have been considered within the previous two years[3]. The lawfulness of the policy had not been challenged in the proceedings.

The P family were Albanian asylum seekers from Kosovo. One member of the family, a six year old son, had been shot dead there by Serbian troops, whilst another, a teenage son, had been tortured. As a result of the traumatic events in Kosovo, Mr P had exhibited signs of depression and a loss of the will to live. Without the assistance of his family, the evidence suggested that he would not have been able to look after himself or even get out of bed. Prior to these events, he had

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1 *Under section 47(1), the local authority must carry out an assessment of a person's needs for community care services if "it appears to the authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services"*

2 *Para 1 of the judgment*

3 *ibid*

lived a normal life and had worked to support the family.

A report following a visit from a community mental health nurse indicated that Mr P was unwilling to be interviewed and that he presented with symptoms suggestive of a depressive episode with psychotic symptoms, and possible symptoms of post-traumatic stress disorder. A consultant psychiatrist, Dr McK, concluded in August 2002 that he was suffering from reactive depression and possibly the early stages of dementia, although Mr P's lack of English made this difficult to assess properly. Even under normal circumstances Mr P would have had only a fairly low level of function. On the same day, Islington wrote to Mr P's solicitors that Mr P was not sectionable under the Mental Health Act 1983. He did not, in other words, satisfy the criteria for compulsory admission to hospital and detention under the powers provided by the Act[4].

On 18th March 2003, Dr B, Dr McK's specialist registrar, visited Mr P and reported in a letter written on the same day that there was no evidence of the abnormal perception or auditory hallucinations which had presented previously, that Mr P had experienced some improvement while on his medication with respect to the paranoid symptoms, but there remained evidence of depressive symptoms.

On the same date, following a CPA meeting, a final version of Mr P's health and social care assessment was signed by Mr P's social worker and her team manager. It concluded that Mr P did not have a firm psychiatric diagnosis but might be suffering from reactive depression resulting from the traumatic events he had experienced in Kosovo. The depression was described as "reasonably appropriate to his circumstances"[5] and was not a severe and enduring mental illness. At the same time, however, he was assessed as being at risk of severe self-neglect and vulnerable to deterioration in his mental state "particularly if he stops taking his medication."[6]

The "statement of need" identified needs under five headings:

(1) a need for prompting to attend to all aspects of daily living including personal care;

(2) a need for reminders to take medication;

(3) treatment with depression and bereavement issues;

(4) safe accommodation with more privacy for Mr P and his family; and

(5) a requirement of support with socialising.

The outcome of the assessment was that Mr P did not meet the eligibility criteria for care management[7].

The CPA community care plan broadly repeated the needs identified in the first document. With the exception of the housing needs, which were to be met by the local authority, all the assessed needs were to be met by provision of support from Mr P's family.

These assessments were challenged immediately by Mr P's solicitors. On 1st April 2003, an independent social work report was obtained, which concluded that Mr P should be placed on an enhanced CPA on account of his "complex and long term mental health needs"[8] and that he was

4 *The criteria for civil detention, outside the criminal justice system, are contained in sections 2(2) and 3(2) Mental Health Act 1983, and are not identical. It is not clear which criteria, those within section 2 or those within section 3, were being referred to in the Authority's letter; see also footnote 21*

5 *Para 9 of the judgment*

6 *ibid*

7 *Para 10*

8 *Para 13*

likely to be suffering from a psychotic illness, not a reactive depression. Further, according to the report, the effect of this on his daily functioning indicated that he should fulfil the criteria for care management and should be allocated a Care Co-ordinator[9]. In consequence two letters of complaint issued from P's solicitors in April 2003 criticising the quality of the community care assessment.

The London Borough of Islington responded on 25th April 2003, explaining that Mr P had been seen by two psychiatrists as part of the community care assessment and that the decision had been made not to provide community care services as Mr P did not have *a severe and enduring mental illness*[10].

The Islington Crisis Resolution Team discharged him on 27th May 2003 following an apparent improvement in his mental state.

On 10th June 2003, the solicitors obtained an independent psychiatrist's report from Dr H, which contradicted that of the London Borough of Islington, concluding that Mr P was suffering from severe depression with psychotic symptoms, which was a very severe mental illness. He fulfilled the ICD 10[11] Diagnostic Criteria for Category F32.3, having suffered depressive symptoms of a psychotic intensity and been unwell for over two years. There was also concern that Mr P might be suffering from an organic brain disorder linked to a history of head injury. The symptoms of his depressive disorder were, moreover, being aggravated by noise from the neighbours. Mr P was therefore in need of regular supervision by mental health services, and without the support of his family would need in-patient care. The report recommended that they should also be well supported and given some respite if possible.

The London Borough of Islington refused to accept Dr H's conclusions, replying that as Mr P had no community care needs, no carer's assessment was required to be undertaken of B, Mr P's son, who was caring for his father[12]. A file note written by the social worker on the same day indicated that there was insufficient evidence for changing Mr P's assessment, that the case should now be closed and the carers' assessment cancelled. On 15th July 2003 Islington wrote to Mr P's solicitors confirming its decision that Mr P did not have a severe and enduring mental illness "*thus* warranting Community Care provision"[13].

Issues

Four complaints were raised on behalf of Mr P.

(1) The first complaint was founded on the statement in the 18th March 2003 health and social care assessment that there was no firm psychiatric diagnosis of Mr P. It was argued that it was therefore unlawful, in the absence of such a diagnosis, for Islington to conclude that Mr P did not have a need for community care services and/or that he did not meet its CPA eligibility criteria.

9 *ibid*

10 *Para 14; emphasis added*

11 *The International Statistical Classification of Diseases and Related Health Problems, 1989 Revision, Geneva, World Health Organization, 1992*

12 *Under the Carers (Recognition and Services) Act 1995 there is a duty, upon request, on the local authority to conduct an assessment of the ability of a carer to provide and continue to provide care; the Carers and Disabled Children Act 2000 now provides for a carer to be assessed at any time, not only when an assessment is being conducted of the needs of the person being cared for*

13 *Para 22 of the judgment (emphasis added by Munby J)*

(2) That the London Borough of Islington failed to reconsider its assessment in the light of the independent psychiatric report from Dr H.

(3) That the authority had erred in its conclusion that Mr P did not meet its CPA eligibility criteria, especially as he had been considered for hospital admission within the previous two years.

(4) The final complaint, the fourth, was that even if Mr P did not meet the CPA criteria owing to the lack of a severe and enduring mental illness, this could not determine whether he had a need for generic health or social services community care.

Judgment

(1) Diagnosis Issue

This argument was rejected by Munby J, confusing as it did two different kinds of statement: one, that there was no firm diagnosis of any condition whatsoever, the other, that there was no firm diagnosis of a particular condition, but which would be consistent with a firm diagnosis of some other condition[14]. It is one thing to say that there is no firm psychiatric diagnosis, quite another to say there is no firm diagnosis of anything at all. Here there was a firm diagnosis, but not of a psychiatric illness falling within the CPA eligibility criteria. It was a diagnosis of reactive depression, on which basis the London Borough of Islington was entitled to proceed, and on the view of their doctors and social worker that Mr P was not suffering from any psychiatric illness within the eligibility criteria[15].

(2) Reconsideration of Medical Opinions

This complaint was factually incorrect. Munby J was of the opinion that the real substance of the complaint was different. Rather, it appeared to be an assertion that, in the face of the clear diagnosis of the independent psychiatrist Dr H, Islington could not continue to rely on the uncertain diagnoses of Dr McK and his specialist registrar, Dr B. It was therefore, ran the argument, irrational to reject Dr H's diagnosis[16].

The complaint also appeared to allege an absence of reasons in Islington's decision, with no indication of whether Dr H's diagnosis was dismissed as wrong or whether, in Islington's view, Mr P remained ineligible for services irrespective of a correct diagnosis[17].

