ISSN 1466-2817

Journal of Mental Health Law

NORTHUMBRIA
LAW • PRESS

May 2005 pages 1–100

Journal of Mental Health Law

May 2005 Edition No. 12. Pages 1–100

Notes for contributors

Material intended for publication should be sent to the Editor, John Horne, School of Law, Northumbria University, Sutherland Building, Northumberland Road, Newcastle upon Tyne, NE1 8ST, United Kingdom or e-mailed to john.horne@northumbria.ac.uk.

The Editor encourages the submission of articles, case reviews and comments on topics of interest in the area of Mental Health Law. When submitting manuscripts for publication, it would be helpful if authors could observe the following suggestions:

Form of manuscript

Contributions should be typed with double spacing throughout on one side of uniform size paper (preferably A4 size) with at least a one inch margin on all sides. Manuscripts should be submitted in triplicate and pages should be numbered consecutively. Submissions on disc will be accepted where they are of Word 6 format. In such cases a hard copy should also be submitted. Articles should be a maximum of 5,000 words. Longer articles will be considered at the Editor's discretion. A cover page should be included, detailing the title, the number of words, the author's name and address and a short biographical statement about the author.

All papers submitted to the Journal of Mental Health Law are refereed and copies will not be returned except by request and unless a postage paid envelope is provided by the author.

Footnotes and references

Footnotes to sources should be numbered in one consecutive series of Arabic numerals and placed at the foot of the page. Footnote style must conform to the standards set forth in a Uniform System of Citation, published by Harvard Law Review Association. The publishers are unable to check the accuracy of references and the onus of the accuracy falls on the author.

Copyright

It is the responsibility of the author to obtain any permission necessary to reproduce or quote from published work and suitable acknowledgment should always be made.

Yearly subscription rates (2 issues)

£50 Organisations
£30 Individuals
Please contact Ann Conway: 0191 243 7593
E-mail ann.conway@northumbria.ac.uk

The views expressed by contributing authors are not necessarily those of the Journal of Mental Health Law.

Contents

Page

Foreword

As readers of this journal will be all too aware, there has been much activity in the world of mental health law since the last issue of the JMHL was published[1]. For example, in October 2004 the European Court issued its long-awaited judgment in the case of *H.L. v United Kingdom*[2] (the 'Bournewood' case). By the end of the year the Government had provided 'Interim Advice'[3] on the implications of the judgment, to be followed three months later by the promised 'Bournewood' Consultation document[4]. Throughout the winter months the *Draft Mental Health Bill*[5], published in September 2004, received a most thorough, comprehensive and public scrutiny, and at the end of March, the Joint Parliamentary Scrutiny Committee published the fruits of their extensive labours in a highly critical and concerned report[6]. In the meantime the *Mental Capacity Bill* was making its way through the complex procedures of Parliament before finally receiving the Royal Assent on 7th April[7], just over 10 years after publication by the Law Commission of its influential Report, '*Mental Capacity*'[8].

Furthermore the domestic courts have witnessed judicial consideration of a number of issues. For example: Approved social workers have learnt that the number of circumstances in which they are not obliged to consult with the patient's nearest relative is greater than many had previously thought[9]; Mental Health Review Tribunals (MHRTs) have received further advice on the distinction between deprivation of liberty and restriction on liberty when considering the position of a restricted patient[10]; the standard of proof in MHRT hearings has received detailed judicial analysis[11]; the Court of Appeal has declared that the lack of provision within the *Mental Health Act 1983* for MHRT access by (a) the 'incapable' section 2 patient; and (b) the section 2 patient whose detention is extended beyond 28 days[12], is incompatible with Article 5(4) of the European Convention on Human Rights[13]; the House of Lords has disagreed with the Court of Appeal on the significance of mental disorder classification when determining the lawfulness of compulsory treatment[14]; responsible medical officers have received further judicial encouragement in relation to the use of section 17 leave[15]; and, the Home Secretary has been advised about his responsibilities when contemplating the transfer of a mentally ill prisoner[16].

Such developments are obviously good news for the editor of a journal devoted to issues in the area of mental health law. There is plenty to write about, to consider and to analyse. However it also has its 'down side'. Firstly how can it all be covered? Secondly how can it be ensured that in a rapidly-changing scene, what is published is up-to-date at the time of publication? So far as the first question is

1 *September 2004*

2 *App. No 45508/99 (5/10/04)*

3 *Department of Health – 10/12/04*

4 *Department of Health – March 2005*

5 *Cm 6305-1*

6 *HL Paper 79-1, HC 95-1*

7 *Mental Capacity Act 2005. The Stationary Office. ISBN 0 10 540905 7*

8 *Law Com 231, published in February 1995*

9 *R (on the appl'n of E) v Bristol City Council [2005] EWHC 74 (Admin)*

10 *R (on the appl'n of G) v MHRT [2004] EWHC 2193 (Admin); R (on the appl'n of Secretary of State for the Home Dept.) v MHRT [2004] EWHC 2194 (Admin)*

11 *R (on the appl'n of DJ) v MHRT and R (on the appl'n of AN) v MHRT (and interested parties) [2005] EWHC 587 (Admin)*

12 *By application of section 29(4) Mental Health Act 1983*

13 *R (on the appl'n of MH) v Secretary of State for Health [2004] EWCA Civ 1690 (soon to be considered on appeal by the House of Lords)*

14 *R v Ashworth Hospital Authority (Appellants) and another ex parte B (FC) (Respondent) [2005] UKHL 20*

15 *R (on the appl'n of CS) v MHRT and Managers of Homerton Hospital (East London and the City Mental Health Trust) [2004] EWHC 2958 (Admin)*

16 *R (on the appl'n of D) v Secretary of State for the Home Office (1) National Assembly for Wales (2) [2004] EWHC 2857 (Admin)*

concerned, it is perhaps appropriate to re-state that although we aim to publish topical, thoughtful, analytical and high quality articles of interest to the readership, we do not seek to provide a comprehensive 'news' coverage of all significant developments. Other publications, organisations and specialist solicitors' firms provide that service. The second question can be more problematic, and indeed has been particularly so in the preparation of this issue for publication. As noted above, a lot has happened in recent months, particularly in the period between the date of acceptance of articles for publication and the date of the issue 'going to press'. It has been possible and appropriate to amend some, although not all, articles at the proof-reading stage. Where a query might arise in the reader's mind as to when a particular article was finalised, we have sought to provide the answer in a footnote on its first page. In this way we trust that any confusion will be rapidly resolved.

So, what does this issue contain? We lead with the publication of the Paul Sieghart Memorial Lecture delivered by Brenda Hale for the British Institute of Human Rights on 7th July 2004. We are very grateful to Lady Hale and the Institute for permission to publish this acclaimed[17] consideration of the question 'What can the Human Rights Act do for my mental health?'. Within this lecture Lady Hale identifies 'those core human rights values in the mental health field', and powerfully states that 'underlying and overriding' all such values is 'respect for the equal dignity and humanity of all people, however great their disorder or disability'. Given the facts that gave rise to the litigation which spanned a seven year period culminating in the Strasbourg decision of October 2004[18], it seems most appropriate to follow Lady Hale's lecture with 'Making sense of Bournewood'. This article by two of the lawyers most involved with the Bournewood litigation, Robert Robinson (H.L.'s solicitor) and Lucy Scott-Moncrieff, provides very welcome consideration of the practical implications of the decision, and is of course most timely given the 'Bournewood' Consultation document published by the Department of Health at the end of March.

On 12th November 2004 the Law School of Northumbria University, together with Eversheds (solicitors), hosted the 2nd North East Mental Health Law Conference in Newcastle upon Tyne[19]. We are very pleased to publish three papers arising from (and updated since) the Conference. Denzil Lush, Master of the Court of Protection, very helpfully considers 'The Mental Capacity Act and the new Court of Protection'. Genevra Richardson (chair of the Expert Committee established in 1998 to consider possible reforms to mental health legislation[20]) tackles the unenviable but much-needed task of comparing and contrasting critical provisions of the proposed mental health and mental capacity legislation in 'Two Bills; Two Agendas'. Jill Peay (a member of the Expert Committee, and the author of '*Decisions and Dilemmas - working with mental health law*'[21]) in an article entitled 'Decision-making in mental health law: can past experience predict future practice?' looks at how practitioners make decisions within the existing legal framework and makes a number of observations against the backdrop of both the *Mental Capacity Act 2005* and the *Draft Mental Health Bill 2004*.

In the December 2002 issue of the JMHL, we published a number of 'responses' from individuals and organisations to the *Draft Mental Health Bill 2002*[22]. Following publication of the 2004 Draft Bill, we had intended to repeat this exercise. However we soon appreciated that if we did so we would be in danger of simply replicating a number of submissions made to the Joint Parliamentary Scrutiny Committee,

17 *For example, in an address to the Human Rights Lawyers Association on 6th April 2005 Richard Gordon Q.C. described the lecture as 'masterly'.*

18 *See footnote 2*

19 *The 3rd North East Mental Health Law Conference will be held in Newcastle upon Tyne in June or July 2006.*

20 *The Report of the Expert Committee, 'Review of the Mental Health Act 1983', was published by the Department of Health in November 1999.*

21 *Hart Publishing (2003) – reviewed in the February 2004 issue of the JMHL.*

22 *Cm 5538-1*

submissions which are readily accessible on line. Therefore we abandoned the idea. Instead we confine ourselves to two responses to the draft Bill, one from an individual and the other from an organisation. Mat Kinton, Senior Policy Analyst with the Mental Health Act Commission, but writing in a personal capacity, in a detailed consideration of the Draft Bill's contents, raises the question, 'Mental Health Law for the 21st Century?'. We are also pleased to publish 'The Law Society's response to the Draft Mental Health Bill' which we were grateful to receive following a request made to the Society.

As noted above, the Joint Parliamentary Scrutiny Committee reported their findings at the end of March. This followed months of receiving detailed oral and written evidence. All those who care about the future development of mental health law in England and Wales surely owe a considerable debt of gratitude both to those who submitted the evidence, and to the Committee members themselves, for the energy and commitment applied to the debate, not least since many will also have contributed previously at various stages of what has become a very long drawn-out review of the law[23]. The *Draft Mental Health Bill 2004* has been widely criticised but it can certainly be credited with providing the stimulus for many to participate in a wide-ranging public debate about the future direction of mental health law. We are very grateful to Lucy Scott-Moncrieff for providing a preliminary response to the findings of the Scrutiny Committee in her article 'A sense of déjà vu'. It is also an 'immediate' response – the article was submitted for publication on the day the Committee reported in the hope that it would be published in this issue of the JMHL rather than having to wait for the November issue.

In 'A private function', David Hewitt, who kindly contributes so regularly to the JMHL, has analysed the Administrative Court's decision in *R (on the application of Mersey Care NHS Trust) v Mental Health Review Tribunal; Ian Stuart Brady (1st Interested Party); Secretary of State for the Home Department (2nd Interested Party)*[24]. This case was concerned with a consideration of how a MHRT should respond to a request from a patient that it conduct its proceedings in public. Readers may well be disappointed that this issue does not carry any other case reviews. Space will be made available to ensure that some of the cases referred to earlier in this Foreword (and maybe others which arise in the interim period) are analysed in the November 2005 issue.

This issue concludes with a review by Simon Foster of the 9th edition of the Mental Health Act Manual by Richard Jones[25]. The first line of the review states that 'a new edition of the Mental Health Act Manual is always an event'. Since it was published in the autumn of 2004, publication of a further edition of this book is clearly another significant 'activity' which should have been referred to in the opening paragraphs of this Foreword. The book is of course quite invaluable to all who work in, and/or study, this area of law.

As always, we are very grateful to all those who have so generously contributed to this issue of the JMHL.

John Horne

Editor

23 Starting with the appointment of the Expert Committee in September 1998.

24 [2004] EWHC (Admin) 1749

25 Sweet and Maxwell (2004)

What can the Human Rights Act do for my mental health?

Paul Sieghart Memorial Lecture 2004[1]

Brenda Hale[2]

There are at least three reasons why I should not be here! First, I am standing in for Amartya Sen and the very idea that I should be thought able to do so is preposterous. Second, and much to my regret, I never knew Paul Sieghart. Fortunately, though, I recently chanced upon a wonderful portrait of him by Paul Benney. This confirmed all that I had ever heard about him – a formidable intellect combined with originality and humanity as well as considerable good looks. Even if I should not be here, I am glad to be able to honour his commitment to human rights in some small way. Third, although I listen to lawyers' arguments about human rights almost every day, I sometimes wonder whether we can recognise a real human rights abuse when we see one.

Here are a couple which seem obvious to me but would they seem obvious to the law?

> "An agency worker told us about going into a home at breakfast time. She was instructed to get the residents up and onto their commode. She was then told to feed them breakfast. When she started to get the residents off their commodes first she was stopped. The routine of the home was that residents ate their breakfast while sitting on the commode and the ordinary men and women who worked there had come to accept this as normal."
>
> "... a man in his 80s, in a nursing home,... needs assistance to get dressed and uses a catheter. That man was made to sit with absolutely no clothes on in a double room with 5 members of staff, a mixture of male and female staff for over 25 minutes whilst they took turns to do the bits that they needed to do, with the door wide open leading into the corridor.... One was coming in to wash him, another one was coming in to change his catheter bag, another one was coming in to change his medication, and he was just left sitting with absolutely no clothes on whatsoever in the middle of this congregation taking place around him, with people walking past the door...."

Those extracts come from the research done by Jenny Watson for the British Institute of Human Rights, published in December 2002[3] She found a lamentable ignorance of human rights values

1 *This is the text of the Paul Sieghart Memorial Lecture delivered for the British Institute of Human Rights at King's College, London, on 7 July 2004. The footnotes have been updated (to January 2005) to take account of later developments*

2 *Baroness Hale of Richmond*

3 *Something for Everyone: The impact of the Human Rights Act and the need for a Human Rights Commission, 2002, British Institute of Human Rights*

amongst the providers of public services for vulnerable people. The Human Rights Act was seen as something for the lawyers, rather than 'something for everyone... for the good of the people.' Perhaps this is part of the generally negative image of the Act portrayed in the media, who seem to see it as a vehicle for stopping the Government doing things that it wants and the people want it to do, rather than as a vehicle for protecting and enhancing the core values of human dignity as well as human freedom. That is why I want to ask the question, 'what can the Human Rights Act do *for* my mental health?'

What are those core human rights values in the mental health field? Services for mentally distressed and disabled people are perpetually struggling to reconcile three overlapping but often competing goals: obtaining access to the treatment and care that people need, safeguarding their civil rights, and protecting the public. Basing myself on the 1991 United Nations' *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*,[4] I would sum up those core human rights something like this:

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

(2) That treatment and care should be available to all who need it, without discrimination on grounds such as sex, racial or ethnic origin, membership of a particular religious or social group, or the nature of their disability (including, I would add, their age).

(3) Enabling should not entail enforcing: a person's right to choose – at least if she is capable of choice – what may be done to her body or her mind should only be taken away with due legal process.

(4) That due legal process requires (i) principled grounds for intervention; (ii) a fair machinery for determining disputes; and (iii) appropriate and humane treatment and care in return.

(5) Underlying and overriding all of these is respect for the equal dignity and humanity of all people, however great their disorder or disability.

These are grand aspirations which we cannot hope to meet all of the time. What can the Human Rights Act do to help us try? The difficulty is that the law generally is better at preventing people and authorities from doing things than it is at making them take the necessary let alone desirable action. The same is true of the Human Rights Act. The European Convention on Human Rights was originally aimed at some very different targets. As we all know, it emerged from the horrors of the Second World War, the holocaust and the advance of communism across Eastern Europe. Like the United States Constitution, its focus is on freedom: freedom from slavery and torture, from arbitrary imprisonment, from intrusions into private and family life, freedom of religion, of expression and of association, freedom to marry and found a family, and freedom from confiscation or interference with property rights. Unlike the Universal Declaration of Human Rights, the Beveridge Report which led to the post war welfare state, and some later human rights instruments,[5] it did not address the other great freedoms: from want, from disease, from squalor, from ignorance, and from idleness. It is, if you like, the New Zealand Bill of Rights Act 1990, which says in section 11:

"Everyone has the right to refuse to undergo any medical treatment",

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

5 *Most prominently in the United Nations International Covenant on Economic, Social and Cultural Rights, 1966; also in the United Nations Convention on the Rights of the Child, 1989*

rather than the Bill of Rights in the Constitution of the Republic of South Africa 1996, which not only says in section 12:

> "Everyone has the right to bodily and psychological integrity, which includes the right... (b) to security in and control over their body... "

but adds in section 27:

> "(1) Everyone has the right to have access to – (a) health care services...
>
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."

This focus on freedom makes it easiest to use the European Convention to improve the procedural protection against compulsory detention and treatment. That is where most of the successful activity has been. This dates back to the first case of *X v United Kingdom* (1981) 4 EHRR 181, long before the Human Rights Act, but has continued since. An early declaration of incompatibility related to the requirement for patients to prove to a tribunal that they were not detainably ill rather than for the hospital to prove that they were.[6] This led to the first remedial order under section 10 of the Act.[7] But there are some big ideas in the Convention which it might be possible to put to more constructive use.

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

A delegate to last year's International Congress on Law and Mental Health ruefully observed that the only people in the United States with a constitutional right to free health care are serving prisoners. Over here too, it may be easier to use the Convention to secure proper treatment for compulsory hospital patients than for others. The usual route to this is through Article 3, which prohibits the use of torture and inhuman or degrading treatment or punishment.

This is an unqualified right: there are no ifs and buts. If the conduct complained of comes within Article 3, it cannot be justified or excused. This has understandably led to a very high threshold test of severity, although it does have a strong subjective component in the effect on the individual concerned: see, for example, *Keenan v United Kingdom* (2001) 33 EHRR 38, paragraphs 108 and 109:

> "108 The Court recalls that ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum is relative: it depends upon all the circumstances of the case, such as the duration of the treatment, its physical and/or mental effects and, in some cases, the sex, age and state of health of the victim.
>
> 109 In considering whether a punishment or treatment is degrading within the meaning of Article 3, the court will also have regard to whether its object is to humiliate or debase the person concerned and whether as far as the consequences are concerned it adversely affected him or his personality in a manner incompatible with Article 3. This has also been described as involving treatment such as to arouse feelings of fear, anguish and inferiority capable of humiliating or debasing the victim and possibly breaking their physical or moral resistance or as driving the victim to act against his will or conscience."

6 *R (H) v Mental Health Review Tribunal [2001] EWCA Civ 415; [2002] QB1*

7 *Mental Health Act 1983 (Remedial) Order 2001, SI 2001 No 3712*

The Strasbourg case law and literature tend to deal with prisoners and patients together. But in *R (Munjaz) v Mersey Care NHS Trust; R (S) v Airedale NHS Trust* [2003] EWCA Civ 1036; [2003] 3 WLR 1505 (paragraph 55) the Court of Appeal was keen to point out the difference. For prisoners, the mere fact of detention is an end in itself, as prevention, deterrence and punishment. For patients, detention is not, or should not be, an end in itself. It is merely the means to an end, which is treatment and care. Hospitals are there to look after people, contain their symptoms and hopefully make them better. They are not there simply to imprison and keep people off the streets. Standards that might be acceptable in a prison, therefore, ought not be acceptable in a hospital.

On the other hand, viewed from the point of view of the patient or even the outsider looking through the door, a great deal of what goes on in psychiatric hospitals has the potential to be inhuman or degrading. But the Strasbourg court has imported a concept of medical necessity into its assessment of what amounts to inhuman or degrading treatment. In *Herczegfalvy v Austria* (1992) 15 EHRR 437, the Court started well in paragraph 82:

> "The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit of no derogation."

But then it gave the game away:

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

Mr Herczegfalvy had been force-fed, forcibly given psychotropic drugs, and most worryingly kept for more than two weeks in handcuffs and tied to a security bed, but the Court decided (in paragraph 83) that

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

Although this was in many ways a very conservative decision, the Court of Appeal was able to use it in *R (Wilkinson) v RMO Broadmoor Hospital* [2001] EWCA 1545; [2002] 1 WLR 419 to hold that the court must be able to hear evidence and adjudicate upon disputes about a controversial treatment decision which may breach the patient's Convention rights. Simon Brown LJ put it this way (in paragraph 26):

> "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... his RMO and, depending upon the court's conclusion on that issue, as to whether the proposed forcible administration of such treatment would (a) 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."

How far is this concept of medical necessity dependent on the patient's incapacity? It was argued in *Wilkinson* that to impose treatment forcibly upon a patient who had the capacity to refuse it was a breach of his Convention rights, either under Article 3 or Article 8 (of which more later). Under the English Mental Heath Act, however, the criteria for detention do not depend on incapacity and most forms of medical treatment for her mental disorder may be imposed upon a detained patient against her will, albeit some only with a second opinion. What did the European court mean in *Herczegfalvy* by 'patients who are entirely incapable of deciding for themselves'? Was it referring to a legal or a mental disability? I see the logic of saying that treatment for mental disorder should be no different from treatment for physical disorder. If so, it can only be given with the consent of a capable patient or where it is necessary in the best interests of an incapable one.

But I also see dangers in using capacity as a criterion for defining what is degrading treatment. Why should it be acceptable to treat an incapacitated person in a way which would be degrading if done to a capacitated person? This obviously would not do with, say, living conditions, food, and general care. What difference should it make if the elderly people described in my earlier examples were or were not demented? In *Wilkinson* (at paragraph 79), therefore,

> "...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."

Thus far I have been looking at the preventive or negative aspects of Article 3. But it also has the potential to develop a positive right to appropriate treatment: one which says, if you are going to take away the liberty of a vulnerable person, there are certain minimum standards of care with which you must provide him. The best statement is in *Keenan v United Kingdom* (2001) 33 EHRR 38:

> "110 It is relevant in the context of the present application to recall also that *the authorities are under an obligation to protect the health of persons deprived of liberty*. The lack of appropriate medical treatment may amount to treatment contrary to Article 3. In particular, the assessment of whether the treatment or punishment is incompatible with the standard of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment.
>
> 112 ... there are circumstances where proof of the actual effect upon the person may not be a major factor. For example, *in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3*. Similarly, treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be capable of pointing to any specific ill-effects." (my emphasis, not theirs)

This is reminiscent of ideas being developed by Larry Gostin 20 years ago.[8] It is reflected in the principle of 'reciprocity' developed by the much-lamented Richardson Report[9] which preceded the Government's current attempts to reform mental health law. There is even a glimmer in the draft Mental Health Bill, published for consultation in 2002. This required as a condition of compulsion that 'appropriate medical treatment is available in the patient's case'.[10] That falls somewhat short of an enforceable obligation to provide that treatment, but might the courts be prepared to construct one either under Article 3 or under Article 8?

Article 8 gives everyone the right to respect for their private and family life, their home and their correspondence. Unlike Article 3, it is a qualified right. Interference is permissible under Article 8(2) if: (i) it is in accordance with a national law which conforms to the Convention concept of legality (ie it must be sufficiently clear and predictable to enable the citizen to conform his conduct to it); (ii) it is for a legitimate aim (eg 'the protection of health or morals' or 'the protection of the rights and freedoms of others;' and (iii) there is a pressing social need to which it is a proportionate response.

As with Article 3, Article 8 has both a negative and a positive aspect. Primarily, it is there to prevent the state interfering arbitrarily in family and private life. But it may do so to protect, for example, the health and welfare of a child. If it does so, the Court of Appeal has said that there should be a corresponding obligation to use its best endeavours to supply an alternative family life which will better protect the child's health and welfare.[11] This again is the notion of reciprocity where compulsory powers have been used.

So far, however, Article 8 has rarely featured in mental health law, except in relation to patients' correspondence: Mr Herczegfalvy won his complaint about unjustified censoring of his mail while losing his complaint about how he was treated. I do see how dangerous it is if institutions are allowed to cut off an inmate's access to the outside world, but it is equally dangerous if there is nothing that anyone outside can do about her treatment in the institution. So far, the Strasbourg court has not found it necessary to consider complaints about treatment in prison or hospital under Article 8 separately from complaints under Article 3. But there are indications that it may be prepared to do so. The concept of private life is a fluid and dynamic one. It includes physical and moral integrity. The Court has said, in *Bensaid v United Kingdom* (2001) 33 EHRR 205 (at paragraph 46), that treatment which does not reach the severity of Article 3 treatment may nonetheless breach the right to respect for private life in Article 8 if there are sufficiently adverse effects on physical and moral integrity. It went on (at paragraph 47):

> "Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity. Article 8 protects a right to identity and personal development, and the right to establish and develop relationships with other human beings and the outside world.

8 *Gostin L, 'The Ideology of Entitlement: the Application of Contemporary Legal Approaches to Psychiatry' in Bean P, ed, Mental Illness: Changes and Trends, 1986, Wiley; see also 'Human Rights of Persons with Mental Disabilities: the European Convention on Human Rights' (2000) 23 (2) Int J Law and Psych 125*

9 *Review of the Mental Health Act: Report of the Expert Committee (Chair: Professor Genevra Richardson), 1999*

10 *Cm 5538–I, 2002, Draft Mental Health Bill, clause 6(5). The same condition is repeated in the 2004 re-draft, currently under scrutiny by a Parliamentary Committee: Cm 6305–I, 2004, Draft Mental Health Bill, clause 9(6)*

11 *Re W and B (Children) [2001] EWCA Civ 757; [2001] 2FLR 582; reversed by the House of Lords under the name Re S(Children; Care Order: Implementation of Care Plan) [2002] AC 291, but not, I believe, on this point*

> The preservation of mental stability is in that context an indispensable precondition to effective enjoyment of the right to respect for private life."

The threshold for what constitutes 'interference' under Article 8 can be much lower than for 'inhuman or degrading treatment' under Article 3, because of the qualifications. The qualifications are a sensitive instrument for determining whether the interference was indeed justifiable and proportionate. And the concept of 'respect' is also a powerful one because it is capable of bringing with it positive as well as negative obligations. Whether in due course Strasbourg would be willing to develop these to require minimum standards of appropriate treatment and care for vulnerable people who are unable to secure these for themselves, I do not know.

But there are signs that Strasbourg is beginning to develop concepts of self-determination and autonomy out of Article 8. In *Pretty v United Kingdom* (2002) 35 EHRR 1, it upheld our law's ban on assisting suicide but appears to have thought (at paragraph 61) that Article 8 was engaged:

> "Though no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees."

A great deal of what goes on in hospitals and care homes betrays a lack of proper respect for patients' and residents' privacy and autonomy. Many of the incidents noted in the BIHR research show this only too well. Promoting a positive attitude to their rights as human beings could be a much more effective way of attaining proper standards than the big sticks of criminal or civil liability or even the Care Standards Act.

But what about securing proper treatment and care for people outside hospitals and care homes? One might naively have thought that it would be a breach of the right to liberty, protected by Article 5, to detain someone in hospital for the sake of her mental health if she did not need to be there. But the English cases suggest that it will rarely be possible to complain even if the only reason for the continued detention in hospital (or in the particular type of hospital) is the lack of appropriate community or half way house facilities. If a patient still meets the criteria for detention, our law says she may be detained. It does not say where she should be detained. Nor does it oblige the authorities to find appropriate facilities for a patient whom the hospital or a mental health review tribunal deems ready to move on but not ready for immediate discharge into the community. Even if she could be discharged into the community with appropriate help and support, the law only obliges health and social services authorities to use their best endeavours to arrange this.[12] For some patients, the tribunal has power to order a conditional discharge, but if the community agencies do not make the arrangements necessary to meet the conditions, our courts have held that it is not contrary to Article 5 to continue to detain a person who is 'of unsound mind' within the meaning of the Convention.[13] It would be otherwise if he were no longer 'of unsound mind' at all:[14] but the Convention criteria set out by the Strasbourg court in *Winterwerp v The Netherlands* (1979) 2 EHRR 387 (paragraph 39) are not very demanding:

> "The very nature of what has to be established before the competent national authority – that is a true mental disorder – calls for objective medical expertise. Further, the mental disorder

12 *R (K) v Camden and Islington Health Authority [2001] EWCA Civ 230; [2002] QB 198; W v Doncaster MBC [2004] EWCA Civ 378*

13 *R (IH) v Home Secretary [2003] UKHL 59 upholding [2002] EWCA Civ 246; [2003] 3 QB 320; W v Doncaster MBC [2004] EWCA Civ 378*

14 *Cf Winterwerp v Netherlands (1979) 2 EHRR 387 and Johnson v United Kingdom (1999) 27 EHRR 296*

> must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder."

There is as yet little hint of a positive obligation to provide what the patient needs to be able to live safely in the community. Yet we know that it is the failure to do this which so often keeps people in unsuitable surroundings long after they could have moved on. The other side of the coin is that people may be forced into unsuitable institutional care, against their will, because of a lack of adequate domiciliary services to keep them within their own homes. The BIHR report gives many examples of this: elderly people who are not incontinent being expected to use incontinence pads because there is no-one to help them to the lavatory.

It is in this area of access to proper treatment and care that the Convention has least to offer, but there are a few ideas on which to build.

(2) That treatment and care should be available to all who need it, without discrimination on grounds such as sex, racial or ethnic origin, membership of a particular religious or social group, or the nature of their disability (including, I would add, their age)

One of the complaints made in the BIHR research was that the level and standards of community provision for elderly people varied so much from place to place. Article 14 requires that

> "The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

Some other Convention right must be in play, even if it has not actually been breached. So it might be possible to attack some inequalities of access on the basis that the right to respect for private life in Article 8 was engaged even if it had not been breached. Differences in treatment which serve a legitimate aim are allowed, as long as they are proportionate to that aim. But the Court has said that 'very weighty reasons' would be required to justify differences of treatment based solely on race or gender. In the UK, there is some evidence of inequality in access to mental health care based on gender, rather less of it based on ethnicity, but much more of it based on socio-economic status.[15] The inequalities can cut either way: in the use of compulsion or in the offer of services of particular kinds. For example, drug therapy is available to all, but talking treatments are much less readily accessible. The whole picture is distorted by the use or prospect of compulsion, which deters people from seeking treatment, denies them the right to choose the treatment they want, and prioritises certain kinds of patient in the offer of services.

The use of compulsion also raises some more fundamental questions about discrimination between people with mental disorders and everyone else. Why should the criteria for treatment for mental disorder be different from the criteria for treatment for physical disorder? In other words, why should not this too depend upon consent or incapacity? And why should capacitated people be able to make advance directives about treatment for future physical disorder but not about treatment for future mental disorder? But is mental disorder or disability a 'status' for the purpose of Article 14? If it is, and Article 8 protects personal integrity and autonomy, when is it justifiable to distinguish between that group and others in the enjoyment of that right?