Munby J rejected this latter assertion on the grounds that Islington's refusal to review its decision was clearly based on an acceptance of Dr McK's opinion in preference to that of Dr H[18]. There was no doubt that Dr McK had read Dr H's report; he was, however, merely standing by his earlier opinion. Islington was simply maintaining its position that Mr P did not have a psychiatric condition within the CPA eligibility criteria qualifying him for community care provision.

Moreover, Islington's decision could not be said to be *Wednesbury*[19] unreasonable. It could be argued that Dr H's independent report was based on a more recent visit and more up to date information than that available to either Dr McK or Dr B. In the opinion of Munby J, however, both medical opinions were worthy of careful consideration and neither could be said to be so

14 *Para 26*

15 *ibid*

16 *Para 27*

17 *ibid*

18 *Para 28*

19 *Associated Provincial Picture Houses v Wednesbury Corporation [1948] 1 KB 223*

obviously right as to justify rejecting the other. The views expressed earlier by Dr McK and Dr B, combined with those expressed by Dr McK on reading Dr H's report, did supply a rational basis for rejecting Dr H's diagnosis. Either opinion was one which a reasonable authority could have chosen to follow[20].

(3) Did Mr P meet the CPA eligibility criteria?

The eligibility test was a two-fold one. It depended on the existence of a relevant illness or disorder which also must be sufficiently serious to merit possible hospital admission. Here the authority had determined that Mr P was not sectionable at all[21], and therefore this argument advanced on behalf of Mr P was also unsustainable. In the estimation of Munby J, Islington had not misunderstood or misapplied its own criteria[22].

(4) Community Care other than under the Care Programme Approach

This proposition was one which Munby J had no hesitation in accepting[23]. He also agreed with the argument advanced on behalf of Mr P that there had never been a proper Community Care assessment, only a CPA assessment[24].

The assessments of March 2003 identified some serious and pressing needs, as well as establishing that Mr P was at risk of severe self-neglect and "vulnerable to deterioration in his mental state"[25]. It could not be said that there was no need for investigation. Islington's duty was to produce a "needs assessment" identifying needs which could be met by service provision and then to arrive at a "service provision decision"[26]. This would confirm whether the needs were such as to warrant provision of services by the authority.

Even if it were to be assumed that the first stage of the process had been carried out properly (about which there was doubt) it was clear that the second stage had not been carried out properly or lawfully. Islington had committed an error of law in applying its decision on Mr P's CPA eligibility to the quite different question of his need for generic health or social services community care[27]. It was not merely an administrative matter of filling in the wrong forms[28]. The inherently flawed nature of its reasoning was revealed in crucial passages contained in letters from Islington[29] linking the decision not to provide community care services with the absence of a severe and enduring mental illness. The wrong test had been applied.

The effect of the error was not only to invalidate the second stage of the process, the service provision decision, but also to cast doubt on the valid execution of the first part, the "needs

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20 *Para 32*

21 *See footnote 4; in the case of section 2(2) Mental Health Act 1983, the following criteria would need to be satisfied: "An application for assessment may be made … on the grounds that – (a) he is suffering from a mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment … for at least a limited period; and (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons."*

22 *Para 36*

23 *Para 37*

24 *ibid*

25 *Para 38*

26 *ibid*

27 *This could have been, for example, under section 47(1) National Health Service and Community Care Act 1990, for social care needs; or Standard Two of the National Health Service Framework for Mental Health, Circular HSC 1999/223: LAC (99) 34, which offers medical assessment and treatment to service users (including those not within the CPA) with a common mental health problem*

28 *Para 39*

29 *ibid; see also paragraphs 14 and 22 of the judgment*

assessment". The serious and demonstrable error evident in the approach taken to the fundamental underlying questions must invalidate both parts of the process[30].

The judgment concluded[31] that there had never been a proper and comprehensive community care assessment of Mr P, only a CPA assessment, and in relation to Mr P's community care assessment, the process must begin again.

The Law

Given the complexity of the facts, and the importance of the issue of Mr P's diagnosis in the resolution of this case, it is perhaps hardly surprising that the factual discussion should have figured so prominently in this judgment. It is nevertheless unfortunate that the relevant law and guidance were not afforded greater elaboration, as a judicial analysis would have strengthened the decision against future challenges and provided greater clarity for future claimants and their legal advisers. The judge's thoughts on the distinction between the basis for community care assessments and CPA assessments would have been especially useful.

The Nature of Community Care Services

These are services which a local authority can provide or arrange, under powers contained in "community care" legislation[32], for the benefit of specified classes of people, who are subject to health problems or disabilities which increase their need for care or support. Common examples include the provision of residential accommodation under section 21 of the *National Assistance Act 1948*[33]; provision of support services under section 29 of the same Act[34]; provision of recreational facilities and practical adaptations to the home under section 2 of the *Chronically Sick and Disabled Persons Act 1970*[35]; and the provision of after-care services under section 117 of the *Mental Health Act 1983*[36].

In the case of the section 117 after-care services[37], a joint duty is imposed on both the health and social services authorities:

30 *Para 40*

31 *Para 41*

32 *Listed in section 46(3) National Health Service and Community Care Act 1990, as: Part III National Assistance Act 1948; section 45 Health Services and Public Health Act 1968; section 21 and Schedule 8 National Health Service Act 1977; and section 117 Mental Health Act 1983*

33 *For "persons aged eighteen years or over who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them" and for "expectant and nursing mothers who are in need of care and attention not otherwise available"*

34 *Under section 29(1) "... the local authority shall make arrangements for promoting the welfare of ... persons aged eighteen or over who are blind, deaf or dumb or who suffer from mental disorder of any description, and other persons aged eighteen or over who are substantially and permanently handicapped by illness, injury, or congenital deformity ..."*

35 *See section 29(1) National Assistance Act 1948 for people to whom the section 2 CSDPA 1970 duty applies. Section 28A extends the duty to disabled children in relation to whom a local authority have functions under Part III Children Act 1989 "as it applies in relation to persons to whom section 29 of the National Assistance Act 1948 applies." Services provided under the Chronically Sick and Disabled Persons Act 1970 are now regarded as community care services: Wyatt v. London Borough of Hillingdon [1976] LGR 727, although this continues to take place via the `gateway' of section 29 National Assistance Act 1948, see R v. Powys County Council ex parte Hambidge (1998) 40 BMLR 73, Court of Appeal (1999) 45 BMLR 203*

36 *See also National Health Service Act 1977, paragraph 2(1), Schedule 8*

37 *According to section 117 (1) Mental Health Act 1983: those eligible to receive these services have left hospital after ceasing to be detained under sections 3, 37, 45A, 47 and 48 of the Act*

> "It shall be the duty of the [Primary Care Trust or] [Health Authority] 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] [Health Authority] and the local social services authority are satisfied that the person concerned is no longer in need of such services ..."[38]

Some community care legislative provisions are expressed in mandatory language, imposing a duty on the responsible authorities, such as section 117 of the *Mental Health Act 1983*. Others introduce nothing more than a power to provide the services, although this has sometimes been converted subsequently to a duty[39].

The purpose of these provisions, it could be said, is to ensure, by the provision of services, a minimum quality of life for an individual in the community, whether at home or elsewhere; sometimes the purpose is to enable him or her to live independently away from hospital or residential care[40]. It is however difficult to find a universal purpose here as there appear to be no unifying principles underlying what has been described as a "hotchpotch of conflicting statutes"[41].

A Two-Stage Process: (i) The Duty to Assess and the Right to an Assessment

The local authority must carry out an assessment of a person's needs for community care services if section 47(1) *National Health Service and Community Care Act 1990* applies:

> "... where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority –
>
> (a) shall carry out an assessment of his needs for those services; and
>
> (b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services."