15 A Rogers and D Pilgrim, Mental Health and Inequality, 2003, Palgrave Macmillan

(3) Enabling should not entail enforcing: a person's right to choose – at least if she is capable of choice – what may be done to her body or her mind can only be taken away with due legal process

The Convention can protect against forcible interferences with liberty and self-determination. Indeed, some would say that it is rather too good at doing this, at the expense of affording access to desperately needed treatment and care. But there is still the so-called 'Bournewood gap':[16] the common law allows necessary treatment and care, including admission to psychiatric hospital, to be given without consent and without legal formality to those who are incapable of making the decision for themselves and do not actively protest. The Mental Capacity Bill, now before Parliament, maintains the basic principle that the compliant person without capacity may be given care and treatment without formality, although it does set some limits and provide some safeguards. Is incapacity a rational and sufficient reason for drawing this distinction? *Bournewood* was argued last year before the European Court of Human Rights in Strasbourg but news of a result has not yet reached me.[17]

(4) That due legal process requires (i) principled grounds for intervention; (ii) a fair machinery for determining disputes; and (iii) appropriate and humane treatment and care in return

This is the area where the Convention ought to do best. Under Article 5(1)(e) only those who are genuinely 'of unsound mind' can be deprived of their liberty. Yet in *Winterwerp* (paragraph 37) the Strasbourg court deliberately declined to define that concept,

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

There was little hint there of the philosophical debates about the justifications for compulsion which have been worrying mental health lawyers for decades if not centuries. The Richardson Committee, like the Law Commission in its work on mentally incapable adults,[18] saw much of the answer in a rigorous definition of incapacity, although they acknowledged the need to cater for some who posed a risk to others. If incapacity were the criterion, rather than the severity of symptoms or the prospect of harm to others, then some people might be given the help they need before their situation became too desperate.

The other problem is that the Convention provides protection against arbitrary deprivation of liberty in the narrow sense of detention. Restrictions are not covered, especially if they are for the person's own good. Thus a discharge from hospital on conditions which still restrict the patient's

16 *Re L, R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] 1 AC 458*

17 *The Court gave judgement in the Case of HL v United Kingdom, App No 45509/99 on 5 October 2004. It found that, in contrast to the facts in HM v Switzerland [2002] MHLR 209, the applicant had been deprived of his liberty, that the lack of procedural safeguards meant that this was not lawful contrary under article 5.1, and that there was no procedure meeting the requirements of article 5.4 available. Accordingly, the Mental Capacity Bill, currently before Parliament, does not permit patients without capacity to be deprived of their liberty under the codified doctrine of necessity; but it has not yet been decided what will take its place*

18 *Report on Mental Incapacity, 1995, Law Com No 231*

liberty, by requiring her to live in another hospital or hostel, even under 24 hour surveillance and only allowed out under escort, may not amount to a 'deprivation of liberty' under Article 5.[19] The difference is one of degree rather than kind, so Strasbourg has found that measures taken in the best interests of a patient or child are less likely to amount to a deprivation of liberty.[20] This means that the procedural protections of Article 5 may not apply if and when compulsory treatment in the community becomes possible.

The best procedural protection is that required under Article 5. Article 5(4) requires a speedy review of the lawfulness of detention: and this has to be a proper merits review which can lead to release. Article 6 requires a fair process in the determination of civil rights and liabilities: and even if the right to bodily self-determination is not fully protected under the Convention, it is undoubtedly a civil right in domestic law. But protection of civil rights has traditionally been individually initiated after the event: people can sue for monetary remedies if wrongly interfered with and occasionally obtain an injunction to prevent it in advance. The same now applies to past or threatened breaches of Convention rights. There is also a useful procedural component in Article 8, under which Strasbourg has developed the right to be involved in the decision-making processes before the authorities interfere with the right to respect for family life: there is no reason in principle why the same should not apply to interferences in private life.

We have already seen that the Convention may help to secure appropriate and humane conditions of treatment and care for people detained in institutions, although the Strasbourg institutions appear able to tolerate much that we would not.

(5) Underlying and overriding all of these is respect for the equal dignity and humanity of all people, however great their disorder or disability.

Human dignity as a distinct concept has recently begun to appear in constitutions and human rights instruments; an example is the Constitution of the Republic of South Africa 1996 (s 10):

> "Everyone has inherent dignity and the right to have their dignity respected and promoted."

The Strasbourg court emphasised in *Pretty v United Kingdom* (paragraph 65):

> "The very essence of the Convention is respect for human dignity and human freedom."

I would suggest that human dignity is all the more important for people whose freedom of action and choice is curtailed, whether by law or by circumstances such as disability. The Convention is a living instrument. The recent development of its ideas on gender reassignment, homosexuality and sentences of life imprisonment gives me hope that it can develop a more positive role in the field of mental health. We need to be able to use it to promote respect for the inherent dignity of all human beings but especially those who are most vulnerable to having that dignity ignored. In reality, the niceties and technicalities with which we have to be involved in the courts should be less important than the core values which underpin the whole Convention. If everyone in the mental health and community care services were imbued with and committed to those values, I am sure that it would do much more for my mental health, and that of everyone else, than any number of cases in the courts.

19 *R (Home Secretary) v Mental Health Review Tribunal, PH interested party [2002] EWCA Civ 1868*

20 *HM v Switzerland [2002] MHLR 209 (admission of an elderly woman to a nursing home); applying Nielsen v Denmark (1988) 11 EHRR 175 (admission of a 12 year old boy to a psychiatric hospital)*

Making Sense of Bournewood

Robert Robinson[1] and Lucy Scott-Moncrieff[2]

Introduction

The judgment of the European Court of Human Rights (ECtHR) in *HL v UK*[3] has been understood by some commentators as making it unlawful, without the use of formal legal powers, to give treatment in a psychiatric hospital to a person who lacks capacity to consent and over whom the mental health professionals directly involved are exercising complete and effective control. This understanding follows from a reading of the judgment which equates complete and effective control with deprivation of liberty for the purposes of Article 5 of European Convention on Human Rights (ECHR). If this interpretation is correct, the same principle would apply to people living in nursing homes who require a high level of care and supervision and who lack capacity. While the former could be formally detained in hospital (or a 'registered establishment')[4] under the Mental Health Act 1983 (MHA), the Act's detention powers do not extend to other care settings.

This article suggests that to understand the ECtHR's judgment in HL v UK it is necessary to take account of the unusual facts of the case. It is suggested that it does not follow from the judgment that the admission of a compliant incapacitated patient will necessarily deprive that person of liberty for the purpose of Article 5. The Government's initial responses[5] to the judgment fails to distinguish admissions which do engage Article 5 from those which do not. It is suggested that the Government should provide guidance to assist mental health professionals and others to make this distinction in individual cases.

Why was the Bournewood case brought?

In July 1997, when he was admitted informally to a psychiatric hospital (Bournewood) under the common law principle of necessity, HL had been living with Mr and Mrs E for three and a half years. He had come to them under an adult fostering scheme as part of the process of closing the long-stay institution where he had lived for over 30 years. Mr and Mrs E do not run a residential care home. HL lives with them as a member of the family. Caring for HL is not easy. He is profoundly autistic, without speech and capable of only very restricted social interactions; he needs help with his self-care and with eating; his behaviour is unpredictable: something as simple as a shopping trip may have to be called off because of his distress or disruptive behaviour; he needs to be with someone at all times and is not good at adjusting to new people or new situations.

1 *Solicitor, Scott-Moncrieff , Harbour and Sinclair (London), solicitor for HL*

2 *Partner, Scott-Moncrieff, Harbour and Sinclair (London)*

3 *HL v The United Kingdom (Application no. 45508/99). Judgment 5th October 2004*

4 *s.34(2) MHA 1983*

5 *Ms R Winterton, Minister, Department of Health to the Standing Committee on the Mental Capacity Bill on 28 October 2004; Department of Health Advice – 10 December 2004*

To look after HL is a major commitment. Mr and Mrs E have seen that he has benefited enormously from their care and has achieved a measure of happiness and fulfilment which is beyond anything they would have believed possible when he first came to live with them in 1994. This is without doubt a community care success story. If authoritative confirmation were needed, it is to be found in the report of the Health Service Ombudsman, which is quoted in the Strasbourg judgement, to the effect that HL has a significantly better quality of life with Mr and Mrs E than he would have in institutional care.[6]

So why did Mr and Mrs E bring the case, beyond the simple fact that in July 1997 HL was removed from their care without their agreement?

- First, because they were convinced that there was no valid clinical justification for taking him to hospital and keeping him there, a view which finds powerful support in the Ombudsman's report.
- Second, because they believed he was unhappy and distressed in hospital, and that he wanted to return home.
- Third, because they knew that institutional care was inferior to what they could offer.
- Fourth, because they had no confidence in the psychiatrist who had arranged HL's admission. They were aware that she had not seen him for many months prior to the incident – a very minor incident – which provided the justification for his admission.
- Fifth, because they believed that the psychiatrist and other members of the local NHS learning disability service had convinced themselves that Mr and Mrs E were not suitable carers. This was despite the contrary opinion of the social services learning disability team, and the truly outstanding care manager, who is referred to in the Strasbourg judgement as AF, and abundant evidence attesting to the exceptional quality of their care, which was to be found in care plans and in the minutes of regular care planning meetings. Mr and Mrs E feared that reasons would be found to justify delaying HL's return home and that eventually a point would be reached where their claims, based on love and affection but also on their conviction that HL wanted to live with them and had benefited from doing so, would be displaced by professional opinions about his best interests, derived from a combination of clinical judgement and self-serving notions of 'good practice'.

Proceedings in the Domestic Courts

Acting as HL's litigation friend, Mr. E commenced judicial review proceedings and issued a writ of habeas corpus. For the case to succeed it was necessary for the court to find both that HL was detained in Bournewood hospital and that there was no lawful justification for his detention. The Trust asserted that he was not detained, as he was not subject to either physical coercion or legal powers of detention. But if, on the contrary, he was detained the Trust asserted that his detention was lawful by virtue of section 131(1) of the MHA which permitted the informal admission of compliant incapacitated patients under the common law principle of necessity.

The proceedings failed at first instance because the judge found HL was not detained.[7] HL's appeal to the Court of Appeal was allowed. The judges concluded that HL was detained because he was

6 *See the reference to the Health Service Commissioner's investigation of the case which is summarised in paragraphs 50 – 51 of the ECtHR's Judgment.*

7 *Judgment of Owen J, 9th October 1997.*

not free to leave: "*had he attempted to leave the hospital, those in charge of him would not have permitted him to do so*".[8] The Court decided that only those with capacity to consent could lawfully be given in-patient psychiatric treatment otherwise than under formal Mental Health Act powers: "*They were only allowed to admit him for treatment if they complied with the statutory requirements ... The [hospital's] powers to act under the common law doctrine of necessity can arise only in relation to situations not catered for by [the Mental Health Act]*".[9] It followed that HL was, in the Court of Appeal's judgment, unlawfully detained.

In giving this judgment, the Court of Appeal did not make findings as to the desirability of HL remaining in hospital. The Court's decision meant that the hospital had to choose either to discharge HL or to admit him formally under the MHA and thus render his detention lawful. They chose the latter. He was then able to exercise his right to apply for his discharge. In December 1997 there was a short hearing before the hospital managers. Their decision was to discharge HL from section 3 with immediate effect and he returned home.

At the instigation of the Department of Health, the Trust appealed against the Court of Appeal's judgment because of its wide implications. The Department said that if the judgment was allowed to stand, it was possible that an additional 48,000 people would have to be detained under the MHA every year. HL lost in the House of Lords, where it was held that his admission was authorised in common law by the principle of necessity.[10] The law, as stated by the House of Lords, was once more that the compliant mentally incapable psychiatric patient could be admitted and treated under common law without recourse to MHA powers and safeguards, even if the admission amounted to detention.

Proceedings in the European Court of Human Rights

An application was then made to the ECtHR. The issues before the court were:

- Was HL detained for the purposes of Article 5 of the ECHR?
- If so, was his detention in accordance with a procedure prescribed by law, as required by Article 5(1)?
- And was he afforded his right under Article 5(4) to have his detention reviewed by a court, in the light not only of domestic law requirements but also in accordance with the principles established by case law under the Convention on detention of persons of unsound mind?

The ECtHR found that he was detained for the purposes of Article 5; that his detention was not in accordance with a procedure prescribed by law because under the common law principle of necessity there was an absence of procedural safeguards to protect against arbitrary deprivation of liberty; and that he was denied his right under Article 5(4) because there was in 1997 no domestic court which could review the Article 5 lawfulness of his detention.

In relation to admission to psychiatric hospital, the effect of the decision in *HL v UK* is twofold:

1) Where a person who lacks capacity is admitted to hospital in circumstances which amount to deprivation of liberty, informal admission under section 131(1) of the MHA will be unlawful, as being in breach of the right in Article 5(1) not to be arbitrarily detained.

8 *R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998] 2WLR 764, per. Lord Woolf MR.*

9 *Ibid.*

10 *R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] AC 458.*

2) Pre-Human Rights Act (HRA) judicial review proceedings were not capable of fulfilling the requirements of Article 5(4).

The judgment also has clear implications where someone who lacks capacity is detained elsewhere than in a hospital. Such a person enjoys the same rights under Article 5 as someone who is detained in a hospital but under domestic law the simple expedient of an application for admission under Part II of the MHA is not available to remedy the breach of Article 5(1).

The Government's Response to the ECtHR's Judgment

The Government's response to the decision was published on 10th December 2004.[11] This was followed by proposed amendments to the Mental Capacity Bill.[12] In relation to point 1) above, the Mental Capacity Bill was to be amended to permit the creation of a new legal mechanism for authorising the detention of people who lack capacity, to be known as protective care. It would have applied to: "*persons who lack capacity, for the purpose of providing them with treatment or care which is determined, in accordance with the regulations, to be in their best interests*". The Government had intended that details of the procedures and safeguards under the protective care regime would be left to regulations made under the Bill, having stated that their drafting would have followed consultation with interested parties to "*ensure that there are procedural safeguards which are effective, proportionate and deliverable in practice*".[13] However on 17th March 2005 Parliament's Delegated Powers and Regulatory Reform Committee ruled the proposed amendments as unacceptable, presumably concluding it to be inappropriate to leave issues of such fundamental importance to regulations rather than primary legislation. The Mental Capacity Act was passed without any reference to the issues, but the "Bournewood" Consultation document, published by the Department of Health in March, makes it clear that the Government still wishes to bring in its "protective care" provisions.

The Government's response to the Article 5(4) point was to assert, as it did in the Strasbourg proceedings, that the position has changed fundamentally since the passage of the Human Rights Act. According to the Government, judicial review proceedings brought by a person alleging unlawful detention would now require the court, in a case where Article 5 lawfulness rests on the detained person being of "unsound mind", to apply the *Winterwerp* criteria.[14] The regulations to be made under the Mental Capacity Bill would have provided for: "*the circumstances in which a person's protective care must, and those in which it may, be referred to a prescribed court (or tribunal) for a decision as to whether it should continue*" and "*as to rights of persons in protective care to appeal to such court (or tribunal) as may be prescribed*".[15] It is not clear which court (or tribunal) is intended to have jurisdiction under the proposed 'protective care' regime. But if judicial review is to be used, there will have to be major changes to the system to allow non-means tested legal aid, to abolish the requirement to get permission, to provide for automatic references, and to allow solicitors without higher rights of audience to advocate on behalf of the detained person. What is clear is that Article 5(4) requires a review of the substance of the medical and other evidence relevant to Article 5(1)

11 *Advice on the Decision of the European Court of Human Rights in the Case of HL v UK (The "Bournewood" Case).*

12 *Amendments to be moved by Baroness Ashton of Upholland (Minister, Department of Constitutional Affairs) on Report, printed on 22nd February 2005. (http://www.publications.parliament.uk/pa/ld200405/ldbills/027/amend/am027–a.htm).*

13 *Paragraph 31 of the Advice, footnote 7 ante.*

14 *Winterwerp v Netherlands (1979–80) 2 E.H.R.R. 387, ECHR.*

15 *It is not clear what is meant here by the reference to a prescribed court or tribunal but the regulations would appear not to have contemplated such cases being heard by mental health review tribunals as constituted under the MHA.*

lawfulness. In effect, the court (or tribunal) would be performing, in respect of a detained person in protective care, the function performed by the mental health review tribunal in reviewing the lawfulness of the detention of patients under the MHA.

Providing Additional Safeguards for Compliant Incapacitated Patients

In principle, a legal regime, albeit falling short of full MHA protection and safeguards, which provides greater protection for mentally incapacitated people who require a high level of care, whether in hospital or elsewhere, is to be welcomed.

There are, however, a number of concerns about the embryonic protective care regime.

a. There would be two parallel legal frameworks for people lacking capacity who are deprived of their liberty: full MHA protection and protective care. This would necessarily give rise to the difficulty of deciding into which regime a given individual fits.

b. It is likely that some individuals would, as their mental capacity fluctuates, move between the two regimes, which would make for undesirable complexity and increase the number of court or tribunal hearings.

c. There is a risk that a two-tier system, where protective care offers lesser safeguards, would perpetuate the present distinction between the long-term mentally incapacitated and others, for example people who experience episodes of acute mental illness, whose capacity fluctuates.

d. This distinction would be reinforced if the regime for the long-term incapacitated offered fewer rights and safeguards than full MHA protection, and would perpetuate, in a new form, the "Bournewood Gap".[16] Of particular importance in this context is the right under section 117 to free after-care, which one assumes would not be extended to people discharged from protective care.

One reason the Government proposes a new framework of protective care is presumably to deal with those people who are detained elsewhere than in hospital and therefore fall outside MHA detention powers. It is suggested, however, that the necessary legal safeguards could instead be provided by an enhanced MHA guardianship regime. Where the effect of placing someone under guardianship is to deprive them of their liberty, the admission and discharge criteria would have to comply with Article 5, which would mean in such cases applying the same legal test for any detection element of guardianship as for admission to hospital under the MHA. Arguably, this could be achieved without amending the MHA because by virtue of section 3 of the HRA, primary legislation must so far as is possible be "read and given effect in a way that is compatible with the Convention rights".[17] There would, however, following *R (MH) v (1) Secretary of State for Health (2) Mental Health Review Tribunal*,[18] have to be a system for automatic referral of deprivation of liberty guardianship cases to the mental health review tribunal in order to comply with Article 5(4).

16 *This refers to what was said by Lord Steyn in his speech in the House of Lords: "Given that [compliant incapacitated patients] are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of [the MHA] from a large class of vulnerable mentally incapacitated individuals."*

17 *See Ghaidan v Godin-Mendoza [2004] 2 AC 557.*

18 *See R (MH) v (1) Secretary of State for Health (2) Mental Health Review Tribunal [2004] EWCA Civ 1609, where it was held that Article 5(4) requires there to be a mechanism to ensure that the case of a patient detained under s2 and judged to be incompetent is referred, within the 28 day period, to the mental health review tribunal.*

Deprivation of Liberty

Prior to the decision in *HL v UK*, those proposing additional safeguards for mentally incapacitated adults did not generally make a connection between deprivation of liberty and reciprocal rights and safeguards. This is true, for example, of the Law Commission's recommendation, in its report on Mental Incapacity, that some of the protective aspects of the MHA regime, such as the consent to treatment provisions, should be extended to informal mentally incapacitated patients.[19] The same approach was also found in the Mental Capacity Bill which, as originally drafted, was not concerned with deprivation of liberty. What is different now, following *HL v UK*, is that deprivation of liberty has unavoidably become the touchstone for certain rights and safeguards, specifically those guaranteed by Article 5. It is therefore essential in every case to decide whether or not the person concerned is being deprived of liberty. In this regard the Government's guidance, which goes little further than quoting excerpts from the ECtHR's judgment, is of very little assistance. The amendments put down by the Government to the Mental Capacity Bill defined detention as: "*any deprivation of liberty within the meaning of Article 5(1) of the Human Rights Convention*".

The starting point under Article 5, in determining whether a person is being deprived of their liberty, is "*the specific situation of the individual*".[20] HL's situation during his 5 months in Bournewood hospital included the following factors:

- He did not have any family members who could be consulted about the admission.
- Immediately before admission, he had been living in a family home with his carers, Mr and Mrs E, for over three years.
- His carers were opposed to the admission and at all times wanted him to return home to live with them (which he eventually did).
- Initially they were banned from visiting him.
- He had a significantly better quality of life with Mr and Mrs E than Bournewood hospital could offer.
- His care co-ordinator, an experienced social worker, believed he did not need to be in hospital and would have been better off at home.

The guidance issued on 10th December 2004 emphasises the statement in the Court's judgment that: "*the key factor in the present case [is] that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements...*". Other commentators have also tended to treat this statement as the ratio decidendi of the case.[21] The paradox is that if this is what the ECtHR meant by deprivation of liberty then, because of the nature of his condition, it is difficult to envisage circumstances in which HL is free. Wherever he is, whether at home, in hospital or anywhere else, someone has to take responsibility for HL's care and, if necessary in the interests of his own safety, control his movements. When he is at home with

19 *Mental Incapacity, The Law Commission, Report 231, March 1995.*

20 *This is taken from the judgment in HL v UK.*

21 *The following is taken from Morgan Cole, solicitors Mental Health Law Bulletin 13, dated 13th October 2004: "On the issue of detention, the ECtHR held that during his time in hospital the patient had been under continuous supervision and control and was not free to leave the hospital. It made no difference whether the ward in which he was treated was locked or lockable. The patient had therefore been deprived of his liberty for the purposes of Article 5(1)."*

Mr and Mrs E they do not allow him out on his own, and if he went off they would bring him back. But this level of control is consistent in HL's case with a care regime which maximises his freedom and autonomy, for example by providing opportunities for him to attend social gatherings and to participate in a range of everyday activities such as shopping and going out for a meal. Whatever distinguished life for HL in Bournewood hospital from life at home with Mr and Mrs E, it cannot be that in one situation but not the other he was subject to the exercise of "*complete and effective control over his care and movements*". The answer must lie elsewhere.

The judgment continues: "*...His responsible medical officer (Dr M) was clear that, had the applicant resisted admission or tried to leave thereafter, she would have prevented him from doing so and would have considered his involuntary committal under section 3 of the 1983 Act. The correspondence between the applicant's carers and Dr M ... reflects both the carers' wish to have the applicant immediately released to their care and, equally, the clear intention of Dr M and the other relevant health care professionals to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence: the applicant would only be released from the hospital to the care of Mr and Mrs E as and when those professionals considered it appropriate.*"

It could be argued that the relevant distinction here is between Mr and Mrs E as private individuals and the Bournewood mental health professionals as agents of state power. In both situations he is detained but only the latter is relevant for the purposes of Article 5. However, if this were so, then Mr and Mrs E's objections to the admission and their wish for HL to return to their care as soon as possible would surely be irrelevant to the question whether or not he was deprived of his liberty at Bournewood. But the clear implication of the judgment is that in going from Mr and Mrs E's care to Bournewood, HL lost his liberty.

How then can the specific situation of HL in Bournewood hospital be distinguished from his situation at home, so that the former, but not the latter, amounts to deprivation of liberty? This can only be done by asserting the primacy of home and family life over institutional care. In effect, home and family life stand for liberty and institutional care must always be seen as a potential deprivation of liberty. Whether in any particular case it will amount to deprivation of liberty will depend on the particular circumstances, and of course this formulation does not seek to suggest that life at home is inevitably better, or freer, than life in an institution.

When it is read in conjunction with earlier decisions of the ECtHR, three factors stand out in HL's case. First, that his admission to hospital was effected against the wishes of those with whom he shared his home and family life. Second, that there was at all times an alternative to institutional care. Third, that the quality of his life in hospital was not only worse than that with his carers but more restrictive than it needed to have been even in an institutional setting.

Two previous ECtHR judgments were referred to extensively in *HL v UK*. *Nielsen*[22] concerned the admission to a psychiatric ward of a 12 year old boy. That this was arranged with his mother's consent appears to have been the decisive factor in the decision of the majority that he was not deprived of his liberty. While in *HM v Switzerland*,[23] which concerned the admission of an elderly woman to a nursing home, the most important consideration appears to have been that what was done was for her own good, there being no alternative to the protective care offered by the nursing home, which in the *HL v UK* judgment was described as "*an open institution which allowed freedom*

22 Nielsen v Denmark (1989) 11 E.H.R.R. 175

23 HM v Switzerland (2004) 38 E.H.R.R. 17

of movement and encouraged contacts with the outside world". The important point is that in both cases the Court found, notwithstanding that what was done was imposed on the individual concerned, there was no deprivation of liberty. It is instructive to read the dissenting judgments in the latter case, which found that Article 5 was engaged. They rest on the proposition that: "*she [HM] was not permitted to leave the institution and go home, and that if she did, she would have been brought back to the nursing home ...*". That line of reasoning, which in HL's case would lead to the conclusion that he is detained when at home with Mr and Mrs E, was rejected by the majority in *HM v Switzerland*. They emphasised that the reason HM had been removed from her home was because she had refused to co-operate with the agency which provided help to people in their own homes and that "*the living conditions and standards of hygiene and of medical care at the applicant's home were unsatisfactory ...*". In those circumstances, the Court found that "*the applicant's placement in the nursing home did not amount to a deprivation of liberty within Article 5(1), but was a responsible measure taken by the competent authorities in the applicant's interests*".

In the Mental Capacity Act the Government is introducing a legal framework for decisions affecting mentally incapable adults which is comparable to the idea of parental responsibility. Under the Act, the general authority confers power to make decisions and take actions affecting the well-being of a mentally incapable adult. Unlike the Danish law which was considered in *Nielsen*, the general authority does not confer the power to consent to medical treatment, or to admission to hospital, on behalf of a mentally incapable adult. But for most practical purposes this is not important. The Act answers an obvious social need, that someone has to make decisions on behalf of those who are not capable of deciding for themselves, and it presumes that on the whole people who care for mentally incapable adults will act in their best interests. In those circumstances, it is surely not unreasonable to suggest that the agreement of family members, or the main carers, is a significant factor in deciding whether what is being done in a given instance amounts to *the state* depriving someone of their liberty. It does not look like an instance of healthcare professionals exercising "*complete and effective control*" but rather of those professionals acting in co-operation with the people who would otherwise be caring for the person concerned. Clearly, for this to be valid the family or carers would genuinely have to agree that admission to hospital or a nursing home really was the most appropriate way forward in all the circumstances. Further, if what is being done in admitting a mentally incapable adult to a psychiatric hospital or nursing home is a response to a situation, such as arose in *HM v Switzerland*, where it is no longer safe for the person concerned to be living at home, it may be that this would give rise to a presumption that the admission does not deprive the person concerned of their liberty. This may be because they are not capable of enjoying their liberty, as in the case of someone with advanced dementia who requires total care, or it may be because the liberty which the Convention exists to protect does not include the liberty to neglect oneself to the detriment of one's health and safety.[24] That the institution to which the person is admitted is open and the care regime aims to maximise the incapacitated person's autonomy, would also tend to point to the conclusion that the admission does not constitute a deprivation of liberty.[25]

24 *Cf. Re F (Adult: Court's Jurisdiction) [2000] 2 FLR, 512 per Sedley LJ at p. 532: "The purpose [of Article 8], in my view, is to assure within proper limits the entitlement of individuals to the benefit of what is benign and positive in family life. It is not to allow other individuals, however closely related and well-intentioned, to create or perpetuate situations which jeopardise their welfare."*

Conclusion

If the Government fails to provide guidance about the circumstances in which Article 5 is engaged where a mentally incapacitated adult is admitted to psychiatric hospital or to a nursing home, the result may be that a narrow interpretation of the law, which simply equates a sufficient degree of restriction of liberty with detention, will prevail. This interpretation will be justified by those who advise NHS Trusts and the like as demonstrating the greatest possible respect for human rights, by erring on the side of regarding someone as being detained in cases of doubt, and as protecting hospitals and nursing homes from actions under the Human Rights Act for unlawful detention.[26] An outcome far more to be desired would be for the Government to advise providers on how deprivation of liberty can be avoided, for example by ensuring that institutional care is only used if properly supported home care is not possible; by involving families and carers in deciding where and how the incapacitated person should be cared for; and by making sure that institutions are sufficiently well resourced to be able to provide as much freedom for residents in their daily lives as they can manage and enjoy. The additional safeguards required by the decision in *HL v UK* will then be correctly focused on those cases where there is, as in HL's case, what can properly be regarded as a deprivation of liberty.

What is now needed is Government guidance on the circumstances in which the actions of public authorities such as NHS Trusts amount to depriving a person who lacks capacity of their liberty. The role of guidance would be to assist practitioners and carers decide in any particular case whether what was proposed or implemented in respect of a mentally incapacitated adult engaged Article 5. The guidance would have to go beyond the words "complete and effective control" to embrace wider issues which arise from the institutional care of mentally incapacitated adults. Guidance which correctly defines the scope of the *HL v UK* ruling would be widely welcomed and would be timely in the context of the Mental Capacity Act which is intended to enhance the legal protection of people who lack capacity.

25 *See 'Conditional Discharges – 'Discharge' from What?' Robert Robinson JMHL July 2003 at pp 102 – 105 for a consideration of the Court of Appeal's judgment in R (on the application of the Secretary of State for the Home Department) v MHRT and PH (Interested Party) [2002] EWCA Civ 1868, a case which clearly demonstrates the need to distinguish between restriction on liberty from deprivation of liberty.*

26 *This approach would not necessarily protect NHS Trusts, as they would not only have to show that they followed the correct legal procedure, but also that deprivation of liberty was warranted by the person's mental disorder.*

Two Bills; Two Agendas

Genevra Richardson[1]

This short article[2] represents, in substance, a memorandum of evidence submitted to the Joint Scrutiny Committee on the Draft Mental Health Bill.[3]

A. The Relationship between the Draft Mental Health Bill and the Mental Capacity Bill

The government has published two Bills concerning similar, but not identical, populations and dealing with some similar decisions. The Mental Capacity Bill (MC) concerns those, mainly adults, who lack decision-making capacity, while the Mental Health Bill (MH) covers people, including children, who have a mental disorder of the required severity.[4] Both Bills deal with decisions relating to care and treatment for mental disorder. So adults:

- who have a mental disorder of sufficient severity to attract MH powers,
- who require care and treatment for mental disorder, and
- who lack decision-making capacity,

could fall under the remit of either Bill.

B. The Present Confused Relationship:

Clause 28, Mental Capacity Bill gives priority to MH powers where these have already been engaged, but offers no indication of how the initial choice is to be made. MC further provides that people acting under the Bill (clause 6), including attorneys and court appointed deputies (clauses 11 and 20), may in certain circumstances restrain the incapable person (P). MC therefore envisages the need to override physical objections on the part of P, suggesting that the Bill's powers are not to be limited to those who appear to comply.

Clause 9, Draft Mental Health Bill sets out the conditions for the use of compulsory powers under that framework. These would cover people with a mental disorder, who require treatment for that disorder in order to protect them from suicide, serious self-harm or serious self-neglect, or in order to protect others. There is no requirement that the person must first lack capacity, but many of those who met these conditions would certainly do so. However, clause 9(5) specifically excludes from MH powers those who can be lawfully treated without the use of those powers, provided

1 *Professor of Public Law, Queen Mary, University of London. Chair of the Expert Committee appointed by the Government in September 1998 to advise on mental health law reform, and whose report 'Review of the Mental Health Act 1983' was published in November 1999.*

2 *An earlier version of this text was presented at the North East Mental Health Law Conference held in November 2004. This article was accepted for publication before (a) the Joint Parliamentary Scrutiny Committee on the Draft Mental Health Bill reported (23rd March 2005), and (b) the Mental Capacity Bill received the Royal Assent (7th April 2005).*

3 *Oral evidence was given on 20th October 2004 (ref: HCii); written evidence was printed on 21st January 2005 (ref: DMH 408).*

4 *Mental Capacity Bill 2004, as introduced in the Commons 24 November 2004, and Draft Mental Health Bill, published by the Department of Health, September 2004, Cm 6305–1.*

they pose no serious threat to others. This suggests that in cases where care and treatment for mental disorder can be provided under MC powers, those powers should take priority, provided there is no substantial risk of serious harm to others. This would include a significant number of those cases where the person lacks capacity. Indeed, on a very literal reading of clause 60 of the Draft Mental Health Bill a person who entered MH powers while having capacity would have to be discharged from those powers if he or she subsequently lost that capacity. That clause requires the clinical supervisor to discharge a patient if at any time he or she is not satisfied that all the relevant conditions are met. It could thus impose on the clinical supervisor a continuing duty to keep capacity under review.

Further clause 9 does not cover people who need treatment for mental disorder and who lack capacity, but who present no threat to others and the danger they pose to themselves is insufficiently severe to meet the clause 9 threshold of risk of suicide, serious self-harm or serious self-neglect. Such people would have to be treated under MC, if at all, even if they were non-compliant.

There is therefore a considerable area of ambiguity and possible overlap between the two Bills. This uncertainty matters for patients, carers and mental health professionals and in certain crucial respects cannot be left to resolution through the Codes of Practice; it will require the amendment of both Bills.

Implications for patients. The uncertainty matters for patients because the choice of framework will carry significant implications. In many respects the provisions of MC might be preferable because all decisions would have to be made in P's best interests, the principle of least restriction would apply, a valid advance decision would be respected, a single framework would apply to all decisions P was unable to make for him or herself and there would be less stigma. However, under MC P would enjoy less rigorous safeguards than those which would apply under MH (see below).

Implications for carers and health professionals. The uncertainty also matters for carers and for health professionals who need to know with as much clarity as possible which framework to apply. It is possible that they too might have a preference for MC powers because those powers would involve less bureaucracy and would place all decisions under the same framework, an issue of particular importance in relation to medical care and treatment. To some extent the required clarity might be achieved through Codes of Practice but some of the issues reach beyond the proper scope of a Code.

C. Safeguards and *Bournewood*[5]

While it might be possible to accommodate most of the above issues by selective redrafting of both Bills and the production of carefully co-ordinated Codes of Practice, this would not deal with the central issue of safeguards. MC provides far less rigorous safeguards to the patient, in relation to both treatment and the deprivation of liberty, than does MH. It is hard to justify this distinction in anything other than pragmatic terms and it is now evident that no pragmatic justification for the absence in MC of adequate safeguards in relation to the deprivation of liberty will suffice. The *HL* decision of the ECrtHR[6] is quite clear that the common law regime under which individuals who lack the capacity to consent are currently deprived of their liberty in hospital fails to comply with

5 *R v Bournewood Community and Mental Health NHS Trust, ex p L [1999] AC458*

6 *HL v United Kingdom ECrtHR decision 5 October 2004.*

the requirements of either article 5.1 or article 5.4. The detention in hospital under the authority of the common law is itself unlawful, since there are no formal admission procedures, no clarity over the purpose of admission and insufficient safeguards to protect against arbitrary detention, as required by article 5.1. Also there is no access to a court to determine the legality of the detention under article 5.4. Although this note is primarily concerned with those people who are deprived of their liberty within hospital, the reasoning of the court in *HL* could apply equally in respect of those detained in non-hospital institutions.

While the ECrtHR's judgement in *HL* presents immediate practical problems for all those concerned with the provision of care and treatment for people who lack capacity, particularly when that care involves the imposition of significant restrictions on the liberty of the incapable person. This note does not attempt to offer any answers to those immediate problems. Rather it considers how the two current Bills might be amended to provide possible long-term solutions.

D. *HL* and both Bills.

In broad terms the provisions of MH are designed to comply with the requirements of article 5. The same is not true of MC. Significantly perhaps the explanatory notes accompanying MC make no mention of article 5 in their section *Compatibility with ECHR*.[7]

Article 5.1: MC has been drafted with no appreciation of the implications of the fact that the people resident in hospital under its provisions might be detained in the terms of the ECHR. As a consequence no provision has been made for the formal recognition of detention, its recording, its justification and its review. While the substantive provisions of the Bill are such as to render detention under its powers potentially lawful under 5.1, there are insufficient procedural safeguards. And, according to the court in *HL*, lawfulness under 5.1 requires 'the existence in domestic law of adequate legal protections and "fair and proper procedures"'(para115).

Article 5.4: The breach of article 5.4 is perhaps even more evident. In *HL* the Court refused to accept that either proceedings for judicial review or habeas corpus, or the ability to seek declaratory relief from the High Court could satisfy the requirements of article 5.4. Neither the developments in judicial review following the Human Rights Act[8] nor the present extension of the role of the Court of Protection under the MC Bill itself would be sufficient to fill the gap. In theory the role of the Court of Protection could be amended to do so, but it is not the obvious body for the task since its expertise lies in the assessment of decision-making capacity and in the determination of the best interests of people lacking capacity, not in reviewing detention, imposing compulsory treatment or approving care plans.

Quite clearly steps have to be taken to bring the new provisions into compliance with article 5 and, against the uncertainties outlined above, those steps must involve redrafting the primary legislation. There is no single obvious solution but two distinct and, to some extent, polar options present themselves. Each has both advantages and disadvantages but it is possible that a combination of their strengths might eventually be achieved. As a first step the two options are described below.

7 *Explanatory Notes accompanying the Bill as introduced in the Commons 24 November 2004.*

8 *In this regard it is interesting to note the decision of the Court of Appeal in R (MH) v Secretary of State for Health [2004] EWCA Civ 1690.*

E. The Extension of the Mental Health Bill.

On the assumption that the admission and discharge procedures in MH will comply with article 5, one option would be to extend the ambit of MH to cover all those who lack capacity and need treatment for mental disorder in hospital. This could be done by amending clause 9 to restrict the scope of clause 9(5), and by extending the conditions to include those with mental disorder who need medical treatment in hospital in the interests of their own health and/or safety and who lack the capacity to make the necessary decisions themselves. This would include both compliant and non-compliant patients and, because of the breadth of the definition of medical treatment (clause 2(7)), could include those who simply require secure accommodation in the interests of their own safety. Further, in order to remove any residual borderline issues, it might be necessary to restrict the use of restraint under MC, so that restraint amounting to the deprivation of liberty could only be used in situations of emergency.

Advantages:

- Such an extension of MH would ensure compliance with article 5.
- It would also clarify the relationship between MH and MC.

Disadvantages:

- The application of full MH requirements to all patients lacking capacity and requiring treatment in hospital would have unrealistic resource implications. In part this could be dealt with by reintroducing provisions similar to those included in Part 5 of the 2002 Draft Mental Health Bill.[9] These could be adjusted to enable them to relate specifically to the amended clause 9 conditions and to provide sufficient procedural formality within the process of admission to ensure compliance with article 5.1
- Patients without capacity who would now move from MC to MH would be at a disadvantage unless MH was also amended to reflect the provisions in MC in relation to best interests, the least restrictive principle and advance decisions.
- The relevance of the MC framework would be greatly reduced for a significant proportion of those for whom it was specifically designed: those lacking capacity who require medical treatment for mental disorder (very broadly defined, clause 2(7)) in conditions amounting to detention under the ECHR.

F. The Introduction of Enhanced Safeguards in the Mental Capacity Bill.

The procedure for admission to detention could be tightened up in MC and access to a tribunal to review the legality of that detention could be introduced. The MC framework might then become the preferred option for the provision of treatment and care for mental disorder in hospital in cases where the individual lacked capacity.

Advantages:

- It would achieve compliance with article 5 for all people detained in hospital who lack capacity, whatever the nature of the treatment they were receiving.

9 *2002 Department of Health, Cm 5538–1*

- It could reduce the need to use MH powers with all their resource and stigma implications.
- It would enable the provision of treatment for both mental and physical disorder under the same provisions.
- It would extend the remit of capacity legislation designed in accordance with the principles of non-discrimination and respect for patient autonomy.

Disadvantages:

- It would be very difficult to achieve at this late stage in the progress of the MC Bill, but it could be effected through consequential amendments to the MC Act made subsequently in the MH Bill.
- There may be a concern that the article 5.1 safeguards included in MC would be too resource intensive if they simply replicated those in MH and included the early automatic involvement of the tribunal. However, admission procedures could be devised which were essentially administrative with a right of appeal to a tribunal, and yet were compliant with article 5.1
- There might be fears that the provision of article 5.4 safeguards in MC would lead to the creation of a second tribunal. This could be avoided by the creation of a single body to operate under both MC and MH.
- If MC were to become the primary framework for the provision of treatment in hospital in cases of incapacity, then attention would need to be paid to the safeguards relating to treatment provided within that framework: the inclusion of regular reviews of care and treatment plans, for example, and access to advocacy services.
- An extension in the coverage of MC would not solve all the borderline issues unless a matching restriction in coverage were to be expressly introduced in MH. Thus MH might be expressly restricted to, for example, the core population of those who, whether capable or incapable, present a substantial risk of serious harm to others and possibly those who, despite being capable, present a similar risk to themselves.
- There would remain a need to provide for the transfer of an individual from MC to MH if he or she remained a sufficient risk after regaining capacity.

The preceding paragraphs do not provide a comprehensive answer to the difficulties raised by the interface between the two Bills, nor to the issues presented by *HL*. The solution which is eventually chosen will have to reflect government priorities. However, it is possible to argue from the above that the weight of advantage lies with an extension of the Mental Capacity Bill and a corresponding restriction in the scope of the Mental Health Bill.

The Mental Capacity Act and the new Court of Protection

Denzil Lush[1]

Introduction

The Mental Capacity Bill was introduced in the House of Commons on 17 June 2004,[2] and received the Royal Assent on 7 April 2005.

The Act, which has been fifteen years in gestation and involved an extensive consultation process,[3] abolishes the existing Court of Protection, and replaces it with a new court, also to be known as the Court of Protection, which will have jurisdiction to deal with all areas of decision-making for people who lack capacity. Thus, it will combine the personal welfare and healthcare jurisdiction currently exercised by the Family Division with the property and financial decision-making jurisdiction of the present Court of Protection. The new court will be regional, served by a centralised administration office and registry.

It is important for people with disputes or problems to have access to the most effective means of resolving them, and in many cases the existing health and social welfare mechanisms, mediation or discussion will be sufficient. Although no one will be compelled to mediate before going to court, the current policy is that the new court should be the last resort for the resolution of complex or particularly sensitive cases, or when other forms of dispute resolution have been tried without success.

---

1 *Master of the Court of Protection. This article is an amended version of a paper presented at the North East Mental Health Law Conference in November 2004. It has been updated at proof-reading stage to reflect the fact that on 7th April 2005 the Mental Capacity Bill received the Royal Assent.*

2 *The Bill was re-published with amendments on 4 November 2004, 15 December 2004 and 8 February 2005.*

3 *In 1989 the Law Commission embarked on an "investigation into the adequacy of legal and other procedures for decision-making on behalf of mentally incapacitated adults". It published four consultation papers – An Overview (1991), A New Jurisdiction (1993), Medical Treatment and Research (1993), and Public Law Protection (1993) – before producing its final report, Law Com. No. 231, Mental Incapacity, on 1 March 1995, which contained a draft Mental Incapacity Bill. The Lord Chancellor's Department issued a further consultation paper, Who Decides? followed by its own report, Making Decisions (1999). In June 2003 the Lord Chancellor's Department (then recently renamed the Department for Constitutional Affairs) issued a draft Mental Incapacity Bill, which was subjected to pre-legislative scrutiny by a joint committee of members of the House of Commons and the House of Lords. The Joint Scrutiny Committee reported on 28 November 2003, http://www.publications.parliament.uk/pa/jt/jtdmi.htm*

The court's clientele

The Court of Protection is unique. It is the only specialised court of its kind in the world, and is eyed with envy by most other jurisdictions. Its origins go back to at least the second half of the thirteenth century, when the crown assumed responsibility for the estates of lunatics and idiots, and this jurisdiction was certainly in place by 1324, when the Statute *de Praerogativa Regis* confirmed its continuation.

The court's current clientele fall into four main constituent groups:

- people with psychiatric illnesses, such as schizophrenia or bipolar affective disorder.
- people with learning difficulties or intellectual disabilities.
- the elderly mentally infirm, mainly suffering from Alzheimer's disease or multi-infarct dementia; and
- people who have acquired brain damage as a result of an accident, assault, or clinical negligence, and have been awarded compensation for their personal injuries.

It may come as a surprise to note that the present court has comparatively little involvement with the mainstream mentally ill or people with learning difficulties, the two constituent groups for whom it was originally created. Most of the court's time is spent on matters relating to elderly patients or people with damages awards, principally because these generally tend to be the more complex, higher value cases. The court takes on about 400 new personal injury and clinical negligence cases each year. The average award for a road traffic accident is in the region of £900,000. The average award in a clinical negligence case is about £2,500,000, and the largest award the court is currently handling is £12,000,000.[4] I anticipate that the new court, with its jurisdiction embracing healthcare and personal welfare decision-making, as well as decisions on property and financial matters, will involve a re-alignment in terms of meeting the needs of all four groups.

Children

The original intention was that the legislation would only involve adults who lack capacity, as does the Adults with Incapacity (Scotland) Act 2000. Section 2(5) of the Act still states that no powers under the Act are to be exercised in relation to a person under 16. However, approximately 70% of the clinical negligence cases the present court deals with result from perinatal injuries, and often the patients are under 16. Accordingly, section 18(3) provides that, as far as property and financial affairs are concerned, the powers under the Act may be exercised even though the person concerned has not reached 16, if the court considers it likely that they will still lack capacity to make decisions in respect of such matters when they reach 18. The converse of this is that the Family Division will retain its jurisdiction to make healthcare decisions on behalf of children, as it did recently, for example, in the two cases involving babies, Charlotte Wyatt in Portsmouth, and

4 Parkin v. Bromley Hospitals NHS Trust [2002] EWCA Civ. 478. Kerstin Parkin was born in 1968. She and her husband, Mark, were world-class Latin American dance champions. She suffered profound brain damage following a cardiac arrest whilst in labour at Farnborough Hospital, Orpington, on 26 November 1996. The total compensation awarded was £12,000,000, of which £7,000,000 was received as a lump sum, and the remaining £5,000,000 was used to fund an annuity (known as a "structured settlement"), yielding an index-linked income of £250,000 a year for the rest of her life.

Luke Winston-Jones at Alder Hey.[5] Section 21 provides for the transfer of proceedings to the court best suited to deal with the particular issues involved. So, for example, it may be more appropriate for the Court of Protection to deal with a case involving a seventeen-year-old who lacks capacity, since any order under the Children Act 1989 would expire on the child's eighteenth birthday, at the latest.

The principles

Before I comment on the expanded role of the new Court of Protection, I think it is important to consider the basis on which the court will make its decisions in future. Any legislation on mental incapacity involves striking a balance between two extremely important values: the value we place on the freedom of individuals to make their own choices about how they live their lives (*autonomy* or *self-determination*), and the value we place on promoting their well-being (*paternalism* or *protection*).

Benjamin Disraeli once said, in the context of the repeal of the Corn Laws, that "protection is not only dead, but damned." The Mental Capacity Act doesn't go quite that far, but it certainly gives autonomy and self-determination the upper hand, and almost grudgingly concedes that protection and paternalism have a subordinate role to play, once it is established that a person lacks the capacity to make a particular decision. In this respect the Act endorses the views of the liberal school of philosophy, of which the leading British exponent was Disraeli's contemporary, John Stuart Mill (1806–1873). In his essay *On Liberty*, first published in 1859, Mill said:[6]

> "The object of this essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used be physical force in the form of legal penalties or the moral coercion of public opinion. That principle is that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him or visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of anyone for which he is amenable to society is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign."

If you read them in sequence, the principles in section 1 of the Mental Capacity Act form a flowchart or blueprint of how in future all of us – parents, carers, doctors, lawyers, social workers, and the court itself – should deal with people who are unable to make decisions for themselves in

5 *Charlotte Wyatt (Mr Justice Hedley, 8 October 2004), Luke Winston-Jones (Dame Elizabeth Butler-Sloss, 22 October 2004).*

6 *John Stuart Mill, On Liberty, Penguin Classics, pages 68 and 69. Mill suffered from several nervous breakdowns and, although he was never the subject of a commission de lunatico inquirendo, he reserved his fiercest invective for a description of such proceedings: ibid, page 134.*

relation to a particular matter at a particular time because of an impairment of, or a disturbance in the functioning of, their mind or brain.

We must start by assuming that they are entirely autonomous, regardless, at this stage, of whether they are actually capable of making the decision in question.[7]

We must take all practicable steps to help them make the decision that needs to be made.[8] This involves providing information relevant to that decision, including information about the reasonably foreseeable consequences of deciding one way or another, or not deciding at all.[9] It also involves taking all practicable steps to help them communicate their decision, whether by speech, sign language, or any other means.[10]

Even though they may be suffering from a condition that restricts their ability to govern their life and make independent choices, as long as they have the basic ability to consider the options and make choices, we must not intervene against their will. By intervening against their will, even for their own good, we show less respect for them than if we had allowed them to go ahead and make a mistake. This lack of inter-personal respect is potentially a more serious infringement of their rights and freedom of action than allowing them to make an unwise decision.[11]

A paternalistic intervention is only justified when all practicable steps to help a person make a decision have been taken without success, and it is established that they do not have the basic ability to consider options and make choices. And such an intervention must be in their best interests.[12] The idea of "best interests" is not the traditional one that parents, carers, doctors and social workers are used to. It is heavily permeated by the principle of "substituted judgment", which in recent years, particularly in the United States, has been identified as a preferred alternative to best interests as the standard for substitute decision-making.[13] It is a mandatory requirement, so far as is reasonably ascertainable, to consider the person's past and present wishes and feelings, the beliefs and values that would be likely to influence his decision if he had capacity, and the other factors that he would be likely to consider if he were able to do so.[14] Similar requirements are expected when consulting others as to what would be in a person's best interests.[15]

Even then, before intervening in a person's best interests, we must explore other ways of overcoming the particular problem, and, where feasible, choose the option that restricts the individual's autonomy and freedom of action to the least extent.[16] I shall be returning to this idea of "the least restrictive alternative" later, when considering the court's appointment of deputies.

---

7 Section 1(2): "A person must be assumed to have capacity unless it is established that he lacks capacity."

8 Section 1(3): "A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success."

9 Section 3(3).

10 Section 3(1)(d).

11 Section 1(4): "A person is not to be treated as unable to make a decision merely because he makes an unwise decision."

12 Section 1(5): "An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests."

13 The modern literature on capacity generally considers that the origin of the doctrine of "substituted judgment" was the decision of Lord Chancellor Eldon in Ex parte Whitbread, In the matter of Hinde, a lunatic (1816) 2 Mer. 99, in which an allowance or gift was made to a member of the family who was not dependent upon the lunatic. The present Court of Protection exercises substituted judgment when authorising the execution of a statutory will on behalf of a patient pursuant to the Mental Health Act 1983, s 99(1)(e): see Re D(J) [1982] 2 All ER 37.

14 Section 4(6).

15 Section 4(7).

16 Section 1(6): "Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."

During the Bill's second reading in the House of Lords on 10 January 2005, the Rt. Rev Dr Peter Selby, Bishop of Worcester, said:[17]

> "Clause 1 contains a statement about a vision of humanity and how humanity is to be regarded. I hope children in generations to come will study that as one of the clearest and most eloquent expressions of what we think a human being is and how a human being is to be treated. ....
>
> I renew my congratulations to those who brought the Bill forward and to all those who worked to make it what it is. I believe that it states what is fundamentally right. In the course of Committee we shall no doubt improve and tighten some of the wording, but we shall never take away the powerful and eloquent statement in Clause 1. That should underlie our treatment of one another in all circumstances and for all purposes."

The new Court of Protection

The new Court of Protection will be a superior court of record, as distinct from the present court which is an office of the Supreme Court.[18] It will be able to sit at any place in England and Wales, on any day, and at any time.[19] Like the High Court, it will be able to respond appropriately to emergency cases that need to be heard urgently.[20] If need be, part of a hearing can be conducted outside a conventional courtroom, for example in hospital, or at the home or bedside of the person who lacks capacity.

At this stage, it is not certain where the more formal, permanent venues will be. Since 1 October 2001 the present court has had a regional centre at Preston, where District Judge Gordon Ashton sits as a Deputy Master and deals with Court of Protection matters most Thursdays, and we will build on this experience when expanding the court's presence nationwide. Technology, such as e-mail links, electronic case management systems and video-conferencing facilities, will play a pivotal role.

The new court will have a central office and registry at a place appointed by the Lord Chancellor.[21] We expect the central administration to be based in London, mainly because this is where the expertise currently is, in terms of the Family Division, and the existing Court of Protection and Public Guardianship Office. However, this will need to be considered further in the light of two recent reviews: Sir Michael Lyons' review of public sector relocation, *Well placed to deliver? – Shaping the pattern of Government Service* (March 2004),[22] and Sir Peter Gershon's review, *Releasing resources to the front line: Independent Review of Public sector Efficiency* (July 2004).[23]

The judges of the new Court of Protection will be nominated from various levels of the judiciary, ranging from the President of the Family Division and the Vice-Chancellor, through puisne judges

17 *Hansard, vol 668, no 18, pages 54 and 55.*

18 *Section 45(1) and (6).*

19 *Section 45(4).*

20 *Section 48 confers an emergency jurisdiction on the court to make interim orders and directions where there is reason to believe that a person lacks capacity, and it is in their best interests to make the order or give the directions without delay.*

21 *Section 45(4). Under the proposals in the Constitutional Reform Bill, the functions of the Lord Chancellor under the Mental Capacity Bill will become the responsibility of the Lord Chief Justice, either after consultation with, or with the concurrence of, the Secretary of State for Constitutional Affairs or the Lord Chancellor.*

22 *The text is available online at http://www.hm-treasury.gov.uk/consultations_and_legislation/lyons/consult_lyons_index.cfm*

23 *The text is available online at http://www.hm-treasury.gov.uk/media/B2C/11/efficiency_review120704.pdf*

from all three divisions of the High Court,[24] to circuit judges and district judges.[25] I imagine that the jurisdiction will be confined, initially at least, to two or three judges per circuit, and specific individuals will be named for the purpose, rather than a generic class of judiciary. At present, appeals and references can be heard by any judge of the Chancery Division or Family Division, some of whom have had little or no experience, either in practice or on the bench, of matters involving people who lack capacity.

The new court will have a President and Vice-President, who will be nominated from the two heads of divisions or from the High Court bench,[26] and a Senior Judge, who will be nominated from the circuit or district bench.[27] It has been assumed that the President of the Family Division will also be the President of the new Court of Protection, though there is no specific requirement that the same person should hold both offices. It may be advantageous for the independence of the fledgling court not to be seen as an adjunct to the Family Division. One of the main functions of the President will be to give directions relating to the practice and procedure of the court.[28]

Individual cases will be dealt with by a judge at the appropriate level. For example, nominated district judges will hear cases similar in nature to their existing jurisdiction in family proceedings, or where local knowledge may be an important factor. Nominated circuit judges will deal with difficult residence and access disputes, and cases involving complex financial issues. The nominated High Court judges will deal with more high profile cases, such as those involving end-of-life decisions. There is a right of appeal to a higher judge of the Court of Protection and thereafter, for cases involving important points of law, practice or procedure, to the Court of Appeal.[29]

In connection with its jurisdiction, the new court will have the same powers, rights, privileges and authority as the High Court.[30] At present, it is unclear whether this provision merely relates to matters such as evidence, enforcement of orders, and contempt, or whether the new court will have the powers that the Chancery Division has to make freezing injunctions or search orders in abuse cases.

Section 51 provides that the Lord Chancellor may make rules of court with respect to the practice and procedure of the court. As the Court of Protection is a relatively small and highly specialised jurisdiction, no provision has been made for a formal statutory rules committee. However, it is envisaged that a wide range of stakeholders will be invited to contribute to the process of drawing up the rules, and that the consultation will take place before the end of 2005, with a view to publishing the rules by the end of 2006, in readiness for the implementation of the Act in April 2007.

The functions of the new Court of Protection

In brief, the new Court of Protection will be able to:

- make declarations as to whether or not someone has the capacity to make a particular decision; for example, where professionals disagree on whether someone with learning difficulties has the capacity to refuse major heart surgery;[31]

24 It was originally intended that the nominated High Court judges would come from either the Family Division or the Chancery Division. However, this has been extended to all three divisions because of the expertise within the Queen's Bench Division in handling personal injury and clinical negligence cases.

25 Section 46(2).

26 Section 46(3).

27 Section 46(4).

28 Section 52.

29 Section 53.

30 Section 47(1).

31 Section 15(1). It is likely that these declarations will be dealt with by a circuit judge, or, if the issues are particularly complex, by a High Court judge.

- make declarations as to the lawfulness or otherwise or any act done, or yet to be done, in relation to a person.[32]
- make single, one-off orders; for example, the sale of a house and the investment of the proceeds of sale.[33]
- appoint a deputy to make decisions in relation to the matter or matters in which a person lacks the capacity to make a decision.[34]
- resolve various issues involving lasting powers of attorney.[35]
- make a declaration as to whether an advance decision to refuse treatment exists, is valid, or is applicable to a particular treatment.[36]

The power to make declarations is similar to, though slightly wider than, the present declaratory jurisdiction of the Family Division. I am concerned, however, that the new court may be deluged with applications to make a definitive decision on capacity, where there is a respectable body of evidence on either side of the line. Since the decision of the Court of Appeal in the personal injury case, *Masterman-Lister v. Brutton & Co.*,[37] there has been a steady stream of applications for the court to decide in cases of borderline capacity to manage property and financial affairs.[38] I can also envisage solicitors coming to the court to declare whether a client has testamentary capacity or the capacity to make a lasting power of attorney.

Appointing deputies

There is a widespread misunderstanding that deputies appointed by the court will simply be receivers with a new name. This is not the case at all, and the Act provides that, when deciding whether it is in a person's best interests to appoint a deputy, the court should have regard to the principles that (a) a decision by the court is to be preferred to the appointment of a deputy to make a decision, and that (b) the powers conferred on a deputy should be as limited in scope and duration as is reasonably practicable in the circumstances.[39]

This is a good illustration of the operation of the principle of the least restrictive alternative, which requires the existence of alternative courses of action to be investigated and compared, and the preferred course of action to be the one that achieves the desired objective in a manner that interferes least with the rights and freedom of action of the person concerned. The modern origin of this principle is generally acknowledged to be the decision of the United States Supreme Court in *Shelton v. Tucker* (1960),[40] in which the court said:

> "In a series of decisions this court has held that, even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle

32 Section 15(1)(c).

33 Section 16(2)(a). It is anticipated that decisions of this kind will be made at district judge level.

34 Section 16(2)(b).

35 Sections 22 and 23. These are likely to be dealt with by a judge at district bench level.

36 Section 26(4).

37 Masterman-Lister v. Brutton & Co. [2003] 3 All ER 162. The decision of Mr Justice Wright, at first instance, is reported at [2002] Lloyds Rep Med 239.

38 Capacity is now also raised more frequently in personal injury proceedings. See, for example, the judgment of Mrs Justice Cox in Mitchell v Alasia, which was handed down on 11 January 2005. At paragraph 76 her ladyship decided that Russell Mitchell, now 23, is currently a patient, but should no longer be a patient in approximately three years time after intensive rehabilitation.

39 Section 16(4).

40 Shelton v. Tucker, 364 U.S. 479 (1960).

> fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose."

This doctrine was first applied in the context of mental health law in *Lessard v. Schmidt* (1972)[41] by a Wisconsin district court, which placed the burden of exploring alternatives on the person recommending full-time involuntary hospitalisation. They have to prove (1) what alternatives are available; (2) what alternatives they investigated; and (3) why the investigated alternatives were considered unsuitable.

In the United States the principle of the least restrictive alternative also applies to adult guardianship and conservatorship proceedings, which are broadly similar to the appointment of a receiver under the Mental Health Act 1983. The Uniform Guardianship and Protective Proceedings Act, which was finalised for adoption by states in 1982, introduced the concept of a "limited guardianship" in response to a call for more sensitive procedures, and for appointments to be fashioned so that the authority of the protector would only intrude on the liberties and prerogatives of the protected person to a degree that was absolutely necessary.

The Uniform Guardianship and Protective Proceedings Act 1982 was replaced by a new Act in 1997, which provides that guardianship should be viewed as a last resort, that limited guardianships should be used whenever possible, and that the guardian or conservator should always consult with the ward or protected person, to the maximum extent feasible, when making decisions.[42]

The National College of Probate Judges issues guidance for its judges: the *National Probate Court Standards* (1993).[43] Standard 3.3.10, which is headed "Less Intrusive Alternatives", states as follows:

(a) The probate court should find that no less intrusive alternatives exist before the appointment of a guardian.

(b) The court should always consider, and utilize, where appropriate, limited guardianships.

(c) In the absence of governing statutes, the court, taking into account the wishes of the respondent, should use its inherent or equity powers to limit the scope of and tailor the guardianship order to the particular needs, functional capabilities, and limitations of the respondent.

(d) The court should maximize co-ordination and co-operation with social service agencies in order to find alternatives to guardianships or to support limited guardianships.

It is likely that the new Court of Protection will apply similar criteria when deciding whether or not to appoint a deputy.

---

41 Lessard v. Schmidt, 349 F.Supp.1078 (E.D.Wis.1972).

42 See text at http://www.law.upenn.edu/bll/ulc/fnact99/1990s /ugppa97.htm See, in particular, section 311.

43 See text at http://www.probatect.org/ohioprobatecourts/pdf /national_probate_standards.pdf

Applications to the court

The present Court of Protection has rules as to who may make an application, as of right, and who needs to obtain leave to make an application, but these are contained in secondary legislation.[44] The Act will make similar provisions within the primary legislation.[45] As a general rule, the court's permission will need to be obtained before an application can be made, but some categories of person can apply as or right, without the need to obtain permission. These are:

- a person who lacks, or is alleged to lack, capacity.
- if that person is under 18, anyone with parental responsibility for him or her.
- the donor or donee of a lasting power of attorney.
- a deputy appointed by the court; or
- any person named in an existing order of the court, if the application relates to that order.

Interestingly, this list does not include the Public Guardian, the Official Solicitor,[46] health authorities, social services, the independent consultee service, and, in many cases, the next-of-kin or close family members. They will need to obtain the court's permission before they can make an application, and I am concerned that, particularly in abuse cases, there may be satellite litigation as to whether an organisation has sufficient standing to make an application. When deciding whether to grant permission, the court is required to have regard to:[47]

- the applicant's connection with the person.
- the reasons for the application.
- the benefit to the person of any proposed order or direction, and
- whether that benefit can be achieved in any other way.

The relationship between the court and the Office of the Public Guardian

At present, the Public Guardianship Office (PGO) operates as the administrative or executive arm of the Court of Protection, and the two organisations are accommodated in the same building, Archway Tower, 2 Junction Road, London N19 5SZ. The PGO is an executive agency of the Department for Constitutional Affairs, and its existence is not formally recognised in any statute. The Act provides for the creation of a new, statutory office-holder to be known as the Public Guardian,[48] and confers on him or her various functions, such as:

- establishing and maintaining a register of lasting powers of attorney.
- establishing and maintaining a register of orders appointing deputies (though not a register of the one-off decisions of the court, which, in accordance with clause 16(4)(a) of the Act are to be preferred to the appointment of a deputy).
- supervising deputies appointed by the court.