Section 47(1) clearly indicates the existence of a two-stage process: an assessment of that person's needs (the "needs assessment"), which a local authority is obliged to carry out; followed by a decision as to whether those needs can be met by, and are such as to warrant, provision of any community care services (the "service provision decision").

The first stage, the duty to assess, arises on the `appearance of need'[42]: "where it appears ... that any person ... may be in need ...". There need be no proof or certainty that the person definitely does need the services[43]: the possibility that they *may* need them is sufficient to put the authority on notice that an assessment is required. This duty may be triggered by a request from a potential service user or a carer; but a request is not essential: it is probably sufficient that a local authority

38 *Section 117(2), as amended by the Health Authorities Act 1995, section 2(1), Schedule 1, para 107(8)*

39 *The power to provide accommodation under section 21 National Assistance Act 1948 has been converted to a duty by directions, see circular LAC (93) 10 Appendix 1; likewise, the power to provide services under section 29, see circular LAC 93(10) Appendix 2.*

40 *The Code of Practice to the Mental Health Act 1983 takes the view with respect to section 117 Mental Health Act 1983 after-care that "a central purpose of all treatment and care is to equip patients to cope with life outside hospital and function there successfully without danger to themselves or other people": para 27.1, Code of Practice, third edition, Department of Health and Welsh Office, 1999. There are striking similarities with the purpose of the Care Programme Approach: see discussion below*

41 *See Luke Clements, Community Care and the Law, p. 8, third edition, Legal Action Group, 2004*

42 *Luke Clements, op. cit., pp. 62–68*

43 *See also Richard Gordon and Nicola Mackintosh, Community Care Assessments: A Practical Legal Framework, p. 21, second edition, published by FT Law & Tax, 1996*

has the knowledge, from whatever source, that a person may be in need of community care services[44]. The availability of resources should not be considered at the point of determining the need to assess, as the obligation to assess is triggered once an applicant has crossed the threshold test that there *may* be some need for a community care service[45].

A Two-Stage process: (ii) The Service Provision Decision

The duty to carry out the second stage of the process, the service provision decision, is introduced by section 47(1)(b) of the *National Health Service and Community Care Act 1990*. The decision is taken once the needs assessment is complete and discretion is exercised, including resource considerations, as to how to match the services available, or any potential services which could be provided[46], to the needs identified[47]. Guidance on the eligibility of individuals for services has been produced by the Department of Health[48], which proposes four eligibility bands according to the level of an individual's needs, with each authority setting the level of provision for each band and taking resources into account[49].

The Care Programme Approach

The Care Programme Approach (CPA) embodies the basic principles governing the discharge from care and continuing care of all people diagnosed with a mental illness, including dementia. Relevant guidance states that the same approach should also be applied to the after-care of other "mentally disordered" patients[50]. The CPA was required to be introduced by authorities in 1991[51]. There need not have been a *Mental Health Act* detention in order for the CPA to apply[52]. Neither does a person need to have been in hospital[53]. It provides a framework for the care of mentally ill people outside hospital[54]. It is intended to apply to all those receiving treatment and care from specialist psychiatric services[55]. The guidance is explicit on the point that those who have been

44 *Virginia Bottomley, HCD, 15/2/1990, col.1025, mentioned by Michael Mandelstam, in Community Care Practice and The Law, second edition, p. 73, Jessica Kingsley Publishers, 1999*

45 *R v. Bristol City Council ex parte Penfold (1998) 1 CCLR 315*

46 *The assessment should consider whether there is a potential need for all services the local authority has an obligation or a power to provide, not only those which it provides currently: R v. Berkshire County Council ex parte Parker [1998] 1 CCLR 141*

47 *However see the Gloucestershire litigation, especially in relation to provision of services under section 2 Chronically Sick and Disabled Persons Act 1970, where resources may be a relevant consideration in establishing whether this is a "need" which must be met: R v. Gloucestershire County Council ex parte Barry [1996] 4 All ER 421 (Court of Appeal); [1997] 2 All ER 1 (House of Lords)*

48 *Circular LAC (2002) 13, Fair Access to Care Services – Guidance on Eligibility Criteria for Adult Social Care*

49 *Luke Clements argues that community care service provision has developed in a way which is now more `resource' than `rights' oriented: Community Care and the Law, p. 6, third edition, Legal Action Group, 2004*

50 *Health Service Guidelines HSG (94) 27, para 7. The Guidance also states that the CPA circular (see note 51 below) applies only to mentally ill people, but the good practices promoted by the CPA "are equally relevant" to those diagnosed with personality (or psychopathic) disorders who can be "safely and suitably" cared for by specialist psychiatric services in the community, para 20. Likewise, similar arrangements may need to be considered in respect of some people with learning disabilities discharged from in-patient care, para 21*

51 *Health Circular (90)23/Local Authority Social Services Letter (90)11. It appears, however, that strictly speaking it is purchasers of mental health services who bear the bulk of the responsibility of ensuring successful local implementation of the CPA, as it is they who are to ensure that key elements of the CPA are implemented through contracts with providers: HSG (94) 27, paras 39 and 40*

52 *HSG (94) 27, para 8*

53 *ibid, para 9*

54 *Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people, Department of Health, November 1995, para 1.3.4*

55 *Code of Practice to the Mental Health Act 1983, op. cit, para 27.2*

detained under, and discharged from, certain sections of the *Mental Health Act 1983* may fall within both the statutory after-care regime under section 117 *Mental Health Act 1983* and the care programme procedure[56]. Thus the community care provisions and the CPA are not mutually exclusive. There is nothing to indicate that an individual could not be subject to both processes. However, some individuals will be subject to one process, but not to the other[57].

The purpose of the CPA is stated to be "to ensure the support of mentally ill people in the community thereby minimising the possibility of their losing contact with services and maximising the effect of any therapeutic intervention"[58]. The essential elements of an effective care programme include:

- systematic assessment of health and social care needs both in the immediate and longer term;
- a written care plan agreed between professionals, the "patient" and carers;
- the allocation of a key worker (nowadays a care co-ordinator[59]) who will co-ordinate the process by keeping in touch with the patient and monitoring delivery of the agreed programme of care; and,
- a regular review of any progress made by the patient and his or her health and social care needs[60].

Priority is to be given to the most severely mentally ill patients[61].

The Guidance stresses the importance of systematic recording of decisions and actions and of clear arrangements for communication between members of the care team[62]. Great concern is expressed regarding the need for continuity of care and for the avoidance of gaps in service provision ("falling through the net"[63]) owing to poor co-ordination of services or communication. This is to be achieved by introducing and maintaining co-ordinated arrangements for inter-agency working[64].

Finally the Guidance indicates that an overlap does exist between the CPA arrangements and a local authority's statutory duty to assess needs for community care services under the *National Health Service and Community Care Act 1990*, as this duty, it suggests, will be fulfilled if a multi-disciplinary assessment under the CPA is implemented properly[65]. Health and Social Services authorities will need to ensure proper co-ordination between CPA and care management arrangements[66], as it has been suggested that "one way of looking at the CPA is as a specialist variant of care management

56 *HSG (94), para 8*

57 *For example, those who could be subject to the CPA but not section 117 Mental Health Act 1983 after-care planning include those discharged from a section 2 Mental Health Act detention, those discharged from voluntary in-patient care, and those who have always received medical treatment for mental health problems in the community; see section 117(1) for further details of who falls within the authorities' duty to provide after-care*

58 *HSG (94) 27, para 9; see also Building Bridges, op. cit., para 1.3.6*

59 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach, Department of Health, 1999, paras 26, 60*

60 *HSG (94) 27, para 10*

61 *ibid, para 40*

62 *ibid, para 11*

63 *ibid, para 14*

64 *ibid, paras 14 and 15; part of this strategy in relation to higher-risk patients would have been their inclusion on a supervision register (although these have since been withdrawn, see footnote 69): Code of Practice to the Mental Health Act 1983, 1999, at para 27.6*

65 *See Building Bridges, op. cit., para 1.3.8; but the author doubts whether this can be true in every case, see discussion post*

66 *HSG (94) 27, para 16; 'care management' has been defined in Building Bridges in Appendix 1.1 as applying to "all people subject to the CPA who have associated care needs"*

for people with mental health problems"[67]. Moreover since April 2001 the CPA has been integrated with care management to form a single approach for adults with mental health problems[68], with different levels of CPA now in existence[69] to cater for simpler or more complex needs[70].