---

44 For example, rule 18 of the Court of Protection Rules 2001 (SI 2001/824), which sets out the persons who are entitled to apply for a statutory will, and rule 21 of the Court of Protection (Enduring Powers of Attorney) Rules 2001 (SI 2001/825)

45 Section 50(1).

46 Section 50(2) provides that the Court of Protection Rules can specify others who can apply to the court without permission, and it is probable that they will specify the Public Guardian and the Official Solicitor.

47 Section 50(3).

48 Section 57.

- directing Court of Protection Visitors to make visits.
- receiving security.
- receiving reports from donees of lasting powers of attorney and deputies.
- reporting to the court on such matters as the court requires.
- dealing with representations and complaints about attorneys or deputies.

Although there is provision for the Lord Chancellor to make regulations conferring additional functions on the Public Guardian, the list of functions conferred by the Act does not expressly include the PGO's present functions of processing originating applications to the court, and acting as the receiver of last resort.

So, it is envisaged that in future there will be two distinct organisations, of broadly similar size, in separate offices, and that the court will have an administrative staff as well as members of the judiciary. This is designed to create a clearer and sharper distinction between the work of the new Court of Protection and the Office of the Public Guardian. In practical and change management terms, there is a need to disentangle the close relationship that currently exists between the Court of Protection and the PGO in a way that achieves a proper distinction between the two organisations, whilst retaining the positive aspects of the present close working arrangements.

Preliminary costings

It is possible that an increased awareness of capacity issues during the passage of the Bill and in the lead up to and implementation of the Act will result in a higher number of cases than usual. I have seen somewhere that the cost of establishing the new Court of Protection and the Office of the Public Guardian will be £4,700,000 for the set-up costs prior to implementation, and that the annual running costs will be £8,600,000 thereafter. The annual running costs have been calculated on the basis that the number of health and welfare cases, which currently go to the High Court, but in future will go to the new Court of Protection, will double to 200, and that of the estimated 1,200,000 people who might have recourse to the Bill because they lack capacity, 1.5% will seek and receive legal advice and assistance each year.

Conclusion

In conclusion, I must apologise for not being able to be more informative and precise about the new court and its expanded role. For those of you who have studied the Mental Capacity Act, I will have told you nothing you didn't know already. So far, the main focus of the Department for Constitutional Affairs has been to ensure the safe passage of the Bill, make positive messages known, rebut inaccuracies, and engage groups with particular concerns. The finer points of detail relating to the new jurisdiction will need to be considered after the Act has been passed and during the two years' lead-up to its implementation.

Decision-Making in Mental Health Law: Can Past Experience Predict Future Practice?

Jill Peay[1]

Introduction

The short answer to this is no. Whilst it may be possible to be certain about the occurrence of some events, the prediction of decision-making requires caution and qualification. Yet past practice can be a good guide to making informed guesses about the future. Accordingly, this article addresses the question of whether what we know about how practitioners make decisions in respect of current mental health law can help us to understand how the government's latest proposals for reforming mental health law are likely to fare. Two main issues are discussed: first, the nature of the proposed criteria; and second, the nature of the process, who will get involved with whom? The article concludes with some miscellaneous observations and engages in some autopoietically inspired kite-flying.

Before embarking on this a few words of warning are necessary. Nothing that follows is rocket science (or as rocket scientists say, quantum physics).[2] It is based on what practitioners have said honestly and frankly about their own problems in applying the current legislation. And the problems that they have encountered are not exceptional. It is commonplace for many of our decisions to be based on fear, uncertainty and occasionally, frank ignorance. Moreover, lawyers are not an exception to the rule. As Lady Hale has observed 'lawyers might be clearer about the legal principles involved, but they would still be torn about how to fit the perceived needs of the individual case into the prescribed legal framework'.[3] Finally, what people say they do, and say they have done, is not always wholly consistent with their practice. In this context, predicting what they will do is hazardous.

---

1 *Dr. Jill Peay, Reader in Law, London School of Economics. This article was presented first to the 2nd North East Mental Health Law Conference organised by Northumbria University Law School and Eversheds (solicitors) in November 2004. I am grateful for the comments I received then and latterly to my colleagues Richard Nobles and David Schiff. Any misunderstandings that remain of the relevance of autopoietic theory are entirely of my own making.*

2 *Perkins, E. (2002), Decision-Making in Mental Health Review Tribunals London: Policy Studies Institute; Peay, J. (1981), 'Mental Health Review Tribunals: Just or Efficacious Safeguards?' Law and Human Behavior 5, 2/3, 161–186; Peay, J. (1989), Tribunals on Trial: A Study of Decision Making Under the Mental Health Act 1983. Oxford: Oxford University Press; Bryson B. (2003) A Short History of Nearly Everything London: Random House*

3 *In Peay, J (2003) Decisions and Dilemmas: Working with Mental Health Law Oxford: Hart Publishing at page v.*

The Draft Mental Health Bill 2004 underwent detailed examination by the Joint Scrutiny Committee (JSC).[4] Their report was published in March 2005. This article is based on the proposals as set out in the Bill as it was first published in September 2004. There are a number of features in this that I welcome. This is not surprising since these features stem largely from the recommendations of the Richardson Committee: for example, the single gateway to compulsory power, early intervention by an independent decision-making body – the Tribunal – to approve an agreed care plan, arrangements for advocacy and the nominated person proposals. There are some features about which I am agnostic, being in support in principle but anxious about their practical application; for example, the need for independent decision-making by doctors and an approved mental health professional before compulsory assessment can take place with those decisions being independently justified. However, I am anxious that these potentially welcome developments are likely to be obviated by the practical application of the new Bill, since this will, in my view, extend the boundaries of compulsion in a way that makes many aspects of the proposed legislation unworkable. And then there are numerous features of the Bill that I find problematic. These include consigning the limited and non-obligatory principles to the Code of Practice (which will prove an unreliable sign-post for non-legal practitioners); new criteria for admission and treatment which are broader in scope than even the existing criteria (which will act as a lobster pot in drawing people into compulsion but making it conversely harder to escape from the pot of compulsion); the use of compulsion in new settings (outside of hospital and without the natural restraint of the requirement for a hospital bed); the introduction of more explicit obligations on professionals (see, for example, clause 60) whilst reducing existing discretion (see, for example, the absence of an overarching discretion on the tribunal to discharge in any circumstances); the need only to *consult and involve* patients and nominated persons in decision-making; reliance on language which is subjective 'appropriate treatment must be available' and value driven, relying on such terms as 'warrant', 'expedient' and 'necessary'; and a Bill that runs to 307 clauses, 14 schedules, an application which may be modified geographically (note, as ever, the Isles of Scilly in 307(7)) and details as yet to be specified in Regulations and the Code of Practice. In short, a non-lawyer's nightmare and a lawyer's paradise.[5] The government has quaintly asserted that only people who need compulsion will be subject to it (that is, compulsion won't be used unnecessarily). It is not clear on what basis this assertion is made.

Many of these problematic features arguably derive from the fundamental approach adopted by the government, since it has chosen to justify the use of compulsion on grounds of necessity. In so doing it has rejected the Richardson Committee's approach, which was based on the principles of autonomy and non-discrimination; an approach that would have resulted in some form of, albeit attenuated, capacity based legislation.[6] However, as Rosie Winterton has stated in defending the government's necessity based approach

4 *The proceedings of the Joint Scrutiny Committee (JSC) on the Mental Health Bill can be found at: http://www.parliament.uk/parliamentary_committees/jcdmhb.cfm*

5 *The introduction of conspicuously unclear and complex legislation that requires extensive judicial clarification has attracted criticism before. In January 2005 Lord Justice Rose, Vice President of the Court of Appeal's Criminal Division, observed that bringing the provisions of the Criminal Justice Act 2003 into force before appropriate training could be given obliged the Court of Appeal to engage in 'unsatisfactory activity, wasteful of scare resources in public money and judicial time'. See J.Rozenberg 'Judge condemns new jury ruling' news.telegraph filed 15th January 2005.*

6 *G. Richardson (1999) Review of the Mental Health Act 1983. Report of the Expert Committee, Presented to the Parliamentary Under Secretary of State for Health 15 July 1999, published November 1999 by the Department of Health.*

'we have concluded that existing mental health legislation relies on the only practicable basis for compulsion to prevent harm. Whilst a capacity based system may suffice to protect people from unnecessary intrusion, it is ineffective to prevent the harm to themselves or others which may result from their disorder.'[7]

1. The Proposed Criteria and their Likely Application

The government has proposed in Clause 9 of the Draft Mental Health Bill 2004 that the following conditions should apply to the use of compulsion

9 The relevant conditions

(1) In this Part, references to the relevant conditions are to the following conditions (subject to subsection (7)).

(2) The first condition is that the patient is suffering from mental disorder.

(3) The second condition is that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.

(4) The third condition is that it is necessary –

(a) for the protection of the patient from –

(i) suicide or serious self-harm, or

(ii) serious neglect by him of his health or safety, or

(b) for the protection of other persons,

that medical treatment be provided to the patient.

(5) The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.

(6) The fifth condition is that medical treatment is available which is appropriate in the patient's case, taking into account the nature or degree of his mental disorder and all the other circumstances of his case.

(7) The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons.

(8) For the purposes of this Part, a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.

A number of these terms will be familiar to those working with the Mental Health Act 1983, and in that context, decision-making under that Act should provide some guide as to the interpretation and application of these terms. I will be drawing for my observations and limited predictions mainly on *Decisions and Dilemmas: Working with Mental Health Law*.[8] This research involved 106 mental health practitioners, made up of s.12(2) approved psychiatrists, second opinion appointed doctors (SOADs) and approved social workers (ASWs), who variously took part in three decision-

7 *Memorandum from Rosie Winterton, Minister of State, Department of Health (2004) Mental Health Bill – Necessity vs Capacity submitted to the JSC (DMH 396) and available on the JSC web site (above). See also the responses to that memorandum by Richardson (DMH 408) and Peay (DMH 407) on the same site.*

8 *See Peay 2003 above*

making exercises. These required the practitioners to make decisions individually and as part of a pair on the basis of extensive written and video-materials. Here is not the place to defend the methodology, but it does enable me to make some observations about how non-lawyers perceive, apply and justify their use of mental health law in respect of one of three decisions: to admit a patient under compulsion, to discharge a patient or to give treatment without consent.

So, how are these criteria likely to be applied?

Do notions of uncertain risk promote use of compulsory powers?

The most striking aspect of the criteria is that they are imbued with notions of risk; this is not surprising given the government's form on this issue.[9] The criteria will require practitioners to assess whether action is necessary to prevent the future occurrence of harm; practitioners will have further to make a prediction as to the level of harm that is thought likely to occur. Whilst self-harm requires a high threshold to be passed (suicide or serious self-harm), harm to others is couched in the most general language 'the protection of others'. No indication is given as to the degree of probability of this harm occurring. However, it is logical to infer that the degree of probability is something less than a 'substantial risk', since clause 9(7) makes explicit reference to a substantial risk when serious harm to others is entailed. Thus, 'the protection of others' in clause 9(4)(b) may draw in any degree of physical, psychological or financial harm, or arguably even mere perturbation to the well-being of others. Whilst it is hard enough to weigh known facts, weighing the future is impossibly difficult. In those circumstances where mental health professionals are currently required to make predictions about uncertain risk, their thinking and their decisions were imbued with caution: thus,

> *we are trying to make predictions in situations of uncertainty and in a sense we are bound to err on the side of safety. In some ways it's the only error we are permitted to make because we are expected to protect individuals, and we are expected to protect the public. This is part of our overall responsibility and if the balance is tipping towards increasing concerns, I don't think we can put it aside.....not to do something and wait to find out, well, we might find out what we don't want to find out* ASW, pair 17

> *In some ways I feel that the law gives you that little bit more support. Say he goes on a s.3, it does tighten everything up. I don't think it's so bad to use the law and I'm not saying I don't think twice about it. There are times when I have put people on a section and I've thought gosh I'm depriving that person of their liberty. It's not something that you can take lightly. I think that I do use best interests all round. I think now, almost all of us are so fearful to let things slip, it's almost like you are saying, it's in the best interests for me as well because if this goes horribly wrong then I cop for it. I am the scapegoat.* ASW, pair 22

Interacting with one another, different kinds of uncertainty about the law, the possibility of future harm and the obligation to protect 'others', combined to produce a situation that was potentially full of dread; resort to the law provided a kind of prop. And whilst the law was not fully

9 *See the government's Draft Mental Health Bill 2002; and the preceding White Paper, Department of Health and Home Office (2000) Reforming the Mental Health Act Part I: The New Legal Framework Cm 5016–1; Part II: High Risk Patients Cm 501–II London: The Stationery Office Ltd; and the Green Paper, Department of Health (1999) Reform of the Mental Health Act 1983. Proposals for Consultation. Cm 4480 London: The Stationery Office Ltd; and commentary thereon, Peay, J. (2000), 'Reform of the Mental Health Act 1983: Squandering an Opportunity?', Journal of Mental Health Law 5–15.*

understood, it was sufficiently familiar to provide some element of comfort. In cases of doubt therefore, there was an incentive to resort to the use of law. By introducing greater uncertainty and lower thresholds for action in the face of risk, the Draft Bill looks likely to be used more, not less, than the current Act.

The use of informal admission – avoiding the Act

Whilst there is an incentive to use the Act in cases of uncertainty, another theme that can be seen in the decision-making of practitioners was to avoid using the 1983 Act where a desired result could be achieved informally. It is hard to predict quite where the resolution of the problem posed by Bournewood patients (the compliant but incapacitous patient) will ultimately fall,[10] but historically the bulk of these patients have not been admitted under section. The research findings illustrated the thinking that sometimes lay behind these decisions: pair 37 would have taken the patient, Mr Draper, into hospital informally where he assented to admission, informally for a 'rest', informally even if he was very deluded (although here the psychiatrist would have wanted to section) and would have accommodated coerced informal admission, that is in circumstances where they knew that his consent to admission was given in order to avoid being taken into hospital under section. Thus,

> *if he is willing to hold his hand out and say I'll come in for a rest, then it would achieve most of my objectives, at least in terms of keeping him safe and keeping his neighbours safe and I would be prepared to settle for that in the first instance, knowing full well that if he changes his mind, after whatever length of time it takes us to make our assessment, to take a decision about what we want to do in treatment terms. The options are still open to us at that stage to do something ...* ASW, pair 37

This approach is not uncommon, and is supported by the statistics on the use of coercion in hospital; that is, of patients who enter hospital either by consent or informally, who subsequently find themselves subject to section. To illustrate, in 2002–3 there were 25,112 compulsory admissions under Part II of the 1983 Act and 18,611 conversions of voluntary/informal patients to compulsory status in hospital.[11] In short 43% of the uses of compulsion under Part II occurred with patients already in hospital. And, as Bindman and his colleagues have suggested, the use compulsory sections *in* hospital may take place more readily where staff have acquired a sense of responsibility for patients as a result of their prior voluntary/informal admission.[12]

Of course, not all practitioners responded in the same way to a patient showing clear signs of incapacity in the context of compliance. For some, the ethical dilemmas involved were acknowledged:

> *I don't think it is satisfactory... It is not very fair on the in-patient nursing staff either, because you are really just transferring the responsibility of making the decision to them.* Psychiatrist, pair 26

---

10 The government clearly needs to address the breaches of Article 5 set out by the European Court of Human Rights in HL v UK October 2004, but they have seemed uncertain as to whether the remedy is best addressed under a new Mental Health Act or under the new Mental Capacity Act; see, for example, Department of Health (2005) Interface between the Draft Mental Health Bill and the Mental Capacity Bill (DMH 405) available on the JSC web site above.

11 Department of Health (2003) Statistical Bulletin: In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation 2002–03. London: Department of Health and National Statistics, Statistics Division 2.

12 J. Bindman, Y. Reid, G. Thornicroft, G. Szmukler and J.Tiller (2001) A Study of Experiences of Hospital Admission. London: Report of a Study Commissioned by the Department of Health Research and Development Division

This psychiatrist would also have used the compulsory provisions for admission where the patient's agreement to admission occurred after some mention of the 1983 Act

> *otherwise he is not really coming in informally, he is coming in under duress.*

Others were more influenced by resources issues. For example, the ASW in pair 35, who used informal admission liberally, observed:

> *If you have a view of the mental health services as excellent services then those who can be persuaded will be persuaded and those who can't because they are deluded can come in informally anyway. I'm not certain in what context you'd want to use the Mental Health Act because the safeguards become almost redundant if you have a very positive view of mental health services.* ASW, pair 35

Where a practitioner's view of mental health services is not so positive, resort to compulsion may be more likely. As the Rethink Report has questioned, is it the inadequacy of community mental health services or the bleakness and squalor of acute wards that makes voluntary admission less likely and compulsion more likely.[13] What cannot be denied is that there has been an increase in the use of compulsion of nearly 30% in the last decade.[14] Again, it is not clear how clause 9(5) will be interpreted (*that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part*) in the context of a pre-existing Mental Capacity Act that provides for lawful medical treatment of those lacking capacity, even if some use of restraint is entailed.

Complex criteria – conflating the issues

Another issue concerns how practitioners use complex legal criteria, criteria that may need to be independently satisfied. That non-legal practitioners may use the law in novel ways, ways not anticipated by the legislature, was evident from the research. Thus, the phenomenon of conflation across all of the criteria for admission could be seen.

> *I've got three parameters here. I've got nature or degree and I've got risk and any one of them can add points onto the score to take me up to my threshold. There has got to be a bit of illness, but if the risks are getting higher, the risks of me not engaging with this man and leaving it are becoming unacceptable. I then have to decide right, if this man is not safe out there where does he need to be? Does he need to be in hospital or does he need to be in custody? ... If he's not ill then it would be the police. If I am a bit more towards ill then I'd probably go for hospital. With history, I'd go for illness, just because of his history ... because the Act is couched in such non-specific terms, isn't it? That's all we can do. It does have the potential to be misused.* Psychiatrist, pair 14

Yet even this 'graphic equaliser' approach would suggest that for some practitioners a pure form of preventive detention (that is, in the absence of illness) would not be acceptable. How practitioners will respond to the proposal under Clause 9(7) that patients with a mental disorder of a nature or degree warranting medical treatment who are at substantial risk of causing serious harm to other persons *cannot* be treated on a voluntary basis is not clear.

---

13 Rethink (2004:7) Behind Closed Doors: Acute Mental Health Care in the UK London: Rethink

14 See Department of Health 2003 above

A pragmatic approach?

Of course, some risks are more pressing than others. And not all risk is related to some underlying abnormality. What should happen where a potential patient has no history of offending, but is making threats? Where the risk is one that is merely predicted, practitioners recognised that there was greater difficulty. As one ASW put it:

> *I think you'd have to look at that very carefully, because people make threats to other people and indeed carry them out and it has absolutely nothing to do with them being mentally ill. So, is this an issue perhaps for the police if he is making those kinds of threats under the influence of drinking…or is this about somebody who is relapsing into a psychotic illness and acting under some kind of delusion or hallucination in some way?* ASW, pair 14

The research study illustrates well how, through experience, decision-makers tend to learn the rules of the game and make their decisions in the light of all of the factors that they might be required to consider. Constraining themselves to use only those that legitimately apply to the particular facts of a given case was more problematic.

Will the new tribunal make a difference?

Another reason why some practitioners used the current Act was because it provided patients with a formal safeguard against the abuse of compulsion. To some, this was a comfort.

> *I don't feel comfortable about section 3 being renewed, but, it may be what we need to do, so that he has got some rights while he is in hospital to call a tribunal which he wouldn't have as an informal patient. It also gives us powers if we do find somewhere that he can go on leave, but we can recall him as and when necessary.* ASW, pair 17

However, it is self-evident that if the new Tribunal is to have no discretionary power to discharge and will apply the same broad criteria used to justify assessment and treatment, then there is little prospect of it acting to remedy the inappropriate use of compulsion, for there will be little bite in the criteria it is obliged to apply. On the other hand, this situation may not be so different from that as currently envisaged by some practitioners, who clearly took the view that tribunals are as 'realistic' in their application of the law as were practitioners. Difficult choices resulted in pragmatic solutions by all concerned.

> *Hopefully, it's morally defensible. Yes, I must say that in my experience I think the tribunal will probably uphold, whether or not they are right in doing it in law I don't know, but I think they probably use the same line of reasoning as us – this is a chap who is a pretty serious risk and he needs to be closely supervised – and perhaps one would hope that they might not be so strict about the rigid letter of the law. I don't know.* Psychiatrist, pair 35

For some who took part in the research the conflict between their ethics and a pragmatic solution was all too apparent, but this conflict could be resolved by adopting a cautious approach (when considering renewal of a section).

> *I think ethically the more justifiable thing would be not to renew it and to say the problem is one of resources, not one which can be solved with the use of the Mental Health Act. I've been at a tribunal where a patient of mine was discharged on the basis that the tribunal felt she could be managed at home safely providing there was a community psychiatric nurse visiting twice a day over a period of two or three weeks. We endeavoured to do this in that individual case by withdrawing resources from other*

clients, so in the end it was an economic decision which probably is possible in theory. Taking each case in isolation so you could manage a lot of people at home if you could put in sufficient resources. But if you can't, then the safest option is to detain. ... I might be inclined to renew with misgivings. Psychiatrist, pair 36

Will compulsory community treatment be over-used?

Moving patients seamlessly from compulsion in hospital to compulsion in the community is likely to prove attractive to those practitioners who are understandably cautious about tolerating risk. There was evidence from the research that practitioners were fully prepared to renew a section solely in order to ensure that a patient could be moved from hospital into some community setting on s.17 leave where medication could still be administered under compulsion and the patient could be returned to hospital if matters deteriorated (or the practitioner's ability to tolerate risk changed).[15] Thus:

It seems a shame that one is having to renew a section 3 just to allow a period of leave of absence down the line. But given his history, I think there will be a risk if he went out without any legal structure around him. Also, I think he is getting restless and very frustrated, although he is not trying to abscond at this point in time. Once he realises he could leave, I am not sure that he would stay and he may make his way to his sister's and cause problems there. Psychiatrist, pair 17

Practitioners' perceptions that they had no other option are also evident in their use of the terminology of constraint.

It's difficult to place people with this sort of history and his combination of needs. So I feel my hands are tied really ....renewal on a section 3, but I would welcome him appealing against it. It's one of those sections where I feel unhappy about it. Psychiatrist, pair 17

This perception can be self-constructed (and indeed, in the research, it was evident that other practitioners given exactly the same factual situation did feel that there were other options). But, the ready availability of community treatment is likely to prove popular amongst some practitioners, at least in the first instance. And once community treatment is in place successfully, the conditions under which it might be deemed unnecessary become even harder to envisage. Hence, patients and clinicians may become trapped in a coercive relationship akin to the current arrangements for conditional discharge for restricted patients.

Use of supervised discharge

Using the law as a coercive tool was not without its ethical difficulties, which were acknowledged by some. Thus, one psychiatrist, who had experience of successfully maintaining three psychotic young men on s.25A in the community, recognised that using supervised discharged raised an ethical dilemma.

I think the trouble with it is the lack of ethics around being completely open with people about what it actually means. To be perfectly honest, this section 25 is a piece of paper and it means nothing. You say 'these are the conditions, do you agree to them?' Well they say 'alright then' and I am going to renew it and I have renewed all three of them and it has worked and they have perceived a legal framework, and it is dodgy, I think morally dodgy but in the end, this is an end that justifies the means. They stayed

15 *R v Barking Havering and Brentwood Community Healthcare NHS Trust [1999] 1 FLR 106, R (on the application of DR) v Mersey Care NHS Trust (2002) Times October 11 2002, and CS v MHRT [2004] EWHC 2958 (Admin)*

> *out of hospital, they stayed well and they are starting to work and doing all sorts of things.* Psychiatrist, pair 14

However, the dilemma for this psychiatrist was acute for, when challenged about whether he told his patients that medication could not be enforced in the community, he responded:

> *Yes...and I told them the truth, obviously in a sort of whisper.*

Under the Draft Bill's proposals the dilemma is somewhat different. The clear expectation is that compulsion will not be used in a patient's home, but that transport to an appropriate facility will be required. However, when a patient is faced with the choice of transport plus compulsion, or immediate 'compulsion' in the privacy of their own home, how many are likely eventually to concede?

Substantial vs significant: what is the difference?

The Draft Bill employs a great deal of subjective language; uncertainty will necessarily accompany its use. However, there is a further problem; namely, that language of particular significance to lawyers does not necessarily have the same significance to non-lawyers. Thus, the Draft Bill uses the words 'substantial risk of serious harm'. At face value substantial seems to imply more than significant. But to the participants in the research the relationship between these two terms was variable and often obscure.

> *I think because I'm hesitating, I can't think of a good reason why it's different, I think it probably means the same.* Psychiatrist, pair 40

Some felt the terms were interchangeable; others rated a substantial risk as low as a 10% chance of the predicted event occurring during the six months period of the s.3; and some as high as 70%. There was, therefore, considerable tolerance in use of terms.

For whose benefit?

There was also evidence that some practitioners were prepared to use the law to protect themselves, by adapting a clinical opinion in order to fit the Act. One has considerable sympathy with a practitioner's preparedness to do this, particularly when confronted by a perceived risk or where it enables a practitioner to pursue what are regarded as actions in the best interests of a patient. Thus:

> *... pragmatically, if it gets me to the position where I have him on a section 3, then I can work towards the supervised discharge and try him out in a hostel. I would rather be in that position, than let him go.* Psychiatrist, pair 35

But what lay behind this was only occasionally revealed. For in one case there was an honest admission that this strategy of manipulating the 1983 Act was not in order to achieve the objective the psychiatrist had earlier claimed, namely to prevent the patient from relapsing and returning to Broadmoor Special Hospital, but rather:

> *It's really there for our protection, I think. I think the Mental Health Act is there for the protection of patients, but it is very obviously there for the protection of medical practitioners as well. I admit that. I think that your personal experience exposes you to the crucifixion of other doctors; there was a major incident where they allowed a schizophrenic chap to go home, he stabbed his sister-in-law to death, two years ago. It made the front page of the Yorkshire press. As a result, you can feel them breathing down your neck. It does change your view.* Psychiatrist, pair 35

Self-protective strategies were evident in the thinking of other practitioners. For example, in pair 30 the ASW argued for s.25A and wanted to place the patient, Mr Wright, on the local supervision register; the psychiatrist revealed that nothing could convince her that Mr Wright was 'safe' and so she wished to use renewal under the Act as a form of desensitization for herself. As she stated

> *He hasn't had a structured pattern of leave or been integrated into the community with supervised leaves. And just to expect him to go straight from the hospital to the community...it's really nerve wracking. In fact, I wouldn't do it.* Psychiatrist, pair 30

On being confident that you have reached the right clinical decision?

The SOAD in pair 6 was concerned that there was no way of being certain whether other SOADs would agree with the proposed course of action.

> *Just like most consultants act autonomously, where you don't really know what your colleagues are doing, likewise with SOADs. SOADs act by themselves. We get together for training days and we might let off steam about how difficult it is to arrange second opinions and all sorts of mechanics but I don't know if we actually discuss ethics..... we're asked to give an opinion on somebody else's treatment plan and there has to be a line between what is acceptable and what is unacceptable.* SOAD, pair 6

The Draft Bill proposes establishing new expert panels. Quite how these will operate is not clear. Indeed, will there be training for them together with all of that necessary for the new tribunal members? How are standards to be achieved? How are expert panel members to feel supported in their decision-making?

Or the right legal decision?

Whilst the Draft Mental Health Bill 2004 makes no reference to advance directives, the Mental Capacity Bill 2004 does. It is therefore entirely possible that practitioners will have to deal with complex situations where advance directives are in place, but their legal effect under the 1983 Act is unclear. Under the current arrangements practitioners have enough problems knowing how to deal with the conflicting views of relatives and a patient about a patient's (non-binding) advance directive. Thus:

> *the whole thing with this one is a real minefield, but I would want to approach them separately just to check out that she really was competent when she made the advance directive and ask them what they want me to do. I'm afraid these days, more and more you're thinking, how is this going to look in court? What is this going to look like at the inquest, if you take the worst-case scenario? What is the coroner going to say, when I say to the coroner 'yes, I let her down'?* SOAD, pair 11

The desire to share the responsibility for these difficult decisions was evident.

> *I'm very hesitant on this because I don't know what I would really do. In reality I may well say I would rather have somebody else participate in the decision or take the decision, and say go ahead, do this.* RMO, pair 11

> *I believe I ought to respect the advance directive but would find it extremely difficult to do so and I would probably try to park the responsibility with the SOAD.* RMO, pair 13

To which the SOAD responded:

> *To be honest with you, I would phone the Mental Health Act Commission and try to chew it over with somebody legal, as I am honestly not sure of the position.* SOAD, pair 13

All of this implies some confusion about the operation of the current Act, a statute that has been in force for over 20 years. Quite how practitioners will cope with the demands of the new legislation is not clear. The Royal College of Psychiatrists already anticipate that psychiatry will become an even more difficult discipline in which to fill the necessary consultant posts.[16] But what is clear is that to many practitioners the law was a foreign land and certainly an unfamiliar language. But curiously, it largely did not seem to matter. The question that was uppermost in the minds of these practitioners was not whether their decisions were lawful or unlawful, but rather whether they were the right decisions in all the circumstances. And being right might entail right for the patient now, or it might entail right for the practitioner, or it might entail right with a prospective view of hindsight. But all these possibilities would suggest a creative and defensive application of the legal tools available. On the basis of this platform of current knowledge about decision-making, I remain unconvinced of the government's assertion that the use of compulsion would not increase were the Draft Mental Health Bill to be enacted in its current form.

2. The Process: Who Makes Decisions with Whom?

Two issues will be addressed here: those relating to group decision-making and those relating to multi-disciplinary decision-making.

Group decision-making – are two or more heads better than one or just different?

Too many years ago, when I was a PhD student looking at the decision-making of Mental Health Review Tribunal (MHRT) members under the 1959 Mental Health Act, there was much discussion about whether groups made riskier decisions than individuals (this was known as the 'risky-shift' phenomena).[17] However, during my research it became apparent to me that the process was subtler than the name implied; in practice, what seemed to occur was that groups made more extreme decisions than a consensus model of decision-making might suggest. Thus, group decision-making seemed to result in decisions that were either more risky than their individual members would have tolerated or more cautious. And in my research it was evident that the tripartite structure for MHRT decisions was resulting in decisions that were generally more cautious than the individual members would have made had the decision been one for them to make alone.

This phenomenon could also be observed in the *Decisions and Dilemmas* research.[18] For example, in the decision about discharge in the case of Mr Wright, 63% of the 80 psychiatrists and ASWs who looked at the case individually would *not* have renewed his section. But when the decision was then made in pairs, 58% of the pairs ultimately favoured renewal, the more cautious strategy for the management of this case. What had occurred between the individual decision and the paired decisions to bring about this remarkable change of heart? Was it that the individuals favouring renewal always had the more persuasive arguments, or that they were in a position to override anyone favouring not renewing? Intuitively, one would have expected the psychiatrists to have been

16 *See, for example, the evidence of the Royal College of Psychiatrists to the JSC (DMH 24 at p.27), and from the Department of Health (DMH 404) Resources and the Regulatory Impact Assessment which notes at paras 20–21 that vacancy rates in 2004 for psychiatrists exceeded those for other medical and dental groups (9.6% compared with 4.3%) and that this differential had increased since 1996.*

17 *See Peay (1980) A Study of Individual Approaches to Decision-Making under the Mental Health Act 1959, unpublished PhD thesis submitted to the Department of Psychology, University of Birmingham and Peay 1981, 1989 above*

18 *See Peay 2003 above*

dominant in this decision, since in law the discretion to renew lies exclusively with the Responsible Medical Officer (RMO). Yet tellingly, in all the 6 cases where the ASW's view prevailed (a counter-intuitive finding) the ASW was arguing for a more cautious strategy than the RMO; and in four of those cases the ASW favoured renewal, where initially the RMO would *not* have renewed. Thus, there was a shift to caution where the decision was made in pairs. What this seemed to imply is that the use of compulsion under the current Act may be facilitated by the method by which decisions are made. Two heads are different than one.

Under the arrangements proposed for the Draft Bill 2004,[19] individual practitioners will have to make the decision as to whether a person should be admitted under compulsion for assessment and then justify those decisions in writing. Three practitioners will be required (in non-emergency situations) to authorise compulsion. If any one practitioner decides against the use of compulsion the process of moving towards assessment under compulsion will be stopped. At first sight, this may imply a welcome pressure against the unnecessary use of compulsion. However, in practice, it is possible that practitioners will quickly gain a reputation in respect of their compulsion-mindedness. And that professionals will find themselves teaming up for assessments with others of a like mind, thereby undermining the structural 'reverse pressure'. Alternatively, if one practitioner ultimately says no to compulsion where two others have already endorsed its use, will the process be re-commenced but with a replacement third party being nominated to undertake the assessment? Whilst this may be an overly cynical assessment, there is evidence from the research (see below) that practitioners are aware of their own and others 'track-records' and moderate their behaviour accordingly. Thus, heads sequentially structured may make a difference, or they may not.

Multi or duo-disciplinary decision-making

A great deal has been written about whether it is possible for different disciplines, such as law and psychiatry, to talk to one another in a meaningful fashion. I do not intend, indeed I am not qualified, to explore the finer points of autopoietic theory here.[20] However, an albeit crude analysis of its central tenets does provide an insight into what may be happening when decisions are made in a multi-disciplinary context.

Autopoietic theory propounds that the law (and presumably other disciplines like medicine) is an autonomous system whose operations are self-referential and closed: the law thus deals in specialised communications which have different meanings from those of other closed systems, for example, medicine. Yet, the multi-disciplinary nature of decision-making under mental health law, whether it is by MHRTs (entailing lawyers, doctors and lay people) or by the duo-disciplinary decision-making entailed in the decision to admit a patient to compulsion, is predicated on effective shared communications between different disciplines. Evidence of the ability of different disciplines to communicate effectively with one another is mixed,[21] but there is some evidence

19 *See clauses 15–18*

20 *M. King and A. Schutz (1994) 'The Ambitious Modesty of Niklas Luhmann' Journal of Law and Society 21, 3, 261–87. And for a helpful analysis by G. Teubner, R. Nobles and D. Schiff (2002) 'The Autonomy of Law: An Introduction to Legal Autopoiesis', in J. Penner, D. Schiff and R. Nobles, Jurisprudence and Legal Theory: Commentary and Materials London: Butterworths.*

21 *See for example, M. King and C. Piper (1995) How the Law Thinks About Children Aldershot: Arena; and R. Nobles and D. Schiff (2004) 'A Story of Miscarriage: Law in the Media' Journal of Law and Society 31, 2, 221–224.*

from a fascinating observational study of the role of doctors on MHRTs that doctors can and do act in the role of 'translators' when moving between clinical and legal issues.[22]

Autopoiesis does not state that effective communication can never occur between functionally different worlds. Indeed, the theory provides a more complex understanding of what comes within 'effective communication' through the concept of structural coupling. This concept describes a potential process for facilitating relationships between different social domains. The key, as Teubner and his colleagues observe, to successful structural coupling 'lies in unlocking a hidden agenda toward compatibility between different worlds';[23] and this in turn entails the 'processes of "creative misunderstanding"'.[24] This concept will be returned to below, but suffice it to say at this stage, it is possible that under current legislation the unstated concept of best interests may fulfil this role, thereby enabling effective communication to occur between doctors and ASWs.

However, another possibility exists; namely, that the true nature of multi-disciplinary decision-making is not multi-disciplinary at all; one discipline, for whatever reason in the particular context, simply trumps. During the research it was evident that on a number of occasions either ASWs or psychiatrists (but usually the former) were prepared to defer to the other professional, seemingly against their better judgement, on the basis of what was perceived to be privileged knowledge.[25] Thus, in a number of pairs either the notion of clinical risk or that of risk to others would cause the ASW to defer to a psychiatrist who was promoting a more cautious strategy than the ASW would have preferred (that is either to admit under compulsion to treatment, or to renew a section in the case of a patient who was already detained).

The conventional role of the ASW in the decision to admit a patient has historically been seen as one of potentially acting as a brake on an otherwise overenthusiastic psychiatrist employing a decision-making approach dominated by the medical model; ASWs are thus able to offer a different context for decision-making and, in an ideal world, provide alternatives to mere resort to compulsion in hospital. And there was evidence in the research to support the notion that ASWs could be effective in this role. For, of the 40 paired decisions about whether to admit Mr Draper, 22 were cases where the ASW's views prevailed, in 9 the psychiatrist prevailed and in 9 the decision was evenly balanced. These numbers are in marked contrast to those in the decision to discharge where exactly the same pairs considered the case of Mr Wright, but here in 22 pairs the psychiatrist dominated the decision outcome, in 6 the ASW prevailed and in the remaining 12 pairs neither party dominated the outcome. The evidence is therefore that where the law favours one discipline over another (and in the decision to admit the compulsion cannot be used unless the ASW is prepared to 'sign the pink forms', whereas in the decision to renew, the statutory responsibility falls to the RMO) that party can dominate in the decision-outcome irrespective, arguably, of the persuasive value or legitimacy of their arguments.

As interestingly, it is possible to use the data to look at the influence that individuals have irrespective of their professionally privileged position. This is a topic of some importance where

22 *See G. Richardson and R. Machin (2000) 'Doctors on tribunals: A confusion of roles' British Journal of Psychiatry 176, 110–115 at p114.*

23 *Teubner et al (2002) above at 914–915*

24 *Ibid. at 915*

25 *One of the advantages of the research design was that it was possible to look not only at which professional in each group dominated the decision-making, in the light of knowledge as to their preferred individual strategy, but to look also at whether the law privileged one professional over another in respect of either the decision to admit or the decision to discharge. This would not be possible merely by observing real-life decision-making where individual decisions do not currently have to be pre-stated.*

individuals make decisions with or alongside other individuals with whom they already have a decision-making track record. Two matters are of note. First, even over the course of two decisions involving the same pairs of decision-makers it was possible to observe the consequences of a past interaction: some individuals, who had failed to operate effectively in the first paired decision, approached the second in a more measured fashion, whilst others appeared more combative. Independence of mind can be moderated both by the knowledge of past interactions and by the prospect of future ones. Second, some individuals were just more dominant than others. In nine of the pairs one party dominated both decisions irrespective of their statutory role: thus, six psychiatrists and three ASWs were dominant in both the case of admission and of discharge. In 11 pairs the decision-making followed the statutory pattern (that is, the ASW dominated admission; the psychiatrist dominated discharge); in one case, this pattern was reversed, and for the remaining 19 cases there appeared to be reasonable agreement between the pairs. So, in some pairs the law has an influence through its allocation of statutory roles, but in others, individuals trump seemingly regardless of any structure the law might have tried to impose.

All of this leads me to be somewhat cautious in making predictions as to how the new tripartite, but sequential, model for the decision to admit under compulsion for assessment will function. What I feel I can be confident about is that there will be unanticipated perturbations in the process.

3. Miscellaneous (and Concluding) Observations

Decision-avoidance

You don't need to do research to know that there are some decisions that we all try to avoid making and that some people are more indecisive than others. So it is no revelation that there was evidence in the research that some of the paired decision-making was dominated by a seeming desire not to have to make a decision at all: this could entail a hunt for more or better information, a decision to delay taking any further action until some designated future point, or to admit a patient informally on the basis that this deferred the current problem to a different context. On questioning, a number of ASWs who did night-time or week-end rotas also reported a tendency for other practitioners to delay a case until it fell into the purview of the out-of-hours practitioners, in essence passing the buck to them. In respect of the Draft Mental Health Bill 2004, it might be argued that it will be more difficult to engage in these strategies and avoid making decisions since the Bill is generally much more prescriptive than the 1983 Act, requiring explanations of inaction as well as action.[26]

The new kid on the block

There was also in the research a curious fascination with all things new, as if somehow these might be the solution to long-standing problems. For example, there was considerable discussion of the potential role of s.25a (supervised discharge) in Mr Wright's case (even though he would probably not have satisfied the criteria for this section).[27] The notion that supervised discharge could give practitioners some additional control over a patient in the community was attractive. Yet, s.25a is

26 *For example, under clause 15(3) where the decision is made to assess the patient in the community, rather than to detain, the practitioner is required to specify the conditions to protect the patient's health or safety or that of others thought to be at risk of harm; and clause 38, where there is a duty on the clinical supervisor to apply to the tribunal where the relevant conditions are met.*

27 *Introduced in 1995 as an amendment to the Mental Health Act 1983.*

arguably a section with few, if any, teeth; treatment cannot be given under compulsion in the community even on this section. Indeed, the section is not dissimilar to the long-standing option of guardianship. Yet that provision was almost never mentioned during the research. Thus, if compulsory treatment in the community is introduced as outlined in the new Draft Bill, it may prove popular partly because of its very newness.[28]

Context – training and experience

How decisions get made about any individual case will be influenced by a host of factors unrelated to the law: for example, a practitioner's experience and case-load, the resources available, the objectives being pursued by any one practitioner, the climate of opinion, and/or an individual's ability to tolerate risk and uncertainty. One striking example from the research will suffice: of the 40 psychiatrists drawn from across the country who reviewed the case of Mr Draper, 30 of them would have admitted him under compulsion had the decision been one for them to take alone. Of the 20 psychiatrists with a forensic background from the Institute of Psychiatry who reviewed the same case, none of them would have admitted Mr Draper. He was, to them a 'soft case'.[29] Similarly ASWs with a large forensic load seemed much more tolerant of potential risk than did newly qualified s.12(2) psychiatrists with no forensic patients. Undoubtedly, the new arrangements under the Draft Bill will both extend responsibilities to new practitioner groups (psychologists if acting as clinical supervisors, and others who qualify as approved mental health professionals) and draw in more practitioners *per se* under the expanding boundaries of compulsion under the Act.[30] All of these people will require training.[31] Maintaining consistency is likely to be problematic, which in itself is unlikely to help address one current and very real concern with the use of the current Act; namely, its inconsistent use and its seeming over use with some ethnic minority groups.[32]

Cognitive errors

The study of cognitive errors is a subject in its own right. Again, suffice it here to say that these are relatively enduring features of decision-making that will bedevil any attempt to impose a new regime in decision-making in mental health law with a view to achieving specified objectives. Subjects such as frame constriction, the single option fallacy, over-confidence and ignoring your track record all have a part to play.[33]

---

28 The Draft Bill does not mention community treatment orders as such since the Bill envisages a seamless transition from treatment in hospital to treatment the community; however, evidence to the JSC, see above, was replete with discussion of the disadvantages (and advantages) of having a power to treat under compulsion outside hospital.

29 See Peay 2003 at 159

30 See also J. Peay, C. Roberts, and N. Eastman (2001), 'Legal Knowledge of Mental Health Professionals: Report of a National Survey', Journal of Mental Health Law 44–55.

31 See, for example, the submission of the Regional Chairman to the JSC where it is asserted that it would take approximately nine years to complete the interview processes alone for the appointment of all the necessary new tribunal members (DMH 200 at para 9).

32 See Department of Health (2005) Delivering race equality in mental health care: an action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett (Available on the DoH web site: 11th January 2005)

33 See, for example, A. Bartlett and L. Phillips (1999) 'Decision Making and Mental Health Law' in Eastman N and Peay J. (eds) Law Without Enforcement: Integrating Mental Health and Justice. Oxford: Hart Publishing; Peay, J. (1999), 'Thinking Horses not Zebras', in Webb, D. and Harris, R. (eds.), Managing People Nobody Owns London: Routledge.

Best interests: the autopoietic solution?

Whilst the concept of best interests clearly has a defining role to play in the Mental Capacity Act 2005, its role under the Mental Health Act 1983 is limited and it is much more limited under the Draft Mental Health Bill 2004. Yet, when practitioners were asked how they defined their own roles under the 1983 Act it was clearly a key concept. Coming from a clinical perspective this is entirely understandable. It is also perhaps not so surprising that some ASWs also saw this approach as being more relevant to their work than a legalistic approach or an autonomy-based ethical approach. It would therefore probably be unwise to assume that its practical centrality will be downgraded in terms of the *application* of any new Mental Health Act, particularly in the absence of clear defining principles on the face of the statute; as currently drafted, the 2004 Bill would assign its limited principles to a Code of Practice and then permit those principles to be disapplied, for example, where 'inappropriate or impracticable'.[34]

Whether clinicians, ASWs and indeed lawyers mean the same thing when they assert that their decisions are based on the principles of 'best interests' is a moot point. However, from the perspective of autopoietic theory, its very malleability and lack of agreed definition may make the concept of 'best interests' hugely useful to facilitating communication. Creatively misunderstanding precisely what is meant when both psychiatrists and ASWs strive to achieve what they (differentially) believe to be in a patient's best interests may facilitate ultimate 'agreement' between these different disciplines involved in the application mental health law. In short, the paternalistic form of best interests arguably provides the invisible mortar that keeps the edifice of the 1983 Act in place. For, if autopoietic theory is correct and one discipline cannot speak meaningfully to another, then having a creative misunderstanding based on a term that has meaning in all three disciplines (psychiatry, social work and law), even if not necessarily the same meaning, may permit the impossibilities of accurate translation to be at least partially obviated.

But autopoietic theory also provides an avenue to think about how such creative misunderstandings can lead to newly invented opportunities for co-ordinated action.[35] If practitioners are prepared to adhere to a self-defining regime that may not wholly reflect what is on the face of a statute, it is possible that as mental health becomes increasingly to be seen as on a par with physical health, that practitioners will reach for a newly invented understanding of best interests. This version of best interests, already present in the Mental Capacity Act 2005 in a nascent form, may be one that requires clinicians to respect what a patient determines is in their interests, where that patient retains capacity.[36] Thus, autonomy-based best interests rather than paternalism-based best interests may serve to ameliorate what might otherwise be the less attractive features of the proposed new legislation. If so, then multi-disciplinary decision-making based on a creative misunderstanding may revive the justification for a several-headed approach to mental health law.

34 Clause 1(4)(a)

35 See Teubner at al 2002 above at 915

36 See S.4

Mental Health Law for the 21st Century?

Mat Kinton[1]

Lord Shaftesbury complained that it took him 'seventeen years of labour and anxiety' to get the Lunacy Act 1845 onto the statute books[2]. The revision of the Mental Health Act 1983 is also turning out to be a long and difficult process, both for Government and for those that it calls 'stakeholders' in mental health services. What follows does not seek to examine that process, although it relies heavily on the public sessions of the Joint Committee on the draft Mental Health Bill (hereafter 'the Joint Committee'). Nor will I attempt to summarise the Mental Health Act Commission's public comments on the draft Bill of 2004, which are readily available[3]. My conclusions, especially insofar as they exhibit a certain pessimism over the future direction of mental health law, are a personal view rather than one which is necessarily held by the MHAC.

Human rights and the reach of mental health law

Many service users and mental health professionals appear to view with some scepticism the Government's claim that a concern with human rights lies at the hearty of its drive for a new law.[4] But the current law has taken quite a battering from challenges under the Human Rights Act 1998, being the most found-against law on the statute books to date in terms of incompatibility declarations.[5] Although remedial action has been taken in some cases to patch up the 1983 Act after such judicial declarations of its incompatibility with the tenets of the European Convention

1 *Senior Policy Analyst, Mental Health Act Commission. This article was accepted for publication before (a) the Joint Parliamentary Scrutiny Committee on the Draft Mental Health Bill reported (23rd March 2005), and (b) the Mental Capacity Bill received the Royal Assent (7th April 2005).*

2 *Mental Health Act Commission (2003) Placed Amongst Strangers: Tenth Biennial Report. London, Stationery Office, p 290.*

3 *Joint Committee evidence DMH 20, DMH 90. Available from www.mhac.org.uk*

4 *For the Government view, see Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 19 January 2005, Q814 (Ms. Rosie Winterton MP). Uncorrected transcript of oral evidence to be published as HC 95-x. For examples of scepticism, see the responses to the Joint Committee on the Draft Bill's consultation question 9 at DMH24 (Royal College of Psychiatrists); DMH 105 (Mental Health Alliance); and DMH 111 (Law Society).*

5 *If, that is, the measure is of frequency of findings rather than profundity of offence against human rights. The most profoundly incompatible statute, given the issues involved and the tone of the judgment, must be the Anti-Terrorism Crime and Security Act 2001 (ATCSA). However, the Mental Health Act 1983 shares in some of the ignominy of ATCSA, given that four ATCSA detainees were transferred to hospital under the powers of the 1983 Act in conditions that, in the view of the MHAC, denied any effective review mechanism under the 1983 Act's powers. The MHAC gave evidence of its concerns about this to the Joint Committee of Human Rights in June 2004, which was published in the Committee's report Review of Counter-terrorism Powers (HL Paper 158,HC 713, pp63) and visited and monitored the care of the patients.*

on Human Right (ECHR),[6] the prospect of continued rearguard action of this sort is unlikely to be palatable to Government ministers. The temptation to wipe the slate clean and rebuild the law with a specific focus on ECHR compliance must be great for that reason alone.

Even those who are sceptical over the continued role of human rights legislation have called for legislative reform. The Conservative party has indicated that it would consider repealing the Human Rights Act to 'check the escalating volume of 'rights' claims against the criminal justice system and other public bodies' and 'retain proper parliamentary oversight of our justice system'[7] (thereby potentially rooting out the causes of ministerial discomfort in the courts by other means). But it has also claimed that 'we desperately need an update to the 1959 and 1983 mental health legislation'.[8] It seems that, despite disagreement over the appropriate mechanisms of protecting individual rights, there is consensus, at a rhetorical level at least, that what is needed in mental health law is a new focus on patients as individuals and new safeguards to support this focus.[9]

Such rhetoric, in any case, takes place at a level abstracted from the real tensions that pull upon the drafting of this legal framework. After all, the purpose of mental health law is not simply to protect liberties, but also to empower authorities to take them away. The roots of Government action over the 1983 Act extend back to the announcement of the Home Secretary, more or less contemporaneously with the enactment of a domestic human rights law, that something would be done over the group of patients given the political label of 'dangerous severe personality disorder' who were perceived to be excluded from psychiatric compulsion or intervention.[10] Many of the most contentious aspects of the draft Bill emanate from Government's aim of providing a civil form of preventive detention for this group of people.

The challenge facing the Government is to balance the need to establish parameters for psychiatric compulsion whilst facilitating such compulsion where it is proportionate and justifiable. It is

6 *The finding in R (on the application of H) v MHRT, North & East London Region [2001] EWCA Civ 415; [2001] MHLR 48 was addressed in the Mental Health Act 1983 (Remedial Order) Order 2001 (SI 2001/3712), which amended ss 72 and 73 of the 1983 Act to shift the burden of proof in Tribunal appeals. A Consent Order subsequent to R (on the application of SSG), v Liverpool City Council, the Secretary of State for Health and LS (interested party) October 22 2002 ensured that MHA 1983 s26(6) should be read to apply to homosexual partners. The finding of Bennett J in R (on the application of E) v Bristol City Council (Administrative Court, 13 January 2005) may have resolved some Article 8 issues regarding Nearest Relatives (R (on the application of M) v Secretary of State for Health [2003] EWHC 1094 (Admin); [2003] 3 All ER 672) although, even if ASWs choose not to contact a 'Nearest Relative' on the grounds of objections by the patient, there still remains no mechanism to remove the designation of 'Nearest Relative' from someone on the grounds of a patient's wishes. Government has yet to provide a solution to the determination in the ECtHR judgment HL v UK [2004] that the current legislative framework fails to protect the rights of incapacitated but compliant patients, or to the lack of Tribunal access for a patient whose section 2 detention is extended through a s.29 application (R (on the application of MH) v Secretary of State for Health [2004] EWCA Civ 1609).*

7 *Conservative Party press release, 23 August 2004.*

8 *Hansard HC 3 Dec 2003, col.517 (Mr Tim Yeo MP). Mr Yeo prefaced his comment with the caveat that the Opposition 'have repeatedly said that the Government's draft mental health Bill is not the answer'.*

9 *Conservative Party press release, 8 September 2004: Shadow Health Minister (Tim Loughton MP) has stated that "we have waited too long already to update our mental health laws, which mainly hark back to the 1950s", but that the draft Bill is overly focused on the dangers to the public rather than the medical needs of the patients: "the Government have still failed to grasp that mental illness is a medical condition requiring treatment like any other physical problem rather than a criminal offence demanding incarceration. Compulsion should be a means of last resort".*

10 *The Guardian, 19 July 1999: Straw unveils plan to lock up 'dangerous' mental patients before they commit crimes. See also House of Commons Home Affairs Committee (2000) First Report of session 1999–2000. Managing Dangerous People with Severe Personality Disorder. March 2000, Introduction p.v–vi.*

important that the law sets no arbitrary or unhelpful limitations on mental health services (as, for example, might be argued to result from the current Act's apparent exclusion of patients with acquired brain injuries). It is equally important, however, that this does not lead to the structure of the law being wide open to abusive practices. Where basic definitions must remain relatively broad, robust principles of application, explicit exclusions, and appropriate regulation of practice are means for Government to fulfil its obligation to ensure that powers used in its name are implemented in accordance with human rights principles.

In its aim to ensure that its legislation is 'inclusive'[11] (i.e. wide-ranging in scope), Government displays its determination that nothing in its Bill should be a hostage to future legal challenges of the right of the State to intervene in patients' mental healthcare. But this nervousness may be self-defeating: where the Bill fights shy of setting parameters through loosely drafted or implied powers it is most vulnerable to future judicial interpretation. A balance must be reached between 'inclusive' legislation and a meaningful framework of defined powers and duties, unless Government wishes to abrogate the role of establishing law to the judiciary.

In responding to points raised during consultation and scrutiny, Government understandably seeks to give a positive presentation of the measures that it proposes. But in doing so it may overlook the potential for use of powers in ways other than it intends. It is not difficult to envisage the inappropriate use, however well meant, of mental health legislation for disproportionate medical interventions in the lives of the mentally disordered, or for non-medical purposes of social control. The duty provided by the Human Rights Act 1998 upon public authorities to construe (so far as it is possible to do so[12]) the powers of mental health legislation in a way compatible with the ECHR does not necessarily restrict the potential for overly broad interpretation of mental health powers. The Convention itself can be interpreted quite widely in terms of acceptable interventions regarding the mentally disordered.[13]

I think that we must reject the premise that the wide powers proposed in the Bill should be curtailed solely through the checks and balances of professional judgment and the Tribunal. For the law to be of value – to patients, State administrators, mental health professionals, the police, the courts or the Tribunal – its meaning cannot rest upon the discretion of those working within its framework.

Out-dated legislation?

There is, in both Government and its opposition's repeated emphasis on the current Act's origins in the 1950s, a sense that something has changed materially in services since that time and that the law has not kept pace. In this sense the 2004 Bill stands as the latest in a string of attempts to

11 For instance, Improving Mental Health Law: Towards a New Mental Health Act , para 3.20.

12 s.3 (1) Human Rights Act 1998

13 The European Convention does of course allow for the lawful detention of persons of unsound mind, alcoholics or drug addicts or vagrants (Article 5(1)(e)), and allows restrictions on liberties as prescribed by law for the protection of health or morals (Articles 8(2), 10(2)). The Convention itself could not therefore be relied upon to exclude the use of mental health law to incarcerate drug addicts, alcoholics or other persons where the law itself made no clear limitation on such use. Although the interpretation of Convention rights is dynamic in nature, leading cases such as Herczegfalvy v Austria (1993) have also shown that treatment which falls below acceptable practice standards may nevertheless not be in breach of the Convention.

formulate law regarding psychiatric compulsion that can be applied in community-based settings.[14] It is possible, however, that these attempts are themselves based upon a questionable premise, which is that compulsion must or indeed should follow services out of hospitals.[15] As no medical professional will countenance administering psychiatric medication under some form of restraint without the patient first being removed to a medical facility that, in practical reality, is as likely to be a hospital as not, such powers of compulsion are not really about 'community treatment', but rather they circumscribe the limits of extended leave of absence or conditional discharge from hospital inpatient treatment. The concessions and reassurances offered over non-residential orders in the draft Bill – such as that these will normally be imposed only after a period of in-patient assessment[16] – indicate that the new powers it proposes may turn out to be no different in overall structure to those that already exist.

From the change in the interpretation of the 1983 Act in 2002,[17] there may already be an increasing number of patients managed outside hospital under legal conditions that closely approximate those proposed as 'non-residential' orders. However, the draft Bill proposals do widen the group of patients who may be given extended leave. At present, extended leave is not easily applicable to patients detained under section 2 of the 1983 Act, whose detentions are neither renewable nor, if such a patient is on leave at the time, convertible to section 3, although there is little to stop an inpatient's detention under section 2 from being converted to a section 3 with the aim of granting long-term leave.[18]

The draft Bill proposals could therefore lead to more patients being made subject to compulsion than at present, with the increase being cumulative as community orders are used to free hospital places through what used to be tastelessly referred to as 'long-leash' arrangements. If non-residential orders are used simply to enforce medication regimes, the relatively loose criteria for continuing such orders and the restrictions on the Tribunal's discretion to discharge them could make it difficult for patients to return to informal status. In addition, of course, both the MHAC and the Law Society have raised the prospect of non-residential orders operating as a form of psychiatric Anti-Social Behaviour Order, as there will be no restrictions on the sorts of requirement that may

14 Guardianship has been an available but lightly used form of psychiatric compulsion from the Mental Deficiency Acts of the early twentieth century. Reviews of the 1959 and 1983 Act expressed a hope that its use might increase overall and also extend to more mentally ill patients as well as the learning disabled. Practice has generally not met these aspirations. The 1983 Act defined and restricted the powers available to guardians (who until its passing previously had legal rights over a patient equivalent to a father's powers over a child of 14) to powers to require residence at a specified place, attendance at specified places for treatment and access for professionals. No power of imposing treatment is given, and there are no sanctions for non-compliance with any requirement, although detention in hospital under the Act could be an available option if conditions for this are met. A similar but medicalised framework of powers, applicable only to patients subject to s117 aftercare but with a power of conveyance, was introduced through 'aftercare under supervision' (supervised discharge) in the Mental Health (Patients in the Community Act) 1995. In common with community treatment order proposals in the draft Bill, Supervised Discharge was targeted at 'revolving door patients'. Other means of coercive community treatment already exist: since the enactment of the Mental Health Act 1959, at least 40,000 patients have been required to undergo psychiatric treatment as a condition of probation orders (author's own research).

15 A similar question is posed in Cavadino, M (1989) Mental Health Law in Context: Doctors' Orders? Aldershot: Dartmouth p159

16 Improving Mental Health Law para 3.37

17 R (on the application of D.R.) v Mersey Care NHS Trust [2002] August 7 2002, QBD.

18 Similarly, a patient detained under section 2 may not be discharged under supervised discharge arrangements, and it is, in theory at least, unlawful to convert a detention from section 2 to section 3 for the sole purpose of initiating supervised discharge

be made on a patient subject to such an order. The Joint Committee's Chairman has suggested that the use of the Bill's powers as an ASBO might be addressed by ensuring that the thresholds for application of powers to protect others from harm are sufficiently robust.[19]

The scope of compulsion – definition of mental disorder and exclusions

The Bill's definition of the term 'mental disorder' is intended to ensure that this term is used as 'a neutral description of the gateway to the use of formal powers'[20]. The Bill's initial scope, as defined with this term, must therefore be read to extend to alcoholism, addictions, 'disorders of sexual preference' etc.[21]

This would *perhaps* be all very well if the effect of the 'relevant conditions', when considered as a whole, created further definition and an appropriate threshold for compulsion. It is notable that, even though the Richardson Committee was satisfied that its proposals would establish 'sufficiently demanding' conditions for compulsion that would justify a broadly defined criterion of mental disorder, it nevertheless suggested retaining the exclusions of the 1983 Act in a modified form.[22] Professor Richardson has made it clear that she does not view the Bill's conditions for compulsion to be as demanding as those suggested by her Committee.[23]

The Government's justification for its proposal to set aside exclusions is that under the current law these have been widely misunderstood by clinicians as a bar to the detention of persons with drug or alcohol problems, even in the face of a coexisting mental disorder. There is scant evidence that the law is the real problem here: it is quite possible that mental health services seek to turn away such persons, or divert them to addiction services, but this may be more to do with practical resource limitations, or notions of clinical appropriateness, than mistaken ideas about the limit of mental health powers. Even if some practitioners are misapplying the current law through ignorance, this is a training issue rather than a justification for reducing the protections established against misuse of mental health powers.

The Government's proposal would leave as a matter of professional discretion (possibly guided by a Code of Practice, and no doubt liable to judicial interpretation) whether dependence on or harmful use of psychoactive substances, or disorders of sexual preference, etc, could be construed as the sole basis of mental disorder and thus compulsion under mental health law.[24] This *could* in theory lead to counterproductive compulsion being imposed on the basis of

19 For the MHAC comment, see Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 20 October 2004, Q40 (Chris Heginbotham), uncorrected transcript of oral evidence to be published as HC -ii. For the Minister of Health's discussion with the Joint Committee Chairman on 'psychiatric ASBOs' see uncorrected transcript of oral evidence to be published as HC 95-x, 19 January 2005, Q836 et seq (Ms Rosie Winterton MP).

20 Improving Mental Health Law, para 3.12

21 World Health Organisation (1992) The ICD-10 Classification of Mental and Behavioural Disorders. WHO, Geneva

22 Department of Health (1999) Review of the Mental Health Act 1983: Report of the Expert Committee (the Richardson Report), page 49 para 5.17, and page 38 –39, paras 4.9 et seq.

23 Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 20 October 2004, Q1 (Professor Richardson), uncorrected transcript of oral evidence to be published as HC -ii.

24 It is notable in this context that recent mental health legislation in Scotland (Mental Health (Care and Treatment) Scotland Act 2003) and the Republic of Ireland (Mental Health Act 2001) has contained explicit exclusions from the definition of mental disorder (see note [21] below on the use of mental health powers to detain intoxicated persons In Eire prior to this change).

substance misuse alone.[25] There is no evidence, however, that medical and other professionals who work in addiction services actually want powers of compulsion under a mental health act, or that psychiatric services want to treat addiction or alcohol problems under such powers. Leaving aside the ethical question of incarcerating persons with addictions under mental health powers, it has been prevailing wisdom for almost half a century that removal of responsibility from such persons is likely to be counter-productive to therapeutic effect: this point was made by Government advisors in the review of the 1959 Act and was then accepted.[26]

It may be argued that, if clinicians do not want to abuse the powers that the draft Bill would hand to them, clinical discretion can in fact be relied upon as the gatekeeper for compulsion over this issue. But this perhaps overlooks the fact that clinicians are not the sole gatekeepers of psychiatric compulsion: there are also the police (at least for place of safety detentions), the courts and the Home Office. Compulsion in the treatment of drug-addicts is already a factor in criminal law (particularly through probation 'treatment orders'). The Home Office-sponsored Drugs Bill now before parliament would provide powers of compulsory drugs intervention parasitic on the making of an ASBO under the Crime and Disorder Act 1998[27]. This appears to mark an extension in powers to order the compulsory treatment of addiction beyond the sphere of criminal disposals upon conviction to matters dealt with in civil cases. It is perhaps conceivable that in this climate the use of mental health powers for the compulsion of addicts also becomes an acceptable policy aim, particularly if such powers are used to impose ASBO-like conditions upon patients' behaviour.