Comment

The cogent and well-reasoned judgment in this case highlights the very serious consequences for the individual which may flow from an inadequate appreciation on the part of public bodies, of the nature and purpose of processes in which their legal duties oblige them to engage. Happily, on this occasion, the right decision was reached. Injustice to the Claimant and a potential breach of his rights were averted. Mr P's case was sent back to the Authority for a fresh assessment, from which a more promising outcome could be awaited. What remains is to seek to understand why the confusion between the two processes arose, when they have been in operation for the past decade[71], and to expand on the implications of this.

It cannot be denied that similarities do exist between the two processes and that they *can* be confused. They may appear to fulfil similar aims[72], answer the same needs, and can involve the same patients, and the same professionals. They are alike in imposing no legal obligations on recipients of services[73]. Notwithstanding these apparent similarities, it is submitted that there exist important and fundamental differences in terms of creation and underlying purpose.

The CPA process is a strategy introduced by guidance and, unlike community care service provision, has never had a statutory basis[74]. A CPA assessment is not driven by the need to comply with a source of legal authority[75]; it is not clear what sanction a failure to undertake it would attract.

67 *Building Bridges, op. cit., para 3.2.8*

68 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach, Department of Health, 1999, paras 21, 35 to 40; also National Service Framework for Mental Health, Department of Health, 1999; e.g. there should be a single care plan and a single key worker for each person, and any duplications between care management and CPA resolved: Building Bridges, op. cit., para 3.2.12*

69 *E.g. `standard' and `enhanced' levels of CPA : Effective Care Co-ordination in Mental Health Services, op. cit., paras 24, 56–58; see also Building Bridges, op. cit., paras 3.2.2 to 3.2.5; enhanced CPAs now supersede use of the supervision register, Effective Care Co-ordination, paras 25, 59*

70 *A patient with less complex needs should still receive an assessment, not necessarily multi-disciplinary, and a care plan: Building Bridges, op. cit., para 3.1.6; there is a right to a thorough assessment of needs, Effective Care Co-ordination in Mental Health Services, op. cit., para 18*

71 *They both date from 1990: Health Circular (90)23/Local Authority Services Letter (90)11 and the National Health Service and Community Care Act 1990*

72 *"The care programme approach is being developed ...to ensure that ... future patients treated in the community ... receive the health and social care they need, by ... ensuring proper arrangements are made ... for the continuing health and social care of those patients ..." HC (90) 23/LASSL (90) 11, para 4*

73 *There is scant legal authority for this proposition but it is one which finds favour with other commentators: Richard Gordon and Nicola Mackintosh, op.cit., p.23; but as for the right to refuse an assessment, see Luke Clements, op.cit., p. 64*

74 *Circulars not issued under section 7 Local Authority Social Services Act 1970 were treated as strongly persuasive rather than binding in nature, but since the case of R. v. Islington Borough Council ex parte Rixon [1998] 1 CCLR 119, the position seems to be that the guidance contained in them should not be departed from without good reason*

75 *Introducing the Care Programme Approach placed no new requirement to provide services on health or social services authorities: Circular HC (90) 23/LASSL (90) 11, para 1*

The CPA singles out the "mentally ill" for attention and particularly prioritises those who have been diagnosed as "severely mentally ill"[76]. Its overriding concern is for those judged to be at risk of losing contact with the services[77]. It seeks to introduce systems designed to avoid this possibility, chiefly through the co-ordination of administrative procedures for recording, monitoring and reviewing meetings between professionals and service users, and for following up any gaps or anomalies uncovered by these measures. The use of supervision registers was an important example of the thinking behind this strategy: a sort of tracking or 'keeping tabs on' exercise. The details of eligibility criteria for care under the CPA may vary between authorities. The Department of Health has stated that the Care Programme Approach is an approach, and nothing more, and that the NHS Executive will not prescribe exactly what should happen at a local level[78].

Community care service provision is more likely to give rise to legal duties and obligations[79], and even where it does not appear to do so, it is still clearly underpinned by the community care legislation. This means that where an authority has a power to act, but not a duty, it must still exercise its discretion whether or not to use the power. This is a decision which must be made in accordance with the principles of administrative law[80]. Here there was, however, a duty to assess and not merely a power.

The question arises of whether there was an 'appearance of need' which would have triggered the duty to assess Mr P under the *National Health Service and Community Care Act 1990*. Both the purpose and target group of the legislation here, it is submitted, are broader in scope than those within the Care Programme Approach guidance. The language of section 47(1) *National Health Service and Community Care Act 1990* is couched in appropriately inclusive terms:

"... where it appears to a local authority that *any person for whom they may provide or arrange for the provision of community care services*[81] may be in need of any such services, ... the authority shall carry out an assessment ..."

Although there is a single gateway to obtaining community care services – the needs assessment – for an individual in a given situation there may be a variety of ways of satisfying the legal criteria for obtaining services. For the same individual there may be only one set of criteria to be satisfied under the Care Programme Approach, but this should not be surprising considering its self-avowed singleness of purpose. A set of eligibility of criteria which filters out those with a less acutely urgent need of treatment and monitoring reflects that purpose perfectly. If a person fails to satisfy these criteria, however tightly drawn, he or she will simply be treated as "discharged", thereafter to disappear from the CPA picture, regardless of any appearance of need for community care or health services.

76 *See footnote 61*

77 *In the second edition of his book (Legal Action Group, 2000) (at page 185) Luke Clements stated that the CPA is dominated by `risk assessment' issues and is targeted especially at those eligible for section 117 Mental Health Act 1983 after-care services*

78 *Building Bridges, op. cit, at para 1.3.6*

79 *E.g. section 47(1) National Health Service and Community Care Act 1990: "where it appears to a local authority that any person ... may be in need of any such services, the authority ... shall carry out an assessment ...; and ... shall then decide whether his needs call for the provision by them of any such services." Section 117(2) Mental Health Act 1983: "it shall be the duty of the ... [Health Authority] and the local social services authority to provide ... after-care services ..."*

80 *See Clements, op.cit., p. 10*

81 *Emphasis supplied*

Conclusion

This latter hurdle appears to have been the one which Mr P failed to clear. He failed to satisfy the authorities that he suffered from one of the illnesses listed in the criteria, with a risk of self-harm or harm to others serious enough to have warranted consideration for hospital admission during the preceding two years. Yet had a true community care assessment been carried out, it is possible to argue that, for example, he need only, to have qualified for support services under section 29 *National Assistance Act 1948*, have demonstrated the presence of a "mental disorder of any description"[82], arguably a far easier test for him to have satisfied, but for which he was never assessed.

There are many factors within the knowledge of the Local Authority which could have constituted the `appearance of need' of community care services necessary to trigger the duty to carry out an assessment. These include Mr P's reactions to his traumatic experiences in Kosovo, resulting in medical evidence for the existence of post traumatic stress disorder symptoms. These undoubtedly affected his ability to function and to cope with the normal demands of life in a new country, as there seems to have been common agreement, at least on this point, that without the support of his family, Mr P could not have survived here. There was evidence for ongoing depressive symptoms, notwithstanding the Authority's verdict that this was not a severe and enduring mental illness. The possibility of dementia and head injury were also mentioned. In spite of the difficulties of confirming the precise psychiatric diagnosis, with conflicting evidence for and against the presence of a serious mental illness, Mr P's `statement of need' demonstrated clearly the presence of needs which could have been met by community care service provision. Finally, assessments prepared in March 2003 identified him as at risk of "severe self-neglect" and "vulnerable to deterioration in his mental state".