Such speculation is perhaps besides the point, given my earlier statement over the need for the law to establish boundaries regarding the limits of compulsion. The Home Office estimate that 90% of prisoners suffer from a mental disorder is arrived at through the inclusion of drug-addicts and alcoholics in that category. Professor Nigel Eastman alluded to this statistic in his evidence to the Joint Committee, suggesting that it is unclear "how mental health services will guard against the wholesale transfer of prisoners...straight into mental health beds". The point that Professor Eastman was making was not that such a transfer is a real or immediate danger, but rather that the Bill provides no boundaries in the legal framework to prevent it: "...that is not going to happen, but the way in which it is not going to happen is not at all clear at the moment"[28]:

25 *In one health district studied in Eire between 1989–91, alcoholics accounted for 24% of all compulsory admissions under mental healh powers and it is suggested that 'certification was being used as a way of dealing with social and behavioural crises in relation to intoxication' (Carey, T and Owens, J (1993) "Involuntary admissions to a district mental health service – implications for a new mental treatment act". Irish Journal of Psychological Medicine, 1993 October; 10(3):139–144). The UK Government's 1978 White Paper Review of Mental Health Act 1959 (Cmnd 7320) stated that "powers of compulsory admission or detention [are] sometimes usefully employed in relation to alcoholics or drug addicts. The power compusorily to admit for observation (under s25) a person suffering from 'any other disorder or disability of the mind' seems often to be invoked to provide temporary protection for an alcoholic or addict who is a danger to himself and to detremine whether there is an underlying mental disorder' (para 1.28), but accepted nonetheless that what became the 1983 Act should include a specific provision excluding alcohol and drug dependency from its scope (para 1.30).*

26 *Review of Mental Health Act 1959 (Cmnd 7320), para 1.29*

27 *Drugs Bill, introduced 16 December 2004 [Bill 17].*

28 *Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 8 December 2004, Q461 (Prof Nigel Eastman). Uncorrected transcript of oral evidence to be published as HC 95–iii.*

The Tribunal as a safeguard over the imposition of treatment

It is probably fair to say that the benefits to *civil* patients from the draft Bill's proposed legal framework of compulsion will stand or fall on the practical effect of the Tribunal established as the gateway into long-term compulsion. The Bill misses some opportunities to extend the safeguards of the Tribunal to patients entering psychiatric compulsion through the criminal justice system. In particular, it is disappointing that criminal courts are given the job of authorising patients' care-plans before such patients are diverted from the criminal justice system, and that the decision to sanction transfers or discharges of patients where such courts make restriction orders will continue to be taken by a politician with executive powers. The new Tribunal system could have been charged with establishing the details of court orders, and with taking decisions over restricted patients (no doubt with the Home Office retaining a monitoring role and interested party status at hearings), so that all mentally disordered persons coming under the powers of the Act would have its full protection.

The Government estimates that its current proposals would lead to a total of about 42,000 Tribunal hearings each year, provided that the numbers of people subject to formal powers does not increase under the new legal framework. In 2004 there were slightly less than 13,000 Tribunal hearings, although Government has estimated that there are, in addition to this figure, some 10,000 managers' hearings.[29] There seems to be a widespread pessimism amongst Tribunal users, particularly amongst professionals who seek to arrange or attend at hearings under the current Act, that the new Tribunal can be resourced to meet the administrative challenge of a greater number of more complicated Tribunal hearings. In part, this is because some of the resources needed (such as doctors' time to prepare cases and attend hearings) are finite and, at the moment, inadequate. The 'nightmare scenario'[30] is that this administrative burden could reduce the quality of patient care rather than enhance it.

The Council on Tribunals has supported the principle of having an independent judicial body confirm the need for continued compulsion after the initial 28 day period, particularly in light of what it views as a significant reduction in other safeguards available to patients under the draft Bill compared to the 1983 Act. (In its evidence the Council has cited the abolition of managers' hearings and Nearest Relatives' rights of discharge, reduced consent to treatment safeguards and a reduction of the visiting function as presently carried out by the MHAC as examples of such reduced safeguards).[31] The liaison judge for the Mental Health Review Tribunal (MHRT) and the current MHRT Chairs are less supportive of the new Tribunal proposals, in part because of their concern they require the Tribunal to first authorise and then hear any appeal against compulsion,[32] and have therefore proposed relatively minor changes to the current legislation (such as moving forward the point at which an uncontested detention is referred to the MHRT for appeal) as an alternative to the new Tribunal role.

---

29 *Resources and the Regulatory Impact Assessment: Further Memorandum from the Department of Health to the Joint Committee on the Draft Mental Health Bill, 14 December 2004. DMH 404, Q33.*

30 *Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 12 January 2005, Q724 (Judge Sycamore – Liaison Judge, MHRT service) Uncorrected transcript of oral evidence to be published as HC 95–ix*

31 *ibid, Q737 (Ms Letts)*

32 *ibid, Q724, 726, 727 (Judge Sycamore). The MHAC raised similar concerns over the Tribunal's dual role (i.e. authorising detention and hearing appeals against such authorisation) in its submissions to the Richardson Committee.*

The Tribunal and care-planning

The clinical supervisor will drive the care-planning process relating to compulsory orders, which may be (and indeed may have to be) quite separate from the CPA process driven by the care co-ordinator. It is likely that the role of clinical supervisor is likely to be applicable to a narrower range of professionals than the role of care co-ordinator, perhaps particularly for non-resident patients. This raises the possibility of a patient's care being the responsibility of two different professionals, which could be deleterious to the effectiveness of the CPA policy overall. It may also imply that patients could have more than one 'care-plan'. It seems unlikely that a care-plan whose purpose is to describe the limits of compulsory powers for judicial authorisation can also serve as the co-ordinating document for CPA processes. Whilst the Tribunal should want to know that CPA arrangements are in place and appear to be roughly adequate, the CPA documentation is likely to go well beyond those elements of compulsion in a patient's care that the Tribunal must ultimately decide whether or not to sanction. This could be damaging to the centrality of CPA care-planning where compulsion is involved. CPA planning may also suffer fro the Bill's removal of current legal duties to plan, provide and pay for aftercare services.

The chairs and the Liaison Judge of the MHRT appear uncomfortable with the Tribunal's proposed role in approving care plans. This may well involve a 'case conference' scenario, where the Tribunal is expected to adjudicate between competing clinical views as to appropriate treatment at a quite detailed level. The concern is that this might detract from the question of whether the conditions for compulsion are in fact met.[33] I think that this concern has a sounder basis as a question of resources than as a question of principle: since the *Wilkinson* case, the courts have been prepared to adduce oral evidence with cross-examination over disputed issues of fact and opinion on the appropriate treatment of a detained patient, but they do so rarely.[34] I know from experience that the hearings are long and complex affairs, and that these could not be replicated for a great number of patients.

The Tribunal process for authorising amendments to care-plans certainly appears to be cumbersome, as it involves three stages (the doctor applies to the Tribunal; the expert visits and reports to the Tribunal; the Tribunal agrees any amendments with the doctor) where we currently have a single stage (SOAD visit). It is questionable whether there is likely to be any real advantage to the more complex procedure and it perhaps should be reconsidered, if only from a resource point of view.

The Tribunal system is bound to be resource-intensive and there must be a danger that its procedures could become formalised and perfunctory.[35] One immediately obvious danger is that care-plans submitted for approval by the Tribunal may be very broadly drawn and over-inclusive. This problem is likely to be exacerbated by the reduced consent to treatment safeguards in the draft Bill's provisions.

---

33 *Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 12 January 2005, Q724, 733, 743–747 (Judge Sycamore). Uncorrected transcript of oral evidence to be published as HC 95–ix.*

34 *R (on the application of Wilkinson) v the Responsible Medical Officer Broadmoor Hospital, the Mental Health Act Commission Second Opinion Appointed Doctor and the Secretary of State for Health [2001] EWCA Civ 1545; [2002] 1 WLR 419. See also R (on the application of N) v Dr M [2002] EWCA Civ 1789; MHLR 157.*

35 *The MHAC evidence to the Joint Committee pointed to the study of the Los Angeles mental health court's use of the Californian Lanterman-Petris-Short Act (LPS) as discussed in Scull A (1989) Social Order / Mental Disorder, Anglo-American Psychiatry in Historical Perspective. University of California, p287–289 as an example of such degeneration of legal procedure.*

When the 1959 Act was in force, the Government advised parliament and practitioners that detained patients' consent to treatment was simply not required.[36] This position was challenged or queried by, amongst others, MIND, the Butler and Davies Committees and the Royal College of Psychiatrists. In 1977 legal advisors to the Confederation of Health Service Employees warned that the 1959 Act should not be taken to confer upon staff any right to impose treatment without consent.[37] Government used the 1983 Act to define the extent to which treatment could be imposed, but also introduced safeguards such as second opinion authorisation of certain treatment without consent. The medical professional bodies resisted Government's initial suggestion that such an opinion should be provided by a multi-disciplinary panel, and the current position (whereby a doctor appointed by the MHAC provides the second opinion and has duties to consult across disciplines) is a compromise position.[38]

There is an echo of the pre-1983 position in the wording of clause 199 of the draft Mental Health Bill, which allows that consent 'is not required' for any treatment being neither ECT nor psychosurgery, provided that this is described on a care plan. In this way, the very fact of compulsion (involving as it could the approval of a generic care-plan) could once again become the authority for imposing treatments.

Government may of course argue that the resemblance between the pre-1983 position and the Bill is superficial and that the authorisation of a care-plan by the Tribunal provides the safeguard now supplied by second opinions under section 58 of the 1983 Act. Indeed, it could be argued that we are at long last to have a properly multi-disciplinary panel decide whether to sanction treatment. But if care-plans are too broadly drawn, this safeguard is nothing more than a rubber-stamp. The risk that Tribunals will not be able to have proper oversight of treatment that will actually be administered upon their authority is exacerbated by two changes that the draft Bill would make to current consent to treatment provisions:

(i). The Bill provides no emergency power to provide medication for mental disorder equivalent to s. 62 of the 1983 Act. This may encourage practitioners to try to anticipate many eventualities in the treatment plans submitted for Tribunal approval, rather than rely on common-law powers at moments of necessity. If the treatment plans are too broadly drawn and all-inclusive, then the Tribunal practitioner is in effect seeking a free hand to administer whatever treatments he or she thinks necessary.

(ii). Under the current law a doctor must certify on a statutory form any ECT or psychiatric medication that is consented to by a patient. The Bill retains this for ECT, but leaves consent to medication as a matter for the common law. This may lead to Tribunals having incomplete information about a patient's proposed or actual treatment at the time of the care-plan's submission. It will also hinder effective monitoring by hospital managers and outside bodies of the realities of consent and of the sorts of treatment given. Mental Health Act Commissioners take a great interest in the statutory recording of patient's consent status, and of the procedures that lead to such certification. Whilst, generally speaking, practice is

36 In 1973 the Secretary of State for Health, Keith Joseph, replied to a parliamentary question (23 January) to the effect that where detained patients were concerned, consent to medical treatment for mental disorder was not necessary but that it was normal practice to try to obtain the patient's agreement if he or she was capable of understanding the treatment.

37 Review of the Mental Health Act 1959 (Cmnd 7320, 1978) para 6.14.

38 Review of the Mental Health Act 1959 , para 6.28

probably better now than it has ever been before, there is no reason for complacency over how this is done in many cases.

Some of the uncertainties that the 1983 Act sought to clarify could be reintroduced by the consent to treatment provision at clause 199 of the draft Bill. For example, the authority for interventions such as control and restraint or seclusion probably falls to the approved care-plan under clause 199 of the draft Bill, just as it may stem from section 63 of the current Act. But it would surely be a retrograde step if every patient's care-plan were to anticipate seclusion or restraint on a 'just in case' basis. Even if it is possible to derive 'implied' authority for restraint such as that which is proportionate to administer an authorised injection on the basis of this being ancillary to an authorised treatment,[39] this implied authority may not easily extend to wider control and management issues, such as seclusion. This could be an early judicial test of the draft Bill's provisions. It would seem more appropriate for the Bill to make specific provision outlining the legal authority for such control and management issues whilst providing a framework of safeguards against misuse (including, as a minimum, statutory requirements for recording seclusion episodes so that these are open to scrutiny and hospital managers can be accountable for staff actions).

Tribunals and discharge from compulsion

The broad criteria for imposing compulsion also, of course, raise the possibility that patients will find it harder to achieve discharge from compulsory powers. In any appeal against compulsion, the burden of proof must technically rest with the detaining authority for continuing powers over a patient, but the legal thresholds established by the criteria for compulsion and discharge could make this burden relatively undemanding. Under the draft Bill, when the Tribunal considers an appeal it is required to refuse the application where all the conditions for compulsion continue to be met.[40] Under the 1983 Act (as amended), the Tribunal is told to discharge a patient where it is not satisfied that treatment under compulsion is necessary for a patient's health or safety, or the safety of others, and it has discretion to have regard to whether treatment is likely to be effective and whether a patient might manage if discharged.[41] The Bill therefore changes the emphasis of the Tribunal and provides it with less discretion than is provided to the MHRT under current law.

The criminalisation of the mentally disordered?

The 1959 Act was specifically designed to end the stigmatising requirements of 'certification' of patients through quasi-judicial process. It could be that the stigma implied in the processes and terminology of 'certifying' under the Lunacy Acts which were in force until 1959 is in no small part responsible for the continuing stigmatisation of patients who have been 'sectioned' today.[42]

The reverse side of the rights-based legalism in mental health compulsion is that the processes through which a patient passes increasingly resemble those of the criminal law.[43] This, it might be argued, is not an inevitable consequence: other court-based systems (such as child welfare) are

39 B v Croydon Health Authority [1995] 1 All ER 683, CA

40 i.e. draft Mental Health Bill clause 56(6)

41 MHA 83 s. 72(1)(b), 72(2)

42 The MHAC discourages the use of the term 'sectioned' (rather than, for example, 'detained') in mental health services on account of its inaccuracy and the stigmatising effect.

43 Sometimes this is the result of pressure from civil-libertarian approaches; such as Mind's ongoing legal action seeking the adoption of the criminal burden of proof (i.e. beyond reasonable doubt) for Tribunal determinations.

clearly established as civil processes, although children are, of course, already the ward of someone and the basic issues of personal liberty and detention are not so clearly engaged. In this way it is unfortunate that the draft Bill imports into civil psychiatric compulsion a number of mechanisms that could distort clinical priorities and that give the Bill the flavour of a criminal justice measure. In particular, I would point to:

- The particular provisions in the conditions for compulsion of civil patients who are deemed to be at 'substantial risk of serious harm ' to others, above and beyond those provisions that set a threshold for the compulsion of any other civil patient for the protection of other persons;
- The provision allowing the Tribunal to make an order requiring a civil patient to be detained in hospital for a fixed period of time[44]
- The introduction of the equivalent of restriction orders for civil patients deemed to be at substantial risk of serious harm to others, where the Tribunal may reserve powers of leave, discharge or transfer to itself.

The relation between the Mental Capacity Bill and the draft Mental Health Bill

The Mental Capacity Bill codifies (and possibly extends) common-law powers relating to the treatment of patients who lose capacity to provide consent, including powers of restraint and coercive treatment.[45] It has been argued that the Mental Capacity Bill, by enacting such powers as statute law, may come into contention with the draft Mental Health Bill in relation to which authority may appropriately be used, or may be available, for compulsory treatment for mental disorder.[46]

The Government initially rejected that such contention had any real basis, primarily on the grounds that the Mental Capacity Bill is worded carefully to authorise '*restrictions*' on liberty, whereas Mental Health Act powers are concerned with '*deprivation*' of liberty[47]. Insofar as the case-law of the European Court of Human Rights (ECtHR) makes a clear distinction between restriction of liberty (which does not engage Article 5 rights) and deprivation of liberty (which does engage such rights), this distinction would form the operative threshold between the two Bills. However, the Government now appears to have had second thoughts, and may yet use the Mental Capacity Bill to provide powers to authorise and provide safeguards for the deprivation of liberty of incapacitated patients who are compliant with their care.[48]

---

44 Draft Mental Health Bill, clause 46(6).

45 Clauses 5 and 6 of the Mental Capacity Bill provide powers to 'restrain' incapacitated patients, provided that such restraining actions are: (i) believed to be in the patient's best interests; (ii) not in conflict with any decision taken by a donee of lasting power of attorney or a deputy appointed by the court; (iii) believed necessary to prevent harm coming to that patient; and (iv) a proportionate response to the likelihood of that harm and its seriousness. Restraint is defined (clause 6(4)) as the use, or threatened use, of force to secure the doing of an act which the patient resists, or an act which restricts the patient's liberty of movement whether or not s\he resists.

46 See, for example, Joint Committee Evidence DMH 90 (Supplementary memorandum from the Mental Health Act Commission) and DMH 378 (Memorandum from Genevra Richardson)

47 Joint Committee on Human Rights (2005) Scrutiny: First Progress Report. Fourth Report of Session 2004–05. HL paper 26, HC 224, January 2005. See Appendix 4: Mental Capacity Bill. Letter from Baroness Ashton of Upholland to the Chair, response to Q2. See note 45 above for the wording of the Bill.

48 As this issue of the JNHL goes to press, the amendment text of 23 February 2005, proposing a new clause "Protective care for certain persons lacking mental capacity" after Clause 59, had been withdrawn because the Delegated Powers and Regulatory Reform Committee ruled it unacceptable.

This, perhaps, still assumes too readily that the distinction between restricting and depriving liberty can be applied easily to practical examples of health and social care interventions in the lives of the mentally disordered. In *HL v United Kingdom* the Court determined that 'the distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance' but found that deprivation of liberty had resulted in the case they were considering as 'health care professionals treating and managing the [patient] exercised complete and effective control over his care and movements'[49]. It seems likely that this description could be applied very widely to the practical arrangements for managing mentally disordered patients in and out of hospital environments. Furthermore, as Government 'is minded' to allow an aspect of clinical discretion over whether any particular patient falls within the frameworks of either mental health or mental incapacity law (similar to the scope for discretion in using child protection powers or the 1983 Act in certain circumstances)[50], it will be for the practitioners themselves to decide whether their actions amount to deprivation of liberty and should be subject to the formal admission and review mechanisms that are required following the ECtHR ruling last year.

The European Court has therefore necessitated a refocus on the 'Bournewood gap' at a relatively late stage in the development of both mental capacity and mental health legislation. This may have serious consequences for the landscape of our mental health law that were not a part of the original intentions of legislators or those who called for reform. In particular, though, it may exacerbate the potential consequences of mental capacity legislation narrowing the scope of mental health law.

Not all interventions under the draft Mental Health Bill would necessarily involve a deprivation of liberty. Indeed, one of the motivations of new law was that it would no longer be necessary to detain patients in hospital to treat them under mental health act powers[51], and the Bill will require that its powers must be operated according to a principle of using the least restriction necessary[52]. Because a condition of treatment under the draft Bill's powers will also be that no other legal authority for such treatment exists[53], any alternative legal frameworks that can be used to impose either restrictions or deprivation of liberty in providing psychiatric care will always have to be used in preference to mental health act powers. At the very least this would militate against the use of mental health powers to provide incapacitated patients with care short of detention. The Mental Health Act's full range of powers could consequently become reserved for the imposition of treatment to mentally capable patients and, perhaps, to mentally incapacitated patients who pose 'a substantial risk of serious harm to others'.

This separation between the two legal frameworks might appeal to some supporters of capacity-based criteria for psychiatric compulsion, but I think that it contains the seeds of the most illiberal mental health laws that this country has ever seen. There would be a sad irony if, at the end of this process of 'reforming' the framework established by the 1959 and 1983 Mental Health Acts, we were left with a new Mental Health Act whose *entire* focus was the civil extension of criminal justice powers to confine the 'dangerous'.

---

49 HL v United Kingdom (2004), Application no. 45508/99, decision of 5 October 2004. Paras 89 & 91.

50 Minutes of Evidence, Joint Committee on the draft Mental Health Bill, 19 January 2005, Q847 (Ms Rosie Winterton MP, Professor Appleby). Uncorrected transcript of oral evidence to be published as HC 95-x.

51 Department of Health (2004) Improving Mental Health Law: Towards a New Mental Health Act (Summary) p 4

52 Draft Mental Health Bill clause 1(3)(c)

53 Draft Mental Health Bill clause 9(5)

Future monitoring of mental health legislation in practice

The MHAC would not have sought its own demise, although it has acknowledged potential efficiencies in a single body of healthcare inspection. It has considerable worries that its core remit, and perhaps just as importantly the unique way in which it carries out that remit through visiting detained patients in private, may be lost or diminished in the transition to a wide-based health (and now also social care) inspectorate[54]. Hopefully this concern has been recognised by officials of the Healthcare Commission and there may yet be safeguards put in place to address it, although there are perhaps fundamental differences in approach to be overcome. More could be done with the Bill itself: although many of the powers of the MHAC were restored to the draft Bill of 2004 after having been omitted from the previous draft, the duty of keeping the powers of the Act under review and of visiting are still not explicit.

I am struck by the analogy between MHAC concerns over future mental health monitoring and the concerns of the Chief Inspector of Prisons (Ms. Anne Owers) over plans for a new super-inspectorate for the criminal justice system[55]. Ms. Owers told the press of her concerns that a human rights inspectorate may be marginalised in such a body, with fewer inspections that are reduced to measuring whether government performance targets are met, and that the ability and resources to go into any prisons at any time without warning with a sharp focus on inspecting individual places of custody could be lost. Ms Owers said that genuinely independent inspection "lifts the lid on closed institutions on behalf of the public, pulls out common practices, and exposes them to the light of what is normal, and what is right." That is also a fair summation of the job of the MHAC.

The increasing prominence of criminal-justice concepts and measures in mental health law for civil compulsion, and the strong possibility that the increase of community facilities may result in many inpatient units becoming increasingly custodial-based and 'total institutions' than at present, perhaps suggests that any future monitoring body for mental health law should be given full independence from Government and be remodelled in the mould of the current prison inspectorate, rather than dissolved into a general health and social care inspectorate. Of course, the content of this article does give a particularly dystopian reading of future mental health law and practice: but if any of this is even half-right, a specialist human rights watchdog will be needed more than ever in the coming years.

54 *The Chancellor's budget speech of 16 March 2005 announced the Government's intention to merge eleven public sector inspectorates into four broadly based organisations, including a single social care and health inspectorate created from the merger of the Healthcare Commission and the Commission for Social Care Inspection.*

55 *The Guardian, 11January 2005: Prison inspectors warn on merger plan. The budget speech announcement (note 54 above) confirmed that Government intends to create a single criminal justice inspectorate, although it has promised consultation (The Guardian, 17 March 2005: Time called on inspectors).*

The Law Society's Response to the Draft Mental Health Bill[1]

The Law Society has long campaigned for reform of the Mental Health Act 1983 ('the 1983 Act'), which is widely recognised as out of date and not fully compatible with the Human Rights Act 1998.[2]

However the Law Society believes that the proposals contained in the Draft Mental Health Bill 2004 ('the Bill') are misconceived and fail to provide adequate safeguards to protect the rights of people with a mental disorder.

The relevant conditions for compulsion

Like many other organisations, the Law Society believes that the Bill's criteria for compulsory care and treatment are too broad. This is illustrated by the example of a smoker, who has tried and failed to give up, and would fulfil all the relevant conditions in clause 9:

1. *The patient must be suffering from a mental disorder.* Nicotine dependency is included in the ICD-10 classification of mental disorders (F17) and is listed in the DSM-IV classification (code 305.20)
2. *The mental disorder must be of such a nature or degree as to warrant the provision of medical treatment.* There is no requirement that the person's mental disorder has to justify compulsory in-patient treatment. In this case the addiction warrants treatment (nicotine patches, counseling, etc).
3. *It must be necessary for the protection of the patient from suicide or serious self harm or serious neglect of his health or safety.* Smoking causes serious neglect of the patient's health.
4. *Medical treatment cannot be lawfully provided without the patient being subject to compulsion.* This condition is met because the patient continues to smoke despite being advised of the harm being caused to him/herself.
5. *Medical treatment must be available which is appropriate to the patient's case.* Treatment is available for nicotine dependency.

1 *The Law Society gave oral evidence to the Joint Parliamentary Scrutiny Committee on 3rd November 2004 (ref: HC 127-vi). Its written evidence can be found at www.lawsociety.org.uk. Its response to the Draft Mental Health Bill 2002 was published in the JMHL December 2002 at pp 373 – 375. This article was accepted for publication before (a) the Joint Parliamentary Scrutiny Committee on the Draft Mental Health Bill reported (23rd March 2005), and (b) the Mental Capacity Bill received the Royal Assent (7th April 2005).*

2 *R (MH) v Secretary of State for the Department of Health [2004] EWCA Civ 1609 being the latest in a series of declarations of incompatibility between the ECHR and the 1983 Act.*

The Government may claim that such situations are unlikely to arise because the good sense and discretion of doctors can be relied upon. However the Bill gives clinicians no discretion about the use of compulsory powers if the relevant conditions are satisfied.[3] This is in contrast to the 1983 Act, where even if the relevant conditions are met the clinicians can use their discretion as to whether or not to use compulsory powers. The Law Society believes that patients' rights will only be protected by tightly defined relevant conditions and by providing clinicians with discretion about the use of compulsory powers.

Community Treatment Orders

The introduction of compulsory community treatment orders appears to be based on the misconception that it is a lack of legal powers which places the public at risk from people suffering from mental disorder. The various homicide inquiries overwhelmingly show that it is lack of resources, lack of information and lack of communication that causes care and treatment to break down in such a way as to increase the likelihood of a tragedy.[4] Increased legal powers, such as community treatment orders, will not improve this situation unless they are backed-up by sufficient resources and if patients in the community are properly supported there would be less need for compulsory powers.

The Law Society is concerned that the Bill fails to ensure that only a limited and strictly defined group of patients could be made subject to community treatment orders. The Bill refers to the use of regulations to limit the group of patients who can be compulsorily assessed in the community without an immediately preceding hospital admission[5] but there is no equivalent provision for a non-resident treatment order.[6] The Bill is also silent on the matters that the Mental Health Tribunal will have to take into account in deciding on residence or non-residence as part of the treatment plan. This will mean that the use of compulsory community treatment is not restricted to a tightly defined group of patients and therefore it could be imposed on patients with severe and non severe mental health problems.

The Bill authorises a compulsory community assessment to be carried out without an immediately preceding hospital admission for "revolving door patients".[7] However the Law Society is concerned that the Government has not clarified what it means by a "revolving door patient" and specifically whether this will be based on previous compulsory admissions. If the definition of revolving door patients includes voluntary admissions, this will make many people with mental health problems reluctant to agree to short voluntary admissions, because they will be 'collecting points' towards a disadvantageous status.[8]

The Law Society also believes that the proposals for community assessment and treatment are impracticable. The experience of supervised discharge under s25A of the 1983 Act illustrates that

3 *Clauses 16 and 38*

4 *See 'McGrath and Oyebode (2002) Qualitative Analysis of Recommendations in 79 Inquiries after Homicide Committed by Persons with Mental Illness', Journal of Mental Health Law – December 2002, pp262–282).*

5 *Clause 15 (2) and Explanatory Notes Para. 66*

6 *Similarly there is also nothing to restrict the circumstances in which a patient who is liable to assessment is made a non-resident patient by the clinical supervisor for the duration of the assessment period.*

7 *Clause 15 (2) and Explanatory Notes Para. 66*

8 *Para. 66 of the explanatory notes mentions patients "who are known to services", "prone to relapse" and "get into a cycle of admission and discharge"; but does not specifically mention previous compulsory admissions*

where people in the community are 'required' to comply with certain conditions, this has proved difficult to enforce.[9] Under the Bill, a clinical supervisor is given the power to 'take and convey' a non-resident patient back to hospital where he/she fails to comply with the conditions, however it is not made clear how this is to be achieved.[10] The use of a warrant under clause 225 may be intended for this purpose but would be dependent on police and ambulance availability and resources. Also, since the patient must be detained within 24 hours, it is likely that a hospital bed must be kept free thus putting extra strain on limited resources.[11]

It is also of some concern that the legal thresholds for the provision of compulsory community treatment are very wide indeed. Crucially the Bill breaks the link in the 1983 Act between the use of compulsion and the requirement that it is necessary for the patient to receive treatment in hospital. For example, the third condition specifies that medical treatment must be necessary for the protection of other persons, which is a far lower threshold than the 1983 Act which requires that detention in hospital must be necessary for the protection of others. In a risk-averse society such as ours, it is quite easy to imagine that mere nuisance behaviour could be used to justify making a person subject to compulsory powers in the community. This raises the alarming possibility of using mental health legislation to create psychiatric Anti-Social Behaviour Orders (ASBOs).

In addition, the Bill authorises non resident treatment orders to include a condition that 'the patient does not engage in specified conduct'.[12] The meaning of 'specified conduct' is not defined but potentially includes preventing a person going to the pub or associating with certain people. This raises further fears that the Bill authorises psychiatric ASBOs.

Mental Capacity

One of the Bill's major failings is the lack of any reference to a patient's mental capacity to make treatment decisions in the relevant conditions for compulsion. There has been increasing judicial recognition that the imposition of treatment on competent patients raises issues under Article 3 (prohibition of inhuman or degrading treatment) and Article 8 (respect for private and family life) of the ECHR, especially where the person does not present a danger to the health or safety of others.[13] This is likely to form the basis of future challenges to the Bill.

The lack of explicit reference to mental capacity means that the relevant conditions are fundamentally flawed. For example, the requirement that treatment must protect the patient from 'suicide or serious self-harm, or from serious neglect by him of his health or safety'[14] is too narrow for people who lack capacity and would prevent treatment being provided to an incapacitated patient who resists treatment but presents a low level of risk.[15] On the other hand, where a person has capacity to make treatment decisions this condition is too wide.

9 *For example, the power to take and convey has been found to be of 'minimal importance and rarely used (Bindman et al (2001) 'National Evaluation of Supervised Discharge and Guardianship' Report of a study commissioned by the DOH, p.75).*

10 *Clause 48*

11 *Clause 48 (7)*

12 *Clauses 46 (7) and 119(7)*

13 *See R (Wilkinson) v RMO Broadmoor Hospital [2001] EWCA Civ 1545*

14 *Clause 9(4)*

15 *For example a person with a learning disability who lacks mental capacity to make treatment decisions and who is being treated by a psychiatrist for challenging behaviour but also suffers from mild depression and refuses treatment. Under the Bill they could not be treated for depression. The Mental Capacity Bill would also not permit forced treatment in these circumstances.*

The Bill also provides that a mentally disordered person thought to be at 'substantial risk of causing serious harm to other persons' will not be allowed to receive treatment informally, if the other relevant conditions in clause 9 apply.[16] This will mean that people who have the capacity to consent to treatment and who do consent will still be made subject to compulsory powers. The Law Society believes that this fails the ECHR requirement that any restrictions on liberty must be proportionate to the objective to be achieved.

Interface with the Mental Capacity Bill

The Law Society is concerned that the relationship between the Draft Mental Health Bill and Mental Capacity Bill will be complex and confusing. The Draft Mental Health Bill provides that an individual cannot be subject to compulsory powers unless "medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part".[17] This means that if a person lacks capacity and can be treated under the Mental Capacity Bill, he/she cannot come under the Draft Mental Health Bill. It is therefore likely that the Bill will mainly be used to impose treatment on people who have capacity but refuse treatment.

Under the Mental Capacity Bill a doctor can treat an incapacitated person in his/her best interests.[18] This includes using restraint, whether or not the incapacitated person resists, if this is necessary to prevent harm and is proportionate to the likelihood of the incapacitated person suffering harm and the seriousness of that harm.

Under the Draft Mental Health Bill, the clinical supervisor must discharge a treatment order if at any time he/she is not satisfied that all of the relevant conditions are met in the patient's case.[19] This means that if the patient loses capacity and can be treated under the Mental Capacity Bill, he/she must be discharged from the Draft Mental Health Bill.[20] Therefore the clinical supervisor must keep the patient's capacity under constant review and may be required to discharge the patient as soon as he/she becomes aware that the patient has lost capacity to make treatment decisions.

If the incapacitated person has an Attorney or a court appointed deputy who objects to treatment, the Mental Capacity Bill cannot be used to authorise treatment and they would be subject to the Draft Mental Health Bill if the other conditions under clause 9 are met. Furthermore, if the person has made a valid advance decision under the Mental Capacity Bill refusing admission to psychiatric hospital and/or the provision of psychiatric medication should they lose capacity in the future, they could only be treated under the Draft Mental Health Bill, so long as all the relevant conditions in clause 9 applied.

The Law Society believes that the relationship between the two Bills is so complex that, in many cases, it would be practically impossible to work out when one Act should be used and the other should not.

16 Clause 9 (7)

17 Clause 9 (5)

18 Clause 5, The Mental Capacity Bill 2004

19 Clause 60

20 This is because in accordance with clause 9 (5) lawful treatment can be provided under the Mental Capacity Bill and therefore the relevant conditions in the Mental Health Bill are not met.

HL v United Kingdom[21]

The case of HL has created further confusion about the interface between the two Bills. The decision makes clear that a person who lacks capacity to consent to his/her admission to hospital but who does not object, can nevertheless be 'deprived of his liberty' within the meaning of Article 5(1) ECHR. Moreover, the legal framework provided by the common law doctrine of 'necessity' and 'best interests' contains inadequate procedural safeguards to protect such patients. This could apply to incapacitated informal patients in hospitals and people who lack capacity and are living in nursing homes or care homes whose particular circumstances may amount to a deprivation of liberty.

In future, such patients will need to be detained under a properly regulated system in order to guarantee them the kind of safeguards that are lacking at common law. It was implicitly accepted by the Court that the proper procedure need not be the full compulsory admission procedure of the Mental Health Act 1983. The Law Society accepts that the Mental Capacity Bill could be amended to provide the necessary Article 5(1) ECHR procedural safeguards to avoid arbitrary detention. These safeguards should include clear conditions for detention, a formal assessment process and the appointment of a representative for the patient.

However, if the Mental Capacity Bill were amended in this way, there would also be a need for further amendment to include the review safeguards necessary under Article 5(4) ECHR. In principle the Court of Protection provisions would provide sufficient safeguards. However, in practice it is unlikely that the Government would wish to use a High Court procedure to deal with thousands of routine decisions, many of which will be uncomplicated, uncontroversial and uncontested. The regulatory impact assessment for the Mental Capacity Bill suggests that it was only anticipated that the Court of Protection would deal with about 200 cases a year.[22]

The alternative option would be to substantially amend the Mental Health Act 1983 (and the Mental Health Bill) and widen its ambit to cover all those who lack capacity and need treatment for mental disorder in hospital. This would provide sufficient Article 5 safeguards, for example by providing access to the Mental Health Review Tribunal, and would increase the numbers of patients entitled to free section 117 aftercare services. However, this option would also have substantial resource implications and does not address the needs of incapacitated people who are not in hospital but are living in circumstances amounting to a deprivation of liberty.

What is clear is that the Government needs to urgently address this issue because there will be many people who are "HL" detained but who do not meet the criteria for the use of compulsory powers under either the current Mental Health Act or the Draft Mental Health Bill.

Mental Health Tribunals

The Law Society believes that the proposals to create a new Tribunal system are elaborate and far-reaching. However, there remain serious doubts as to whether it would safeguard patients' rights.

The relevant conditions in the Bill are extremely wide. The Mental Health Tribunal is to have no discretion to discharge if all the relevant conditions are met, and as the conditions are so widely defined, it may be extremely difficult for a person to be discharged once he/she has been made subject to the provisions of the Bill.[23]

21 Application no. 45580/09 5 October 2004

22 Para. 43

23 Clauses 45 and 56

The Bill does not address the difficulty that will arise if the Mental Health Tribunal and the approved clinician cannot agree on the care plan.[24] If the Tribunal is to have a real role in monitoring the treatment of patients, the care plans will need to be detailed and precise. The opportunities for disagreement will be considerable, not only between any particular Tribunal and the approved clinician, but also between one Tribunal and the next. It will be logistically impossible to ensure continuity of tribunal membership as a patient's care develops. It will therefore be necessary for the approved clinician to re-argue the whole case before each Tribunal, as the new Tribunal members will have to be satisfied on their own account that the treatment plan is appropriate.

Furthermore, although the Bill will require a Mental Health Tribunal to make decisions about a patient's ongoing treatment and to authorise care plans, the Tribunal will not be in a position to monitor or police its decisions. This may result in considerable amounts of litigation when the arrangements go wrong and people suffer as a result of a Tribunal decision. Equally, there are likely to be many appeals to the Mental Health Appeal Tribunal.[25] The Law Society therefore has grave concerns about whether the new expanded system is realistic and practicable.

The proposals are extremely resource intensive, both in terms of time and money. The Mental Health Review Tribunal system is struggling to manage at present with many appeals being cancelled and delayed.[26] The Bill will lead to a significant increase in the numbers of hearings and a vast expansion in the types of decisions that tribunals will have to consider, such as authorising care plans, displacing nominated persons, authorising ECT and examining whether the relevant conditions apply. This will require a major change in the culture of Tribunals.[27] It is also likely that hearings will be significantly longer, which will have massive resource implications for recruitment and training. Each hearing may last at least 50% longer, due to the Tribunal's extended remit to include consideration and approval of the care and treatment plan, so there will be fewer hearings carried out per panel, per day.

The Law Society believes that the Bill will only be workable if there is a dramatic increase in resources. For example, the new Mental Health Tribunal system would require a significant increase in the numbers of mental health professionals, approved clinicians, tribunal members and expert panel members, together with proper administrative support. However it seems unlikely that resources will be available in the foreseeable future given the current staff shortages in the provision of mental health services.[28]

Article 5 (4) of the ECHR requires that a person deprived of their liberty shall have the lawfulness of their detention decided speedily by a court. Court judgements have recognised that the current Mental Health Review Tribunal system has been beset with resource and administration difficulties that have led to delays and cancellations of hearings which have seriously prejudiced

24 For example, clauses 45 and 56 assume that the Tribunal and clinical supervisor will agree

25 For example, it is well established that the 'reasonableness' of an action taken by a person carrying out a public function, such as an approved clinician or a Mental Health Tribunal, is a point of law.

26 The Institute of Mental Health Act Practitioners (2004) has recently documented this in a survey of 11 Mental Health Trusts between May–August 2004.

27 The main function of the current MHRT is to review justification for continued detention. This is far narrower than the proposals in the Bill.

28 See 'National Service Framework for Mental health: Five Years On' (2004) MIND publications.

patient's interests.[29] We are concerned that the Bill will put additional stress on this system and unless considerable resources are made available, patients will continue to be denied a speedy review of their detention.

It is clear from the Bill that the Tribunal is intended to play a pivotal role in safeguarding the interests of detained patients. However, the Law Society believes that the proposed Tribunal structure is unworkable. If we are correct, then the main safeguard for patients will fall away, patients will be left in a vulnerable position and the exposure to human rights claims will be very serious.

Conclusion

Mental health legislation is in need of reform but the Bill is not an improvement on the existing law. The Law Scoiety's view is that the Government should focus on amending aspects of the 1983 Act and, before introducing any major reform, should monitor the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, which is due to come into effect in October of this year.

29 For example, R v MHRT London South and South-West Region, ex p. C [2002] 1 WLR 176 and R v MHRT and Secretary of State for Health, ex p. KB [2002] EWHC 639.

A Sense of 'Déjà Vu' –

a preliminary (and immediate[1]) response to the Report of the Scrutiny Committee on the draft Mental Health Bill

Lucy Scott-Moncrieff[2]

Introduction

The draft Mental Health Bill[3] was published on the 8th September 2004. In advance of publication a joint committee of both Houses of Parliament was set up to subject the draft Bill to pre-legislative scrutiny and, following consultation, to recommend improvements before a final version of the Mental Health Bill is introduced in parliament.

The Committee first met on the 15th September 2004, and the report was published on the 23rd March 2005[4]. In the intervening period the Committee considered 450 written submissions, heard oral evidence from 124 witnesses (including professionals, carers and service users) and visited three hospitals, including Broadmoor.

The Scrutiny Committee came up with 107 conclusions and recommendations, and I think it would be fair to say that if the Government accepts these, the Mental Health Bill that will be introduced to Parliament will bear very little relationship to the draft Bill published last September. On several occasions the Committee commends the very different approach taken in the Scottish *Mental Health (Care and Treatment) (Scotland) Act 2003* due to be introduced in stages starting in April of this year.

It makes its recommendations under 11 separate headings, which I will follow:

Background

It says that the case for reform of the *Mental Health Act 1983* is "cogent but is by no means overwhelming"; on balance it supports the introduction of new legislation, but it emphasises that the need to incorporate effective risk management and public protection into mental health policy must never be allowed to predominate as the primary objective of reform.

1 *This article was written and submitted for publication on the day on which the Joint Parliamentary Scrutiny Committee reported (23rd March 2005) in order to meet the printing deadline for this issue of the JMHL. Footnote 11 was added at the proof-reading stage.*

2 *Partner, Scott-Moncrieff, Harbour and Sinclair (Solicitors, London)*

3 *Cm 6305-I*

4 *HL Paper 79-1, HC 95-1*

Principles and Codes of Practice

The draft Mental Health Bill left principles to be developed in codes of practice. The Committee says that fundamental principles should be set out on the face of the Bill, and should not only include a "least restrictive alternative" principle but should also introduce a principle that non-consensual treatment should only be imposed if the patient's ability to make decisions about his or her treatment is, as a result of his or her mental disorder, impaired. The form of words is adopted from the Scottish Act, and is probably not an exact equivalent of the current definition of lack of capacity, but it is, of course, related to it.

The Expert Committee, chaired by Professor Genevra Richardson, which reported in 1999[5], recommended the introduction of a capacity test, but this was not accepted by the Government at that time and has continued to be absent from the Green Paper,[6] the White Paper[7] and the two draft Bills[8] that have since been published Many of us believe that to allow detained patients with capacity the same right to refuse treatment as is enjoyed by every other person with capacity would do more to raise standards, challenge stereotypes and reduce stigma than any other legislative decision. Perhaps the Scrutiny Committee will succeed where the rest of us have failed, and if the Government rejects the recommendation, let us hope that members of both Houses of Parliament will respect the views of their (now very well-informed) colleagues on the Committee, and insist on introducing this proposal.

Definitions and Conditions

The Committee accepts the broad definition of mental disorder contained in the draft Bill, but recommends that the scope of the definition should be narrowed by means of specific exemptions and by placing restrictions on the use of compulsory powers. A specific exclusion on the grounds of substance misuse alone (including dependence on alcohol and drugs) is recommended, as is an exclusion on the basis of sexual orientation (but not sexual deviancy). It also recommends that people with learning disabilities or communicative disorders such as autistic spectrum disorders should only fall within the ambit of the legislation if they also display seriously aggressive or severely irresponsible behaviour as a result of their condition and if such treatment as is properly and reasonably required can only be provided to such patients under conditions of compulsion. In effect, the Committee imports the concepts of mental impairment and severe mental impairment from the 1983 Act, and extends the requirement that there should be seriously aggressive or severely irresponsible behaviour to those with pervasive developmental disorders such as autism, which are classified as mental illnesses under the 1983 Act.

It recommends tightening-up the provisions of Clause 9, which sets out the conditions for compulsory treatment. Most controversially, as far as the Press will be concerned, it recommends that a treatability test should be re-introduced, so that people with severe mental disorders who cannot benefit from treatment will be excluded from this legislation.

The Committee acknowledges that one of the driving forces for the legislation was the case of Michael Stone, who was said to be "untreatable" and therefore undetainable under the 1983 Act. However it accepted the argument that to detain people on the grounds of mental disorder without

5 *'Review of the Mental Health Act 1983' – report of the Expert Committee (November 1999)*

6 *Cm 4480*

7 *Cm 5016-I*

8 *Cm 5538-I; Cm 6305-I*

being able to offer any therapeutic benefit goes beyond the business of mental health professionals, and that if the Government wishes to detain such people it must find another way of doing so.

The Committee also considered that it was unacceptable to have in the Draft Bill, a condition that insisted on compulsory treatment even where a patient was willing to accept treatment voluntarily. It also recommended that a new condition should be inserted at Clause 9, without which compulsory powers could not be used: "That by reason of mental disorder the patient's ability to make decisions about the provision of medical treatment is significantly impaired". As mentioned above, this is hugely significant and goes considerably further than the 1983 Act which allows capacitous refusal to be over-ruled if the SOAD agrees with the RMO, and the draft Bill which allows clinicians to treat without regard to the person's capacity.

Interface with Mental Capacity Bill[9]

The Committee recommends that a clearer analysis of the inter-relationship between the Mental Capacity Bill and the Mental Health Bill should be provided, so that clinicians would know which piece of legislation they should be using when a patient could be subject to either. They propose that the respective codes of practice should have a common part to deal with this. They also recommend that the Government brings forward "a comprehensive and universal set of proposals to deal with hospitalisation and treatment of patients affected by the Bournewood judgement"[10] and they say that legislation should be brought forward that would enable people to make advance statements and to record advance decisions, particularly if there is a treatment that they would prefer not to receive. Advance directives feature in the Mental Capacity Bill and the committee was clearly convinced by witnesses that there was a very good case for extending these provisions to all people likely to be subject to compulsory powers.[11]

Compulsory Treatment in the Community

The Committee accepts the principle of compulsory community treatment, but considers that it is unlikely to be appropriate or satisfactory for anything other than a small minority of patients and it therefore recommends that it should be explicitly limited to a clearly defined and clinically identifiable group of patients who have previously been hospitalised, and who have previously responded to and co-operated with treatment. In addition, the areas of compulsion should be limited to medical treatment and a person's place of residence only, rather than the proposals in the draft Bill that could mean that a person's every hour and every activity could be controlled. Furthermore, there must be a maximum time limit for compulsory community treatment – certainly not more than 3 years in any 5 year period. Finally, a non-residential treatment order must not be able to authorise the use of force on the patient in the community, other than allowing someone to convey the patient to a hospital or clinic for treatment.

A complaint of many of those who gave evidence to the Committee was that compulsory community treatment did not carry with it a reciprocal obligation to provide good community services, and there was a real risk that families and carers would have to shoulder the burden of ensuring compliance with the order. The Committee has responded by saying that the use of non-

9 Mental Capacity Bill 2004

10 H.L. v U.K. (ECtHR – 5/10/04)

11 Since the Scrutiny Committee reported, the Mental Capacity Bill has received the Royal Assent, and the "Bournewood" Consultation has been published by the Department of Health.

residential orders must be accompanied by a requirement on health and local authorities to provide adequate care, other than that provided by families and carers, on whom unreasonable burdens should not be placed which should fall more properly on clinicians and the health and social services.

Children and Adolescent Mental Health Services

The Committee recommends: improving the safeguards for 16 and 17 year olds who are being treated under compulsion by giving them the same safeguards as those under 16 in addition to the rights they share with adult patients; that under-18's should be accommodated in age-appropriate facilities; that at least one of the medical assessments prior to the imposition of compulsory treatment should be by a clinician specialising in child and adolescent mental health services; that the tribunal considering the case of a child or adolescent patient has to seek the advice of a medical member of the Expert Panel who is a doctor specialising in child and adolescent mental health services; that child welfare principles be included on the face of the Bill; that, when someone under 18 needs compulsory treatment for mental disorder, this is provided under the terms of mental health legislation, with all its safeguards, rather than under the *Children Act 1989*; and, finally, that in relation to the right to education and safeguards for ECT, 16 and 17 year olds should have the same entitlements as those under 16.

Patients Concerned in Criminal Proceedings, Restricted Patients and Victims

The Committee starts off by recommending that the drafting is improved so that people can understand this part of the Act. It then recommends that the Bill provides a mechanism to ensure that a prisoner who needs treatment is not denied that treatment because of a dispute between Trusts as to who is responsible for him or her; that when a prisoner is recommended for transfer to hospital the Home Secretary has to agree to the transfer; that a mental health order or hospital direction should only be made if the prisoner's mental disorder is of a nature or degree which makes treatment under compulsory powers appropriate; and that when considering assessments of risk, those carrying out the assessments should disregard whether that risk could be minimised by the imposition of a prison sentence. These recommendations are needed to deal with the very unsatisfactory provisions of the Draft Bill which combine the right to impose treatment on prisoners, regardless of the nature or degree of their disorder with a lack of any provision that would entitle such a person to access proper care and treatment.

Rather spectacularly, the Committee also recommends that mental health tribunals be given the power to order the transfer and leave of absence of restricted patients. The logic of this recommendation is inescapable; in the draft Bill the Mental Health Tribunal is given the power to retain control over the care plans of some unrestricted patients if they give special cause for concern, and it must follow that, despite the Home Office's unwillingness to surrender any of its powers over restricted patients, a tribunal which is to be trusted with such a responsibility with some potentially dangerous patients should be trusted with all of them.

In relation to the making of care plans by Judges, the Committee recommends that the Expert Panel should have to be consulted, and that when care plans are being prepared for restricted patients, the usual consultations should take place as if the patient were a non-offender patient.

Interestingly, the Committee points to the fact that although the focus of much of the draft Bill is on the assessment and control of risky behaviour, the role and needs of victims are not specifically

addressed. The Committee therefore recommends that where the patient subject to compulsory powers has been responsible for violence which has resulted in death or serious injury, the authorities must place a written "victim impact" statement before the Court or tribunal so as to aid in the assessment of risk; and that victims should be defined widely to cover people who are subject to threats or attacks from mentally disordered people, and the family of anyone who has been killed or seriously injured by a mentally disordered offender.

Institutional Safeguards

The Committee is extremely sceptical about the Government's calculations regarding the extra resources that will be needed to provide the safeguards (primarily the Mental Health Tribunal), which are such a central feature of the draft Bill. It suggests that the Government does its sums again, and gets better information before reaching any conclusions, and it recommends that no new Act be brought into force until the Government can demonstrate that sufficient resources are available, both financial and human, to allow for the proposed extensions in hearing numbers and remit.

It also recommends a clearer distinction between the roles of the tribunal as a detaining body and as a review tribunal, and it proposes a number of procedural changes to improve the quality of decision-making.

It also suggests that the successor to the Mental Health Act Commission has a duty similar to the visiting duty currently imposed on the Mental Health Act Commission, and that the successor body has a responsibility to investigate and report on the Secretary of State's management of restricted patients, and that the successor body should be better resourced, to enable it to carry out its functions properly.

Other Rights and Safeguards for Patients, Carers and Relatives

The Committee makes 30 separate recommendations under this heading: to improve the rights of patients to assessment and treatment; to improve their involvement in the preparation of care plans; to improve the safeguards in relation to certain forms of compulsory treatment, including ECT; to re-introduce the safe-guarding function of the current SOAD system and give it to the new Expert Panel; to require the recording of details of treatment being given with consent during assessment, and details of the consent; to restrict the ability of clinicians to prescribe doses above BNF levels; to regulate the use of seclusion and mechanical restraint; to monitor the use of such seclusion and mechanical restraint; to provide for the review of emergency administration of medication for mental disorder; to look into the costs of setting up a discrete mental health advocacy service; to require local authorities and health authorities to provide local advocacy plans for the development and funding of independent health advocacy services; to provide independent mental health advocates to meet the reasonable requirements of patients as soon as any statutory procedure with regard to the potential exercise of formal powers in their cases commences; to ensure that independent advocacy is available to all people with a mental disorder; to give the nominated person broadly the same rights and powers as those currently enjoyed by nearest relatives, including ordering the discharge of a patient; to allow patients to appoint an enduring nominated person; to restrict the circumstances in which the Approved Mental Health Professional is able to disqualify a patient's choice of nominated person; and to improve the rights of carers to be consulted unless the patient is expressly opposed to it. It seems very likely that both carers and users will be considerably reassured by this recognition of their legitimate concerns with the draft Bill.

Resources and Professional Roles

The Committee expresses concern at the adequacy of the Regulatory Impact Assessment that has been provided with the draft Bill, and suggests that it be redone, taking into account the various recommendations of the Committee and the likely cost of them, and it makes a recommendation that no new Act be introduced without assurances that the increased work-force requirements in the legislation will be met and, moreover, that the additional requirement will not be met at the expense of other parts of the mental health service, in particular the non-compulsory service. It suggests that the best way to do this is for the Act to be implemented in several stages and it says that it is very important that Approved Mental Health Professionals have the right training to ensure that they are able to carry out their functions satisfactorily.

The Committee accepts that in appropriate cases professionals other than psychiatrists should be able to act as clinical supervisors, and recommends that regulations stipulate the appropriate standards and competencies clinical supervisors will need to demonstrate following training. It invites the Government to reconsider whether clinical supervisors with non-medical backgrounds should be able to prescribe ECT.

The Application of the Bill in Wales and Devolved Issues

The Committee considers that the standard of mental health services in Wales needs to be at least as good as it is now in England before the provisions in the draft Bill could be implemented, and increased resources should be allocated to enable the service to be brought up to English standard.

My Conclusions

1) The system of pre-legislative scrutiny is A Good Thing.

2) The recommendations of the Scrutiny Committee bear a striking resemblance to the proposals and recommendations made to the Department of Health by the Expert Committee in 1999 and by interested parties engaged in the endless consultations since that time. I spoke to Professor Richardson on the 23rd March and she said that reading the Report of the Scrutiny Committee brought on a distinct feeling of 'déjà vu'. If the Department of Health had listened to what has been said to it, repeatedly, over the years, the draft Bill would not have met with such hostility and huge amounts of public money, time and energy would have been saved. Whichever financial watchdog looks into Departmental wastes of money should be looking into this.

3) The Government should seriously consider adopting the Scottish Act; lock, stock and barrel.

4) If the Government does not accept the main recommendations of the Scrutiny Committee, no-one should deceive themselves that there would be any point in engaging in further consultation with the Department of Health.

5) The alliance between users, relatives, carers and professionals that has developed over the last few years to oppose the various attempts at "reform" should be nurtured in the interests of improved patient care and in the interests of improving the status of people with mental health problems.

6) Active attempts to amend and improve the 1983 Act should continue, as problems with resources make it most unlikely that new legislation will be arriving any time soon.

Casenotes

A Private Function

David Hewitt[1]

R (Mersey Care NHS Trust) v Mental Health Review Tribunal; Ian Stuart Brady (First Interested Party) and Secretary of State for the Home Department (Second Interested Party)

Queen's Bench Division (Administrative Court), Beatson J, 22 July 2004

EWHC (Admin) 1749

A MHRT may sit in private even though a patient requests a public hearing and the ECHR presumes in favour of such a course

Introduction

Ian Stuart Brady is a restricted patient, who, having been transferred from prison, is detained at Ashworth Hospital.[2] The Mental Health Review Tribunal ('MHRT') decided that when it next considered his case, it would do so in public. The Trust challenged that decision and ultimately, its challenge was successful.

The Facts

In 2000, Mr Brady had made an unsuccessful attempt to stop Ashworth Hospital force-feeding him when he was on hunger strike.[3] He hadn't previously taken part in MHRT proceedings concerning his case.[4] Now, however, he wished to make public his complaints against the Hospital and his desire to be moved from there.

Mr Brady asked that his next hearing take place in public and the MHRT granted his request. (In the three years to January 2003, no more than one of approximately 600 MHRT hearings at Ashworth Hospital had been in public.[5])

Mersey Care NHS Trust, which is "the managers" of Ashworth Hospital for the purposes of the Mental Health Act 1983 ('MHA 1983'), sought to challenge the Tribunal's decision by way of

1 *Solicitor; Partner in Hempsons dwh@hempsons.co.uk*

2 *MHA 1983, s 47/49*

3 *R v Collins and Ashworth Hospital Authority, ex parte Brady [2000] Lloyds Medical Reports 355*

4 *Judgment, para 2*

5 *Ibid., para 1. On 1 March 2005, Broadmoor Hospital was the venue for a brief, public MHRT hearing in the case of Mahmoud Abu Rideh, who was being held as a suspected international terrorist. The hearing was adjourned pending the conclusion of proceedings concerning Mr Abu Rideh in the Special Immigration Appeals Commission. (See www.guardian.co.uk /guardianpolitics/story/0,,1428266,00.html)*

proceedings for judicial review. Neither the MHRT nor the Home Secretary took any part in the judicial review proceedings.[6]

Ultimately, the matter came before Mr Justice Beatson in the Administrative Court. Mr Brady was refused permission to attend the hearing. Although legal argument took place in public, the factual and medical aspects of the case were heard in private.[7]

The Law

The law relevant to the case consisted of the MHRT rules on public hearings, the general law of contempt, and the right to a fair trial, which is to be found in Article 6 of the European Convention on Human Rights ('ECHR'). The Court also found it necessary to refer to decisions concerning the adequacy of reasons for MHRT decisions.

1. The Tribunal Rules

Under section 78 of MHA 1983, the Lord Chancellor may make rules governing MHRT procedure. In particular, those rules may make provision:

> "(e) for enabling a tribunal to exclude members of the public, or any specified class of members of the public, from any proceedings of the tribunal, or to prohibit the publication of reports of any such proceedings or the names of any persons concerned in such proceedings."[8]

Such provision is made in the Mental Health Review Tribunal Rules 1983,[9] rule 21 of which states:

> "(1) The tribunal shall sit in private unless the patient requests a hearing in public and the tribunal is satisfied that a hearing in public would not be contrary to the interests of the patient.
>
> (2) Where the tribunal refuses a request for a public hearing or directs that a hearing which has begun in public shall continue in private the tribunal shall record its reasons in writing and shall inform the patient of those reasons.
>
> (3) When the tribunal sits in private it may admit to the hearing such persons on such terms and conditions as it considers appropriate.
>
> (4) The tribunal may exclude from any hearing or part of a hearing any person or class of persons, other than a representative of the applicant or of the patient to whom documents would be disclosed in accordance with rule 12(3), and in any case where the tribunal decides to exclude the applicant or the patient or their representatives or a representative of the responsible authority, it shall inform the person excluded of its reasons and record those reasons in writing.
>
> (5) Except in so far as the tribunal may direct, information about proceedings before the tribunal and the names of any persons concerned in the proceedings shall not be made public.
>
> (6) Nothing in this rule shall prevent a member of the Council on Tribunals from attending the proceedings of a tribunal in his capacity as such provided that he takes no part in those proceedings or in the deliberations of the tribunal."

It was rule 21(5) that was to excite most debate in this case.

---

6 Ibid., para 3
7 Ibid., para 4
8 MHA 1983, s 78(2)(e)
9 SI 1983 No 942

2. Contempt of court

A large part of this case turned on the MHRT's understanding of the law of contempt. It is established law that the MHRT is a 'court' within the meaning of the Contempt of Court Act 1981[10] and therefore, that the law of contempt applies to its proceedings.[11] The Court considered contempt in both private and public proceedings.

(a) Contempt in private proceedings

The contempt provisions concerning court hearings in private are set out in section 12 of the Administration of Justice Act 1960, which states:

> "(1) The publication of information relating to proceedings for any court sitting in private shall not of itself be contempt of court except in the following cases, that is to say –
>
> [...]
>
> (b) where the proceedings are brought under [Part VII of the Mental Health Act 1983] or under any provision of that Act authorising an application or reference to be made to a [MHRT] or to a county court ...
>
> [...]
>
> (e) where the court (having power to do so) expressly prohibits the publication of all information relating to the proceedings or of information of the description which is published.
>
> (2) Without prejudice to the foregoing subsection, the publication of the text or a summary of the whole or part of an order made by a court sitting in private shall not of itself be a contempt of court except where the court (having power to do so) expressly prohibits the publication.
>
> (3) In this section references to a court include references to a judge and to a tribunal and to any person exercising functions of a court, a judge or a tribunal; and all references to a court sitting in private include references to a court sitting in camera or in chambers.
>
> (4) Nothing in this section shall be construed as implying any publication is punishable as contempt of court which would not be so punishable apart from this section."

When interpreting section 12, the Court found that even where a case was held in private and the 1960 Act applied, the power to prohibit reporting of the proceedings would not be limitless.[12] Likewise, where a MHRT sat in private, some information about its proceedings might be published,[13] including:

(i) "the fact that a named patient has made an application to the tribunal for his discharge";

(ii) "information as to the date, time or place at which the tribunal hearing had occurred or was to occur";

---

10 Contempt of Court Act 1981, s 19

11 Pickering v Liverpool Daily Post & Echo Newspapers plc [1991] 2 AC 370

12 Judgment, para 13. See: Re S, a Child (identification: restriction on publication) [2003] EWCA Civ 936, per Lord Phillips MR

13 Pickering v Liverpool Daily Post and Echo Newspapers plc, supra

(iii) "the fact that a patient has been released from detention".[14]

(b) Contempt in public proceedings

The law about contempt of *public* proceedings is contained in the Contempt of Court Act 1981. In summary:

(i) One who publishes information about legal proceedings (including MHRT proceedings) conducted in public may be guilty of a criminal offence regardless of his/her intent.[15]

(ii) However, if s/he is to be so guilty, the proceedings in question must be still 'active' at the time of publication[16] and it must create a substantial risk that the course of justice will be seriously impeded or prejudiced.[17]

(iii) A person will not be guilty of contempt of public proceedings if what s/he publishes is a fair and accurate report of legal proceedings held in public, which is published contemporaneously and in good faith.[18]

Furthermore, even though a court may prohibit or restrict publication of information about public proceedings,[19] such a course would have to be justified under ECHR, Article 10.[20]

3. Cases

Article 6 of the ECHR states, in part:

> "1. In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice."