These were the material factors which should have triggered the duty to carry out an assessment. Astonishingly, none of them succeeded in doing so. Not only did the Authority in this case err in rejecting him for consideration for community care service provision on the basis of his eligibility under the Care Programme Approach; the much more serious procedural error and fundamental breach of statutory duty was in failing completely to consider carrying out a proper assessment under section 47 *National Health Service and Community Care Act 1990*, which does not require any consideration of the CPA eligibility criteria. The result was to leave the Claimant, assessed as being at risk and vulnerable to deterioration by the Authority itself, entirely devoid of any support apart from that provided by his family, to whom the whole responsibility of his care was thus consigned.

It is a cause of great concern that such a wholesale misunderstanding of the law should occur at all, and that the effect of an apparent legal compliance on the part of authorities could potentially be to render many individuals like Mr P invisible to the services until such time as they seek redress, or their health and ability to care for themselves deteriorate to the extent that their cases are re-considered. It is perhaps time to press for the drafting of guidance which would set out clearly all the duties which local authorities may have to assess an individual's needs of community care services, the sources of those duties, and the factors which should be considered during the assessment process.

82 *Section 29(1)*

Book Reviews

Community Care and the Law by Luke Clements (3rd edition)

Published by Legal Action Group (2004) £37.00

> "Community care law remains a hotchpotch of conflicting statutes, which have been enacted over 50 years; each statute reflects the different philosophical attitudes of the time"

So concludes Luke Clements in the Introduction to the third edition of *Community Care and the Law*, which to the relief of community care practitioners has just been published. In other words the law in this field is in a mess and cries out for reform in the way that the law relating to children was reformed by the *Children Act 1989*. Sadly, as the author observes there appears to be little sign that this will occur. All this is well known to practitioners and presents a considerable challenge to anyone who seeks to encompass the relevant law in a way that is useful both to the experienced lawyer as well as the non-lawyer who needs to be able to understand its essentials. On both counts Luke Clements succeeds in a way that is masterly.

One of the keys to the author's success is to know what to leave out. As he asks at the beginning: "How can you do justice to the subject and yet exclude detailed consideration of welfare benefits or special education?" He does however do this and for very good reason (the ever changing nature of the former and the availability of alternative sources of information), and he focuses on the central community care statutes listed in the *National Health Service and Community Care Act 1990* – a substantial component of which remains the *National Assistance Act 1948*, a key aspect of the package of legislation that ushered in the welfare state. As a consequence the third edition resolutely maintains the focus of its predecessors on that mishmash of statutes, regulations, directions and guidance that make up the law relating to the provision of community care services and which, at first sight and probably at second sight as well, seems to the uninitiated, terrifyingly complex.

The other key to successfully addressing this topic is to set its development firmly within its historical context. In his Introduction Luke Clements in 8 pages sets out a most succinct summary of the relevant history from the great post-war reforms of 1948 through to the *Health and Social Care Act 2001*, acknowledging on the way the emergence in the 1990s of the disability rights movement, and observing that over the last ten years there has been a marked absence of any radical new thinking by the Government in philosophical or legal terms. The focus has been on structural and administrative reform and he quotes with approval Onora O'Neill's observation in the 2002 Reith Lecture that "central planning may have failed in the Soviet Union but it is alive and well in Britain today"

Having set the scene, the author then proceeds to approach (attack is possibly a better word) the subject in such a way as to disentangle its complexity and persuade even the most timorous reader that it is possible, at the very least, to grasp the essentials of this demanding and at times rather rambling subject. At the outset it is essential to acquire some understanding of the legal basis of the functions of social services authorities and the regulatory framework in which they are undertaken. Some comprehension of the obligatory and discretionary functions of social services authorities (the distinction between which is not always as clear as it may seem), "target" and "specific" statutory duties and the relationship between regulations, directions and guidance are important if the reader is to make headway, and in the first chapter Luke Clements addresses these issues in a clear and comprehensive manner. It is followed by a discussion of the strategic context with an exploration of the obligations of both social services and the NHS to plan strategically, increasingly in collaboration with each other. He then moves to identify the potential beneficiaries of all this effort, and deals with the obligations of local authorities and health bodies to provide disabled people with relevant information, as well as data protection and confidentiality issues.

Having disposed of a number of key contextual issues, the author turns in the next three chapters to address what many would regard as the heart of the subject: the duty of social services to assess need, the provision of services and the care plan, and the important ancillary topic of the meaning of 'ordinary residence' (a reminder of the persistent survival of a number of Poor Law concepts in the current law). Assessment and care planning are as Luke Clements reminds us, central to the social work process and seek to reconcile the demand for services with the resources available. He quotes Phyllida Parsloe's comments of over ten years ago that "the *NHS and Community Care Act* backs a whole field of horses, with the two front runners being user choice and scarce resources. Local authorities are apparently expected to give equal weight to empowering users and keeping within their own budget".[1]

Eligibility for assessment, the nature of an assessment, the assessment process itself, what needs must be satisfied by the provision of services, the issue of resources and the limits of the eligibility criteria (in particular the key case of *R v Gloucestershire CC ex p Barry*[2]), and timescales for assessments are amongst the issues dealt with in the assessment chapter with the assistance of helpful explanatory diagrams. A similar logical approach is taken to the provision of services and care planning with a particularly helpful diagram addressing common service problems.

Care home accommodation and domiciliary and community-based services are the subjects of the next two chapters. Particularly helpful are the discussion about the legal implications of home closures (especially the *Coughlan*[3] case) and the author's attempt to present diagrammatically the ludicrously complicated legal basis for the provision of domiciliary and community based services. An example of the author's attention to detail as well as the practical value of this book for non-lawyers working in the field, is the section on manual handling – relevant not only in care homes but increasingly in domiciliary and community settings.

An alternative way in which local authorities can discharge their community care responsibilities is by way of direct payments. It is probably fair to observe that this particular alternative is where the aims and objectives of the disability rights movement and community care provision appear to be least in

1 *Community Care, "Making a bid for fair play", 5 August 1993.*

2 *[1997] 2 All ER 1*

3 *R v North and East Devon Health Authority ex p Coughlan. [2000] 3 All ER 850.*

collision and the legal framework within which they are administered is presented in a separate chapter.

Social services authorities and their responsibilities are the principal focus of the first nine chapters. One of the reasons for the complexity of the subject is that as Luke Clements notes: "At no time since the formation of the NHS has there been a clear separation between its responsibilities for health services and those of the local authorities for care services." In a chapter entitled NHS responsibilities for community care services, Luke Clements places those responsibilities in a concise historical context and then addresses a number of crucial issues. These include the NHS's continuing health care responsibilities, the scope of which has been exercising the service since at least 1957 and the publication of the Bouchier Report which addressed the worries of local authorities that their residential homes were caring for many people who ought to be in hospital. More recently this problem has been the subject of high profile publicity commencing with the publication of a highly critical Health Service Commissioners report in 1994, the *Coughlan* case, no less than three separate sets of guidance, and finally '*The Continuing Care (National Health Service Responsibilities) Directions 2004*'. That it has taken so long to begin to resolve this issue is an indicator in itself of the wider challenges faced by those seeking to work with the law in this area.

Twenty years ago it is probably correct to note that the law made no provision for the needs of carers in the community. In that time three separate piece of legislation have been enacted that give increased recognition and rights to Britain's 6 million carers, including young carers. One again a consequence of the incremental development of the relevant statutory provision is that the resulting legal framework is in places mind numbingly complex, and the author's diagrammatical representation of the rights of carers is a great assistance in fully understanding the implications of the chapter on carers. Similarly complex are the arrangements for charging for community care services; an issue highlighted in 2002 for mental health services by the decision of the House of Lords in *R v Manchester CC ex p Stennett and others*[4] that it is unlawful for local authorities to charge for services under section 117 of the Mental Health Act 1983. Charging by social services for community services falls under two headings: the general duty to charge for accommodation in registered care homes and the discretionary power to charge for non-accommodation services. In relation to the latter, one of the challenges is that there is no statutorily defined procedure for assessing non-accommodation charges. It is no use pretending that the home care charging rules are very easy to comprehend but the presentation in the text of a tabular example goes a long way to providing some enlightenment.

The next five chapters deal with specific groups of community care service users: people with a learning disability; older people; mental health service users; users of drug, alcohol and HIV/AIDS services; tenants and owner occupiers in receipt of housing-related community care services, and finally children. The chapter on mental health service users helpfully links The National Service Framework standards, in particular Standards 2, 3 and 4, with the Care Programme Approach and entitlements to community care assessments under the *National Health Service and Community Care Act 1990*, and considers the decision in *R (on the application of HP and KP) v London Borough of Islington*[5]. It finishes with a comprehensive examination of the implications of section 117 of the Mental Health Act 1983, and the author's consideration of the duration of the duty under this section is especially helpful.

4 *(2002) UKHL 34. See 'Charging for after-care services under section 117 of the Mental Health Act 1983' by Nicolette Priaulx, JMHL December 2002 pp 313–322.*

5 *[2004] EWHC 7 (Admin). This decision is reviewed by Joanna Sulek in this issue of the JMHL.*

Community Care and the Law concludes with detailed examination of the remedies available in law by which a failure in the provision of community care services may be challenged: for example, the various complaints procedures, judicial review, default powers; and an application to the court under the Human Rights Act 1998. As with the rest of the book the discussion is clear, concise and accessible to the interested non-lawyer.

Since the publication of the first edition, *Community Care and the Law* has been an essential tool for all those who advise on community care entitlements, and the third edition merely confirms that position. It is well presented with a good index and an extensive range of different tables including those listing local government ombudsman complaints decisions referred to in the text and relevant circulars and guidance. In addition a number of helpful precedents are provided. Whilst it is always possible to identify topics that could usefully be included – for example a little more on the implications of the *Disability Discrimination Act 1995* and the *Race Relations (Amendment) Act 2000* for the public authorities undertaking community care responsibilities would have been interesting – this third edition more than enhances the reputation established by its predecessors. It is an essential requirement for anybody seriously interested in this subject.

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The Mental Health Act Commission Tenth Biennial Report 2001–2003

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Reviewing published work requires a particular form of discipline and is perhaps a responsibility that should be more widely distributed. It necessitates and requires attention to detail in reading which, in the modern era of information technology and preoccupation with circulating copy correspondence, data and reports, particularly in the present day health service, may not always be possible to achieve elsewhere given the sheer volume of material that each of us seems to be required to assimilate. On the upside, however, one learns so much more than perhaps one might otherwise. That said, for anyone with even half an interest in mental health law, and certainly readers of this Journal, the *Mental Health Act Commission Tenth Biennial Report 2001–2003* should not pose any sort of difficulty in terms of information overload. Even if one finds oneself at odds with some of the views put forward or recommendations made, and there are no fewer than seventy of the latter, there is no doubt that this book, for that is what it is, is well written and constructed, wide-ranging, clearly thought-through and both stimulating and challenging to all those involved with the operation, management or provision of mental healthcare services at whatever level, from hospital ward staff to Government Ministers. I confess readily that to an academic forensic psychiatrist with a major area of interest in mental health law, like myself, it is a fascinating and absorbing piece of work.

The Report has as its sub-heading "*Placed Amongst Strangers*" which are words taken from John Perceval's 1840 description of his own confinement with mental health problems written in the early part of the reign of Queen Victoria. The quotation from his work entitled "*A Narrative of the Treatment Experienced by a Gentleman During a State of Mental Derangement*" is both apt and well chosen and, albeit regrettably, may still today ring true with many who have been involved, in whatever capacity, with those detained in hospital against their will under compulsory legal powers.

The principal author of the 2001–2003 Report, as stated at the outset is, as in previous years, Mat Kinton of the Commission's Policy Unit[1]. He is to be congratulated once again on the production of such an important document, and on this particular occasion, at so crucial a time in the history and development of Mental Health related law in the UK. As the Chairman, Professor Kamlesh Patel, says in his Foreword, the Commission itself is set for change, and we now have the *Human Rights Act 1998*, and the *European Convention of Human Rights*, both hugely influential and important in relation to the operation of the *Mental Health Act 1983* and other, allied, legislation. In addition, with the judgement in *R (Munjaz) v Mersey Care NHS Trust*[2], the status of the Code of Practice[3] has changed in a way that quite rightly makes it so very much more important, even than previously, in day-to-day clinical practice. There will of course also, and almost inevitably now, be new legislation, probably at least in its preliminary form sooner rather than later. Not only that but

1 *For a summary of the Report by Mat Kinton, see JMHL February 2004, pp 44–51.*

2 *[2003] EWCA Civ 1036. See 'Judicial recognition of the status of the Code of Practice' by Anna Harding JMHL February 2004, pp 66–74.*

3 *Mental Health Act 1983 Code of Practice, The Stationery Office (1999).*

there has been a huge increase in case law rulings relevant to the field of mental health law in recent times, so much so that the Report suggests, probably correctly, that practitioners, in attempting to use the 1983 Act, may have come to feel overwhelmed by the various changes that have been made, even to the point where, as the Commission points out, some seemingly well and long established previous judgements have actually been reversed. One of the other very striking things about the content is the number of times reference is made to cases still being heard, awaiting definitive judgements or simply unresolved "at the time of going to press". So this Report necessarily covers a huge range of issues encompassing recent change and future potential developments.

In the past the issue of the statutory remit of the Mental Health Act Commission has been raised in relation to the scope of its previous Reports[4]. I would not be so concerned. Now, as then, the 2001–2003 "edition" covers a vast area and goes well beyond just the description and presentation of figures for the number of compulsory admissions to hospital or episodes of Second Opinion Appointed Doctor involvements in issues relating to consent to treatment or indeed the day-to-day operation of the Commission itself, its various constituent parts and its individual members and employees. And it is this, to my mind, that makes it of most interest. It remains, of course, vital that good quality data relating to the operation of the Mental Health Act are collected and analysed critically and that all the other required duties, functions and responsibilities of the Commission are comprehensively and properly fulfilled. That, one has to assume, goes without saying and would not be a matter for dispute. What the Biennial Report offers in addition, however, is an opportunity for those with an intimate, detailed knowledge of all areas of the law in this sphere, and also of the ways in which it is so rapidly developing, to offer analysis and opinion from an essentially unique standpoint. Nevertheless, in my view this is not a dense, impenetrable, purely academic or overly analytical, document. Neither is it by any means simplistic, or, in the main, naïve to the realities of, as it were, day-to-day life. In most areas it does not presume the need for expert knowledge or understanding of the underlying principles or detail of the law in order for the reader to be able to approach and grasp the subject matter of the various sections and sub-sections and comprehend their meaning and potential importance. The Report is therefore appropriately, and one imagines quite deliberately, designed to be accessible to all interested parties, not just those from a legal, psychiatric or other professional background. It makes the links between the law and its operation and the reality of the real practical situations encountered in providing services for those subject to involuntary powers quite explicit. It also shows simple good sense and in some areas in particular is extremely effective in offering clarification of complex, difficult concepts and their application.