The Court said it was agreed that cases under both domestic law and Article 6 recognise the importance of judicial proceedings being held in public.[21] This is because:

(i) they deter a court from behaving inappropriately;

(ii) they enable the public to know that justice is being administered impartially; and

(iii) they help to ensure that evidence becomes available that would not be so if the case were heard in private.[22]

---

14 *Judgment, para 13. (Hereafter, this information is said to have been rendered disclosable by 'the Pickering conditions'.)*

15 *Contempt of Court Act 1981, s 1*

16 *Ibid., s 2(3)*

17 *Ibid., s 2(2)*

18 *Ibid., s 4(1)*

19 *See, for example, ibid., s 4(2) or s 11*

20 *Judgment, para 12. Article 10 contains the right to freedom of expression.*

21 *Ibid., para 13. See: Schuler-Zgraggen v Switzerland (1994) 16 EHRR 405, para 66; Campbell and Fell v United Kingdom [1985] 7 EHRR 165; Ex parte Guardian Newspapers [1999] 1 WLR 2130, at pp 2144 & 2148; Clibbery v Allan [2002] EWCA Civ 45, Fam 261; Scott v Scott [1913] AC 417, 437*

22 *R v Legal Aid Board, ex parte Kaim Todner [1999] QB 966, per Lord Woolf MR at 976 & 977*

The Court said that under Article 6, a person might be permitted to waive his/her right to a public hearing, but only if to do so would not run counter to the public interest.[23] The cases established that a private hearing might be justified in some circumstances – for example, proceedings relating to minors and MHA 1983 proceedings.[24]

Ultimately, the Court said, the authorities showed that the requirement that justice be done must take precedence over the preference for a public hearing.[25] Furthermore, Article 6 recognised that a public hearing was not required where considerations of security or public order dictated otherwise, or where it would place a disproportionate burden on the state to hold one.[26] In fact, the Court found that Article 6 places a presumption in favour of private hearings where such was necessary in the interests of morals, public order or public security, or where it was required by the interests of juveniles or the protection of *private* life.[27] It would be for those who desired a public hearing to justify it.[28]

4. Tribunal reasons

As for the reasons a MHRT must give for its decision, the Court found that the relevant provisions had been set out by the Court of Appeal in the case of H.[29] In particular, and as the Hospital's counsel had suggested, the Court of Appeal held that:

> "1. Reasons must enable the parties to understand why a decision maker has reached his decision. Both the detained person and members of the public are entitled to adequate reasons.
>
> 2. If there is a conflict of expert evidence, there must be an explanation as to why the evidence of one expert is preferred to another, and the court must 'enter into the issues' canvassed before it.
>
> 3. Reasons should demonstrate the tribunal grappled with the major issues.
>
> 4. There should be no reliance on the argument that a mental health review tribunal decision is addressed to an 'informed audience', to justify, for example, the failure to set out material oral evidence or arguments made during the hearing."[30]

In addition, and as Mr Brady's counsel had suggested, it would seem that in H, the Court of Appeal also held that:[31]

> "5. The adequacy of reasons must be judged by reference to what is demanded by the issues which caused the decision."[32]

And finally, as the Court itself noted:[33]

> "6. The mere recitation of evidence or submissions is no substitute for giving reasons."[34]

---

23 *Schuler-Zgraggen v Switzerland, supra*

24 *R v Legal Aid Board, ex parte Kaim Todner, supra*

25 *Scott v Scott, supra*

26 *Campbell and Fell v United Kingdom, supra*

27 *B and P v United Kingdom (2002) 34 EHRR 529, para 39*

28 *Clibbery v Allan, supra, paras 81–82 & 123*

29 *R (H) v Ashworth Hospital Authority [2003] 1 WLR 127, at paras 76, 70, 74 & 79, respectively*

30 *Judgment, para 75*

31 *R (H) v Ashworth Hospital Authority, supra, per Dyson LJ at para 76*

32 *Judgment, para 76*

33 *Ibid., para 77*

34 *L v Devon County Council [2001] EWHC Admin 958*

Previous Hearings

The MHRT had two opportunities to consider whether Mr Brady's hearing should take place in public. It reached different conclusions on each occasion.

The MHRT first considered the matter at a preliminary hearing. It was argued on Mr Brady's behalf that the presumption in rule 21 in favour of a private MHRT hearing offended against the presumption of open justice and therefore breached section 78 of MHA 1983 and Article 6(1) of the ECHR. The MHRT did not agree, and it found against Mr Brady. Subsequently, he was denied permission to seek judicial review of that decision.

Mr Brady made a further application for a public hearing when the substantive MHRT hearing began on 4 September 2003. This time, the Tribunal found for him.

Mersey Care NHS Trust told the MHRT that Mr Brady did not have the capacity to make a request for a public MHRT hearing, and that such a hearing would be inappropriate in view of its impact, both in its own right and in terms of the publicity it would generate, upon clinical matters and wider security issues. For Mr Brady, it was argued that security considerations were irrelevant as far as the MHRT Rules were concerned, and that in any event, appropriate arrangements could be made in that regard. The MHRT was assured that Mr Brady recognised that by seeking a public hearing he might be waiving his right to medical confidentiality.[35]

The MHRT held that:

1. A hearing must be in private unless the patient requests a public hearing and it is not contrary to his/her interests to hold one.
2. According to the test laid down in *Re C*,[36] it was not satisfied that Mr Brady lacked the capacity to request a public hearing.[37]
3. A public hearing would not be contrary to Mr Brady's interests.

The Court said that this last finding was for two chief reasons. First, that it was possible under rule 21(2) and (4) for a MHRT to open its proceedings in public, then exclude from the hearing everyone save the parties,[38] and finally announce its decision in public once again.

The second reason the MHRT decided to conduct proceedings in public was its belief that it had sufficient powers to control the publication of information about such proceedings. It said that in *Pickering*, the House of Lords had held that the combined effect of rule 21(5) of the MHRT Rules 1983 and section 12 of the Administration of Justice Act 1960 was:

1. That some information about a MHRT hearing may be published: "the fact that the tribunal application has been made by a named patient; the fact that an application or reference to a tribunal will sit, is sitting, or has sat at a certain date time or place; a direction made by a tribunal that the patient be discharged either absolutely or conditionally."[39]

35 Judgment, para 17

36 Re C (adult: refusal of medical treatment) [1994] 1 All ER 819

37 Judgment, para 18

38 In fact, under r 21(4), a MHRT may exclude anyone from the proceedings, save a representative of the applicant or (if different) of the patient.

39 Quoted in Judgment, para 22

2. That some information should not be published: "the recorded reasons for the tribunal's decision to the extent that they disclosed the evidential and other material on which it is based; any conditions imposed by the tribunal."[40]
3. That this applies whether the MHRT hearing is in private or public.
4. That rule 21(5) of the MHRT Rules 1983 enables a tribunal to control the extent to which information is made public, and the rule is "underpinned by the contempt laws".

Mersey Care NHS Trust sought judicial review of the decision to hold a public hearing. In the course of the judicial review proceedings, the Court would be particularly critical of the findings at 3 and 4.

The Decision

The Court found against Mr Brady. It did so under three discrete heads.

1. The power of the MHRT to control publicity

The MHRT believed that if it held a public hearing, it could address the Trust's concerns and also protect Mr Brady's interests. It would do this by: (a) invoking rule 21(4) of the MHRT Rules 1983, and by excluding the public and press from all or part of the hearing; or (b) by using its power under rule 21(5) to direct that information about the proceedings should not be made public. It was the second of these that was contested. The Trust thought the MHRT was irrational or unreasonable to imagine that such a thing was possible.

The Court identified two questions as being relevant under this head:

(a) Did the MHRT think that the *Pickering* conditions applied to a public hearing?

(b) Does rule 21(5) apply to a public hearing, and if so, does it enable the MHRT "to prohibit the publication of evidence and other information revealed at the public hearing and the reasons for the tribunal's decision to the extent that they disclose the evidential and other material on which it is based?"[41]

(a) Contempt of a public hearing

The Court found that the MHRT *did* believe that the *Pickering* conditions applied to a public hearing.[42] This belief was wrong. As the Court noted, in *Pickering*,[43] one of the judges had stated that the protected privacy "attaches to the substance of the matters *which the court has closed its door to consider*."[44] The Court found that the Tribunal's mistaken understanding of *Pickering* had influenced its decision that a public hearing would not be contrary to Mr Brady's interests.

(b) Rule 21 and the public hearing

The Court held that the Tribunal *did* believe that rule 21(5) applied to a public hearing, and that it was right to do so.[45] Therefore, the next question was whether the MHRT had properly understood its powers under the Rules.

40 Ibid.
41 Judgment, para 44
42 Ibid., para 45
43 [1991] 2 AC 371, 413 at 423
44 Judgment, para 46 (original emphasis)
45 Ibid., para 50

For Mr Brady, it was argued that any error as to the ambit of the contempt provisions was irrelevant because, in rule 21(5), the MHRT had sufficient power to control publicity. However, the Court suggested that the Tribunal's error about *Pickering* might be material in this regard too, and it pointed out that that MHRT had declared that its confident pronouncement on the sufficiency of the rule 21(5) power was made "in the knowledge that it is underpinned by the contempt laws."[46] This declaration was to prove significant.

There had been considerable press interest in Mr Brady's next MHRT application, and the Court said it was clear that in opting for a public hearing the Tribunal had been influenced by the belief that it had sufficient power to control the publicity such a hearing might attract. However, the MHRT had misunderstood *Pickering*, and it had also assumed "that Rule 21(5) applies in the same way whether the hearing is public or private". Therefore, the Court concluded:

> "In view of [the Tribunal's] erroneous approach to the decision in [Pickering], and the assumption in [its] decision that Rule 21(5) applies in the same way whether the hearing is public or private, [...] it is not possible to infer that the general reference to the protection of the contempt laws encompassed an assessment by the tribunal of the real difficulties [...] in enforcing any restrictions, or that the tribunal had these difficulties in mind in reaching its decision."[47]

The "real difficulties" referred to had been identified by the Trust's counsel:[48]

(i) In a public hearing, the Contempt of Court Act 1981 would only apply where publicity would create a substantial risk that the administration of justice would be seriously impeded or prejudiced.[49]

(ii) Likewise, for there to be contempt of court, it would be necessary to show that the proceedings were still 'active' at the time of publication.[50]

(iii) Finally, any prohibition on publication would only be lawful if it could be justified under ECHR, Article 10(2).[51]

Because of the MHRT's "general reference to the protection of the contempt laws", the Court felt unable to decide whether it had erred in law or merely failed to take into account relevant considerations as to the exercise of its Rule 21 power. There were two possibilities:

> "If the tribunal assumed that the strict liability contempt rule would give the same protection as the *per se* rule in section 12, it fell into error. If the tribunal did not take into account the difficulties in enforcing any prohibition or restriction as to the publication of information given at a public hearing in concluding that to hold a public hearing was not contrary to Mr Brady's interests, it failed to take account of relevant considerations on a matter which its decision shows was central to its conclusion."[52]

---

46 Ibid., para 52

47 Ibid., para 55. (Of course, the Court also held that the MHRT had been correct in its belief that rule 21(5) applied equally to private and public proceedings; see Note 45, supra.)

48 Ibid, para 53

49 Contempt of Court Act 1981, s 2(2)

50 Ibid., s 2(3)

51 Article 10(2) contains exceptions to the right to freedom of expression, and it provides that the right may be interfered with where the interference is 'proportionate' and, for example, necessary "for the protection of health or morals" or for "the protection of the rights and freedoms of others".

52 Judgment, para 56

There were "analytical differences" between the two courses, but they made no difference to the overall result: the MHRT had acted unlawfully.

2. Failure to consider relevant considerations

The Court found that when considering whether a public hearing would be contrary to the interests of a patient, a MHRT must take into account its powers to prevent or limit publication of information about the proceedings. However, in this case the MHRT had misunderstood those powers and, the Court concluded, "This error affected its assessment of whether holding such a hearing would be contrary to Mr Brady's interests."[53]

Because the MHRT had over-estimated its powers, there were two particular factors to which it had not given proper consideration.

(a) Security, public order and the interests of other patients

The Court found that although the only interests the Rules require the MHRT to consider are those of the patient, it may also take account of wider considerations when considering whether to hold a public hearing.[54]

Even though Rule 21(1) may not *require* a public hearing, the MHRT will still have *discretion* to hold one, and in deciding how to exercise that discretion, the MHRT must take into account "the law and the well-known public law principles of propriety of purpose and relevance", and it must consider such relevant matters as are brought to its attention.[55]

The Judge found support for this approach in the Strasbourg jurisprudence:

(i) In deciding whether to depart from the principle of a public hearing, a MHRT might take account of considerations of public order and security, and whether requiring a public hearing would impose a disproportionate burden on the state.[56]

(ii) The decision whether to depart from a public hearing must be made with regard to the wider public interest.[57]

The Court found that two security concerns were also relevant to the question of whether a public MHRT hearing would be contrary to Mr Brady's interests. They are considered below.[58]

(b) The best interests of the patient

The Court found that in considering whether a public hearing would be contrary to the interests of a patient, a MHRT must consider, not only the patient's immediate and short-term interests but also those in the medium and longer term after the conclusion of the tribunal proceedings.[59]

In addition, the Court said that a MHRT should consider the extent to which a patient understands what it means to request and participate in a public hearing. Whilst the patient's capacity would be relevant to the question of whether his/her request for a public hearing was *validly* made, a finding that s/he was capable in that regard did not necessarily mean that s/he understood the likely *consequences* of the hearing being in public:

---

53 Ibid., para 60

54 Ibid., para 63

55 Ibid.

56 Campbell and Fell v United Kingdom, supra

57 Schuler-Zgraggen v Switzerland, supra

58 See section 2(b)

59 Judgment, para 55

> "The threshold for capacity is [...] low and where concerns as to the nature and extent of a patient's understanding about the likely impact of his request are raised (as they were in this case [...]) they are clearly relevant to the determination of whether a hearing would be contrary to the interests of that patient, a determination which the tribunal is required to make."[60]

In this regard, too, the MHRT had fallen short:

> "In the part of its decision dealing with whether a public hearing would be contrary to Mr Brady's interests, the tribunal makes no reference to the nature and extent of Mr Brady's understanding about the likely impact and ramifications of the hearing being in public or the [Trust's] concerns [about the risk to Mr Brady of such a hearing]. It appears only to have considered Mr Brady's understanding in the context of its determination as to his capacity to make the request for a public hearing."[61]

This aspect of the MHRT's decision is dealt with further, below.[62]

The Court found that the following two security concerns were also relevant to the question of whether a public MHRT hearing would be contrary to Mr Brady's interests:

(i) Mr Brady's own safety at a public hearing (which might in itself justify a departure from the Article 6 presumption in favour of a public hearing[63]).

(ii) The impact on Mr Brady's mental state of the considerable security that would be required if a public hearing were to be held.

Whilst it was possible that the MHRT *had* considered these concerns, and concluded that it *was* possible for suitable arrangements to be put in place, such was not apparent from its decision.[64] Again, the inadequacy of the reasons given by the MHRT for its decision is considered further, below.[65]

3. Inadequate reasons for MHRT decision

The Court found that although they occupied five pages, the reasons given by the MHRT for ordering a public hearing did not meet the standard set by the Court of Appeal in *H*.

First, those reasons did not properly record the Tribunal's findings as to the concerns of Mersey Care NHS Trust about security and the adverse effect of a public hearing upon Mr Brady's mental state:

> "The [Trust's] concerns about security are mentioned in the summary of [its] submissions but are simply not addressed in the tribunal's decision. The tribunal's decision does not enable the [Trust], [...] to understand why its concerns have been set aside or what security arrangements the tribunal envisages. It does not display that it has 'grappled' with the issue, which, in view of Mr Brady's profile, is a serious and substantial one."[66]

---

60 Ibid., para 66

61 Ibid., para 67

62 See section 3

63 Campbell and Fell v United Kingdom, supra, at paras 86–88

64 Judgment, para 72

65 See section 3

66 Judgment, para 77

Second, the reasons did not properly record its conclusion as to whether the level of Mr Brady's capacity was such that a public hearing would be contrary to his interests. The Tribunal should have considered, "the nature and extent of his understanding about the likely impact and ramifications of the hearing being in public:"[67]

There were two further possibilities:

(a) That the MHRT had rejected the evidence, given on behalf of Mersey Care NHS Trust, that because of Mr Brady's previous "aversion to publicity", a public hearing would have such an adverse impact on his clinical condition that it must be judged contrary to his interests. However, the Court said, such a finding "is not discernible from the decision."[68]

(b) That the MHRT had preferred the written evidence provided by a psychiatrist instructed on behalf of Mr Brady. However, the MHRT had pronounced this evidence to be "of limited assistance". Although Mr Brady's RMO was hampered by the fact that his patient would not discuss matters with him, he had had "long involvement" with Mr Brady's treatment, "particular weight should be given to his views",[69] and when those views were rejected, "there is a particular need for reasons to be given."[70]

However, the Court found that the MHRT *had* given adequate reasons for its conclusions as to Mr Brady's capacity and, in particular, the conclusion that he possessed sufficient of it to request a public hearing. In fact, the only evidence as to Mr Brady's capacity to *request* a public hearing – as distinct from his capacity to understand its possible *implications* – was in a report from his RMO that had been prepared for the MHRT. In this report the RMO stated,

> "that, as Mr Brady had refused to discuss his reasons for wanting a public hearing with him, he was unable to comment on his motivation and its possible relationship to his disorders with any certainty."[71]

Then, citing the opinion of a colleague that was referred to in the judgment of Maurice Kay J in Mr Brady's force-feeding case,[72] the RMO said, "Mr Brady did not have capacity in relation to his decision to refuse food and I am concerned that this may still be the case."[73]

The High Court said this statement was "the high point of the evidence as to lack of capacity".[74] There had been no oral evidence on the question of Mr Brady's capacity to request a public hearing, and the Trust had placed "significant reliance" on the decision in the force-feeding case, which had been "on a different issue four years ago".[75] Notwithstanding that evidence, the MHRT had concluded that it was not satisfied that Mr Brady's thinking was "so dominated that the decision to make the request [for a public hearing] was not a true one". This conclusion, the High Court said,

> "addresses the issue raised by the RMO as to whether Mr Brady gives proper regard to the risks which he runs and enables the [Trust] to understand why the decision was reached."[76]

---

67 Ibid., para 78

68 Ibid.

69 Here, the Court cited R (N) v Dr M [2003] 1 WLR 562, para 39.

70 Judgment, para 78

71 Ibid., para 80

72 R v Collins & Ashworth Hospital Authority, ex parte Brady, supra, at para 35

73 Judgment, para 80

74 Ibid., para 81

75 Ibid.

76 Ibid.

The (limited) evidence before the MHRT enabled it to demonstrate that it had "grappled" with this issue, even if it had done so succinctly.[77]

Conclusion

Accordingly, the Court found that the MHRT decision of 4 September 2003 was flawed. It ordered that the decision be set aside and the matter remitted to the MHRT for re-hearing.

Comment

The judgment of Beatson J is not always easy to follow. Some of its key conclusions are founded on inferences that are more apparent (at least to the learned Judge) than real, and the shifting sands of its logic always threaten to engulf the unwitting reader.

To some eyes, the judgment might seem to accord rather too much weight to the Tribunal's apparent misunderstanding of the *Pickering* case, and rather too little to the ambit of rule 21(5) and its impact upon the MHRT.

The Court believed the MHRT had concluded that there was a direct link between rule 21(5) and the contempt provisions exemplified by *Pickering*. However, any such belief is surely a creature of inference, not of hard evidence. There is a three-fold possibility that the Court seems to have been unwilling to countenance: that rule 21(5) gives the MHRT all the power it requires in public proceedings; that in consequence, the MHRT need have no recourse to the general laws of contempt; and that the MHRT knew this. The Court was prepared to infer that the MHRT believed its rule 21(5) power to be derived from *Pickering* merely because there was no evidence to the contrary. That may not have been an appropriate course to take.

There was one inference, however, that the Court was not prepared to draw. It declared itself unsatisfied that the MHRT had taken full account of the difficulties it might face in enforcing restrictions on publication. The Court made this declaration because, it said, the Tribunal had assumed "that rule 21(5) applies in the same way whether the hearing is public or private". However, closer inspection of the Tribunal's reasons reveals that this assumption was based upon an assessment of the *combined* effect of rule 21(5) and section 12 of the Administration of Justice Act 1960 (as the Tribunal believed it to have been summarised in *Pickering*). While it may be the case that the contempt provisions do not apply to a public hearing, that – as the Court's own judgment in this makes clear – is not so of rule 21(5). Of the MHRT Rules it assuredly *can* be said that they apply in the same way whether the Tribunal hearing is public or private. Therefore, it might be argued, the Court should not have allowed the passage upon which it alighted to cast doubt upon the Tribunal's assessment of its powers.[78]

There are other key questions about the Court's approach to this case. Was it right to distinguish between the capacity to *request* a public hearing and that required to understand its *implications*? Further, having decided that Mr Brady had sufficient capacity for the first task, was the Court justified in refusing to find that he possessed it for the second? Was the Court correct to impose a capacity test of any kind? The 'c' word is not mentioned in rule 21. Surely the issue is dealt with

77 Ibid.

78 Compare paras 22 & 24 of the Judgment with para 72 of the Judgment

when the MHRT determines the patient's 'best interests': the lower his/her level of capacity the more likely it is that the Tribunal will contradict him/her in that regard.

And there is a further point that might cause concern. When finding that the MHRT had given sufficient reasons for its decision on the first capacity question, the Court said it had rightly considered, "whether Mr Brady gives proper regard to the risks which he runs." But aren't the 'risks' Mr Brady 'runs' properly part of the second capacity question? He could hardly be 'running' a 'risk' merely by *requesting* a public hearing (unless, perhaps, things have come to such a pass within the MHRT secretariat that its response is likely to be a physical one). Having insisted on two discrete capacity questions, did not the Court hopelessly confuse the two?

This decision provides a further illustration of the relative weakness of some parts of the European Convention on Human Rights. It would appear that the force of Article 6 is diminished by the jurisprudence it has spawned. Its preference for a 'public hearing' is clearly no more than that, and the Article itself is far from the statement of unwavering principle that some have supposed it.

Mr Brady has not enjoyed good fortune when challenging the organs of the state. He failed to stop Ashworth Hospital force-feeding him and now he has failed to compel the MHRT to hear his case in public. A common theme of both cases is, of course, Mr Brady's intellectual capacity. However much of it he is shown to have, it never seems to be enough. His force-feeding was lawful under the common law doctrine of 'necessity' because, although he was perfectly capable in most every other facet of his life, Maurice Kay J felt he was not so in relation to decisions about food refusal. Now, his acknowledged capacity to request a public hearing has been held not to imply that he is capable of understanding the implications of such a course. The Court has shown itself willing to make an inference against Mr Brady from the mere absence of information to support him.

In Mr Brady the State has indeed been fortunate in its choice of adversary, for, despite the merit his claims have sometimes seemed to have, and despite the skill and tenacity with which they have usually been pursued, its judges have always been able to find sufficient – and sufficiently *legal* – reasons to deny him what he wants, and to do so, moreover, for his own good.

Book review

Mental Health Act Manual by Richard Jones (9th edition)

Published by Sweet and Maxwell (2004) £59.00

A new edition of the Mental Health Act Manual is always an event. Richard Jones has long been treated as *the* authority in the field of mental health law; indeed, some mental health professionals need convincing that Jones's commentary does not embody the law (the "Jones says" phenomenon, noted before in these pages[1]). Fortunately Jones's views are always well-argued: his interpretation is usually based upon both a thorough knowledge of what the settled law says and, where it is not settled, fierce opinions on what it ought to be. (I return to Jones's opinions later in this review.)

So what is new in the 9th edition? The mixture is much as before: the focus is on the text of the 1983 Act, with a detailed commentary on how it has been interpreted in the decided cases, the 1983 Tribunal Rules and commentary, the Human Rights Act 1998 and commentary, and the Code of Practice, which carries no commentary as such but occasional 'general notes' (which frequently dissent from the guidance given). As far as I can see, every important case since the last edition[2] has been included, and a large number that I have not encountered before. I am particularly grateful for the excellent updating of the commentary on Part III sentencing, where the caselaw is harder to track down. What is more, having for once read through the whole Manual (albeit at a gallop) I am left awestruck at the clarity of the materials: how Jones manages each time to reduce such complexity of detail to a book which can be so readily understood, without complete mental collapse, is nothing less than astonishing.

I welcome the four annexes which deal with specific contentious issues – medical treatment under common law, medical treatment of children, further powers to restrain and/or detain patients and the legal protection of mentally incapable adults – which have helpfully been extracted from their former positions in the general text. This approach could perhaps be extended to other key parts of the Manual where the 'general notes' have got out of hand: section 3, for example, occupies 3/4 page of text, while the commentary runs to 13 1/2 pages.

1 *See the review of the 7th edition of the Manual by Anthony Harbour and Robert Brown at pp 81 - 84 JMHL Feb. 2002*

2 *8th edition, published by Sweet and Maxwell (2003)*

It is a pity that this edition went to press before the European Court of Human Rights delivered its long-delayed judgment in the 'Bournewood' case (*HL v United Kingdom*, October 2004[3]). Jones's summary of the position at common law and its interaction with the European Convention is in fact largely borne out by how the European Court subsequently viewed the case. Health professionals struggling to implement the recent Department of Health guidance[4] that people should not be admitted informally 'in circumstances amounting to a deprivation of liberty' would, I am sure, now welcome an authoritative review of the vexed question of when, exactly, someone is 'detained', given the conflicting caselaw[5]. Is it possible to reconcile these authorities with the recent 'discharge to hospital' cases such as *R (Secretary of State for the Home Department) v Mental Health Review Tribunal*[6], *R (G) v MHRT & Secretary of State for the Home Department*[7], *R (Secretary of State for the Home department) v MHRT*[8]? I think we should be told – and I can imagine no-one better than Jones at the telling.

So the Manual is as wonderful and definitive as ever. And yet, I am left with two nagging questions: what is the purpose of the Manual, and who is it written for? With regard to the first question, the obvious answer is that it is primarily a working handbook for professionals in the field. But not all the material is equally accessible. Who, for example, is the target readership of the lengthy and ever-expanding section on the Human Rights Act? It makes fascinating reading for academics and policy-makers, and is doubtless invaluable for counsel preparing an appeal, but is unlikely to be of much use to busy professionals seeking to uphold Convention rights in their everyday practice.

The Manual is long and getting longer (and of course more expensive); in my view the space would be better used if Jones could, for example, reinstate the key pieces of Government guidance, which at one time were included in full but which remain banished to summary notes in the general commentary. It is hard for health professionals, let alone lawyers, to keep up with what guidance is currently in force. If it is apparently possible to include in full the 1995 guidance on supervised discharge, which remains little-used, could we please have the text – or extracts from it – of the key documents on mentally disordered offenders, unfitness to plead, confidentiality, etc.? Jones would be doing us all a great service by restoring this section of the Manual.

I am more troubled by the second question. Veteran Jones-watchers have long been aware that the Manual tends to be written largely with mental health professionals in mind, and this is clearly reflected in the passages in which Jones sets out his personal views. There is nothing wrong with him giving his opinions – he knows the law as thoroughly as anyone and has great clarity of thought (though it would be helpful if he could differentiate more clearly between passages summarising the law and his occasional pieces of kite-flying). The problem is, rather, with the areas in which he chooses to express a dissenting view: these are almost always where it appears that current practice places the statutory authorities at a disadvantage. In the matter of charging for s.117 services, for example, Jones continues to grumble about unfairness years after the matter has been decided definitively by the House of Lords[9] (see page 430 of this edition).

3 *Application no. 45508/99*

4 *10th December 2004*

5 *Compare the majority decision of the House of Lords in R v Bournewood Community and Mental Health NHS Trust ex parte L [1999] 1 AC 458, following Ashingdane v UK (1979) 2 EHRR 387, with HL v UK and earlier cases such as Murray v Ministry of Defence [1988] 2 All ER 521.*

6 *[2002] EWCA Civ 1868*

7 *[2004] EWHC 2193 (Admin)*

8 *[2004] EWHC 2194 (Admin)*

This does not mean that Jones is usually wrong: on the contrary, his concerns are frequently vindicated by the courts. For example, one of his familiar themes concerns the duty to consult the nearest relative 'unless it appears (to the ASW) that in the circumstances such consultation is not reasonably practicable...' (s.11(4) MHA). Is the ASW permitted not to consult the nearest relative if he or she is believed to have been harmful to the patient, or where the patient has severed all links with him or her? The Code of Practice states at paragraph 2.16: "Practicability refers to the availability of the nearest relative and not to the appropriateness of informing or consulting the person concerned." Jones takes a characteristically robust line over this guidance. It is "both incorrect and inconsistent with the requirements of the European Convention of Human Rights" (page 81, bottom). "Approved social workers should therefore be advised not to interpret this provision in the manner advocated by the Code of Practice and the Mental Health Act Commission" (page 83, top). As we now know, the courts have finally confirmed the correctness of this approach: see *R (E) v Bristol City Council*[10].

My concern is, rather, that there are a number of examples in the Manual of decisions which would appear to undermine the patient's rights, upon which Jones makes no comment. Take for example the practice of displacing a nearest relative by interim order, without notice, following *R v Central London County Court ex parte London*[11]: there is apparently a growing practice of displacing without notice and without providing a return date, putting the nearest relative to the effort of having to make an application in order to assert his or her statutory rights. I once raised concerns about this practice with the county court concerned but was told that it was perfectly lawful under the County Courts Act 1984. The court rather missed the point: surely there is a problem of principle here? If so, Jones says nothing about it. Or take the extension of a section 2 detention pending displacement under s.29(4) MHA. At the time of this edition Jones had access to the first instance judgment in MH[12] which dismissed the claim under Article 5(4), but again, although he provides a detailed summary of Silber J's key points, he makes no comment on them, despite the manifest unfairness which was later picked up by the Court of Appeal[13].

The most worrying expression of opinion occurs in the preface. Jones complains about "unnecessary" Managers' hearings, which he says "must be confusing to patients", and states that "NHS and independent hospitals should review their protocols to ensure that Managers' hearings are only convened when there is a legal requirement to do so." He gives further advice on the convening of Managers' hearings in his general note to paragraph 23.9 of the Code of Practice: "A Managers' hearing should not take place during the currency of the section if the patient has made a concurrent application to a Mental Health Review Tribunal" (page 725).

Jones surely exceeds his brief here. Managers' hearings are not of course statutory, but part of their general duty of care towards their patients: as paragraph 23.7 of the Code makes clear, Managers may conduct a review of detention at any time at their discretion. Those representing detained patients are perfectly entitled to ask for a hearing in order to test the case for detention, even if a tribunal hearing is imminent; the Managers can always refuse such a request, having carried out a paper review of the position (see paragraph 23.9). Jones is of course entitled to be

9 *R v Manchester City Council ex p. Stennett [2002] UKHL 34*

10 *[2005] EWHC 74 (Admin)*

11 *[1999] 3 All ER 991*

12 *R (on the application of MH) v Sec. of State for Health and MHRT [2004] EWHC 56 (Admin)*

13 *R (on the application of MH) v Sec. of State for Health [2004] EWCA Civ 1690*

concerned about the potential waste of clinician time; but the Mental Health Act Manual is surely not the right place for him to give advice on how patients' rights may be restricted?

I do not want to make too much of these concerns. The Manual remains an invaluable resource for patients and their lawyers. But I – and no doubt many other people – would be saddened if Jones continued down the track about which I have expressed concerns above. The danger would be that the Manual would then become in effect an advice handbook for the detaining authority, and not – as now – the definitive text for everyone in the field.

Simon Foster

Solicitor; Independent Legal Consultant; formerly Principal Solicitor, Mind (London)