As it does cover such a diverse range of subject matter it is difficult to pick out specific parts to highlight. There are, however, some areas that may be of particular interest to particular groups. I found the discussion of VBP, or Values Based Practice, both interesting and enlightening. Here this approach, which is intended to foster an understanding and balance of different value perspectives in decision-making in mental health care, and in particular in relation to those surrounding removal of the individual's liberty, is compared and contrasted with Evidence Based Practice. It did seem to me that while the evidence base in its true scientific sense in psychiatry at least is relatively sparse compared to some other areas of medical practice for instance, the

4 *For example, see 'The Mental Health Act Commission, Ninth Biennial Report 1999–2001', by Anselm Eldergill, JMHL February 2002, pp 85–92 @ p 87.*

value-based approach is one which has, hopefully, been espoused in many ways already but which will obviously be further strengthened from being made explicit.

The Report makes much of the fact that there have been a number of important judgements, and others pending, in relation to the use of the *Mental Health Act 1983* and suggests that this may be in part a result of lawyers and the judiciary being willing to pursue different approaches in the light of the likelihood of new law. There is a particularly good, if brief, section in Chapter Six ('Achieving a human rights-based service') which rehearses some of the most important matters to do with compulsory hospital care and stigma.

An issue that should concern us in reading the Report has to do with a number of surveys the Commission has undertaken in relation, for instance, to hospital practice, an example being that concerned with detained patients' access to telephones. What is most regrettable in each of the potentially very important, but nevertheless simple, questions being asked in each of these, is the very disappointing response rates that were obtained. One cannot help but wonder what this means about how the Commission and its work are perceived and how the care of compulsorily detained patients is viewed.

Much of the Report inevitably is written in the context of the human rights background and there is, as one would expect, due weight placed upon the vital issue of user involvement, advocacy and the dissemination of information to patients. Again, there is a particularly instructive section on the role of social workers under the current Act and the potential for the widening of the ASW role to involve other professionals and thus the potential for a considerable change in approach. For anyone interested in either unidisciplinary or multidisciplinary education in mental health care the contrast between the requirements for Section 12 approval of medical practitioners under the 1983 Act and the rigorous teaching and evaluation of social workers in preparation for the role of ASW, which is alluded to in Chapter Eight, is a stark reminder of the evident differences in standards and previous concerns expressed and identified around the whole issue of training of doctors in the use of compulsory powers[5].

Throughout the Report there is the very clear suggestion of the need for better reporting systems for gathering data on the use of the Act nationally when new legislation finally emerges. One can only hope that this will indeed improve and that recording and monitoring will be centralised in some sensible, practicable way, especially to allow for research and audit to improve practice and standards of clinical care.

For those working in the forensic field there are some important areas of discussion around, in particular, liaison with the police over the use of Sections 135 and 136, the place of the *Police and Criminal Evidence Act 1984* and the involvement of police officers at the time of mental health assessments.

Regrettably, there are old concerns raised still which seem to have changed little over the course of time. These include patients contact with their Responsible Medical Officer and, in some cases, the difficulties in identifying the latter. Those regarding the use and practice of secluding patients seemed, to me at least, to be unaltered.

In Chapter Eleven there is a discussion of the use of mechanical restraint. This is interesting in the context of recent recommendations which have emerged in relation to the use of physical restraint

5 *See 'Psychiatrists' knowledge of Mental Health Legislation' by Martin Humphreys, JMHL October 1999 pp 150–153*

of patients by staff[6]. There are, of course, some parts of the world where mechanical restraints are still used in preference to physical methods or sedation by the use of drugs. While I would not wish to argue in favour of the use of the former it is of note that, anecdotally at least, patients have been said to report a preference for this at times rather than having hands laid upon them or being subjected to the degrading experience of the administration of intramuscular injections.

There are two specific points made which exercised me especially. One, on page 127 at sub-section 9.27, is about the use of the term "RMO" to refer to the doctor in charge of any patient's treatment, be they subject to compulsory powers or not. I strongly concur with the view that this should be corrected wherever possible and actively discouraged. It is inaccurate, inappropriate and shows a lack of understanding of the law. Secondly, in Chapter Thirteen, which addresses the *Mental Health Act 1983* and the criminal justice system, it is suggested, within the discussion of the making of hospital orders under Section 37 of the current Act and in relation to the problem sometimes encountered in identifying a bed within the prescribed statutory period, that "28 days to arrange hospital admission is a considerable length of time, ...". Unpalatable and regrettable though it might seem, in reality this is not the case, particularly when it comes, in the present day, to finding a placement in a medium secure facility. This is not the result of poor standards of clinical practice or dilatory management anymore than it is the fault of the courts. At its most simple it is the result of there being too many mentally ill and mentally disordered people who require this sort of placement.

The *Mental Health Act Commission Tenth Biennial Report 2001–2003* is in many ways a monumental piece of work. There will be those who will take the time to read it in its entirety and, in my judgement, this will repay the labour many times over. It lends itself equally well to those who may take an alternative approach and use it as a reference document to dip into at particular times and for a particular reason. It should certainly be included in the library of every psychiatric unit in England and Wales where there are detained patients.

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The Biennial Report can be obtained from
The Stationery Office.
Tel: 0870 600 5522
Fax: 0870 600 5533
E-mail: book.orders@tso.co.uk

6 *See 'Report of the Inquiry into the death of David Bennett' (Chair: Sir John Blofeld QC) (Feb. 2004) (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority).*

Assessment of Mental Capacity – Guidance for Doctors and Lawyers (2nd Edition)

Published by the British Medical Association and the Law Society (2004) £19.50

This is an outstanding book which should be read and retained by all lawyers, doctors and any other professionals, including social workers, who work with those vulnerable to mental disorder or incapacity.

It is nine years since the first edition and the law has developed in several crucial areas since that time. Once more it has a distinguished list of contributors drawn essentially from both the legal and medical professions[1]. The book is jointly published by both the Law Society and the BMA. The aim of the book primarily is to assist doctors and lawyers to apply capacity tests in a series of "real-life" situations.

As with the first edition, the book is very clearly written without the use of jargon. Wherever technical terms are used they are clearly explained and, again as in the first edition, the book is designed for busy professionals to dip into the relevant section without the need to trawl through a complicated index to find what they want; although a clear index is also available. The application of this approach is made clear in the introduction and although this necessarily leads to some duplication, this is far outweighed by the convenience of quick use.

The book starts with a precise and basic outline of the principles behind the assessment of mental capacity. Here the book explains that the law adopts a "functional" approach to capacity tests with the need for an assessment in relation to a particular decision at the time it needs to be made. So the legal understanding for any decision depends on the ability to comprehend the necessary complexity of the relevant decision and, additionally, to apply any relevant test of capacity that exists.

However, before exploring basic legal principles further, the book carefully places the role of both doctor and lawyer in the context of applied ethics for both professions. Thus solicitors are gently reminded that they would be acting negligently if they did not satisfy themselves of a client's capacity before accepting instructions. Issues of confidentiality are reviewed here and the principle of generally retaining this, or at least only releasing the minimum amount of information required to complete a capacity assessment. Here not only is the narrow test arising in *W v Egdell*[2] referred to but also the more recent case of *R (on the application of S) v Plymouth City Council*[3] and the comments of Lady Justice Hale (as she then was) regarding disclosure to a mother of social services records in a case involving the mental impairment of her son.

Lawyers are further reminded of the "golden rule" set down in *Kenward v Adams*[4] of obtaining approval, or witnessing, of a will of an aged or potentially unwell testator. Again the prospect of a negligence action hovers over those who do not comply!

1 *The Managing Editor of the book is Penny Letts, Policy Consultant to the Mental Health Act Commission, former Law Society Policy Advisor on Mental Health and Disability, and a contributing author to both this edition and the first edition of 1995.*

2 *[1990] 1 All ER 835*

3 *[2002] EWCA Civ 388*

4 *(1975) The Times 29/11/75*

As part of its "practical approach" in the application of proper ethics in this area, the book offers an excellent range of ways in which "the right environment" can be created for the subject of an assessment. Thus, for example, an assessor should try to:

- "minimise stress and anxiety";
- consider if factors leading to incapacity could be treated or whether otherwise capacity is likely to improve;
- consider the side-effects of any medication;
- consider cultural issues or language problems;
- consider the best time of day for the assessment;
- consider the role of background noise, and the avoidance of rapid repetition of cognitive tests or interruptions (such as from mobile phones).

This list alone, which was not included in the 1995 edition, should be compulsory reading for all doctors required to assess capacity. It was developed by Denzil Lush, Master of The Court of Protection, and is aimed to protect the highly vulnerable likely to be the subject of a capacity test. It shows great sensitivity for such subjects and its proper application could make the difference as to whether someone is found to lack capacity or not, with all the prospective and dramatic life-changing implications arising from such decisions. This list is supplemented by a useful "model letter" of instruction covering various situations.

In its useful summary of ethical issues for lawyers, the book obviously takes the opportunity of applying the 8th Edition of the Law Society's "*Guide to Professional Conduct*" published in 1999.

In its review of legal principles the book again takes a practical approach. It reminds instructing lawyers that not all doctors are experts; furthermore even those who are will need to be asked the correct questions to make a proper assessment. Here there are also invaluable sections outlining "practical suggestions" for the instructing of doctors. There is a straightforward review of the legal position with regards to the rebuttable assumption of capacity. This is expanded to include a review of any "ongoing" lack of capacity, if that has been found initially, and the arising of any "lucid period" of capacity; potentially important in the field of mental health law given the fluctuating nature of some mental illnesses. A brief consideration of the standards of proof and evidence is included.

There is an introduction (expanded upon in the "medical treatment" section) of the need to make decisions as to capacity and resulting "best interest" actions on a daily basis without the intervention of a Court. Here, and throughout the book, the opportunity is included to add reference to the latest caselaw, for example *Re MB (Medical Treatment)*[5], together with the role of the *Human Rights Act 1998* and relevant post-Act cases such as *R (on the application of Wilkinson) v Broadmoor Special Hospital Authority & Others*[6]. As in the earlier edition a "Sample" certificate of Capacity is included.

Once it has completed its consideration of the "basics" the book moves on to expand on the application of capacity tests in particular areas. These are the same as those in the 1995 edition and cover effectively what most doctors and lawyers will face in practice.

5 *[1997] 2 FLR 426*

6 *[2001] EWCA Civ 1545*

At the top of the list comes the issue of financial affairs. Again the book assumes no specialised knowledge, commencing with a review of the powers of attorney, both ordinary and enduring. However, with regards to application of the latter the book is able to add the important new case of *Re K*, *Re F*[7] and the "four factors" which any person creating an enduring power of attorney (EPA) should understand; that is the complete authority over the donor's affairs; the range of this power over any property; the permanence on arising incapacity: and its irrevocability, without the confirmation of the Court of Protection. The importance of registering the EPA is outlined and the statutory form explained. Here, as throughout the book, reference is made to the impending new legislation in relation both to Mental Capacity and Mental Health, together with their potential implications; these, of course, include the wider definitions of mental disorder requiring the involvement of the Court of Protection. That Court's role and functions (in its less expansive existing form) is given a useful outline. For social workers there is a valuable summary regarding Appointeeship. Finally, the implications of the phrase "capacity to manage property and affairs" is now expanded in light of the case of *Masterman-Lister v Brutton & Co*[8], including the comments of Lord Justice Kennedy in that case. Thus legal capacity is based on *understanding* rather than wisdom; it is essentially *functional and subjective* and that *background personal information* including family and social responsibilities should be considered. Such capacity remains essentially "issue specific".

Another much used application of the capacity test will be that applying to the creation of Wills. A useful checklist is included, broken down into the *nature* of the act; the *effect* of the act; the *extent* of the property; and the *claims* of others. In addition to classic cases such as *Parker v Felgate*[9], more recent cases (such as *Buckenham v Dickinson*[10]) are included, again reminding lawyers of the importance of the "golden rule" (supra).

No list of specific capacity tests would be complete without the inclusion of those applying to the ability to consent to, or refuse, medical treatment. Again the book adopts a systematic and basic approach in explaining the position: first setting out the general proposition of the need for patient consent and then moving to explore the question of capacity in relation to that. Two critical cases have, of course, arisen in the area since the first edition: *Re C (Adult: Refusal of Medical Treatment) (1994)*[11] and *Re MB (Medical Treatment)*[12]. Thus, of course, in C the evolution of the test for capacity as applied to a patient from Broadmoor suffering from schizophrenia is clearly spelt out as set down by the then Mr. Justice Thorpe; that is *understanding and retention; believing; and weighing in the balance for a decision to be made*; in turn illustrating the difference between the common law capacity test and that required for detainability under the *Mental Health Act 1983*. This test was essentially confirmed in Re MB by the Court of Appeal, here allowing that a phobia of needles might render a patient incapable.

The book then clearly follows the familiar path set down in *Re F (Mental Patient: Sterilisation)*[13] in clarifying the doctrine of necessity applicable in incapacity cases, including temporary unconsciousness cases, in order to carry out treatment to ensure improvement or prevent deterioration in health. The duty to act by way of necessity is then coupled with an explanation of the 'best interests' concept, confirmed by the recent case of *Re S (Sterilisation: Patient's Best Interests)*[14]. Thus doctors are reminded to consider a range of factors, including the patient's wishes

7 *[1998] 1 All ER 358*
8 *[2003] 3 All ER 162*
9 *(1883) 8 PD 171*
10 *[1997] CLY 661*
11 *[1994] 1 All ER 819*
12 *[1997] 2 FLR 426*
13 *[1990] 2 AC 1*
14 *[2000] 2 FLR 389*

and values, the effectiveness of treatment, the least restrictive option, the views of those close to him, together with his cultural and religious values. There is then an explanation as to how the Court would view a range of situations, including those rare ones where intervention would be required and those day-to-day ones which require doctors to act under the existing common law. Adapted guidelines include the incorporation of the case of *St Georges Healthcare NHS Trust v S*[15] and updated BMA Guidance.

The important and evolving area of "advance statements", including the proposals for legal reform in this area, are then considered, including of course, an analysis of the implications of *Re T (Adult: Refusal of Treatment)*[16]. Finally important practical advice is given to the role of the *Data Protection Act 1998*, again a new development subsequent to the first edition.

Other specific tests of capacity covered include the capacity to consent: to sexual relations (including a consideration of sexual offences); to research; to vote; to litigate; and to enter into contracts.

The book ends with two important chapters on practical guidelines for both doctors and lawyers in assessing capacity. For doctors, critical issues regarding the application of the capacity are outlined, including the requirement to properly clarify the role of the assessment and a lawyer's instructions. For lawyers, the need to fully outline the factors required in the assessment are stressed as well as the need to choose the appropriate expert. A model letter of instruction is included in the appendix as well as illustrative case studies. These are accompanied by updated Guidance Notes and Practice Directions from the Official Solicitor and from the Court of Protection. Useful resources, and addresses, including website details, complete the book.

This is certainly a book which is required reading for all doctors and lawyers; and not just for those who are "regulars" in the field. This second edition builds on the highly successful format of the first edition with even greater emphasis on practical application and with succinct coverage of legal developments and their implications. Questions of capacity could arise at any time for both types of practitioner and failure to act in the manner outlined in this book could well lead to successful negligence suits and perhaps even gross misconduct actions. However, perhaps more importantly the book could prevent serious exploitation and miscarriages of justice with its very clear guidance for entrusted professionals to properly carry out their duties towards this highly vulnerable group of people, a group which could well include our family or friends and, in the future, ourselves.

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Solicitor and partner, Kaim Todner Solicitors (London); Chair of the Mental Health Lawyers Association.

The book can be obtained from BMJ Bookshop, c/o John Smiths Medical Bookshop, 399–401 Oxford Road, Manchester, M13 9BL; alternatively e-mail: orders.bmj@johnsmith.co.uk.

15 [1998] 3 All ER 673

16 [1992] 4 All ER 649